Monumental Life Insurance Company

A Stock Company
Home Office: Cedar Rapids, Iowa
Administrative Office: 520 Park Avenue, Baltimore, Maryland 21201

CERTIFICATE OF INSURANCE

Policyholder: **American Military Insurance Trust**
Policy Number: **MZ0925777H0001A**

Monumental 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.

Secretary **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 CHAMPVA SUPPLEMENT COVERAGE

GENERAL DEFINITIONS

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

Calendar Year means a period of 12 months in a row, starting on January 1 and ending on December 31 of the same year.

CHAMPVA means the Civilian Health and Medical Program of the Department of Veterans Affairs, established by Section 613 of the Veterans Health Care Expansion Act of 1973 (Public Law 93-89), as amended.

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

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

CHAMPVA Diagnostic Related Group (DRG) means a system adopted by CHAMPVA 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 CHAMPVA benefit payments for the hospital confinement regardless of actual cost. We will recognize the DRG as the cost of the hospital confinement if CHAMPVA so recognizes it.

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

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.

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 CHAMPVA.

Covered Person means 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.

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

Hospital means an institution which CHAMPVA 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.

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 who sponsors the Member's eligible dependents for coverage under the Policy. In the event the sponsor is deceased, Member means the Member's widow(er) who is a member of the Organization and is covered under the Policy.

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 applied on a Calendar Year basis, as defined and determined by CHAMPVA.

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 CHAMPVA.

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 Calendar 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 Calendar 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.

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.

Service means Uniformed Service of the United States.

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.

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.

PERIOD OF COVERAGE

Eligible Dependents: Your Eligible Dependents are described below.

Eligible Spouse: "Spouse" means your Spouse who is under age 65 and a CHAMPVA benefits recipient, but not a spouse from whom you are legally separated or divorced. "Spouse" also means your widow or widower, if the spouse is a member of the Organization. Spouses over age 65 are also eligible if documentation from the Social Security Administration certifying their non-entitlement to or exhaustion of Medicare Part A benefits is submitted with their enrollment form.

Eligible Child: "Child" means your or your Spouse's unmarried child who is a CHAMPVA benefits recipient and is dependent on you or your Spouse for at least one-half support, including a stepchild or legally adopted child and who is under age 18 (23 if enrolled full-time in a school of higher learning).

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 CHAMPVA Supplement Plan stated across from the Eligible Dependent class. If "None" 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. 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. The child's coverage will cease on 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.

Termination: A Covered Person'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 date you or your widow(er) terminates membership in the Participating Organization;
(4) the first premium due date on or next following the date the dependent ceases to be an Eligible Spouse or an Eligible Child;
(5) the date we or the Participating Organization cancel coverage for a Class of Eligible Person to which the Covered Person belongs;
(6) the first premium due date on or next following the date the Covered Person ceases to be covered by CHAMPVA;
(7) the date the Covered Person becomes eligible for Medicare unless the Covered Person resides in an area where Medicare is not available, in which case coverage will not terminate until the Covered Person returns to residency in an area where Medicare is available;
(8) if a child, the date the child attains age 18, or age 23 if the child is enrolled full time at a school of higher learning;
(9) the date a Covered Person 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 age 18 or 23 (if a full-time student), the child is: (a) covered under the Policy; (b) mentally retarded or physically handicapped and incapable of earning his or her own living; and (c) unmarried and primarily dependent on you for support and maintenance; the child's coverage will not terminate solely due to age. But you must give us written notice of the incapacity within 31 days of the termination date. Coverage will continue as 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.

CHAMPVA SUPPLEMENT PLAN

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 CHAMPVA.

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, if such charge is made.

Benefits in a Civilian Hospital or Skilled Nursing Facility: For Confinement in a Civilian Hospital or Skilled Nursing Facility which is subject to the CHAMPVA DRG, we will pay the lesser of:
(a) the CHAMPVA Per Diem Charge for the Period of Confinement; or
(b) 25% of the amount billed for Covered Expenses, not to exceed the CHAMPVA DRG Amount;
until the CHAMPVA Cap is met.

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

For Inpatient Physician Services, we will pay 25% of the CHAMPVA Allowed Amount until the CHAMPVA 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 CHAMPVA; and
(d) incurred after the Covered Person has satisfied the Outpatient Deductible charged by CHAMPVA.

In addition, we will pay 25% of the CHAMPVA Allowed Amount for the Covered Expenses, until the CHAMPVA 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 pay the Inpatient and Outpatient Covered Expenses once the Plan Deductible per Covered Person has been satisfied. Expenses incurred to satisfy the CHAMPVA Calendar Year Outpatient Deductible cannot be used to satisfy the Plan Deductible.

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 CHAMPVA Supplement Plan 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 Benefit of the CHAMPVA Supplement Plan 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; or
(c) 150 Inpatient treatment days in a CHAMPVA authorized Residential Treatment Center for a Covered Person under age 21;

per Calendar Year.

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

In rare instances, CHAMPVA 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 CHAMPVA pays for such Inpatient treatment during the Calendar Year; or
(b) 90 Inpatient days per Calendar Year.

The coverage provided under the Outpatient Benefit of the CHAMPVA Supplement Plan for:

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

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

CHAMPVA Cap

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

Additional Coverage Limits

Coverage provided under the CHAMPVA Supplement Plan for:

(a) routine newborn and Well Baby Care;
(b) Hospital nursery charges for a well newborn;
(c) dental care;
(d) treatment for the prevention or cure of alcoholism or drug addiction; and
(e) prosthetic devices;

will be limited to those expenses covered by CHAMPVA for such care or services.

SAMPLE

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 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.

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 benefit, the increase will not be paid for Pre-Existing Conditions.

EXCLUSIONS

The Policy does not cover:

1. injury or sickness resulting from war or act of war, whether war is declared or undeclared;
2. treatment or confinement not ordered by a Physician or necessary for medical care;
3. intentionally self-inflicted injury;
4. suicide or attempted suicide, whether sane or insane (in Colorado and Missouri while sane);
5. routine physical exams and immunizations, except when considered Well Baby Care covered by CHAMPVA;
6. domiciliary or custodial care, care received in a retirement home, rest home or halfway house;
7. rest cures;
8. eye refractions and routine eye exams except when considered Well Baby Care covered by CHAMPVA;
9. eyeglasses and contact lenses;
10. cosmetic procedures, except those resulting from Sickness or Injury while a Covered Person;
11. hearing aids or hearing exams except when considered Well Baby Care covered by CHAMPVA;
12. orthopedic footwear;
13. care for the mentally incapacitated or physically handicapped if the care is required because of the mental incapacitation or physical handicap;
14. drugs which do not require a prescription, except insulin and other diabetic supplies;
15. any confinement, service, or supply that is not covered under CHAMPVA;
16. expenses in excess of the CHAMPVA Cap;
17. expenses in excess of the CHAMPVA Allowed Amount;
18. expenses which are paid in full by CHAMPVA;
19. any expenses or portion thereof applied to the CHAMPVA Deductible;
20. any part of a covered expense which the Covered Person is not legally obligated to pay;
21. care received as part of a grant, study or research program;
22. care considered experimental or investigational.

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, 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.