



**Companion Life Insurance Company
PO Box 100102
Columbia, South Carolina 29202-3102**

Companion Life Insurance Company, herein called the Company, hereby certifies that it has issued and delivered to the Policyholder a group Policy, described on the Schedule of Benefits page. The group Policy covers certain eligible persons as described in the Policy.

This Certificate describes the benefits and provisions of the group Policy. This Certificate becomes effective only if: (1) the Insured is eligible for insurance; (2) the Insured is on Active Service on the date it is to take effect; and (3) the Insured becomes insured in accordance with all of the provisions of the Policy.

The insurance is to be effective only if the required premium payments are made by the Insured or on the Insured's behalf to the Company. (See Section 2, Eligibility and Effective Date provisions.)

No agent may change the Policy or waive its provisions.

This Certificate takes the place of any other Certificate previously issued to the Insured under the group Policy. It should be kept in a safe place.

IN WITNESS WHEREOF Companion Life Insurance Company caused this Certificate to be executed on the Date of Issue to take effect on the Effective Date.

A handwritten signature in black ink, appearing to read 'Alicia Smith', is written above a horizontal line.

President

For service or complaints about the policy, please address any inquiries to the address shown above or call 1(888)-583-3057.

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Schedule of Benefits

DEFINITION OF ELIGIBLE PERSONS: All regular full time hourly employees who work a minimum of 28 hours per week and their eligible Dependents (unless specified otherwise), under age 70. (Compliance with ADEA (Age Discrimination in Employment ACT) is observed, where applicable.)

HEALTH INDEMNITY INSURANCE

SERVICE:	PLAN PAYS:
OUTPATIENT PHYSICIAN OFFICE VISIT BENEFIT (may substitute a visit to an emergency room, urgent care center or convenience care center (e.g., Minute Clinic) for an outpatient office visit)	Up to \$75 per visit, up to 6 visits per calendar year.
OUTPATIENT DIAGNOSTIC X-RAY AND LABORATORY BENEFIT	Up to \$175 per day, up to 3 testing days per calendar year.
PREVENTIVE CARE BENEFIT (See attached Rider.)	Counts as one Outpatient Physician Office Visit Benefit and one testing day under the Outpatient Diagnostic X-Ray and Laboratory Benefit for one wellness visit per calendar year.
OUTPATIENT PRESCRIPTION DRUG BENEFIT <i>Retail 30-day prescription & mail order maintenance drug discount benefit.</i> Network discounts, available through Caremark, are not part of the insured benefit.	Up to \$25 per prescription, up to 10 prescriptions per calendar year.
SUPPLEMENTAL ACCIDENT BENEFIT For the necessary care and treatment received within 90 days of an accidental injury. (See attached Rider.)	100%, up to \$1,400 per Covered Accident.
DAILY IN-HOSPITAL INDEMNITY BENEFIT Hospital discharge is a break in confinement.	\$700 per day, up to 30 days per confinement.
HOSPITAL INTENSIVE CARE UNIT CONFINEMENT Paid in addition to Daily In-Hospital Indemnity Benefit. (See attached Rider.)	\$250 per day, limited to the first 30 days of confinement.
SURGICAL INDEMNITY BENEFIT (Inpatient and Outpatient)	Benefit varies and is stated in the Policy Surgical Schedule. Examples: <i>Hiatus Herniotomy: \$1,800</i> <i>Appendectomy: \$960</i> <i>Simple Fracture/Lower Jaw: \$480</i>
ANESTHESIA INDEMNITY BENEFIT (Inpatient and Outpatient) Benefit payable only if surgery is covered	20% of the Surgical Indemnity Benefit amount.

**SECTION 1
DEFINITIONS**

1.01 “Accident” means sudden, unexpected and unintended injury which is independent of any Sickness and which takes place while the Covered Person’s coverage is in force.

1.02 “Active Service” means that the Insured is:

- (a) doing in the usual manner all of the regular duties of his or her employment on a scheduled work day; and
- (b) these duties are being done at one of the places of business where he or she normally does such duties or at some location to which his or her employment sends him or her.

An Insured will be said to be on Active Service on a day which is not a scheduled work day only if he or she would be able to perform in the usual manner all of the regular duties of his or her employment if it were a scheduled work day and was actively at work on the last preceding regular work day.

1.03 “Calendar year” means the period from January 1 through December 31 of the same year.

1.04 “Certificate” means the individual certificate issued to the Insured. It describes the coverage under the Policy.

1.05 “Company” means Companion Life Insurance Company, located in Columbia, South Carolina.

1.06 “Confinement (or Confined)” means that period of time during any Hospital stay that the Covered Person is actually admitted on an inpatient basis. “Confinement” does not include that period of time during which a Covered Person is in a Hospital emergency room, an observation room, a free-standing surgical facility, or outpatient facility.

1.07 “Covered Benefits” means those services or supplies shown in the Health Indemnity Benefit(s), if included in this policy, that:

- (a) are for necessary treatment and recommended by a Physician;
- (b) are received while the Covered Person is insured under the Policy, subject to any Extension of Benefits; and
- (c) are not excluded under Section 4.

1.08 “Covered Person(s)” means the Insured and his or her Dependents insured under the Policy.

1.09 “Dependent” means an Insured’s:

- (a) married spouse who lives with the Insured and is under age 70; or
- (b) unmarried child (natural, step or adopted) who is not eligible for medical coverage as an Insured under this Policy or any other group policy and who:
 - (1) is less than age 25;
 - (2) is a grandchild of the Insured, is less than age 25 and is a dependent of the Insured for federal income tax purposes at the time application for coverage is made. (Coverage for a grandchild may not be terminated solely because he is no longer a dependent of the policyholder for federal tax purposes); or
 - (3) becomes incapable of self-support because of mental retardation or physical handicap while insured under the Policy and prior to reaching the limiting age for dependent children. The child must be dependent on the Insured for support and maintenance.

**SECTION 1
DEFINITIONS**

The Company must receive proof of incapacity within 31 days after coverage would otherwise terminate. Then, coverage will continue for as long as the Insured's insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age 25; or

- (4) a child who is adopted by the Insured or placed for adoption with the insured prior to age 25 (a child for which the Insured is a party in a suit in which the adoption of child is sought shall be deemed an adopted child); or
- (5) is a child for which the Insured is required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court of this state, and any other person dependent upon the Insured.

The term Dependent does not include a child who engages for compensation, profit or gain in any employment or business for 30 or more hours per week.

1.10 "Effective Date" means the date coverage takes effect under the Policy. The Effective Date of the Insured will be the first day after the Normal Pay Date for which the first payroll deduction is taken for this coverage. The "Effective Date" will start at 12:01 a.m. at the main place of business of the Employer.

1.11 "Hospital" means a licensed institution that has on its premises:

- (a) permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician;
- (b) 24-hour-a-day nursing service by graduate registered nurses; and
- (c) the patient's written history and medical records.

It shall also have (or have available on a pre-arranged basis) laboratory, x-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians, or be accredited by the Joint Commission on Accreditation of Hospitals.

"Hospital" shall not include any institution or portion thereof used as a place for rehabilitation, rest, the aged, education or training; or a nursing or convalescent home or an extended care facility for the care of convalescent patients.

1.12 "Immediate Family" means the parents, spouse, children, or siblings of a Covered Person, or any person residing with a Covered Person.

1.13 "Insured" means any person who is eligible for insurance under Section 2 and is insured under the Policy by virtue of employment by an Employer.

1.14 "Normal Pay Date" means the day of the week the Insured's employer normally issues payroll. This date will remain the same regardless of a change in the payday which may occur due to holidays.

1.15 "Physician" means a practitioner of the healing arts who:

- (a) is practicing within the scope of his or her license in the state where so licensed; and
- (b) is not a member of the Covered Person's Immediate Family.

1.16 "Policy" means the policy issued to the Policyholder.

SECTION 1
DEFINITIONS

1.17 "Policyholder" means the Employer who holds the Master Policy.

1.18 "Pre-Existing Condition" means a disease, Accident, Sickness or physical condition for which a Covered Person:

- (a) had treatment;
- (b) incurred expense;
- (c) took medication; or
- (d) received a diagnosis or advice from a Physician,

during the 12-month period immediately before the Effective Date of his or her coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Accident, Sickness or physical condition.

1.19 "Schedule of Benefits (or Schedule)" means the benefit schedule set forth in the Policy or Certificate.

1.20 "Sickness" means illness or disease which begins while the Covered Person's coverage is in force and is the direct cause of the loss.

1.21 "Total Disability" or (Totally Disabled) means the Insured is disabled and prevented from performing the material and substantial duties of his or her occupation. For Dependents, "Totally Disabled" means the inability to perform a majority of the normal activities of a person of like age in good health.

SECTION 2
ELIGIBILITY AND EFFECTIVE DATE

2.01 All persons who:

- (a) are on Active Service as employees of an Employer; and
- (b) qualify as eligible Insureds as defined in the master application; and
- (c) meet the definition of eligible Employee as stated in the Schedule, are eligible to be insured under the Policy. Evidence of insurability acceptable to the Company may be required.

2.02 The insurance on eligible employees will take effect on the Effective Date of the Employer if:

- (a) an application is completed on or before said Effective Date;
- (b) the underwriting rules of the Company are met;
- (c) such person is on Active Service; and
- (d) the first premium is paid and received by the Company.

After the Effective Date of the Employer, the insurance of eligible employees will take effect on the first day after the Normal Pay date for which the first payroll deduction is taken for this coverage, subject to (a), (b), (c) and (d) above and the rules stated in the master application.

2.03 If and where Dependent coverage is available under the Policy, each Insured will be eligible for such coverage on the latest of the following dates:

- (a) the day the Insured becomes eligible for insurance; or
- (b) the day the Insured acquires his or her first Dependent.

With respect to Health Indemnity coverages, if both husband and wife are eligible for coverage under the Policy and have no Dependent children, the husband and wife may only elect individual coverage. If both husband and wife are eligible for coverage under the Policy and they have Dependent child(ren), either spouse, but not both, may elect Dependent coverage.

2.04 Dependent coverage may be elected by:

- (a) Completing and signing an application within 31 days of the date the Dependent becomes eligible; and
- (b) By completing any required form of payroll deduction.

2.05 The Effective Date of coverage for each eligible Dependent will be the first day after the Normal pay date for which the first payroll deduction is taken for this coverage, following:

- (a) the Company's acceptance of the application; and
- (b) receipt of the first premium by the Company.

However, if on such date the coverage for the eligible employee has not yet taken effect, the Effective Date for Dependent coverage will be the same as the Effective Date for such employee.

SECTION 2
ELIGIBILITY AND EFFECTIVE DATE (continued)

A newborn child will become insured for Accident or Sickness automatically on the day he or she is born as long as the Insured's coverage was in force on that date. Accident or Sickness includes prematurity, congenital defects and birth abnormalities. The newborn child's coverage will not continue past the 31-day period following birth unless:

- (a) the Company is notified by the end of that 31-day period of the addition of such newborn child; and
- (b) any applicable additional premium is paid.

An adopted child who has not attained 18 years of age, will become insured for Accident and Sickness automatically as of the date of adoption or placement for adoption. Placement for adoption means the assumption and retention by a person of legal obligation for total or partial support of a child in anticipation of the child's adoption. Coverage for an adopted child will not continue past the 31-day period following birth unless:

- (a) the Company is notified by the end of the 31-day period of the addition of such adopted child; and
- (b) any applicable additional premium is paid.

In all other instances if a Dependent is Totally Disabled on the date coverage (with respect to that particular Dependent) would otherwise take effect, the coverage of the Dependent will be deferred until the first of the month following the Dependent's cessation of Total Disability.

2.06 If a Covered Person is Totally Disabled when his or her coverage would otherwise take effect, coverage will take effect on the earlier of the following dates:

- (a) with respect to coverage for the disabling condition:
 - (1) the day following the expiration of any extension of benefits or continuation of coverage provided under the plan this plan replaces; or
 - (2) the day coverage would otherwise take effect if the plan this plan replaces does not provide an extension of benefits or continuation of coverage;
- and
- (b) with respect to coverage for conditions other than the disabling condition:
 - (1) the day following the expiration of any continuation of coverage provided under the plan this plan replaces; or
 - (2) the day coverage would otherwise take effect if the plan this plan replaces does not provide for continuation of coverage.

SECTION 3
BENEFIT PROVISION

3.01 HEALTH INDEMNITY BENEFITS. Subject to the provisions of the Policy, the Company will pay Covered Benefits for one or more of the following:

Daily In-Hospital Indemnity Benefit

If a Covered Person, while insured, is Confined in a Hospital as a result of Accident or Sickness, the Company will pay the Daily In-Hospital Indemnity Benefit amount, as shown in the Schedule, for each day of Confinement, for up to the Maximum Number of Days of Confinement, as shown in the Schedule. No benefit will be paid during any period the Covered Person is not under the regular care and attendance of a Physician.

Surgical Indemnity Benefit If a Covered Person has a covered surgery performed, the Company will pay the Surgical Indemnity Benefit amount. This amount is based on the Payment Factor amount, as shown in the Schedule of Surgical Indemnity Benefits, times the number of Surgical Procedure Units, as shown in the Schedule.

If two or more procedures are performed through the same incision or operative field, payment will be made only for the procedure of the larger benefit. If more than one procedure is performed but each through separate incisions or in a separate operative field, the amount payable shall be the specified amount for the primary procedure plus 50% of the amount payable for all other surgical procedures performed.

Unlisted Procedures: In addition to the procedures listed in the Schedule of Surgical Indemnity Benefits, amounts shall be payable for any other covered operations. The amounts for such procedures shall be determined by the Company in amounts consistent with those listed in the Schedule of Surgical Benefits.

SECTION 3
BENEFIT PROVISION (continued)

Anesthesia Indemnity Benefit

If the Surgical Indemnity Benefit is payable, the Company will pay the Anesthesia Indemnity Benefit amount, as shown in the Schedule, for the administration of anesthesia.

Outpatient Physician Office Visit Indemnity Benefit

(Applicable only if the benefit is not excluded on the Schedule.)

The Company will pay the Outpatient Physician Office Visit Indemnity Benefit, as shown in the Schedule, for a Physician office visit as a result of Sickness or Accident, not to exceed the Maximum Number of Office Visits per Calendar Year, as shown in the Schedule.

Outpatient Diagnostic X-Ray and Laboratory Indemnity Benefit

(Applicable only if this benefit is not excluded on the Schedule.)

The Company will pay the Outpatient Diagnostic X-Ray and Laboratory Indemnity Benefit, as shown in the Schedule, when a Covered Person has diagnostic x-ray and laboratory tests performed. This benefit is limited to once per day of testing, not to exceed the Maximum Number of Testing Days per Calendar Year, as shown in the Schedule. These include tests that show a need for treatment or that are made because of definite symptoms of Accident or Sickness.

Outpatient Prescription Drug Indemnity Benefit Option

(Applicable only if this benefit is not excluded on the Schedule.)

The Company will pay the Outpatient Prescription Drug Indemnity Benefit, as shown in the Schedule, for each prescription filled for a Covered Person. This benefit is subject to the Outpatient Prescription Drug Indemnity Benefit Maximums, as shown in the Schedule.

TEXAS MANDATES

Mammography Benefit

The Company will pay for an annual screening by low-dose mammography for women 35 years of age or older.

As used here, "low-dose mammography" means the X-ray examination for the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, films and cassettes with an average radiation exposure delivery of less than one rad mid-breast with two views for each breast.

Phenylketonuria Or Other Inheritable Diseases

The Company will include the formulas necessary for the treatment of phenylketonuria or other inheritable diseases under the Outpatient Prescription Drug Indemnity Benefit Option. As used here, "other inheritable diseases" means an inherited disease that may result in mental or physical retardation or death.

**SECTION 3
BENEFIT PROVISION (continued)**

SCHEDULE OF SURGICAL INDEMNITY BENEFITS

*** Note: Benefit Amounts for Outpatient Surgery are limited to the Annual Outpatient Maximum shown in the Schedule. Benefits for Inpatient and Outpatient Surgery are limited to the Policy Annual Maximum.**

Procedure	Surgical Indemnity Benefit
1. ABDOMINAL SURGERY	
Abdomen, paracentesis	\$120
Herniotomy, single, inguinal, femoral or umbilical	\$960
Herniotomy, bilateral, inguinal, or femoral	\$1,440
Herniotomy, hiatus or diaphragmatic	\$1,800
Herniotomy, ventral or incisional	\$960
Esophageal diverticulum	\$1,800
Gastrotomy or gastrostomy	\$1,200
Gastrectomy, total	\$1,800
Gastro-enterostomy	\$1,400
Peptic ulcer, perforated, closure	\$1,200
Peptic ulcer, subtotal gastrectomy	\$1,620
Pyloric stenosis (Ramstedt's in infant)	\$1,200
Intestines anastomosis	\$1,440
Intestines (small) resection	\$1,440
Laparotomy	\$960
Colon, resection	\$1,620
Colonoscopy	\$300
Colostomy	\$1,200
Appendectomy	\$960
Diverticulum intestinal (Meckel's)	\$1,200
Common duct with or without Cholecystectomy	\$1,620
Appendiceal, abcess, drainage	\$720
Subdiaphragmatic abcess	\$960
Cholecystectomy	\$1,200
Cholecystoduodenostomy	\$1,800
Pancreas drainage	\$1,200
Splenectomy	\$1,440

SECTION 3
BENEFIT PROVISION (continued)

SCHEDULE OF SURGICAL INDEMNITY BENEFITS

Procedure	Surgical Indemnity Benefit
2. OPHTHALMOLOGY	
Foreign body removal within anterior or posterior chamber	\$960
Cornea, paracentesis	\$360
Conjunctival suture	\$240
Conjunctival flap for corneal ulcer, etc	\$480
Chalazion (excision)	
Simple	\$120
Multiple	\$180
Lacrimal sac, plastic	\$1,200
Entropion or ectropion or ectropion, Zeigler's puncture	\$180
Entropion or ectropion, plastic operation	\$960
Entropion or ectropion, plastic operation, graphs or flaps	\$1,440
Symblepharon, release	\$240
Pterygium	\$360
Corneal ulcer cauterization	\$180
Corneal ulcer, delimiting keratotomy	\$240
Tarsorrhaphy, orbicularis paralysis	\$480
Ptosis (single)	\$1,200
Strabismus, one or more muscles	\$1,200
Cataract, needling	\$360
Cataract, removal	\$1,680
Iridectomy	\$720
Removal foreign body of cornea	\$120
Glaucoma, filtration operation	\$960
Enucleation or evisceration	\$720
Enucleation with implant	\$1,200
Tumor, exenteration or orbit	\$1,800
Dacryocystorhinostomy	\$1,440
Detached retina	\$1,680

SECTION 3
BENEFIT PROVISION (continued)

SCHEDULE OF SURGICAL INDEMNITY BENEFITS

Procedure	Surgical Indemnity Benefit
3. ORTHOPEDIC	
Spinal fusion	\$1,800
Cartilage of condyle of femur, removal	\$720
Bone plate, removal	\$480
Talipes	
Metatarsus vargus	\$960
Calcaneus valgus	\$960
Equinovarus	\$1,200
Semilunar cartilage, removal from joint	\$960
Tenotomy, simple,	
	Open
	Closed
Claw foot, except bone surgery (see foot stabilization)	\$480
Coccyx, excision	\$360
Arthrotomy, any major joint	\$720
Hallux valgus, single radical operation	\$960
Hallux valgus, bilateral radical operation	\$720
Exostosectomy	\$1,200
Osteomyelitis, sequestrum removal	\$720
Foot stabilization	\$720
Hammer toe, operation	\$1,440
Arthrodisis of knee, hip, shoulder, or elbow	\$480
Torticollis, operation	\$1,620
Arthorplasty, any major joint	\$720
Hip joint, resection	\$1,680
Any major joint resection	\$1,680
Any joint resection of fingers or toes	\$1,440
	\$360

SECTION 3
BENEFIT PROVISION (continued)

SCHEDULE OF SURGICAL INDEMNITY BENEFITS

Procedure	Surgical Indemnity Benefit
4. AMPUTATIONS	
Upper Arm	\$720
Forearm	\$720
Hand	\$480
Finger, one	\$240
Additional	\$120
Hip	\$1,440
Thigh	\$1,200
Knee	\$960
Leg	\$960
Toe, one	\$240
Additional	\$120
Foot	\$720
Elbow	\$720
Scapulothoracic amputation	\$1,800
5. DISLOCATIONS	
Carpal bone, one	\$360
Additional	\$180
Clavicle	\$360
Elbow	\$360
Finger, one	\$180
Additional	\$120
Hip	\$720
Knee	\$720
Mandible	\$180
Metacarpal bone, one	\$180
Additional	\$120
Metatarsal bone, one	\$240
Additional	\$120
Patella	\$240
Rib	\$180
Shoulder	\$480
Tarsal bone, one	\$420
Additional	\$180
Thumb	\$180
Toe, one	\$180
Additional	\$120
Vertebra, one or more	\$1,440

SECTION 3
BENEFIT PROVISION (continued)

SCHEDULE OF SURGICAL INDEMNITY BENEFITS

Procedure	Surgical Indemnity Benefit
6. SIMPLE FRACTURES	
Lower jaw	\$480
Carpal bone, one	\$480
Each additional	\$240
Clavicle	\$480
Coccyx	\$180
Femur	\$1,440
Tibia or fibula or both	\$960
Pott's or Cotton's fracture	\$960
Finger, one simple	\$180
Each additional	\$120
Extension with traction	\$360
Additional	\$180
Humerus	\$720
Metacarpal bone, one	\$240
Each additional	\$180
Metatarsal bone, one	\$360
Each additional	\$180
Patella, closed	\$480
Nasal bone or bones, reduced	\$480
Pelvis	\$960
Radius or ulna, or both	\$480
Rib, one or more	\$240
Sacrum	\$360
Skull	\$480
Sternum	\$360
Tarsal bone, one (exclude os calsis and astragalus)	\$480
Each additional	\$180
Toe, one	\$180
Each additional	\$120
Vertebra, one or more	\$1,440
Oscalsis or astragalus, or both	\$960
7. COMPOUND FRACTURES	Two time Simple Fracture Payment, not to exceed \$1,500.00

SECTION 3
BENEFIT PROVISION (continued)

SCHEDULE OF SURGICAL INDEMNITY BENEFITS

Procedure	Surgical Indemnity Benefit
8. SKULL	
Simple fracture (non-operable) with brain injury	\$540
Depressed	\$1,260
Compound	\$900
Brain Tumors	\$1,800
9. INFECTIONS AND TRAUMATA	
Abcess incision and drainage	\$60
Deep cervical abcess	\$240
Carbuncle	\$240
Ulcer, surface, excision	\$240
Tendon, repair, one	\$240
Each additional	\$120
Septic finger (tendon sheath involvement)	\$240
Septic hand (tendon sheath and compartment)	\$360
Lacerations, extensive	\$240
Lacerations, minor	\$120
10. CYSTS	
Removal of Sebaceous Cyst	\$180
Additional removals	\$60
Removal of ganglion cyst	\$180
Pilonidal cyst or sinus	\$720
Thyroglossal cyst, removal	\$960
Branchial cyst, removal	\$1,140
11 TUMORS	
Tumors, benign external removal	\$180
Additional removals	\$60
Tumors, benign, removal	\$240
Parotid tumor, removal	\$960
Epithelioma of face, surgical removal	\$180
Cancer of tongue (resection or removal)	\$720
Cancer of lip (local operation)	\$1,380
Same with neck dissection	\$1,020
12. BIOPSY	
Biopsy, superficial	\$120
Biopsy, bone, or bone marrow	\$144

SECTION 3
BENEFIT PROVISION (continued)

SCHEDULE OF SURGICAL INDEMNITY BENEFITS

Procedure	Surgical Indemnity Benefit
13. GLANDS	
Glands, superficial, removal	\$240
Dissection glands	\$960
Radical axilla or groin	\$960
14. THYROID	
Thyroidectomy	\$1,200
Thyroidectomy, two-stage, subtotal (with or without ligation) complete procedure	\$1,440
Parathyroidectomy	\$1,440
15. OBSTETRICS	
Pregnancy, deliver (does not include prenatal and postnatal care)	\$540
Miscarriage (curretage)	\$360
Caesarean section, vaginal	\$1,200
Caesarean section, abdominal	\$960
Pregnancy, ectopic	\$960
16. PROCTOLOGY	
Hemorrhoids, injections, each	\$60
Maximum	\$480
Hemorrhoids, external, single incision	\$120
Hemorrhoids, thrombosis, incision	\$120
Complete Hemorrhoidectomy	\$720
Fistulectomy, single, excision of tract	\$720
Multiple	\$780
Fissurectomy	
Office	\$240
Hospital	\$480
Polypectomy	\$240
Abscess, ischio-rectal or peri-rectal drainage	\$240
Carcinoma of rectum resection	\$1,620
Prolapsed rectum, repair or injection	\$960

SECTION 3
BENEFIT PROVISION (continued)

SCHEDULE OF SURGICAL INDEMNITY BENEFITS

Procedure	Surgical Indemnity Benefit
17. UROLOGY	
Circumcision, infant not requiring anesthesia	\$120
Circumcision, excepting the above	\$60
Ureterotomy	\$1,200
Prostatic abscess	\$360
Prostatectomy, perineal	\$1,440
Radical	\$1,800
Prostatectomy suprapubic - one side, including vasectomy	\$1,440
Prostatectomy suprapubic - two stage, including vasectomy	\$1,440
Prostatectomy, transurethral	\$1,440
Punch operation with suprapubic drainage	\$960
Perincoplasty with urethral repair	\$1,440
Hydrocele, radical operation	\$720
Litholapaxy	\$720
Epididymectomy	\$480
Vasectomy (when not preliminary to prostatectomy)	\$240
18. GYNECOLOGY	
Bartholin's gland, incision	\$120
Bartholin's gland, excision	\$360
Atresia of vagina, plastic	\$1,800
Fistula recto-vaginal	\$1,440
Fistula vesico-vaginal	\$1,440
Cul-de-sac, drainage	\$240
Cauterization, electric	\$240
Dilation and curettage with or without cauterization	\$240
Uterine polyp removal with dilation and curettage	\$240
Cervical polyp removal	\$120
Trachelorrhaphy	\$360
Cervix amputation	\$480
Oophorectomy or resection of ovaries	\$960
Hysterectomy (subtotal)	\$960
Hysterectomy (total)	\$1,440
Myomectomy	\$960
Uterine flexions, etc, correction (plus surgery of tubes and ovaries)	\$960
With vaginal plastic work	\$1,440
Salpingectomy	\$960
Tubal ligation (independent procedure)	\$720
Salpingo-oophorectomy	\$960
Cystocele	\$480
Rectocele	\$480
Combined cystocele and rectocele	\$960
Vulvectomy	\$960
With groin dissection	\$1,680

SECTION 3
BENEFIT PROVISION (continued)

SCHEDULE OF SURGICAL INDEMNITY BENEFITS

Procedure	Surgical Indemnity Benefit
19. PRELIMINARY ENDOSCOPY (Examination by Endoscope)	
Bronchoscopy, diagnostic, preceding surgery	\$240
Operative	\$360
Cystoscopy	\$360
Observation (preceding surgery)	\$240
Ureteral catheterization	\$240
Operative	\$360
Gastrosocopy	\$240
Operative	\$360
Laryngoscopy	
Diagnosis (by laryngoscope)	\$120
Operative	\$480
Sigmoidoscopy and biopsy	\$120
Esophagoscopy	\$240
Vesiculectomy	\$1,200
Varicocelectomy	\$480
Orchidectomy, simple	\$480
Bilateral	\$720
With gland dissection	\$1,440
Cystotomy or cystostomy	\$960
Cystostomy with fulguration	\$960
Cystectomy	\$1,800
Ureter transplantation, single	\$1,200
Bilateral	\$1,800
Bladder tumor, diverticula, etc (resection) open operation	\$1,200
Urethero-lithotomy	\$1,200
Nephrotomy	\$1,200
Nephrostomy	\$1,200
Nephrectomy	\$1,440
Nephropexy	\$960
Plastic on pelvis and ureter	\$1,440
Heminephrectomy	\$1,440
Excision and suture or urinary fistula-suprapubic	\$480
Vaginal	\$960
Penis amputation	\$960
With groin dissection	\$1,680
Plastic hypospadias or epispadias	\$1,800
Meatotomy	\$120
Caruncle excision	\$240
Caruncle fulguration	\$240

SECTION 3
BENEFIT PROVISION (continued)

Procedure	Surgical Indemnity Benefit
20. THORACIC SURGERY	
Pneumolysis	\$1,200
Pleura, paracentesis	\$120
Empyema, closed drainage	\$480
Empyema, rib section	\$960
Phrenic nerve crushing	\$720
Thoracoplasty (First state or partial)	\$840
Complete	\$1,800
Lobectomy	\$1,800
Induction of artificial pneumothorax	\$120
Refills	\$60
21. OTOLOGY (Science of the Ear)	
Aural polyp	\$240
Paracentesis, tympani	\$120
Mastoidectomy, acute single	\$960
Mastoidectomy, acute bilateral	\$1,440
Mastoidectomy, radical single	\$1,140
Myringotomy	\$120
Fenestration for otosclerosis	\$1,800
22. NOSE AND THROAT	
Nasal polyps, removal	\$120
Antrum, Caldwell-Luc	\$720
Ethmoidectomy	\$480
Frontal sinus, radical	\$960
Turbineotomy	\$180
Submucous resection	\$720
Palatorrhaphy	\$1,200
Tonsillectomy and adenoidectomy	
Under age 15	\$360
Age 15 and over	\$480
Laryngectomy	\$1,440
Tracheotomy	\$720
Malignant disease, accessory sinuses	
Radical operation, one sinus	\$1,620
Multiple	\$1,620
Malignant disease, tonsil and pharynx	
Radical operation	\$1,800
Antrum puncture and irrigation	\$120
Antrum window	\$240

SECTION 3
BENEFIT PROVISION (continued)

SCHEDULE OF SURGICAL INDEMNITY BENEFITS

Procedure	Surgical Indemnity Benefit
23. BREASTS	
Breast abscess	\$240
Breast cyst or abscess, aspiration	\$60
Breast tumor or benign, removal	\$480
Breast, radical removal, including auxiliary dissection	\$1,680
Breast, simple removal	\$840
24. OPERABLE BRAIN INJURIES	
Extradural hematoma	\$1,260
Subdural hematoma	\$1,260
Exploratory trephination,	
One side	\$540
Two sides	\$780
Intracortical clot	\$1,800
Arterio-venous fistula, intracranial	\$1,800

3.02 If an Insured is not on Active Service on the date a change in benefits takes effect, such change, with respect to that Insured, will be deferred until the first of the month following the date of return to Active Service.

If a Dependent is Totally Disabled on a date a change in benefits takes effect, such change, with respect to that Dependent, will be deferred until the date of cessation of such disability.

3.03 A charge is incurred on the date that treatment is given, service is rendered or a supply is furnished.

SECTION 4
EXCLUSIONS AND LIMITATIONS

4.01 With respect to all of the benefits provided under the Policy, no benefits will be payable as the result of:

- (a) suicide or any attempt thereat, while sane or insane. (If any Covered Person, sane or insane, should die by suicide within two years (one year in Colorado and North Dakota) of his or her Effective Date of coverage, Life Insurance benefits will not be payable; (In Missouri, the reference to insanity does not apply and suicide is no defense to payment under this Policy where the Covered Person is a Missouri citizen unless the Company can show that the Covered Person intended suicide when he or she applied for coverage, regardless of any language to the contrary in the Policy.)
- (b) any intentionally self-inflicted injury or Sickness;
- (c) rest care or rehabilitative care and treatment;
- (d) cosmetic surgery or care or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to cosmetic surgery resulting from a covered Accident if initial treatment of the Covered Person is begun within 12 months of the date of the Accident;
- (e) routine newborn care, including routine nursery charges;
- (f) voluntary abortion, except with respect to the Insured or covered Dependent spouse:
 - (1) where such person's life would be endangered if the fetus were carried to term; or
 - (2) where medical complications have arisen from an abortion;
- (g) pregnancy of a Dependent child, unless required by law;
- (h) the treatment of:
 - (1) mental illness;
 - (2) functional or organic nervous disorder, regardless of cause;
 - (3) alcohol abuse;
 - (4) drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed, for more than 10 days in any Calendar Year, with respect to payment of the Daily In-Hospital Indemnity Benefit;
- (i) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority;
- (j) committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation;
- (k) participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee-jumping, or hang gliding;
- (l) air travel, except:
 - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
 - (2) as a passenger for transportation only and not as a pilot or crew member;
- (m) any Accident occurring as a result of the Covered Person being intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the state where the Accident took place);
- (n) sex changes;
- (o) experimental treatments or surgery;
- (p) the reversal of tubal ligation and vasectomies;
- (q) artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications, or Physician's services, unless required by law;
- (r) treatment of exogenous obesity or weight control;
- (s) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. The Company will refund the pro rata unearned premium for any such period the Covered Person is not covered;
- (t) accident or sickness arising out of and in the course of any occupation for compensation, wage or profit. Expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits have been made;
- (u) for loss incurred, care or treatment received, or hospital confinement occurring outside of the United States or its possessions (except with approval from Companion Life).

SECTION 4
EXCLUSIONS AND LIMITATIONS (continued)

4.01 In addition to the Exclusions and Limitations for all coverages, the following are not covered under the Outpatient Physician Office Visit Indemnity Benefit and the Outpatient Diagnostic X-Ray and Laboratory Indemnity Benefit:

- (a) visits made, examinations given, or x-rays or laboratory tests performed as an in-patient while Confined to a Hospital;
- (b) routine eye examinations or fitting of glasses;
- (c) fitting of hearing aids;
- (d) dental examinations or dental care other than expenses resulting from accidental injury; and
- (e) benefits which are provided under any other part of the Policy.

4.02 In addition to the Exclusions and Limitations for all coverages, the following are not covered under the Outpatient Prescription Drug Indemnity Benefit, if applicable:

- (a) drugs and medicines which may be lawfully obtained without a Physician's prescription; except insulin;
- (b) therapeutic devices or appliances. This includes hypodermic needles, syringes, support garments and other non-medical items;
- (c) drugs labeled "Caution – limited by federal law to investigational use" or experimental drugs;
- (d) drugs, medicines or insulin, in whole or in part, used by or administered to a Covered Person while Confined in a Hospital, rest home, sanatorium, extended care facility, convalescent hospital, nursing home or similar institution;
- (e) immunization agents, biological sera, blood or blood plasma; or
- (f) infertility medication, or abortifacients or any other drug or device that terminates a pregnancy.

**SECTION 5
TERMINATION OF INSURANCE**

- 5.01** The insurance on an Insured will cease on the earliest of:
- (a) the last day of the payroll deduction period during which the Insured ceases to be a member of a class eligible for coverage as shown in the Schedule;
 - (b) the end of the last period for which premium payment has been made to the Company;
 - (c) the date the Policy terminates;
 - (d) the last day of the payroll deduction period during which the Insured is retired or pensioned;
 - (e) with respect to those Insureds working for employers with less than 20 employees on a typical work day in the preceding Calendar Year, the last day of the payroll deduction period during which the Insured attains age 70; or
 - (f) the last day of the payroll deduction period during which the Insured terminates employment.

- 5.02** The insurance on a Dependent will cease on the earliest of:
- (a) the date the Insured's coverage terminates;
 - (b) the end of the last period for which premium payment has been made to the Company;
 - (c) the date the Dependent no longer meets the definition of Dependent, as defined in the Policy; or
 - (d) the date the Policy is modified so as to exclude Dependent coverage.

5.03 The Company shall have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

5.04 TERMINATION OF POLICY AND PARTICIPATION THEREUNDER: The Policy may be terminated as described below.

The Employer may terminate coverage under the Policy by giving written notice to the Company. Termination will be effective on the latter of:

- (a) the date we receive the notice; or
- (b) the requested termination date.

After the first anniversary date of the Policy, the Company may terminate any or all of the insurance under the Policy, as of any premium due date, by giving written notice to the Policyholder at least 60 days prior to the termination date.

5.05 EXTENSION OF BENEFITS: (For other than Life and Accidental Death & Dismemberment coverage): If a Covered Person is totally disabled at the time insurance ends, coverage for the disabled person will continue during such Total Disability, but only for the Accident or Sickness causing the Total Disability. This extension of benefits will end on the earliest of the following:

1. The date on which such person ceases to be Totally Disabled.
2. On the later of:
 - a) the day after the disabled person is no longer Hospital confined if he was confined when coverage would otherwise terminate; or
 - b) Ninety (90) days from the date coverage would otherwise terminate.
3. The date the Insured acquires coverage under a replacement plan which provides similar benefits, but only if the plan covers the Accident or Sickness causing the Total Disability without limitation due to the Accident or Sickness having commenced prior to the effective date of the replacement coverage.

5.06 CONTINUATION OF COVERAGE DURING A STRIKE OR LOCKOUT: If the Insured ceases to work because of a strike or lockout and the Employer is paying all or a portion of the premium for the Insured's medical coverage pursuant to the terms of a collective bargaining agreement, the Insured may continue his or her medical coverage subject to the following terms and conditions:

SECTION 5
TERMINATION OF INSURANCE (continued)

- A. Continuation of coverage is contingent on:
1. the Insured's payment to the employer which represents the employees, of the monthly premium required for this coverage;
 2. the employer collects such payments from at least 75% of the persons who cease to work because of the strike or lockout; and
 3. the timely payment of premiums to the Company by the employer as required under the group plan for proper payments of premiums.
- B. If any premium is unpaid on the date work ceases, there will be no continuation unless such premium is paid by the Employer prior to the next premium due date.
- C. The amount of the Insured's monthly payment for continued coverage will be equal to the full group monthly cost for the coverage, including any portion usually paid by the Employer and, except as provided in item D below, such premium rate will be the applicable rate then in effect for coverage under the group plan on the date work ceases.
- D. The premium rates for the group plan will be automatically increased by 20% on the premium due date on or next after the date work ceases due to the strike or lockout. Such increase will apply during the time coverage is continued under this special provision. The Company maintains the right to increase the premium rates before, during and after the date work ceases if, in fact, the Company would have had the right to increase rates under the Policy if work had not ceased.
- E. The Insured's coverage under the special provisions will cease on the earliest of:
1. the end of the period of time for which the employer has made payment for the Insured's coverage, if the next payment due is not made;
 2. the premium due date for which monthly premium payments for continued coverage are received from less than 75% of the persons who are not working because of the strike or lockout;
 3. the premium due date on or next after the date the Insured begins full-time work as an employee of an employer other than the Employer for whom the Insured ceased to work because of the strike or lockout;
 4. the premium due date on or next after the end of the 6-month period from the date the Insured ceased to work because of the strike or lockout; or
 5. the premium due date on or next after the date the strike or lockout ends.
- F. If an Insured has Dependents insured on the date the Insured ceased to work, in order for the Insured to continue his or her coverage, the Insured must also continue coverage for his or her Dependents by including the monthly cost for Dependents coverage with his or her monthly payment for continued coverage.
- G. Coverage will not be continued for any persons unless the entity or entities responsible for collection of the premium payments for the person for whom coverage is to continue agrees to keep adequate books and records and agrees to furnish the Company all needed information and certifications to allow the Company to properly pay claims. If the Company receives moneys for any period for which the Company is not obligated to continue coverage, such amount received will be returned to the entity from which the Company received such moneys, for refund to the persons from which they were collected. The Company shall have no responsibility to see that the money is properly refunded.

SECTION 6
PREMIUMS

6.01 All premiums are payable on or before the date they are due. Premiums are payable by a mode of payment that has been agreed upon between the Employer and the Company.

6.02 The premium rates may be changed by the Company. If the rates are changed, the Company will give at least 31 days advance written notice. If an increase takes place on other than a premium due date, they will be due on the date of the increase to the next premium due date. If such premium is not paid when due, the coverage will automatically be discontinued as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

6.03 If a change in benefits increases the Company's liability, premium rates may be changed on the date that the liability is increased.

**SECTION 7
GENERAL PROVISIONS**

7.01 ENTIRE CONTRACT-CHANGES: The entire contract shall include:

- (a) the Policy;
- (b) the application of the Policyholder;
- (c) the Insured's application, if any, attached to the Certificate; and
- (d) all endorsements and amendments.

Statements made by the Policyholder or the Insured are representations and not warranties, if fraud was not intended. (The words "if fraud was not intended" do not apply in Georgia or North Carolina.) No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Policy unless:

- (a) the statement is in writing; and
- (b) a copy of that statement is given to the Insured or his or her beneficiary.

The terms of the Policy can be changed only by endorsement or amendment signed by the President or Secretary of the Company. No agent may change the Policy or waive its provisions.

7.02 TIME LIMIT ON CERTAIN DEFENSES: The validity of the Policy cannot be contested after two years from its date of issue, except for nonpayment of premiums. After coverage for a Covered Person has been in force for two years, the Company cannot:

- (a) void the coverage; or
- (b) deny a claim for loss that starts after the two-year period, because of statements in the application unless they were fraudulent misstatements.

7.03 GRACE PERIOD: A grace period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy will terminate at the end of the grace period if the premium has not been paid. The Policyholder must still pay all unpaid premium due for the grace period.

The Policyholder may, by writing to the Company, cancel the coverage under the Policy:

- (a) on any future premium due date; or
- (b) on any date during the grace period.

If coverage is cancelled on a premium due date, the grace period will not apply. If cancellation is during the grace period, the Policyholder will be liable for any unpaid premium including the pro rata premium for that part of the grace period coverage was in force.

7.04 NOTICE OF CLAIM: Written notice of claim must be given to the Company at our home office, or to any third party administrator authorized by the Company. Such notice should be made within 30 days after any loss covered by the Policy (60 days in Kentucky, six months in Montana). If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay.

7.05 CLAIM FORMS: Claim forms should be used for filing proof of loss. They will be sent to the claimant within 15 days of receipt of notice of claim. If claim forms are not supplied within 15 days, a claimant can give proof as follows:

- (a) in writing;
- (b) setting forth the nature and extent of the loss; and
- (c) within the time stated in the Proof of Loss provision.

(If the Insured resides in Georgia, the reference to 15 days is changed to 10 working days.)

SECTION 7
GENERAL PROVISIONS (continued)

7.06 PROOF OF LOSS: Proof of loss for which the Policy provides any periodic payment contingent upon continuing loss must be given to the Company within 90 days after termination of the period for which the Company is liable. For any other loss, proof of loss must be given to the Company within 90 days after such loss. Late proof may be accepted if:

- (a) it was not reasonably possible to give proof in that time; and
- (b) the proof is given within one year from the date proof of loss was otherwise required. This one year limit will not apply in the absence of legal capacity.

7.07 TIME OF PAYMENT OF CLAIMS: All accrued benefits for loss for which the Policy provides periodic payment will be paid each month, subject to written proof of loss. Any balance not paid when liability ends will be paid immediately upon receipt of written proof. Benefits for any other covered loss will be paid as soon as the Company receives written proof of such loss.

7.08 PAYMENT OF BENEFITS: Health Indemnity Benefits may be assigned to the provider(s) of such benefits. Otherwise, all benefits payable under the Policy will be paid to the Insured. Accrued benefits that are not paid at the Insured's death will be paid to his or her beneficiary or estate. If a benefit is to be paid to the Insured's estate, or to an Insured or beneficiary who is not competent to give a valid release, the Company may pay up to \$1,000.00 of such benefit to one of the Insured's relatives who is deemed by the Company to be justly entitled to it. Such payment, made in good faith, fully discharges the Company to the extent of the payment.

Payment to the Texas Department of Human Services. All benefits paid on behalf of the child or children under the Policy must be paid to the Texas Department of Human Services whenever: (1) the Texas Department of Human Services is paying benefits under the Human Resources Code, Chapter 31, or Chapter 32, i.e., financial and medical assistance service programs administered pursuant to the Human Resources Code; and (2) the parent who is covered by the Policy has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support. The Company must receive at the Company's home office written notice affixed to the insurance claim when the claim is first submitted stating that all benefits paid must be paid directly to the Texas Department of Human Services.

Payment to the Texas Department of Human Resources. Benefits will not be reduced or denied because such benefits are covered by the Medical Assistance Act of 1967, as amended. Benefits will be paid to the Texas Department of Human Resources for the actual cost of medical expenses it pays through medical assistance for a person insured by the Policy, if the Insured would otherwise be entitled to payment of benefits for such medical expenses. Benefits so paid, in no event, will exceed benefits otherwise payable under the Policy. Any benefits payable for expenses not paid by such Department will be paid as provided in the Policy.

Payment to Possessory or Managing Conservator of Dependent Child. For a minor child who otherwise qualifies as a dependent of the Insured, benefits may be paid on behalf of the child to a person who is not the Insured if an order issued by a court of competent jurisdiction in this or any other state names such person the possessory or managing conservator of the child.

To be entitled to receive benefits, a possessory or managing conservator of a Child must submit to the Company with the claim form, written notice that such person is the possessory or managing conservator of the Child on whose behalf the claim is made and submit a certified copy of a court order establishing the person as the possessory or managing conservator. This will not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised or to claims submitted by the Insured where the Insured had paid any portion of a medical bill that would be covered under the terms of the Policy.

SECTION 7
GENERAL PROVISIONS (continued)

7.09 PHYSICAL EXAMINATION: The Company has the right to have a Covered Person examined by a Physician of its choice as often as reasonably necessary while a claim is pending. The Company will pay for such examination. In case of death, the Company may request an autopsy where it is not forbidden by law.

- 7.10 LEGAL ACTIONS:** No legal action may be brought to recover under the Policy:
- (a) within 60 days after written proof of loss has been furnished as required; or
 - (b) more than three years (five years in Kansas, six years in South Carolina and the applicable statute of limitations in Florida) from the time written proof of loss is required to be furnished.

7.11 CONFORMITY WITH STATE LAWS: A provision of the Policy that, on the Effective Date, conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law as of the Effective Date.

7.12 MISSTATEMENT OF AGE: If the age of any Covered Person is incorrectly stated, the amount of benefits payable will be the amount shown on the Schedule. The premium will be adjusted so that the Company will be paid any amount due based on such Covered Person's true age.

7.13 NEW INSUREDS: To the group or class originally insured, there will be added from time to time all persons eligible and applying for insurance in such group or class.

7.14 CERTIFICATES: The Company will supply individual Certificates for each Insured. This Certificate will describe:

- (a) the insurance benefits;
- (b) to whom benefits will be paid;
- (c) any limitations of the Policy; and
- (d) all other essential features of the Policy.

If more than one Certificate is issued under the Policy to an Insured, only the last one issued will be in effect.

7.15 REPLACEMENT PROVISIONS APPLICABLE TO MEDICAL BENEFITS:

- (a) Definitions – As used in this Provision:
 - 1. *“The Policy”* means the group insurance policy which includes these provisions that apply to medical benefits payable to replace similar medical benefits discontinued under the Replaced Policy on the day immediately prior to the Replacement Date.
 - 2. *“Replaced Policy,”* as used herein, means: (a) a group medical insurance policy (other than a “salary budget” plan utilizing individual insurance policies); or (b) a group medical subscriber contract (other than a “salary budget” plan utilizing individual subscriber contracts) which was discontinued in its entirety.
 - 3. *“Replacement Date,”* as used herein, means the date on which the Policy replaces the medical coverage discontinued under the Replaced Policy.
 - 4. *“Person”* means an Insured or a Dependent.
- (b) Replacement Provisions
 - 1. Each Person who meets the eligibility requirements for coverage under the Policy on the Replacement Date shall become covered under the Policy on the Replacement Date and shall remain covered subject to payment of the required premium. If a Person does not meet those eligibility requirements on the Replacement Date, the Person's effective date of coverage under the Policy shall be deferred until the date the Person meets those requirements.

SECTION 7
GENERAL PROVISIONS (continued)

2. If a Person does not meet the eligibility requirements for coverage under the Policy on the Replacement Date, the level of medical benefits to be provided by the Company, (subject to payment of the required premium) shall be the level of medical benefits provided to the Person under the Replaced Policy reduced by any medical benefits payable by the Replaced Policy. These medical benefits shall be provided to such Person until the earliest of the following dates:
 - a) The date the Person meets the eligibility requirements and qualifies for coverage under the Policy;
 - b) The date the Person's medical coverage under the Policy would terminate in accordance with the termination of insurance provisions; or
 - c) The date the extension of benefits period terminates for a Person who became Totally Disabled while covered under the Replaced Policy and continues to be Totally Disabled on the Replacement Date regardless of whether the Replaced Policy was required to provide that extension of benefits. However, medical benefits provided under the Policy in accordance herewith shall not be payable for any condition which caused the Total Disability of the Person.
3. The level of medical coverage benefits applicable to the Pre-Existing Condition Limitation under the Policy for a Person who is subject to such limitation, shall be the lesser of:
 - a) The medical coverage benefits under the Policy without application of such limitation; and
 - b) The medical coverage benefits or services under the Replaced Policy.
4. If a Person has satisfied any benefit waiting period(s) (probationary periods) under the Replaced Policy, that Person shall be given credit for the satisfaction, or partial satisfaction, of the same or similar benefit waiting period (probationary) provisions under the Policy.

COMPANION LIFE INSURANCE COMPANY
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Effective Date: The Effective Date of the Insured will be the first day after the Normal Pay Date for which the first payroll deduction is taken for this coverage. (if different from Certificate)

SUPPLEMENTAL ACCIDENT BENEFIT

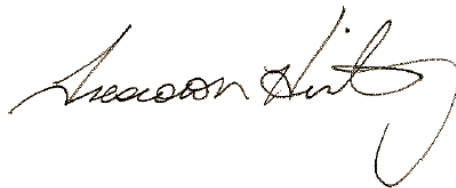
The Policy to which this Rider is attached is hereby amended as follows:

If a Covered Person has an Accident while Insured under the Policy, a Supplemental Accident Benefit will be provided if:

- (a) the Accident resulted in injury to that person; and
- (b) the charges are:
 - (1) incurred during the 90-day period after the date of the Accident; and
 - (2) not excluded under the terms of the Policy; and
 - (3) not reimbursed in full under any other provision(s) of the Policy.

After any and all other benefits are payable under the Policy, the Company will pay the remaining actual expense incurred, if any, for the necessary care and treatment of the Injury. The maximum amount payable will not exceed the amount shown in the Schedule of Benefits.

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached.



President

COMPANION LIFE INSURANCE COMPANY
Columbia, South Carolina 29223

Effective Date: The Effective Date of the Insured will be the first day after the Normal Pay Date for which the first payroll deduction is taken for this coverage. (if different from Certificate)

PREVENTIVE CARE INDEMNITY BENEFIT

The Policy/Certificate to which this Rider is attached is hereby amended as follows:

Subject to the terms of the Policy/Certificate, a Preventive Care Indemnity Benefit will be paid for a Covered Person as described below:

- A. The Company will pay the indemnity benefit shown in the Schedule of Benefits for an annual physical examination for the Insured and his covered Dependents up to the Policy Year maximum shown on the Schedule of Benefits. These services will only be covered to the extent that the services are provided by, or under the supervision of, a single Physician during the course of one (1) visit. Services include:
1. A history;
 2. Physical Examination;
 3. X-rays;
 4. Laboratory services including, but not limited to, a Pap test, colorectal screening and prostate cancer screening.
- B. The Company will pay the indemnity benefit shown in the Schedule of Benefits for a low-dose screening mammogram for any nonsymptomatic woman covered under the Policy/Certificate with the following frequency.
1. One (1) baseline mammogram for women aged thirty-five (35) through thirty-nine (39);
 2. One (1) every two (2) years for women aged forty (40) through forty-nine (49); and
 3. One (1) annually for women age fifty (50) AND OVER.
- C. The Company will pay the indemnity benefit shown in the Schedule of Benefits for well child care from the moment of birth to Age six (6) years. [Benefits will be limited to one (1) Physician's visit at the following specified age intervals: 1 visit at age 30 days to 1 year, and annually thereafter, up to Age 6.]
Covered well child care is the periodic review of a child's physical and emotional status. This periodic review will only be covered to the extent that the services are provided by, or under the supervision of, a single Physician during the course of one (1) visit. A review shall include:
1. A history;
 2. Complete physical examination;
 3. Developmental assessment;
 4. Anticipatory guidance;
 5. Appropriate immunizations;
 6. Laboratory tests; and
 7. Hearing and vision screening;
- In keeping with prevailing medical standards.

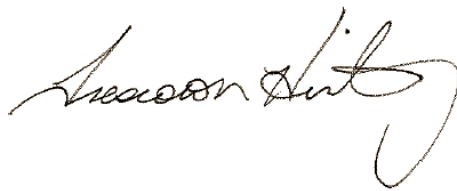
Such services must be provided within one (1) month prior to or after reaching each Age without benefit or carrying over any visitations. In the event an appropriate immunization, lab test or portion of

an examination cannot be performed at a particular Age, such service shall be deemed to be covered upon the next scheduled visit.

If a benefit is already shown for one of the above-described benefits, the benefit terms of the Policy/Certificate will control to the extent the terms are not consistent with the above described benefit.

The benefits described above will be paid directly to the provider of services. To authorize the benefit payment to the Covered Person, the Insured must make the proper authorization on the medical claim form.

This Rider only applies if it is elected and the required premiums are paid. This Rider is subject to all of the provisions of the Policy/Certificate as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy/Certificate to which it is attached.



President

COMPANION LIFE INSURANCE COMPANY
Columbia, South Carolina 29223

Effective Date: The Effective Date of the Insured will be the first day after the Normal Pay Date for which the first payroll deduction is taken for this coverage. (if different from Certificate)

HOSPITAL INTENSIVE CARE UNIT CONFINEMENT

The Policy/Certificate to which this Rider is attached is hereby amended to include a new benefit as follows:

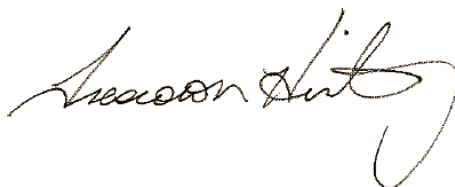
Hospital Intensive Care Unit Confinement

If a Covered Person, while insured, is confined in a Hospital Intensive Care Unit, the Company will pay the Intensive Care benefit amount up to \$250 per day, limited to the first 30 days of confinement. If the covered person is confined in a Hospital Intensive Care Unit and is confined to a hospital intensive care unit again within 90 days for the same or related condition, it will be treated as a continuation of the prior confinement. If more than 90 days have passed between the periods of confinement in a Hospital Intensive Care Unit, it will be treated as a new confinement. The Hospital Intensive Care Unit Confinement and Hospital Confinement benefit will not be paid concurrently.

For purposes of this Rider, Hospital Intensive Care Unit means a place which is a specifically designated area of the hospital called an intensive care unit that provides the highest level of medical care; is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care; is separate and apart from the surgical recovery and from rooms, beds and wards customarily used for patient confinement; is permanently equipped with special lifesaving equipment for the care of the critically ill or injured; and is under and has a physician assigned to the Hospital Intensive Care unit on a full time basis.

A Hospital Intensive Care Unit is not any of the following step down units: a progressive care unit; a private monitored room; sub-acute intensive care unit; an observation unit; or any facility not meeting the definition of a Hospital Intensive Care Unit as defined in this policy.

This Rider only applies if it is elected and the required premiums are paid. This Rider is subject to all of the provisions of the Policy/Certificate as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy/Certificate to which it is attached.



President