MARYLAND

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

UNDER THE LIFE AND HEALTH INSURANCE GUARANTY

CORPORATION

Residents of this state who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the Maryland Life and Health Insurance Guaranty Corporation. The purpose of this is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Guaranty Corporation will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Corporation is not unlimited, however. And, as noted in the box, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Maryland Life and
Health Insurance Guaranty Corporation

Disclaimer

The Maryland Life and Health Insurance Guaranty Corporation may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Maryland. You should not rely on coverage by the Maryland Life and Health Insurance Guaranty Corporation in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies and their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty corporation to induce you to purchase any kind of insurance policy.

The Maryland Life and Health Insurance
Guaranty Corporation
P.O. Box 671, Suite 216C
Owings Mills, Maryland 21117
(410) 998-3907

The state law that provides for this safety-net coverage is called the Life and Health Insurance Guaranty Corporation. **The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.** The following contains a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the law or the rights or obligations of the Guaranty Corporation. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Corporation.

(Please turn to other side.)

a. Coverage:

Generally, individuals will be protected by the Life and Health Insurance Guaranty Corporation if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live in another state.

b. Exclusions from Coverage:

However, persons holding such policies are not protected by this corporation if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a Health Maintenance Organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessment, or by an insurance exchange.

The corporation also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance, unless an assumption certificates have been issued;
- interest rate yields that exceed an average rate;
- any portion of a policy or contract to the extent that it provides dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employer's plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them); and
- unallocated annuity contracts (which give rights to group contract holders, not individuals).

c. Limits on Amount of Coverage:

The statute also limits the amount that the corporation is obligated to pay. The corporation cannot pay more than the amount the insurance company would owe under a policy or contract. Also, with respect to any one life, regardless of the number of policies or contracts with the member insurer, the corporation will pay a maximum:

- in the case of life insurance, $300,000 in death benefits but not more than $100,000 in net cash surrender or withdrawal values;
- in the case of health insurance, $300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
- with respect to annuities, $100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values.

TRUSTMARK INSURANCE COMPANY (MUTUAL)
400 Field Drive
Lake Forest, Illinois 60045
(Herein We, Us and Our)

MAJOR MEDICAL POLICY

This is Your Policy of Insurance (Policy) while You are insured. It is issued in consideration of Your application and the first Premium payment.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy if premium has been timely paid. Benefit payment is governed by all the terms, conditions, exclusions and limitations of the Policy.

This Policy was issued on the basis that the information on Your application was correct and complete. **If any information on the application was not correct or complete, write to Us explaining the error or omission. An error or omission of conditions, not previously revealed, affecting the issuance of this Policy may result in loss of coverage as of its effective date.**

Right to Examine for Ten Days: If You are not satisfied with this Policy, return it to Our home office or to Your agent within ten (10) days after the date You received it. The Policy will then be canceled and any premium paid will be refunded.

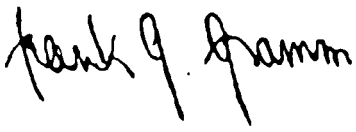
The Policy is conditionally renewable and will renew automatically upon payment of Premium. The Company may terminate coverage on:

- The date We elect not to renew all of Our individual health benefit plans in Your state.
- The date We receive Your written request to have Your insurance terminated.
- The end of the period for which Premium is paid, subject to the Grace Period.
- The date of Your death.
- The date We refuse to renew Your coverage because of fraud or intentional misrepresentation of a material fact under the terms of coverage.

At least 30 days prior written notice will be given to You if We terminate Your coverage for any reason, except for nonpayment of premium.

Please Read this Policy Carefully

J. Grover Thomas Jr.
President & Chief Executive Officer



Frank G. Gramm
Corporate Secretary & General Counsel

TABLE OF CONTENTS

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DEFINITIONS

Approved Transplant Services: Services and supplies which are related to a transplant procedure, approved in writing by Us, and include but are not limited to:

- Pre-transplant evaluation for the Medical Necessity of the transplant;
- Hospital charges;
- Physician charges; and
- Tissue typing and ancillary services.

Chemical Abuse: A disease that is characterized by a pattern of pathological use of alcohol or drugs with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Chemical Dependency: A disease characterized by alcohol or drug abuse, and physical symptoms of withdrawal or tolerance.

Complications of Pregnancy: A condition which: (a) is not part of a normal pregnancy; and (b) whose diagnosis is distinct from pregnancy but is adversely affected by or caused by pregnancy.

Complications of Pregnancy include: (1) nonelective caesarean section or ectopic pregnancy which is terminated; (2) spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible; (3) acute nephritis; (4) nephrosis; (5) cardiac decompensation; (6) missed abortion; (7) hyperemesis gravidarum; (8) eclampsia; (9) puerperal infection; (10) RH factor problems; (11) severe loss of blood requiring transfusions; and (12) similar medical and surgical conditions of comparable severity.

Complications of Pregnancy does not include: (1) false labor; (2) occasional spotting; (3) Physician prescribed rest during pregnancy; (4) morning sickness; (5) preeclampsia; and (6) similar conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.

Covered Person: A person listed on the Schedule as insured under this Policy.

Deductible: The amount of Covered Charges a Covered Person must incur before We pay any benefits. No benefits are paid until the amount of Covered Charges for a Covered Person exceeds the Deductible. This amount does not apply toward the satisfaction of the Out-of-Pocket Limit.

Dependent: A person who is:

(1) Your legally married spouse.

(2) Your unmarried natural or legally adopted children who are dependent upon You for support and maintenance and are under the age of 19.

(3) Your step children who reside with You and are under the age of 19.

(4) Your unmarried natural, step or legally adopted children age 19 to age 24, but only if they are:

  (a) Full-time students at an accredited educational institution; and

  (b) Dependent upon You for support and maintenance.

(5) Your unmarried grandchild who is in Your court-ordered custody and residing with You under the age of 19 and grandchildren age 19 to age 24, but only if they are:

  (a) Full-time students at an accredited educational institution; and

(b) Dependent upon You for support and maintenance.

(6) Your unmarried child for whom a court or administrative agency has issued a medical support order which decrees that You must provide medical coverage.

(7) A child in Your custody as a result of guardianship, other than a temporary guardianship of less than 12 months duration, granted by a court or testamentary appointment.

A child or grandchild age 19 to age 24 ceases to be a Dependent on the last day of the month in which the child fails to qualify as a full-time student, except for regularly scheduled vacation periods.

Designated Facility: A facility which has an agreement with Us to render Approved Transplant Services. The facility may be outside a Covered Person's geographic area.

Emergency: An Injury or sudden onset of a medical condition, which manifests itself by acute symptoms, including sudden and severe pain, which is sufficiently severe that without immediate medical care the person could reasonably expect: (a) his life or health would be in serious jeopardy; (b) his bodily functions would be seriously impaired; or (c) a body organ or part would be seriously damaged. This would include childbirth.

Experimental/Investigational: A drug, device or medical treatment or procedure is considered experimental or investigational if:

- It has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law;

- Reliable evidence shows it is the subject of ongoing Phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; or

- Reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility or other facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical treatment or procedure.

Family Member: You, Your spouse, or the parent, child, brother or sister of You or Your spouse.

Free Standing Surgical Center: A facility licensed as a free standing or ambulatory surgical center; which is operated solely for the purpose of providing outpatient surgical care.

Home Health Care: Treatment, services or supplies furnished in a Covered Person's home by a licensed or certified home health agency pursuant to a written plan prescribed by a Physician as Medically Necessary.

Hospice Care: A program of palliative, supportive, nursing and other health services care provided by a licensed or certified hospice. Hospice Care is available to a Covered Person and his immediate family upon a Physician's diagnosis of terminal illness. Hospice Care benefits are paid in addition to, and not in lieu of, other policy benefits. But, Hospice Care benefits will not duplicate other policy benefits for the same expense.

Hospital: An institution licensed, accredited or certified by the State which: (a) is accredited by the Joint Commission on Accreditation of Hospitals, or is operated as a hospital by the State of Maryland or any of its counties or municipalities; (b) provides 24-hour nursing service by, or supervised by, registered nurses (RN);

(c) mainly provides diagnostic and therapeutic care under the supervision of Physicians on an inpatient basis; and (d) maintains permanent surgical facilities, except for hospitals operated by the State of Maryland or any of its counties or municipalities or Maryland public or private mental hospitals.

A place, special ward, floor or other accommodation used for: custodial or educational care; rest; the aged; a nursing home; or an institution mainly rendering extended care or intermediate care will not be considered a Hospital.

Injury: Accidental bodily injury independent of disease, bodily infirmity or other cause.

Manipulative Treatment: The diagnosis, analysis and adjustment of spinal subluxation; and manipulative therapy and related treatment of the musculoskeletal structure for other than fractures and dislocation of the extremities.

Medically Necessary/Medical Necessity: A service, supply or drug that is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to a confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A service, supply or drug shall not be considered as Medically Necessary if it:

- Is Experimental, Investigational or furnished in connection with medical research;
- Is provided solely for the convenience of the patient, the patient's family, Physician, Hospital or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
- Could have been omitted without adversely affecting the person's condition or the quality of medical care;
- Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration; or
- Involves a service, supply or drug not considered reasonable and necessary according to common and accepted medical practices within the United States.

We retain the right to determine whether a service, supply or drug is Medically Necessary.

Medicare: Title XVIII of the Social Security Act of 1965, as amended. A person is considered to be eligible for Medicare on and after the date the person is first eligible for any Medicare coverage.

Mental Illness: Any condition or disease, regardless of its cause, listed in the most recent edition of the Diagnostic and Statistical Manual of Disorders of the American Psychiatric Association as a mental illness.

Non-Designated Facility: A facility which is not a Designated Facility.

Nurse: A Registered Graduate Nurse (R.N.); a licensed practical or vocational nurse; certified nurse-midwife; or a certified nurse practitioner who is acting within the scope of his license. This does not include a Family Member.

Outpatient: A Covered Person will be considered an outpatient when he receives any treatment services, or supplies, while not confined as an inpatient in a Hospital and this would include, but is not limited to treatment received in a doctor’s office or prescriptions obtained at a pharmacy.

Physician: A licensed medical doctor; surgeon; osteopath; podiatrist; dentist; optometrist; psychiatrist; licensed certified social worker; nurse; anesthetist; chiropractor or health care provider licensed under the Health Occupations Article, acting within the scope of such license, who is not a Family Member.

Pre-existing Condition: During the 12 months prior to the Effective Date: (a) a Sickness or Injury for which medical care, treatment, diagnosis or advice was received or recommended; or (b) the existence of symptoms which would cause an ordinarily prudent person to seek medical care, treatment, diagnosis or advice.

A Sickness or Injury disclosed on the application will not be considered a Pre-Existing Condition.

Sickness: Illness; disease; Complication of Pregnancy; and congenital defect, birth abnormality or prematurity of a covered newborn child.

Skilled Nursing Home: A licensed facility which: (a) operates within the scope of its license; (b) provides room and board accommodations at the patient's expense; (c) keeps a daily medical record of each patient; (d) routinely provides skilled nursing care under the direction of a Physician; and (e) provides skilled nursing care by, or under the supervision of, a registered nurse.

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

Usual and Customary Charge: The lesser of: (a) the actual charge; (b) the fee most often charged by the provider for the same service or supply; or (c) the fee most often charged in the same area by providers with similar training and experience for a comparable service or supply. "Area" means a metropolitan area, a county, in the same zip code or a greater area if needed to find a cross-section of providers of a comparable service or supply.

Year: The calendar period beginning each January 1 and ending the following December 31. The first Year shall begin on the Effective Date.

You or Your: The Insured named on the Schedule.

All male terms will include the female terms, unless stated otherwise.

CONDITIONS OF INSURANCE

ELIGIBILITY

- INSURED - You are eligible for coverage when You complete a valid application, provide evidence of insurability and pay the Initial Premium.

- DEPENDENT - A Dependent is eligible for coverage on the later of:

    - The date You become eligible for insurance; or
    - The date You acquire the Dependent.

    A Dependent is deemed to be acquired as follows:

    - **Spouse:** On the date of the marriage.
    - **Natural Child:** On the date of birth.
    - **Adopted Child:** On the date of adoption which is the date the child is placed in Your custody or the date You are legally or financially responsible for the child, if earlier.
    - **Step Child:** On the date the Insured marries the step child's natural parent.
    - **Grandchild:** On the date the child is residing with You as a result of court-ordered custody.
    - **Dependent Child due to Guardianship**: On the date of appointment of guardianship.

If an eligible person does not meet Our underwriting standards, We may:

- Refuse to insure that person;
- Insure that person but exclude a specific disease or physical condition from coverage; or
- Make a surcharge for that person's coverage.

Persons covered under this Policy are shown as Covered Persons in the Schedule. A new Schedule will be issued as Dependents are added to coverage.

EFFECTIVE DATE

- INSURED - Coverage will start at 12:00 a.m. standard time at Your residence, on the Effective Date shown on the Schedule.

- DEPENDENT

  - **Newborn:** Coverage for a newborn is effective from the moment of birth. For coverage to continue:

    1. We must receive written notice of the newborn within 45 days of the birth or before the end of the period for which Premium has been paid if later, and

    2. You must pay any additional Premium within 31 days of receiving a notice of the amount due.

    If notification of a newborn is received late, insurance will be effective only if an application for coverage is accepted by Us and Premium is paid. Notice of a newborn is not required if You already have three children who are Covered Persons under this Policy and no additional Premium is required. However, written notice of a newborn may prevent claim delays.

  - **Other Than A Newborn:** You must complete and sign an application which includes Your Dependents. If accepted by Us, an Effective Date will be assigned as follows:

    - The date Your insurance is effective for Dependents eligible on that date and for whom coverage is applied for;

    - For Dependents eligible on or first acquired after Your Effective Date; coverage will be effective on the date We assign.

    - For Dependents for whom a court or administrative agency has issued a medical support order which decrees that You must provide medical coverage; coverage will be effective on the date coverage is applied for by You, the Dependent's custodian, Child Support Enforcement Agency, or the Department of Health and Mental Hygiene.

- **Dependent Child due to Guardianship:** Coverage for a child due to guardianship granted by a court or testamentary appointment is effective on the date of appointment. For coverage to continue:

  1. We must receive written notice of the appointment within 45 days of the appointment, or before the end of the period for which Premium has been paid if later, and

  2. You must pay any additional Premium within 31 days of receiving a notice of the amount due.

  - **Adopted child:** Coverage for an adopted child is effective from the date of adoption. For coverage to continue:

  1. We must receive written notice of the adopted child within 45 days of the date of adoption, or before the end of the period for which Premium has been paid, if later; and

  2. You must pay any additional Premium within 31 days of receiving a notice of the amount due.

TERMINATION DATE

- **INSURED**

Coverage will terminate at 12:00 a.m. standard time at Your home on the earliest of:

- The date We elect not to renew all of Our individual health benefit plans in Your state.
- The date We receive Your written request to have Your insurance terminated.
- The end of the period for which Premium is paid, subject to the Grace Period.
- The date of Your death.
- The date We refuse to renew Your coverage because of fraud or intentional misrepresentation of a material fact under the terms of coverage.

At least 30 days prior written notice will be given to You if We terminate Your coverage for any reason, except for nonpayment of premium.

- **DEPENDENT**

Dependent coverage will terminate at 12:00 a.m. standard time at Your home at the earliest of:

- The premium due date following the date a Dependent ceases to be a Dependent as defined.
- The end of the period for which Premium for Dependent coverage is paid, subject to the Grace Period.
- The date Your coverage terminates, subject to any Continuation Of Coverage.
- The date We receive Your written request to terminate Dependent coverage, provided We receive written evidence that any applicable medical support orders are no longer in effect or that the Dependent is enrolled in other reasonable health insurance coverage effective on the date of termination.

CONTINUATION FOR DEPENDENTS

If You die or become eligible for Medicare and voluntarily terminate Your coverage, Your Dependents whose coverage was in effect on the date of Your death, or the date You became eligible for Medicare, may continue coverage under this Policy. We should be notified of this within 31 days of Your date of death, or within 31 days of Your Medicare eligibility. Benefits will be paid to the Dependent or a legal guardian, if the Dependent is a minor.

The premium for the child's continued coverage will be the premium for the attained age of the child according to our then current rate schedule.

CONTINUATION FOR INCAPACITATED CHILDREN

Dependent children, insured herein, that reach the limiting age and are incapable of self-sustaining employment due to mental or physical incapacity may continue to be covered regardless of age. The Dependent must be chiefly dependent on You for support and maintenance.

You must claim incapacity status within 31 days of such child attaining the limiting age. We will require proof of incapacity as often as necessary, but not more than once a year.

Coverage for an incapacitated child will end on the earliest of:

- The date the Dependent marries;
- The date the Dependent obtains self-sustaining employment;
- The date the Dependent ceases to be incapacitated;
- The date the Dependent ceases to be chiefly dependent upon You for support and maintenance;
- Sixty (60) days after a written request for proof of disability, if proof is not provided within such 60 days;
- The date You refuse to allow Us to examine the Dependent; or
- The date coverage would otherwise terminate.

The premium for the child's continued coverage will be the premium for the attained age of the child according to our then current rate schedule.

CONVERSION

If coverage ends due to divorce or attainment of the limiting age, the Dependent may elect to convert to individual coverage.

Notice of this election must be received by Us within 60 days of the event. No evidence of insurability will be required. Premium for the conversion policy must be paid within 31 days after the election is made. Premium will be based on Our rates in effect at the time of conversion. The effective date of the Conversion policy will be the original effective date of coverage for the Dependent.

Benefits under the Conversion policy will not be greater than those provided under this Policy.

Conversion is not available if:

- The Dependent has been covered by this Policy for less than 3 months;
- The Dependent is eligible for Medicare; or
- The Dependent is eligible for Other Medical Expense Coverage.

EXTENSION OF BENEFITS

If a Covered Person is Hospital confined or a claim is in progress on the date the Policy terminates or coverage is terminated for all Policy holders in Your state, We will extend that Covered Person's benefits.

Extension applies only during Hospital confinement or the period in which claims are incurred. Benefits will be paid, for the Sickness or Injury for which You were confined or incurred claims at the time the Policy terminated, as if coverage had remained in effect.

Extension of Benefits will end at the earliest of:

- 12 months from the date coverage otherwise ended; or
- The date You become eligible for Other Medical Expense Coverage which would pay a similar benefit for the expense.

Any unpaid Premium will be deducted from the claims paid. Extension of Benefits will not be available if the Policy terminates for failure to pay Premium.

BENEFIT PROVISIONS

Benefits are only payable for incurred Covered Charges which are Medically Necessary and provided by or under the direction of a Physician. The requirement of Medical Necessity will not apply to benefits for preventive care, hospice and the routine physical examination which are specifically listed as Covered Charges. Payment for any Covered Charge or Preventive Benefit is subject to:

1. The Usual and Customary Charge as established by Us and any portion of a charge that exceeds the Usual and Customary Charge is excluded and will not be considered as part of a Covered Charge;
2. Definitions, limitations, exclusions, benefit maximums and other provisions of the Policy; and
3. The Cost Containment Procedures.

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

DEDUCTIBLE

The Deductible applies separately to each Covered Person each Year. A separate Deductible must be met for a covered newborn child, unless it is a Covered Charge not subject to the Deductible. We will pay the Insured Percent of Covered Charges that exceed the Deductible. No benefits are paid for Covered Charges which are used to satisfy the Deductible. The Individual Deductible is shown on the Schedule.

FAMILY MAXIMUM: All Covered Persons under this Policy need only satisfy a set number of Deductibles each Year. Once that happens, any remaining Deductible amounts are considered satisfied for that year. The Family Maximum Deductible is shown on the Schedule.

COMMON ACCIDENT: If two or more Covered Persons are injured in the same accident, only one Deductible will be applied to the Covered Charges for that accident in the Year the accident occurs.

INSURED PERCENT AND OUT-OF-POCKET MAXIMUMS

The Insured Percent is the portion of Covered Charges that We will pay after the Deductible has been met. The Insured Percent may vary for certain Covered Charges. The Insured Percents are shown on the Schedule.

The Individual Out-of-Pocket Maximum is the amount of Covered Charges that You are legally responsible to pay each Year for each Covered Person, due to Your coinsurance. Once the Individual Out-of-Pocket Maximum has been reached, Covered Charges are payable at 100 percent for that Covered Person for the remainder of the Year. The Individual Out-of-Pocket Maximum is shown on the Schedule.

The Family Out-of-Pocket Maximum is the total amount of Covered Charges that You are legally responsible to pay each Year for all Covered Persons, due to Your coinsurance. Once the Family Out-of-Pocket Maximum has been reached, Covered Charges are payable at 100 percent for all Covered Persons for the remainder of the Year. The Family Out-of-Pocket Maximum is shown on the Schedule.

The following Out-of-Pocket amounts for which You are legally responsible to pay will not apply toward the Out-of-Pocket Maximums:

1. Any applicable Deductible(s);
2. Covered Charges incurred for the treatment of Mental Illness;
3. The portion of a Covered Charge in excess of the Usual and Customary Charge;
4. Any expense which is not a Covered Charge; or
5. Any benefit reduction for failure to use the Cost Containment Procedures.

MAXIMUM BENEFIT AMOUNTS

LIFETIME MAXIMUM: The Lifetime Maximum is the maximum amount of benefits We will pay on behalf of any Covered Person over the lifetime of that person for all Covered Charges. This includes any amounts paid under any conversion policy issued as a result of this Policy. At no time, will total benefits available exceed the Lifetime Maximum shown on the Schedule.

SEPARATE COVERED CHARGE MAXIMUMS: Covered Charges for treatment of a certain Sickness or Injury are subject to Separate Benefit Maximums. These maximums are shown on the Schedule and are the greatest amount that will be paid for treatment of a certain Sickness or Injury. Benefits paid pursuant to a Separate Benefit Maximum are included in the Lifetime Maximum.

COVERED CHARGES

- Inpatient Hospital charges for:

    1. Room, board and general nursing care for each day of confinement, up to the rate set by the Health Services Cost Review Commission.
    2. Confinement in an intensive care or coronary care unit.
    3. Other Medically Necessary services and supplies furnished by a Hospital for inpatient medical care.
    4. Hospital admission.

- Physician charges for:

    1. Home, office and inpatient visits.
    2. Surgery.
    3. Dental treatment or surgery for Injury, except chewing injuries, to sound natural permanent teeth, within 6 months of the accident. Sound natural teeth are teeth that are not capped or crowned and which are free from disease or a previous Injury.
    4. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

- Outpatient medical care charges furnished at:

    1. A Free Standing Surgical Center; or
    2. The outpatient department of a Hospital.

- Inpatient Hospital charges for pregnancy of You or Your covered spouse, including:

    1. A minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean section;
    2. 2 home health care visits, if discharged within 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean section, or 1 home health care visit if the Physician prescribes the visit as Medically Necessary;
    3. Hospital Charges for a newborn up to 4 days, if the mother is required to remain hospitalized and requests that the newborn remain hospitalized.

The Insured Percent for these home health care visits is 100% and they are not subject to the Deductible.

- Outpatient medical care charges for in vitro fertilization procedures performed on You or Your Dependent spouse provided that:

    1. Your or Your Dependent spouse's sperm is used to fertilize Your or Your Dependent spouse's oocytes;
    2. You and Your Dependent spouse have a history of infertility of at least 5 years or the infertility is associated with endometriosis, exposure to diethylstilbestrol, or blockage or surgical removal of 1 or both fallopian tubes;
    3. You and Your Dependent spouse have been unable to attain a successful pregnancy through any less costly infertility treatments payable under this Policy; and
    4. The procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics.

- Charges for:

    1. Anesthetics and its administration;
    2. Professional local ambulance service to or from the nearest Hospital with available facilities to treat the Covered Person.
    3. X-rays, except dental x-rays, and laboratory tests for diagnosis or treatment.
    4. X-ray and radioactive isotope therapy.
    5. Dental x-rays necessary for the removal of a cyst or tumor.

- Manipulative Treatment, heat treatments and ultrasound, subject to the Separate Benefit Maximum shown on the Schedule.

- Supply and Equipment charges for:

    1. Blood and blood plasma and their derivatives or components.
    2. Oxygen and rental equipment for its administration.
    3. Original purchase of standard artificial limbs or eyes. Subsequent purchase only as needed due to: (a) growth of a child; or (b) progression of a Sickness or Injury.
    4. Original purchase of casts, splints, non-dental braces or crutches and surgical dressings.
    5. Rental of a wheelchair or hospital style bed or other durable medical equipment with the minimum features necessary for the circumstances. We may, at Our option, purchase such equipment. If purchased, the Covered Charge is limited to the purchase price and the cost of installation reduced by any amount paid for rental.
    6. Heart pacemaker.
    7. Intraocular lens implant or the first contact lenses or glasses following cataract surgery.

- Charges for orthodontics, oral surgery, ontological, audiological and speech/language treatment involved in the management of the birth defects known as cleft lip and cleft palate.

- Physical or speech therapy provided by a licensed therapist acting within the scope of that license who is not a Family Member.

- Private duty nursing care by a registered nurse (RN) or licensed practical nurse (LPN) who is not a Family Member, subject to the Separate Benefit Maximum shown on the Schedule.

- Inpatient and outpatient prescription drugs, insulin and supplies for insulin administration. Prescription drugs do not need to be approved by the federal Food and Drug Administration (FDA) for the treatment of the specific type of Sickness for which the drug has been prescribed. The drug, however, must be approved by the FDA and it must also be recognized for the treatment of that specific type of Sickness in any one of the following:

    1. The American Medical Association Drug Evaluations;
    2. The American Hospital Formulary Service Drug Information; or
    3. The United States Pharmacopedia Drug Information.

    If not listed in the compendia, the drug must be recommended for that specific type of Sickness in formal clinical studies. The results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

- Inpatient, partial hospitalization and outpatient treatment of Mental or Emotional Illness, chemical abuse or dependency, subject to the Insured Percent and Separate Benefit Maximum for partial hospitalization shown on the Schedule.

- Reconstructive surgery:

    1. Related to or following surgery for Injury, trauma, infection or other disease; or
    2. For the correction of birth abnormalities or congenital defects of a newborn child.

- Reconstructive breast surgery, including all stages of reconstructive breast surgery, performed as a result of a mastectomy, on a diseased or non-diseased breast to reestablish symmetry between the two breasts. “Mastectomy” means the surgical removal of all or part of a breast as a result of breast cancer. “Reconstructive breast surgery” means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts. “Reconstructive breast surgery” includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

- Home Health Care for which benefits are payable. The attending Physician must certify prior to the first visit, that confinement would otherwise be required if Home Health Care were not provided.

- Home Health Care benefits are subject to the Separate Benefit Maximum shown on the Schedule, and are limited to:

    1. Physician home visits.
    2. Nursing care by or under the supervision of a registered nurse (RN).
    3. Home health aide services of a medical or therapeutic nature.
    4. Physical or speech therapy.
    5. Nutrition counseling by a registered dietitian.
    6. Medical services, prescription drugs and supplies which would be covered if Confined.

    Up to 4 hours of treatment or services in any 24-hour period will be considered as one Home Health Care visit. This includes time spent evaluating the need for or developing the home care plan.

    No Home Health Care benefits are payable for: medical care not included in the written home care plan; services provided by a Family Member; homemaker services; services to aid in the normal activities of daily living; or services not listed above as a benefit.

- Skilled Nursing Home charges for room, board and skilled nursing care, subject to the Separate Benefit Maximum shown on the Schedule, when such confinement:

    1. Begins within 14 days following a Hospital confinement; and
    2. Continues treatment of the Sickness or Injury which caused the Hospital confinement.

- Inpatient and outpatient Hospice Care prescribed by a Physician. Hospice Care charges will not be considered under any other Covered Charge benefit. Hospice Care is subject to the Separate Benefit Maximum shown on the Schedule and is limited to the following:

    1. Inpatient care;
    2. Part-time nursing care by or supervised by a registered graduate nurse;
    3. Counseling for the Covered Person, including dietary counseling;
    4. Family counseling for the immediate family of the Covered Person before the death of the terminally ill Covered Person. Immediate family means the spouse, parents, siblings, grandparents, and children of the terminally ill insured;
    5. Bereavement counseling for the immediate family of the terminally ill Covered Person within the six month period following a Covered Person's death. Immediate family means the spouse, parents, siblings, grandparents, and children of the terminally ill insured;
    6. Respite care, which is the temporary care provided to the terminally ill Covered Person to relieve the family caregiver from the daily care of the insured. A family caregiver is a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the terminally ill Covered Person; and
    7. Medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the terminally ill Covered Person.

- Charges for non-dental diagnostic, surgical and nonsurgical procedures, excluding intraoral prosthetic devices, involving any bone or joint disorder of the face, neck or head.

- Charges for medical food intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and are formulated to be consumed or administered enterally under the direction of a Physician.

- Charges for low protein modified food which is specifically formulated to have less than 1 gram of protein per serving and is intended to be used under the direction of a Physician.

The medical food or low protein modified food will not include a natural food that is naturally low in protein or a food which is not prescribed as Medically Necessary for the dietary treatment of inherited metabolic diseases and is not administered under the direction of a Physician.

- Coverage for medically necessary diabetes equipment, diabetes supplies and diabetes outpatient self-management training and educational services, including medical nutritional therapy, that the health care provider certifies is necessary for the treatment of:

  1. Insulin-using diabetes;
  2. Non-insulin using diabetes;
  3. Elevated blood glucose levels induced by pregnancy.

- If a Maryland hospital utilization review board requires a second opinion, We will pay 100% of the Usual and Customary charge for a second opinion.

- Patient costs for clinical trials according to the terms and conditions of Section 15-826 of the Maryland Code.

TRANSPLANT BENEFITS

Benefits are payable only for Approved Transplant Services.

Transplant Benefits are subject to Pre-Treatment Certification.
No Transplant Benefits will be paid without prior authorization. You should contact Us when a transplant has been decided, but before the donor selection process begins, to establish available benefits.

Prior authorization means You must:

1. **Notify Us of the procedure to be performed;**
2. **Have the Physician submit a complete medical history, including current diagnosis, transplant protocol and informed consent; and**
3. **Have the Physician certify that the procedure is Medically Necessary and that alternative procedures, services or courses of treatment would not be effective.**

Expenses must be incurred during the transplant benefit period. The transplant benefit period begins 5 days before the date the transplant is performed and ends 12 months thereafter. During the transplant benefit period, if a second admission is required, and a retransplant occurs, a new transplant benefit period starts 5 days before the date the retransplant is performed and ends 12 months thereafter. Once the transplant benefit period has expired, any expenses incurred will be reviewed and paid according to the Covered Charges section, including any coverage for immunosuppressive drugs under the prescription drug benefit.

TRANSPLANTS

Transplants are limited to the following, subject to all Benefit Maximums shown on the Schedule:

A) Organ transplants

Benefits are payable only for human to human organ Transplants.

1. Cornea;
2. Heart;
3. Liver;
4. Kidney; and
5. Lung;

B) High Dose Chemotherapy (HDC);

C) Stem Cell Infusion (SCI);

D) Stem Cell Infusion (SCI);

E) Autologous Bone Marrow Transplant (ABMT(1)); and

F) Allogenic Bone Marrow Transplant (ABMT(2)).

Donor Expenses:

Unless covered by Other Medical Expense Coverage, Approved Transplant Services are payable for an organ donor. Benefits payable for the donor will be charged to the recipient's claim and subject to the Lifetime Maximum shown on the Schedule.

Designated Facilities for Approved Transplant Services

A person who is authorized for a transplant procedure will be referred to a Designated Transplant Facility. If the person is denied the procedure by the Designated Transplant Facility, he will be referred to a second such facility for evaluation. If the person is denied the procedure at the second Designated Transplant Facility, no benefits will be paid for any services or supplies related to that transplant procedure. This applies regardless of whether the procedure is performed at a third Designated Transplant Facility or at a Non-Designated Transplant Facility.

In addition to Approved Transplant Services, benefits will be paid, up to $10,000 per procedure, subject to the Lifetime Maximum shown on the Schedule, for:

1. Reasonable and necessary travel, by the covered person and family member(s) accompanying him, to a Designated Transplant Facility over 50 miles away from the Covered Person's residence;
2. Reasonable and necessary lodging and meal expenses for family member(s) accompanying the Covered Person to the Designated Transplant Facility; and
3. Air ambulance or other emergency transportation to, but not from, a Designated Transplant Facility, when necessary and approved.

PREVENTIVE BENEFITS

1. For female Covered Persons, screening by low dose mammography for the presence of occult breast cancer at the following intervals:
   - One baseline mammogram between ages 35 and 39;
   - One mammogram every 2 years between ages 40 and 49, or more frequently if recommended by a Physician; and
   - An annual mammogram at age 50 and older.

   Not subject to the Deductible.

2. One Papanicolaou (PAP) smear test per Year and associated office visit.
3. Well child care, including:
   - All visits for and costs of childhood and adolescent immunization;
   - All visits for the collection of adequate samples for hereditary and metabolic newborn screening between birth and 4 weeks of age;
   - All visits for and costs of age-appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing, and vision as determined by the American Academy of Pediatrics; and
   - The following services at each of the above visits:
     - a physical examination;
     - a developmental assessment;
     - parental anticipatory guidance; and
     - laboratory tests considered necessary by the Physician as indicated by the services provided.

   Not subject to the Deductible.

4. Coverage for digital rectal exams and PSA tests for the following:
   - Men between age 40 and 75;

- When used to monitor the response to prostate cancer treatment;
- When used for staging to determine the need for a bone scan in patients with prostate cancer; and
- When used for male patients at a high risk for prostate cancer.

5. Charges for bone mass measurements for prevention, diagnosis and treatment of osteoporosis when the measurements are requested by a health care provider for the following:

    - An estrogen deficient Covered Person at risk for osteoporosis;
    - A Covered Person with specific signs of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention of for an extensive diagnostic evaluation for metabolic bone disease;
    - A Covered Person receiving long-term glucocorticoid therapy;
    - A Covered Person with primary hyperparathyroidism; or
    - A Covered Person being monitored to assess the response or efficacy of an approved osteoporosis drug therapy.

ROUTINE PHYSICAL EXAMINATION

- For each Covered Person, one annual routine physical examination subject to the Separate Benefit Maximum shown on the Schedule.

COST CONTAINMENT PROCEDURES

REQUIRED OUTPATIENT SURGERY

Certain surgical procedures must be performed on an outpatient basis. If such surgery is performed on an inpatient basis, benefits will be reduced. This reduction is shown on the Schedule.

Benefit reduction will be waived if:

- Your Physician provides evidence, satisfactory to Us, that confinement is Medically Necessary; or
- Appropriate outpatient facilities, as determined by Us, are not available within 50 miles of the Covered Person's residence.

Surgical procedures which must be performed on an outpatient basis are:

- Adenoidectomy
- Arthroscopy and cartilage removal
- Breast biopsy
- Carpal tunnel
- Cataract removal
- Cystometrogram
- Dilatation and Curettage (D&C)
- Endoscopic procedures, including but not limited to:
    - Colonoscopy
    - Cystoscopy
    - E.R.C.P.
    - Esophagoscopy
    - Gastroscopy
    - Laparoscopy
- Examination under anesthesia
- Excisions:
    - Exostosis excision
    - Ganglion excision
    - Hammertoe excision

    - Neuroma or Morton's neuroma excision
- Eye muscle surgery
- Hemorrhoidectomy
- Hernia:
    - Inguinal hernia
    - Umbilical hernia repair
- Hydrocelectomy
- Palmer fasciectomy
- Pilonidal sinus
- Simple fistulectomy
- Tonsillectomy
- Tympanostomy with insertion of ventilatory tube

Other surgical procedures may be required to be performed on an outpatient basis. You will be notified of such additional requirement as part of the Pre-Treatment Certification process.

PRE-TREATMENT CERTIFICATION

Pre-treatment Certification (Certification) requires You, Your representative or Your Physician to notify Our review agency of all Hospital admissions, including inpatient surgery.

Certification is a review process to determine the Medical Necessity of a Hospital admission or proposed surgery. A determination as to the necessary length of a Hospital stay is also made. You or Your Physician may, at any time prior to discharge, request a reevaluation or extension of the number of Hospital days certified.

If Certification is not completed, benefits will be reduced. The reduction is shown on the Schedule.

Certification will be valid for 60 days for the requesting Physician and the named Hospital. A change in Physician or Hospital will require a new Certification.

How to Certify: To certify a Hospital admission or surgery, call the telephone number on Your identification card. Be prepared to give the following information:

- Insured's name, social security number and Policy Number.
- Patient's name and date of birth.
- Hospital name and address.
- Physician's name and telephone number.
- The diagnosis (what is wrong).
- The treatment (what will be done and when).

We will acknowledge Your request in writing within five days after notification is given and We have received all pertinent medical information to conduct a review. The Certification decision will be provided to You, the attending Physician, and the Hospital.

It is Your responsibility to ensure that proper Certification is made. We recommend that You follow-up with the attending Physician to ensure that all medical information is provided.

If We do not agree with the Medical Necessity of any treatment, we will pay 100% of the Usual and Customary charge for a second opinion. If the second opinion does not confirm the Medical Necessity of the treatment, no benefits will be payable for any expense related to the Hospital confinement, including surgical expenses.

When to Call: For routine elective admission or surgery, You must call at least 2 business days before You are admitted to the Hospital.

Emergency admission: An Emergency admission must be called in within 48 hours of the admission or the next business day if a weekend or holiday is involved.

Transplants: a transplant procedure must be called in before the transplant benefit period begins.

If it is not reasonably possible to make the Certification call within the times provided, payment will not be reduced if the call is made as soon as is reasonably possible.

Certification does not guarantee that proposed Hospital admissions or surgeries are covered under the Policy. Please read the coverage provisions carefully.

EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for any expenses arising from or in connection with:

- Treatment, services or supplies which are not listed as Covered Charges.
- Treatment, services or supplies which are incurred when coverage is not in effect, except while coverage is extended in accordance with the Extension of Benefits provision.
- The portion of charges in excess of the Usual and Customary Charge.
- Treatment, services or supplies which:
  - Are not Medically Necessary or recognized by Us as effective. This exclusion will not apply to Maryland mandated coverage for preventive care, hospice benefits, and routine physical examinations which are specifically listed as Covered Charges;
  - Are not prescribed by a Physician as necessary to treat a Sickness or Injury;
  - We determine to be Experimental or Investigational in nature;
  - Are received without charge or legal obligation to pay, except Medicaid;
  - Would not routinely be paid in the absence of insurance, but this does not apply to Hospitals or other institutions operated by the State of Maryland or any of its counties or municipalities, even if they are charitable;
  - Are received outside of the 50 United States and the District of Columbia, except as specifically stated; or
  - Are received while incarcerated for conviction of a felony by legal authorities of any state or country.
- Routine physical examinations; x-ray; laboratory tests; and immunizations not related to diagnosis or treatment of a Sickness or Injury, except as specifically stated.
- Dental treatment or surgery, except as specifically stated.
- Temporomandibular Joint Dysfunction Syndrome (TMJ); except for diagnosis of TMJ and surgery to the temporomandibular joint and expenses related to the surgery.
- Cosmetic surgery or procedures and related care or complications arising therefrom; except for specifically stated reconstructive surgery.
- Routine eye or hearing examinations; radial keratotomy or other surgery to correct errors of refraction; eyeglasses or contact lenses, except as specifically stated; any type of external appliances used to improve visual acuity and their fittings; and vision therapy.
- Routine hearing examinations, hearing aids or fitting thereof, except as specifically required for the treatment of cleft lip or cleft palate.
- Treatment, services or supplies for which the Covered Person receives, or is eligible to receive, Workers' Compensation, Occupational Disease Act or similar benefits.
- Normal pregnancy or childbirth, except as specifically stated.
- Nursery care or circumcision for a Dependent child following birth, unless Medically Necessary or specifically covered.

- Artificial insemination; fertility testing or treatment; contraceptives, but excluding in vitro fertilization as specifically covered.
- Sterilization procedures or procedures to reverse sterilization.
- Treatment, services or supplies to change gender and related care or complications arising therefrom.
- Custodial care or rest care.
- Injury sustained while traveling in any type of aircraft, except as a fare-paying passenger in a scheduled or chartered flight operated by a commercial airline.
- Military or naval service of any country.
- War or act of war, declared or undeclared.
- Suicide, attempted suicide, or intentionally self-inflicted Injury, while sane or insane.
- A Covered Person engaging in civil disturbance or an illegal occupation.
- A Covered Person's commission of, or attempt to commit, a felony.
- A Covered Person's being intoxicated or under the influence of intoxicating or hallucinogenic drugs or medicine, unless taken on the advice of, and in accordance with the direction of, a Physician.
- Over-the-counter drugs or medicine, even if prescribed by a Physician.
- Benefits which are provided as a result of a referral prohibited by 1-302 of the Health Occupations Article as determined by the appropriate regulatory licensing board.
- Charges paid by Medicare.

PRE-EXISTING CONDITION LIMITATION

Expenses that result from care or treatment of a Pre-existing Condition will not be considered as Covered Charges for the 24 months following the Covered Person's Effective Date of coverage.

TRAVEL OUTSIDE OF THE UNITED STATES

No benefits are payable for any medical care, treatment, services or supplies received outside of the United States, except for Emergency treatment. Benefits are limited to Injury or Sickness which first occurs during the initial 180 days of travel. No benefits are payable for any Injury or Sickness that occurs during travel for the 180 day period following the Effective Date of coverage for a Covered Person.

Hospital confinement for Emergency treatment is limited to 30 days per trip for each Covered Person. Pre-Treatment Certification of Hospital admission is not required when so confined outside of the United States.

The term "United States" means the 50 states and the District of Columbia. It does not include territories or possessions such as Puerto Rico or Guam.

PREMIUM PROVISIONS

PAYMENT OF PREMIUM

All premium, charges or fees (hereinafter "Premium") must be paid to Us at Our home office. All Premium is payable in advance.

We reserve the right to change the method of Premium payment selected with proper notice to You.

DUE DATE

The first Premium is due on the Effective Date of coverage. Subsequent Premium is due on the premium payment date shown on the Schedule. Failure to pay Premium when due shall result in termination of coverage on such due date subject to the Grace Period.

RETURNED OR DISHONORED PAYMENT

If a payment for any Premium is dishonored for insufficient funds, a reasonable service charge may be debited to You. A dishonored payment shall be considered a failure to pay Premium. A rejected debit to Your bank account or credit card shall be considered a failure to pay Premium.

If Your selected method of payment is dishonored as described, You will need to submit Premium in a method acceptable to Us prior to the end of the Grace Period. You will be notified by written letter that the Premium payment has not been made. If Premium is not received by Us within the later of the end of the Grace Period or 14 days from the date of the letter, coverage shall terminate.

GRACE PERIOD

Unless not less than thirty days prior to the premium due date We have delivered to You or mailed to Your last address as shown by Our records, a written notice of Our intention not to renew this Policy beyond the period for which the premium has been accepted or if written notice of termination has not been received from You, a Grace Period of 31 days will be allowed for each Premium payment after the first Premium, during which Grace Period the Policy shall continue in force. If any Premium is unpaid at the end of the Grace Period, coverage shall automatically terminate. We will deduct any unpaid premium from any claim paid during the Grace Period.

REINSTATEMENT

If coverage ends for failure to pay Premium, You may request a reinstatement. Such request must be in writing and is subject to Our approval. If approved by Us, reinstated coverage will become effective on the date We assign or 45 days from the date a written request for reinstatement is received, unless the request has been declined in writing. The reinstatement will occur promptly upon Our approval of the reinstatement request. Benefits are limited to Covered Charges incurred after the date of reinstatement. Credit will be given for waiting periods satisfied prior to the date coverage ended.

If premium is accepted by Us or Our duly authorized agent without requiring an application, We shall reinstate the Policy immediately and apply Premium to the 60 day period prior to reinstatement, if Premium has not been paid. Credit will be given for waiting periods satisfied prior to the date coverage ended. Benefits are limited to Covered Charges incurred after the date of reinstatement.

PREMIUM ADJUSTMENT

Premium rates may be adjusted from time to time as determined necessary by Us. No rate adjustment will take effect until:

- The end of any rate guarantee period; and
- At least 31 days prior written notice is given to You.

The rate guarantee and notice period shall not apply to any rate adjustment due to:

- Your request for a change in benefits or coverage;
- A change in any Premium tax law;
- A change in Federal or State law or regulation which affects the benefits or provisions of the Policy;
- A misstatement of age, sex, or residence of any Covered Person; or
- A change in the residence of any Covered Person.

When coverage ends for a Covered Person, any resulting change in Premium will be made on the next premium Due Date.

CLAIMS PAYMENT PROVISIONS

NOTICE OF CLAIM

We must receive written notice of claim within 30 days after a covered loss starts or as soon thereafter as reasonably possible. Notice should include Your name and Policy Number.

CLAIM FORMS

When We receive the notice of claim, We will send You or a Dependent's custodian forms for filing a Proof of Loss. If these forms are not sent to You or a Dependent's custodian within 15 days of notice of claim, You or a Dependent's custodian will meet the Proof of Loss requirement by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

PROOF OF LOSS

Written Proof of Loss must be completed and returned to Us within 90 days of the loss or as soon thereafter as reasonably possible. Except for absence of legal capacity, no claim for benefits will be accepted after one year from the end of the 90 days.

FORGIVENESS OF OUT-OF-POCKET MAXIMUMS AND/OR DEDUCTIBLE

If any provider intentionally does not attempt to collect any Covered Charge amount, benefits payable will be recalculated as follows:

- The amount accepted by the provider as payment in full will be considered the actual fee (i.e. the reported charge less any forgiven amount).
- The adjusted charge will be reduced by the applicable Deductible.
- The corresponding Insured Percent will be applied to the result.

Any resulting overpayment will be billed to Your provider without prejudicing any other right or remedy available to Us at law or in equity.

PAYMENT OF CLAIMS

Benefits will be paid to You immediately upon receipt of written Proof of Loss, unless assigned to the provider. In the case of a Dependent child in the legal custody of a person other than You, payment may be made directly to the custodian or the Department of Health and Mental Hygiene when the custodian has incurred expenses. Any unpaid Premium that is due may be deducted from a claim. Payment of benefits will discharge Us from all liability to You and Your beneficiary, to the extent of such payment.

PAYMENT ERROR

Any benefit paid in error may be recovered from the person receiving the incorrect payment or from You. At Our option, We may offset the overpayment against future benefit payments. The acceptance of Premium or paying other benefits shall not constitute a waiver of Our rights under this section. Recovery or offset shall be in addition to any other remedies available to Us at law or in equity.

FRAUDULENT CLAIM SUBMISSION

If any Covered Person knowingly submits or participates in the submission of a claim for benefits which contains false or misleading information that would have the effect of increasing the benefit payable, We shall have the right to rescind that Covered Person's coverage to the date the fraud was perpetrated. Such rescission is without prejudice to any other right or remedy available to Us at law or in equity.

APPEAL OF DENIED CLAIMS

If a claim for benefits is wholly or partially denied, You will be sent a written notice of the decision. This notice will:

- Give the specific reason(s) for the denial;
- Make specific reference to the provisions on which the denial is based; and
- Provide an explanation of the review procedure.

On any denied claim, You or Your representative may appeal to Us for a full and fair review. You may:

- Request a review in writing within 60 days of receipt of a claim denial; and
- Submit issues and comments in writing.

We will make a decision no more than 60 days after receipt of the request, except in special circumstances, but in no case more than 120 days after the request for review is received. The written decision will include specific references to the provision(s) on which the decision is based.

PHYSICAL EXAMINATIONS

We have the right, at Our expense, to have a Covered Person examined as often as reasonably necessary while a claim on that Covered Person is pending.

GENERAL PROVISIONS

POLICY AMENDMENT AND ALTERATION

Company may amend or change the Policy with Your written agreement. Benefit changes made to the Policy will take effect on the date of the change or other date assigned by Company.

Company may amend or change the Policy at any time, without Your consent, and without the consent of any Insured, Covered Person or beneficiary, if required by law. Any amendment shall be without prejudice to any claim starting prior to the effective date of the amendment.

No person other than Company's President or Secretary has authority to waive, alter or amend any provision of the Policy. Any such waiver, alteration or amendment shall be in writing and signed by the President or Secretary. Any such waiver, alteration or amendment shall not be valid unless endorsed or attached to the Policy.

No agent has authority, implied or express, to determine insurability, make any contract in the name of Company or waive, alter or amend any provision of the Policy.

ENTIRE CONTRACT; WAIVER; DISCRETION

The Policy, including any endorsements, riders and amendments, the Policy application and the Insured's application represent the entire contract. All provisions of the Policy shall apply separately to each Insured.

Failure by Company to enforce any Policy provision shall not waive, modify or render such provision unenforceable; at any other time; at any given time; or under any given set of circumstances, whether the circumstances are or are not the same.

Company has full, exclusive and discretionary authority to determine all questions arising in connection with the Policy, including its interpretation, but this does not mean the courts of the state of Maryland do not have jurisdiction over this Policy or the ability to review the Policy and make judicial decisions accordingly.

STATEMENTS IN THE APPLICATION

No statement made by You shall be used to contest coverage or reduce benefits unless: (a) the statement is contained in an application; and (b) a copy of the statement is furnished to You.

TIME LIMIT ON CERTAIN DEFENSES

After a Covered Person's coverage has been in effect for 2 years, during the lifetime of that person, only fraudulent misstatements in the application may be used to void coverage or deny any claim.

Expenses that result from care or treatment of a Pre-existing Condition which is not excluded from coverage by specific name or description, will be considered as a Covered Charge after the 24 months following the Covered Person's Effective Date of coverage.

MISSTATEMENT OF AGE

If the age of a Covered Person is misstated such that coverage is provided for which the person is not otherwise eligible at the correct age, the misapplied coverage shall be rescinded and any applicable Premium refunded.

If the age of a Covered Person is misstated such that the person is eligible for coverage at the correct age, Premium will be adjusted. Any additional Premium due must be paid within 31 days of receiving a notice of the amount due.

LEGAL ACTIONS

No legal action may be brought against Us within 60 days after written Proof of Loss has been sent to Us. No such action may be brought more than 3 years from the time written Proof of Loss is required to be given.

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.

NOTICE OF ANNUAL MEETINGS

Our annual meetings are held at Our home office at 2:30 p.m. on the first Thursday of March.

NON-PARTICIPATION

The Policy is non-participating. It does not share in the Company's profits or surplus earnings.

COORDINATION OF BENEFITS

DEFINITIONS

Allowable Expense: An expense that is considered a usual charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.

Coordination of Benefits: Taking other Plans into account when We pay benefits.

Plan: Any plan, including this one, that provides benefits or services for medical expenses incurred or the portion of hospital indemnity benefits exceeding $100.00 per day on a group or individual basis. "Plan" includes group, individual and blanket insurance and self-insured and prepaid plans. It includes government plans, and plans required or provided by statute (except Medicaid). "Plan" shall be treated separately for that part of a plan which reserves the right to coordinate with benefits or services of other plans and that part which does not.

Primary Plan: The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.

Year: The Calendar Year, or any part of it, during which a person claiming benefits is covered under this Plan.

BENEFIT COORDINATION

Benefits will be adjusted so that the total payment under all Plans is no more than 100 percent of the Covered Person's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of coordination.

Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

THE ORDER OF BENEFIT DETERMINATION

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.

2. When a person is covered by a Plan without a coordination provision, the Plan without the provision will be the Primary Plan.

3. When a person is covered by more than one Plan with a coordination provision, the order of benefit payment is as follows:

    - **Non-Dependent/Dependent.** A Plan which covers a person other than as a Dependent will pay before a Plan which covers that person as a Dependent.

    - **Dependent Child/Parents Not Separated or Divorced.** For a Dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan which has covered the Dependent child for the longer period will pay first.

    - If the other Plan uses gender to determine which Plan pays first, We will also use that basis.

    - **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:

        A. The Plan of the parent who has responsibility for providing insurance as determined by a court order;

        B. The Plan of the parent with custody of the child;

        C. The Plan of the spouse of the parent with custody; and

        D. The Plan of the parent without custody of the child.

    - **Dependent Child/Joint Custody.** If the joint custody court decree does not specifically state which parent is responsible for the child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.

4. When an order of payment is not established by the above, the Plan which has covered the person for the longer period of time will pay first.

RIGHT TO EXCHANGE INFORMATION

We may release to, or obtain from, any other insurance company, organization or person information necessary for coordination. This will not require the consent of, or notice to You or any claimant. You are required to give Us information necessary for coordination.

RIGHT TO MAKE PAYMENTS TO ANOTHER PLAN

Coordination may result in payment made by another Plan which should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amount so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

RIGHT TO RECEIVE PAYMENTS

Coordination may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

LIMITED RIGHT OF REIMBURSEMENT

If a Covered Person incurs medical expenses for Covered Charges that occurred due to the negligence of a third party, We will not provide any benefits unless and until the Covered Person, or his legal representative, agrees in writing:

1. To reimburse Us from any and all damages collected whether by action at law, settlement or otherwise, all benefits paid for the same medical expenses; and

2. To assign to Us, the right to recover from that third party, or its insurer, to the extent of the benefits paid under this Plan.

Legal fees will be paid on a pro-rata share of the amount to which We are reimbursed. In no case may the legal fees exceed one-half of the amount We are reimbursed.