STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

485 Madison Avenue, New York, NY 10022

CERTIFICATE OF INSURANCE

GROUP SHORT TERM MEDICAL EXPENSE INSURANCE

Covered Person:

Covered Dependents:

Group Policyholder:

Effective Date of Coverage:

Term of Coverage

Coverage is provided in consideration of payment of the initial premium and continued payment of premiums when due and that the answers in Your application are correct and complete.

SCOPE OF CERTIFICATE

This Certificate is a part of, and is governed by, Group Policy No. SSL GP-001 that has been issued in the District of Columbia.

This Certificate summarizes the Group Policy provisions affecting Covered Persons. References to Covered Dependents' insurance apply only if You have elected such coverage. The Group Policy is the contract between the Group Policyholder and the Company. The Group Policy is held by the Group Policyholder and may be inspected at any reasonable time on request. This Certificate is evidence that you, as the Certificateholder, have coverage under the Group Policy. The names of the Certificateholder and Group Policyholder are shown above on this face page of the certificate of insurance.

10-DAY RIGHT TO RETURN THE CERTIFICATE

If for any reason you are not satisfied with this Certificate, you may return it to us within 10-days after you receive it. We will refund any premium paid and your coverage issued under the Group Policy will be deemed void, just as though coverage had not been issued.

THE COVERAGE IS NON-RENEWABLE SHORT TERM INSURANCE.

IT WILL NOT BE RENEWED AT THE END OF THE COVERAGE PERIOD.

READ THIS CERTIFICATE CAREFULLY.

Rachel Lipari
President

David Kettig
Secretary

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The following provisions appear within this Certificate in the following order:

SCHEDULE

HOSPITAL PRECERTIFICATION NOTICE

This plan requires a Precertification by a Professional Review Organization prior to in-patient Hospitalization or surgery. A Covered Person must call the Professional Review Organization:

1. For elective or non-emergency Hospitalization or surgery, at least 10-days prior to the date of proposed Hospitalization;
2. Within 48-hours of an emergency admission; or
3. Within 48-hours of delivery for complicated childbirth.

Non-compliance with the Pre-Admission Certification procedure will result in a **reduction in benefits of 50%,** unless the Covered Person is incapacitated and unable to contact us. In such cases, the Covered Person must contact us as soon as possible. You have been provided with information and procedures necessary for Pre-Admission Certification. You may obtain more information regarding Pre-Certification and its procedures from the Company.

SECTION I

The Deductible, Coinsurance Percentage, Coinsurance Limit and Coverage Period Maximum Benefit Amount for Covered Expenses apply to each Covered Person, unless otherwise stated for a specific benefit, including any maximum benefits for each Covered Person, in SECTION II.

THE FOLLOWING SHALL APPLY TO COVERED EXPENSES FOR EACH COVERED PERSON

DEDUCTIBLE:

Deductible Family Maximum: When 3 Covered Persons each satisfy their individual Deductible, the Deductibles for any remaining Covered Persons are deemed satisfied for the remainder of the Coverage Period.

COINSURANCE:

Coinsurance Percentage:

Coinsurance Limit:	$10,000 of Covered Expenses per Covered Person.
Coinsurance Percentage Thereafter:	100%

COVERAGE PERIOD MAXIMUM BENEFIT AMOUNT: $2,000,000 per Covered Person.

SECTION II

MAXIMUM BENEFITS FOR COVERED EXPENSES FOR EACH COVERED PERSON:

Covered Expenses, not to exceed the Coverage Period Maximum Benefit Amount, are subject to the Usual, Reasonable and Customary charge and the following Maximum Benefit, if applicable.

HOSPITAL COVERED EXPENSES:

Hospital Room, Board and General Nursing Care:	Up to the most common Average Semi-Private Room Rate.
Intensive or Specialized Care Unit:	Up to 3 times the most common Average Semi-Private Room Rate.

SCHEDULE (Continued)

OTHER COVERED EXPENSES:

Doctor Administering Anesthetics:	Up to 20% of the surgeon's benefit.
Assistant Surgeon:	Up to 20% of the surgeon's benefit.
Surgeon's Assistant:	Up to 15% of the surgeon's benefit.
Ambulance, Ground or Air Services:	Up to $500 per occurrence for Ground ambulance; up to $1,000 per occurrence for Air ambulance.
Acquired Immune Deficiency Syndrome (AIDS)	Up to $10,000 per Coverage Period.
Organ, Tissue, Bone Marrow Transplants	Up to $150,000 for all Covered Expenses per Coverage Period.

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DEFINITIONS

This section provides the meaning of special terms used in this Certificate. Whenever the following terms appear capitalized in this Certificate, these definitions apply.

Ambulatory Surgical Center means a licensed health care facility whose main purpose is the diagnosis or treatment of patients by surgery. It must (1) admit and discharge the patient within the same working day; (2) be supervised by a Doctor; (3) require a licensed anesthesiologist or licensed Certified Registered Nurse Anesthetist to administer anesthesia and remain during the surgery; (4) provide a post-anesthesia recovery room; and (5) have a written agreement with at least one Hospital for immediate acceptance of patients who develop complications.

"Ambulatory surgical center" does not include: (1) a facility whose main purpose is performing terminations of pregnancy; (2) an office maintained by a Doctor for the practice of medicine; or (3) an office maintained for the practice of dentistry.

Coinsurance Percentage is the applicable percentage specified in the Schedule that We will use in computing the amount payable for a benefit.

Complications of Pregnancy means: 1) Conditions (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion hyperemesis gravidarum, preeclampsia, and similar medical and surgical conditions of comparable severity; and (2) non-elective Cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

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

Confined/Confinement means the time in which a Covered Person is a Registered Bed Patient in a Hospital, on the order of a Doctor, for Medically Necessary medical treatment.

Covered Dependent means Eligible Dependents who have become Covered Person(s) under this Certificate.

Covered Expenses means Expenses for treatments, services and supplies which a Doctor recommends (1) as Medically Necessary to treat a Sickness or Injury; (2) which are Usual, Reasonable and Customary; and (3) which do not exceed any amount payable under the terms of the Policy.

Coverage Period means the maximum length of time coverage is in force under this Certificate. The Coverage Period is shown on the first page of the Certificate.

Covered Person(s) means You and Your Covered Dependents.

Deductible means the amount of Covered Expenses that each Covered Person must pay before benefits will be payable. The Deductible is shown in the Schedule.

Doctor means a licensed practitioner of the healing arts who is practicing and treating within the scope and limitations of that license. "Doctor" does not include You, a Covered Dependent, Immediate Family, or a Covered Person's employer.

Effective Date means the date coverage under the Group Policy begins for a Covered Person. The Effective Date is shown on the face page of the Certificate.

Expenses means the amounts billed for treatments, services and supplies rendered to a Covered Person. An expense shall be considered to have been incurred on the date the treatment, service or supply was provided.

Experimental or Investigational: means a treatment, drug, device, procedure, supply or service and related services (or any portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any one of the following exists: (1) It cannot be legally marketed without the approval of the

United States Food and Drug Administration (FDA) and such approval has not been granted at the time of its proposed use. (2) It is not yet recognized as acceptable medical practice throughout the United States to treat that Illness or Injury. (3) It is the subject of either: (a) a written investigational or research protocol; or (b) a written informed consent or protocol used by the treating facility in which reference is made to it being experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or (c) an ongoing phase I, or phase II clinical trial or as the experimental or research arm of a phase III clinical trial, as the phases are defined in regulations and other official actions and publications issued by the FDA and the Department of Health and Human Services (HHS) ; or (d) an ongoing review by an Institutional Review Board (IRB); or (4) It does not have either: (a) the positive endorsement of national medical bodies or panels, such as the American Cancer Society; or (b) multiple published peer review medical literature articles, such as the Journal of the American Medical Association (J.A.M.A.), concerning Health Care Service and reflecting its recognition and reproducibility by non-affiliated sources the Claims Administrator determines to be authoritative. (5) It is regarded within a Doctor's profession as appropriate only when provided in a clinical research setting.

We may also determine whether a treatment, drug, device, procedure, supply or service is experimental or investigational by using the following evaluations: (1) Reports in peer review medical literature. (2) Scientific evaluations published by organizations that conduct health care research such as the Agency for Health Care Policy and Research, the National Institutes of Health, the American Medical Association, and the American College of Physicians. (3) Opinions of independent medical consultants. (4) Listings in drug correspondence, including the American Medical Association's Drug Evaluations, the American Hospital Formulary Service Drug Information, and the United States Pharmacopoeia Drug Information. (5) Use of a written informed consent addressing the experimental or investigational nature of the service or supply. This applies whether consent is used by the Covered Person's Doctor or by any other Doctor studying the same or similar service or supply. (6) Any requirement that the use of the service or supply be subject to Institutional Review Board ("IRB") approval. (7) Written protocols used by the health care provider.

Group Policy means the contract issued to the Group Policyholder providing the benefits described herein.

Hospital means an institution which is legally constituted and operated in accordance with the laws pertaining to Hospitals in the jurisdiction where it is located, which meets all of the following requirements:

1. It is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patient's expense;
2. It provides 24-hour-a-day nursing service by a Nurse;
3. It is under the supervision of a staff of duly-licensed Doctors;
4. It provides organized facilities for diagnosis and for major operative surgery either on its premises or in facilities available on a prearranged basis; and

“Hospital” does not mean primarily a clinic, nursing home, rest or convalescent home, extended care facility, Hospice or similar establishment nor, other than incidentally, a place providing care for persons with mental illness or nervous disorders; the aged; or those suffering from alcoholism or drug addiction.

Confinement in a special unit of a Hospital used primarily as a nursing, rest, or convalescent home shall be deemed to be Confinement in an institution other than a Hospital.

Immediate Family means: (1) the parent, spouse, brother, sister or children of a Covered Person; (2) a resident in a Covered Person’s household; or (3) any person related to a Covered Person by blood, marriage or legal adoption.

Injury means bodily harm caused by an accident, directly and independently of Sickness or bodily infirmity, resulting in unforeseen trauma requiring immediate medical attention. The Injury must occur after the Covered Person’s Effective Date of coverage and while such person’s coverage is in force. All injuries to the same Covered Person sustained in one accident, including all related conditions and recurring symptoms of the Injuries, will be considered one injury. Bodily damage caused by chewing is not considered an Injury.

Intensive Care Unit means a section, ward or wing within a Hospital which is separated from other Hospital facilities and: (1) is operated exclusively for the purpose of providing professional care and treatment for critically ill patients; (2) has special supplies and equipment necessary for such care and treatment which are available on a standby basis for immediate use; (3) provides room and board, and constant observation by a Nurse or other specially-trained Hospital personnel; and (4) is not maintained for the purpose of providing normal postoperative recovery treatment or service.

Lifetime Maximum Amount is the total aggregate amount of benefits payable under the Group Policy for all Covered Expenses which are incurred for Sickness or Injury by each Covered Person during such person's lifetime.

Medically Necessary means a Confinement, service, supply, or treatment that meets each of these requirements:

1. It is ordered by a Doctor for the diagnosis or the treatment of a Sickness or Injury;
2. For services, supplies, or treatment, the prevailing opinion within the appropriate specialty of the United States medical profession is that such service, supply, or treatment is safe and effective for its intended use, and that omission would adversely affect the Covered Person's medical condition. For Confinement in a Hospital, the prevailing opinion within the appropriate specialty of the United States medical profession is that inpatient acute care Confinement is necessary and any lesser level of care would adversely affect the Covered Person's medical condition; and
3. It is furnished by a provider with appropriate licensing, training, experience, staff and facilities to offer that particular service or supply.

The fact that a Doctor may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy.

Nurse means a licensed registered graduate professional Nurse (R.N.) or a licensed practical Nurse (L.P.N.) who is under the direction of a Doctor. Nurse does not include the Immediate Family of a Covered Person.

Participating Organization means the entity that has elected to offer you coverage under the Group Policy and who has completed a Participation Agreement that has been accepted by us.

Prescription Or Legend Drugs means (1) a Legend Drug; (2) injectable insulin prescribed by a Doctor; (3) a compounded drug of which at least one part is a Legend Drug; or (4) any other drug that, under state law, may only be dispensed upon the written prescription of a Doctor. "Prescription or Legend Drugs" does not include oral contraceptives for prevention of pregnancy.

Registered Bed-Patient means an individual who, while Confined to a Hospital, is assigned to a bed in any department of the Hospital, and for whom a charge for room and board is made by the Hospital.

Rehabilitative means treatment for purposes of restring bodily function which has been lost due to a Covered Sickness/Injury. Care ceases to be rehabilitative when the patient can perform the activities which are normal for someone of the same age and gender or the patient has reached maximum therapeutic benefit and further treatment cannot restore bodily function beyond the level the patient currently possess.

Sickness means an illness, disease, or infection which begins while coverage is in force under this Certificate for the Covered Person. All related conditions and recurring symptoms of sickness to the same person will be considered one sickness. Sickness includes Complications of Pregnancy, provided conception occurred after the Covered Person's Effective Date of coverage.

Usual, Reasonable and Customary means:

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

In reaching a determination as to what amount should be considered as Usual, Reasonable and Customary for services and supplies, We may use and subscribe to a standard industry reference source that collects data and makes it available to its member companies. The data base used reflects the amounts charged by providers for health care services based on geographic zip code areas generating a statistically credible charge distribution. The data is reflective of reported provider charges from the lowest to the highest for each service or supply. The data is also adjusted periodically to reflect negotiated fee schedules with providers not included in the data base.

We, Us, Our or Company means Standard Security Life Insurance Company of New York.

You or Your (also, Certificateholder) means the primary insured person who is named in the Schedule as the Certificateholder.

ELIGIBILITY

I. YOU

You will be eligible for insurance provided:
1. You continue to be and qualify as a member of the Participating Organization;
2. You are at least 1 but under 65 years of age;
3. You are not covered as a dependent under the Group Policy;
4. You are not pregnant at the time of application;
5. You have lived in the U.S. for 12 consecutive months;
6. You are not an active member of the armed forces;
7. You submit a written application for insurance, provide evidence of insurability, if evidence is required, and meet our enrollment and underwriting requirements; and
8. You pay all required premiums when due.

II. ELIGIBLE DEPENDENTS

Spouse - You will be eligible to apply for insurance for Your lawful spouse who:
1. Is under age 65 at the time of application;
2. Is not pregnant at the time of application;
3. Is not an active member of the armed forces;
4. Has lived in the U.S. for 12 consecutive months; and
5. Has provided a written application for insurance and evidence of insurability, if evidence is required, have been approved, and meets our enrollment and underwriting requirements.

Dependent Children - You will be eligible to apply for insurance for your dependent children who:
1. Are unmarried children primarily dependent upon You for support and maintenance; and
2. (a) Are less than 19 years or age; or
   (b) Are at least 19 years of age but less than 25 years and enrolled and attending as a full-time student at an accredited college, university, vocational or technical school.
3. Are not pregnant at the time of application;
4. Are not active members of the armed forces; and
5. Have provided a written application for insurance and evidence of insurability, if evidence is required, have been approved, and meet our enrollment and underwriting requirements.

"Children" means natural children, stepchildren, legally-adopted children, children placed with You for the purpose of adoption, and children subject to Your legal guardianship.

If You and Your spouse are both Covered Persons, only one parent will be eligible for insurance on any Covered Dependent children You may have.

III. ENROLLMENT REQUIREMENTS

You and your Eligible Dependents who desire coverage must complete and submit an application for the plan and complete or provide any other documents (including evidence of insurability) as we deem necessary. You must submit the required premium with Your application form. Any misrepresentation or omission of information in Your application or any documents submitted to Us may result in rescission of all coverage for all Covered Persons.

IV. UNDERWRITING REQUIREMENTS

You and your Eligible Dependents are subject to our underwriting requirements. We reserve the right to decline or rate any person at Our discretion.

V. ADDITIONAL CONDITIONS

Insurance will not be effective unless all eligibility requirements are met and You receive written acceptance from Us. Insurance on a Covered Person will not be effective unless premium is paid and accepted by Us for such insurance. Issuance of a Certificate is not a waiver of any of the above conditions.

EFFECTIVE DATES

I. YOU AND ELIGIBLE DEPENDENTS

Coverage is effective as of the Effective Date for You and any Eligible Dependents who were included in Your initial application, provided that You meet Our eligibility, underwriting and enrollment requirements. Coverage will not become effective for any person whose medical history changes prior to the Effective Date, such that the person's answer would be "Yes" to any of the medical history questions in the Application. If Your medical history changes prior to the Effective Date, coverage is automatically declined for all persons included in Your Application.

II. ADDING PERSONS AFTER THE EFFECTIVE DATE

You may wish to apply for coverage for a previously uncovered spouse or dependent child. To do so, the following requirements must be met:

1. You must complete and submit to Us for approval an application form for such person;
2. Such person must meet Our definition of an Eligible Dependent; and
3. You must pay any additional premium, if approved for coverage.

III. NEWLY-ACQUIRED DEPENDENT CHILDREN

Coverage for Your child or children born after the Effective Date will be effective from the moment of birth and will remain in force for 31-days. A child adopted by You after the Effective Date or a child placed with You for the purpose of adoption after the effective date will be covered for 31-days from the date of adoption or placement. For coverage to continue beyond the 31-day period, You must send Us written notice directing us to add the child or children to Your coverage. We must receive this notice within 31-days after the child's date of birth, adoption or placement. Any required additional premium must accompany Your notice. A claim form or Hospital bill does not constitute written notice. If You do not send us the required notification and any additional premium, the child's coverage will end after the 31-day period. To add the child after the initial 31-days has expired, see the provision titled Adding Persons After The Effective Date.

Coverage for Your child or children will be for Injury or Sickness, including care or treatment of congenital defects, birth abnormalities, and premature birth. Coverage is not provided for normal newborn care.

IV. WHEN CHANGES IN COVERAGE OCCUR

1. Any change in benefits which occurs automatically under the Certificate provisions or Schedule will become effective on the date that the status of the Covered Person changed.

2. If any decrease in benefits or coverage is requested, such decrease shall become effective as of the first premium due date coinciding with or next following the date of the approval of such decrease.

3. If any increase in benefits or coverage is requested, such increase shall become effective as of the first day of the month coinciding with or next following the date of the approval of such increase.

4. If any requested change increases benefits or coverage, the Effective Date of the increase will be delayed for You or a Covered Dependent who is Confined for medical treatment in an institution. The delay will end and the increase shall become effective on the day following final medical discharge from such Confinement.

TERMINATION OF INSURANCE

I. TERMINATION OF YOUR INSURANCE

Your insurance will automatically terminate on the earliest of the following dates:

1. The date that the Group Policy terminates;
2. The due date of a premium payment that is not paid when due, if such payment has not been made within 31-days following such premium due date;
3. The date that we determine fraudulent statements or a material misrepresentation has been made by the You or with Your knowledge in filing a claim for benefits;
4. The date that You enter full-time active duty in the armed forces of any country or international organization;
5. The date You become eligible for Medicare;
6. The earlier of: (1) the Expiration Date of Your coverage; or (2) 12-months from the Effective Date of Your insurance, whichever occurs first; or
7. The date You cease to be a member of the Participating Organization. However, if a premium payment was accepted to continue coverage past that date, such coverage will stay in force until the end of the period the premium payment covers, subject to the other provisions for termination under this section.

II. TERMINATION OF A COVERED DEPENDENT'S INSURANCE

A Covered Dependent's insurance will automatically terminate on the earliest of the following dates:

1. The date that the Group Policy terminates;
2. The due date of a premium payment that is not paid when due, if such premium payment has not been made within 31-days following such premium due date;
3. The date that insurance under the Group Policy is discontinued;
4. The date that we determine fraud or material misrepresentation has been made by You or a Covered Dependent or with Your or a Covered Dependent's knowledge in filing a claim for benefits;
5. The date that Your insurance terminates. However, if termination is due to Your death, a Covered Dependent may elect to continue coverage beyond the original Expiration Date by making written request for such coverage and by continuing payments toward the cost of that insurance. When such an election is made, Your Covered Dependent spouse will be considered the primary insured;
6. The date You or a Covered Dependent becomes eligible for Medicare;
7. The date the Covered Dependent ceases to be eligible. However if, upon attaining any limiting age, a Covered Dependent has a handicapped condition rendering such person incapable of earning his own living and is chiefly dependent upon You or other care providers for lifetime care and supervision because of a handicapped condition that occurred before attainment of the limiting age, benefits with respect to such person may be continued on a premium-paying basis during the continuance of such incapacity up to the end of the Coverage Period, provided that we receive written proof of such incapacity within 31-days after the date on which the Covered Dependent attains the limiting age. During continuance of insurance, We have the right to require due proof of the continuance of the incapacity and to have such dependent examined by Doctors designated by us at any time during the term of coverage. The continuance of insurance as described will cease in the event of:
   a. The termination of the Group Policy;
   b. The termination of Your insurance; or
   c. The discontinuance of insurance under the Group Policy; or
   d. The earlier of: (i) the Expiration Date shown in the Schedule; or
      (ii) 12-months from the Effective Date of Your insurance, whichever occurs first.

HOSPITAL PRECERTIFICATION

Hospital admissions and lengths of stay are subject to certification by the pre-certification service, as stated below:

1. You must notify the pre-certification service on behalf of a Covered Person:
   a. Ten (10) days prior to non-emergency admission of the Covered Person to a Hospital;
   b. Within 48-hours or on the first business day following an emergency admission of the Covered Person to a Hospital, or as soon thereafter as is reasonably possible; or
   c. Within 48-hours of delivery for complicated birth.

2. The pre-certification service, after reviewing the applicable information, will certify:
   a. If the Hospital admission is Medically Necessary;
   b. The appropriate length of stay; and
   c. Appropriate extensions beyond the initially-certified length of stay.

3. REDUCTION OF BENEFITS - If Covered Expenses for the Hospital admission, length of stay, or extensions of stay are not certified by the Professional Review Organization, we will only pay 50% of the benefits which would otherwise have been payable for Covered Expenses, unless the Covered Person is incapacitated and unable to contact us. In such cases, the Covered Person must contact us as soon as possible. No benefits will be payable in the event such Hospital admission, length of stay or extension of stay is not Medically Necessary or Experimental or Investigational.

4. Not a Guarantee of Benefits – Pre-certification does not guarantee that benefits will be paid. Payment of benefits will be determined by Us in accordance with and subject to all terms, conditions, limitations and exclusions of the Policy.

DESCRIPTION OF BENEFITS

I. WHAT IS COVERED

Subject to the Hospital Precertification provision, if You or a Covered Dependent incurs Covered Expenses for medical treatment, supplies or services as a result of a Sickness or Injury which occurs while coverage is in force, and after satisfaction of the Deductible, We will pay the Coinsurance Percentage for Covered Expenses incurred in excess of the Deductible up to the Maximum Benefit amounts as shown in the Schedule. We will pay this amount for all Covered Expenses unless otherwise noted for a specific benefit or specified as limited or excluded in the Limitations and Exclusions provision.

Covered Expenses do not include Expenses which are in excess of the Maximum Amounts shown in the Schedule. Expenses in excess of the Maximum Amounts shown in the Schedule do not apply to the Deductible or the Coinsurance Limit.

After Covered Expenses for which benefits are payable at the Coinsurance Percentage have equaled the Coinsurance Limit for a Covered Person, we will pay Covered Expenses in excess of the Coinsurance Limit at the amount shown in the Schedule for each such person while coverage is in force, but not to exceed the Lifetime Maximum Amount payable for each Covered Person.

The Deductible, Coinsurance Percentage, Coinsurance Limit and Lifetime Maximum Amount are shown in Section I of the Schedule and apply to each Covered Person and for all benefits, unless otherwise stated for a specific benefit in Section II of the Schedule.

II. COVERED EXPENSES

Covered Expenses means the Usual, Reasonable and Customary charges for the following Medically Necessary services, supplies, or treatment prescribed or provided by a Doctor for a covered Injury or Sickness while coverage is in force for a Covered Person. **Covered Expenses do not include Expenses which are in excess of the Maximum Amounts shown in the Schedule. Expenses in excess of the Maximum Amounts shown in the Schedule do not apply to the Deductible or the Coinsurance Limit.**

A. HOSPITAL COVERED EXPENSES

1. **Hospital Room, Board and General Nursing Care** while Confined in a Hospital, not to exceed the Maximum Benefit amount shown in the Schedule. For confinement in a private room, the Covered Expense is limited to the Hospital's average daily charge for a semi-private room not to exceed the Maximum Benefit amount shown in the Schedule.

2. **Intensive or Specialized Care Unit** provided four or more hours of nursing care is being provided each day, not to exceed the Maximum Benefit amount shown in the Schedule.

3. **Emergency Room Treatment** for services, supplies and treatment, not to exceed the Maximum Benefit amount shown in the Schedule.

4. **Inpatient Miscellaneous Medical Expense Services** for services and supplies provided on an inpatient basis in a Hospital, not to exceed the Maximum Benefit amount shown in the Schedule. Miscellaneous charges do not include charges for a telephone, radio, television, extra beds or cots, meals for guests, take home items, or other items of convenience.

5. **Inpatient Doctor Visits** for treatment provided by a Doctor during a Hospital confinement, not to exceed the Maximum Benefit amount shown in the Schedule.

B. COVERED EXPENSES FOR TREATMENT , SERVICES, OR SUPPLIES

1. **Doctor Office Visits** for treatment provided by a Doctor in a Doctor's office, not to exceed the Maximum Benefit amount shown in the Schedule. This benefit is not payable for treatment provided by a member of your Immediate Family.

2. **Ambulatory Surgical Center or Outpatient Hospital Surgery** for treatment or services in a state-approved freestanding Ambulatory Surgical Center that is not part of a Hospital, or a Hospital Outpatient Surgery Facility, not to exceed the Maximum Benefit amount shown in the Schedule.

3. **Surgeon Services** for Covered Expenses incurred from a Doctor performing surgery in either an inpatient or outpatient setting, not to exceed the Maximum Benefit amount shown in the Schedule.

4. **Services** of a Doctor administering anesthetics, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule.

5. **Assistant Surgeon** services for a Doctor assisting in the performance of a surgery, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule.

6. **Surgeon's Assistant** services for an assistant to the Doctor performing the surgery, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule.

7. **Complications of Pregnancy.** Treatment for Complications of Pregnancy on the same basis as any other Sickness.

8. **Cosmetic or Reconstructive Surgery (except Breast Reconstructive Surgery)**, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule, for cosmetic or reconstructive surgery and complications of cosmetic procedures when services and treatment are:
   1. Incidental to or follows a covered Injury or Sickness occurring while this coverage is in force; or
   2. Performed due to a congenital defect or birth anomaly of a Covered Person born while this coverage is in force.

9. **Breast Reconstructive Surgery** for a female Covered Person who undergoes a covered mastectomy surgery while such persons coverage under this Certificate is in force. Benefits payable, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule include:
   1. Reconstructive surgery of the breast on which the mastectomy has been performed;
   2. Surgery and reconstruction of the other breast for the purpose of obtaining a symmetrical appearance; and
   3. Prostheses and for treatment for physical complications related to the mastectomy.

10. **Ambulance Services** for local licensed ground ambulance service, or air ambulance service within the 48 contiguous states, to the nearest Hospital qualified to treat the covered Injury or Sickness, not to exceed the Maximum Benefit amount shown in the Schedule. Such service must be Medically Necessary due to a sudden and unexpected Injury or Sickness that involves a life-threatening element.

11. **Prescription or Legend Drugs** when prescribed on an inpatient basis for a covered Injury or Sickness.

12. **Dental Treatment** for treatment or care required as a result of a covered Injury to a tooth that is natural, free of disease, and vital where the major portion of the tooth is present regardless of fillings or caps.

13. **AIDS** for the treatment of Acquired Immune Deficiency Syndrome (AIDS) or any complication or condition caused by, resulting from or related to AIDS or HIV, not to exceed the Maximum Benefit amount shown in the Schedule.

14. **Knee Injury or Disorder** The knee consists of the bones, muscles, cartilage, ligaments, membranes and menisci of the anterior aspect of the leg at the articulation of the femur and tibia. Coverage does not include charges incurred to diagnose or treat an injury or disorder of the knee including surgery in excess of the maximum benefit amount shown in the Schedule.

15. **Gallbladder Surgery** includes cholecystectomy and any type of surgical procedure to diagnose or treat a disorder of the gallbladder, including any condition related to or caused by a gallstone(s) in the bile duct. Surgery includes the pre-operative and post-operative visits, testing, the services of the surgeon, assistance surgeon, anesthesiologist, radiologist, pathologist, the Hospital or outpatient facility charges, and any other charges related to the surgery or complications there from, not to exceed the maximum benefit shown in the Schedule.

16. **Organ or Tissue Transplants** including bone marrow transplants, not to exceed the Maximum Benefit amount shown in the Schedule. This benefit shall include all expenses related to the transplant before the transplant is performed, for the procurement of the donor organ or tissue, including the Hospital expenses of the donor, and for follow-up care, including any complications while this coverage is in force.

    Covered Expenses do not include organ or tissue transplants which:
    1. Are animal-to-human transplants;
    2. Use artificial or mechanical organs;
    3. Are Experimental or Investigative; or
    4. Are not generally accepted by the medical community as an effective treatment for a covered Injury or Sickness.

    "Bone marrow transplant" means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy with curative intent. Human blood precursor cells may be obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor, and may be derived from bone marrow, circulatory blood, or a combination of bone marrow and circulator blood. If chemotherapy is an integral part of the treatment involving bone marrow implementation, it is included in the definition.

C. OUTPATIENT MISCELLANEOUS MEDICAL EXPENSE SERVICES

Outpatient Miscellaneous Medical Expenses as listed below are payable up to the Maximum Benefit amount shown in the Schedule for all services combined.

1. **Blood or Blood Plasma** and their administration, if not replaced.

2. **Artificial limbs or eyes.**

3. **Casts, non-dental splints, trusses, crutches, or non-orthodontic braces.**

4. **Equipment Rental** for a wheelchair, hospital-type bed or similar durable medical equipment. At our option, benefits may be available for purchase of such equipment, payable in monthly installments, while Your coverage remains in force under the Policy.

5. **Oxygen** for oxygen and rental of equipment for the administration of oxygen, not to exceed the purchase price of such equipment.

6. **Diagnostic Testing Services** for diagnostic tests including related professional fees, incurred on an outpatient basis. Diagnostic tests include x-rays, laboratory tests, electrocardiograms (EKGs),

electroencephalograms (EEGs), nuclear medicine imaging, radioimmune assay, ultrasound/echography, computerized tomography (CT), magnetic resonance imaging (MRI), cholecystography, cytourethroscopy, endoscopy, duodenoscopy, hysterosalpingography, laparoscopy, myelography, pyelography, pancreatogrpahy, vasography, or venography.

7. **Therapy Services** for treatment provided by a physical therapist, inhalation therapist (respiratory), and speech therapist for diagnosis and Rehabilitative treatment. This benefit is not payable for treatment provided by a member of your Immediate Family.

8. **Radiation Therapy and Chemotherapy Services** for therapeutic treatment of covered benign and malignant conditions, including charges for x-rays, radium, radioactive isotopes and chemotherapy drugs and supplies used in treatment.

9. **Mammography, Pap Smear and Prostate Antigen Test** for: 1) one baseline mammogram for a female Covered Person 50 years of age or older; 2) one annual cervical cytological screening for a female Covered Person and 3) one Prostate Antigen Test (PSA) for a male Covered Person 50 years of age or older. This benefit is not subject to satisfaction of the Deductible.

III. ALLOCATION AND APPORTIONMENT OF BENEFITS

We reserve the right to allocate the Deductible to any Covered Expenses and to apportion the payment of benefits between You and any person designated by You. Such allocation and apportionment shall be conclusive and shall be binding upon You and all assignees.

IV. EXTENSION OF BENEFITS

If a Covered Person is Hospital confined on the date insurance ends, other than for failure to pay the required premium, benefits will be continued only for the condition causing the Hospital confinement until the earlier of:

1. the date Hospital confinement ends;
2. the date when treatment for the Hospital confinement is no longer required;
3. the expiration of a 90 day period after the insurance ceases;
4. the date the Covered Person becomes eligible for any other group insurance plan providing coverage for the same conditions causing the Hospital Confinement; or
5. the date the Maximum Lifetime Benefit under the Group Policy has been reached.

Benefits payable due to the Extension of Benefits provision after the Expiration Date or when a Covered Person's coverage ends, are subject to a new Deductible and satisfaction of the Coinsurance Limit.

LIMITATIONS AND EXCLUSIONS

We will not pay for loss or expense caused by or resulting from any of the following:

1. Expenses for the treatment of Preexisting Conditions, as defined in the Preexisting Conditions Limitation provision;
2. Expenses incurred prior to the Effective Date of a Covered Person's coverage or incurred after the Expiration Date, regardless of when the condition originated, except in accordance with the Extension of Benefits provision;
3. Expenses to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the Policy;
4. Expenses incurred for Experimental or Investigational services or treatment or unproven services or treatment;
5. Expenses for purposes determined by Us to be educational;
6. Amounts in excess of the Usual, Reasonable and Customary charges made for covered services or supplies;
7. Expenses You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed;
8. Expenses to the extent that they are paid or payable under another group insurance or medical prepayment plan;
9. Charges that are eligible for payment by Medicare or any other government program except Medicaid;

10. Expenses for care in government institutions unless You or Your Covered Dependent are obligated to pay for such care;
11. Expenses for which benefits are paid or payable under workers' compensation or similar laws;
12. Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited);
13. Expenses incurred by a Covered Person while on active duty in the armed forces. Upon written notice to us of entry into such active duty, the unused premium will be returned to you on a pro-rated basis;
14. Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection;
15. Expenses incurred while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony or assault;
16. Expenses for the treatment of normal pregnancy or childbirth, except for Complications of Pregnancy;
17. Charges for a Covered Dependent who is a newborn child not yet discharged from the Hospital, unless the charges are Medically Necessary to treat premature birth, congenital Injury or Sickness, or Sickness or Injury sustained during or after birth;
18. Expenses for voluntary termination of normal pregnancy, normal childbirth or elective cesarean section;
19. Expenses incurred for any drug, including birth control pills, implants, injections, supply, treatment device or procedure that prevents conception or childbirth;
20. Expenses for the diagnosis and treatment of infertility, including but not limited to any attempt to induce fertilization by any method, invitro fertilization, artificial insemination or similar procedures, whether the Covered Person is a donor, recipient or surrogate;
21. Expenses for sterilization or reversal of sterilization;
22. Expenses related to sex transformation or penile implants or sex dysfunction or inadequacies;
23. Expenses for physical exams or other services not needed for medical treatment, except as specifically covered;
24. Expenses for prophylactic treatment, including surgery or diagnostic testing, except as specifically covered;
25. Expenses for the treatment of mental illness or nervous disorders, including, but not limited to, neurosis, psychoneurosis, psychopathy, psychosis, attention deficit disorder, autism, hyperactivity, or mental or emotional disease or disorder of any kind;
26. Expenses for the treatment of alcoholism or alcohol abuse, chemical dependency, substance abuse or drug addiction;
27. Expenses incurred for loss sustained or contracted in consequence of the Covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of a Doctor. Intoxication shall be established conclusively by a blood alcohol level of .10 or the legal limit in the state where the incident occurred, whichever is less;
28. Expenses incurred in connection with programs, treatment, or procedures for tobacco use cessation;
29. Expenses resulting from suicide or attempted suicide or intentionally self-inflicted Injury, while sane or insane;
30. Expenses for dental treatment or care or orthodontia or other treatment involving the teeth or supporting structures, except as specifically covered;
31. Expenses incurred in the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofacial pain dysfunction or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint;
32. Expenses of radial keratotomy or correction of refractive error, eye refractions, vision therapy, routine vision exams to assess the initial need for, or changes to prescription eyeglasses or contact lenses, the purchase, fitting or adjustment of eyeglasses or contact lenses, or treatment of cataracts;
33. Expenses for routine hearing exams to assess the need for or change to hearing aids, or the purchase, fittings or adjustments of hearing aids;
34. Expenses for cosmetic or reconstructive procedures, services or supplies except as specifically covered;
35. Expenses for breast reduction or augmentation or complications arising from these procedures except as specifically covered in the Benefit section;
36. Outpatient Prescription or Legend Drugs, medications, vitamins, and mineral or food supplements, including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor;
37. Expenses incurred in connection with any drug or other item used to treat hair loss;
38. Expenses incurred in the treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions, spurs, or the removal of corms, calluses or toenails, unless specifically for the treatment of a metabolic or peripheral vascular disease or for the prompt repair of an Injury sustained while coverage is in force for the Covered Person;
39. Expenses incurred in the treatment of acne, or varicose veins;

40. The Expenses of weight loss programs or diets;
41. Transportation Expenses, except as specifically covered;
42. Expenses for rest or recuperation cures or care in an extended care facility, convalescent nursing home, a facility providing rehabilitative treatment, Skilled Nursing Facility**,** or home for the aged, whether or not part of a Hospital;
43. Expenses for services or supplies for personal comfort or convenience, including homemaker services or supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to bathing, dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops;
44. Expenses for services or supplies furnished or provided by a member of your Immediate Family;
45. Expenses for diagnosis or treatment of a sleeping disorder;
46. Expenses incurred in the treatment of Injury or Sickness resulting from participation in skydiving, scuba diving, hang or ultra light gliding, riding an all terrain vehicle such as a dirt bike, snowmobile or go-cart, racing with a motorcycle, boat or any form of aircraft, any participation in sports for pay or profit, or participation in rodeo contests;
47. Expenses for the purchase of a noninvasive osteogenesis stimulator (bone stimulator);
48. Expenses for services or supplies of a common household use, such as exercise cycles, air or water purifiers, air conditioners, allergenic mattresses, and blood pressure kits;
49. Expenses during the first 6-months after the Effective Date of coverage for a Covered Person for a (a.) total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma ; (b.) tonsillectomy; (c.) adenoidectomy; (d.) repair of deviated nasal septum or any type of surgery involving the sinus; (e.) myringotomy; (f.) tympanotomy; (g.) herniorraphy; or (h.) cholecystectomy; (subject to all other coverage provisions, including but not limited to, the Pre-existing Conditions exclusion);
50. Expenses for participating in interscholastic, intercollegiate or organized competitive sports;
51. Medical care, treatment, service or supplies received outside of the United States, Canada or its possessions;
52. Expenses for spinal manipulation or adjustment;
53. Expenses for private duty nursing services;
54. Expenses for the repair or maintenance of a wheelchair, hospital-type bed or similar durable mechanical equipment;
55. Expenses for orthotics, special shoes, spine and arch supports, heel wedges, sneakers or similar devices unless they are a permanent part of an orthopedic leg brace;
56. Expenses incurred in connection with the voluntary taking of a poison or inhaling gas;
57. Expenses incurred in connection with obesity treatment or weight reduction including all forms of intestinal and gastric bypass surgery, including the reversal of such surgery even if the Covered Person has other health conditions that might be helped by a reduction of obesity or weight;
58. Expenses for marital counseling or social counseling;
59. Expenses for acupuncture;
60. Expenses for a service or supply whose primary purpose is to provide a Covered Person with (1) training in the requirements of daily living; (2) instruction in scholastic skills such as reading and writing; (3) preparation for an occupation; (4) treatment of learning disabilities, developmental delays or dyslexia; or (5) development beyond a point where function has been demonstrably restored;
61. Expenses for replacement of artificial limbs or eyes;
62. Expenses for removal of breast implants; or
63. Expenses that do not meet the definition of or are not specifically identified under the Group Policy as Covered Expenses.

PRE-EXISTING CONDITIONS LIMITATION - We will not provide benefits for any loss caused by, or resulting from, a Pre-existing Condition. **"**Preexisting Conditions**"** means any medical condition or Sickness for which:

1. Medical advice, care, diagnosis, treatment, Consultation, or medication was recommended by or received from a Doctor within the 5-years immediately prior to a Covered Person's Effective Date of coverage; or
2. Symptoms existed within the 5-years immediately prior to the Covered Persons Effective Date of coverage which would cause a reasonable person to seek diagnosis, care or treatment.

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

COORDINATION OF BENEFITS PROVISION

Whenever used in this provision, the following definitions apply:
"Plan" means any:
1. Group, blanket or franchise insurance coverage;
2. Service plan contracts, group or individual practice or other prepayment plans;
3. Coverage under any labor management trusted Plans, union welfare plans, employer organization plans, self-funded plans or employee benefit organization plans which provides medical or dental benefits or services; or
4. Medicare plan or similar governmental plan offering benefits.

“Plan” does not include coverage under individual policies or contracts. Each Plan or part of a Plan that has a right to coordinate benefits will be considered a separate Plan.

"Allowable Expense" means any necessary, Usual, Reasonable and Customary item of expense at least a part of which is covered by any one of the Plans that covers the person for whom claim is made. When benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

“Claim Determination Period" means a calendar year or that part of a calendar year in which the person has been covered under the policy.

COORDINATION OF BENEFITS - If a Covered Person is also covered under one or more other Plans, the benefits payable under this Certificate will be coordinated with the benefits payable under all other Plans. Coordination of Benefits will be used to determine the benefits payable for a Covered Person for any Claim Determination Period if, for the Allowable Expenses incurred in that period, the sum of (1) and (2) below would exceed those Allowable Expenses:
1. The benefits that would be payable under this Certificate without coordination; and
2. The benefits that would be payable under all other Plans without the coordination of benefits provisions in those Plans.

The benefits that would be payable under this Certificate for Allowable Expenses incurred in any Claim Determination Period without Coordination of Benefits will be reduced to the extent required so that the sum of:
1. Those required benefits; and
2. All the benefits payable for those Allowable Expenses from all other Plans will not exceed the total of those Allowable Expenses.

Benefits payable under all other Plans include the benefits that would have been payable had proper claim been made for them. However, the benefits of another Plan will be ignored when the benefits of this Certificate are determined if:
1. The Benefit Determination Rules would require this Certificate to determine its benefits before that Plan; and
2. The other Plan has a provision that coordinates its benefits with those of this Certificate and would, based on its rules, determine its benefits after this Certificate.

When Coordination of Benefits reduces the total amount otherwise payable in a Claim Determination Period for a Covered Person, each benefit that would be payable in the absence of Coordination of Benefits will be reduced in proportion. The reduced amount will be charged against any applicable benefit limit of this Certificate.

We reserve the right to release to, or obtain from, any other insurance company or other organization or person, any information that, in Our opinion, is needed for the purpose of the Coordination of Benefits.

When payments that should have been made under this Certificate based on the terms of this provision have been made under any other Plans, We have the right to pay to any other organization making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered benefits paid under this Certificate. We will be released from all liability under this Certificate to the extent of these payments. When an overpayment has been made by Us, at any time, we will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other insurance company or organization, as We may determine.

BENEFIT DETERMINATION RULES - The rules below establish the order in which benefits will be determined:

Benefits not as a Dependent
The benefits of a Plan that covers the person for whom claim is made other than as a dependent will be determined before a Plan that covers that person as a dependent.
Dependent Benefits under Different Parent Plans

The benefits of a Plan that covers the person for whom claim is made as a dependent of the parent whose birthday falls earlier in the year will be determined before the benefits that covers that person as a dependent under the other parent's Plan.

When both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. However, if the other Plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

Notwithstanding the foregoing, in the case of a dependent child of divorced or separated parents, the following rules will apply.

1. If there is a court decree that establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan that covers the child as a dependent of the parent so responsible will be determined before any other Plan, otherwise:
2. The benefits of a Plan that covers the child as a dependent of the parent with custody will be determined before a Plan that covers the child as a dependent of a step-parent or a parent without custody;
3. The benefits of a Plan that covers the child as a dependent of a step-parent will be determined before a Plan that covers the child as a dependent of the parent without custody.

Benefits for Person Longest Covered
When the above rules do not establish the order, the benefits of a Plan that has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time.

CLAIM PROVISIONS

Notice of Claim: When a claim arises, the claimant should notify us or our authorized administrator of the loss in writing. This written notice of claim must be given within 30-days (Kentucky: 60-days) after commencement of any loss, or as soon as reasonably possible.

Claim Forms: After receiving notice of claim, we or our authorized administrator will furnish the clamant with a claim form for filing proof of loss. If this form is not received within 15-days after notice has been given, the claimant should submit written proof which covers the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss: The claimant must furnish us or our authorized administrator with written proof of loss within 90-days of the loss. Where this Certificate provides for payments contingent upon a period of Confinement, these 90-days shall begin at the end of the period for which we are liable. If the claimant does not furnish proof within 90-days as required, benefits shall still be paid for that loss if: (1) it was not reasonably possible to give proof within those 90-days; and (2) proof is furnished as soon as reasonably possible and, except in the absence of legal capacity, no later than 1-year after the end of those 90-days.

Time of Payment of Claims: We will make payment promptly upon receipt of due written proof of loss.

Payment of Claims: Payment will be made directly to You or the provider of the service, as directed by You in writing at the time of submitting proof of loss. If You are deceased or, in our opinion, are incapable of giving a valid receipt for payment and if no claim has been made by a duly-appointed legal representative, we shall have the option of making payment to either (1) the Hospital or the person who actually incurred the loss for which payment is due; or (2) Your surviving relative. Such a payment shall discharge us from all further liability to the extent of the payment made.

Appeal of Claim Denial: If a claim is denied, You will receive written notice giving the reason for the denial. If You wish to appeal the denial of the claim, such appeal must be submitted to us in writing within 60-days from the date of notice. You must clearly state the reason You believe the claim decision is incorrect.

GENERAL PROVISIONS

Amendment: We may amend or change the Group Policy at any time by giving written notification to the Group Policyholder. Insurance provided by the Group Policy may be amended, changed or canceled without the consent of any Covered Person and without prior notice to him.

Arbitration: If any Covered Person has a dispute, disagreement or claim against the Company, its authorized administrator, or any employee or agent of the Company or of its authorized administrator, which has not been resolved or

settled after exhaustion of the Company's appeals procedures, then the dispute or disagreement shall be resolved by arbitration. This provision shall be applicable to all claims or controversies arising under the Policy. Arbitration shall be conducted in accordance with the Commercial Rules of Arbitration of the American Arbitration Association.

Assignment and Claims of Creditors: Benefits are not assignable except that You may direct us to pay benefits to the person or institution on whose charges any claim is based. Any such payment that we make will fully discharge Us to the extent of the payment.

Certificate: This Certificate describes the main features of the Group Policy. In the event of any conflict, the terms of the Group Policy will govern. Individual Certificates will be issued to the Certificateholder or to our authorized administrator for delivery to each Certificateholder. The rights described in this Certificate are controlled by the provisions of the Group Policy and are subject to any changes in the Group Policy. The Participating Organization has the Group Policy available for inspection by Covered Persons at all reasonable times.

Changes in Benefits: Changes in the benefits of a Covered Person will apply only to Covered Expenses or losses incurred after the effective date of the change.

Clerical Error: Clerical errors that We or Our authorized administrator make in Your Schedule of benefits, the issuance of a Certificate, or in record keeping will not afford You benefits or validate insurance for which You have not applied and paid the appropriate premium and been approved by Us. We have the right to setoff or recover from You any overpayment of benefits made due to such errors.

Conformity With Statutes: Any provision of this Certificate that is in conflict with the statutes of the jurisdiction in which the Group Policyholder is located on such date is hereby amended to conform to the minimum requirements of such statutes.

Contract/Changes: The effective time for any dates used shall be 12:01 A.M. Standard Time at the address of the Group Policyholder.

Entire Contract: The entire contract consists of the Group Policy, the Certificate, the group Application, Your application form and any other documents requested and accepted by Us. No change in the Group Policy or Your coverage is valid unless approved by Our Chief Executive Officer. Such approval must be signed by Our Chief Executive Officer and attached to the Group Policy and Certificate. No broker, agent or producer can change or waive any provision of the entire contract or any of our requirements.

Grace Period: You have a 31-day Grace Period for the payment of each premium due after the first premium. Your coverage will continue in force during the Grace Period unless You have given us prior written notice of termination. If such a premium is not paid by the end of the Grace Period, all such insurance will end as of the due date of such premiums, and no expenses incurred during the Grace Period will be considered for benefits.

Incontestability: All statements You make will, in the absence of fraud, be deemed representations and not warranties. No such statement will be used in defense of any claim or in a contest unless You have been given a copy. Any misstatement or omission of information made on Your application form or on any other materials on which We relied to issue, change or increase coverage will be considered a misrepresentation and may be the basis of later rescission of coverage.

Legal Proceedings: No proceedings to obtain benefits may be brought against Us until 60-days after We have received proper written proof of loss and any other documentation necessary to establish the benefits due. No proceedings may be brought more than 3-years (Kansas: 5-years; South Carolina: 6-years) after proof is required to be filed.

Medical Records: The Company shall have access to medical and treatment records of the Covered Persons to determine benefits, process claims, utilization review, quality assurance, or for any other purpose reasonably related to the Policy benefits. Each Covered Person shall complete and submit to the Company such additional consents, releases and other documents as may be requested by the Company in order to determine or provide benefits under the Policy. The Company reserves the right to reject or suspend a claim based on lack of supporting medical information or records.

Physical Exam and Autopsy: We may require, at Our expense, medical examinations of any person for whom claim is made. We may also make an autopsy, if not forbidden by law. (Autopsies will not be required in Massachusetts, Mississippi, and South Carolina).

Premium Payments: All premiums are paid to Us, or if We direct, to Our authorized administrator. The first premium is due on the Effective Date. Subsequent premiums are due monthly, in advance, on the anniversary date and month of the Effective Date. Except as otherwise provided herein, all such insurance will terminate on the premium due date, except as provided in the Grace Period provision, if premiums are not paid when due.

Premium Changes: We will determine the premium for each Covered Person. We have the right to change premium rates on any premium due date by giving you 60-days advance written notice of such change. The premium rates may also be changed at any time the terms of the Group Policy are changed.

Pronouns: Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine also, unless the context clearly indicates to the contrary.

Right of Reimbursement: As a condition to receiving benefits under the Policy, Covered Persons receiving medical care benefits agree to reimburse Us in full any such benefits when they are recovered from another person or business entity. If a repayment agreement is required to be signed, We shall be entitled to full reimbursement regardless of whether it is actually signed. Our right of reimbursement may be from funds received from any person or business entity, in accordance with the laws of the jurisdiction wherein the Injury or Sickness occurred. We may enforce Our right of reimbursement by requiring the Covered Person to assert a claim to any of the coverages to which he/she may be entitled. We will not pay fees or expenses associated with any claim/lawsuit without express written consent.

Rescission: A misrepresentation or omission in the application form or other documents provided to Us may be the basis for later rescission of all coverage of all Covered Persons. Rescission voids all coverage as of the Effective Date and means that no benefits will be paid to any person for any claim submitted, whether or not such claim relates to the condition about which information was misrepresented or omitted. We will refund to You premiums paid after deduction for any claims We paid.

Subrogation: As a condition to receiving benefits under the Policy, Covered Persons receiving medical benefits agree to transfer in full to Us their rights to recover damages for these benefits when the Injury or Sickness occurs through the act or omission of another person. If a repayment agreement is required to be signed, all rights of recovery are transferred to Us regardless of whether it is actually signed. It is only necessary that the Injury or Sickness occurs through the act of a third party. Our subrogation rights of full recovery may be from any person or business entity, in accordance with the laws of the jurisdiction wherein the Injury or Sickness occurred. We may enforce Our right of subrogation by requiring the Covered Person to assert a claim to any of the coverages to which he/she may be entitled. We will not pay fees or expenses associated with a claim/lawsuit without express written authorization.

Third Party Clause: Medical care benefits are not payable to or for a Covered Person under the Policy when the Injury or Sickness to the Covered Person occurs through the act or omission of another person. However, We may elect to advance payment for medical expenses incurred for an Injury or Sickness caused by a third party. The Covered Person or guardian must sign an agreement to repay Us in full any sums advanced for such medical expenses from any judgment or settlement received. We have the right to recover in full the medical expenses advanced regardless of whether that person actually signs any required repayment agreement. It is only necessary that the Injury or Sickness occurs through the act of a third party. Our right of recovery in full may be from any person or business entity, in accordance with the laws of the jurisdiction wherein the Injury or Sickness occurred. We may enforce this provision by requiring the Covered Person to assert a claim to any of the coverages to which he may be entitled. We will not pay fees or expenses associated with the claim/lawsuit without express written authorization.

Waiver of Rights: The Company's failure to enforce any provision of the Policy does not affect Our right to enforce any provision at a later date, and does not affect the Company's right to enforce any other provision of the Policy.

Workers' Compensation: This Certificate is not a substitute for Workers' Compensation insurance and does not affect any requirement for Workers' Compensation coverage.

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

485 Madison Avenue, New York, NY 10022

AMENDATORY ENDORSEMENT
(Applicable to the Pennsylvania Residents Only)

Group Policy Number:	SSL-GP-001
Group Policyholder:	Communicating for Agriculture and the Self-Employed, Inc.
Effective Date:	[January 1, 2005]

This Amendatory Endorsement is attached to and made a part of the Group Policy and Certificate shown above. The provisions of this Amendatory Endorsement are effective on the Effective Date shown above and will expire concurrently with the Group Policy and Certificate unless otherwise terminated. In consideration of issuance, the Group Policy and Certificate is hereby amended and modified, as follows:

If any benefits appearing in these mandated benefits are also provided in the Certificate, we will not duplicate the payment of benefits. Benefits will be payable either under the Certificate or these mandated benefits, whichever provides the better benefit.

A. The following are added to the Covered Expenses provision under the section entitled Description of Benefits:

Childhood Immunizations, including booster doses which are considered Medically Necessary, subject to the same coinsurance amount as for any other sickness or injury. Benefits for childhood immunizations are not subject to the Policy Deductible or limited by any dollar amount. The schedule of immunizations will be determined by the Pennsylvania Department of Health.

Medical Foods Coverage are payable for the cost of nutritional supplements (formulas) as Medically Necessary for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a Physician. Such benefit will not be subject to the Policy Deductible.

Except as stated herein, this Amendatory Endorsement does not change coverage in any other way and is subject to all provisions, terms, and conditions of the Group Policy and Certificate. If there is a conflict between the Group Policy, the Certificate, and this Amendatory Endorsement, the terms of this Amendatory Endorsement will govern.

Rachel Lipari
President

David Kettig
Secretary

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

[485 Madison Avenue, New York, NY 10022]

AMENDATORY ENDORSEMENT

[Group Policy Number:

Group Policyholder:

Effective Date:]

This Amendatory Endorsement is attached to and made a part of the Group Policy and Certificate shown above. The provisions of this Amendatory Endorsement are effective on the Effective Date shown above and will expire concurrently with the Group Policy and Certificate unless otherwise terminated. In consideration of issuance, the Group Policy and Certificate is hereby amended and modified, as follows:

[The deductible amount has been changed from $250 to $500.]

Except as stated herein, this Amendatory Endorsement does not change coverage in any other way and is subject to all provisions, terms, and conditions of the Group Policy and Certificate. If there is a conflict between the Group Policy, the Certificate, and this Amendatory Endorsement, the terms of this Amendatory Endorsement will govern.

Rachel Lipari
President

David Kettig
Secretary

SUMMARY OF THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

INTRODUCTION

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

IMPORTANT DISCLAIMER

The Pennsylvania Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require residency in Pennsylvania. You should not rely on coverage by the Pennsylvania Life and Health Insurance Guaranty Association 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.

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

This Information is Provided By:

Pennsylvania Life and Health
Insurance Guaranty Association
290 King of Prussia Road
Radnor Station Bldg. Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
Bureau of Consumer Services
1300 Strawberry Square
Harrisburg, PA 17120

(717) 787-2317

SUMMARY

The state law that provides for this safety-net coverage is called the Pennsylvania Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Association.

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

Exclusions From Coverage. Persons holding such policies or contracts are not protected by this Association if:

* they are not residents of the State of Pennsylvania, except under certain very specific circumstances;
* the insurer was not authorized or licensed to do business in Pennsylvania at the time the policy or contract was issued;
* their policy was issued by a nonprofit hospital or health service corporation (e.g., the "Blue"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association 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;
* any policy of reinsurance (unless an assumption certificate was issued);

* plans of employers, associations or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
* interest rate yields that exceed an average rate;
* dividends;
* experience rating credits;
* credits given in connection with the administration of a policy or contract;
* annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
* policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
* sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
* unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
* financial guarantees, funding agreements or guaranteed investment contracts not containing mortality guarantees and not issued to or in connection with a specific employee benefit plan or governmental lottery;
* any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

Limits On Amount Of Coverage. The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages.

Subject to the over-all $300,000 limit, the Association will pay up to $300,000 in life insurance death benefits but not more than $100,000 in net cash surrender or withdrawal values. For annuities, the Association will pay up to $300,000 in annuity benefits, including $100,000 in net cash surrender or withdrawal benefits. For health insurance, the Association will pay up to $100,000, including any net cash surrender or withdrawal benefits.

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

485 Madison Avenue • New York, NY 10022

(Herein called the Company, We, Us, or Our)

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes how we protect personal health information we have about you which relates to our medical, dental, vision, and prescription drug coverage. Protected Health Information ("PHI") is individually identifiable information about you. All of the following are examples of PHI: demographic information like your name, address and social security number; medical information that relates to your past, present or future physical or mental health that is collected, created or received from you, a health care provider, a health plan, employer or a health care clearinghouse; the providing of health care; or the past present or future payment for providing health care to you.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003 or the date coverage became effective for you, whichever is later, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our Insureds at the time of change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Your PHI

In conducting our business we will create records regarding you and the insurance services we provide you. The main reasons for which we may use and may disclose your PHI are to evaluate and process any requests for medical coverage and claims for benefits you may make. The following describe these and other uses and disclosures, together with some examples:

Treatment: We may use or disclose your PHI to facilitate medical treatment by providers. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to treat you. We may request the services of a business associate to assist us in these activities.

Payment: We may use and disclose your PHI to facilitate payment of benefits under your insurance coverage. For example, we might disclose your PHI to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain payments and to issue explanations of benefits. We also may use your PHI to obtain payment from third parties that may be responsible for your premium payments, such as family members.

Health Care Operations: We may use and disclose your PHI as necessary, and as permitted by law, to operate our business. Health care operations include: (i) rating our risk and determining our premiums for your insurance; (ii) conducting quality assessment and improvement activities; (iii) conducting or arranging for medical review, legal services, audit services, fraud and abuse detection and compliance programs; and (iv) business planning and development.

On Your Authorization: You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.

To Your Family and Friends: We may disclose your PHI to a family member, friend, or other person to the extent necessary to help with your health care or for payment of your health care. We may use or disclose your name, location and general condition or death to notify, or assist in the notification, of (including identifying or locating) a person involved in your care.

Before we disclose your PHI to a person involved with your health care or payment for your health care, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your PHI based on our professional judgment of whether the disclosure would be in your best interest.

Your Employer or Organization Sponsoring Your Health Plan: We may disclose Your PHI and the PHI of others enrolled in your group insurance plan to the employer or other organization that sponsors your group insurance plan to permit the plan administrator to perform plan administration functions. We may also disclose summary information about the enrollees in your group insurance plan to the plan administrator to use to obtain premium bids for the health insurance coverage offered through your group insurance plan or to decide whether to modify, amend or terminate your group insurance plan. The summary information we may disclose will summarize claims history, claims expenses, or types of claims experienced by the enrollees in your group insurance plan. The summary information will be stripped of demographic information about the enrollees in the group insurance plan, but the plan administrator may still be able to identify you or other participants in your group health plan from the summary information. We may also disclose enrollment and disenrollment information to either the plan administrator or plan sponsor of your group insurance plan.

Underwriting: We may receive your PHI for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose this PHI for any other purpose, except as required by law, unless the contract of health insurance or health benefits is placed with us, or where we disclose such information to MIB Group, Inc., a non-profit membership organization of life and

health insurance companies, which operates an information exchange on behalf of its members. In those cases, our use and disclosure of your PHI will only be as described in this notice.

Public Benefit: We may use or disclose your PHI as authorized by law for the following purposes deemed in the public interest or benefit:

-as required by law;
-for public health activities, including disease and vital statistic reporting, child abuse reporting; FDA oversight, and to employers regarding work-related illness or injury;
-to report adult abuse, neglect, or domestic violence;
-to health oversight agencies;
-in response to court and administrative orders and other lawful processes;
-to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
-to coroners, medical examiners, and funeral directors;
-to organ procurement organizations;
-to avert a serious threat to health and safety;
-to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
-to correctional institutions regarding inmates; and
-as authorized by state worker's compensation laws.

Business Associates: Certain aspects and components of our business are preformed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our duly appointed insurance agents, third party administrators, financial auditors, actuarial and underwriting services, reinsurers, legal services, enrollment and billing services, claim payment and medical management services and collection agencies. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations who assist us with our payment or health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Individual Rights

Access: In most cases, you have the right to inspect and obtain a copy of the PHI that we maintain about you. To inspect and copy PHI, you must submit your request in writing using the "Contact Information" provided at the end of this Notice. To receive a copy of your PHI, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes and PHI collected by us in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances we may deny your request to inspect and obtain a copy of your PHI. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes other than for treatment, payment, health care operations or as otherwise authorized by you since April 14, 2003 or the date coverage became effective for you, whichever is later. For example, we would account for your PHI or demographic information we disclose during an audit by an insurance department or pursuant to a court order. You must make your request in writing using the "Contact Information" provided at the end of this Notice. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Restriction: You have the right to request a restriction or limitation on PHI we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, we are not required to agree to it. If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing using the "Contact Information" provided at the end of this Notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.

Confidential Communications: You have the right to request that we communicate with you about PHI in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing using the "Contact Information" provided at the end of this Notice and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Amendment: If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must provide your request and your reason for the request in writing using the "Contact Information" provided at the end of this Notice. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend PHI that: (i) is accurate and complete; (ii) was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment; (iii) is not part of the PHI kept by or for us; or (iv) is not part of the PHI which you would be permitted to inspect and copy.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, submit your complaint using the "Contact Information" provided at the end of this Notice. All complaints must be submitted in writing. You will not be retaliated against for filing a complaint.

Contact Information: If you have questions regarding this Notice or need further assistance regarding this Notice, please contact us at:

Privacy Officer
Insurers Administrative Corporation
Post Office Box 37587; Phoenix, AZ 85069-7587
Phone: (602) 395-7043

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

485 Madison Avenue, New York, NY 10022

AMENDATORY ENDORSEMENT

This Amendatory Endorsement made a part of the Group Policy and Certificate to which it is attached. The provisions of this Amendatory Endorsement are effective on the Effective Date stated herein and will expire concurrently with the Group Policy and Certificate unless otherwise terminated. In consideration of issuance, the Group Policy and Certificate is hereby amended and modified, as follows:

Under the Section entitled "Definitions" the following changes are hereby made:

1. The definition of "Deductible" is deleted and replaced with the following:

   Deductible. The Deductible means the amount of Covered Expenses that each Covered Person must pay before benefits will be payable. The Deductible amount must be satisfied each Coverage Period. The daily Deductible amount must be satisfied each day, and applies per calendar day regardless of the number of providers rendering services on that day. The applicable Deductible or daily Deductible, as elected by You, is shown in the Schedule.

2. The following definition is added:

   Copay/Copayment. The Copay/Copayment means the amount the Covered Person must pay to each provider for each service or each supply as specified in the Schedule. If the Covered Person has a Copay, the Copay amount is specified in the Schedule. Copayments do not apply toward the Deductible, Coinsurance or Coinsurance Limit.

This Rider is endorsed and made part of the Group Policy and Certificate as of Your Effective Date of coverage.

This Rider is subject to all provisions of the Policy and Certificate which are not in conflict with the provisions of this Amendatory Endorsement. Nothing in this Endorsement will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

Rachel Lipari
President

Adam C. Vandervoort
Secretary

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

485 Madison Avenue, New York, NY 10022

AMENDATORY ENDORSEMENT

This Amendatory Endorsement made a part of the Group Policy and Certificate to which it is attached. The provisions of this Amendatory Endorsement are effective on the Effective Date stated herein and will expire concurrently with the Group Policy and Certificate unless otherwise terminated. In consideration of issuance, the Group Policy and Certificate is hereby amended and modified, as follows:

Under the Section entitled “Limitations and Exclusions” the exclusion pertaining to expenses incurred during the first 6-months after the Effective Date of coverage for a Covered Person is deleted in its entirety.

This Rider is endorsed and made part of the Group Policy and Certificate as of Your Effective Date of coverage.

This Rider is subject to all provisions of the Policy and Certificate which are not in conflict with the provisions of this Amendatory Endorsement. Nothing in this Endorsement will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

Rachel Lipari
President

Adam C. Vandervoort
Secretary