JOHN ALDEN LIFE INSURANCE COMPANY
501 West Michigan
Milwaukee, WI 53203
A Stock Company

SHORT TERM MEDICAL CERTIFICATE

THIS CERTIFICATE IS NOT RENEWABLE

John Alden Life Insurance Company has issued a group policy to a trustee to insure You and Your Covered Dependents as shown in the Benefit Summary. This certificate describes the coverage available under the group policy. You may review the group policy during normal business hours at Our office.

RIGHT TO EXAMINE CERTIFICATE FOR 10 DAYS: If You are not satisfied, return the certificate to Us or Our agent within 10 days after You have received it. All premiums will be refunded and Your coverage will be void.

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR ENROLLMENT FORM FOR INSURANCE

Please read the copy of the enrollment form included with Your certificate. Omissions or misstatements in the enrollment form can cause an otherwise valid claim to be denied or coverage to be rescinded. Carefully check the enrollment form and, if any information shown in the enrollment form is not correct and complete, write to John Alden Life Insurance Company, at the address above, within 10 days. The enrollment form is part of the insurance contract. Your coverage was issued on the basis that the answers to all questions and any other material information shown in the enrollment form are correct and complete. No agent or employee of John Alden Life Insurance Company, other than an executive officer, has the authority to waive any of the requirements within the enrollment form or waive any of the provisions of the plan.

Executed by John Alden Life Insurance Company on the Effective Date.

Secretary

President

- READ YOUR CERTIFICATE CAREFULLY -

NO RECOVERY FOR PRE-EXISTING CONDITIONS: No benefits will be provided during the term of this certificate for any Pre-Existing Condition as defined in Your certificate.

THIS CERTIFICATE CONTAINS AN AUTHORIZATION PROVISION

READ YOUR CERTIFICATE CAREFULLY

I. DEFINITIONS

The capitalized terms used in this certificate are defined below.

BENEFIT PERIOD: The length of time this certificate is in force, as shown in the Benefit Summary. The Benefit Summary shows the maximum Benefit Period that You are covered under this certificate. This certificate is not renewable.

COPAYMENT: A Copayment only applies if it is shown in Your Benefit Summary. The Benefit Summary will identify what the applicable Copayments are along with the Covered Expenses to which they apply.

A Copayment is the dollar amount You pay each time You receive a Covered Expense. The Copayment amounts apply separately to each Insured during a Benefit Period, except as otherwise provided by this certificate. These amounts will not count toward satisfying any Deductible or Out–of–Pocket Limit. More than one Copayment may need to be satisfied before benefits are payable for certain Covered Expenses.

We may waive a Copayment that applies to certain Covered Expenses if You receive care in a different setting or at a different level. For example, a separate Copayment that might apply to an Emergency room visit in a Hospital would be waived if You were admitted for an inpatient stay immediately following the Emergency room visit. Any Copayment amounts that might be waived, and the circumstances under which they would be waived, are shown in the Benefit Summary.

COVERED DEPENDENT: If the Primary Insured has a Single Plan, as shown in the Benefit Summary, on the Effective Date of his or her certificate, a Covered Dependent cannot be added after the Primary Insured's Effective Date. If the Primary Insured has a Family Plan, as shown in the Benefit Summary, on the Effective Date of his or her certificate, only a newborn or newly adopted child can be added as a Covered Dependent after the Primary Insured's Effective Date subject to the requirements below.

In order to be considered a Covered Dependent, a person must be listed as an Additional Insured in the Benefit Summary on the Primary Insured's Effective Date of this certificate. A Covered Dependent is the Primary Insured's lawful spouse; or unmarried, dependent child who is age 18 or less and either a natural child, a child legally adopted or placed for adoption, or a stepchild. If an unmarried child is age 19 or older, the child may be considered to be a Covered Dependent if We receive proof that the child:

1. Meets the standards for a full–time student at an accredited educational institution. The student will be considered a Covered Dependent until the student is no longer a full–time student, graduates, attains age 25, or marries, whichever occurs first; or
2. Is not capable of self–sustaining employment because of mental incapacity or physical handicap and the child is chiefly dependent on You for financial support. You must give Us this proof no later than 31 days after the child has reached the normal age for termination. Additional proof may be requested periodically.

The Primary Insured's newborn child will be covered from the moment of birth only if the pregnancy is found by a Health Care Practitioner to have begun after the Primary Insured's Effective Date and the Primary Insured had a Family Plan on his or her Effective Date. You must send Us written notice of the birth of a child and We must receive any required additional premium within 31 days of birth. If these requirements are not met, Your newborn child will be covered for Sickness or Injury, including the necessary care and treatment of medically diagnosed congenital defects, only for the first 31 days from birth or until the Benefit Period ends, whichever comes first.

A newly adopted child can be added as a Covered Dependent from the moment of adoption or placement for adoption in the Primary Insured's residence only if the Primary Insured had a Family Plan on his or her Effective Date. You must send Us written notice of the adoption or placement for adoption of the child and We must receive any required additional premium within 31 days of the adoption or placement for adoption. If these requirements are not met, Your adopted child will be covered for Sickness or Injury only for the first 31 days from adoption or placement for adoption or until the Benefit Period ends, whichever comes first.

COVERED EXPENSE: An allowable charge that is covered by this certificate and We determine is:

1. Incurred for services, treatment or supplies prescribed by a Health Care Practitioner; and
2. Incurred for Medically Necessary care; and
3. Incurred by an Insured while this certificate is in force as the result of a Sickness or an Injury. Benefits are available from the first day Covered Expenses are incurred for an Injury that is sustained on or after the Effective Date of Your coverage. Benefits are available for a Sickness that first manifests itself after the Waiting Period, as shown in the Benefit Summary. A Sickness manifests itself if You receive medical treatment or consultation for it or have signs or symptoms of it.

Covered Expense is incurred on the date the service is received or rendered. Covered Expense does not include any charge in excess of the Reasonable and Customary Amount.

CUSTODIAL CARE: Care that can be performed by persons without professional medical training and that is primarily for the purpose of meeting the personal needs of the patient, including feeding and personal hygiene. Custodial Care:

1. Does not contribute substantially to the improvement of a medical condition according to accepted medical standards; and
2. Is provided primarily to assist with daily living activities; and
3. Is supportive or primarily for the purpose of providing companionship or ensuring saftey.

DEDUCTIBLE: The amount of Covered Expense that is the financial responsibility of an Insured before benefits are paid. The Deductible amounts apply separately to each Insured during a Benefit Period, except as otherwise provided by this certificate. These amounts will not count toward satisfying any Out–of–Pocket Limit. More than one Deductible may need to be satisfied before certain Covered Expenses are received. Any applicable Deductible amounts and Covered Expenses to which they apply are shown in the Benefit Summary. If indicated in the Benefit Summary, Deductibles may apply to specified periods other than the Benefit Period for this plan.

We may waive a Deductible that applies to certain Covered Expenses if You receive care in a different setting or at a different level. For example, a separate Deductible that might apply to an Emergency room visit in a Hospital would be waived if You were admitted for an inpatient stay immediately following the Emergency room visit. Any Deductible amounts that might be waived, and the circumstances under which they would be waived, are shown in the Benefit Summary.

EFFECTIVE DATE: The day on which Your coverage begins, as shown in the Benefit Summary. The Effective Date is the later of:

1. The day after the date the enrollment form is signed; or
2. The date You request on the enrollment form provided this is no more than 30 days in the future from the date We receive the enrollment form; or
3. The day after the postmark date affixed by the U.S. Postal Service on the envelope containing the enrollment form; or
4. The day after the date the enrollment form is received by Us when it is sent by electronic submission, express mail or means other than the U.S. Postal Service; or
5. The date Your enrollment form is approved for coverage by Us.

In no event will the Effective Date occur earlier than one day after the enrollment form is completed.

If the envelope containing Your enrollment form is not postmarked by the U.S. Postal Service or if the postmark is not legible, the Effective Date will be the later of:

1. The date the enrollment form is received by Us through the mail; or
2. The date You requested on Your enrollment form, provided this is no more than 30 days in the future from the date We receive the enrollment form; or

3. The date the enrollment form is received by Us when it is postmarked by a private postal meter; or

4. The date Your enrollment form is approved for coverage by Us.

All the following conditions must be met for Your coverage to become effective:

1. Your enrollment form and full premium payment are received by Us. Note: If sent through the mail, We must receive the original postmarked envelope in which the enrollment form was mailed to Our agent; and

2. Your answers on the enrollment form are complete and meet Our requirements for acceptance.

EMERGENCY: A life threatening medical condition resulting from Sickness or Injury that arises suddenly and requires immediate care to prevent permanent disability or jeopardy to life.

EXPERIMENTAL OR INVESTIGATIONAL TREATMENT: Treatment that, at the time the charges were incurred, We determine was:

1. Not proven to be of benefit for the diagnosis or treatment of the Sickness or Injury; or

2. Not generally used or recognized by the United States medical community as safe, effective, or appropriate for the Sickness or Injury; or

3. In the research or investigational stage; or

4. Not generally accepted throughout the United States as We determine by reference to English language peer review literature, consultation with physicians, authoritative medical compendia, the American Medical Association, and other pertinent professional medical organizations or governmental agencies.

FAMILY DEDUCTIBLE: When the Family Deductible amount is reached, We will consider the Deductible requirements for all Insureds in Your family to be satisfied for the remainder of the Benefit Period. The Family Deductible amount is shown in the Benefit Summary.

FREE-STANDING AMBULATORY SURGICAL FACILITY: A licensed facility that has at least:

1. Two operating rooms; and

2. A recovery room; and

3. Equipment for Emergency care.

HEALTH CARE PRACTITIONER: A person licensed by the state in which the Covered Expense is rendered to treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed. A Health Care Practitioner does not include a member of the Insured's Immediate Family.

HOSPITAL: A state–licensed facility that:

1. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and

2. Provides facilities for medical, diagnostic and acute care on an inpatient basis. If these services are not on its own premises, they must be available through a prearranged contract; and

3. Provides 24–hour nursing care supervised by professional registered nurses (RN's); and

4. Has x–ray and lab facilities either on its own premises or available through a prearranged contract; and

5. Charges for the services performed.

A special ward, floor or other accommodation used primarily for Custodial Care, convalescent, nursing or rehabilitation purposes is not considered a Hospital.

IMMEDIATE FAMILY: You, Your spouse, and the children, brothers, sisters and parents of either You or Your spouse; or anyone with whom You have a relationship based on a legal guardianship.

INJURY: Accidental bodily damage, independent of all other causes, occurring unexpectedly and unintentionally.

INSURED: Any person named as an Insured, as shown in the Benefit Summary.

LIFETIME MAXIMUM BENEFIT: The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Expenses incurred by an Insured while covered under this certificate and under any other plan We have issued over the lifetime of that Insured. When an Insured has been paid the Lifetime Maximum Benefit, coverage will end and no other benefits are payable.

MEDICALLY NECESSARY/MEDICAL NECESSITY: Confinement, treatment or service that is rendered to diagnose or treat a Sickness or an Injury. Medical Necessity is determined by Us and does not include care that is prescribed or provided on the recommendation of a member of the Insured's Immediate Family. We must determine that such care:

1. Is appropriate and consistent with the diagnosis and does not exceed (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis and treatment of the Sickness or Injury; and
2. Is commonly accepted as proper care or treatment of the condition in accordance with United States medical practice and federal government guidelines; and
3. Can reasonably be expected to contribute substantially to the improvement of a condition resulting from a Sickness or an Injury; and
4. Is not Experimental or Investigational Treatment; and
5. Is provided in the least intensive setting without adversely affecting the condition or the quality of medical care provided; and
6. Is not primarily for the convenience of You, Your family, Your Health Care Practitioner, or provider.

The fact that a Health Care Practitioner may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

MEDICARE: The Health Insurance for the Aged Act, Title XVIII of the Social Security Act as amended.

MENTAL ILLNESS: All conditions classified as mental disorders as shown in the International Classification of Diseases (ICD).

OUT-OF-POCKET LIMIT: The sum of the Covered Expenses for which We do not pay benefits during a Benefit Period because of the Rate of Payment. The Rate of Payment will be increased to 100% when the Individual Out–of–Pocket Limit, as shown in the Benefit Summary, is satisfied. The Out–of–Pocket Limit applies separately to each Insured during a Benefit Period, except as otherwise provided by this certificate. We will consider each Insured's Individual Out–of–Pocket Limit to be satisfied during a Benefit Period when the total amount of Covered Expenses applied to the Individual Out–of–Pocket Limit, for all family members covered under the same Family Plan, equals the maximum Family Out–of–Pocket Limit, as shown in the Benefit Summary.

The following do not count toward satisfying the Out–of–Pocket Limit: any Deductible; any Copayment; any penalty applied under the Authorization Provisions section; and any amount in excess of the Reasonable and Customary Amount.

PHYSICAL MEDICINE: The treatment of physical conditions relating to bone, muscle or neuromuscular pathology.

PRE-EXISTING CONDITION: A medical condition due to Sickness or Injury:

1. For which the Insured received medical treatment or advice from a provider within the 12–month period immediately preceding the Effective Date of coverage, regardless of whether the condition was diagnosed or not diagnosed; or
2. That produced signs or symptoms within the 12–month period immediately preceding the Effective Date of coverage.

The signs or symptoms must have been significant enough to establish manifestation or onset by one of the following tests:

a. The signs or symptoms would have allowed one learned in medicine to make a diagnosis of the disorder; or
b. The signs or symptoms should have caused an ordinarily prudent person to seek diagnosis or treatment.

A pregnancy that exists on the day before Your Effective Date will be considered a Pre–Existing Condition.

RATE OF PAYMENT: The amount We will pay for Covered Expense after Your portion is paid by You. Any applicable Copayment and/or Deductible must be satisfied by You before We will pay the Rate of Payment. You are also responsible for any coinsurance balance. The Rate of Payment, as shown in the Benefit Summary, applies separately to each Insured during a Benefit Period. It applies to all Covered Expense unless otherwise noted in this certificate or a rider to this certificate. The payment of Covered Expense is subject to the Lifetime Maximum Benefit or any other maximum benefit for those services under the certificate, whichever is less.

REASONABLE AND CUSTOMARY AMOUNT: The lesser of:

1. The actual charge; or
2. What the provider would accept for the same service or supply in the absence of insurance; or
3. The reasonable amount as determined by Us, based on one or more factors such as:
   a. The amount of resources expended to deliver the service or supply; or
   b. The amount charged for the same or comparable service or supply in a community similar to where the service or supply is furnished; or
   c. The costs incurred by providers in a community similar to where the service or supply is furnished and the amount by which the service or supply is commonly marked up by providers; or
   d. Charging protocols and billing practices generally accepted by the medical community or specialty groups, including charging protocols and billing practices related to Medicare; or
   e. Inflation trends by geographic region; or
4. Another schedule or method of deriving charges, as identified in the Benefit Summary.

SICKNESS: Disease or illness of an Insured, including complications of pregnancy.

SKILLED NURSING FACILITY: A nursing home, licensed as a Skilled Nursing Facility, operating in accordance with the laws of the state in which it is located and meeting all of the following requirements:

1. Is primarily engaged in providing room, board and skilled nursing care for persons recovering from Sickness or Injury; and
2. Provides 24–hour a day skilled nursing service under the full–time supervision of a physician or graduate registered nurse; and
3. Maintains daily clinical records; and
4. Has transfer arrangements with a Hospital; and
5. Has a utilization review plan in effect; and
6. Is not a place for rest, the aged, drug addicts, alcoholics or the mentally ill; and
7. May be a part of a Hospital.

SUBSTANCE ABUSE: Abuse of, addiction to, or dependence on drugs, chemicals or alcohol.

TOTAL DISABILITY/TOTALLY DISABLED: You or Your covered spouse are unable to perform the duties of any occupation for which reasonably fitted by education, training or experience, whether performed for financial gain or not. Retired individuals and homemakers shall not be considered unable to perform an occupation soley because they are unemployed. A Covered Dependent child, who is insured under this certificate, is Totally Disabled if confined as a patient in a Hospital.

WAITING PERIOD: A Waiting Period for Sickness only applies if it is shown in Your Benefit Summary. A Waiting Period is the period of time that must pass before an Insured is eligible to be covered for Sickness under the terms of this plan. The Waiting Period applies separately to each Insured during a Benefit Period, except as otherwise provided by this certificate. Benefits are available from the first day Covered Expenses are incurred for an Injury that is sustained on or after the Effective Date of Your coverage.

WE, US, OURS: John Alden Life Insurance Company or its administrator.

YOU, YOUR, YOURS: Any person named as an Insured, as shown in the Benefit Summary.

II. BENEFITS

After You have paid any Deductible and/or Copayment, We will pay benefits for Covered Expenses at the Rate of Payment up to the Out–of–Pocket Limit and subject to the Lifetime Maximum Benefit or any other maximum benefit for those services under the certificate, whichever is less, for each Insured during a Benefit Period. Any applicable Deductibles and/or Copayments and the Covered Expenses to which they apply are shown in the Benefit Summary. Benefits are subject to all the terms, limits and conditions in this certificate. Only the services and supplies listed in this certificate will be considered Covered Expenses. Your certificate provides benefits for the following Covered Expenses:

1. **Inpatient Hospital Services:** Covered Expenses for room, board and routine nursing services that are provided to all inpatients while confined in a semi–private room, ward, coronary care or other intensive care unit in a Hospital. The maximum benefit for Covered Expenses for inpatient Hospital services is shown in the Benefit Summary. For confinement in a private room, the Covered Expense is limited to the Hospital's most common daily charge for a semi–private room. Inpatient confinements must be authorized by Us. See the Authorization Provisions section for further direction.

2. **Outpatient Hospital Services:** Covered Expenses for services performed in a Hospital's outpatient department or in a Free–Standing Ambulatory Surgical Facility. The maximum benefit for Covered Expenses for outpatient Hospital services is shown in the Benefit Summary. Oupatient services and day surgeries must be authorized by Us. See the Authorization Provisions section for further direction.

3. **Health Care Practitioner Services, Surgical and Anesthesia Services:** Covered Expenses for surgical services, anesthesia services and Health Care Practitioner services (not including office visits) are provided up to the maximum benefit shown in the Benefit Summary. The maximum benefit for Covered Expenses for office visits to a Health Care Practitioner is shown separately in the Benefit Summary. Inpatient and outpatient surgeries must be authorized by Us. See the Authorization Provisions section for further direction. Covered Expenses do not include services rendered by members of Your Immediate Family or an employer.

4. **Reconstructive Surgery:** Covered Expenses for reconstructive surgery are for:

   a. Surgery to restore function for conditions resulting from accidental Injury provided the Injury occurred while the Insured is covered under the certificate; and

   b. Surgery that is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part if the trauma, infection or other diseases occurred or had their onset while the Insured was covered under this certificate; and

   c. Surgery because of congenital illness or anomaly of a Covered Dependent child, born while this certificate is in force, that resulted in a functional defect.

   The maximum benefit for Covered Expenses for reconstructive surgery is shown in the Benefit Summary.

5. **Inpatient Rehabilitation Programs:** Covered Expenses in an inpatient rehabilitation program must be:

   a. Ordered by a Health Care Practitioner; and
   b. Medically Necessary; and
   c. Rendered to an Insured as a result of a Sickness or an Injury; and
   d. Provided on an inpatient basis in a facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitative Facilities; and
   e. Provided in lieu of acute hospitalization.

   Rehabilitation programs must be authorized in advance by Us. See the Authorization Provisions section for further direction.

   A rehabilitation program includes, but is not limited to:

   a. Physical therapy; and
   b. Occupational therapy; and
   c. Speech therapy.

Progress toward expected outcomes of services rendered will be evaluated by Us for Medical Necessity for such services to be a Covered Expense. Coverage for a rehabilitation program will cease when progress toward the established rehabilitation outcomes has plateaued or the outcomes can be achieved utilizing a less intense setting. Reimbursement for any billed charges will be based on Our Reasonable and Customary Amount limits.

The maximum benefit for Covered Expenses for an inpatient rehabilitation program is shown in the Benefit Summary.

6. **Skilled Nursing Facility Care:** Covered Expenses in a Skilled Nursing Facility must be:

   a. Provided in lieu of acute hospitalization; or
   b. For the same condition that required a Hospital confinement and the Insured must enter the Skilled Nursing Facility within 14 days after discharge from the Hospital after a confinement of at least 3 days.

   The maximum benefit for Covered Expenses for Skilled Nursing Facility care is shown in the Benefit Summary. The maximum daily benefit for confinement in a Skilled Nursing Facility will not exceed one-half of the semi-private Hospital room rate for the Hospital confinement. If not previously Hospital confined, the maximum daily benefit for confinement in a Skilled Nursing Facility will not exceed one-half of the most common semi-private Hospital room rate for the area in which You live. Skilled Nursing Facility care must be authorized in advance by Us. See the Authorization Provisions section for further direction.

7. **Home Health Care:** The maximum benefit for Covered Expenses for home health care is shown in the Benefit Summary. One visit consists of up to 4 hours of home health aide service within a 24-hour period by anyone providing services or evaluating the need for home health care. Home health care must be authorized in advance by Us. See the Authorization Provisions section for further direction.

   For home health care to be a Covered Expense, the Health Care Practitioner must certify that:

   a. The care prescribed in the treatment plan is Medically Necessary; and
   b. Medically Necessary care is not available from members of the Insured's Immediate Family or persons living with the Insured; and
   c. The home health care will be provided by a state licensed or Medicare certified home health agency.

   The following services are not Covered Expenses under this certificate:

   a. Services that are not included in the home health care plan established for the Insured by the Health Care Practitioner.
   b. Services provided by the Insured's Immediate Family, an employer, or anyone residing with the Insured.
   c. Homemaker services.
   d. Custodial Care or care that is supportive in nature or provided as maintenance therapy where there is no measurable, progressive achievement of established goals.

8. **Outpatient Physical Medicine Services:** For outpatient Physical Medicine services to be a Covered Expense, they must be: a) prescribed by a Health Care Practitioner; and b) provided by a licensed therapist. The maximum benefit for Covered Expenses for outpatient Physical Medicine services is shown in the Benefit Summary. One visit consists of up to 4 hours of therapy within a 24-hour period. Physical Medicine must be authorized in advance by Us. See the Authorization Provisions section for further direction. Physical Medicine includes, but is not limited to: physical, speech or occupational therapy; pulmonary or cardiac rehabilitation therapy; or adjustments and manipulations. Physical Medicine may be provided in the outpatient department of a Hospital, by a licensed or certified home health care agency or by a licensed therapist in Your home. Services are not covered if they are rendered for maintenance only and/or there is no measurable, progressive achievement of established goals.

9. **Ambulance Services:** Covered Expenses are for professional, Emergency ground transportation in an ambulance to the nearest Hospital that is able to treat the Sickness or Injury. Air ambulance service is covered only when Medically Necessary as determined by Us. The maximum benefit for Covered Expenses for ground and air ambulance services is shown in the Benefit Summary. We will provide coverage for one trip to a Hospital for an Insured for each Sickness or Injury.

10. **X-ray and Laboratory Services:** The maximum benefit for Covered Expenses for x-ray, radioactive treatment and laboratory charges for treatment of a Sickness or an Injury is shown in the Benefit Summary. This provision includes 1 screening mammography exam per Benefit Period for a covered female, age 35 or over. The maximum benefit for a mammography screening is $60.

11. **Durable Medical Equipment and Supplies:** Covered Expenses are for the following items if required as a result of a Sickness or Injury that occurred while this certificate is in force.

    a. Rental, up to the purchase price, or purchase, when approved in advance by Us, of the following items when prescribed by a Health Care Practitioner. Repairs to, replacement or maintenance of the whole or parts of such items are not a Covered Expense.

        - A basic non-electric wheelchair, basic non-electric hospital bed or basic crutches; and
        - The initial permanent basic artificial limb or eye; and
        - Oxygen and the equipment needed to administer oxygen; and

    b. Casts, orthopedic braces, splints, dressings and sutures; and

    c. The initial external breast prosthesis needed because of Medically Necessary surgical removal of all or part of the breast. Such surgery must have been done while the Insured was covered under the certificate.

12. **Blood Product Transfusions:** Covered Expenses are for whole blood, blood plasma and blood products if not replaced.

13. **Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction:** Covered Expenses are for surgical treatment of temporomandibular or craniomandibular joint dysfunction, provided the charges are included in a treatment plan authorized by Us prior to the surgery. See the Authorization Provisions section for further direction. Non-surgical treatment of temporomandibular or craniomandibular joint dysfunction is limited to:

    a. Diagnostic examination; and
    b. Diagnostic x-rays; and
    c. Injection of muscle relaxants; and
    d. Therapeutic drug injections; and
    e. Physical therapy; and
    f. Diathermy therapy; and
    g. Ultrasound therapy.

    NOT included are charges for anything not listed above including, but not limited to:

    a. Any appliance or the adjustment of any appliance.
    b. Any electronic diagnostic modalities.
    c. Occlusal analysis.
    d. Muscle testing.

    The combined maximum per Benefit Period payable for all surgical and non-surgical treatment is limited to $1,000 for each Insured.

14. **Complications of Pregnancy:** Covered Expenses are for the following complications arising from a pregnancy that begins after the Effective Date of coverage for an Insured who is covered under this certificate. Benefits are provided on the same basis as for any other covered Sickness.

    a. Ectopic pregnancy;
    b. Spontaneous termination of pregnancy (miscarriage) that occurs before the 26th week of gestation;
    c. Missed abortion.

    No benefits will be paid for: false labor; premature labor; high risk pregnancy or delivery; caesarean section delivery; occasional spotting; Health Care Practitioner prescribed rest; morning sickness; hyperemesis gravidarum; pre-eclampsia; placenta previa; or similar conditions that occur in a difficult pregnancy.

15. **Prescription Drugs:** Covered Expenses are for drugs and medicines that are fully approved by the U.S. Food and Drug Administration, are received as an outpatient and require the written prescription of a Health Care Practitioner for treatment of a condition that is a Covered Expense under this certificate. A prescription drug must be dispensed through a licensed pharmacy. The maximum benefit for Covered Expenses for prescription drugs received on an outpatient basis is shown in the Benefit Summary. When a prescription drug is available under two or more names or manufacturers' packaging or when more than one drug may be used to treat a covered condition, the least expensive drug will be considered a Covered Expense under this certificate. Covered Expenses are limited to a one–month supply of each prescription drug per prescription order or refill, unless further limited by the drug manufacturer's packaging or the Health Care Practitioner's written prescription order. When the maximum prescription drug benefit has been paid, no further benefits will be considered for any prescription drugs or medicines received as an outpatient under this or any other provision of this certificate. Payment for a prescription drug does not constitute any assumption of liability for any services provided in the treatment of a Sickness or an Injury under the Benefits section of this certificate.

16. **AIDS/HIV Services:** Covered Expenses for treatment of AIDS, AIDS Related Complex (ARC) or related immunodeficiency disorders will be considered as though they were for any other covered Sickness, except that the maximum per Benefit Period is limited to $10,000 for each Insured.

17. **Transplantation Benefit:** The maximum lifetime transplant benefit for all Covered Expenses for transplants, combined transplants, and sequential transplants is $ ####### per Benefit Period. The maximum lifetime transplant benefit for donor expenses is $10,000 per Benefit Period for all transplants and is applied to the maximum lifetime transplant benefit. Charges are applied toward the maximum lifetime transplant benefit for all Covered Expenses incurred 14 days before a transplant until 365 days after a transplant or a lesser period not to exceed the Benefit Period under this certificate. All transplant related benefits apply toward the Lifetime Maximum Benefit under this certificate.

    When generally accepted indications and standards for transplantation are met and all assessments required by the treating institution are successfully completed, Covered Expenses are limited to the following Organ Transplants and Marrow Reconstitution or Support.

    Organ Transplants:

    a. Cornea;
    b. Heart;
    c. Lung;
    d. Combined heart/lung;
    e. Kidney;
    f. Combined kidney/pancreas;
    g. Liver (Candidates for liver transplantation must have abstained from alcohol for one year immediately prior to transplantation).

    Marrow Reconstitution or Support (often called bone marrow transplant or stem cell transplant): A transplantation procedure in which human blood precursor cells are administered to a patient following myelosuppressive or ablative therapy. Such cells may be derived from bone marrow or circulating blood obtained from the patient in an autologous harvest or from a matched donor for an allogenic transplant. The Marrow Reconstitution or Support procedure includes all chemotherapy, the harvesting, and the reinfusion of the marrow or blood precursor cells.

    We will not pay for:

    a. Multiple organ, tissue and cellular transplants during one operative session, except for a heart/lung, double lung or simultaneous kidney/pancreas transplant.
    b. Any non–human (including animal or mechanical) organ transplant.
    c. Transplants approved for a specific medical condition, but applied to another condition.
    d. The purchase price of an organ or tissue that is sold rather than donated.
    e. Any transplants not listed above.

    Transplantation must be authorized in advance by Us. See the Authorization Provisions section for further direction. No benefits will be paid for any organ, tissue or cellular transplants not reviewed by Us prior to transplant evaluation, testing, preparative treatment or donor search or for transplants which are the result of Sickness or Injury that had its onset prior to the Effective Date of this certificate.

18. **Pediatric Preventive Care Benefit:** Covered Expenses are for preventive care services that are consistent with the published recommendations of the American Academy of Pediatrics, prescribed by a Health Care Practitioner and rendered to a Covered Dependent child from birth through age 19.

III. AUTHORIZATION PROVISIONS

Call the toll free number on Your identification (ID) card to obtain Our authorization of the services listed below. We will review the proposed medical care with You or Your Health Care Practitioner to determine the appropriateness of treatment and to assist You with discharge needs. We will notify You and Your Health Care Practitioner of the outcome of Our review. Refer to the Reduction of Payment provision below to determine how Your benefits will be reduced if Our authorization is not obtained.

Before You call Us, have the following information on hand:

1. Your social security number; or the patient's social security number, if different from Yours; and
2. Your certificate number; and
3. The Health Care Practitioner's name and telephone number; and
4. The procedure and/or diagnosis; and
5. The proposed date of admission or date the procedure will be performed; and
6. The facility's name and phone number.

Contact Us for authorization of the following services:

- **Non-Emergency Confinements:** Call at least 7 business days prior to an inpatient stay in a Hospital. A Non-Emergency Confinement is an inpatient stay for a Sickness or Injury that is not immediately life-threatening but is Medically Necessary.
- **Emergency Confinements:** Call within 48 hours (excluding Saturdays, Sundays and legal holidays), or as soon as reasonably possible, after an inpatient admission for Emergency treatment.
- **Organ Transplant or Marrow Reconstitution or Support:** Call prior to any transplant evaluation, testing, preparative treatment or donor search.
- **Skilled Nursing Facility Confinements:** Call at least 7 business days prior to Your admission.
- **Inpatient Rehabilitation Programs:** Call at least 7 business days prior to Your admission.
- **Outpatient Physical Medicine:** Call at least 7 business days prior to receiving any services.
- **Outpatient or Day Surgery Procedures:** Call at least 7 business days prior to a scheduled outpatient procedure. Authorization is not required for: magnetic resonance imaging (MRI); computerized axial tomography (CAT) scan; ultrasound testing; an Emergency room visit; or an office visit to a Health Care Practitioner unless surgery is performed.
- **Home Health Care:** Call at least 7 business days prior to receiving any services.
- **Durable Medical Equipment:** Call at least 7 business days prior to obtaining the equipment if the purchase or rental price per month is more than $500.

The review process must be repeated if treatment is received more than 30 days after Our review or if the type of treatment, admitting Health Care Practitioner or facility differs from what We authorized. **NOTE:** That portion of a confinement that exceeds the number of authorized days will be considered unauthorized, unless an extension is granted. To receive an extension, the Health Care Practitioner must call Us at least 24 hours prior to the originally scheduled discharge date and request an extension. We may or may not authorize an extension. Benefits will be reduced for unauthorized extensions per the Reduction of Payment provision below.

REDUCTION OF PAYMENT: These authorization requirements are included to assist You in obtaining the most appropriate medical care. Follow the requirements described above so You can receive the full benefits of Your certificate. If You do not obtain authorization for the services listed above or if the course of treatment is not performed in the manner authorized, Your benefits will be reduced for otherwise Covered Expenses by $2,500 or 50%, whichever is the lesser amount. The reduced amount, or any portion thereof, will not be applied to any Deductible, Out-of-Pocket Limit and Rate of Payment determination.

In addition, NO benefits will be paid for expenses:

1. That are not for Medically Necessary services; or
2. That are otherwise not considered Covered Expense; or
3. For Organ Transplant or Marrow Reconstitution or Support if the procedure was not authorized prior to the beginning of the transplant evaluation, testing, preparative treatment or donor search.

APPEAL PROCESS: If Your provider disagrees with Our decision, You have the right to a review of that decision. Submit a written appeal request to Us that includes: Your name, address, certificate number, social security number and any other information, documentation or evidence to support Your appeal request. Until such time as authorization may be granted, the service will be considered unauthorized.

AN AUTHORIZATION IS NOT THE SAME AS "VERIFICATION OF BENEFITS" AND DOES NOT GUARANTEE THAT BENEFITS WILL BE PAID. AUTHORIZATION ADDRESSES ONLY THE MEDICAL NECESSITY AND APPROPRIATENESS OF THE CARE TO BE RECEIVED, INCLUDING THE TYPE OF TREATMENT AND FACILITY. PAYMENT OF BENEFITS IS SUBJECT TO ALL THE TERMS, LIMITS, AND CONDITIONS IN THIS CERTIFICATE.

IV. PRE-EXISTING CONDITIONS LIMITATION

We will not pay benefits during Your Benefit Period for charges incurred due to a Pre–Existing Condition. Benefits are subject to all the terms, limits and conditions in this certificate.

We will not pay benefits during Your Benefit Period for charges incurred due to a Sickness that manifests itself before any Waiting Period. A Waiting Period for Sickness only applies if it is shown in Your Benefit Summary. Benefits are available from the first day Covered Expenses are incurred for an Injury that is sustained on or after the Effective Date of Your coverage. Benefits are subject to all the terms, limits and conditions in this certificate.

V. EXCLUSIONS

EXPENSES NOT COVERED BY THIS CERTIFICATE: This certificate does not cover any of the following:

1. Conditions for which claims were submitted under a prior Short Term Medical policy or certificate issued by Us that provided coverage that ended within 90 days before the Effective Date of this certificate.
2. Intentionally self–inflicted Sickness or Injury, whether sane or insane.
3. Free services of a federal, veteran's, state or municipal Hospital.
4. Sickness or Injury to the extent that benefits are paid by Medicare or any other government law or program, except Medicaid (Medi–Cal in California); or medical coverage under any automobile or no fault insurance.
5. Sickness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when You do not file a claim for benefits.
6. Treatment of Sickness or Injury caused by or contributed to by:
   a. War or any act of war; or
   b. Participation in the military service of any country. Any premium paid for a time not covered will be returned pro–rata.
7. Dental treatment unless a Hospital stay is required due to Injury from an accidental blow to the mouth causing trauma to sound, natural teeth, the gums or supporting structures of the teeth. A sound, natural tooth has no decay and has never had a filling, root canal therapy or crown. Inpatient Hospital care must be the least expensive setting needed to produce a professionally adequate result and the Hospital charges only are Covered Expense. The treatment must be received while the certificate is in force.
8. Treatment of temporomandibular or craniomandibular joint dysfunction, except as provided in the Benefits section.
9. Expense incurred that is not for treatment of Sickness or Injury. This includes, but is not limited to, charges for:
   a. Eyeglasses, contact lenses, eye exams, eye refraction or eye surgery for correction of refraction error; vision therapy; or artificial hearing devices.
   b. Preventive treatment including, but not limited to, routine physical exams and immunizations, unless otherwise noted as a Covered Expense in this certificate or a rider to this certificate.
   c. Normal pregnancy or childbirth; routine well baby care including Hospital nursery charges at birth; or abortion, except as provided in the complications arising from pregnancy provision in the Benefits section.
   d. Infertility diagnosis and treatment for males and females including, but not limited to, drugs and medications, artificial insemination, in–vitro fertilization and reversal of sterilization.
   e. Genetic testing or counseling including, but not limited to, amniocentesis and chorionic villi testing.
   f. Sex transformation; treatment of sexual function, dysfunction or inadequacy; or treatment to enhance sexual performance or desire.
   g. Treatment and medication to stimulate growth and growth hormones for any purpose.

h. Treatment, services or supplies to address quality of life or lifestyle concerns including, but not limited to: smoking cessation; snoring or sleep disorders; the treatment or prevention of hair loss; change in skin pigmentation; or cognitive enhancement.
i. Sterilization and drugs or devices used directly or indirectly to promote or prevent conception.
j. Weight reduction or weight control programs or treatment; or surgery for weight control, obesity or morbid obesity.
k. All treatments for varicose veins.
l. Therapy or treatment for learning disorders or disabilities or developmental delays.
m. Sales tax or gross receipt tax; provider administrative expenses including, but not limited to, charges for claim filing, contacting utilization review organizations, or case management fees.
n. Travel, transportation or living expenses.

10. Cosmetic treatment or reconstructive or plastic surgery that is primarily a cosmetic procedure, including medical or surgical complications arising therefrom, except as provided in the Benefits section.

11. Treatment of Mental Illness or Substance Abuse, whether organic or non–organic, chemical or non–chemical, biological or non–biological in origin and irrespective of cause, basis or inducement, unless otherwise noted as a Covered Expense in this certificate or a rider to this certificate.

12. Treatment, repair or removal of tonsils or adenoids, except on an Emergency basis.

13. Treatment or services rendered by, or supplies purchased from, a member of Your Immediate Family or an employer.

14. Treatment or services required due to accidental Injury sustained in operating a motor vehicle while the Insured's blood alcohol level, as defined by law, exceeds that level permitted by law or otherwise violates legal standards for a person operating a motor vehicle in the state where the Injury occurred. This exclusion applies whether or not the Injury occurred in connection with an incident involving the operation of a motor vehicle, and whether or not the Insured is charged with any violation in connection with the accident.

15. Treatment or services required due to Injury received while engaging in any hazardous occupation or other activity, including the following: Participating, instructing, demonstrating, guiding or accompanying others in parachute jumping, hang–gliding, bungee jumping, flight in an aircraft other than a regularly scheduled flight by an airline, racing any motorized or non–motorized vehicle, rock or mountain climbing, professional or semi–professional contact sports of any kind. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.

16. Treatment or services required due to Injury received while engaging in any hazardous occupation or other activity for which compensation is received, including the following: Participating, instructing, demonstrating, guiding or accompanying others in skiing and horse riding. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.

17. Treatment or services required due to Injury sustained while participating in any interscholastic or inter–collegiate sport, contest or competition or while practicing, exercising, undergoing conditioning or physical preparation for any such sport, contest or competition.

18. Treatment or services required for Sickness or Injury resulting from consumption, abuse, or overdose of alcoholic beverages or any illegal or controlled substance.

19. Expense incurred due to Sickness or Injury of which a contributing cause was the Insured's voluntary attempt to commit, participation in or commission of a felony, whether or not charged, or as a consequence of the Insured's being under the influence of illegal narcotics or non–prescribed controlled substances.

20. Custodial Care; respite care; rest care; or supportive care.

21. Expenses incurred outside of the United States or its possessions or Canada.

22. Expenses incurred for Experimental or Investigational Treatment.

23. Private duty nursing services rendered during Hospital confinement and charges for standby Health Care Practitioners.

24. Dental braces, dental appliances, corrective shoes, repairs to or replacement of prosthetic devices, or orthotics, except as provided in the Benefits section.

25. Inpatient treatment of chronic pain disorders; biofeedback; repair of diastasis recti; reduction mammoplasty; revision of breast surgery for capsular contraction or replacement of prosthesis; orthognathic surgery; non–medical self–care or self–help programs.

26. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) and related immunodeficiency disorders, except as provided in the Benefits section.

27. The first $2,500 or 50%, whichever is the lesser amount, of an otherwise Covered Expense not authorized in accordance with the Authorization Provisions section.

28. Transplants, except as covered in the Benefits section.

29. Services or supplies for foot care, including care of corns, bunions or calluses, except capsular or bone surgery.

30. Complications resulting from leaving an inpatient or outpatient facility against the advice of the Insured's Health Care Practitioner; complications of any condition that existed prior to the Effective Date; or treatment for an excluded service or procedure.

31. Treatment, services or supplies rendered or received when coverage under the certificate is not in effect, except as provided under the Extension of Benefits provision.

32. Any amount in excess of the Reasonable and Customary Amount, as determined by Us under this certificate.

33. Prophylactic treatment or services. Prophylactic means any surgery or other procedure performed to prevent a disease process from becoming evident in the organ or tissue at a later date.

34. Treatment, services or supplies that are not Medically Necessary as determined by Us under this certificate.

35. Treatment, services or supplies that are prescribed, provided or furnished in a manner primarily for the convenience of the Insured or Health Care Practitioner.

36. Drugs and medicines, except as covered in the Benefits section.

37. Treatment, services or supplies not described in the Benefits section.

VI. COORDINATION OF BENEFITS - COB

The purpose of this provision is to limit the total benefits paid on an Insured's behalf to no more than the actual medical charges. Thus, if an Insured is entitled to benefits through any other medical or dental plan, We will take those benefits into account before We pay Our benefits.

DEFINITIONS: Where used in this provision, these terms have the following meanings:

ALLOWABLE EXPENSE: The reasonable charge for any service that is covered by at least one Plan. If a Plan provides services rather than cash payments, We will determine a reasonable charge for the service and that charge will be considered the Allowable Expense and the amount paid by the other Plan. The difference between the cost of a private Hospital room and a semi–private Hospital room will not be considered an Allowable Expense, except while the Insured's stay in a private Hospital room is Medically Necessary.

PLAN: Any:

1. Health coverage, whether issued or administered on a group or individual basis; or
2. Group Blue Cross, group Blue Shield, group practice or prepaid group coverage; or
3. Coverage under trust or association plans or plans sponsored by unions, employer groups, or employee benefit groups; or
4. Medical coverage under automobile or no fault insurance, if coordination of benefits with such coverage is allowed by law.

A Plan may consider the benefits of other Plans in determining some, but not all of its benefits. That Plan will then be considered two separate Plans – the Plan that considers the benefits of other Plans and the Plan that does not.

CLAIMANT: The person on whose expense claim is based.

EFFECT ON BENEFITS: The Prime Carrier rule is used to determine the order in which the Plans pay their benefits. This rule is used if, without the COB provision or one like it, the total benefits paid by all Plans on an Insured's behalf during one Benefit Period would exceed the Allowable Expense.

If, according to the Prime Carrier rule, another Plan is to pay its benefits before Us, We will pay the lesser of:

1. The difference between the Allowable Expense and the amount paid by any Plan that pays before Us; or
2. Our normal benefit determined without the COB provision.

PRIME CARRIER RULE: The Prime Carrier Rule is as follows:

1. A Plan that does not have a COB provision, or one like it, pays its benefits first.
2. An automobile or no fault insurance Plan pays its benefits before Us, unless it has a secondary benefits clause.
3. A Plan that insures the Claimant as other than a dependent pays its benefits before a Plan that insures such person as a dependent.
4. Except as provided in 5 below, the Plan that covers the Claimant as a dependent of a person whose birth date (excluding year of birth) occurs earlier in the calendar year pays its benefits before the Plan that covers the Claimant as a dependent of a person whose birth date (excluding year of birth) occurs later in the calender year. If both persons have the same birth date, the Plan that covered the person for a longer period of time pays its benefits before the Plan that covered the other person for a shorter period of time. If one Plan has the birth date rule and the other does not, the Plan that does not pays first.
5. If the Claimant is a child of parents who are divorced or separated, the following applies:
   a. If a court decree establishes which parent is responsible for the child's health care expenses, the Plan of that parent pays its benefits before any other Plan that covers the child as a dependent.

b. Otherwise the Plan of the parent with custody pays its benefits before the Plan of the spouse of the parent with custody; and the Plan of the spouse of the parent with custody pays its benefits before the Plan of the parent without custody.

6. When the above rules do not determine which Plan pays benefits first, the Plan that has insured the Claimant the longest pays first; unless the Plan covers the Claimant as a laid–off or retired employee or the dependent of such an employee. In that case, the Plan that insures the Claimant as other than a laid–off or retired employee or the dependent of such an employee pays its benefits first. The rule regarding laid–off or retired employees will not apply. However, if either Plan does not have a provision regarding laid–off or retired employees, each Plan would, by its rules, pay its benefits after the other.

GENERAL PROVISIONS: An Insured is required to furnish Us, when requested, all information regarding other Plans and the benefits paid or payable by these Plans.

As permitted by law, We may, without the Insured's consent:

1. Obtain information from all Plans that may be involved; and
2. Release to all Plans any information We have; and
3. Reimburse such Plans, to the extent necessary, if We determine that benefits were paid by another Plan that should have been paid by Us. Such reimbursement shall count as a valid payment under this Plan; and
4. Obtain reimbursement from any other Plan, the Insured and/or any person to whom benefits were paid, if We paid benefits that should have been paid by any other Plan; and
5. Obtain reimbursement of whatever amount is appropriate for the proper working of this provision when payment from all sources exceeds the Allowable Expense, if We determine that the Allowable Expense was exceeded as a result of Our payment.

VII. CLAIMS

NOTICE/PROOF OF LOSS: We must receive written Notice/Proof of Loss within 90 days after a covered loss occurs or begins or as soon as reasonably possible. Notice/Proof of Loss is written proof covering the occurrence, character and extent of the loss for which the claim is made. The Notice/Proof of Loss must include Your name and certificate number and must identify the provider of services (including provider's federal tax ID) for which claim is made.

If You are sending bills directly to Us, please send an itemized bill and not a balance due statement. Include Your certificate number or social security number.

Unless You are declared incompetent by a court of law, Notice/Proof of Loss must be sent to Us within 15 months of the date of loss. To determine Our liability, We may request that You furnish proof of benefits from other sources, proof that You have applied for all benefits from other sources, and confirmation that You have furnished all necessary proof to receive them.

PAYMENT OF CLAIMS: Benefits will be paid to You unless they have been assigned to a Health Care Practitioner, Hospital or other provider. Any benefits unpaid at Your death will be paid at Our option to Your spouse, Your estate, or the providers of treatment.

TIME OF PAYMENT OF CLAIMS: Benefits will be paid upon receipt of due written Proof of Loss. Any benefit paid in error may be recovered from You or the person receiving the incorrect payment. We may offset the overpayment against future benefit payments.

PHYSICAL EXAMINATIONS: While a claim is pending, We have the right to have You or Your dependents examined. The exams will be at Our expense and as often as reasonably required.

CLAIM APPEAL: If any claim for benefits is denied, in whole or in part, You will be given a written explanation of the reason for the denial. You have the right to have the denial reviewed and reconsidered. To obtain a review, You must submit a written request to Us at Our office within 90 days of the denial. Your request should include Your name, address, certificate number, social security number and the nature of the problem along with supporting documentation. Your appeal will be reviewed by Our appeal review committee. You will receive a written notice of Our final determination within 30 days following Our receipt of Your appeal.

Your claim will not be honored if You or the medical provider will not, or cannot, provide adequate documentation to substantiate that treatment was rendered for the claim submitted. If You, or anyone acting on Your behalf, knowingly file a fraudulent claim, You may be subject to civil and/or criminal penalties.

VIII. OTHER PROVISIONS

ELIGIBILITY FOR COVERAGE: You and Your Covered Dependents may be covered under this certificate upon approval under Our coverage criteria, provided that coverage was requested for each person at the time of the Primary Insured's enrollment, except as otherwise provided by this certificate, and provided all persons covered are:

1. U.S. citizens residing in the United States or foreign residents who have been living in the United States for at least one year at the time of enrollment for coverage under this plan and who have proof of alien registration or other appropriate visas or required documentation; and
2. Between the ages of 30 days and age 64 and 11 months; and
3. Not currently incarcerated; and
4. Not engaged in hazardous activities for pay.

CONFORMITY WITH STATE STATUTES: If this certificate on its Effective Date, is in conflict with any laws of the State where it is issued, it is changed to meet the minimum requirements of those laws.

CONSIDERATION: This certificate is issued in consideration of the premium payment.

MODIFICATION OF YOUR COVERAGE: The group policy may be changed at any time. We will give the trust 30 days notice prior to any change. You will receive an amendment to Your certificate showing any change.

WHEN YOUR COVERAGE BEGINS AND ENDS: Your Effective Date, premium due date(s), and Benefit Period are shown in the Benefit Summary. Insurance begins at 12:01 A.M. Standard Time at Your residence on the Effective Date.

Coverage ends at 11:59 P.M. Standard Time on the last day of the Benefit Period or the earliest of:

1. The date You become eligible for Medicare; or
2. The date there is fraud or material misrepresentation made by or with the knowledge of any Insured applying for this coverage; or
3. The date You, or anyone acting on Your behalf, knowingly files a fraudulent claim.

If benefits are paid by Us as a result of fraud or misrepresentation, We will be entitled to a refund from You or the provider.

EXTENSION OF BENEFITS: When the Benefit Period ends, coverage may be extended for a Sickness that commenced or an Injury sustained while the certificate is in force and for which an Insured is then being treated. The Extension of Benefits provision is subject to the Deductible, the Lifetime Maximum Benefit and all other terms, limits and conditions in this certificate. It will apply when the following conditions exist:

1. Only for the Insured receiving Covered Expenses while confined as an inpatient in a Hospital. The Insured must be under the care of a Health Care Practitioner for the inpatient Hospital stay.

   We will extend benefits to the earliest of:

   a. The date on which the Insured is no longer continuously confined in a Hospital; or
   b. The end of Total Disability; or
   c. Payment of the Lifetime Maximum Benefit or any other maximum benefit for those services under the certificate; or
   d. ## months from the date coverage would have ended without an Extension of Benefits provision; or
   e. The earliest date otherwise permitted by law.

2. Only for the Insured who:

   a. Has met his or her Deductible during the Benefit Period; and
   b. Is being treated for complications of, or needs follow–up treatment for, a Sickness that commenced or an Injury sustained during the Benefit period.

   A $1,000 maximum benefit will be provided for Covered Expenses incurred during a period of not more than 60 days from the date coverage would have ended without an Extension of Benefits provision. The Insured does not have to be Totally Disabled to qualify for this portion of the Extension of Benefits provision.

Coverage is not extended for any condition that is not a cause of the Insured's Total Disability. This Extension of Benefits provision does not create coverage for expenses incurred as a result of conditions not covered, as noted in the Exclusions section or elsewhere in the certificate. The Extension of Benefits provision is subject to all other applicable terms, limits and conditions in this certificate.

AGE LIMITATION: If You or Your Spouse are over age 64 and 11 months, or have a dependent child over age 19 (age 24 if a full time student) on the Effective Date, Our sole liability will be for the return of premiums paid for that person.

TIME LIMIT ON CERTAIN DEFENSES: If Your coverage has been in force for less than two years, a material misrepresentation in Your enrollment form may be used to rescind this certificate and deny a claim. If Your coverage is rescinded, Our sole liability will be to refund all of the premiums paid for this certificate.

MEDICARE LIMITATION: If the Primary Insured or any Covered Dependents are covered by Medicare, Our sole liability will be for the return of premiums paid for that person.

ENTIRE CONTRACT; CHANGES: The group policy, the application of the policyholder, the Insured's enrollment form and any riders constitute the Entire Contract. No change in the policy is valid unless approved by one of Our executive officers. The approval must be endorsed by the officer and attached to the policy. You will be notified of any such changes. No agent may change the certificate or waive any of its provisions.

LEGAL ACTION: You cannot bring a lawsuit before 60 days after written Proof of Loss has been given to Us. No action can be brought after 3 years from the time that Proof of Loss is required to be given. The time limit to bring suit is 5 years in Kansas. The time is 6 years in South Carolina.

OTHER INSURANCE WITH THIS INSURER: Insurance effective at any one time on the Insured under a like contract or certificate with Us is limited to the one such plan elected by the Insured or the Insured's beneficiary or estate, as the case may be. We will return all premiums paid for all other such plans.

PREMIUM DUE DATE: Initial premium must be paid with submission of the enrollment form prior to coverage taking effect. Subsequent premiums are due as shown in the Benefit Summary. There is a grace period of 10 days for the payment of each premium due after the initial premium. If the full premium due is not received at Our office by the end of the grace period, this certificate will lapse. Premiums must be received in cash or check at Our office on the date due. We may agree to accept premium payment in alternative forms, such as credit card or automatic charge to a bank account. We reserve the right to dishonor any such agreement for payment of premium during the grace period if We have first unsuccessfully attempted to obtain payment for the amount due using the alternative method.

SUBROGATION RIGHT: Subrogation is the process by which We seek reimbursement from another company or person for a claim We have already paid. Upon payment of benefits, We will be subrogated to all rights of recovery an Insured may have against any person or organization. Such right extends to the proceeds of any settlement or judgment; but is limited to the amount of benefits We have paid. In this regard, the Insured will:

1. Do nothing to prejudice or hinder any right of recovery; and
2. Execute and deliver any required instruments or papers; and
3. Do whatever else is necessary to secure such rights.

If We are precluded from exercising Our Subrogation Right, We may exercise Our Right to Reimbursement below.

RIGHT TO REIMBURSEMENT: If benefits are paid under this certificate, and any Insured recovers against any person or organization by settlement, judgment or otherwise, We have a right to recover from that Insured an amount equal to the amount We have paid.

Any payments We make prior to a determination of a work–related Injury will be reimbursed when an Insured receives payment for such Injury from another source.

RIGHTS OF ADMINISTRATION: We maintain Our ability to determine Our rights and obligations under the certificate including, without limitation, the eligibility for and amount of any benefit payable.

RIGHT TO COLLECT INFORMATION: You must cooperate with Us and, when asked, assist Us by:

1. Authorizing the release of medical information including the names of all providers from whom You have received treatment, services, medications or supplies; and
2. Providing information regarding the circumstances of Your claim; and
3. Providing information about other insurance coverage and benefits; and
4. Having an examination completed when requested.

Your refusal to provide information requested is cause for denial of claims or termination of this coverage.