TRANSAMERICA FINANCIAL LIFE INSURANCE COMPANY

Home Office: 440 Mamaroneck Avenue, Harrison, New York 10528
Administrative Office: 520 Park Avenue, Baltimore, Maryland 21201

CERTIFICATE OF INSURANCE

Policyholder: **American Military Insurance Trust**
Policy Number: **MZ0925772H0001A**

Transamerica Financial Life Insurance Company (we, us, our) has issued a Policy to the Policyholder (our name, the Policyholder name and the Policy Number are shown above). The provisions of the Policy which are important to you are summarized in this Certificate; consisting of this form, the Schedule with the most recent effective date, and any additional forms which may have been made a part of this Certificate. This Certificate replaces any certificates which may have been given to you earlier for the Policy. The Policy alone is the only contract under which payment will be made. Any difference between the Policy and this Certificate will be settled according to the provisions of the Policy. The Policy may be inspected at the office of the Policyholder.

Craig D. Vermie
Secretary

Peter G. Kinkel
President

30 DAY FREE LOOK

You have the right to examine your Certificate. If you are not satisfied, you may return it to us within 30 days of your effective date. In that event, we will consider it void from the Certificate Effective Date and any premium paid will be refunded. Any claims paid under the Policy during the initial 30 day period will be deducted from the refund.

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GROUP TRICARE SUPPLEMENT COVERAGE

GENERAL DEFINITIONS

Active Duty means active duty in a Uniformed Service of the United States for more than 30 days.

Active Duty Member means a member of the Organization who is on Active Duty.

Age means the age a Covered Person has attained on any Premium Due Date.

CHAMPUS means: (a) the Military Medical Benefits Amendments of 1966 (Public Law 89-614); or (b) Section 613 of the Veterans Health Care Expansion Act of 1973 (Public Law 93-89), also known as CHAMPVA; as amended. CHAMPUS is an acronym for the Civilian Health and Medical Program of the Uniformed Services.

Civilian Hospital means any Hospital, as defined, other than a Government Hospital.

Confined or **Confinement** means being an Inpatient in a Hospital or Skilled Nursing Facility due to Sickness or Injury.

Cost Share Amount means the amount the Covered Person is required to pay for services received from a TRICARE provider whether expressed as a cost share amount or copayment fee, or as a coinsurance percentage of the contracted fee for the service.

Covered Expense means the reasonable expense incurred by a Covered Person for needed medical or surgical treatment, services or supplies. The expense must be: (a) incurred for the sole purpose of treating the Covered Person's Injury or Sickness; (b) prescribed by the Covered Person's attending physician, except for routine nursing services; and (c) incurred while the Covered Person is an Inpatient in the Hospital to be covered under an Inpatient Benefit; or (d) incurred while the Covered Person is not confined as an Inpatient in a Hospital to be covered under an Outpatient Benefit. In addition, the expense must be incurred: (a) by the Covered Person while the Covered Person is covered under such benefit; (b) for a Confinement, service, or supply that is covered under TRICARE.

Covered Expense in Excess of the TRICARE Allowed Amount means the difference between the TRICARE Allowed Amount for an expense and the actual charge, but only if: (a) the Allowed portion is a Covered Expense under such benefit; and (b) the non-participating doctor or supplier will not reduce the Covered Person's charge to the Allowed Amount. It does not include any part of a charge that is more than 115% of what TRICARE allows.

Covered Person means you, your Eligible Spouse and your Eligible Child, while such person is covered under the Policy.

Daily Subsistence Charge means the current amount that the Department of Defense determines is applicable to a day of confinement in a Uniformed Services Hospital.

Employer Health Program means a program issued to or sponsored by a Covered Person's employer which provides coverage for basic hospital, medical or surgical expenses incurred as a result of injury or sickness. Such program may be an insurance policy, a hospital or medical service contract, a Blue Cross or Blue Shield contract, a medical practice or other prepayment plan, or a managed care plan.

Fiscal Year means the Federal Government's 12-month accounting period. Currently, that is the period from October 1st of one year to September 30th of the next year.

Government Hospital means a Service Hospital or any other hospital owned by the Federal Government including Veterans Administration Facilities.

Hospital means an institution which TRICARE recognizes as a hospital.

Injury means bodily injury of a Covered Person resulting from an accident.

Inpatient means confinement in a Hospital or Skilled Nursing Facility for which the Covered Person is charged at least one full day's room and board.

Insured Person means you (your or yours), a Member of the Organization named on the Schedule.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Act of 1965, as amended.

Member means you (your or yours), a member of the Organization.

Organization means the Participating Organization named on the Schedule.

Outpatient means a Covered Person's treatment for Injury or Sickness on a day that Covered Person is not Confined.

Outpatient Deductible means the Outpatient deductible as defined and determined by TRICARE.

Period of Confinement means an interval of time during which the Covered Person is an Inpatient in a Hospital or Skilled Nursing Facility. A Period of Confinement: (a) begins on the date the Covered Person is admitted to a Hospital or Skilled Nursing Facility while the Covered Person is covered by the Policy; and (b) ends on the date the Covered Person is discharged from the Hospital or Skilled Nursing Facility.

Physician means a legally qualified physician or surgeon or other practitioner who is recognized by TRICARE.

Plan Administrator means: Association & Society Insurance Corporation, P.O. Box 2510, Rockville, Maryland 20847.

Plan Deductible means: the deductible amount applied to each Covered Person's expenses each Fiscal Year. Once Covered Persons in a family have collectively satisfied the applicable amount, no further deductible amount shall apply for that family for the remainder of the Fiscal Year. The Plan Deductible amount per Covered Person and family is shown on the Schedule. For the purposes of this definition, the term "family" means all members of your immediate family covered under the Policy referred to as Covered Persons. The Plan Deductible may only be satisfied by: (a) with respect to Inpatient charges: any TRICARE Inpatient copayment; and (b) with respect to Outpatient charges: any TRICARE Outpatient copayment charges.

Point-of-Service means TRICARE Prime enrollees have the freedom to receive services without a referral or authorization.

Policyholder means the legal entity in whose name the Policy is issued, as shown on the Schedule.

Request means a written request made on the form we or the Plan Administrator furnish for making the request.

Retiree or Retired Member means a member of the Organization who is retired from Active Duty and is covered by TRICARE.

Service means Uniformed Service of the United States.

Service Disabled Member means a member of the Organization who has a service-related total disability as determined by the Veteran's Administration.

Service Hospital means: (a) a U.S. Military Service hospital; or (b) a U.S. Public Health Service hospital.

Sickness means: (a) a Covered Person's sickness or disease including pregnancy; or (b) Well Baby Care, as defined.

Skilled Nursing Facility means one which: (a) is approved by Medicare or is qualified to receive approval by Medicare if so required; (b) operates pursuant to law; (c) primarily and continuously provides skilled nursing care and related services to persons convalescing from Sickness or Injury on an Inpatient basis for which a charge is made; (d) provides 24-hour-a-day nursing service by or under the supervision of registered nurses (R.N.); (e) provides adequate procedures for the administration of drugs; (f) maintains daily medical records of each patient; and (g) provides each patient with a planned program of medical care and treatment by or under the supervision of a Physician. Skilled Nursing Facility does not mean: (a) a hospital; (b) a place for rest, custodial care, or the aged; or (c) a place for the treatment of mental disease, drug addicts or alcoholics.

Totally Disabled means disabled by an Injury or Sickness that continuously confines the Covered Person: (a) in a Hospital; (b) in a Skilled Nursing Facility; or (c) indoors under the regular care and attendance of a Physician.

Total Disability will not be ended: (a) by going to and from a doctor's office of Hospital for treatment; or (b) by resting out-of-doors at home; if advised to do so by a Physician.

TRICARE means the Department of Defense regional managed care program for members of the uniformed services and their families, and survivors and retired members and their families. TRICARE provides TRICARE beneficiaries three choices for their health care delivery: TRICARE Standard, a fee-for-service option which is the same as the former standard CHAMPUS program; TRICARE Extra, a preferred provider option which offers discounts; and TRICARE PRIME, an enrolled health maintenance organization (HMO) option.

TRICARE Allowed Amount means the amount TRICARE determines is a reasonable charge for a Covered Expense. It may be less than the actual charge. The TRICARE Allowed Amount will not exceed the TRICARE DRG Amount, if the Covered Expenses are subject to the TRICARE DRG.

TRICARE Cap means the amount TRICARE determines is the limit for expenses applied to the TRICARE Outpatient Deductible and TRICARE Covered Expenses subject to coinsurance for all members of a family in a Fiscal Year. After a family has incurred Covered Expenses which meet the TRICARE Cap, TRICARE will increase its rate of payment to 100% of the TRICARE Allowed Amount for all members of such family.

TRICARE Diagnostic Related Group (DRG) means a system adopted by TRICARE establishing a relative value to hospitalizations based on the Covered Person's diagnosis and the customary costs for Inpatient hospital services connected with such diagnosis. The value assigned forms the basis for TRICARE benefit payments for the hospital confinement regardless of actual cost. We will recognize the DRG as the cost of the hospital confinement if TRICARE so recognizes it.

TRICARE Extra means the preferred provider option of TRICARE which offers discounts when a TRICARE beneficiary uses a civilian preferred network provider. TRICARE beneficiaries do not enroll in TRICARE Extra, but may participate in TRICARE Extra on a case-by-case basis.

TRICARE Extra Contracted Fee means the preferred network provider's discounted allowable amount.

TRICARE Per Diem Charge means the fixed daily amount TRICARE uses to determine the Covered Person's cost share for each continuous Confinement in a Civilian Hospital or Skilled Nursing Facility.

TRICARE PRIME means the health maintenance organization (HMO) option of TRICARE which requires enrollment by the TRICARE beneficiary.

TRICARE Standard means the fee-for-service option of TRICARE.

Well Baby Care means expenses incurred during the first 6 years after birth for: (a) newborn examination; (b) PKU tests; (c) newborn circumcision; (d) medical history and physical exams; (e) discussion and counseling by a physician; (f) vision, hearing, and dental screening; (g) developmental appraisal; (h) immunizations; (i) tuberculin tests; and (j) hematocrits or hemoglobin and urinalysis. Well Baby Care does not include the Hospital's charge for nursery care of a well newborn.

INSURED PERSON PERIOD OF COVERAGE

Insured Person's Effective Date: Subject to the Deferred Effective Date provision, you will become covered by the Policy on the Effective Date of the Schedule that first shows coverage for you. Coverage is shown for you by a TRICARE Supplement Plan stated across from "Member" in the Schedule. If no coverage is shown across from "Member", you are not covered under the Policy.

Deferred Effective Date for Insured Person: If on the date you are to become covered under the Policy, you are confined in a Hospital, your coverage will be deferred until the first day after you are discharged.

Request for Change in Insured Person's Coverage: If you Request a change in coverage, the change will become effective on the first day of the month on or after the date we receive the Request, provided the required premium is paid. No change will be made if you are not eligible for the change requested.

Insured Person Termination: Your coverage under the Policy will cease on the first to occur of:

(1) the date the Policy terminates or the date the Organization ceases to be a Participating Organization of the Policyholder;
(2) the date the required premium is not paid, subject to the Grace Period provision;
(3) the first day of the month on or next following the date you cease to be a member of the Organization;
(4) the first day of the month on or next following the date you cease to be eligible for the Plan under which you are covered;
(5) the date we or the Organization cancel coverage for a Class of Eligible Person to which you belong;
(6) the date you attain age 65;
(7) the date you cease to be covered under TRICARE;
(8) the date you become eligible for Medicare unless you reside in an area where Medicare is not available, in which case coverage will not terminate until you return to residency in an area where Medicare is available.

Termination of coverage will be without prejudice to any claim which originated before the effective date of termination.

COVERED DEPENDENT PERIOD OF COVERAGE

Eligible Dependents: Your Eligible Dependents are described below.

Eligible Spouse: "Spouse" means your Spouse who is under age 65 but not a spouse from whom you are legally separated or divorced. "Spouse" also means your widow, widower, or former spouse. Spouses who are not covered by TRICARE are **not** eligible for coverage under the Policy.

Eligible Child: "Child" means your or your Spouse's unmarried child, including a stepchild or legally adopted child. A legitimate child who is covered by TRICARE and: (a) under age 21; or (b) age 21 or over, but under age 23 if enrolled full time in a school of higher learning; is eligible for coverage under the Policy. A child who is not covered by TRICARE is **not** eligible for coverage under the Policy.

No person can be covered as both a Member and a Member's Eligible Spouse, nor can any person be covered as a Dependent Eligible Child of more than one Member.

Covered Dependent Effective Date: Subject to the Deferred Effective Date provision, an Eligible Dependent will become covered by the Policy on the Certificate Effective Date that first shows coverage for the Eligible Dependent. Dependent coverage is shown in the Schedule by a TRICARE Supplement Plan stated across from the Eligible Dependent class. If no coverage is shown across from "Spouse" or "Child(ren)", the Eligible Dependent is not covered under the Policy.

Deferred Effective Date of Dependent: If, on the date that an Eligible Dependent is to become covered under the Policy, the Eligible Dependent is confined in a Hospital, coverage of that Eligible Dependent will be deferred until the first day after that Eligible Dependent is discharged. This provision does not apply to a newborn child.

Request for Change in Dependent's Coverage: If you Request a change in your dependent's coverage, the change will become effective on the first day of the month on or after the date we receive the Request, provided the required premium is paid. No change will be made if your dependent is not eligible for the change requested.

Newborn Child: If a child is born to you or your Covered Spouse, the child will become covered by the Policy from the moment of birth, including an adopted newborn child. The child will be covered for Injury or Sickness (including congenital defects, birth abnormalities and prematurity) under the same plans and benefits that apply: (a) to your other child(ren), if you have other children covered under the Policy; or if not (b) to your Spouse, if your Spouse is covered under the Policy; or if not (c) to you. The child's coverage will cease on the later of: (a) the Premium Due Date next following the child's effective date; or (b) the 31st day next following the child's effective date; unless we receive notice and the required premium to continue the child before that date.

Adopted Child: An adopted child is eligible on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.

Dependent Termination: A dependent's coverage under the Policy will cease on the first to occur of:

(1) the date the Policy terminates or the date the Organization ceases to be a Participating Organization of the Policyholder;
(2) the date the required premium is not paid, subject to the Grace Period provision;
(3) the first day of the month on or next following the date the dependent ceases to be an Eligible Spouse or an Eligible Child;
(4) the first day of the month on or next following the date the dependent ceases to be eligible for the Plan under which the dependent is covered;
(5) the date we or the Organization cancel coverage for a Class of Eligible Person to which the dependent belongs;
(6) the date you cease to be covered, subject to the Covered Dependent Continuation provision (this will not apply to the Spouse or Child of an Active Duty Member or a Service Disabled Member);
(7) the date the dependent becomes eligible for Medicare unless the dependent resides in an area where Medicare is not available, in which case coverage will not terminate until the dependent returns to residency in an area where Medicare is available;
(8) if a child, the date the child attains age 21 or age 23 if the child is enrolled full time at a school of higher learning;
(9) the date a dependent ceases to be covered under TRICARE;
(10) the date a dependent attains age 65.

Termination of coverage will be without prejudice to any claim which originated before the effective date of termination.

Incapacitated Child Continuation: If on the date a child reaches the limiting age for a Dependent Child the child is: (a) covered under the Policy; (b) incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap; and (c) unmarried and chiefly dependent on you for support and maintenance; the child's coverage will not terminate solely due to age. But you must submit proof of the incapacity within 31 days of the child's attainment of the termination age. Coverage will continue a long as: (a) the child qualifies as an incapacitated child; and (b) the required premium is paid. We may, from time to time, require proof of continued incapacity and dependency. After the first two years, we cannot require proof more than once each year.

Covered Dependent Continuation: If your Dependent Coverage under the Policy terminates because your coverage ends due to Medicare eligibility, attainment of age 65, or your death, then your spouse may continue the coverage for any of your Dependents who are covered under the Policy on the date your coverage ceases. We must receive the Spouse's Request and required premium to continue coverage within 90 days of the Premium Due Date next following the date coverage terminates. Solely for the purposes of continuing the coverage, the Spouse may be considered the Member. However, this will not continue the Spouse's coverage beyond a date the coverage would normally cease under a Dependent Termination provision of the Policy. Any coverage continued under this provision due to your death will terminate on the Premium Due Date on or next following the date the Spouse remarries.

Widow or Widower's Continuation: If you die while your Spouse is covered under the Policy, your Spouse may continue: (a) your Spouse's coverage; and (b) coverage for any of your Dependents who are covered under the Policy on the date of your death. We must receive the Spouse's Request and required premium to continue coverage within 90 days of the Premium Due Date next following the date of your death. Solely for the purposes of continuing the coverage, the Spouse may be considered the Member. However, this will not continue the Spouse's coverage beyond a date the coverage would normally cease under a Dependent Termination provision of the Policy. Any coverage continued by this Widow or Widower's Continuation provision will terminate on the Premium Due Date on or next following the date the Spouse remarries.

TRICARE ACTIVE DUTY II FAMILY SUPPLEMENT

INPATIENT BENEFIT: We will pay the benefits described below for a Covered Person's Period of Confinement in a Hospital or Skilled Nursing Facility.

The Period of Confinement must:
(a) be due to Sickness or Injury;
(b) begin while the Covered Person is covered under this benefit;
(c) be approved by TRICARE.

Benefits in a Government Hospital: We will pay the current Daily Subsistence Charge for each day a Covered Person is Confined in a Government Hospital.

Benefits in a Civilian Hospital or Skilled Nursing Facility: We will pay as follows for Covered Expenses incurred while the Covered Person is Confined in a Civilian Hospital or Skilled Nursing Facility.

For the Covered Spouse or Child of an Active Duty Member, we will pay:
Under TRICARE Standard and TRICARE Extra:
the greater of:
(1) the current Daily Subsistence Charge for each day of Confinement; or
(2) $25 for all Confinements which are due to the same or related Sickness or Injury and separated by less than 60 days until the TRICARE Cap is met.

OUTPATIENT BENEFIT: When a Covered Person incurs Covered Expenses while the Covered Person is not Confined in a Hospital or Skilled Nursing Facility, we will pay the benefits described below provided that the expenses are:
(a) due to Sickness or Injury;
(b) incurred while the Covered Person is covered under this benefit;
(c) approved by TRICARE; and
(d) incurred after the Covered Person has satisfied the Outpatient Deductible charged by TRICARE.

For the Covered Spouse or Child of an Active Duty Member, we will pay:
(1) Under TRICARE Standard:
(a) 20% of the TRICARE Allowed Amount for the Covered Expenses until the TRICARE Cap is met; and
(b) 100% of all Covered Expenses in Excess of the TRICARE Allowed Amount, not to exceed the Legal Limit.
(2) Under TRICARE Extra:
15% of the TRICARE Extra Contracted Fee for the Covered Expenses until the TRICARE Cap is met.

All Outpatient Covered Expenses will be deemed incurred on the date the Covered Person received the treatment, service or supply that gave rise to the expense.

We will not pay for expenses which are used to satisfy the Outpatient Deductible charged by TRICARE.

INPATIENT BENEFIT: We will pay the benefits described below for a Covered Person's Period of Confinement in a Hospital or Skilled Nursing Facility.

The Period of Confinement must:
(a) be due to Sickness or Injury;
(b) begin while the Covered Person is covered under this benefit;
(c) be approved by TRICARE.

Benefits in a Government Hospital: We will pay the current Daily Subsistence Charge for each day a Covered Person is Confined in a Government Hospital.

Benefits in a Civilian Hospital or Skilled Nursing Facility: For Confinement in a Civilian Hospital or Skilled Nursing Facility which is subject to the TRICARE DRG, we will pay:

(1) Under TRICARE Standard:
The lesser of:
(a) the TRICARE Per Diem Charge for the Period of Confinement; or
(b) 25% of the amount billed for Covered Expenses not to exceed the TRICARE DRG Amount;
until the TRICARE Cap is met.

For Confinement in a Civilian Hospital or Skilled Nursing Facility which is not subject to the TRICARE DRG, we will pay 25% of the TRICARE Allowed Amount until the TRICARE Cap is met.

For all Confinements with services not subject to the TRICARE DRG, we will pay 100% of all Covered Expenses in Excess of the TRICARE Allowed Amount incurred during the Confinement.

(2) Under TRICARE Extra:
The lesser of:
(a) the TRICARE Extra discounted TRICARE Per Diem Charge for the Period of Confinement; or
(b) 25% of the amount billed for Covered Expenses not to exceed the TRICARE DRG Amount;
until the TRICARE Cap is met.

For Confinement in a Civilian Hospital or Skilled Nursing Facility which is not subject to the TRICARE DRG, we will pay 20% of the amount billed until the TRICARE Cap is met.

OUTPATIENT BENEFIT: When a Covered Person incurs Covered Expenses while the Covered Person is not Confined in a Hospital or Skilled Nursing Facility, we will pay the benefits described below provided that the expenses are:
(a) due to Sickness or Injury;
(b) incurred while the Covered Person is covered under this benefit;
(c) approved by TRICARE;
(d) incurred after the Covered Person has satisfied the Outpatient Deductible charged by TRICARE.

We will pay:
(1) Under TRICARE Standard:
(a) 25% of the TRICARE Allowed Amount for the Covered Expenses after the Covered Person has satisfied the Outpatient Deductible charged by TRICARE until the TRICARE Cap is met; and
(b) 100% of all Covered Expenses in Excess of the TRICARE Allowed Amount, not to exceed the legal limit.

(2) Under TRICARE Extra:
20% of the TRICARE Extra Contracted Fee for the Covered Expenses after the Covered Person has satisfied the Outpatient Deductible charged by TRICARE until the TRICARE Cap is met.

All Outpatient Covered Expenses will be deemed incurred on the date the Covered Person received the treatment, service or supply that gave rise to the expense.

We will not pay for expenses which are used to satisfy the Outpatient Deductible charged by TRICARE.

TRICARE PRIME SUPPLEMENT PLAN

Benefits apply for expenses incurred while the person is covered under TRICARE Prime and this supplement, when services are received from a TRICARE network provider, except as otherwise provided. TRICARE Prime Supplement coverage is subject to all other applicable terms and conditions of the policy. Coverage is provided under either Plan A or Plan B, as indicated on the Covered Person's Schedule:

Plan A – **TRICARE Prime Supplement with No Point-of-Service Benefits**
Inpatient Benefit: We will pay the Covered Person's Cost Share Amount for a Period of Confinement in a Hospital or Skilled Nursing Facility. The Period of Confinement must begin while the person is covered by this benefit.

Outpatient Benefit**:** We will pay the Covered Person's Cost Share Amount for Covered Expenses incurred while **not** Confined in a Hospital or Skilled Nursing Facility. The Period of Confinement must begin while the person is covered by this benefit.

This Plan A supplement does not cover the TRICARE Point-of-Service Cost Share or Outpatient Deductible for non-emergency services received from a provider who does not participate in TRICARE's managed care network or the TRICARE Prime annual enrollment fee.

Plan B – **TRICARE Prime Supplement with Point-of-Service Benefits**
Inpatient Benefit: We will pay the Covered Person's Cost Share Amount for a Period of Confinement in a Hospital or Skilled Nursing Facility. The Period of Confinement must begin while the person is covered by this benefit.

Outpatient Benefit: We will pay the Covered Person's Cost Share Amount for Covered Expenses incurred while **not** Confined in a Hospital or Skilled Nursing Facility. The expenses must be incurred while the person is covered by this benefit.

Point-of-Service Benefit:
If the Covered Person exercises the Point-of-Service Option of TRICARE Prime, we will reimburse the Cost Share Amount:

(a) for Inpatient services; and
(b) for Outpatient services, after the Point-of-Service Outpatient Deductible for such expenses has been satisfied;

subject to a maximum payable under this benefit of $7,500 per Family per Fiscal Year.

Under the Point-of-Service Option, the Cost Share Amount is currently 50% of the TRICARE Allowed Amount for the expense. This means that we reimburse 50% of the TRICARE Allowed Amount for the expense (the Cost Share Amount) unless the TRICARE Cap has been met. Any portion of the expense that exceeds the TRICARE Allowed Amount is not reimbursable under this supplement. This Plan B supplement does not cover any expense applied to the TRICARE Point-of-Service Outpatient Deductible or the TRICARE Prime annual enrollment fee.

PLAN CONVERSIONS

The following conversions are provided under the Policy. All premiums due will be adjusted according to the conversion made. The conversion will not become effective if any additional premium required is not paid.

None of the conversions will continue coverage beyond the date that it would have terminated in accordance with a Termination provision of the Policy.

Active Duty II Family Plan to High Option II Retiree Plan. When you retire from Active Duty, any Spouse or Child coverage under a TRICARE Active Duty Family Supplement Plan will cease. You may then Request coverage under the High Option II Retiree Plan.

You and your Spouse or Child(ren) will become covered under the Plan of your choice provided we receive your Request and the required premium within 63 days of retirement.

TRICARE Standard/Extra Supplement to TRICARE Prime Supplement Conversion: If, while covered by a TRICARE Standard/Extra Supplement, a person enrolls in TRICARE Prime, the TRICARE Standard/Extra Supplement will terminate and coverage will be transferred to a TRICARE Prime Supplement plan of his/her choice. The Pre-Existing Condition Exclusion will be credited for the period covered under the TRICARE Standard/Extra Supplement Plan. Covered Expenses incurred under TRICARE Prime will only be payable under the terms of the TRICARE Prime Supplement. The Covered Person must give us written notice of TRICARE Prime enrollment as soon as possible, but at least within 60 days.

Unless the notice includes a specific request for a cash refund, any overpayment of the premium differential between the TRICARE Standard/Extra Supplement Plan and the TRICARE Prime Supplements will be credited toward subsequent premium payments due. In cases where timely notice was not provided to us, the maximum refund or credit will not exceed one year's premium differential.

TRICARE Prime Supplement to TRICARE Standard/Extra Supplement Plan Conversion: When a Covered Person becomes disenrolled from TRICARE Prime, his/her coverage under the TRICARE Prime Supplement will terminate.

Under certain circumstances, the person may apply for coverage under the TRICARE Standard/Extra Supplement. We will credit his/her Pre-Existing Condition Exclusion for the period covered by the TRICARE Prime Supplement. To qualify, the Covered Person must have been continuously covered under a TRICARE Prime Supplement for a minimum of one year immediately before the disenrollment. This one year requirement will not be applied if:

a) the person disenrolled because he or she moved to a residence located outside the network's area; or
b) the person was covered under a Prior Supplement.

However, it will apply when a person is disenrolled because specialty care for his/her medical condition is not available in the network. In addition, to qualify the Covered Person must apply within 60 days of disenrollment.

In all other circumstances, the TRICARE Supplement coverage will be subject to satisfaction of the Pre-Existing Condition limitation. These would include situations where:

a) the Covered Person does not make timely application or does not meet the minimum one year prior coverage requirement;
b) the Covered Person voluntarily disenrolls prior to the end of the annual TRICARE Prime coverage period, whether through non-payment of TRICARE Prime fees, or for the purpose of procuring a higher level of coverage from TRICARE for treatment from an out-of-network provider, or for any other reason.

EXTENSION OF BENEFITS
IF TOTALLY DISABLED WHEN COVERAGE TERMINATES

If a Covered Person is Totally Disabled on the date the Covered Person's coverage under the Policy terminates, we will extend Inpatient benefits for expense incurred as the result of that disability until the first to occur of:

(a) the date the Covered Person is no longer Totally Disabled; or
(b) the 90th day from the date the Covered Person's Inpatient benefit ended.

After the 90th day, no further benefits will be paid.

If a Covered Person is Totally Disabled on the date the Covered Person's Outpatient Benefit ends, then the Covered Person's benefits under the Policy will continue up to 90 days from the date of termination.

If a Covered Person is not Totally Disabled on the date the Covered Person's Outpatient Benefit terminates, no benefits will be provided for Outpatient expenses the Covered Person incurs after the date of termination.

The continuation will only apply to expense incurred for Injury or Sickness that caused the Total Disability.

LIMITATIONS

Nervous, Mental, Emotional Disorder, Alcoholism, and Drug Addiction Limits

The coverage provided under the Inpatient Benefits of the TRICARE Supplements for nervous, mental, emotional disorders, including alcoholism and drug addiction, is limited to:

(a) 30 Inpatient treatment days for a Covered Person age 19 or older; or
(b) 45 Inpatient treatment days for a Covered Person under age 19;

per Fiscal Year.

This Inpatient limit is based on the number of days TRICARE normally provides each Fiscal Year for such confinements.

In rare instances, TRICARE extends these daily limits. If this occurs, we will limit the number of days that we provide for such Confinement to the lesser of:

(a) the number of days TRICARE pays for such Inpatient treatment during the Fiscal Year; or
(b) 90 Inpatient days per Fiscal Year.

The coverage provided under the Outpatient Benefits of the TRICARE Supplement Plans for:

(a) nervous, mental, and emotional disorders; and
(b) alcoholism and drug addiction;

is limited to $500 during any Fiscal Year for all such disorders.

TRICARE Cap

TRICARE will increase its rate of payment to 100% of the TRICARE Allowed Amount when a Covered Person has met the TRICARE Cap. After the TRICARE Cap has been met, we will not duplicate benefits by paying any part of the cost-share which is payable under TRICARE.

Other Insurance With Us

If a Covered Person is insured under more than one policy underwritten by us which provides TRICARE Supplement benefits, we will limit our payment of benefits to the one policy that affords the greater level of benefits.

Non-Duplication of Coverage under Employer Health Program

If a claim payable under the Policy is also payable under an Employer Health Program with TRICARE as the secondary payor, we will limit our payment to an amount which, when added to the amounts paid by the Employer Health Program and TRICARE, will not exceed 100% of TRICARE Covered Expenses.

PRE-EXISTING CONDITION LIMITATION

Pre-Existing Condition Defined:
Pre-Existing Condition, as used in this limitation, means any Injury or Sickness, diagnosed or undiagnosed, for which Medical Care is received by a Covered Person:

(a) within the 6 month period prior to the Covered Person's effective date of insurance; or
(b) with respect to the limitation for increase in coverage, within the 6 month period prior to the effective date of the Covered Person's increase in coverage.

For the purposes of this limitation, we will consider:

(a) Medical Care received when:
    (1) a Physician is consulted or medical advice is given; or
    (2) Treatment is recommended or prescribed by, or received from, a Physician;
(b) Treatment to include, but not limited to, any:
    (1) medical examination, test, attendance, or observation;
    (2) medical services, supplies, or equipment, including their prescription or use; or
    (3) prescribed drugs or medicines, including their prescription or use.

All manifestations, symptoms, or findings which result:

(a) from the same or related accident or Sickness; or
(b) from any aggravations of accident or Sickness;

are considered to be the same accident or Sickness for the purposes of determining a Pre-Existing Condition.

Conditions Prior to Effective Date: During the first 6 months of a Covered Person's insurance, losses incurred for Pre-Existing Conditions are not covered. This will not apply to loss that the Covered Person incurs after being free of Medical Care for the condition for a six month period (ending any time on or after the Covered Person's effective date).

Conditions Prior to Effective Date of Increase in Coverage: During the first 6 months following the date a Covered Person makes a change in coverage that increases the Covered Person's benefits, the increase will not be paid for Pre-Existing Conditions. This will not apply to loss that the Covered Person incurs after being free of Medical Care for the condition for a six month period (ending any time on or after the effective date of increase).

This Pre-Existing Condition limitation will be considered satisfied to the extent it was satisfied under previous Creditable Coverage, if the previous Creditable Coverage was continuous to a date up to 63 days prior to the effective date of the new coverage.

Creditable Coverage means coverage of the Covered Person under any of the following: 1) A group health plan; 2) Health insurance coverage; 3) Part A or Part B of Title XVIII of the Social Security Act; 4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; 5) Chapter 55 of title 10, United States Code; 6) A medical care program of the Indian Health Service or of a tribal organization; 7) A state health benefits risk pool; 8) A health plan offered under Chapter 89 of Title 5, United States Code; 9) A public health plan (as defined in regulations); 10) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e).

WAIVER OF PRE-EXISTING CONDITION LIMITATION

Waiver for Conditions Prior to Effective Date of Coverage: Under the following conditions, the period of time required to satisfy the Pre-Existing Condition exclusion will be reduced or waived as stated:

If you retire from Active Duty and become eligible for TRICARE Retiree Supplement coverage as provided under "Plan Conversions" and Request such coverage within 63 days of the date you first become eligible for coverage, we will credit you with continuity of coverage from your prior effective date under the Active Duty Family Supplement.

EXCLUSIONS

The Policy does not cover:

1. injury or sickness resulting from war or act of war, whether war is declared or undeclared;
2. intentionally self-inflicted injury;
3. suicide or attempted suicide;
4. custodial care;
5. eye refractions and routine eye exams except when rendered to a child up to 6 years from the child's birth;
6. eyeglasses;
7. cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part, and reconstructive surgery because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;
8. hearing aids;
9. dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly;
10. any confinement, service, or supply that is not covered under TRICARE;
11. expenses in excess of the TRICARE Cap;
12. expenses which are paid in full by TRICARE;
13. any expense or portion thereof applied to the TRICARE Outpatient Deductible;
14. treatment for the prevention or cure of alcoholism or drug addiction except as specifically provided under TRICARE;
15. any part of a covered expense which the Covered Person is not legally obligated to pay because of payment by a TRICARE alternative program;
16. any claim under more than one of the TRICARE Supplement Plans, or under more than one Inpatient Benefit or more than one Outpatient Benefit of the TRICARE Supplement Plans. If a claim is payable under more than one of the stated Plans or Benefits, payment will only be made under the one that provides the highest coverage, subject to the Pre-Existing Condition Limitation.

PREMIUM PROVISION

Individual Premium Due Dates: The first premium for each Covered Person is due on the date the Covered Person becomes covered under the Policy. Each premium after the initial premium is due at the end of the period for which the Covered Person's preceding premium was paid.

Individual Grace Period: A grace period of 31 days from the Individual Premium Due Date is allowed for payment of each premium due after the initial premium. The Covered Person's insurance will be continued during the Grace Period. If the Covered Person incurs a covered loss during the Grace Period, you will be liable to us for payment of any premium accruing during the period we continue coverage in force under this provision. The Grace Period will not continue beyond a date stated in a Termination provision.

Change of Policy Premiums: We have the right on each Premium Due Date to change the rate at which further premiums will be calculated. This includes the right to change premium rates for a benefit that applies to all individuals of the same class, age, plan and effective date. Rates may be changed based on claims experience of the Policy. We will give the Policyholder or Organization notice of any change at least 45 days before the Premium Due Date on which it is to become effective.

CLAIMS PROVISIONS

Notice of Claim: The person who has the right to claim benefits must give us written notice of a claim within 20 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice should include your name, the Covered Person's name, the Policy Number and this Certificate number. Send it to us or give it to the Plan Administrator.

Claim Forms: When we receive the notice of claim, we will send forms to the claimant for giving us proof of loss. The forms will be sent within 15 days after we receive the notice of claim. If the forms are not received, the claimant will satisfy the proof of loss requirement if written proof of the occurrence, character and extent of the loss is sent to us. Claim forms may be obtained from us or the Plan Administrator.

Proof of Loss: Proof of loss must be sent to us in writing within 90 days after the end of each month of our liability for periodic payment claims or the date of the loss for all other claims. If the claimant is not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

Time of Claim Payment: We will pay any daily, weekly or monthly benefit due:

(a) on a monthly basis, after we receive the proof of loss, while the loss and our liability continue; or
(b) immediately after we receive the proof of loss following the end of our liability.

We will pay any other benefit due immediately after we receive the proof of loss.

Payment of Claim: We will pay any benefit due and not assigned, to the Covered Person, if living. Otherwise, we will pay any benefit due for loss which occurred:

(a) prior to the Covered Person's death to the Covered Person's estate; and
(b) after the Covered Person's death to:
    (1) the Covered Persons' spouse if the spouse is covered under the Policy; or, if not
    (2) the person whose loss is the basis of the claim.

If a benefit due is payable to a minor, it will be paid to the minor's guardian.

If a benefit due is payable to the Covered Person's dependent and that dependent dies, it will be paid to the dependent's estate.

If a benefit due is payable to a Covered Person's estate, to a minor, or to a person not competent to give valid release for payment, we may pay up to $1,000 of the benefit due to some other person. The other person will be someone related to the Covered Person by blood or marriage who we believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in good faith.

If the Covered Person provides us with a written release to do so, we may, at our option, pay benefits directly to the institution or person rendering hospital services; or nursing, medical or surgical services, unless the Covered Person or the person to whom the benefit is payable requests otherwise in writing no later than the time proof of loss is filed with us.

"Written release" means any written direction from the Covered Person to pay benefits to the institution or person rendering the service.

We will not require that the service be rendered by a particular institution or person.

Assignment: The Covered Person may assign the benefits of the Policy to the institution or person rendering service as allowed in the Payment of Claims provision. The Covered Person may not assign the Policy in any other way or to any other person.

Physical Examinations: While a claim is pending we have the right at our expense to have the person who has a loss examined by a physician when and as often as we feel is necessary.

Legal Actions: Legal action cannot be taken against us before 60 days following the date proof of loss is sent to us or after 3 years following the date proof of loss is due.