COMPREHENSIVE MEDICAL BENEFIT

GUARANTEED RENEWAL PERIOD

This Comprehensive Medical Benefit is renewable as long as any Covered Member included under this Benefit remains eligible as provided in Sections IV and V of this policy.

SECTION A: THE MEANINGS OF CERTAIN WORDS USED IN THIS BENEFIT

In addition to the meanings given in Section III of this policy, the following apply:

'Hospital' means only an institution (other than a convalescent, nursing, rest home, or Extended Care Facility) lawfully operated for the care of sick or injured persons and with organized facilities for diagnosis and major surgery and twenty-four hour nursing services. 'Hospital' does not include an Extended Care Facility or any part of any institution which is used as a sanatorium, clinic, nursing home, rehabilitation center, home for the aged, or a custodial care or similar institution.

'Confinement' means confinement required for treatment of Injury or Sickness in a Hospital as a resident patient, or in an Extended Care Facility, or at home during a period of Home Care, at the direction of or under the care of your physician.

'Extended Care Facility' means only an institution which meets fully each of the following requirements: (1) It is regularly engaged in providing skilled nursing care for sick and injured persons at the patient's expense; (2) It requires that patients be regularly attended by a currently licensed Physician and that medication be given only on the order of such Physician; (3) It maintains a daily medical record of each patient; (4) It continuously provides nursing care under regular supervision by a Registered Graduate Nurse; (5) It is not a home for the aged, a hotel or the like; and (6) It is not, other than incidentally, a place for drug addicts, alcoholics, or the mentally ill.

'Pregnancy' means a pregnancy of the insured wife (who must be either the Insured or the spouse) which commences after both you and your spouse have been covered under the policy for at least 30 days and which pregnancy terminates while coverage for the pregnant member is still in force.

'Home Care' means an organized program of treatment and nursing care in the homes of patients discharged from a Hospital and which is under the supervision of the staff of such Hospital.

'Nurse' means a Registered Graduate Nurse or a licensed Practical Nurse other than yourself, your spouse, parent, child, brother, sister, or in-law.

'Physiotherapist' means a licensed physiotherapist other than yourself, your spouse, parent, child, brother, sister, or in-law.

'Intensive Care Unit' means that part of a Hospital specifically designated as such, which is permanently equipped and staffed to provide more extensive care for critically ill or injured patients than that available in the general hospital rooms or wards, such care to include constant observation by a staff of Registered Graduate Nurses whose duties are confined to such part of the Hospital.

Other Terms: Maximum Amount, Deductible Amount, Accumulation Period, Daily Room and Board Limit, Maximum Surgery Benefit, Medical Services Benefit, Medicare Daily Hospital Benefit and Beneficiary applicable to each Covered Member are shown for this Benefit in the Policy Schedule.

SECTION B: BENEFIT PROVISIONS

The following provisions under this Section B apply only to Covered Members who are not covered under Medicare and to Covered Members who are covered under Medicare but for whom the Benefit Period in question began prior to the date their Medicare coverage became effective.

i. BENEFIT PERIODS

There are three classes of Benefit Periods under this policy:

Basic

(a) A Basic Benefit Period begins on the date a Covered Member incurs hospital confinement or Basic Benefit Eligible Expenses and continues during such confinement or period such expenses accrue until a Major Medical Benefit Period begins or until the Maximum Amount is exhausted, if earlier, or until a six month period has elapsed during which all Eligible Expenses incurred by the Covered Member fail to exceed the Deductible Amount.

Major Medical

(b) A Major Medical Benefit Period begins on the date the Deductible Amount indicated in the Policy Schedule is satisfied and will continue, subject to the Maximum Amount, for a consecutive period of three years or until the Covered Member incurs no Eligible Expenses for a consecutive period of 90 days, whichever occurs first. After termination, provided the Maximum Amount has not been exhausted, a new Major Medical Benefit Period may be established, subject to the Deductible Amount and the Maximum Amount.

The Deductible Amount for a Covered Member is indicated in the Policy Schedule. It is the amount of Eligible Expenses which must be incurred for hospital, medical or surgical expenses by a Covered Member as a result of Sickness or Injury before a Major Medical Benefit Period will begin. The Deductible Amount must be met in a continuous period no longer than the Deductible Accumulation Period shown in the Policy Schedule. It is not an ordinary "deductible" since expenses which qualify by type and amount as Eligible Expenses and which are incurred during a Basic Benefit Period are counted toward the Deductible Amount even though such expenses are covered under this policy. However, any expenses incurred for daily room and board, surgery or medical services which are in excess of limitations or maximums shown in the policy and all other expenses which do not qualify as Eligible Expenses will not count toward the Deductible Amount.

Maternity

(c) A Maternity Benefit Period will commence on the date a Covered Member incurs confinement because of Pregnancy or incurs Maternity Benefit Eligible Expenses and continues during such confinement or period such expenses accrue until the maximum amount payable as Maternity Benefit Period Eligible Expenses has been paid.

Any complication of 'Pregnancy' as that term is defined in Section A will be covered in the same manner as a sickness under this policy.

Extension of Benefit Period

In the event the Covered Member is hospitalized at the end of his Major Medical Benefit Period and the Maximum Amount has not been exhausted, his Benefit Period will terminate on the day following release from the hospital or the first date the Maximum Amount is exhausted, whichever is earlier.

ii. MAXIMUM AMOUNT

The Maximum Amount which is indicated in the Policy Schedule is a limitation of benefits. It limits the total amount which may become payable in connection with all Benefit Periods combined for all sicknesses and all injuries sustained by any one Covered Member, subject to the paragraph 'Restoration of Maximum.'

iii. BENEFITS PAYABLE

Subject to the paragraph "Maximum Amount" the Company will pay you the amount of (a) Basic Benefit Eligible Expenses incurred during a Basic Benefit Period, (b) Major Medical Benefit Eligible Expenses incurred during a Major Medical Benefit Period, and (c) Maternity Benefit Eligible Expenses incurred during a Maternity Benefit Period, provided that such Eligible Expenses are incurred by a Covered Member during a benefit period which begins for such member.

iv. ELIGIBLE EXPENSES

Eligible Expenses are the stated percentages of the charges listed below which (a) are necessarily incurred for care and treatment of injury and sickness in connection with which the qualification requirement for benefits is satisfied and (b) are prescribed by a physician, and (c) do not exceed regular, customary and reasonable charges for the services and supplies provided in the absence of insurance, and (d) are not covered by Medicare.

All expenses will be considered incurred on the date the service is rendered or the supplies furnished.

1. Basic Benefit Eligible Expenses. Basic Benefit Eligible Expenses are any of the following:

   a. 100% of the charges incurred for daily room, board and general nursing care during confinement in a Hospital but not to exceed the Daily Room and Board Limit for any one day of confinement. For any day that charges are incurred for such expenses, no charges of the type listed in subparagraph (b) below are eligible.

   b. 100% of the charges incurred for daily room, board and general nursing care during confinement in the Intensive Care Unit of a Hospital but not to exceed twice the Daily Room and Board Limit for any one day of confinement. For any day that charges are incurred for such expenses no charges of the type listed in subparagraph (a) above are eligible.

   c. 100% of the charges incurred for surgery and anesthesia as provided in and limited by Section B (v) of this Benefit.

   d. 80% of the charges by a hospital for hospital services, supplies, drugs and medicines necessary to the care of the Covered Member, not including daily room and board and general nursing charges.

2. Major Medical Benefit Eligible Expenses. Major Medical Benefit Eligible Expenses are all Basic Benefit Eligible Expenses plus the following:

   a. 100% of the charges incurred for daily room, board and general nursing care during confinement in an Extended Care Facility provided such confinement immediately follows a period of at least three days of Hospital confinement but not to exceed one-half of the Daily Room and Board Limit for any one day and not to exceed ninety days of confinement in an Extended Care Facility during any one Benefit Period.

   b. 100% of the charges incurred for Physician's service other than surgery, anesthesia, or diagnostic X-ray examinations and laboratory tests as provided in and limited by Section B (vi) of this Benefit.

   c. 100% of the charges incurred for the service of private duty Nurses and Physiotherapists as provided in and limited by Section B (vii) of this Benefit.

   d. 80% of the charges by a hospital for a period of Home Care, provided such period begins immediately after Hospital confinement of at least three days, or after confinement in an Extended Care Facility which began immediately after a Hospital confinement of at least three days. Such period of Home Care shall be limited to 90 days if immediately following a Hospital confinement or in the aggregate to 120 days for a combined period of confinement in an Extended Care Facility and Home Care when such Home Care immediately follows a period of confinement in an Extended Care Facility. Such charges for Home Care shall be limited to the following:

      1) Charges by a Hospital for Home Care administration.

      2) Fees of Nurses.

      3) Charges by Hospital for medical services and supplies furnished at the home.

   e. 80% of the charges incurred for diagnostic X-ray examinations and laboratory tests, drugs and medicines identified by a prescription number and dispensed by a licensed pharmacist, blood and blood plasma, oxygen and other medical supplies and prosthetic appliances.

   f. 80% of the charges incurred for local, professional ambulance service.

3. Maternity Benefit Eligible Expenses. Maternity Benefit Eligible Expenses are identical to Basic and Major Medical Benefit Eligible Expenses except that (a) the total of such expenses for any one Maternity Benefit Period is limited to 3 times the Daily Room and Board Limit shown in the Policy Schedule, plus any amount payable for obstetrical care under Section B (v), (b) such expenses are incurred because of pregnancy, and (c) the Deductible Amount need not be satisfied.

v. SURGERY AND ANESTHESIA

The limit for the operating surgeon's fee for a listed surgical procedure is the percentage listed opposite the procedure in the following Schedule of Procedures, times the Maximum Surgery Benefit shown in the Policy Schedule or $5.00, whichever is greater. This limit applies to the performance of the surgical procedure and a period of post operative care of two weeks or the duration of hospitalization, whichever shall be the greater.

The limits for the fees of an anesthesiologist and assistant surgeon will be determined as follows:

If the limit for the fee of the operating surgeon is $100.00 or more the limit for the fee of an anesthesiologist will be 25% of the limit for the fee of the operating surgeon and the limit for the fee of an assistant surgeon will be 15% of the limit for the fee of the operating surgeon.

If the limit for the fee of the operating surgeon is less than $100.00, then the limit for the fee of an anesthesiologist will be $25.00 or 50% of the fee of the operating surgeon, whichever is the smaller, and the limit for the fee of an assistant surgeon will be $25.00 or 30% of the fee of the operating surgeon, whichever is the smaller.

For any procedure not listed, the Company will compute the maximum benefit on the basis of the amount shown in the schedule for a procedure of comparable gravity and severity, unless payment for the procedure is expressly excepted in such schedule or by the other terms of the policy, and subject to the maximum set forth in the Policy Schedule.

If more than one procedure is performed through the same incision, an amount will be allowed only for that procedure having the highest limit. If multiple procedures are performed at the same operative session through separate incisions, 50% of the amount(s) for the additional procedure(s) will be allowed in addition to an amount for the procedure for which the largest limit is provided, subject to the Maximum Surgery Benefit.

The limit for the fee of the anesthesiologist applies to administration of anesthetic and any fluids incident to the procedure and to the customary pre-operative and post-operative visits. The limit applies only to the fees of a Physician in attendance during the procedure for the sole purpose of rendering such anesthesia service and will be reduced 50% if the operating surgeon or his assistant administers the anesthetic.

SCHEDULE OF PROCEDURES

	Per Cent of Maximum Surgery Benefit
BONES AND JOINTS	
Arthrodesis, hip	24.0%
Excision of tumor or cyst, large bones	10.0
Small bones	6.0
Bone graft, radius or ulna	17.0
Spinal fusion, two or more segments	24.0
Osteotomy of lumbar spine, anterior approach	40.0
Scoliosis, Harrington rod technique	50.0
FRACTURES	
Jaw, closed reduction with wiring of teeth	8.0
Open reduction with wiring of teeth and/or local fixation	16.0
Wrist (Colles), simple, closed reduction	6.0
Open reduction	6.0
Vertebral body; one or more, requiring reduction	24.0
Clavicle, simple, closed reduction	3.0
Simple or compound, open reduction	9.0
Upper arm shaft, simple closed reduction	5.0
Simple or compound, open reduction	11.0
Lower arm shaft	
Radius or ulna, simple closed reduction	4.0
Simple or compound, open reduction	8.0
Radius and ulna, simple closed reduction	5.4
Simple or compound, open reduction	12.0
Finger or thumb, simple, closed reduction	1.6
Open reduction	4.0
Lower leg shaft	
Tibia, simple closed reduction	5.0
Simple or compound, open reduction	12.0
Fibula, compound, with uncomplicated soft tissue closure	4.0
Simple or compound, open reduction	8.0
Tibia and fibula, closed reduction	6.5
Simple or compound, open reduction	14.5
Ankle (Potts), simple, closed reduction	5.0
Open reduction	12.0
Puncture of joint, for aspiration	0.5
Excision of invertebral disc	26.0
With spinal fusion	32.0
Excision of semi-lunar cartilage of knee joint	14.0
Suture of collateral or cruciate ligament, knee, one	16.0
Collateral and cruciate ligament, knee	18.0

	Per Cent of Maximum Surgery Benefit
DISLOCATION	
Shoulder, simple, closed reduction, with anesthesia	1.2%
Knee, simple, closed reduction	3.6
Open reduction	15.0
Tarsal or astragalo-tarsal, simple closed reduction	2.0
Open reduction	6.0
Toe, more than one, one or more joints, Simple closed reduction	1.2
Simple or compound, open reduction	2.4
BRAIN AND NERVES	
Craniotomy: Evacuation of hematoma, subdural, extradural or intracerebral	26.0
Elevation of depressed skull fracture, simple	18.0
Excision of brain tumor, abscess or cyst	34.0
Obliteration of aneurysm	40.0
Craniectomy for tumor of skull	100.0
Pneumoencephalography	4.0
Spinal puncture, lumbar, independent procedure	0.6
Laminectomy for lesion of spinal cord	34.0
For removal of intervertebral discs	32.0
Sympathectomy, lumbar, unilateral	15.0
Bilateral	21.0
Sympathectomy, cervico-thoracic, bilateral	28.0
Repair of encephalocele	100.0
BREAST	
Excision, biopsy of breast	3.6
Excision of cyst, tumor or part of breast	5.0
Simple removal of breast	8.0
Radical removal of breast	18.0
CARDIOVASCULAR SYSTEM	
Repair of heart valve, mitral	32.0
Aortic, pulmonic or tricuspid	50.0
Catheterization of heart, independent procedure	4.0
Double valve procedure, replacement and/or repair by valvuloplasty or replacement	70.0
Triple valve procedure, replacement and/or repair	80.0
Excision and graft, thoracic aorta	48.0
Repair aneurysm of aorta	56.0
Aortography	2.7
Coronary angioplasty (endarterectomy, arterial implantation or anastomosis), with bypass	60.0

	Per Cent of Maximum Surgery Benefit
Ligation of femoral vein	8.0%
Ligation and division of common iliac vein	12.0
Varicose veins: Ligation and division of long saphenous vein at saphenofemoral junction	4.8
Ligation and division and complete stripping of long or short saphenous veins, unilateral	7.0
Bilateral	12.0
Ligation and division and complete stripping of long and short saphenous veins, unilateral	10.0
Bilateral	14.5
Venography	1.4
DIGESTIVE SYSTEM	
Removal of tonsils, with or without removal of adenoids under 18 years of age	4.0
18 years of age or over	4.8
Excision of stomach ulcer or benign tumor	14.5
Removal of stomach, subtotal, with or without vagotomy	19.0
Resection of small intestine, with anastomosis	17.0
Resection of large intestine, in two stages, including first stage colostomy	30.0
Removal of appendix	9.5
Proctosigmoidoscopy, diagnostic, initial	0.6
Subsequent	0.6
Incision of rectal fistula, superficial	2.4
Excision of hemorrhoids, external, complete	4.8
Internal and external	7.0
With excision of fistula	9.5
With excision of fissure	8.0
Removal of gall bladder	14.5
With open exploration of common duct	17.0
Repair of inguinal hernia, unilateral	9.0
With excision of hydrocele	9.5
Recurrent	10.0
Repair of femoral hernia, unilateral	9.0
Recurrent	10.0
Repair of ventral hernia, incisional	11.0
Recurrent	12.0
Repair of epigastric hernia, simple	3.0
Spigelian hernia	9.0
Pancreatectomy, total	34.0
Esophagectomy	40.0
Repair of umbilical hernia, under 5 years of age	7.0
5 years of age or over	8.5
EAR	
Incision of ear drum	1.0
Labyrinthotomy or labyrinthectomy	20.0
Tympanoplasty, Type 1, uncomplicated	22.0
Type V, two stages	24.0
Stapes mobilization	12.0
Stapedectomy, with or without vein plug	20.0
EYE	
Removal of foreign body from surface of cornea	0.4
Excision of pterygium	6.0
Needling of lens for cataracts, initial	5.0
Subsequent	2.4
Extraction of lens for cataracts, unilateral	20.0
Reattachment of retina, electrocoagulation, initial	20.0
Eye muscle operation, one or more muscles, one or both eyes, single stage	14.0
FEMALE GENITAL SYSTEM	
Repair of cystocele, independent procedure	8.5
Repair of cystocele, rectocele and perineoplasty	12.0
Excision of ovarian cyst or tumor, unilateral or bilateral, independent procedure	12.0
Removal of ovary, unilateral or bilateral, independent procedure	12.0
Biopsy of cervix or endometrium, independent procedure	0.6
Total hysterectomy, corpus and cervix	16.0
Radical hysterectomy for malignancy, including regional lymph nodes	30.0
Vaginal hysterectomy, with or without pelvic floor repair	18.0
Excision of lesion of cervix	0.6
Dilation and curettage of uterus, independent procedure	4.0%
Insertion of radioactive substance into cervix, uterus or both	5.0
MALE GENITAL SYSTEM	
Excision of hydrocele, unilateral	6.0
Excision of varicocele, independent procedure, unilateral	8.0
With hernia repair	9.5
Orchiectomy, radical	12.0
Resection of prostate, perineal, suprapubic, retropubic or transurethral	20.0
Radical	26.0
MUSCLES AND TENDONS	
Excision of ganglion, wrist	3.0
Excision of Baker's cyst (synovial cyst in popliteal space)	10.0
Lengthening or shortening tendon	9.5
OBSTETRICAL CARE	
Total Obstetrical Care (including ante partum care, vaginal delivery, and post partum care)	4.0
Classic Caesarian Section (including ante and post partum care)	6.0
Caesarian Section with hysterectomy, subtotal (including ante and post partum care)	8.0
Therapeutic Abortion, by dilation and curettage	3.0
RESPIRATORY SYSTEM	
Excision of nasal polyp, single	1.4
Multiple, unilateral or bilateral, office	1.4
Complicated, requiring hospitalization	4.0
Submucous resection, including septoplasty	8.0
Antrum puncture, maxillary sinus, unilateral	0.4
Radical antrotomy (Caldwell-Luc), unilateral	12.0
Tracheotomy, independent procedure	5.4
Bronchoscopy, diagnostic	3.6
With excision of tumor	5.0
Removal of lung	30.0
Resection of lung with thoracoplasty	30.0
Lobectomy with decortication	30.0
Laryngectomy, without neck dissection	26.0
Laryngectomy, with neck dissection	34.0
SKIN AND SUBCUTANEOUS TISSUE	
Drainage of superficial abscess	0.4
Suture of small wounds (up to 2½ inches)	0.6
Excision of malignant lesion of face, below ¼ inch diameter	3.0
From ¼ to ½ inch	4.0
From ½ to ¾ inch	5.0
Excision of pilonidal cyst or sinus	7.0
Excision of ingrown nail for complete removal	2.0
THYROID	
Excision of small cyst or tumor of thyroid	9.5
Thyroidectomy, total	16.0
Subtotal or partial	14.5
For malignancy with neck dissection	28.0
URINARY SYSTEM	
Removal of kidney	20.0
Excision of cyst of kidney	18.0
Donor Nephrectomy, with preparation and maintenance of homograft from cadaver donor, unilateral or bilateral	100.0
Resection of bladder tumor, large, transurethral	18.0
Cystoscopy, diagnostic, office	1.2
Cystoscopy, diagnostic, hospital	2.0
With urethral catheterization	3.6
With biopsy	2.6
With fulguration of small tumor	6.0
With removal of stone from ureter	7.0
Cystectomy, complete	26.0
Cystectomy, radical with ureteral transplants	34.0
Renal homo-transplantation: implantation of graft, with unilateral recipient nephrectomy	50.0

vi. PHYSICIAN'S SERVICES

The limit for any listed service is the percentage listed opposite such service in the following Schedule of Services times the Medical Services Benefit shown in the Policy Schedule.

No amount will be allowed under this section for the two weeks of post-operative care covered under Section B (v) of this Benefit.

This section does not apply to diagnostic X-ray examination and laboratory tests.

SCHEDULE OF SERVICES

Routine Visits	Per Cent of Medical Services Benefit
Hospital	20.0%
Office	20.0
Home	35.0
Special Medical Procedures (other than routine visits)	
Consultation	
requiring examination	80.0
Electrocardiogram	
with interpretation and report	48.0
without interpretation and report	24.0

For any Physician's service not listed, the Company will compute the maximum benefit on the basis of the amount shown in the schedules for a service of comparable gravity and severity, unless payment for the service is expressly excepted in such schedule or by other terms of the policy, and subject to the maximum shown in the Policy Schedule.

Radiotherapy and Nuclear Medicine	
Limits include use of modality or radioactive substance. Limits for treatment of malignancies include one year of follow-up care. Limits for treatment of non-malignant conditions include 60 days of follow-up care.	
Per treatment:	
Superficial or Low-voltage therapy	
Dermatoses (3 fields or less)	24.0
more than 3 fields	32.0
Benign Tumors	32.0
Malignant Lesions	48.0
Orthovoltage (150-500 KVP)	
Benign Lesions	32.0
Malignant Lesions	48.0
Supervoltages, including cobalt	64.0
Surface application of sealed source to benign lesion	48.0
Radioisotope treatment of hyperthyroidism (not including radioactive drugs or diagnostic test)	
Initial	320.0
Subsequent	160.0

vii. NURSES AND PHYSIOTHERAPIST'S SERVICES

The limit for any service is the percentage listed opposite such service in the following Schedule of Services times the Medical Services Benefit as shown in the Policy Schedule.

SCHEDULE OF SERVICES

	Per Cent of Medical Services Benefit
Registered Graduate Nurse (Private Duty Only):	
Hospitalized care, per shift	48.0%
Non-hospitalized care, up to 30 days, per shift	48.0
Non-hospitalized care, after 30 days, per shift	32.0
Licensed Practical Nurse (Private Duty Only):	
Hospitalized care, per shift	32.0
Non-hospitalized care, up to 30 days, per shift	32.0
Non-hospitalized care, after 30 days, per shift	20.0
Physiotherapist, per each half-hour of treatment or major fraction thereof	16.0

viii. MENTAL ILLNESS

Expenses incurred by a Covered Member as a result of mental or nervous illness or disorder will be considered Eligible Expenses under Section B (iv) of this Benefit only if incurred during Hospital confinement.

ix. COMMUNICABLE DISEASE

If, within thirty days after the beginning of a sickness of one Covered Member, the same or a related sickness begins for a second Covered Member, only one Deductible Amount need be met, but the Maximum Amount is applicable to each Covered Member.

x. MULTIPLE INJURY

If two or more Covered Members are injured in the same accident, only one Deductible Amount need be met, but the Maximum Amount is applicable to each Covered Member.

xi. RESTORATION OF MAXIMUM

On each policy anniversary, if benefits have been paid for a Covered Member, ten per cent of the Covered Member's original Maximum Amount will be added to the remaining balance, provided that the Maximum Amount shall never be greater than its original amount. A Covered Member may apply to restore his Maximum Amount to its original amount at any time by submitting proof of insurability satisfactory to the Company. Any expenses incurred by or on behalf of a Covered Member while his Maximum Amount is exhausted will not qualify as Eligible Expenses, regardless of whether or not his Maximum Amount is later partially or wholly restored.

xii. FUTURE INCREASE OPTION

While this Benefit is in force, you will have the right, without submitting evidence of insurability as to health, to increase the Daily Room and Board Limit for each Covered Member on each 3rd successive policy anniversary, or after a change in your principal place of residence to a new State and until the time of payment of the first renewal premium falling due after such change, provided:

a. each increase elected under the option must apply equally to all Covered Members;

b. the increase elected any one time the option is used on any third successive anniversary shall not exceed $20.00.

c. the sum total of all increases combined shall not exceed the Daily Room and Board Limit originally issued;

d. the minimum increase elected at any one time the option is used shall be $5.00 or the then remaining balance of the Daily Room and Board Limit, if less;

e. any such increase when added to the existing Daily Room and Board Limit shall not exceed the Company's underwriting limits pertaining to hospital or medical insurance in force;

f. the Company must receive written notice of the exercise of such option no earlier than 60 days before the anniversary on which the increase will be effective, nor later than 30 days before such anniversary, or, in the case of a change in residence, within 30 days after the change in residence takes place.

If the Daily Room and Board Limit is increased as provided in this Section, the Maximum Surgery Benefit and the Medical Services Benefit shall be automatically increased in the same proportion.

The premium payable for each increase elected under this Section will be determined from the applicable table or rates in effect at the time of each such increase and according to the attained ages of Covered Members at the time of each such increase. Each such increase shall apply only to Benefit Periods beginning after the effective date of such increase.

Failure to exercise this option at any time, as provided, will not affect your right to exercise this option at later times.

SECTION C: OLDER AGE HOSPITAL BENEFIT PROVISIONS

The following provisions under this Section C apply only to Covered Members who are covered under Medicare except those specifically included in Section B of this Benefit.

The Company will pay you at the rate of the Medicare Daily Hospital Benefit shown in the Policy Schedule for each full day of confinement of a Covered Member if the confinement begins while the member's coverage is in force. This benefit will be payable for no more than 400 days for any one confinement.

Under the circumstances outlined in this paragraph two or more confinements will be treated as one confinement. A confinement, covered under this section and which begins while coverage for the confined member under this policy is in force, will be considered a continuation of a prior confinement (a) if the confinement results from the same or related cause or causes as a prior confinement, unless the member has resumed full, normal and unrestricted activities for a continuous period of six months following the termination of such prior confinement; or (b) if the confinement results from a different and unrelated sickness, unless the member has been released by the attending physician as being able to and does, resume full, normal and unrestricted activities following the termination of the prior confinement.

SECTION D: EXCLUSIONS

This Benefit does not cover any loss or expense due to (1) suicide, or any attempt thereat, or intentionally self inflicted injury, while sane or insane; (2) loss due to mental or nervous illness or disorder irrespective of the cause of such illness or disorder, except as provided in Section B (viii) of this Benefit; (3) rest cures; (4) injury sustained as a result of travel in any type of aircraft except as a passenger in a licensed aircraft operated by a licensed pilot, provided that such injuries are otherwise covered by this policy; (5) loss resulting from war or any act of war, declared or undeclared; (6) loss sustained by any Covered Member who is in the military, naval or air service of any country (any premium paid to the Company for a Covered Member for any period that such member is not covered by this policy by reason of military, naval, or air service will be returned pro rata); (7) diagnostic work, physical examinations or test procedures not for treatment of a specific sickness or injury; (8) service or treatment provided by any facility or hospital operated by the Veterans Administration or by any federal government unit; (9) service or treatment provided, or paid for, by the United States Government, any state or local government, or any instrumentality thereof, unless you (or the injured or sick Covered Member) are legally required to pay such governmental unit therefor; (10) dental surgery, or treatment, unless occasioned by injury to sound natural teeth; (11) cosmetic surgery except as occasioned by injury; (12) expenses incurred for eye refractions or for eye-glasses; (13) hearing aids or fitting thereof; (14) injury or sickness for which any benefits are provided by Workmen's Compensation or Occupational Disease Act or Law.

POLICY AMENDMENT RIDER

INSURED:
POLICY NO.:
EFFECTIVE DATE:

This rider is attached to and forms a part of the policy and, except as herein provided, shall not alter any of the terms, conditions or provisions of the policy.

Notwithstanding any provision of the policy to the contrary, benefits shall not be denied an Insured for charges in connection with any service performed in a hospital's outpatient department or in a freestanding surgical facility, provided such service would have been covered under the policy if it had been performed on an inpatient basis.

BENEFIT TRUST LIFE
INSURANCE COMPANY

Secretary

President

EXAMINED BY _____