UNITED STATES FIRE INSURANCE COMPANY
Administrative Office: 5 Christopher Way • Eatontown, NJ 07724

HOSPITAL INDEMNITY POLICY OF INSURANCE

Coverage under this Policy is provided in consideration of payment of the initial premium and continued payment of premiums when due, and that the answers in your Application are correct and complete.

SCOPE OF COVERAGE

This Policy and any attachments contain the provisions affecting Covered Persons. Any references to Eligible Dependents as Covered Persons apply only if you have elected such coverage. The Policy is the contract between the Policyholder and the United States Fire Insurance Company. The name of the Policyholder is shown on the Schedule.

RIGHT TO CANCEL

You may cancel this Policy by delivering or mailing a written notice or sending a telegram to the Insurer at the above address and by returning the Policy before midnight of the tenth day after the date you receive the Policy. Notice given by mail and return of the Policy by mail are effective on being postmarked, properly addressed and postage paid. The Insurer must return all payments made for this Policy within ten days after it receives notice of cancellation and the returned Policy.

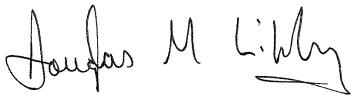
THIS POLICY PROVIDES LIMITED BENEFITS. PLEASE READ IT CAREFULLY.

BENEFITS ARE LIMITED AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS COVERAGE SHOULD NOT BE CONSIDERED AS COMPREHENSIVE HEALTH INSURANCE COVERAGE.

THIS COVERAGE PROVIDES LIMITED INDEMNITY BENEFITS TO REIMBURSE YOU FOR PAID EXPENSES COVERED UNDER YOUR POLICY

THIS POLICY IS GUARANTEED RENEWABLE TO AGE 65. SEE PAGE 20

Signed For **UNITED STATES FIRE INSURANCE COMPANY** By:



Douglas M. Libby
Chairman and CEO

James Kraus
Secretary

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SCHEDULE
HIP 500

POLICYHOLDER:

POLICY NUMBER:

COVERAGE IS VALID FROM THE EFFECTIVE DATE SHOWN ON THE MEMBER ID CARD AND UNTIL THE DATE OF THE MEMBERS' PLAN TERMINATION.

THE FOLLOWING SHALL APPLY TO EACH COVERED PERSON:

WAITING PERIOD:

For Accidental Injury	0 days per Covered Person
For Sickness:	30 days per Covered Person

COVERED EXPENSES FOR EACH COVERED PERSON:

Hospital Room & Board and General Nursing Services**

Daily Maximum, Days 1-30:	$500 per Covered Person
Maximum Benefit for Hospital Confinements:	30 days per Policy Year

Hospital Intensive and Cardiac Care Unit Confinement**

Daily Maximum Days 1- 10:	$1,000 per Covered Person
Pays in addition to Hospital Room & Board	
Maximum Benefit for ICU/CCU Confinements:	10 days per Policy Year

(Once the Intensive and Cardiac Care Unit benefit is exhausted, any additional Intensive and Cardiac Care Unit days will be payable under the Hospital Room & Board and General Nursing Services Benefit.)

Surgery**

Inpatient and Outpatient Maximum Benefit:	$2,000 maximum per operating session
Maximum Benefit for ALL Inpatient & Outpatient Surgeries:	1 per Policy Year

Anesthesia**

Inpatient/Outpatient Maximum Benefit:	$500

****The Pre-existing Conditions limitation is applicable only for Hospital Room & Board and General Nursing Services, Intensive and Cardiac Care Unit, Surgery and Anesthesia related to Surgery.**

DEFINITIONS

The terms shown below have the meaning given in this section. Whenever used throughout this Policy, they will be capitalized. Additional terms may be defined within the provision to which they apply.

Complications of Pregnancy means:

(1) Conditions requiring Confinement to a Hospital or treatment in an Outpatient Surgery Facility (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy, but are adversely affected by or caused by pregnancy, including but not limited to: non-elective cesarean section, acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, pre-eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; and

(2) Termination of ectopic pregnancy and spontaneous termination of pregnancy occurring during a time that a viable birth is not possible.

"Complications of Pregnancy" does *not* mean: false labor, occasional spotting, Doctor-prescribed rest during the period of pregnancy, morning sickness, elective Cesarean section, and similar conditions associated with the management of a difficult pregnancy but not constituting a nosologically distinct complication of pregnancy.

Confined/Confinement means the Medically Necessary admission to, and subsequent continued stay in, a Hospital as an overnight bed patient and a charge for room and board is made. If death occurs before a Covered Person completes one overnight stay, that person will be deemed to have been Confined for 1-day.

Covered Expenses means the Medically Necessary charges for services, supplies, care, or treatment covered under this Policy that are incurred by a Covered Person as a result of Injury or Sickness and for which the Covered Person is legally obligated to pay.

Covered Person means You and any Eligible Dependent(s) for whom proper premium payment has been made and who is under the age of 65 and therefore, insured under this Policy.

Doctor means a licensed practitioner of the healing arts acting within the scope of his or her license. Doctor does *not* include:

(1) You or any other Covered Person;

(2) A Covered Person's spouse, Dependent, parent, brother, or sister; or

(3) A person who ordinarily resides with you or a Covered Person.

Eligible Dependent means

(1) Your lawful spouse; and

(2) Your unmarried child who is under 19 years of age (the Limiting Age).

(3) Your unmarried child who:

(a) Has not yet attained age 25; and

(b) Has enrolled as a full time student at an accredited college or university or at a vocational, technical, vocational technical or trade school or institute, or secondary school; and

(4) Your dependent child of any age who is handicapped and meets the eligibility criteria in section 62A.14, subdivision 1, or any other person whom the state or federal law requires to be treated as a dependent for purposes of health plans.

Your unmarried child under who meets the requirements of (3)(a) and (b) above shall continue to be considered a dependent if the unmarried child develops a mental or nervous condition, problem, or disorder which renders the unmarried child, in the opinion of a qualified psychiatrist unable to attend school as a full-time student and from holding self-sustaining employment until the student reaches the age of twenty-five.

The Limiting Age will be extended from the child's 19th birthday through the child's 25th birthday provided they are enrolled in a school as a full time student and attend classes regularly at an accredited college or university.

"Child" includes stepchild, foster child, child of a legal guardian, legally adopted child, a child of adoptive parents pending adoption proceedings, and natural child.

"Hospital" means an institution which is operated pursuant to its license and is primarily and continuously engaged in providing medical care and treatment to sick and injured persons for which a charge is made that the Covered Person is legally obligated to pay. The institution must:

(1) Maintain a staff of one or more duly licensed Doctors;
(2) Provide 24-hour nursing service by or under the supervision of a graduate registered nurse, (R.N.);
(3) Have medical, diagnostic and treatment facilities, and major surgical facilities to care for persons on an inpatient basis on its premises or available to it on a prearranged basis; and
(4) Keep medical records.

Hospital includes a facility owned or operated by, or on behalf of, the state or any unit of local government, or practitioners therein, on the same basis as are made for like care in other facilities. The unit of government concerned may maintain an action for recovery of such payments.

"Hospital" does *not* include:

(1) A clinic or facility for:
  (a) Convalescent, custodial, educational or nursing care;
  (b) The aged, drug addicts or alcoholics; or
  (c) Rehabilitation; or
(2) A military or veterans hospital or a hospital contracted for, or operated by, a national government or its agency unless:
  (a) The services are rendered on an emergency basis; and
  (b) A legal liability exists for the charges made to the individual for the services given in the absence of insurance.

Immediate Family means a Covered Persons spouse, parent, son, daughter, or siblings.

Injury means bodily harm caused by an accident, directly and independently of Sickness or bodily infirmity, resulting in unforeseen trauma requiring immediate medical attention. The Injury must occur after the Covered Person's Effective Date of coverage and while such person's coverage is in force. All injuries to the same Covered Person sustained in any one accident, including all related conditions and recurring symptoms of the Injuries, will be considered one Injury.

Insured means a Covered Person for whom insurance is in force under this Policy.

Limiting Age – see Eligible Dependent.

Medically Necessary or Medical Necessity means the service or supply is:
Necessary and appropriate, according to conventional medical practice for the diagnosis or treatment of an Injury or Sickness based on generally accepted current medical practice.

A service or supply will *not* be considered Medically Necessary if it:

(1) Is provided only as a convenience to the Covered Person;
(2) Is not appropriate treatment for the Covered Person's diagnosis or symptoms;
(3) Exceeds (in scope, duration or intensity) a level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment.

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

Nurse means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

Policyholder (also **You, Your, Yours**) means the primary insured person who completed the Application for coverage and who is named in the Schedule as the Policyholder and whose coverage has become effective and has not terminated.

Policy Year means the duration of time this Policy is in force during which Covered Expenses are subject to the Policy Year Maximum Benefit. It begins on the Policy Effective Date shown in the Schedule, and ends on the

same day and month of the following calendar year provided coverage is not terminated**.** Thereafter, it means the period beginning on the Policy Renewal Date and ending on the same month and date 12-months later.

Pre-existing Condition means a medical condition, Injury or Sickness, not excluded by name or specific description, for which:

(1) Medical advice, Consultation, care or treatment was recommended by, or received from, a Doctor within 1 year immediately prior to the Effective Date of coverage for a Covered Person; or

(2) Symptoms existed within 1 year immediately prior to the Effective Date of coverage for a Covered Person that would cause a reasonable person to seek Consultation, care, or treatment from a Doctor.

"Consultation" means evaluation, diagnosis, or medical advice given without the necessity of a personal examination or visit.

Sickness means illness or disease, including Complications of Pregnancy, which begins while coverage is in force under this Policy for the Covered Person. All related conditions and recurring symptoms of sickness to the same person will be considered one sickness.

We, us, our means United States Fire Insurance Company.

You, Your, Yours (also, **Policyholder)** means the primary insured person who completed the Application for coverage and who is named in the Schedule as the Policyholder and whose coverage has become effective and has not terminated.

ELIGIBILITY, ENROLLMENT, AND EFFECTIVE DATES

ELIGIBILITY:
You are eligible for coverage provided you qualify and satisfy our underwriting requirements. Persons who meet the definition of an Eligible Dependent are eligible for coverage provided they satisfy our underwriting requirements and you are a Covered Person.

ENROLLMENT REQUIREMENTS:
You and your Eligible Dependent may apply for coverage by:

(1) Submitting a completed application;

(2) Providing evidence of insurability (if evidence is required); and

(3) Paying the initial premium when due.

EFFECTIVE DATES:
If we have approved your application, you and Your Eligible Dependents who were included in your initial application will become Covered Persons under this Policy. Coverage for each Covered Person is effective as of the Policy Effective Date shown in the Schedule.

ADDING PERSONS AFTER THE EFFECTIVE DATE:
You may apply for coverage for a new or previously uncovered person provided they meet the definition of an Eligible Dependent. Such person(s) will be subject to our underwriting requirements. To add a person, you must:

(1) Complete and submit an application for such person to us for approval; and

(2) Pay any additional premium required.

If we approve the application for coverage of a new Eligible Dependent, the Effective Date of such person's coverage will be shown by an endorsement to this Policy.

NEWLY ACQUIRED DEPENDENT CHILDREN:
Coverage for Your child or children born after the Effective Date of this Policy will be effective from the moment of birth. A newborn infant includes grandchildren who are financially dependent upon a covered grandparent and who resides with that covered grandparent continuously from birth. An adopted child or child placed with you for the purpose of adoption will be covered from the date of adoption or placement. A child that you or your lawful spouse have been appointed their legal guardian.

Coverage for your child will be for newborn well-care, Hospital room and board for a newborn, and Injury or Sickness, including care or treatment of congenital defects, birth abnormalities, premature birth and inpatient or

outpatient expenses arising from medical and dental treatment up to age 19, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. If orthodontic services are eligible for coverage under a dental insurance plan and another policy or contract, the dental plan shall be primary and the other policy or contract shall be secondary in regard to the coverage. Payment for dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered.

TERMINATION OF COVERAGE

I. TERMINATION OF YOUR COVERAGE:

Your coverage will automatically terminate, and no benefits will be payable under this Policy and any attached Riders, on the earliest of:

(1) The date the Policy terminates;
(2) The end of the Grace Period for which the last premium was paid;
(3) The date we determine fraudulent statements or a material misrepresentation has been made by you or with your knowledge;
(4) On the date we elect to discontinue this plan or type of coverage in your state;

II. TERMINATION OF A COVERED PERSON'S COVERAGE:

A Covered Person's coverage will automatically terminate, and no benefits will be payable under this Policy and any attached Riders, if any, on the earliest of:

(1) The date Your coverage terminates;
(2) The end of the Grace Period for which the last premium was paid;
(3) The date a Covered Person ceases to be an Eligible Dependent;
(4) The date we receive Your written request to terminate a dependent's coverage; or
(5) Upon expiration of the 31st day after a child has been born to you, adopted by you, or placed with you for the purpose of adoption if you have not notified us and paid any required additional premium for the child.

Attainment of the Limiting Age for a Covered Person will not cause coverage to terminate while that person is, and continues to:

(1) Have a handicapped condition which renders such person incapable of self-sustaining employment; and
(2) Be chiefly dependent upon you or other care providers for lifetime care and supervision because of a handicapped condition that occurred before attainment of the Limiting Age.

Benefits with respect to such person may be continued on a premium-paying basis during the continuance of such condition. We will require proof that the child is in fact disabled and a dependent person. Proof must be submitted to us within 31-days of the date the child would otherwise reach the Limiting Age, as defined in Eligible Dependent. We may, from time to time, require proof of the continuation of such condition(s) and dependence and to have such dependent examined by Doctors designated by us during the first 2-years of such continuance. After 2-years, we will not require proof more often than once a year thereafter. In the absence of such proof, we may terminate the child's coverage after attainment of the Limiting Age. The continuance of insurance as described will cease in the event of termination of the termination of your coverage.

CONTINUATION PROVISION

When a Covered Person's coverage terminates under this Policy because such person ceases to be an Eligible Dependent, or because of divorce, legal separation or your death, coverage may be continued under a new Policy. To continue coverage, you or the Covered Person must:

(1) Request continuation of coverage by application or written notification within 31-days of the date coverage would otherwise terminate; and
(2) Pay any required premium; and

The new Policy will provide the same benefits (or substantially similar) and may contain any limitations or conditions that applied to the Covered Person under this Policy.

The new Policy will be issued without requiring evidence of insurability and will take effect, subject to payment of the first premium, on the later of:

(1) The date coverage under this Policy terminates; or
(2) The date such person applies for the new Policy.

At the option of a covered spouse, any Covered Person under this Policy who is a dependent child and for whom the spouse has the legal obligation of support may also be converted to the new Policy.

Payment under the new Policy for a loss also covered by this Policy will be reduced by the amount of benefits paid under this Policy.

DESCRIPTION OF BENEFITS

We will provide benefits for Covered Expenses, as defined and described in this Policy, to all Covered Persons when medical treatment, services, and supplies are Medically Necessary for the care or treatment of an Injury or Sickness that occurs while coverage is in force for the Covered Person. Covered Expenses are incurred on the date that the service is performed or the supply is furnished. Unless stated otherwise in the benefit itself, all Covered Expenses are subject to:

- The Waiting Period for each Covered Person;
- The Policy Year Maximum Benefit for each Covered Person.
- The maximum amount payable for each benefit.
- The Lifetime Maximum Benefit for each Covered Person.
- The Exclusions and Limitations.
- All other provisions of this Certificate and the Group Policy.

The maximum benefit amounts for each benefit are shown in the Schedule.

HOSPITAL ROOM & BOARD and GENERAL NURSING SERVICES BENEFIT

Coverage is provided for room, board, miscellaneous medical Hospital charges, and general nursing services for each day a Covered Person is Confined to a Hospital due to Injury or Sickness during a Period of Confinement.

For purposes of this benefit, “Period of Confinement” means one continuous Hospital Confinement or two or more separate Hospital Confinements [for the same or a related cause that are each separated by less than 180 days.

If a Covered Person is admitted as an inpatient into a Hospital on a Friday or a Saturday on a non-emergency basis and the procedure for which such person is admitted is not performed on the day of or the day after admission, we will not pay the Hospital charges for room and board, miscellaneous Hospital charges, or general nursing services for the initial Friday or Saturday preceding the procedure.

We will pay charges for Covered Expenses for each day of Confinement, not to exceed the Daily Maximum amount or the Maximum Benefit shown for this benefit in the Schedule.

INTENSIVE CARE / CARDIAC CARE UNIT BENEFIT

Coverage is provided for each day a Covered Person is Confined to a Hospital in an Intensive Care Unit (ICU) or Cardiac Care Unit (CCU) due to an Injury or Sickness during a Period of Confinement.

For purposes of this benefit, “Period of Confinement” means one continuous ICU or CCU confinements, or two or more separate ICU or CCU confinements [for the same or a related cause that are each separated by less than 72- hours.

“Intensive Care Unit / Cardiac Care Unit**”** means that part of a Hospital which:

(1) Is segregated from the rest of the Hospital facilities;

(2) Is exclusively reserved for critically ill patients who require audio-visual observation and/or cardiac monitoring as prescribed by the attending Doctor; and
(3) Provides room and board, specialized registered graduate professional nurses (R.N.), and special life saving equipment and supplies.

We will pay charges for Covered Expenses for each day of Confinement, not to exceed the Daily Maximum amount or the Maximum Benefit shown for this benefit in the Schedule.

SURGICAL BENEFIT

SURGERY - When surgery for a Covered Person is performed in an Outpatient Surgery Facility or while Confined to a Hospital, coverage is provided for the use of the operating and recovery room, including the Doctor's charges for performing surgery. Benefits are also provided for medical services and supplies used in the performance of the surgery. This includes, but is not limited to:

(1) Administration of drugs and medicines during surgery;
(2) Dressings, casts, and splints; and
(3) Diagnostic services including radiology, laboratory or pathology performed during the time of surgery.

Surgery coverage includes reconstructive surgery on a diseased breast following mastectomy surgery performed on a Covered Person in an Outpatient Surgery Facility or while Confined to a Hospital. Coverage is also provided for all stages of breast reconstructive surgery performed on a non-diseased breast to establish symmetry with the diseased breast, and for prostheses and physical complications at all stages of the mastectomy.

If two or more surgeries are performed at the same time through separate incisions, we will pay the one providing the largest benefit. If more than one Surgery is performed through the same incision during the same operation, we will pay for only one surgery, for the surgery providing the largest benefit.

We will pay the Usual, Reasonable and Customary charges for Covered Expenses, not to exceed the Maximum Benefit amount and the Maximum Surgeries shown in the Schedule for this benefit.

ANESTHESIA - When a surgical procedure is performed that is covered under this Policy, coverage is provided for anesthesia and its administration during such surgery.

DEFINITIONS

For purposes of this Surgical benefit, the following definitions apply:

"Outpatient Surgery Facility" means a licensed or certified public or private medical facility:
(1) With an organized staff of Doctors;
(2) Which is permanently equipped and operated primarily for the purpose of performing surgical procedures;
(3) Which does not provide accommodations for overnight stays; and
(4) Provides continuous Doctor and Nurse services whenever a patient is in the facility.

"Outpatient Surgery Facility" includes surgical suites and facilities operated by a Hospital that provide scheduled, non-emergency outpatient surgical care.

"Outpatient Surgery Facility" does *not* include a Hospital emergency room; trauma center; Doctor's office; a clinic; or any facility that an Insured Person is admitted to as an overnight bed-patient and charged for room and board.

Usual, Reasonable and Customary means:
(1) With respect to fees or charges, fees for medical services or supplies which are:
  (a) Usually charged by the provider for the service or supply given; and
  (b) The average charged for the service or supply in the locality in which the service or supply is received; or
(2) With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

PRE-EXISTING CONDITIONS LIMITATION

Benefits are not provided for any loss caused by, or resulting from, a Pre-existing Condition, as defined, unless the loss is incurred at least 12-months after the Effective Date of coverage for a Covered Person.

This provision does not apply to newborn or newly adopted children. The definition of a Pre-existing Condition can be found in the DEFINITIONS section.

LIMITATIONS AND EXCLUSIONS

Benefits will not be paid for charges or loss caused by, or resulting from, any of the following:

(1) Suicide or any intentionally self-inflicted Injury;

(2) Being under the influence of any narcotic unless administered on the advice of a doctor;

(3) Convicted of a commission, or attempt to commit, a felony;

(4) Conviction of participation in a riot or insurrection;

(5) Driving under the influence of a controlled substance, unless administered on the advice of a Doctor;

(6) Driving while Intoxicated and is determined to have a blood alcohol level exceeding the legal limit as defined by state law. "Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs.

(7) Declared or undeclared war or act of war;

(8) Nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180-days of the initial incident and:
   (1) The loss was caused by fire, heat, explosion or other physical trauma which was a result of the release of nuclear energy; and
   (2) The Covered Person was within a 25-mile radius of the site of the release either:
      (a) At the time of the release; or
      (b) Within 24-hours of the start of the release; or

(9) Routine health checkups or immunizations for Covered Person aged 6 and older; expenses for allergies, allergy serum or allergy testing, unless specifically provided for in this Policy;

(10) Surgery to correct vision or hearing; eyeglasses, contact lenses and hearing aids, braces, appliances, or examinations or prescriptions therefore;

(11) Dental care, x-rays, or treatment other than Injury to natural teeth and gums resulting from an accidental Injury and rendered within 6-months of the Injury;

(12) Spinal manipulations and manual manipulative treatment or therapy;

(13) Weight loss or modification and complications arising therefrom, including surgery and any other form of treatment for the purpose of weight loss or modification;

(14) Rest cures or custodial care, or treatment of sleep disorders;

(15) Treatment, services or supplies received outside of the U.S. except for acute Sickness or Injury sustained during the first 30-days of travel outside the U.S.;

(16) Normal pregnancy or childbirth, except for Complications of Pregnancy;

(17) Any drug, treatment, or procedure that either promotes or prevents conception or childbirth regardless of what the drug, treatment, or procedure was originally prescribed or intended for;

(18) Blood or Blood plasma, except for charges by a Hospital for the processing or administration of blood;

(19) Treatment involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy;

(20) Cosmetic surgery. This Exclusion does not apply to reconstructive surgery:
(a) On an injured part of the body following trauma, infection or other disease of the involved part;
(b) Of a congenital disease or anomaly of a covered dependent newborn, adopted infant, or child of a legal guardian; or
(c) On a non-diseased breast to restore and achieve symmetry between two breasts following a covered Mastectomy;

(21) The repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices; dentures, partial dentures, braces or fixed or removable bridges;

(22) Treatment or removal of warts, moles, boils, skin blemishes or birthmarks, bunions, acne, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;

(23) Personal items such as television, telephone, lotions, shampoos, extra beds, meals for guests, take home items, or other items for comfort and convenience;

(24) Treatment of Mental or Nervous Disorders, or alcohol or substance abuse, unless specifically provided for under this Policy;

(25) Prescription medicines, unless specifically provided for under this Policy;

(26) Any Injury that is caused by flight or travel in, or upon:
(a) An aircraft or other, craft designed for navigation above or beyond the earth's atmosphere except as a fare-paying passenger;
(b) An ultra light, hang-gliding, parachuting or bungi-cord jumping;
(c) A snowmobile;
(d) Any two or three wheeled motor vehicle;
(e) Any off-road motorized vehicle not requiring licensing as a motor vehicle;
(f) Any watercraft or other craft designed for water use above or beneath the water, except as a fare-paying passenger;

(27) Any accidental Injury where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license (except in a Driver's Education Program);

(28) Services, treatment or loss:
(a) Rendered in any Veterans Administration or Federal Hospital, unless there is a legal obligation to pay;
(b) Payable by any automobile insurance policy without regard to fault. (Does not apply in any state where prohibited);
(c) Which a Covered Person would not have to pay if he did not have insurance;
(d) Provided by a Doctor, Nurse or any other person who is employed or retained by a Covered Person or who is a member of a Covered Person’s Immediate Family;
(e) Covered by state or federal worker's compensation, employers liability, occupational disease law, or similar laws;
(f) Injury or Sickness sustained while on active duty in the armed forces of any country. This does not include Reserve or National Guard duty for training. Upon receipt of proof of service, we will refund, any unearned premium paid on a pro rata basis;

(29) Hemorrhoids, tonsils, adenoids, middle ear disorders, any disease or disorder of the reproductive organs unless the loss is incurred at least 6-months after the Covered Person becomes insured under this Policy;

(30) Elective treatment or surgery and treatment, procedures, products or services that are experimental or investigative. "Experimental or Investigative" means a drug, device or medical treatment or procedure that:

(a) Cannot lawfully be marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time of being furnished;

(b) Has Reliable Evidence indicating it is the subject of ongoing clinical trials or is under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or its efficacy as compared with the standard means of treatments or diagnosis; or

(c) Has Reliable Evidence indicating that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

"Reliable Evidence" means (i) published reports and articles in authoritative medical and scientific literature; (ii) the written protocol(s) of the treating facility or the protocols of another facility studying substantially the same drug, device, medical treatment or procedure; or (iii) the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

PREMIUM PROVISIONS

PREMIUM DUE DATE:
Premiums are payable to us. Payment of any premium will not maintain coverage in force beyond the next premium due date, except as provided in the GRACE PERIOD provision. Upon payment of a valid reimbursable claim under this Policy, any premium then due and unpaid may be deducted from the claim payment.

GRACE PERIOD:
A grace period of 31-days is granted for each premium due after the initial premium. Coverage will stay in force during this period unless you have sent us, or our authorized administrator, prior written notice of your intent to terminate your coverage in accordance with the TERMINATION OF COVERAGE provision. Coverage will end as of the due date of the premium, and no expenses incurred during the Grace Period will be considered for payment, if the premium has not been paid by the end of the Grace Period.

REINSTATEMENT:
If the renewal premium is not paid before the Grace Period ends, coverage under this Policy will lapse. Coverage may be reinstated during the 45-days following the premium due date]. Upon lapse, we may require an application for reinstatement. The reinstatement will not become effective unless we approve such application and all premiums due have been made. We will advise you of the effective date of reinstatement by giving you written notice of the date by issuing you an amendment or a new Policy. The reinstated Policy will be subject to the INCONTESTABILITY provision from the effective date of reinstatement. The reinstated Policy provides benefits only for:

(1) Injury occurring after the effective date of reinstatement; and
(2) Sickness that begins more than 10-days after the effective date of reinstatement.

In all other respects, your rights and our rights will remain the same, subject to any new conditions imposed by us regarding the reinstated Policy.

CHANGES IN PREMIUMS:
We will determine the premium for each Covered Person. We have the right to change the premium rates becoming due under this Policy at any time and from time to time, provided we have given you at least 30-days advance written notice prior to the effective date of the new rates. The premium rates may also be changed at any time the terms of the Policy are changed. Such Policy changes will coincide with a change in the coverage provided or classes eligible.

Premium payments made in advance, or for more than a one-month period, will not affect any rights we have with regard to premium changes.

CLAIM PROVISIONS

NOTICE OF CLAIM:
Written notice must be given to us or to our authorized administrator within 30-days after a covered loss occurs or begins, or as soon as reasonably possible. Notice should include Your name and Policy number and the Covered Person's name and address, a receipt showing the expense you paid, and any other necessary information that is reasonably required.

CLAIM FORMS:
After receiving notice of claim, the Covered Person will be sent forms for filing proof of loss. If you do not receive claim forms within 15-days after providing your written notice, the proof of loss requirements will be met by submitting, within the time required under PROOF OF LOSS, a written statement of the nature and extent of the loss.

PROOF OF LOSS:
Written proof of loss must be furnished within 90-days after notice of claim has been submitted. Failure to furnish written proof of loss within that time frame will neither invalidate or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than 1-year from the date of the loss, except in the absence of legal capacity.

TIME OF PAYMENT OF CLAIMS:
Benefits payable under this Policy will be paid promptly upon receipt of due written proof of loss.

PAYMENT OF CLAIMS:
All benefits, other than loss of life, are payable to you. If any benefits remain unpaid at your death or if, in our opinion, you are incapable of giving a legally binding receipt for payment of any benefit, we may, at our option, pay such benefit to your estate. Any payment made by us in good faith under this provision will fully discharge us to the extent of the payment. Upon payment of a valid reimbursable claim under this Policy, any premium then due and unpaid may be deducted from the claim payment.

If an Accidental Death Benefit is provided under this Policy, benefits for the Covered Person's loss of life will be paid to the beneficiary named in our records, if any, at the time of payment. The benefit will be paid in one lump sum. If there is no named beneficiary or surviving beneficiary, the Covered Person's loss of life benefits will be paid in one lump sum to the estate of the Covered Person.

If we are to pay benefits to the estate or to a person who is incapable of giving a valid release, we may pay up to $1,000 to a relative by blood or marriage that we believe is equitably entitled. This good faith payment satisfies our legal duty to the extent of that payment.

PHYSICAL EXAMINATION AND AUTOPSY:
We have the right, at our expense, to examine a Covered Person as often as reasonably necessary while a claim is pending. We also have the right to have an autopsy performed at our expense, unless prohibited by law.

MISSTATEMENT OF AGE:
If the age of any Covered Person has been misstated, we will adjust our records to reflect the correct age. Coverage will not be affected if the Covered Person continues to be eligible for coverage at the correct age. However, premium adjustments, including collection of any premium due because of past underpayments, will be made so that we receive the premiums due for the correct age we will pay only the benefit amount that the premium paid would have purchased at the correct age. If a Covered Person was not eligible for coverage at the correct age on such person's effective date of coverage, we will void that Covered Person's coverage as of the date we determine their correct age and return any premiums paid, minus any claims we have paid during the time the Covered Person's coverage was in force.

CHANGE OF BENEFICIARY (Applicable only if an Accidental Death or Dismemberment benefit is provided.)
You may change the beneficiary designation at any time by giving us written notice. The beneficiary's consent is not required for this or any other change that you may make unless the designation of a beneficiary is irrevocable or otherwise required by law.

CONDITIONAL CLAIM PAYMENT:
If a Covered Person incurs expenses for Injury or Sickness and, in our opinion, a third party may be liable, we will pay benefits if:

(1) The Covered Person first agrees in writing to refund the lesser of:
   (a) The amount we actually paid for such expenses; or
   (b) The amount actually received from the third party for such expenses; and
(2) The third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise.

However, prior to our payment of benefits under this Policy, if the third party's liability is satisfied in an amount less than the benefits payable under this Policy, we will pay the difference.

RIGHT OF REIMBURSEMENT:
If a Covered Person receives a benefit payment from a third party by judgment, settlement, compromise, or otherwise for an Injury or Sickness and we have paid benefits for the same Injury or Sickness, we reserve the right to be reimbursed from the third party in an amount equal to the amount we paid to the Covered Person, the Covered Person's parents (if the Covered Person is a minor), or the Covered Person's legal representative.

You must agree to furnish any information and assistance, or provide any documents that we may reasonable require in order to for us to exercise our right of recovery, regardless of whether or not the third party admits liability. Any payment we make by mistake for a work-related Injury must be reimbursed to us when the Covered Person receives payment for such Injury from another source.

It will be assumed that the Covered Person is in receipt of the benefit payment unless such person gives us proof that payment of benefits were denied.

SUBROGATION:
Upon payment of benefits for a Sickness or Injury, we will be subrogated to all rights of recovery a Covered Person may have against any third party responsible for such Sickness or Injury. This includes, but is not limited to, recoveries against such third party, against any liability coverage for such third party or against a Covered Person's automobile insurance in the event a claim is made under the uninsured or underinsured motorist coverages. Such right extends to all proceeds of any settlement or judgment, but is limited to the amount of benefits we have paid. You must (1) do nothing to prejudice any right of recovery; (2) execute and deliver any required instruments or papers; and (3) do whatever else is necessary to secure such rights.

If we are precluded by law from exercising our Subrogation Right, we may exercise our Right of Reimbursement.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:
The Policy, the application (which will be attached to your Policy), endorsements, amendments, riders and any attached papers constitute the entire contract between the parties. If an application for any Eligible Dependent is required, such form may, at our option, also be attached to and made a part of this contract.

No change in this Policy will be valid until approved by one of our executive officers. This approval must be endorsed on, or attached to, this Policy. Such amendment will not require the consent of any Covered Person. No agent may alter or amend coverage or waive any provisions of this Policy.

GUARANTEED RENEWABLE:
Guaranteed renewable means during the renewal period up to age 65 renewal cannot be declined nor coverage changed by us for any reason other than nonpayment of premiums, fraud, or misrepresentation, but we can revise rates on a class basis.

INCONTESTABILITY:
All statements made by you or a Covered Person will, in the absence of fraud, be deemed representations and not warranties. No such statements will be used to contest coverage, deny or reduce benefits, or deny a claim for

loss unless a copy of the instrument containing the statement is or has been furnished to You or, in the event of Your death or incapacity, Your beneficiary or representative.

After a Covered Person's coverage has been in force for 2-years from such person's effective date of coverage, no misstatements, except fraudulent misstatements in the application, may be used by us to contest coverage, or to deny or reduce benefits or claims for loss.

TIME LIMIT ON CERTAIN DEFENSES
No claim for loss incurred after two years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description, effective on the date of loss had existed prior to the effective date of coverage of this Policy.

NARCOTICS:
We will not be liable for any loss sustained or contracted in consequence of a Covered Person being under the influence of any narcotic unless administered on the advice of a physician.

CLERICAL ERROR:
Clerical errors made by us or our authorized administrator in your Schedule, the issuance of a Policy, or in record keeping will not invalidate coverage otherwise in force, or afford benefits for which you have not applied and paid the appropriate premium, or continue coverage otherwise validly terminated. Any such clerical errors must be corrected and promptly reported to us. We have the right to recover from you any overpayment of benefits due to such clerical errors.

LEGAL ACTIONS:
No legal proceedings to obtain benefits under this Policy may be brought against us prior to the expiration of 60-days after written proof of loss and any other documentation necessary to establish the benefits due has been furnished. No such proceedings may be brought more than 3-years after such proof is required to be furnished.

CONFORMITY WITH STATE STATUTES:
Any provision of this Policy that is in conflict with the laws of the state where it is delivered on the Policy Effective Date is amended to conform to the minimum requirements of such laws.