

**MAJOR MEDICAL EXPENSE POLICY**

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

Your policy is issued in consideration of the application and the first premium payment. A copy of the application is attached to, and made a part of, the policy. The first premium is shown in the Schedule. It is due on or before the Policy Date. The first premium will keep the policy in force from the Policy Date to the first renewal date. Renewal premiums are then due on each renewal date. Renewal dates occur at the start of each "Period of Insurance". This period is shown in the Schedule. It may be one, three, six or twelve months. All "Periods of Insurance" start and end at 12:01 a.m. standard time at your home.

**GUARANTEED RENEWABLE FOR LIFE AT PREMIUM RATES IN EFFECT ON RENEWAL DATES.  
BENEFITS REDUCE AT AGE 65 OR AT ELIGIBILITY FOR MEDICARE IF EARLIER.**

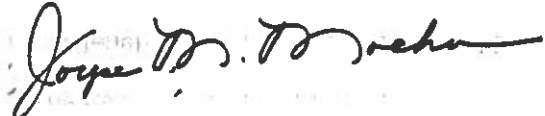
Your policy is guaranteed renewable for life. We cannot cancel or refuse to renew it because of a change in the health of any Covered Member. While the policy is in force, we cannot add any restrictions due to a change in a member's health. You may renew this policy as long as any Covered Member remains eligible under the terms of this policy. To keep the policy in force, just pay each renewal premium when due or within the grace period. Premiums may only be changed on a renewal date as described in Section XVI. Only premiums due on or after the date of the change will be affected by the change. Premiums are guaranteed for the first two policy years.

**NOTICE OF 10 DAY RIGHT TO EXAMINE POLICY**

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



Ralph J. Eckert  
Chairman & Chief Executive Officer



Joyce M. Moehn  
Secretary

Examined by \_\_\_\_\_

Countersigned by \_\_\_\_\_

Licensed Resident Agent

**GUARANTEED RENEWABLE MAJOR MEDICAL EXPENSE POLICY**

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

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

**SCHEDULE**

FORM:

FIRST RENEWAL DATE:

POLICY NUMBER:

\* FIRST PREMIUM:

POLICY OWNER:

PERIOD OF INSURANCE:

POLICY DATE:

\*PREMIUM RATE WILL NOT INCREASE FOR AT LEAST TWO YEARS

COVERED MEMBERS UNDER THIS POLICY . . . . . INSURED:

SPOUSE:

CHILDREN:

DEDUCTIBLE

HOSPITAL DAILY ROOM & BOARD LIMIT

MAXIMUM AMOUNT

\$1,000,000.00

ORGAN TRANSPLANT MAXIMUM

\$50,000.00

MAXIMUM SURGERY BENEFIT

MENTAL ILLNESS MAXIMUM

\$25,000.00

MEDICAL SERVICES BENEFIT

OLDER AGE DAILY HOSPITAL BENEFIT  
(for persons eligible for Medicare)

\$40.00

## I. DEFINITIONS OF CERTAIN WORDS USED IN THIS POLICY

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

**You and your:** Mean the Policy Owner named in the Schedule.

**Covered Member and member:** Mean any person covered by this policy. Covered Members are listed in the Schedule (or its latest amendment).

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

**Sickness:** Means illness, disease or Complications of Pregnancy which are first manifested more than 30 days after the effective date of a member's coverage; and such conditions disclosed in the application which are not specifically excluded.

**Mental Illness:** Means neurosis, psychoneurosis, psychopathy, psychosis and mental disease or disorders as defined in the Diagnostic and Statistical Manual of Disorders of the American Psychiatric Association which are first manifested more than 30 days after the effective date of a member's coverage; and such conditions disclosed in the application which are not specifically excluded.

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

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

**Preexisting Condition:** Means a condition misrepresented or not disclosed in the application for which either: symptoms existed within the five years before the effective date of a member's coverage which would cause an ordinarily prudent person to seek medical advice or care; or for which medical advice or care was recommended by, or received from, a Physician within the five years before the effective date of a member's coverage.

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

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

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

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

**Hospital:** Means a place which is all of the following. (1) It is operated lawfully. (2) It mainly and continuously provides medical, diagnostic and surgical facilities. These facilities may be on the premises or available on a prearranged basis. They must be supervised by one or more licensed Physicians. (3) It provides inpatient care. (4) It provides 24-hour nursing service by, or supervised by, a Registered Graduate Nurse (R.N.).

'Hospital' does not include: a convalescent, nursing or rest home; a Skilled Nursing Home or extended care facility; a home for the aged or a custodial care facility; a sanatorium, clinic or rehabilitation facility; or a place mainly for treating drug addiction or alcoholism.

**Intensive Care Unit:** Is the part of a Hospital designated as an intensive care unit by the Hospital. It must be permanently equipped and staffed to provide, for critically sick or injured persons, more extensive care than is provided in the general Hospital rooms. This care must include constant observation by a Registered Graduate Nurse (R.N.) whose duties are confined to that unit.

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

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

'Skilled Nursing Home' does not include: a rest home or a home for the aged; a place mainly for treating drug addiction, alcoholism or mental illness; or a custodial care or educational care facility.

**Hospice Care:** Means a program of palliative and supportive health care which: is provided by a licensed or certified hospice; and starts within 6 months after a Covered Member is released from a Hospital Confinement for the same Sickness for which the Hospice Care is given; and is provided to such member after he has been diagnosed by a Physician as terminally ill and not expected to live for longer than 6 months.

**Home Care:** Means an organized plan of treatment and care furnished in the home by a licensed or certified home health agency under the supervision of a Physician.

**Confinement:** Means either: being an in-patient in a Hospital, Skilled Nursing Home or hospice; or being continuously confined at home, except for necessary trips for medical treatment or for rest outdoors at or near your home. 'Confinement' must be caused by Sickness or Injury. The confined member must be under a Physician's care for the Sickness or Injury causing the Confinement.

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

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

**Other Terms:** Maximum Amount, Organ Transplant Maximum, Deductible, Hospital Daily Room and Board Limit, Maximum Surgery Benefit, Mental Illness Maximum, Medical Services Benefit and Older Age Daily Hospital Benefit are shown in the Schedule and explained in the policy. The beneficiary is named in the application or later designated by the policy owner. All masculine pronouns include the feminine.

## II. ELIGIBILITY FOR COVERAGE

### A. ELIGIBLE PERSONS

Persons who are eligible to become Covered Members are the following.

1. You.
2. Your spouse.
3. Your, or your spouse's, child who is over 14 days and less than 18 years old.
4. Your, or your spouse's, child age 18 or older and under age 23 who is a full time student at an accredited educational institution or who resides with you.

A child is eligible for coverage only if: (a) he is unmarried; and (b) he is dependent on you for support and maintenance. A 'child' includes a legally adopted child. For a child 18 years or older, the premium for his attained age must be paid.

### B. BECOMING COVERED

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

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

### **C. NEWBORN CHILDREN**

A child born to the Insured while this policy is in force is automatically covered. He remains so for 31 days, or until the end of the Period of Insurance during which he was born, if later. To continue his coverage, notify us in writing within 45 days after his birth, or before the end of the Period of Insurance during which he was born, if later, and make timely payment of the premium for his continued coverage.

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

### **III. TERMINATION OF COVERAGE**

#### **A. WHEN COVERAGE ENDS**

A Covered Member's coverage under this policy ends at the earliest of the following.

1. At the end of the Grace Period for an unpaid premium.
2. For your spouse — on the renewal date next following the date of divorce or annulment.
3. For your child — on the renewal date next following the earliest of his 23rd birthday; his marriage; or the date he stops being eligible for dependent coverage as provided in Section II.

If we accept premium for a Covered Member after he is no longer eligible for coverage, we will continue his coverage to the end of the period the premium applies to. Otherwise, the member's coverage ends at the end of the Period of Insurance during which he stops being eligible.

#### **B. HANDICAPPED DEPENDENTS**

If a dependent child is, due to mental retardation or physical handicap, unable to earn his own living on the date his coverage would otherwise end because of age, his coverage may be continued. All of the following conditions must be met.

1. The child must be, on that date, covered under the policy.
2. His incapacity must continuously prevent him from earning his own living.
3. He must continue, except for his age, to be eligible for coverage.
4. The policy must remain in force.
5. Proof of his incapacity and dependency must be furnished within 31 days of the age his coverage would otherwise end.
6. The premium for his then attained age must be paid.

We may require proof of the child's continuing incapacity and dependency. During the first two years after he attains the age his coverage would otherwise end, we may require proof at reasonable intervals. After such two years, we may not require proof more than once a year.

#### **C. CONTINUATION OF POLICY AFTER DEATH OF THE POLICY OWNER**

If you die while this policy is in force, and there are no surviving Covered Members, the policy ends. If there are surviving Covered Members, your spouse becomes the Policy Owner. Your spouse's coverage, if any, will not change. If no spouse survives, the policy becomes paid up for any surviving covered children. No more premiums will be due. The coverage continues until the end of the term during which the last child's coverage ends according to Sections II and III. While this policy is paid up, benefits are paid to the child or, if he is a minor, to his legal guardian. The person receiving such benefits will, for this purpose only, be considered the Policy Owner.

#### **D. PREMIUM CHANGE**

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

#### **IV. EXTENSION OF BENEFITS**

If a Covered Member is Hospital confined on the date his coverage ends (or if a Covered Member is Hospital confined at age 65 or any earlier date on which he becomes eligible for Medicare) an extension of benefits will be provided. Benefits will be extended:

1. only for a Hospital confined member; and
2. only while he remains Hospital confined; and
3. only for the Sickness or Injury which causes him to be so confined.

Benefits are extended to the earliest of:

1. the date he is no longer Hospital confined; or
2. the end of the calendar year during which his coverage ends (or during which he reaches age 65 or becomes eligible for Medicare, if earlier); or
3. the date his Maximum Amount is paid.

Extended benefits will be paid to the extent they would be paid if coverage had not ended.

#### **V. CONVERSION PRIVILEGE**

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

#### **VI. BENEFIT PROVISIONS FOR PERSONS UNDER AGE 65 AND NOT ELIGIBLE FOR MEDICARE**

The following provisions apply to Covered Members who are under age 65 and not eligible for Medicare. They also apply to Covered Members age 65 and over, or who became eligible for Medicare at an earlier age, but who become Hospital confined before their 65th birthday or Medicare eligibility; but only to the extent described in Section IV above.

##### **A. BENEFIT PERIODS**

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

##### **B. DEDUCTIBLE**

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

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

1. The Deductible does not have to be met for the Preadmission Testing Benefit.
2. Once three Covered Members have met their Deductible for the year, no others need meet it for that year.
3. Any Covered Charges incurred during the last three months of a year which are used toward meeting a member's Deductible for that year will also be used toward meeting his Deductible for the following year.

### **C. MAXIMUM AMOUNT**

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

### **D. BENEFITS PAYABLE**

When a Covered Member does not have any Other Benefits (as defined below) benefit payments are calculated as follows. After the Deductible has been met, we pay the amount of Covered Charges incurred by a Covered Member during a calendar year, up to the Maximum Amount.

When a Covered Member has Other Benefits, benefit payments are calculated differently. Each benefit payment is calculated as follows.

1. We find the amount of benefits we would pay if there were no Other Benefits.
2. We total his expenses incurred during the calendar year and while his coverage is in force for services and supplies covered by this policy.
3. We subtract from those total expenses the total of all benefits previously paid, plus Other Benefits currently payable, for those expenses. This gives the amount of those expenses not reimbursed.
4. We pay the lesser of the amounts in 1. or 3. above.

If the amount we pay is less than what we would have paid if there were no Other Benefits, we will make the difference available to reimburse you for expenses incurred by the Covered Member in the same calendar year which are not reimbursed by any source, as long as those expenses are: incurred while the member's coverage is in force or under the extension of benefits; and are for services and supplies covered by this policy.

### **E. OTHER BENEFITS**

Other Benefits means the sums of money or medical services to which a Covered Member is legally entitled, for the services and supplies covered by this policy, in the absence of this policy, as a result of Sickness or Injury, from:

1. any other medical expense insurance coverage, including motor vehicle insurance, and no-fault insurance where allowed by law;
2. any prepayment plan;
3. any hospital or medical service, group practice or other such plan;
4. any self funded plan provided by an employer or union;
5. any third party responsible for the Sickness or Injury, including the third party's insurer; or
6. any government plan including Medicare (but not Medicaid).

In no event will the total amount we pay during any one calendar year exceed the amount that we would pay if there were no Other Benefits. In no event will the total amount we pay, when added to Other Benefits, exceed expense actually incurred.

If the total benefits paid for a Covered Member in a calendar year is less than would be paid if there were no Other Benefits, the member's Maximum Amount will be increased. It will be increased by \$3.00 for each \$1.00 by which Other Benefits reduce total benefits otherwise payable.

### **F. DELAY IN RECEIVING OTHER BENEFITS**

If you cannot secure your Other Benefits without recourse to legal action; and if for purposes of a claim under this policy we have used such Other Benefits in computing benefits payable under this policy; then we will reopen your claim when we receive proof satisfactory to us that you have made a reasonable effort to secure such Other Benefits and have not been successful. We will pay you the additional amount that would have been paid if benefits had been computed without using such unpaid Other Benefits; but, you thereby subrogate to us the right to collect and receive a portion of such unpaid Other Benefits that equals the amount by which we so increase your claim payment.



## **G. COVERED CHARGES**

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

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

The 'usual' charge is the smaller of: the charge made when there is no insurance; or the usual level of charges made in the same county (or larger area if necessary to find this level) for the same or a similar service or supply.

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

Covered Charges are the following.

- 100% of daily room, board and general nursing care charges during a Hospital Confinement, up to the Hospital Daily Room and Board Limit for any one day of Confinement, unless the Intensive Care Unit benefit is paid for that day.
- 100% of daily room, board and general nursing care charges during Confinement in an Intensive Care Unit, up to twice the Hospital Daily Room and Board Limit for any one day of Confinement. For any day we pay this Intensive Care Unit benefit, we will not pay the room and board benefit above.
- 80% of charges by a Hospital or a Free Standing Surgical Center for services, supplies, drugs and medicines needed for the Covered Member's care. This does not include room, board and general nursing care charges.
- 100% of Physician's charges for surgery and anesthesia, up to the limits described in Section XI. SURGERY BENEFIT.
- 100% of Physician's charges, except for surgery, anesthesia, diagnostic x-rays and laboratory tests, up to the limits described in Section XII. PHYSICIANS BENEFIT.
- 100% of private duty Nurse and Physical Therapist charges, up to the limits described in Section XIII. NURSES AND PHYSICAL THERAPISTS BENEFITS.
- 100% of Skilled Nursing Home charges for daily room, board and general nursing care, up to one-half the Hospital Daily Room and Board Limit for any one day of Confinement. Benefits are paid for up to 50 days per calendar year. Benefits are paid only for Confinement which starts within 14 days after a Hospital Confinement of at least 3 days.
- 80% of Home Care charges for care which starts within one day after a Hospital Confinement of at least 3 days or after a Confinement in a Skilled Nursing Home for which benefits were payable. Benefits are paid for up to 40 Home Care visits. Benefits are paid for Home Care administration, fees of Nurses, and medical services and supplies furnished during home Confinement.
- 100% of charges by a hospice for daily room, board and general nursing care provided under a Hospice Care plan, up to one-half the Hospital Daily Room and Board Limit for any one day of Confinement. Benefits are paid for up to 30 days of confinement.
- 80% of inpatient Hospice Care charges for services, supplies, drugs and medicines provided on any day for which the Hospice Care room and board benefit above is payable.
- 80% of outpatient Hospice Care charges, up to a \$1,000 lifetime benefit, for charges not otherwise covered by this policy.

- 80% of charges for diagnostic x-rays, laboratory tests, drugs and medicines identified by a prescription number and purchased from a licensed pharmacist.
- 80% of charges for blood and blood plasma, oxygen and other medical supplies and initial prosthetic appliances.
- 80% of local professional ambulance charges.

#### **H. PREADMISSION TESTING BENEFIT**

We will pay 100% of Covered Charges incurred for x-rays and tests done at a Hospital on an outpatient basis prior to a Confinement in that Hospital for surgery. We will only pay for x-rays and tests related to the proposed surgery and deemed necessary by your Physician. This benefit will be paid only for charges incurred after the later of:

1. the date on which the surgical diagnosis is made;
2. the date on which the Physician reserves the Hospital room; or
3. the date on which the Physician schedules the operating room.

The Deductible need not be met for this benefit to be paid. But, this benefit is not paid if the Covered Member thereafter refuses to undergo, cancels or postpones the surgery, except when due to reasons beyond his control.

#### **VII. MENTAL ILLNESS BENEFIT**

This policy provides limited coverage for Mental Illness. Benefits are payable as described in Section VI. BENEFIT PROVISIONS. However, they are only paid for expense incurred during Hospital Confinement and only up to 30 days per calendar year. Benefits are paid up to the Mental Illness Maximum shown in the Schedule. The Mental Illness Maximum is the total amount of benefits we will pay for any one Covered Member during his lifetime for all Covered Charges incurred for Mental Illness.

#### **VIII. FOREIGN TRAVEL COVERAGE**

This policy provides limited coverage while a Covered Member is traveling outside of the U.S. and its territories or Canada. Benefits are paid for up to 30 days of treatment, but only for:

1. Injury occurring during the first 30 days of such travel; and
2. Sickness first manifest during the first 30 days of such travel.

No other coverage is provided for treatment given outside of the U.S. and its territories or Canada.

#### **IX. ACCIDENTAL DEATH BENEFIT**

This benefit applies only to the Insured. It is paid if all of the following occur.

1. The Insured's death results, directly and independently of all other causes, from Injury.
2. Death occurs within 90 days after the accident which caused the Injury.
3. The accident occurs while the Insured's coverage is in force and before his age 65.

The benefit equals the total of all premiums paid for this policy to the date of death, or \$1,000.00 if greater.

Payment of this benefit will not affect the continuation of coverage for any surviving Covered Members. Coverage will continue as described in Section III(C). A surviving spouse then becomes covered by this benefit. The benefit payable for such spouse will be the total of premiums paid for the period of time after the Insured's death.

## **X. OLDER AGE HOSPITAL BENEFIT FOR PERSONS OVER AGE 65 OR ELIGIBLE FOR MEDICARE**

The following applies to Covered Members: (a) who are age 65 or over or are eligible for Medicare; and (b) whose Hospital Confinement starts on or after their 65th birthday, or their Medicare eligibility if earlier, and while their coverage is in force.

We will pay you at the rate of the Older Age Daily Hospital Benefit shown in the Schedule for each day a Covered Member is Hospital confined. The maximum paid for any One Confinement will be 400 days.

As used above, 'One Confinement' means either: consecutive days of Confinement; or two or more Confinements due to the same or related causes when discharge from and readmission to the Hospital occur within 60 days.

This benefit will not be paid for any Hospital Confinement for which the Daily Room and Board benefit in Section VI. is payable under the extension of benefits.

## **XI. SURGERY BENEFIT**

We will pay Covered Charges incurred for surgeon's services, up to the limit for the procedure. To find the maximum amount that will be paid for a procedure, multiply the Maximum Surgery Benefit shown in the Schedule by the percent shown in the Table of Procedures. The surgery benefit includes charges for the surgery and for post-surgery care for two weeks, or for the Hospital Confinement, if longer.

We will also pay Covered Charges for anesthesiologist's and assistant surgeon's services, as follows.

1. The limit for the anesthesiologist is 25% of the limit for the surgeon.
2. The limit for the assistant surgeon is 15% of the limit for the surgeon.

The limit for anesthesiologist's fees includes charges for: (1) administration of anesthetic and any fluids related to the operation; and (2) the usual visits made before and after surgery. This limit is only for fees of a Physician attending the surgery for the sole purpose of giving the anesthesia service. The limit will be 50% less if the operating surgeon or his assistant gives the anesthesia.

For a procedure not listed in the Table, the benefit is based on the percent listed for a procedure of similar complexity. This benefit cannot exceed the Maximum Surgery Benefit shown in the Schedule.

If more than one procedure is done at the same time and through the same incision, we will pay only for the procedure with the highest limit. If they are done through different incisions, we pay for the procedure with the highest limit plus 50% of the limit(s) for the other procedure(s). But, the total benefit paid cannot exceed the Maximum Surgery Benefit.

We will pay benefits for surgical sterilization which is not Medically Necessary; but, only such surgery done more than 12 months after the Policy Date will be covered. No benefits will be paid for reversal of a surgical sterilization.

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

## TABLE OF PROCEDURES

	Per Cent of Maximum Surgery Benefit		Per Cent of Maximum Surgery Benefit
<b>Bones and Joints</b>			
Arthrodesis, hip . . . . .	20.0	%	
Bone graft, radius or ulna . . . . .	8.0		
Spinal fusion, two or more segments . . . . .	18.5		
Scoliosis, Harrington rod technique . . . . .	33.0		
Harrington Rod Removal . . . . .	100.0		
Hallux valgus . . . . .	2.9		
Arthroscopy of the knee . . . . .	4.0		
<b>Fractures</b>			
Jaw, closed reduction with wiring of teeth . . . . .	5.3		
Open reduction with wiring of teeth and/or local fixation . . . . .	11.0		
Wrist (Colles), simple, closed reduction . . . . .	3.3		
Open reduction . . . . .	4.2		
Clavicle, simple, closed reduction . . . . .	1.8		
Simple or compound, open reduction . . . . .	6.0		
Upper arm shaft, simple closed reduction . . . . .	3.3		
Simple or compound, open reduction . . . . .	7.2		
Lower arm shaft			
Radius or ulna, simple closed reduction . . . . .	2.9		
Simple or compound, open reduction . . . . .	6.7		
Radius and ulna, simple closed reduction . . . . .	4.0		
Simple or compound, open reduction . . . . .	10.0		
Finger or thumb, simple, closed reduction . . . . .	1.1		
Open reduction . . . . .	2.7		
Hip socket, simple closed reduction . . . . .	3.2		
Simple or compound, open reduction . . . . .	10.0		
Upper leg, proximal end, simple closed reduction . . . . .	6.3		
Simple or compound, open reduction . . . . .	14.0		
Upper leg shaft, simple closed reduction . . . . .	5.3		
Simple or compound, open reduction . . . . .	12.5		
Lower leg shaft			
Tibia, simple closed reduction . . . . .	4.0		
Simple or compound, open reduction . . . . .	8.0		
Fibula, compound, with uncomplicated soft tissue closure . . . . .	2.5		
Simple or compound, open reduction . . . . .	5.3		
Tibia and fibula, closed reduction . . . . .	5.8		
Simple or compound, open reduction . . . . .	9.7		
Ankle (Potts), simple, closed reduction . . . . .	3.2		
Open reduction . . . . .	7.3		
Puncture of joint, for aspiration . . . . .	0.25		
Excision of intervertebral disc . . . . .	14.5		
With spinal fusion . . . . .	18.0		
Excision of semi-lunar cartilage of knee joint . . . . .	8.9		
Suture of collateral or cruciate ligament, knee, one . . . . .	10.5		
Collateral and cruciate ligament, knee . . . . .	12.0		
<b>Dislocation</b>			
Shoulder, simple, closed reduction, with anesthesia . . . . .	3.3	%	
Knee, simple, closed reduction . . . . .	2.0		
Open reduction . . . . .	10.0		
Tarsal or astragalo-tarsal, simple closed reduction . . . . .	1.3		
Open reduction . . . . .	4.0		
Toe, more than one, one or more joints, Simple closed reduction . . . . .	0.7		
Simple or compound, open reduction . . . . .	2.4		
<b>Brain and Nerves</b>			
Craniotomy: Evacuation of hematoma, subdural, extradural or intracerebral . . . . .	16.0		
Elevation of depressed skull fracture, simple . . . . .	11.5		
Excision of brain tumor, abscess or cyst . . . . .	20.0		
Obliteration of aneurysm . . . . .	23.0		
Pneumoencephalography . . . . .	2.2		
Spinal puncture, lumbar, independent procedure . . . . .	0.4		
Laminectomy for lesion of spinal cord . . . . .	17.5		
For removal of intervertebral discs . . . . .	18.0		
Sympathectomy, lumbar, unilateral . . . . .	8.5		
Bilateral . . . . .	12.0		
Sympathectomy, cervico-thoracic, bilateral . . . . .	16.0		
Repair of encephalocele . . . . .	16.0		
Carpal Tunnel Syndrome . . . . .	5.0		
<b>Breast</b>			
Excision, biopsy of breast . . . . .	2.3		
Excision of cyst, tumor or part of breast . . . . .	2.9		
Simple removal of breast . . . . .	5.2		
Radical removal of breast . . . . .	12.0		
<b>Cardiovascular System</b>			
Repair of heart valve, mitral . . . . .	24.0		
Aortic, pulmonic or tricuspid . . . . .	20.0		
Catheterization of heart, independent procedure . . . . .	1.7		
Double valve procedure, replacement and/or repair by valvuloplasty or replacement . . . . .	60.0		
Triple valve procedure, replacement and/or repair . . . . .	80.0		
Coronary angioplasty (endarterectomy, arterial implantation or anastomosis), with bypass . . . . .	25.0		
Ligation of femoral vein . . . . .	3.8		
Varicose veins: Ligation and division of long saphenous vein at saphenofemoral junction . . . . .	2.5		
Ascending Arch Graft Thoracic Aorta, without valve replacement . . . . .	28.0		
with valve replacement . . . . .	35.0		
Transverse Arch Graft . . . . .	40.0		

## TABLE OF PROCEDURES

	Per Cent of Maximum Surgery Benefit		Per Cent of Maximum Surgery Benefit
Ligation and division and complete stripping of long or short saphenous veins, unilateral . . . . .	3.5 %		
Bilateral . . . . .	5.4		
Ligation and division and complete stripping of long and short saphenous veins, unilateral . . . . .	5.0		
Bilateral . . . . .	7.5		
Venography . . . . .	0.25		
<b>Digestive System</b>			
Removal of tonsils, with or without removal of adenoids under 18 years of age . . . . .	2.4		
18 years of age or over . . . . .	2.7		
Excision of stomach ulcer or benign tumor . . . . .	9.4		
Removal of stomach, subtotal, with or without vagotomy . . . . .	13.0		
Resection of small intestine, with anastomosis . . . . .	11.0		
Resection of large intestine, in two stages, including first stage colostomy . . . . .	22.0		
Removal of appendix . . . . .	5.8		
Proctosigmoidoscopy, diagnostic, initial . . . . .	0.4		
Subsequent . . . . .	0.4		
Incision of rectal fistula, superficial . . . . .	1.4		
Excision of hemorrhoids, external, complete . . . . .	3.7		
Internal and external . . . . .	4.5		
Removal of gall bladder . . . . .	8.2		
With open exploration of common duct . . . . .	10.5		
Repair of inguinal hernia, unilateral . . . . .	5.6		
With excision of hydrocele . . . . .	6.3		
Recurrent . . . . .	6.5		
Repair of femoral hernia, unilateral . . . . .	5.5		
Recurrent . . . . .	6.5		
Repair of ventral hernia, incisional . . . . .	6.9		
Recurrent . . . . .	7.8		
Repair of epigastric hernia, simple . . . . .	2.6		
Spigelian hernia . . . . .	5.8		
Repair of umbilical hernia, under 5 years of age . . . . .	4.8		
5 years of age or over . . . . .	5.5		
<b>Eye</b>			
Removal of foreign body from surface of cornea . . . . .	0.3 %		
Excision of pterygium . . . . .	3.4		
Needling of lens for cataracts, initial . . . . .	2.8		
Subsequent . . . . .	1.4		
Extraction of lens for cataracts, unilateral . . . . .	11.0		
Reattachment of retina, electrocoagulation, initial . . . . .	12.5		
Eye muscle operation, one or more muscles, one or both eyes, single stage . . . . .	8.3		
Laser Surgery for Cataracts (one or more stages) . . . . .	12.5		
<b>Female Genital System</b>			
Excision of ovarian cyst or tumor, unilateral or bilateral, independent procedure . . . . .	6.7		
Removal of ovary; unilateral or bilateral, independent procedure . . . . .	7.5		
Biopsy of cervix or endometrium, independent procedure . . . . .	0.4		
Total hysterectomy, corpus and cervix . . . . .	10.0		
Radical hysterectomy for malignancy, including regional lymph nodes . . . . .	20.0		
Vaginal hysterectomy, with or without pelvic floor repair . . . . .	12.5		
Excision of lesion of cervix . . . . .	0.4		
Cauterization of cervix . . . . .	0.4		
Dilation and curettage of uterus, independent procedure . . . . .	2.7		
<b>Male Genital System</b>			
Excision of hydrocele, unilateral . . . . .	4.6		
Excision of varicocele, independent procedure, unilateral . . . . .	4.7		
With hernia repair . . . . .	5.5		
Orchiectomy, radical . . . . .	5.3		
Resection of prostate, perineal, suprapubic, retropubic or transurethral . . . . .	11.5		
Radical . . . . .	15.0		
<b>Muscles and Tendons</b>			
Excision of ganglion, wrist . . . . .	2.7		
Excision of Baker's cyst (synovial cyst in popliteal space) . . . . .	5.1		
Fasciotomy (Dupuytren's contracture) . . . . .	1.7		
Fasciectomy, partial . . . . .	4.1		
Complicated . . . . .	10.0		
<b>Ear</b>			
Incision of ear drum . . . . .	0.65		
Tympanoplasty, Type 1, uncomplicated . . . . .	14.5		
Type V, two stages . . . . .	16.0		
Stapes mobilization . . . . .	7.7		
Stapedectomy, with or without vein plug . . . . .	13.0		
Tympanostomy (in hospital) . . . . .	2.3		

**TABLE OF PROCEDURES**

	<b>Per Cent of Maximum Surgery Benefit</b>		<b>Per Cent of Maximum Surgery Benefit</b>
<b>Respiratory System</b>		<b>Thyroid</b>	
Excision of nasal polyp, single . . . . .	1.0 %	Excision of small cyst or tumor of thyroid . . . . .	6.2 %
Multiple, unilateral or bilateral, office . . . . .	1.0	Thyroidectomy, total . . . . .	9.7
Complicated, requiring hospitalization . . . . .	2.7	Subtotal or partial . . . . .	8.9
Submucous resection, including septoplasty . . . . .	5.0	For malignancy with neck dissection . . . . .	18.5
Antrum puncture, maxillary sinus, unilateral . . . . .	0.25		
Radical antrotomy (Caldwell-Luc), unilateral . . . . .	7.7	<b>Urinary System</b>	
Tracheostomy, independent procedure . . . . .	3.1	Removal of kidney . . . . .	11.5
Bronchoscopy, diagnostic . . . . .	2.4	Excision of cyst of kidney . . . . .	10.5
Removal of lung . . . . .	18.0	Resection of bladder tumor, large, transurethral . . . . .	10.5
Resection of lung with thoracoplasty . . . . .	18.0	Cystoscopy, diagnostic, office . . . . .	0.65
Lobectomy with decortication . . . . .	18.0	Cystoscopy, diagnostic, hospital . . . . .	1.2
Laryngectomy, without neck dissection . . . . .	17.0	With urethral catheterization . . . . .	2.1
Laryngectomy, with neck dissection . . . . .	26.0	With biopsy . . . . .	1.6
		With fulguration of small tumor . . . . .	3.3
		With removal of stone from ureter . . . . .	4.2
		Cystectomy, complete . . . . .	15.0
		Cystectomy, radical with ureteral transplants . . . . .	20.0
<b>Skin and Subcutaneous Tissue</b>			
Biopsy . . . . .	0.4		
Drainage of superficial abscess . . . . .	0.25		
Suture of small wounds (up to 2½ inches) . . . . .	0.4		
Excision of malignant lesion of face, below .5 cm diameter . . . . .	1.6		
from .5 to .10 cm . . . . .	2.2		
from 1.0 to 2.0 cm . . . . .	2.7		
Excision of pilonidal cyst or sinus (simple) . . . . .	1.3		
Excision of ingrown nail for complete removal . . . . .	1.4		

## XII. PHYSICIAN'S BENEFIT

We will pay Covered Charges incurred for Physician's fees, up to the limit for the service given. To find the limit for a covered service, multiply the Medical Services Benefit shown in the Schedule by the percent listed below for the service.

No benefits are paid under this section for the two weeks of post-surgery care covered by Section XI. SURGERY BENEFIT. No outpatient benefits are paid for Mental Illness. No benefits are paid under this section for diagnostic x-rays or laboratory tests.

For treatment, by manual or mechanical means, of structural imbalance, distortion or subluxation in the vertebral column or elsewhere, covered visits are limited to 20 per year. For all other Physician's treatment covered visits are limited to 1 per day for the attending Physician and 1 per day for any required specialist.

<b>Routine Visits</b>	<b>Per Cent of Medical Services Benefit</b>
Hospital . . . . .	20.0%
Office . . . . .	20.0
Home . . . . .	35.0
 <b>Special Medical Procedures (other than routine visits)</b>	
Consultation	
requiring examination . . . . .	80.0
Electrocardiogram	
with interpretation and report . . . . .	48.0
without interpretation and report . . . . .	24.0
 For a service not listed, the benefit is based on the percent listed for a service of similar complexity. This benefit cannot exceed the Medical Services Benefit shown in the Schedule.	
<b>Radiation Therapy and Nuclear Medicine</b>	
Limits include use of modality or radioactive substance. Limits for treatment of malignancies include one year of follow-up care. Limits for treatment of nonmalignant 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
Supervoltages, including cobalt . . . . .	64.0
Surface application of sealed source to benign lesion . . . . .	48.0
 <b>Radioisotope treatment of hyperthyroidism (not including radioactive drugs or diagnostic test)</b>	
Initial . . . . .	320.0
Subsequent . . . . .	160.0

### XIII. NURSES AND PHYSICAL THERAPISTS BENEFIT

We will pay Covered Charges incurred for Nurse's and Physical Therapist's services, up to the limit for the service. To find the limit for a covered service, multiply the Medical Services Benefit shown in the Schedule by the percent listed below for the service.

	<b>Per Cent of Medical Services Benefit</b>
<b>Registered Graduate Nurse (Private Duty Only):</b>	
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
<b>Licensed Practical or Vocational Nurse (Private Duty Only):</b>	
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
Physical Therapist, per each half-hour of treatment or major fraction thereof . . . . .	16.0

### XIV. PREEXISTING CONDITIONS LIMITATION

This policy does not cover any charge incurred or Hospital Confinement starting during the first two years of a member's coverage which is caused by a Preexisting Condition. (See Section I. DEFINITIONS OF CERTAIN WORDS USED IN THIS POLICY.)

### XV. EXCLUSIONS

This policy does not cover loss due to any of the following.

- Suicide, or attempted suicide, while sane or insane.
- Intentionally self-inflicted injury, while sane or insane.
- Rest cures.
- Injury resulting from travel in any type of aircraft, except as a fare paying passenger or crew member in a scheduled commercial airplane.
- War, or act of war, declared or undeclared, and occurring after the Policy Date.
- Expense incurred while in the military, naval or air service of any country. Any premium paid for a Covered Member for a period that he is in such service will be returned pro rata upon notice of entry into such service.
- Diagnostic work, examinations or test procedures not related to a specific Sickness or Injury.
- Dental surgery or treatment, unless caused by injury to sound natural teeth. Bridgework attached to injured teeth is not covered.
- Cosmetic surgery, except reconstructive surgery related to or following surgery resulting from injury, trauma, infection or other disease of the involved part; and except reconstructive surgery of a covered newborn child required due to birth abnormalities or congenital defects.
- Eye refractions or eyeglasses.
- Hearing aids or fitting thereof.
- A condition for which a Covered Member is eligible to receive Workers Compensation or Occupational Disease Act or Law benefits.
- Service or supplies provided by the Veterans Administration, under any law (including Medicare), or by any government unit for which you (or the Covered Member) are, or become, eligible. This exclusion will not apply if you are legally required to pay for such service or supplies, or to Medicaid. This exclusion will not apply to the Older Age Hospital Benefit.
- Sex change surgery. This includes all related services and supplies whether furnished prior to, after, or in lieu of such surgery.
- Normal pregnancy and childbirth.
- External fertilization procedures.
- Alcoholism, drug addiction or chemical dependency.
- Drugs, therapies, procedures or treatments which are experimental or are not approved for reimbursement by the Health Care Financing Administration (or its successor).

This policy will not pay benefits which duplicate Other Benefits payable for the same expense.



## **XVI. PREMIUM PROVISIONS**

### **RENEWAL PREMIUMS**

Renewal premiums are based on our rate schedule in use on the renewal date. We have the right to change this schedule, but not for the first two policy years. If a rate change is made, it must be on an Insurance Class basis for all policies of this plan. Your premium will not change because of the health or claim experience of any Covered Member. Rates for each member are based on age, sex and insurance classification on the Policy Date; except when a child attains age 18 his rate becomes based on that age.

### **CHANGE OF PREMIUM AT AGE 65 AND AT ELIGIBILITY FOR MEDICARE**

Because benefits change for a member at age 65 or eligibility for Medicare, if earlier, premiums also change then. You must notify us if any member becomes covered by Medicare before age 65. We will return any excess premium paid for the period after such notification, or the date on which Medicare coverage starts, whichever is later.

Regardless of any provisions in this policy to the contrary if, when a member reaches age 65, the normal Medicare eligibility age is older than age 65, benefits will not change until the member reaches that age, or until he becomes eligible for Medicare, if earlier. However, premium for the member will change at age 65 and at the normal Medicare eligibility age, or the age the member becomes eligible for Medicare, if earlier.

## **XVII. RIGHT TO INCREASE BENEFIT LEVELS**

While this policy is in force you have the right to increase the Hospital Daily Room and Board Limit every three years on the policy anniversary. You also have the right to increase this limit after a change in your main place of residence to a new state. No evidence that a member is insurable will be required.

We must receive written notice of the increase: (1) no earlier than 60 days before the anniversary on which the increase will be made; (2) no later than 30 days before such anniversary; and (3) in the case of a move to a new state, within 30 days after the move takes place.

Any such increase is subject to the following.

1. The increase chosen must apply equally to all Covered Members.
2. Any time an increase is chosen, except when due to a move to a new state, the increase shall not exceed \$30.00.
3. When due to a move to a new state, the increase shall not exceed \$50.00.
4. The total of all increases shall not exceed the amount of the original Hospital Daily Room and Board Limit.
5. The minimum increase at any one time shall be \$10.00, or the remaining balance of the maximum increase, if less.

When the Hospital Daily Room and Board Limit is increased, the Maximum Surgery Benefit and the Medical Services Benefit will increase in the same proportion.

The premium payable for each increase will be based on our rates in use at the time of the increase. Rates for each member will be based on his age at the time of the increase. Each increase will apply only to charges incurred or Hospital Confinement starting after the effective date of the increase.

If you do not choose to increase at any time you are allowed to, this will not affect your right to increase at a later time.

## **XVIII. UNIFORM PROVISIONS**

### **ENTIRE CONTRACT; CHANGES**

This policy with the attached application and any attached riders is the entire contract. No change in this policy will be effective until approved by one of our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

### **TIME LIMIT ON CERTAIN DEFENSES**

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

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

### **GRACE PERIOD**

This policy has a 31 day grace period for payment of each renewal premium. During the grace period the policy remains in force.

### **REINSTATEMENT**

If a renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by us (or by an agent authorized to accept premium) without requiring a reinstatement application will automatically reinstate this policy. If we, or our agent, require an application, you will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45th day after the date of the conditional receipt unless we have previously written you of its disapproval. The reinstated policy will only cover loss that results from an Injury sustained after the date of reinstatement and Sickness that starts more than 10 days after such date. In all other respects your and our rights will remain the same, subject to any provisions endorsed on or attached to the reinstated policy.

### **CLAIMS**

1. **Notice of Claim:** Written notice of claim must be given within 30 days (60 days in Kentucky; 6 months in Montana) after a covered loss starts or as soon as reasonably possible. The notice can be sent to us at our Home Office, or to our agent. Notice should include your name and policy number.
2. **Claim forms:** When we receive the notice of claim, we will send you forms for filing proof of loss. If these forms are not sent to you within 15 days, you will meet the proof of loss requirements by giving a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss section.
3. **Proofs of Loss:** Written proof of loss must be sent to us within 90 days after such loss. If it was not reasonably possible to send such proof in the time required, we shall not reduce or deny the claim for this reason if the proof is sent as soon as reasonably possible. In any event, the proof required must be sent no later than one year from the time specified unless you were legally incapacitated.
4. **Time of Payment of Claim:** Benefits for loss covered by this policy will be paid as soon as we receive proper written proof.
5. **Payment of Claims:** Benefits will be paid to you, unless you assign them to a health care provider. Accidental death benefits will be paid in accordance with the beneficiary designation at the time of death. If none is then in effect, the benefits will be paid to your estate. Any other benefits unpaid at death may be paid, at our option, either to your beneficiary or to your estate. If benefits are payable to your estate, or a beneficiary who cannot execute a valid release, we can pay up to \$1,000.00 of benefits to someone related to you or your beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged from liability to the extent of any such payment made in good faith.

## **PHYSICAL EXAMINATIONS AND AUTOPSY**

We have the right, at our own expense, to have a Covered Member examined as often as reasonably necessary while a claim is pending. We may also, at our own expense, have an autopsy made where allowed by law (but not in Massachusetts, Mississippi or South Carolina).

## **LEGAL ACTIONS**

No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after 3 years (5 years in Kansas; 6 years in South Carolina) from the time written proof of loss is required to be given.

## **CHANGE OF BENEFICIARY**

You can change the beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

## **MISSTATEMENT OF AGE OR SEX**

If a Covered Member's age or sex has been misstated in the application, the benefits will be those the premium paid would have purchased at the correct age or for the correct sex.

## **UNPAID PREMIUM**

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

## **CONFORMITY WITH STATE STATUTES**

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

## **XIX. OTHER PROVISIONS**

### **STATEMENTS IN THE APPLICATION**

All statements made in the application for this policy are representations and not warranties.

### **CHARTER AND BY-LAWS**

Provisions of our charter or by-laws not contained in the policy will not void the policy or be used in defense in any legal proceedings hereunder.

### **ASSIGNMENTS**

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

### **NOTICE OF ANNUAL MEETINGS**

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