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MEMORANDUM FOR: Director of Personnel

THROUGH: Deputy Director for Science and Technology

FROM: STAT
Director, Foreign Broadcast Information Service

SUBJECT: Contract Health Insurance for FBIS FSN Employees

1. Paragraph five contains a request for your approval.

2. The Foreign Broadcast Information Service (FBIS) employs a number of Foreign Service National (FSN) employees who are not eligible for or do not have available to them health insurance benefit plans. While FSN employees are prohibited by law from membership in U.S. Government group health insurance programs, most are covered by local health or social insurance programs. However, at present 99 FBIS FSN employees are enrolled in Contract Health Insurance (CHI) because such local coverage is not available. CHI premiums and claims are administered internally by the Insurance Branch of the Office of Personnel.

3. CHI provides health insurance coverage to FSN's which is comparable to the coverage available to U.S. staff employees. Upon retirement, however, the FSN's are excluded from group coverage and must either accept individual coverage with the CHI underwriter or seek other health insurance coverage. The post-retirement CHI premiums for individuals are, of course, considerably higher and the benefits package is not adequate to meet today's high costs of medical care. Copies of CHI benefits before and after retirement are attached for comparison purposes. Health insurance coverage under private plans, especially for individuals of retirement age and uncertain health, is also very costly and benefits are not comprehensive.

4. During the early days of CHI, the problems mentioned above were not significant. There were few FSN retirees and the costs of medical care and health insurance were within the means of most people. The dramatic rise in health care costs over the past five to six years has convinced FBIS it is time to review the health insurance program for retired FSN's.

SUBJECT: Contract Health Insurance for FBIS FSN Employees

5. It is requested that the Insurance Branch of the Office of Personnel be directed to explore with the CHI underwriter the possibility of continuing group health insurance coverage for FSN retirees who have been enrolled in CHI. Of the 99 FSN's currently enrolled in CHI, two will reach mandatory retirement age during the next three years. Nine FSN retirees over the past three years have had CHI at retirement. Thus, it does not appear that inclusion of FSN retirees in group CHI, if that proves technically possible, would significantly increase the administrative workload on the Insurance Branch.

STAT

Attachment:
As stated

CONCUR:

Deputy Director for Science and Technology — Date

APPROVED:

Director of Personnel — Date

DDS&T/FBIS-Pers/ (23 July 1981) STAT

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CH1

EFFECTIVE 1-1-81

BASIC BENEFITS

(Payable without a Deductible)

1. ROOM AND BOARD AND HOSPITAL EXTRAS

*Full cost of semi-private room and hospital extras for up to 365 days, including intensive care units (Major Medical Benefits thereafter). If private room is used, patient pays the cost in excess of the hospital's average semi-private rate unless the Plan determines that isolation is necessary to contain a communicable disease. Included in this benefit is: up to $50.00 for private ambulance service and charges for outpatient preadmission tests rendered within 48 hours of admission to the hospital.

*Basic Benefits of up to $20.00 per visit will be payable for each doctor's visit to hospital inpatients for up to 365 days for each confinement - when the visit is unrelated to surgery.

2. HOSPITAL OUTPATIENT EXPENSES

Up to $400.00 per person each calendar year. Charges by a hospital for outpatient services and non-surgical charges by a doctor for emergency room treatment only are payable under this benefit, except for an allowance of up to $50.00 for private ambulance service. Expenses exceeding the $400.00 are payable under Major Medical Benefits.

SPECIAL OUTPATIENT HOSPITAL BENEFIT

PLAN PAYS --

100% of outpatient hospital charges for services and supplies rendered at the time of a surgical operation not requiring hospitalization as an inpatient. This provision also applies to approved Surgi-Centers. Charges for take home drugs billed by a hospital are not payable as a hospital expense, but rather are payable under Major Medical Benefits.

OUT-OF-HOSPITAL ACCIDENTAL BODILY INJURY EXPENSES

PLAN PAYS --

100% of a doctor's reasonable and customary charge for emergency treatment of accidental, bodily injury.

3. SURGICAL EXPENSES

PLAN PAYS --

100% of reasonable and customary charges for surgery under basic benefits.

*Surgery by a doctor or surgeon except cosmetic surgery, unless it is necessary as a result of accidental injury occurring while covered by this Plan. The initial reconstruction of the breast following a mastectomy which was performed while covered under the Plan is also payable.

*Surgical correction of congenital anomalies (including protruding ear deformities, harelip, birthmarks, webbed fingers or toes, or other conditions that the Plan may determine to be congenital anomalies).

*Surgery for operations performed on the jaw or in the mouth including removal of impacted teeth (but excluding dental work).

*Services of a podiatrist on the feet as follows: (a) repair of lacerations and wounds produced by thermal or chemical agents, (b) reduction of fractures or complete dislocation, (c) surgery requiring incision through the true skin, (d) the removal of plantar warts by chemosurgery, electrosurgery, or cryotherapy, (e) aspiration and needling, and (f) office visits and x-ray and laboratory expenses related to the above services.

*Charges incurred for a surgical transplant, whether incurred by the recipient or donor, will be considered expenses of the recipient and will be covered the same as for any other illness or injury.

*Services of an assistant surgeon are covered.

*Charges for voluntary sterilization are covered the same as illness or injury.

4. ANESTHESIA

PLAN PAYS --

For administration of anesthetic up to $50 or 40% of the amount payable for the operation performed, whichever is greater provided the surgical procedure is a covered expense. The difference up to the reasonable and customary charge not payable under this provision is then paid at 80% without the deductible requirement.

5. OUT-OF-HOSPITAL X-RAY AND LABORATORY EXPENSES

100% of reasonable and customary charges for expenses incurred for x-ray, laboratory examinations and other tests (except allergy and TB skin tests) necessitated by accidental bodily injury or sickness and performed by or under the supervision of a doctor when the service is rendered other than in a hospital.

6. ALCOHOLISM AFTERCARE TREATMENT PROGRAM

Plan pays up to $150 for services rendered in an outpatient aftercare treatment program for alcoholism when the program immediately follows and is an extension of care received in an inpatient alcoholic treatment program. (This benefit is payable only twice per person per lifetime).

7. MATERNITY EXPENSES

Same benefits as for illness or injury. Bassinet or nursery charges for days on which mother and child are both confined are considered maternity expenses of the mother and not expenses of the child. Also covered are charges for amniocentesis and related tests on the unborn child when medically necessary.

*DOCTOR - 100% of the reasonable and customary charge for normal delivery and Cesarean Section.

*MIDWIFE EXPENSES - 100% of reasonable and customary charges for normal delivery by a midwife if the services of a licensed midwife are elected instead of the services of a doctor.

*NEWBORN CARE - 80% of the reasonable and customary charge for the initial routine in-hospital examination of a newborn infant, if that infant is eligible for benefits under the Plan.

All other expenses of the child are payable only if the child is covered under a self and family enrollment and if the confinement is for the treatment of illness or injury of the child.

WHEN AND FOR WHOM MATERNITY BENEFITS ARE PAYABLE -

Benefits are payable, without a waiting period, for the care of pregnancies which terminate while covered by the Plan,

for an enrollee and all eligible family members under a self and family enrollment.

MAJOR MEDICAL BENEFITS

1. THE DEDUCTIBLE

The "Deductible" is the $100 you must pay before the Plan starts paying "Major Medical Benefits". There is a separate "Deductible" for each member of your family. The "Deductible" is applied once in a calendar year for each person, regardless of how many different illnesses or accidents the person may have. However, under a family enrollment covering three or more persons only two deductibles need be satisfied in any calendar year. Furthermore, if two or more covered members of your family are injured in the same accident, the deductible need be applied only once for those members for all expenses relating to the accident.

2. MAJOR MEDICAL EXPENSES

PLAN PAYS -- After application of the $100 deductible, 80% of reasonable and customary charges for the following services and supplies to the extent they are not paid for by Basic Benefits:

a. HOSPITAL INPATIENT EXPENSES in excess of the basic benefits, excluding any charge for private accommodations in excess of the hospital's average semi-private rate.

b. HOSPITAL OUTPATIENT EXPENSES in excess of the basic benefits.

c. THE FOLLOWING SERVICES AND SUPPLIES either in or out of hospital, which are not otherwise covered by this Plan and which are recommended by the attending doctor in the diagnosis and treatment of an accident or sickness:

DOCTORS' SERVICES, including doctors' office, home, and hospital visits (unrelated to surgery).

DENTAL SERVICES AND TREATMENT (including initial replacement of natural teeth and dental x-rays) for repair of accidental injury to the jaw or sound natural teeth occurring while insured under this Plan, if received within 24 months from the date of the accident.

CASTS, SPLINTS, BRACES, CRUTCHES, CANES, CERVICAL COLLARS, CERVICAL TRACTION KITS, AND TRUSSES.

X-RAYS AND SPECIAL TESTS in excess of basic benefits shown on page 3.

ONE PAIR OF EYEGLASSES OR CONTACT LENSES and examinations for them per lifetime when required to correct an impairment directly caused by accidental ocular injury or intraocular surgery and obtained within one year of the injury or surgery.

ONE HEARING AID and examination per lifetime if required to correct an impairment directly caused by accidental injury or intra-aural surgery and obtained within one year thereof.

LOCAL AMBULANCE SERVICE or if a special and unique hospital treatment which is not available locally is required, transportation by professional ambulance, railroad or commercial airline on a regularly scheduled flight, within the United States or Canada to the nearest hospital equipped to furnish the treatment, is also a covered expense. This benefit does not apply to transportation necessary to obtain the services of a doctor or any other practitioner.

RENTAL (or purchase at the option of the Plan) OF DURABLE MEDICAL EQUIPMENT. See definition page 9.

PRIVATE DUTY NURSING. Charges for full-time or visiting nursing care by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) are covered only when the care--

*is ordered by the attending doctor; and

*the doctor identifies the specific professional skills of the R.N. or L.P.N. which the patient requires as well as length of time needed; and

*when hospitalized as a bedpatient, the hospital and doctor indicate that the hospital's general nursing staff could not provide the care needed.

Charges for private nursing requested by, or for the convenience of, the patient or the patient's family or which consists primarily of bathing, feeding, exercising, moving the patient, giving oral medication, or acting as a companion or sitter are not covered.

OXYGEN and rental of equipment for its administration.

SERVICES OF A REGISTERED PHYSICAL THERAPIST OR A REGISTERED OCCUPATIONAL THERAPIST for administration of physical therapy in accordance with a doctor's specific instructions as to type, frequency, and duration.

SERVICES of an independent consulting doctor for services in relation to a second opinion regarding the necessity for anticipated surgery.

SERVICES and supplies for renal dialysis and chemotherapy.

TWO EXTERNAL BREAST PROSTHESES and two bras per mastectomy per calendar year designed exclusively for use with an external prosthesis.

RADIUM, RADIOACTIVE ISOTOPES AND X-RAY THERAPY.

DRUGS AND MEDICINES (including generic drugs) which by law of the United States require a doctor's written prescription; and insulin.

ARTIFICIAL EYES AND LIMBS, to replace natural eyes and limbs lost while covered by this Plan.

BLOOD OR BLOOD PLASMA (which is not donated or replaced) and its administration.

d. FOR NERVOUS AND MENTAL DISORDERS -- In addition to other services and supplies covered by Basic or Major Medical Benefits, the following are covered under Major Medical Benefits when rendered to patients with a mental or nervous disorder:

Services of a clinical psychologist who is duly licensed as a psychologist or, in States not requiring a license, is certified by a State psychological association.
Services of a psychiatric social worker under the direct supervision of a psychiatrist.
Day Care in a qualified day care center as determined by the Plan. A qualified day care center is one which provides a planned program of psychiatric care for patients who are at the center for only part of each day.
Doctors' offices, facilities operating principally as schools or recreational or training centers, and facilities primarily providing custodial services will not be recognized as qualified day care centers.

e. CHRISTIAN SCIENCE PRACTITIONERS. Charges of a Christian Science practitioner are allowable expenses if the practitioner's services are elected instead of the services of a doctor. This election must be made separately for each individual the first time a claim is filed each calendar year and will apply to expenses incurred during that year. This election may be changed the following year if desired. The practitioner must be listed as such in the Christian Science Journal current at the time the service is provided. This election will not apply to, nor prevent payment of, a doctor's charges under Maternity Benefits.

3. EXPENSES EXCEEDING $5,000 IN A CALENDAR YEAR

If the sum of allowable major medical expenses incurred in a calendar year by the enrollee and all covered family members, if any, reach $5,000, benefits for additional allowable major medical expenses incurred by them in that calendar year will not be subject to the Deductible and will be paid at the rate of 100% of reasonable and customary charges.

DEFINITIONS

For purposes of this Plan --

A "doctor" is a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.). Dentists, psychologists, optometrists, and podiatrists operating within the scope of their licenses are also doctors for the purpose of services covered by this Plan. In those states designated as MEDICALLY UNDERSERVED, the Plan will consider charges for medical treatment by any medical practitioner licensed by the state to provide such treatment. Medically underserved states are: Alabama, Alaska, Mississippi, Missouri, Oklahoma, South Carolina, South Dakota, West Virginia, Indiana, Kentucky, North Carolina and North Dakota.

A "hospital" is an institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals, or any other institution which is operated pursuant to law, under the supervision of a staff of doctors and with twenty-four hour a day nursing service, and which is primarily engaged in providing:

a. General in-patient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises, or

b. Specialized in-patient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including x-ray and laboratory) on its premises.

"Reasonable and customary" -- This Plan pays for charges, unless otherwise indicated, which are comparable with charges incurred from other providers for similar services and supplies in the same geographic area and which meet the Plan's established guidelines to reasonable and customary charges for that area. The Plan's guidelines to reasonable and customary charges have been developed statistically from actual claims received in each geographic area throughout the United States and are updated at least annually.

"Prescription drugs" are medicines that are obtainable only on a doctor's written prescription and which must be assigned a prescription number and dispensed by a registered pharmacist. Receipts for these drugs must be on a regular pharmacy billing form (not cash register receipts) and show patient's name, prescription name and number, price, date of purchase, and name of doctor who ordered the drug.

"Calendar year" is the 12 month period which begins on January 1 and runs through the following December 31. For a newly covered person, the calendar year begins when coverage begins and runs through December 31 of that same year. Expenses of a calendar year are those incurred during that calendar year.

A "confinement" is an admission (or series of admissions separated by less than 60 days) to a hospital as an in-patient for any one illness or injury. There is a new confinement when an admission is:

(1) for a cause entirely unrelated to the cause for the previous hospitalization;

(2) for an enrolled employee who returns to work for at least one full day before the next admission;

(3) for a dependent or annuitant when admissions are separated by at least 60 days.

"Custodial care" - Provision of room and board or other supportive care in an institution or in the home (with or without routine nursing care; training in activities of daily living and other forms of self-care; or supervisory care by a doctor) to a person who is mentally or physically disabled and who is not under specific active medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to function without such care or when, despite such treatment, there is no reasonable likelihood the disability will be so reduced.

"Cosmetic surgery" is any operative procedure or any portion of an operative procedure performed primarily to improve physical appearance, treat a mental or nervous disorder through change in bodily form, and/or change or restore form without correcting or materially improving a bodily malfunction.

"Durable Medical Equipment" means equipment prescribed by the attending doctor which: 1) is medically necessary; 2) is not primarily and customarily used for a nonmedical purpose; 3) is designed for repeated use; 4) serves a specific therapeutic purpose in the treatment of an illness or injury; and 5) is of no use to a person who has no illness or injury.

"Covered family members" - are spouse and unmarried children under age 22, to include legally adopted children. Unmarried stepchildren, foster children and recognized natural (illegitimate) children under age 22 are also included if they live with you in a regular parent-child relationship. A disabled child age 22 or over (who became disabled before age 22) and who, because of the disability, is incapable of self-support may also be eligible for coverage. Unless covered under the above exception, unmarried children when they reach age 22 are automatically excluded as "covered family members." Final determination of eligibility is made by the Plan.

## EXCLUSIONS

Charges for the following are not covered by this Plan and cannot be counted for any purpose under this Plan:

*Any charges incurred while not covered by this Plan, any charges which are not reasonable, or any charges for services or supplies which are not necessary for the treatment of injury or sickness

*Hospitalization or treatment paid for by any Governmental body or for which no charge would be made if there were no insurance

*Cosmetic surgery, except for repair of accidental injury occurring while insured under this Plan, and the initial reconstruction of the breast following a mastectomy which was performed while covered under this Plan

*Eyeglasses (including Contact Lenses), hearing aids, and examinations for them, except as specifically provided for under major medical benefits

*Routine physical examinations and immunizations

*Charges made by immediate relatives or members of the household of the enrolled employee or patient

*Orthopedic shoes and other supportive devices for the feet

*Weight control or treatment of obesity

*Sex transformations, any treatment related to sexual dysfunction, or reversals of sterilization

*Personal "comfort" services, such as telephone, radio and television, beauty and barber services, etc.

*Air conditioners, humidifiers, and purifiers

*X-ray, laboratory, and pathological services, and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms

*Nursing homes, rest homes, or places for the aged, or in any other place which is not a "hospital"

*Custodial care, even when provided by a hospital

*Blood or blood plasma which is donated or replaced

*Podiatrist's charges, except for certain specified services, see page 2

*Charges for the removal of corns or calluses

*Charges for tooth extractions, preparation for orthodontic treatment or dentures, or other dental work or surgery that involves any tooth or tooth structure, alveolar process, abscess, periodontal disease, or disease of the gingival tissue, except in case of accidental injury and for surgical removal of impacted teeth

*Any services or supplies not shown as covered even if recommended by a doctor

*Services and supplies not prescribed by a doctor in accordance with generally accepted professional medical standards

*Types of practitioners not included in the definition of "doctor" are not considered "doctors" for purposes of this Plan, except Christian Science Practitioners, see page 7

*Nutritional and fluoride supplements and vitamins

*Treatment of congenital anomalies related to teeth or structures supporting teeth

*Infertility (except for the initial diagnostic testing)

*Counselling or therapy for marital, educational and behavioral problems

*Wigs (except one wig per lifetime up to a maximum of §150.00 without a deductible when required due to hair loss in connection with chemotherapy or radiation therapy)

## LIMITATIONS

### DOUBLE COVERAGE

The Double Coverage limitation is intended to prevent payment of benefits which exceed expenses. It applies when a person is eligible for benefits under any other kind of group health coverage, Medicare, or "no-fault" automobile insurance.

When Double Coverage exists, this Plan will pay either its benefits in full or a reduced amount which, when added to the benefits available from all plans for the same covered expenses, will not exceed 100 percent of reasonable and customary charges; but in no case will this Plan pay an amount which is more than what would have been paid in the absence of other insurance.

This provision applies whether or not a claim is filed under Medicare or the other plans. If needed, authorization must be given to obtain information as to benefits or services available under the other plans, or to recover overpayments. Insurance coverage which pays for loss of income or for time lost from work is not Double Coverage.

### TO ASSURE PROMPT PAYMENT OF CLAIMS

*Always submit claims promptly as they are incurred.

*Be sure that all questions on the claim form are answered fully and that all bills are itemized. (Cancelled checks are not acceptable in lieu of itemized bills).

*Give your policy number and certificate number.

MAJOR MEDICAL CLAIMS

You will need complete and accurate records for each charge you want to count toward the "Deductible" and for each charge for which you claim benefits. Benefits for medical expenses are often payable even though you have not been confined to a hospital so it is important that you keep a record of small expenses. Keep in mind that the "Deductible" is applied once each calendar year. Major Medical claims will be retained and applied toward satisfaction of individual family member applicable "Deductibles." Keep separate records for each member of your family since the "Deductible" applies separately to each person. All bills and receipts, including doctors' bills, should be itemized and should show:

*The date of services and supplies are received
*The name of the family member concerned
*The name of the attending doctor
*Diagnosis or nature of illness
*The type of service rendered
*The prescription name and number of drugs and medicines
*The charge for each service

Claims must be filed within 90 days after the expenses for which claim is being made was incurred. The Plan is not required to honor a claim submitted after the 90-day period unless it can be shown that the claim was submitted as soon as reasonably possible, but in no event more than two years after the date the expense was incurred. To avoid the possibility of denial, submit your claims within the 90-day period.

MEDICARE

Claims for services covered by Medicare and this Plan should be submitted initially to Medicare. After Medicare has paid its benefits, this Plan will consider the balance of any covered expenses to the extent they are reasonable and customary. To be sure your claims are processed promptly, please submit the payment voucher from Medicare and duplicates of all bills along with a complete claim form.

Any savings realized by the Plan because of payments made by Medicare are used by the Plan to pay the deductible and coinsurance

which you would have paid in the absence of Medicare coverage. Such savings, however, can only be applied toward covered charges incurred in the year the savings are established and only for the enrollee generating the savings.

IDENTIFICATION CARDS

Upon request you will be given Identification Cards as evidence of your enrollment.

HOW PLAN BENEFITS CHANGE IN JANUARY 1981

Under Basic Benefits, the Plan has added coverage for emergency treatment in a doctor's office in connection with an accidental, bodily injury.

Under Basic Benefits, the Plan has increased the benefit for the administration of anesthesia to $50 or 40% of the amount payable for the operation performed, paying the difference at 80% without the deductible.

Under Basic Benefits, the Plan has increased the benefit for out-of-hospital x-ray and laboratory expenses to 100% of reasonable and customary charges.

Under Basic Benefits, the Plan has extended Podiatrist coverage to include payment for services of aspiration and needling.

Under Basic Benefits, the Plan now pays for the services of a licensed midwife.

COST OF CHI IS $29.82 individual plan and $122.94 family plan per quarter.

# REQUEST FOR GROUP HEALTH CONVERSION

*As specified in the conversion privilege of your group certificate . . .*

## YOU ARE ENTITLED TO CONVERT YOUR GROUP COVERAGE

to one of the conversion plans described in this brochure when you cease to be eligible for your group coverage. You may convert without evidence of insurability, provided:
(a) you continued your group insurance until the date you left the group and
(b) you apply for the conversion policy after the termination of your group insurance within the time period stated.

## NO HEALTH EXAMS REQUIRED TO QUALIFY

This conversion plan will be issued to you regardless of your present or past health history. However, questions in the application must be completed.

## YOUR CONVERSION POLICY WILL COVER

you, your spouse and unmarried dependent children who were insured under your group certificate.

## YOUR CONVERSION POLICY WILL BE EFFECTIVE

on the date you sign the attached application or on the date of termination of your group insurance, whichever is later. The initial quarterly, semiannual or annual payment must accompany your application.

## YOUR CONVERSION POLICY PROVIDES THE FOLLOWING BENEFITS

## HOSPITAL DAILY ROOM AND BOARD BENEFITS

Pays the expenses actually incurred for hospital room, board and nursing services for as long as 70 days for any one period of hospital confinement — up to the benefit amount stated for your Plan.

## MISCELLANEOUS HOSPITAL BENEFITS

Pays for the following services and supplies for actual expenses incurred for any one period of hospital confinement when room and board benefits are payable — up to the benefit amount stated in your Plan.

- Operating room, surgical dressings and casts, routine medicines, use of oxygen, X-rays, anesthetics, laboratory services and other necessary services and supplies (excluding charges for nursing services or physician's services)
- Regular and customary charges for local emergency ambulance service
- Administration of anesthetic by persons other than regular hospital personnel

## HOSPITAL OUTPATIENT BENEFITS

When you or an insured dependent is confined in a hospital
(1) as an outpatient within 48 hours of a covered accident or
(2) for a surgery resulting from covered injuries or sickness for which there is no room and board charge,

the policy provides benefits for hospital expenses actually incurred for care, treatment and services as described under the MISCELLANEOUS BENEFIT provision (up to the Maximum Miscellaneous Benefit stated in your Plan).

## MATERNITY BENEFITS

Pays benefits (up to the amount stated in your Plan) for maternity which has its inception while the policy is in force. Benefits are also payable for miscarriage occurring during any pregnancy which normally would have resulted in childbirth which had its inception while the policy was in force.

This conversion policy will also pay maternity benefits for a pregnancy beginning while the female Insured or dependent wife was insured under the Group Plan if maternity benefits are not payable under any extended benefits provision of the Group Plan, but would have been payable had the female Insured or dependent wife remained under such Group Plan.

## SURGICAL BENEFITS

Provides benefits on a scheduled basis according to the nature of the operation. Pays benefits regardless of where the operation is performed — home, hospital or doctor's office.

Should multiple operations of the same or related cause take place within three months, this Plan will pay no more than the most expensive operation scheduled.

In addition to the General Exceptions, Surgical Benefits are not payable for expense incurred because of childbirth, pregnancy or resulting complications.

## IN-HOSPITAL MEDICAL BENEFITS

Pays benefits for one doctor call each day during hospital confinement — up to the maximum benefit for your Plan for any one period of hospital confinement. When treatment requires surgery, your policy will pay either the in-hospital medical benefit or the scheduled surgical benefit, whichever is greater. This limitation will not apply if your confinement following surgery lasts 14 days or more, in which case benefits would begin on the 15th day.

In addition to the General Exceptions, In-hospital Medical Benefits are not provided for childbirth, pregnancy or resulting complications; tooth extractions or other dental work or surgery that involves any tooth or tooth structure, alveolar process, abscess, periodontal disease or disease of the gingival tissue; eye refractions or the fitting or cost of eyeglasses or lenses.

# SUMMARY OF COVERAGE

## Your renewal agreement

Your policy cannot be terminated because of any future changes in your health or the number of times you receive benefits.

Other than the automatic premium change at specified ages (as shown on the schedule below), your premiums can be changed only when changed for all policies of the same Form issued to all persons of the same classification in your state. You cannot be singled out for a premium change.

## Immediate coverage for sickness or injury

Covers immediately injuries and sickness resulting in loss while the policy is in force.

## Newborn children are automatically covered

Any child of the Insured born while your policy is in force and while at least one other dependent is covered will automatically be covered until the first day of the second month following birth. Thereafter, coverage can be continued simply by notifying the Company in writing of a desire to continue the coverage and by paying the additional premium prior to the expiration of the period of automatic coverage — regardless of health. Coverage for newborn children will be the same as the coverage provided for other dependent children, or if other dependent children are not covered, the same as the coverage provided for your dependent spouse. Benefits are not payable for the usual and customary baby care and treatment following full-term or premature birth.

## General Exceptions

Benefits are not payable for: confinement beginning or other expense incurred while the conversion policy is not in force; workmen's compensation or employer's liability cases; losses caused by an act of declared or undeclared war or sustained while in an armed service; loss for which benefits are payable under the Group Policy from which conversion was made; services provided by or paid for by the Veterans' Administration of the United States Government.

"Hospital" benefits are not payable in any institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, drug addicts or alcoholics.

## Termination

All benefits except the Daily Room Benefit terminate at age 65 or eligibility for Medicare, whichever is first.

# THERE ARE SEVERAL CONVERSION PLANS AVAILABLE (based on Daily Room Benefits)

You may apply for the Plan described below that equals the Daily Room Benefit for which you were insured under the Base Plan of your Group Policy. If the same Daily Room Benefit is not available, you may select either the next higher or any other lower plan. If your Group Policy did not specify a fixed dollar amount for the Daily Room Benefit, you may convert to any plan under which the Daily Room Benefit does not exceed the average semi-private room rate in hospitals in your area of residence.

NOTE: Other insurance you may have will be taken into consideration to determine the conversion Plan you can select.

| Plan | Daily Room Benefits | Maternity Benefits | Hospital Miscellaneous/Outpatient | Surgical | Daily In-hospital Medical | Maximum In-hospital Medical |
|---|---|---|---|---|---|---|
| 1 | $30.00 | $300.00 | $ 400.00 | From $5.33 to $400.00 | $4.00 | $280.00 |
| 2 | 40.00 | 400.00 | 600.00 | From 6.66 to 500.00 | 5.00 | 350.00 |
| 3 | 50.00 | 500.00 | 800.00 | From 8.00 to 600.00 | 6.00 | 420.00 |
| 4 | 60.00 | 600.00 | 1,000.00 | From 9.33 to 700.00 | 7.00 | 490.00 |

Pays Daily Room Benefit up to 70 days.

## QUARTERLY PREMIUMS

| PLAN | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| AGE | | MALE | | |
| 20-29 | $ 48.06 | $ 59.64 | $ 70.47 | $ 80.64 |
| 30-39 | 54.06 | 67.11 | 79.29 | 90.72 |
| 40-49 | 74.10 | 91.95 | 108.63 | 124.32 |
| 50-59 | 120.15 | 149.10 | 176.16 | 201.63 |
| 60-64 | 180.21 | 223.65 | 264.24 | 302.43 |
| 65 & Over | 65.34 | 87.12 | 108.90 | 130.68 |
| | | FEMALE | | |
| 20-29 | 86.40 | 108.06 | 130.38 | 152.01 |
| 30-39 | 75.15 | 94.59 | 112.98 | 130.56 |
| 40-49 | 90.63 | 113.16 | 134.22 | 154.20 |
| 50-59 | 145.56 | 181.62 | 215.31 | 247.23 |
| 60-64 | 218.34 | 272.43 | 322.95 | 370.86 |
| 65 & Over | 65.34 | 87.12 | 108.90 | 130.68 |
| CHILD | 33.33 | 40.17 | 46.68 | 53.04 |

Semiannual Premium: 2 times quarterly premiums.
Annual Premium: 4 times quarterly premiums.