

CERTIFICATE OF INSURANCE

United States Life certifies that the person named on the schedule is insured for the benefits described in this certificate. This insurance is subject to the eligibility and effective date requirements of the group policy.

NOTE: If you are insured for dependents' insurance covering your spouse or your children or both your spouse and your children, "YES" appears after the word "spouse" or "children", or after both words "spouse" and "children" in the COVERAGE FOR section of the schedule. If you are not insured for dependents' insurance covering your spouse or your children, "NOT" appears after the word "spouse" or "children", or after both words "spouse" and "children" in the COVERAGE FOR section of the schedule.

DATE YOUR INSURANCE TAKES EFFECT

Your insurance will take effect on the date shown on the schedule. You must be able to perform the normal activities of a person of like age and sex, with like occupation or retired status on this date. If you are not, your insurance will take effect on the day you resume such activities.

CANCELLATION DURING FIRST 30 DAYS

You may cancel the insurance described in this certificate at any time during the 30 day period after you receive this certificate. Mail this certificate with your written request for cancellation to United States Life. United States Life will promptly refund the premium paid, including any fees.

IMPORTANT NOTICE

This certificate is a summary of the group policy provisions which affect **your** insurance. It is merely evidence of the insurance provided by such policy.

The group policy is a contract between United States Life and the Policyholder. It may be changed or ended without notice to or consent of any insured person.

This certificate replaces any certificate previously issued by United States Life to you under the group policy.

The benefits described in this certificate are provided by the group policy no. E-160,668, issued to the UNIFORMED FIREFIGHTERS ASSOCIATION OF GREATER NEW YORK, the Policyholder.

CERTIFICATE INDEX

Each page in this certificate has a 2 line code at the bottom left of the page. The code "G-19001" means that the page belongs to the certificate series. The letter or letters below the certificate code represents a phonetic description of the particular section (FP = Face page; E = Eligibility). If a section requires more than one page, the descriptive letter is followed by a number indicating its order in the section (MM-2 is the second page in the Major Medical Benefits section).

This index refers you to the phonetic codes.

SECTION	PAGE(S)
Face Page	FP
Schedule of Benefits	SCH
Definitions	DEF
Eligibility	
Date Insurance Ends	E
Dependent Eligibility	
Definition of Dependent	D-1
Date Of Eligibility For Dependents' Insurance	D-1
Date Dependents' Insurance Takes Effect	D-1
Ability Requirement	D-1
Date Dependents' Insurance Ends	D-2
Continuation of Dependents' Insurance With Premium Payment In Accordance With State Law.....	D-2
Pregnancy Benefits	P
Major Medical Benefits	
Cash Deductible and Maximum Benefit	MM-1-DIS
Covered Charges	MM-2, MM-3 MM-4
Charges Not Covered	MM-5
Benefits After Insurance Ends	MM-6
Pre-Existing Conditions Provisions For Medical Care Benefits	PEC
Special Provisions For Groups Taken Over From a Prior Plan	TOG
General Exclusions	GE
Return Of Over Payment.....	ROP
Coordination Of Benefits	COB
Conversion Option For Medical Care Benefits	CO
End Of Insurance Provided By The Group Policy	END
General Provisions	
Misstatements	GP
Assignment	GP
Compliance With Law	GP
Gender	GP
General Provisions For Accident And Health Insurance	
Filing A Claim.....	GPAH
Payment of Claims.....	GPAH
Physical Exams.....	GPAH
Time Limit On Legal Actions.....	GPAH

SCHEDULE OF BENEFITS

MAJOR MEDICAL BENEFITS FOR ALL INSURED PERSONS

Cash deductible for each person per accumulation period	the greater of: <ul style="list-style-type: none">• the benefits of the Basic Plan; or• see schedule
Deductible accumulation period	12 months
Benefit period	3 years
Major medical benefits to be paid during each benefit period after the cash deductible is satisfied	100% of covered charges
Maximum benefit for each person	
• for charges while insured	\$2,000,000
exception: for covered charges incurred for diagnosis and treatment for alcoholism, alcohol abuse, substance abuse or substance dependency, psychiatric, mental, nervous or emotional disorders, ailments or illness	see page MM-4
• for private duty nursing	see page MM-2
• for charges for ambulance service, while insured	\$2,000
• for charges for convalescent care	
- per week	\$400
- while insured	2 years of benefits

DEFINITIONS

PHYSICIAN means:

a medical practitioner licensed to provide medical services and perform general surgery, or any other practitioner whose services, by law of the state where such services are performed, must be covered by the group policy.

Each such person must be licensed in the state where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such state.

HOSPITAL means:

1. A licensed institution which is approved by the Joint Commission on Accreditation of Hospitals. "Hospital" does not mean a place, or part of one, which is used mainly for:

- the aged
- the chronically ill
- convalescents
- drug addicts
- alcoholics
- a rest home
- a nursing home
- custodial, educational or rehabilitary care, or

2. Any other institution whose services, by law of the state where such services are performed, must be covered by the group policy. Each such institution must be licensed and approved, if required, by the appropriate agency of such state.

NON-JOB RELATED INJURY or **SICKNESS** means conditions for which a person is not entitled to benefits from a workers' compensation or similar law.

TOTAL DISABILITY means that solely due to a non-job related injury or sickness the insured person cannot perform the normal activities of a person of like age and sex, with like occupation or retired status.

INSURED PERSON means an insured member or insured dependent. Each will be insured only for the benefits for which he becomes and remains insured by the group policy.

NOTE: If you are insured for dependents' insurance covering your spouse or your children or both your spouse and your children, "YES" appears after the word "spouse" or "children", or after both words "spouse" and "children" in the COVERAGE FOR section of the sticker. If you are not insured for dependents' insurance covering your spouse or your children, "NO" appears after the word "spouse" or "children", or after both words "spouse" and "children" in the COVERAGE FOR section of the sticker.

MEDICARE means Parts A and B of the medical care benefits provided by Title XVIII of the Social Security Act of 1965.

BASIC PLAN means a plan which provides benefits or services for, or by reason of, hospital, surgical or medical care or treatment through:

1. group, individual, blanket, or franchise insurance coverage;
2. group, individual, blanket, or franchise pre-paid plans for:
 - group hospital service
 - group medical service
 - group practice
 - individual practice, and
 - any other such plans for members of a group;
3. any plan provided by:
 - labor management trusts
 - unions
 - employer organizations
 - professional organizations, or
 - employee benefit organizations; and
4. a government program or statute, including Medicare, *other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965;*

which the major medical benefits in the group policy are intended to supplement.

• **Accordance with State Law**
If your insurance ends because you cease to be a member or in an eligible class under the group policy, which stays in effect, he may elect to continue:

- your medical care insurance, and
- your dependents' medical care insurance.

To do so, you must notify the Policyholder in writing within 60 days of the later of:

- the date your insurance ends, or
- the date the Policyholder gives you notice of your right to elect the group continuation.

If you are disabled at the time insurance ends and want the longer disability continuation, you must give notice to the Policyholder within 60 days of the determination under Title II or Title XVI of the United States Social Security Act that you were disabled when insurance ended.

You will be required to pay all the premiums due.

Insurance may continue until the earliest of:

- the end of the period for which the last premium has been paid by you
- the date a person is entitled to Medicare
- the end of a period of 18 months if you are not disabled on the date his insurance ends
- the end of a period of 29 months if you are disabled on the date your insurance ends (However, if your disability ends before the end of the 29 months, your insurance will end on the later of: (a) the end of a period of 18 months; or (b) the month that begins more than 31 days after the date your disability ends.)
- the date the person is insured under another group insurance plan which does not contain a pre-existing conditions or like exclusion, or
- the date the group policy ends.

DEPENDENT ELIGIBILITY

DEFINITION

DEPENDENT means your:

1. lawful spouse, who is covered under a basic plan (as defined on page DEF); and
2. domestic partner, who is covered under a basic plan (as defined on page DEF), provided proof, as outlined below, is provided to United States Life:

Proof includes:

- a. evidence of financial interdependence which may include:
 - joint bank accounts
 - joint credit cards
 - jointly owned property
 - designation of beneficiary of life insurance or pension benefits
 - b. evidence of co-habitation
 - c. evidence of a prior relationship of at least 6 months, with an expectation of a future commitment
 - d. indication of an exclusive mutual commitment
 - e. evidence of attainment of the age of majority
 - f. statement that he is not legally married
 - g. statement that he is not related by blood to the domestic partner
 - h. if a resident of a city, municipality or other governing jurisdiction that allows for filing as domestic partners, evidence of such filing.
3. unmarried children whom you support who are covered under a basic plan (as defined on page DEF), and who are:
 - under age 21, or
 - full-time students between the ages of 21 and 27.

For the purpose of the group policy, references to "spouse" will read "domestic partner" as it applies.

"Children" includes stepchildren and adopted children who are supported by you. A child in the process of adoption will be considered a dependent from the day he is supported by you.

A person who is eligible for insurance under the group policy as a member will not be considered a dependent.

DATE OF ELIGIBILITY FOR DEPENDENTS' INSURANCE

You will be eligible for dependents' insurance on the later of:

- the date you are eligible for members' insurance, or
- the date you obtain a dependent.

DATE DEPENDENTS' INSURANCE TAKES EFFECT

1. You must request insurance in writing and pay the required premium. All dependents must give evidence of insurability to United States Life. Dependents' insurance will take effect on the date stated in writing by United States Life.
2. Each person who becomes a dependent child after you become insured for dependents' insurance which covers children will be insured on the date he becomes a dependent.
3. Each newborn child who becomes a dependent child after you become insured for dependents' insurance which covers a spouse, but no children, will be insured for 31 days from the date of birth. Application must be made and the required premium paid for coverage to continue after the 31 day period.

ABILITY REQUIREMENT

A dependent must be able to perform the normal activities of a person of like age and sex, with like occupation or retired status on the date his insurance is to take effect. If he is not, such insurance will take effect on the day the dependent resumes such activities.

NOTE: If you are insured for dependents' insurance covering your spouse or your children or both your spouse and your children, "YES" appears after the word "spouse" or "children", or after both words "spouse" and "children" in the COVERAGE FOR section of the sticker. If you are not insured for dependents' insurance covering your spouse or your children, "NO" appears after the word "spouse" or "children", or after both words "spouse" and "children" in the COVERAGE FOR section of the sticker.

DEPENDENT ELIGIBILITY (Continued)

DATE DEPENDENTS' INSURANCE ENDS

A dependent's insurance will end at the earliest of:

1. the date the your insurance ends;
2. the date dependents' insurance ends under the group policy;
3. the date the person ceases to be a dependent, except as stated in the exception For Mentally Ill, Developmentally Disabled, Mentally Retarded or Physically Handicapped Children below; or
4. the end of the period for which the last premium has been paid for the dependent.

Exception: For Mentally Ill, Developmentally Disabled, Mentally Retarded or Physically Handicapped Children

Insurance for a dependent child may be continued past the age limit if he cannot support himself because he is mentally ill, developmentally disabled, mentally retarded or physically handicapped. Premium payment will be required. Proof of the illness, disability, retardation or handicap must be sent to United States Life within 31 days after the child attains the age limit.

Insurance will continue for as long as such child:

- remains ill, disabled, retarded or handicapped, and
- meets all the rules for dependents in the group policy, except the age limit.

CONTINUATION OF DEPENDENTS' INSURANCE WITH PREMIUM PAYMENT

In Accordance With State Law

If medical care insurance ends for the dependents listed below, they may elect to continue it. To do so, they must notify the Policyholder in writing within 60 days of the later of:

- the date their insurance ends, or
- the date the Policyholder gives them notice of their right to elect the group continuation.

The dependent will be required to pay all the premiums due.

who may elect continuation

1. a spouse or dependent child whose insurance ends for these reasons:
 - you die
 - the divorce or legal separation of the member from his or her spouse, or
 - you are entitled to Medicare.
2. a dependent child who ceases to be one as defined in the group policy.

duration of continuation

Insurance may continue until the earliest of:

- the end of the period for which the last premium has been paid by the dependent
- the date the dependent is entitled to Medicare
- the end of a period of 36 months
- the date the dependent is insured under another group insurance plan which does not contain a pre-existing conditions or like exclusion, or
- the date the group policy ends.

PREGNANCY BENEFITS

FOR COMPLICATIONS OF PREGNANCY

The benefits to be paid by any section of the group policy for a complication of pregnancy will be the same as those to be paid for a sickness.

COMPLICATIONS OF PREGNANCY means:

- conditions distinct from pregnancy, but caused or affected by it, which require hospitalization, provided the pregnancy does not terminate during such hospitalization
- non-elective caesarean section
- a terminated ectopic pregnancy, or
- spontaneous termination of pregnancy which occurs when a viable birth is not possible.

FOR PREGNANCY PAID AS-ANY-OTHER-SICKNESS

As used in the group policy for the benefits shown below, the term "sickness" includes:

- pregnancy
- childbirth
- abortion
- complications of any abortion, and
- related medical conditions

all referred to as "pregnancy."

For medical care benefits

The benefits to be paid by the group policy for pregnancy will be the same as those to be paid for sickness.

MAJOR MEDICAL BENEFITS (Continued)

COVERED CHARGES

The charges covered by the group benefit section are those listed below. Any amount of such charges which exceeds reasonable and customary charges will not be covered.

REASONABLE AND CUSTOMARY CHARGE means a charge not more than the usual charge for medical treatment in the locality where it is received. The nature and severity of the injury or sickness involved will be taken into account.

Covered charges are:

1. Charges made by a hospital for:

- room and board,
- intensive care, and
- services and supplies.

2. Charges made by a convalescent home for confinement for convalescent or custodial care, up to the amount shown in the Schedule of Benefits.

The confinement must begin within 14 days after a hospitalization of at least 3 days ends and must be due to the injury or sickness which required the hospitalization.

CONVALESCENT HOME means a licensed institution that has on its premises:

- organized facilities to care for and treat its patients
- a staff of physicians to supervise such care and treatment, and
- a registered nurse on duty at all times.

"Convalescent home" does not mean a place, or part of one, which is used mainly for:

- the aged
- alcoholics
- drug addicts
- persons with mental, nervous or emotional disorders.

3. Charges made by a physician for:

- diagnosis
- treatment, and
- surgery.

4. Charges made for private duty nursing by a registered nurse or licensed practical nurse who is not a member of the person's immediate family or household, up to \$120 per 8-hour shift (\$360 per day) up to a lifetime benefit of \$35,000.

5. Charges for physiotherapy given by a licensed physiotherapist.

6. Charges for ambulance service to or from a hospital up to a lifetime benefit of \$2,000.

7. Charges for:

- anesthetics and their administration
- x-ray services
- lab tests and services
- preventive mammography and cytologic screening
- use of radium and radioactive isotopes
- oxygen
- blood and blood plasma (to the extent not replaced by donors)
- drugs which by law may only be dispensed with a prescription.

MAJOR MEDICAL BENEFITS

If an insured person incurs the covered charges listed below due to a non-job related injury or sickness, United States Life will pay the benefits described below.

Benefits will be paid **only** for the covered charges incurred for an injury or sickness which exceed the greater of:

1. the amount payable for the injury or sickness by the basic plan, or
2. the amount of the cash deductible.

All injuries suffered in one accident will be considered one injury. All sicknesses due to related causes, and complications of such causes will be considered one sickness.

CASH DEDUCTIBLE

The cash deductible is the amount of covered expenses that **each insured** must incur *before* any benefits are paid by United States Life. These expenses must be for covered charges incurred within a period of time called the deductible accumulation period.

The cash deductible and the deductible accumulation period are shown in the Schedule of Benefits.

BENEFIT PERIOD

Benefits are payable starting on the date an insured person incurs charges in excess of the cash deductible. The benefit period will begin on the date on which the first covered charge is incurred that is used to satisfy the cash deductible.

Benefits may be paid for such injury or sickness during the period of time called the benefit period. The benefit period is shown in the Schedule of Benefits.

Benefits for any injury or sickness will end on the earlier of:

- the date the applicable maximum benefit has been paid,
- the end of the benefit period,
- the end of a period of 24 months where there is a period of 90 consecutive days during which at least \$150 of charges have not been incurred for the injury or sickness,
- the end of a period of twelve consecutive months during which no charge is incurred for the injury or sickness.

A new cash deductible will be required when the benefit period expires.

if 2 or more insured family members are injured in the same accident or contracts the same contagious disease

The covered charges incurred by **each** such person due to the same accident or the same contagious disease, when contracted within 30 days, will be combined. If the total exceeds one cash deductible amount, no further cash deductible will be required for such persons for any injury caused by the accident or contagious disease.

MAXIMUM BENEFIT

The maximum amount of benefits to be paid for each person is shown in the Schedule of Benefits.

MAJOR MEDICAL BENEFITS (Continued)

COVERED CHARGES (Continued)

B. Charges to buy, rent, repair or maintain:

- artificial limbs
- crutches
- wheel chairs
- other medical equipment, appliances and supplies.

9. Charges made for hospice care, as follows:

- charges made by a hospice, up to 210 consecutive days of confinement per calendar year, and
- charges for 5 visits per calendar year for bereavement counselling to the family of the terminally ill person.

HOSPICE means an entity licensed, approved or authorized to provide inpatient medical relief of pain and supportive care to terminally ill persons. Such entity must have on its premises:

- organized facilities to care for and treat terminally ill persons, and
- a paid staff of medical professionals to supervise such care and treatment.

FAMILY means the parent, spouse, sibling or child of the terminally ill person.

A physician must certify that the terminally ill person has a life expectancy of 6 months or less.

10. Charges made for home health care, as follows:

- part-time or intermittent home nursing care by, or supervised by, a registered nurse
- part-time or intermittent home health aide services which mainly care for the patient

(PART-TIME or INTERMITTENT CARE also means full-time or 24 hour services medically required for not more than 3 days.)

- occupational, speech or respiratory therapy
- medical social work
- special meals and nutritional services.

HOME HEALTH CARE means medical care given to a person at his home and prescribed by his physician. The plan of care must be:

- in lieu of confinement in a hospital or skilled nursing facility (as defined in Title XVIII of the Social Security Act), and
- set up and approved, in writing, by a physician and a home health care agency certified by the state department of health or as defined in title XVIII of the Social Security Act.

Benefits will be paid for up to 100 home health care visits per calendar year. Each visit by a member of a home health care team will be considered one home health care visit. Four hours of home health aide services will be considered one home health care visit.

Benefits will not be paid in excess of those that would be paid by the group policy for similar charges incurred while hospitalized.

MAJOR MEDICAL BENEFITS (Continued)

COVERED CHARGES (Continued)

Limitations

Benefits will be paid for covered charges incurred for the medical services shown below only to the extent described below.

Dental care, treatment or surgery

Charges for these services will be covered only if:

1. they result from a non-job related injury to natural teeth;
2. the injury is caused by an accident which occurs while the person is insured; and
3. such services are rendered within 12 months of the accident;

or they are made by a hospital while the person is hospitalized.

Treatment for temporomandibular joint dysfunction (TMJ)

Charges for these services will be covered, except for those charges for crowns or bridgework.

Eye exams to prescribe or fit corrective lenses for eye glasses

Charges for these services will be covered only if:

1. the charges result from a non-job related injury; and
2. the injury is caused by an accident which occurs while the person is insured.

Cosmetic treatment or surgery

Charges for these services will be covered only if they result from:

1. a non-job related injury or sickness; or
2. a congenital disease or anomaly of a dependent child resulting in a functional defect.

Diagnosis and treatment for alcoholism or alcohol abuse and substance abuse or substance dependence

For these services, only the following charges will be covered:

1. charges incurred while the person is hospitalized.
2. charges incurred for inpatient rehabilitation in a certified or accredited alcoholic or substance abuse treatment center, up to 30 days per calendar year.
3. charges incurred for outpatient diagnosis and treatment in a certified or accredited alcoholic or substance abuse treatment center, up to 60 visits per calendar year. Up to 20 of such visits may be for family members of the alcoholic or substance abuser.

Diagnosis and treatment for psychiatric, mental, nervous or emotional disorders, ailments or illness

For these services, only the following charges will be covered:

1. charges incurred while the person is hospitalized, up to 30 days per calendar year.
2. charges incurred for outpatient visits, up to 30 visits per calendar year, subject to a maximum benefit of \$50 per visit. The facility for such visits must:
 - a. have been issued an operating certificate by the commissioner of mental health pursuant to the mental hygiene law; or
 - b. be operated by:
 - the office of mental health,
 - a psychiatrist or psychologist licensed to practice in New York, or
 - a professional corporation of such psychiatrists or psychologists.
3. charges incurred for up to 3 psychiatric emergency visits per calendar year, subject to a benefit of \$60 per visit. Benefits provided for emergency visits will reduce benefits otherwise payable for inpatient or outpatient care described in items 1 and 2.

MAJOR MEDICAL BENEFITS (Continued)

PREGNANCY BENEFITS

No pregnancy benefits will be paid by the group section, except as described on page P.

CHARGES NOT COVERED

1. Charges to buy or rent:

- air conditioners
- air purifiers
- motorized transportation equipment
- escalators or elevators in private homes
- eye glass frames or lenses
- hearing aids
- swimming pools or supplies for them
- general exercise equipment.

2. Charges incurred after a person's insurance ends, regardless of when the injury or sickness occurred. However, major medical benefits may be provided as described in the Benefits After Insurance Ends provision below.

3. Charges for a routine physical exam, except charges for preventive mammography and cytologic screening.

MAJOR MEDICAL BENEFITS (Continued)

BENEFITS AFTER INSURANCE ENDS

If a person's insurance ends while he is totally disabled, major medical benefits will be paid for covered charges if:

- they are incurred to treat the injury or sickness which caused the total disability
- they are incurred within 12 months after insurance ends
- total disability is continuous from the day insurance ends to the day the charge is incurred, and
- the person is not covered for the total disability under another group plan.

GENERAL EXCLUSIONS

No medical care benefits will be paid by the group policy for charges incurred for treatment which:

1. is given after a person's insurance ends, regardless of when the injury or sickness occurred.

However, medical care benefits may be provided in the Benefits After Insurance Ends provision of a given benefit section.

2. is not essential for the necessary care or treatment of the injury or sickness involved.

NECESSARY CARE OR TREATMENT means care, treatment, services or supplies which are:

- recommended, approved or certified by a physician as necessary and reasonable, and
- commonly viewed by the American Medical Association as being proper treatment.

"Necessary care or treatment" does not mean care, treatment, services or supplies which are:

- to train a person for a job or to educate him, or
- experimental in nature.

3. would be given free of charge if the person was not insured.

However, medical care benefits **will be paid** for covered charges incurred by a state for medical assistance to an insured person under Title XIX of the Social Security Act of 1965.

4. results from a war or an act of war.
5. results from intentionally self-inflicted injury.
6. is given by a person's spouse or his or his spouse's father, mother, son, daughter, brother or sister.
7. is given by a person's employer or an employee of such employer.

PRE-EXISTING CONDITIONS PROVISIONS FOR MEDICAL CARE BENEFITS

PRE-EXISTING CONDITION means:

- an injury or sickness which manifested itself within 6 months before a person became insured under a given benefit section of the group policy in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment;
- an injury or sickness for which a person was recommended or received medical advice, diagnosis, care or treatment within 6 months before a person became insured under a given benefit section of the group policy; or
- a pregnancy that exists on the date a person became insured under a given benefit section of the group policy.

No charges incurred for a pre-existing condition will be considered covered charges under a benefit section until the person stays insured under such benefit section for 12 continuous months.

Exception for persons covered by a previous plan

As used in the group section, PREVIOUS PLAN means: a hospital, surgical or medical expense insurance policy; hospital or medical service plan; health maintenance contract; self-insured or self-funded employer group health plan; or governmental plan which is reasonably equivalent to the coverage under the group policy and under which a person was covered prior to becoming insured under the group policy.

The requirements of the pre-existing conditions provision of the group policy will be reduced to the extent that they were satisfied for a pre-existing conditions provision of a previous plan, as defined, if the coverage under the previous plan ended no more than 60 days prior to the date the person becomes insured under the group policy. Any waiting period preceding eligibility for insurance under the group policy will be excluded when determining whether coverage under the previous plan ended within the prior 60 day period. In the case of previous health maintenance organization coverage, any waiting period preceding eligibility for insurance under the previous plan shall also be used to reduce the requirements of the pre-existing conditions provision of the group policy.

COORDINATION OF BENEFITS

This section will be used to determine a person's benefits under the group policy IF:

- the person is insured for medical care benefits under the group policy and is also covered for these benefits under other plans, and
- the benefits that would be paid by the group policy, without the group section

PLUS

the benefits that would be paid by the other plans, without a section similar to the group section

WOULD EXCEED ALLOWED EXPENSES (as defined below).

DEFINITIONS

PLAN means a plan which provides benefits or services for, or by reason of, hospital, surgical, medical or dental care or treatment through:

1. group or blanket insurance coverage, other than blanket school accident coverages, or coverages issued to like groups where the Policyholder pays the premium.
2. pre-paid plans for:
 - group hospital service
 - group medical service
 - group practice
 - individual practice, and
 - any other such plans for members of a group;
3. any plan provided by:
 - labor management trusts
 - unions
 - employer organizations
 - professional organizations, or
 - employee benefit organizations;
4. a government program or statute, *other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965* or any law or plan when its benefits are required to exceed those of any private insurance plan or other nongovernmental plan; and
5. medical benefits coverage in group and individual mandatory automobile "no fault" and traditional mandatory automobile "fault" type contracts.

THIS PLAN means the medical care benefits provided by the group policy.

ALLOWED EXPENSE means an expense which is:

- necessary, reasonable and customary
- incurred while the person (for whom claim is made) is insured, or is entitled to benefits after insurance ends, under the group policy, and
- at least partly covered under one of the plans covering such person.

When a plan provides a benefit as a service rather than a cash payment, the reasonable cash value of the service will be considered to be **both** an allowed expense **and** a benefit paid.

EFFECT ON BENEFITS UNDER THIS PLAN

When the group section is used, the rules listed below will determine the amount of benefit each plan will pay. All benefits will be determined on a calendar year basis.

These rules may require the group plan to pay its benefits first. If so, the group plan will pay its full benefits without taking into account other plan benefits.

These rules may require one or more of the other plans to pay their benefits before the group plan. If so, the group plan will reduce its benefits so that in any calendar year, the sum of all benefits to be paid to a person (by the group and all other plans) equals the allowed expenses for that year.

Benefits to be paid under other plans include benefits that would be paid if proper claim is made for such benefits.

RETURN OF OVER PAYMENT

IF BENEFITS ARE PAID IN ERROR

Medical care benefits paid by United States Life under the group policy must be returned to United States Life if it is found that such benefits were paid in error.

IF AN INSURED PERSON RECEIVES PAYMENT FROM A THIRD PARTY

United States Life may require the return of medical care benefits paid for an injury or sickness up to the amount an insured person receives for that injury or sickness through a third party settlement or satisfied judgment. We will only require such payment when the amounts received through such settlement or judgment are specifically identified as amounts paid for hospital, medical or surgical services, for which United States Life has paid benefits.

If an insured person makes a claim to United States Life for medical care benefits, as described above, under the group policy prior to receiving payment from a third party, or its insurer, he must agree in writing to repay United States Life from such monies received by him from the third party, or its insurer. The repayment will be to the extent of the benefits paid by United States Life. However, the reasonable pro rata expenses, such as lawyers' fees and court costs incurred in effecting the third party payment, may be deducted from the repayment.

The repayment agreement will be binding upon the insured person regardless of whether:

1. the payment received from the third party, or its insurer, is the result of:

- a legal judgment, or
- a compromise settlement;

2. the third party, or its insurer, has admitted liability for the payment.

The term "insured person" will mean the legal representative of a minor or incompetent, if applicable.

COORDINATION OF BENEFITS (Continued)

EFFECT ON BENEFITS UNDER THIS PLAN (Continued)

Rules to determine which plan pays first

A plan, or part of one, that does not have a section similar to the group section will pay its benefits before a plan that has such a section.

In all other cases, the plan that will pay its benefits first will be:

1. the plan which covers the person as an employee rather than as a retiree or a laid off person.

Item 1 will not apply unless a similar provision is contained in all plans. In the group case item 2, 3 or 4 will determine which plan pays first.

2. if 1 does not apply, the plan which covers the person as an employee, retiree or laid off person rather than as a dependent.
3. if 1 and 2 do not apply, the plan which covers the person as a dependent of the parent whose month and date of birth occurs earlier in the year.

If the other plan has a rule based on the gender of the parent, the gender rule will determine the order of benefits.

However, a child's parents may be divorced or separated. If so, the plan to pay its benefits first will be the plan which covers the child as a dependent of the parent with custody rather than as a dependent of the parent without custody.

If the parent with custody remarries:

- the plan which covers the child as a dependent of a parent with custody will pay its benefits first
- the plan which covers the child as a dependent of a stepparent will pay its benefits next, and
- the plan which covers the child as a dependent of a parent without custody will pay its benefits last.

A court decree may require the parent without custody to be financially responsible for the child's health care. If so, the plan to pay its benefits first will be the plan which covers the child as a dependent of the parent with such responsibility rather than as a dependent of any other person.

4. if 1, 2 and 3 do not apply, the plan which has covered the person for the longer time rather than for the shorter time.

If the benefits of the group plan are reduced due to these rules, such reduction will be done in proportion. Any benefits paid by the group plan on a reduced basis will be charged against the benefit limits of the group plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the group section to work, United States Life must exchange information with other plans. To do so, United States Life may give to or get from any source all such information it thinks necessary. This will be done without the consent of or notice to any person. Any person claiming benefits under the group plan must give to United States Life the information it requires.

FACILITY OF PAYMENT

Another plan may pay a benefit that should be paid by United States Life by the terms of the group section. If the group happens, United States Life may pay to such payor the amount required for it to satisfy the intent of the group section. This will be done at the discretion of United States Life. Any amount so paid will be considered a benefit paid under the group plan. United States Life will not be liable for such payment after it is made.

RIGHT TO RECOVER OVERPAYMENTS

United States Life may pay benefits in excess of those required by the group section. If the group happens, United States Life has the right to recover such excess from:

- any person to or for whom such payments were made
- any other insurer, or
- any other organization.

CONVERSION OPTION FOR MEDICAL CARE BENEFITS

If insurance ends under the group policy for the persons listed below, they may buy an individual policy of medical care insurance from United States Life. Such person must apply for the new policy in writing and pay the first premium during the conversion period. Evidence of insurability will not be required.

CONVERSION PERIOD means the 31 days after insurance ends.

WHO MAY USE THIS OPTION

1. You, if your insurance ends for any reason other than failure to pay the required share of the premium.
2. A surviving spouse.
3. A spouse whose marriage ends by divorce or annulment.
4. A dependent child, if he ceases to be one as defined in the group policy.

You or your spouse referred to above may insure under their new policy any of their dependents insured by the group policy on the date insurance ends.

No person may use the group option:

1. unless they have been insured by the Policyholder's group insurance plan for at least 3 months;
2. if they are eligible for Medicare; and
3. if it would cause them to be "overinsured." This may happen if the person is covered or is eligible to be covered for similar benefits provided by any other plan, insured or not insured. United States Life will determine if the group is so, using its standards for overinsurance.

COVERAGE TO BE PROVIDED BY THE NEW POLICY

The new policy will provide the major medical benefits that United States Life is required to offer in the state in which you are a resident. Details of these plans will be given on request.

After insurance ends, a person may be paid benefits under the group policy. If so, benefits to be paid to such person under the new policy will be reduced by the amount paid under the group policy.

DATE THE NEW POLICY TAKES EFFECT

The new policy will take effect on the day after the person's insurance ends under the group policy.

GENERAL PROVISIONS

MISSTATEMENTS

A person's age, sex or any other data may be misstated. If so, the correct data will be used to determine if insurance is in force. If insurance is in force, the premium and/or benefits will be adjusted according to the facts.

ASSIGNMENT

United States Life will not be bound by any assignment unless it is in writing and is recorded at its home office. United States Life is not responsible for the validity of an assignment.

COMPLIANCE WITH LAW

On the date the group policy takes effect, some of its provisions may conflict with an applicable law. If so, any such provision is changed to comply with the minimums required by such law.

GENDER

Male pronouns will be read as female where it applies.

END OF INSURANCE PROVIDED BY THE GROUP POLICY

IF PREMIUM IS NOT PAID - GRACE PERIOD

Each premium, after the first, may be paid up to 31 days after its due date. This period is the grace period. The insurance provided by the group policy will stay in effect during the group period. If the premium is not paid by the end of the group period, such insurance will end at that time.

United States Life may extend the grace period by written notice. Such notice will state the date insurance will end if the premium remains unpaid.

Premiums must be paid for a grace period and any extension of such period.

GENERAL PROVISIONS FOR ACCIDENT AND HEALTH INSURANCE

FILING A CLAIM

To file a claim, follow these steps:

Step 1:

A claimant should send a written notice of claim to United States Life within 20 days of a loss. No special form is required to do the group. The notice need only identify the claimant and the Policyholder.

Step 2:

When United States Life receives the notice, it will send a proof of claim form to the claimant.

Step 3:

The claimant should receive the proof of claim form within 15 days of the date United States Life received the notice of claim.

If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form.

If the form is not received within such time, the claimant may provide written proof of claim to United States Life on any reasonable form. Such proof must state the date the injury or sickness began and the nature and extent of the loss.

Step 4:

Proof of claim must be sent to United States Life within 90 days of the loss.

If a notice or proof is sent later than the times shown above, United States Life will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS

All benefits will be paid as they accrue.

PHYSICAL EXAMS

United States Life, at its expense, has the right to examine the insured. This may be done as often as needed to process a claim.

TIME LIMIT ON LEGAL ACTIONS

Legal action may only be brought against United States Life during a certain period. This period begins 60 days after the date proof of claim was filed and ends 3 years after the end of the period within which such proof is required.

CERTIFICATE RIDER

The group policy under which you are insured permits the election of an increased benefit for charges for convalescent care. The certificate to which this rider is attached, as identified by the certificate number shown on the schedule, is amended to specify such election as of the Effective Date shown on the schedule. The terms and conditions stated in this rider will apply.

You and any insured dependents must not be confined in a hospital or a convalescent home on the Effective Date. If you or any insured dependent are so confined, this rider will not take effect for such confined person until the day after the person is discharged.

The **Maximum benefit for each person** section of the **SCHEDULE OF BENEFITS** is changed so the item "for charges for convalescent care" will read:

- for charges for convalescent care
 - per week \$400
 - while insured 2 years of benefits

The portion of the increased benefit which represents the additional amount is subject to the Pre-Existing Conditions Provisions stated in your certificate of insurance, unless such Pre-Existing Conditions Provisions are changed to comply with the laws of the state in which you are a resident.

These changes will not affect your certificate, or any prior riders, except as stated above.