SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
Company Tracking Number:	*HM AR0050707C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Filing at a Glance

Company: Transamerica Life Insurance Company

Product Name: Medicare Supplement	SERFF Tr Num: AEGX-126252428	State: Arkansas
TOI: MS08G Group Medicare Supplement - Standard Plans 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 43112
Sub-TOI: MS08G.001 Plan A 2010	Co Tr Num: HM AR0050707C01	State Status: Approved-Closed
Filing Type: Form/Rate/Advertisement		Reviewer(s): Stephanie Fowler
	Author: SPI ADMSLH	Disposition Date: 09/17/2009
	Date Submitted: 08/03/2009	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: Medicare Supplement	Status of Filing in Domicile: Pending
Project Number: HM AR0050707C01	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Association, Discretionary, Trust
Filing Status Changed: 09/17/2009	Explanation for Other Group Market Type:
	State Status Changed: 09/17/2009
Deemer Date:	Created By: SPI ADMSLH
Submitted By: SPI ADMSLH	Corresponding Filing Tracking Number:

Filing Description:

NAIC #468-86231

Forms, Rates and Advertising Filing

RE: MS9000GPT-A.DE et al. - Medicare Supplement Insurance Program
Company Filing#: HM AR0050707C01

The above referenced forms are being submitted for your review and approval. These forms are new and in compliance

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
Company Tracking Number:	*HM AR0050707C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

with the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) will replace previously approved forms MS5000GPT-A.AR et al which were approved by your department on November 17, 2007 under Insurance Department File # 36902. Upon approval, these forms will only be issued with an effective date of June 1, 2010 or later.

Other than the changes required to comply with MIPPA, these forms are the same as those filed and approved for form MS5000GPT-A.AR et al. As with our previously approved filing, the group policy will be issued direct in Delaware or marketed through an out-of-state trust policy and coverage will be marketed to sponsored association groups and financial institutions on a direct response, mass marketed basis.

Included in this submission are: the 10 Standardized Medicare Supplement Insurance Plans A through D, Plans F and G and Plans K through N (we will not offer high Deductible Plan F), the required outline of coverage, application, rates and actuarial materials, and the 2 advertising kits that will be used with this product. One kit will be mailed to applicants turning age 65 and the other to those over the age of 65.

These forms are being filed concurrently in our domicile state of Iowa.

We trust with the enclosed information, you will be able to review our filing and grant an approval. If you have any questions, please contact the undersigned. Thank you in advance for your help and attention to this matter.

Forms including in Filing:
Group Medicare Supplement Insurance Program
Group Policies:
MS9000GPT-A.AR - Group Medicare Supplement Insurance Policy Plan A
MS9000GPT-B.AR - Group Medicare Supplement Insurance Policy Plan B
MS9000GPT-C.AR - Group Medicare Supplement Insurance Policy Plan C
MS9000GPT-D.AR - Group Medicare Supplement Insurance Policy Plan D
MS9000GPT-F.AR - Group Medicare Supplement Insurance Policy Plan F
MS9000GPT-G.AR - Group Medicare Supplement Insurance Policy Plan G
MS9000GPT-K.AR - Group Medicare Supplement Insurance Policy Plan K
MS9000GPT-L.AR - Group Medicare Supplement Insurance Policy Plan L
MS9000GPT-M.AR - Group Medicare Supplement Insurance Policy Plan M
MS9000GPT-N.AR - Group Medicare Supplement Insurance Policy Plan N

Group Certificates of Insurance:
MS9000GCT-A.AR - Group Medicare Supplement Insurance Certificate Plan A
MS9000GCT-B.AR - Group Medicare Supplement Insurance Certificate Plan B

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
Company Tracking Number:	*HM AR0050707C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

MS9000GCT-C.AR - Group Medicare Supplement Insurance Certificate Plan C
MS9000GCT-D.AR - Group Medicare Supplement Insurance Certificate Plan D
MS9000GCT-F.AR - Group Medicare Supplement Insurance Certificate Plan F
MS9000GCT-G.AR - Group Medicare Supplement Insurance Certificate Plan G
MS9000GCT-K.AR - Group Medicare Supplement Insurance Certificate Plan K
MS9000GCT-L.AR - Group Medicare Supplement Insurance Certificate Plan L
MS9000GCT-M.AR - Group Medicare Supplement Insurance Certificate Plan M
MS9000GCT-N.AR - Group Medicare Supplement Insurance Certificate Plan N

MS9000GOTCS - Outline of Coverage, Group Plans, A-D, F, G, K-N

MS9000GAT - Application Form

Advertising Forms:
Kit One - for those turning age 65
MSAMAMIPPATLICBR - T65 - Turning 65 Brochure
MPLTR1 - Turning 65 Solicitation Letter Effort 1
MPLTR2 - Turning 65 Solicitation Letter Effort 2
MPLTR3 - Turning 65 Solicitation Letter Effort 3
MP T65 RS - Turning 65 Rate Sheet
Kit Two - for those age 65 and over
MSAMAMIPPATLICBR -Brochure
MPLTRR1 - Solicitation Letter Effort 1
MPLTRR2 - Solicitation Letter Effort 2
MPLTRR3 - Solicitation Letter Effort 3
MP Resol RS - Turning 65 Rate Sheet
Material available for both Kits
AMAT409 - Discount Flyer

Company and Contact

Filing Contact Information

Cindy Hammonds, Compliance System Specialist
2700 W Plano Parkway
Plano, TX 75075

chammon1@aegonusa.com
972-881-6783 [Phone] 6783 [Ext]
972-881-4097 [FAX]

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
Company Tracking Number:	*HM AR0050707C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Filing Company Information

Transamerica Life Insurance Company	CoCode: 86231	State of Domicile: Iowa
4333 Edgewood Road, N.E.	Group Code: 468	Company Type: Life and Health
Cedar Rapids, IA 52499	Group Name:	State ID Number:
(410) 685-5500 ext. [Phone]	FEIN Number: 39-0989781	

Filing Fees

Fee Required?	Yes
Fee Amount:	$375.00
Retaliatory?	No
Fee Explanation:	Form submission fee ($50) plus Rate Filing Fee ($50) plus Advertising Fee ($25 per advertising = 25 time 11 forms = $275) = Total Filing Fee of $375
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Transamerica Life Insurance Company	$375.00	08/03/2009	29591350
Transamerica Life Insurance Company	$625.00	08/19/2009	29950970

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
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Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	09/17/2009	09/17/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Stephanie Fowler	09/11/2009	09/11/2009	SPI ADMSLH	09/14/2009	09/14/2009
Pending Industry Response	Stephanie Fowler	08/19/2009	08/19/2009	SPI ADMSLH	08/19/2009	08/19/2009

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
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TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Disposition

Disposition Date: 09/17/2009
Implementation Date:
Status: Approved-Closed
Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Transamerica Life Insurance Company	%	%	$		$	%	%

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
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TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved	Yes
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT	Accepted for Informational Purposes	Yes
Supporting Document	AR Cover Letter	Accepted for Informational Purposes	Yes
Supporting Document	Explanation of Variables MS9000	Accepted for Informational Purposes	Yes
Supporting Document *(revised)*	Explanation of Variables - MS9000GAT	Accepted for Informational Purposes	Yes
Supporting Document	Explanation of Variables - MS9000GAT		Yes
Supporting Document	Explanation of Variables - Letters	Accepted for Informational Purposes	Yes
Form *(revised)*	Application	Approved	Yes
Form	Application	Disapproved	Yes
Form	Outline of Coverage	Approved	Yes
Form *(revised)*	Plan A Certificate	Approved	Yes
Form	Plan A Certificate	Disapproved	Yes
Form *(revised)*	Plan B Certificate	Approved	Yes
Form	Plan B Certificate	Disapproved	Yes
Form *(revised)*	Plan C Certifcate	Approved	Yes
Form	Plan C Certifcate	Disapproved	Yes
Form *(revised)*	Plan D Certificate	Approved	Yes
Form	Plan D Certificate	Disapproved	Yes
Form *(revised)*	Plan F Certificate	Approved	Yes
Form	Plan F Certificate	Disapproved	Yes
Form *(revised)*	Plan G Certificate	Approved	Yes
Form	Plan G Certificate	Disapproved	Yes
Form *(revised)*	Plan K Certificate	Approved	Yes
Form	Plan K Certificate	Disapproved	Yes

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
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Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Form *(revised)*	Plan L Certificate	Approved	Yes
Form	Plan L Certificate	Disapproved	Yes
Form *(revised)*	Plan M Certificate	Approved	Yes
Form	Plan M Certificate	Disapproved	Yes
Form *(revised)*	Plan N Certificate	Approved	Yes
Form	Plan N Certificate	Disapproved	Yes
Form *(revised)*	Plan A Master Policy	Approved	Yes
Form	Plan A Master Policy	Disapproved	Yes
Form *(revised)*	Plan B Master Policy	Approved	Yes
Form	Plan B Master Policy	Disapproved	Yes
Form *(revised)*	Plan C Master Policy	Approved	Yes
Form	Plan C Master Policy	Disapproved	Yes
Form *(revised)*	Plan D Master Policy	Approved	Yes
Form	Plan D Master Policy	Disapproved	Yes
Form *(revised)*	Plan F Master Policy	Approved	Yes
Form	Plan F Master Policy	Disapproved	Yes
Form *(revised)*	Plan G Master Policy	Approved	Yes
Form	Plan G Master Policy	Disapproved	Yes
Form *(revised)*	Plan K Master Policy	Approved	Yes
Form	Plan K Master Policy	Disapproved	Yes
Form *(revised)*	Plan L Master Policy	Approved	Yes
Form	Plan L Master Policy	Disapproved	Yes
Form *(revised)*	Plan M Master Policy	Approved	Yes
Form	Plan M Master Policy	Disapproved	Yes
Form *(revised)*	Plan N Master Policy	Approved	Yes
Form	Plan N Master Policy	Disapproved	Yes
Form	Flyer	Filed	Yes
Form	Rate Sheet	Filed	Yes
Form	Rate Sheet	Filed	Yes
Form	Solicitation Letter 1	Filed	Yes
Form	Solicitation Letter 2	Filed	Yes
Form	Solicitation Letter 3	Filed	Yes
Form	Age 65 Letter 1	Filed	Yes
Form	Age 65 Letter 2	Filed	Yes
Form	Age 65 Letter 3	Filed	Yes

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
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Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Form	Brochure	Filed	Yes
Form	Brochure	Filed	Yes
Rate	Arkansas Rate Sheet	Approved	Yes

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
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TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/11/2009
Submitted Date	09/11/2009
Respond By Date	10/12/2009

Dear Cindy Hammonds,

This will acknowledge receipt of the captioned filing.

Objection 1

- Explanation of Variables - MS9000GAT (Supporting Document)

Comment: This explaination seems to be a copy of the Letter Variability. Please attach the correct version if I am correct.

Objection 2

- Application, MS9000GAT (Form)

Comment: Rule 27 s 18 B states "Agents shall list any other health insurance policy they have sold to the applicant. (1) List policies sold which are still in force. (2) List policies sold in the past five (5) years that are no longer in force." Please revise this application.

Objection 3

- Plan A Certificate, MS9000GCT-A.AR (Form)
- Plan B Certificate, MS9000GCT-B.AR (Form)
- Plan C Certifcate, MS9000GCT-C.AR (Form)
- Plan D Certificate, MS9000GCT-D.AR (Form)
- Plan F Certificate, MS9000GCT-F.AR (Form)
- Plan G Certificate, MS9000GCT-G.AR (Form)
- Plan K Certificate, MS9000GCT-K.AR (Form)
- Plan L Certificate, MS9000GCT-L.AR (Form)
- Plan M Certificate, MS9000GCT-M.AR (Form)
- Plan N Certificate, MS9000GCT-N.AR (Form)
- Plan A Master Policy, MS9000GPT-A.AR (Form)
- Plan B Master Policy, MS9000GPT-B.AR (Form)
- Plan C Master Policy, MS9000GPT-C.AR (Form)
- Plan D Master Policy, MS9000GPT-D.AR (Form)
- Plan F Master Policy, MS9000GPT-F.AR (Form)

- Plan G Master Policy, MS9000GPT-G.AR (Form)
- Plan K Master Policy, MS9000GPT-K.AR (Form)
- Plan L Master Policy, MS9000GPT-L.AR (Form)
- Plan M Master Policy, MS9000GPT-M.AR (Form)
- Plan N Master Policy, MS9000GPT-N.AR (Form)

Comment: Cover Page - Right to Renew - Please remove the last sentence from this paragraph. This statement does not accurately reflect when the company can increase the rates and can be misleading to the insured.

Please feel free to contact me if you have questions.
Sincerely,
Stephanie Fowler

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/14/2009
Submitted Date	09/14/2009

Dear Stephanie Fowler,

Comments:
Thank you for your Objection Letter dated September 11. In response we offer the following:

Response 1

Comments: OBJECTION 1
Schedule Items:
Explanation of Variables - MS9000GAT

Response to Comment: We have attached the correct document - Explanation of Variables MS9000GAT. We apologize for inadvertently attaching the wrong document when we initially submitted this filing package.

OBJECTION 2
Schedule Items:
MS9000GAT -Application

Response to Comment: To comply with Rule 27 section 18B, we have revised the Replacement Question on the application form to include: list policies sold to you by the company which are still in force; list policies sold to you by the

company in the past 5 years that are no longer in force. As a result, the form number of this application now reads MS9000GAT.AR.

OBJECTION 3
Schedule Items:
MS9000GCT-A.AR - Plan A Certificate
MS9000GCT-B.AR - Plan B Certificate
MS9000GCT-C.AR - Plan C Certificate
MS9000GCT-D.AR - Plan D Certificate
MS9000GCT-F.AR - Plan F Certificate
MS9000GCT-G.AR - Plan G Certificate
MS9000GCT-K.AR - Plan K Certificate
MS9000GCT-L.AR - Plan L Certificate
MS9000GCT-M.AR - Plan M Certificate
MS9000GCT-N.AR - Plan N Certificate
MS9000GPT-A.AR - Plan A Master Policy
MS9000GPT-B.AR - Plan B Master Policy
MS9000GPT-C.AR - Plan C Master Policy
MS9000GPT-D.AR - Plan D Master Policy
MS9000GPT-F.AR - Plan F Master Policy
MS9000GPT-G.AR - Plan G Master Policy
MS9000GPT-K.AR - Plan K Master Policy
MS9000GPT-L.AR - Plan L Master Policy
MS9000GPT-M.AR - Plan M Master Policy
MS9000GPT-N.AR - Plan N Master Policy

Response to Comment: We have revised the Right to Renew section of the Policies and Certificates by eliminating the last sentence in that provision.

Related Objection 1

Applies To:

- Explanation of Variables - MS9000GAT (Supporting Document)

Comment:

This explaination seems to be a copy of the Letter Variability. Please attach the correct version if I am correct.

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
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TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Related Objection 2

Applies To:

- Application, MS9000GAT (Form)

Comment:

Rule 27 s 18 B states "Agents shall list any other health insurance policy they have sold to the applicant. (1) List policies sold which are still in force. (2) List policies sold in the past five (5) years that are no longer in force." Please revise this application.

Related Objection 3

Applies To:

- Plan A Certificate, MS9000GCT-A.AR (Form)
- Plan B Certificate, MS9000GCT-B.AR (Form)
- Plan C Certifcate, MS9000GCT-C.AR (Form)
- Plan D Certificate, MS9000GCT-D.AR (Form)
- Plan F Certificate, MS9000GCT-F.AR (Form)
- Plan G Certificate, MS9000GCT-G.AR (Form)
- Plan K Certificate, MS9000GCT-K.AR (Form)
- Plan L Certificate, MS9000GCT-L.AR (Form)
- Plan M Certificate, MS9000GCT-M.AR (Form)
- Plan N Certificate, MS9000GCT-N.AR (Form)
- Plan A Master Policy, MS9000GPT-A.AR (Form)
- Plan B Master Policy, MS9000GPT-B.AR (Form)
- Plan C Master Policy, MS9000GPT-C.AR (Form)
- Plan D Master Policy, MS9000GPT-D.AR (Form)
- Plan F Master Policy, MS9000GPT-F.AR (Form)
- Plan G Master Policy, MS9000GPT-G.AR (Form)
- Plan K Master Policy, MS9000GPT-K.AR (Form)
- Plan L Master Policy, MS9000GPT-L.AR (Form)
- Plan M Master Policy, MS9000GPT-M.AR (Form)
- Plan N Master Policy, MS9000GPT-N.AR (Form)

Comment:

Cover Page - Right to Renew - Please remove the last sentence from this paragraph. This statement does not accurately reflect when the company can increase the rates and can be misleading to the insured.

Changed Items:

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
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Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Supporting Document Schedule Item Changes

Satisfied -Name: Explanation of Variables - MS9000GAT

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Application	MS9000GAT.AR		Application/Enrollment Form	Initial		0.000	MS9000GAT_AR.PDF
Previous Version							
Application	*MS9000GAT*		*Application/Enrollment Form*	*Initial*		*0.000*	MS9000GAT.PDF
Plan A Certificate	MS9000GCT-A.AR		Certificate	Initial		0.000	MS9000GCT-A_AR.PDF
Previous Version							
Plan A Certificate	*MS9000GCT-A.AR*		*Certificate*	*Initial*		*0.000*	MS9000GCT-A_AR.PDF
Plan B Certificate	MS9000GCT-B.AR		Certificate	Initial		0.000	MS9000GCT-B_AR.PDF
Previous Version							
Plan B Certificate	*MS9000GCT-B.AR*		*Certificate*	*Initial*		*0.000*	MS9000GCT-B_AR.PDF
Plan C Certifcate	MS9000GCT-C.AR		Certificate	Initial		0.000	MS9000GCT-

					C_AR.PDF
Previous Version					
Plan C Certifcate	*MS9000G CT-C.AR*	*Certificate*	*Initial*	*0.000*	MS9000G CT-C_AR.PDF
Plan D Certificate	MS9000G CT-D.AR	Certificate	Initial	0.000	MS9000G CT-D_AR.PDF
Previous Version					
Plan D Certificate	*MS9000G CT-D.AR*	*Certificate*	*Initial*	*0.000*	MS9000G CT-D_AR.PDF
Plan F Certificate	MS9000G CT-F.AR	Certificate	Initial	0.000	MS9000G CT-F_AR.PDF
Previous Version					
Plan F Certificate	*MS9000G CT-F.AR*	*Certificate*	*Initial*	*0.000*	MS9000G CT-F_AR.PDF
Plan G Certificate	MS9000G CT-G.AR	Certificate	Initial	0.000	MS9000G CT-G_AR.PDF
Previous Version					
Plan G Certificate	*MS9000G CT-G.AR*	*Certificate*	*Initial*	*0.000*	MS9000G CT-G_AR.PDF
Plan K Certificate	MS9000G	Certificate	Initial	0.000	MS9000G

	CT-K.AR				CT-K_AR.PDF
Previous Version					
Plan K Certificate	*MS9000G CT-K.AR*	*Certificate*	*Initial*	*0.000*	MS9000G CT-K_AR.PDF
Plan L Certificate	MS9000G CT-L.AR	Certificate	Initial	0.000	MS9000G CT-L_AR.PDF
Previous Version					
Plan L Certificate	*MS9000G CT-L.AR*	*Certificate*	*Initial*	*0.000*	MS9000G CT-L_AR.PDF
Plan M Certificate	MS9000G CT-M.AR	Certificate	Initial	0.000	MS9000G CT-M_AR.PDF
Previous Version					
Plan M Certificate	*MS9000G CT-M.AR*	*Certificate*	*Initial*	*0.000*	MS9000G CT-M_AR.PDF
Plan N Certificate	MS9000G CT-N.AR	Certificate	Initial	0.000	MS9000G CT-N_AR.PDF
Previous Version					
Plan N Certificate	*MS9000G CT-N.AR*	*Certificate*	*Initial*	*0.000*	MS9000G CT-N_AR.PDF
Plan A Master Policy	MS9000G PT-A.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS9000G PT-

					A_AR.PDF
Previous Version					
Plan A Master Policy	*MS9000G PT-A.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS9000G PT-A_AR.PDF
Plan B Master Policy	MS9000G PT-B.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS9000G PT-B_AR.PDF
Previous Version					
Plan B Master Policy	*MS9000G PT-B.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS9000G PT-B_AR.PDF
Plan C Master Policy	MS9000G PT-C.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS9000G PT-C_AR.PDF
Previous Version					
Plan C Master Policy	*MS9000G PT-C.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS9000G PT-C_AR.PDF
Plan D Master Policy	MS9000G PT-D.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS9000G PT-D_AR.PDF
Previous Version					
Plan D Master Policy	*MS9000G PT-D.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS9000G PT-D_AR.PDF
Plan F Master Policy	MS9000G	Policy/Contract/Fraternal	Initial	0.000	MS9000G

	PT-F.AR	Certificate			PT-F_AR.PDF
Previous Version					
Plan F Master Policy	*MS9000G PT-F.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS9000G PT-F_AR.PDF
Plan G Master Policy	MS9000G PT-G.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS9000G PT-G_AR.PDF
Previous Version					
Plan G Master Policy	*MS9000G PT-G.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS9000G PT-G_AR.PDF
Plan K Master Policy	MS9000G PT-K.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS9000G PT-K_AR.PDF
Previous Version					
Plan K Master Policy	*MS9000G PT-K.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS9000G PT-K_AR.PDF
Plan L Master Policy	MS9000G PT-L.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS9000G PT-L_AR.PDF
Previous Version					
Plan L Master Policy	*MS9000G PT-L.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS9000G PT-L_AR.PDF
Plan M Master Policy	MS9000G PT-M.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS9000G PT-

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
Company Tracking Number:	*HM AR0050707C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

					M_AR.PDF
Previous Version					
Plan M Master Policy	*MS9000G PT-M.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS9000G PT-M_AR.PDF
Plan N Master Policy	MS9000G PT-N.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS9000G PT-N_AR.PDF
Previous Version					
Plan N Master Policy	*MS9000G PT-N.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS9000G PT-N_AR.PDF

No Rate/Rule Schedule items changed.

We hope this satisfies your concerns and review of this submission can continue. If you need any additional information please let me know.

Edward Weigand
410-209-5265
eweigand@aegonusa.com

Sincerely,
SPI ADMSLH

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
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TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/19/2009
Submitted Date	08/19/2009
Respond By Date	09/21/2009

Dear Cindy Hammonds,

This will acknowledge receipt of the captioned filing.

Per Bulletin 7-2005 The correct filing fees are $50.00 for each policy including all forms associated with the policy and filed with the policy and the fee for rates is $50.00 for each form submitted. Please submit the correct filing fee for this filing.

Please feel free to contact me if you have questions.
Sincerely,
Stephanie Fowler

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/19/2009
Submitted Date	08/19/2009

Dear Stephanie Fowler,

Comments:
Thank you for your noted of August 19th and for taking the time to talk to me about the required filing fee.

Response 1

Comments: The total Filing Fee required for this submission is $1,000. To arrive at that fee: 10 policy forms at $50 each ($500) plus 10 rate filings for 10 policy forms at $50 each ($500) for a total of $1,000.

Initially a filing fee of $375 was remitted. I have just submitted an additional EFT transaction in the amount of $625. Therefore a total of $1,000 will be remitted for this filing package.

Changed Items:

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
Company Tracking Number:	*HM AR0050707C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

We hope the above explanation meets with your satisfaction and review of this submission can continue.

Edward Weigand
410-209-5265
eweigand@aegonusa.com

Sincerely,
SPI ADMSLH

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
Company Tracking Number:	*HM AR0050707C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 09/17/2009	MS9000GAT.AR	Application/ Enrollment Form	Application	Initial		0.000	MS9000GAT_AR.PDF
Approved 09/17/2009	MS9000GOTCS	Other	Outline of Coverage	Initial		0.000	MS9000GOTCS.PDF
Approved 09/17/2009	MS9000GCT-A.AR	Certificate	Plan A Certificate	Initial		0.000	MS9000GCT-A_AR.PDF
Approved 09/17/2009	MS9000GCT-B.AR	Certificate	Plan B Certificate	Initial		0.000	MS9000GCT-B_AR.PDF
Approved 09/17/2009	MS9000GCT-C.AR	Certificate	Plan C Certifcate	Initial		0.000	MS9000GCT-C_AR.PDF
Approved 09/17/2009	MS9000GCT-D.AR	Certificate	Plan D Certificate	Initial		0.000	MS9000GCT-D_AR.PDF
Approved 09/17/2009	MS9000GCT-F.AR	Certificate	Plan F Certificate	Initial		0.000	MS9000GCT-F_AR.PDF
Approved 09/17/2009	MS9000GCT-G.AR	Certificate	Plan G Certificate	Initial		0.000	MS9000GCT-G_AR.PDF
Approved 09/17/2009	MS9000GCT-K.AR	Certificate	Plan K Certificate	Initial		0.000	MS9000GCT-K_AR.PDF
Approved 09/17/2009	MS9000GCT-L.AR	Certificate	Plan L Certificate	Initial		0.000	MS9000GCT-L_AR.PDF
Approved 09/17/2009	MS9000GCT-M.AR	Certificate	Plan M Certificate	Initial		0.000	MS9000GCT-M_AR.PDF
Approved 09/17/2009	MS9000GCT-N.AR	Certificate	Plan N Certificate	Initial		0.000	MS9000GCT-N_AR.PDF
Approved 09/17/2009	MS9000GPT-A.AR	Policy/Contract/Fraternal Certificate	Plan A Master Policy	Initial		0.000	MS9000GPT-A_AR.PDF
Approved	MS9000GP	Policy/Cont	Plan B Master Policy	Initial		0.000	MS9000GPT-

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*	
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*	
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TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*	
Product Name:	*Medicare Supplement*			
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*			

09/17/2009	T-B.AR	ract/Fratern al Certificate					B_AR.PDF
Approved 09/17/2009	MS9000GPT-C.AR	Policy/Cont ract/Fratern al Certificate	Plan C Master Policy	Initial		0.000	MS9000GPT-C_AR.PDF
Approved 09/17/2009	MS9000GPT-D.AR	Policy/Cont ract/Fratern al Certificate	Plan D Master Policy	Initial		0.000	MS9000GPT-D_AR.PDF
Approved 09/17/2009	MS9000GPT-F.AR	Policy/Cont ract/Fratern al Certificate	Plan F Master Policy	Initial		0.000	MS9000GPT-F_AR.PDF
Approved 09/17/2009	MS9000GPT-G.AR	Policy/Cont ract/Fratern al Certificate	Plan G Master Policy	Initial		0.000	MS9000GPT-G_AR.PDF
Approved 09/17/2009	MS9000GPT-K.AR	Policy/Cont ract/Fratern al Certificate	Plan K Master Policy	Initial		0.000	MS9000GPT-K_AR.PDF
Approved 09/17/2009	MS9000GPT-L.AR	Policy/Cont ract/Fratern al Certificate	Plan L Master Policy	Initial		0.000	MS9000GPT-L_AR.PDF
Approved 09/17/2009	MS9000GPT-M.AR	Policy/Cont ract/Fratern al Certificate	Plan M Master Policy	Initial		0.000	MS9000GPT-M_AR.PDF
Approved 09/17/2009	MS9000GPT-N.AR	Policy/Cont ract/Fratern al Certificate	Plan N Master Policy	Initial		0.000	MS9000GPT-N_AR.PDF
Filed 09/17/2009	AMAT409	Advertising	Flyer	Initial			AMAT409.PDF

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
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Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Filed 09/17/2009	MP Resol RS	Advertising	Rate Sheet	Initial		MP Resol RS.PDF
Filed 09/17/2009	MP T65 RS	Advertising	Rate Sheet	Initial		MP T65 RS.PDF
Filed 09/17/2009	MPLTRR1	Advertising	Solicitation Letter 1	Initial		MPLTRR1.PDF
Filed 09/17/2009	MPLTRR2	Advertising	Solicitation Letter 2	Initial		MPLTRR2.PDF
Filed 09/17/2009	MPLTRR3	Advertising	Solicitation Letter 3	Initial		MPLTRR3.PDF
Filed 09/17/2009	MPLTRT1	Advertising	Age 65 Letter 1	Initial		MPLTRT1.PDF
Filed 09/17/2009	MPLTRT2	Advertising	Age 65 Letter 2	Initial		MPLTRT2.PDF
Filed 09/17/2009	MPLTRT3	Advertising	Age 65 Letter 3	Initial		MPLTRT3.PDF
Filed 09/17/2009	MSAMAMIPPATLICBR	Advertising	Brochure	Initial		MSAMAMIPPATLICBR.PDF
Filed 09/17/2009	MSAMAMIPPATLICBR-T65	Advertising	Brochure	Initial		MSAMAMIPPATLICBR-T65.PDF

AMA

A American Medical Association

TRANSAMERICA LIFE INSURANCE COMPANY G
[A TRANSAMERICA COMPANY] G
DIRECT RESPONSE DIVISION • BALTIMORE, MARYLAND
Medicare Supplement Insurance Program
C [Sponsored/Endorsed] by the [American Medical Association] D

1c

[THIS Medicare Supplement Application for [both] [PHYSICIAN/Member /applicant/employee/customer] [and/&/OR] [spouse] [& other applicant][Spouse may also be a partner in a civil union]

1a [It's easy to apply:] [To Apply:]

1. Please complete, date and sign this form, and check the Plan you want. Make sure you answer all the questions and read all the statements.
2. 1e [Send NO MONEY at this time. You will be billed when your Insurance Certificate is mailed.] 1f [Be sure to complete the Monthly Deduction Authorization enclosed.] 1g [Send no money now. Your premiums will be automatically deducted from your checking account.] 1h [Send no money now. Your premium will be conveniently billed to your credit card.]
3. Return this application (be sure to have your spouse sign if also applying) in the postage-paid envelope provided[.] [, to: B [AMA Insurance Agency, Inc., 515 North State St., Chicago IL 60654-9687.]

B

Administered by:
AMA Insurance Agency, Inc.
515 North State Street, Chicago, Illinois 6054-9687
(In California, d/b/a:
AMA of Illinois Insurance Agency)
A Subsidiary of the American Medical Association (AMA)

Underwritten by: Transamerica Life Insurance Company, Cedar Rapids, Iowa

1d

[Response Requested by:]
[Month XX, XXXX]

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
Sample A. Sample
Apt. 1-A
123 Main Street
Suite 123
Anytown, US 12345-6789 E

Please check if above address is o Home o Office
If not indicated above, please provide your primary home address here: _____
Street Address

_____
City State Zip

G

PLEASE COMPLETE

o I wish to apply
[Phone No: (_____)_____ [Work Phone: (_____)_____]G
[Name of [physician/member/customer/employee/other applicant] F
[whose spouse is applying for coverage]]_ G

_____
H [Spouse][Other Applicant's] Name (if applying)

_____
E-mail address _____

[Physician/Member/Customer/Cardholder/Employee/Applicant]F:
F [Physician] [Spouse (if applying)]
H [Applicant I] [Other Applicant]

Social Security Number:	_____	_____
Date of Birth:	____-____-____ Month Day Year	____-____-____ Month Day Year
Sex:	o Male o Female	o Male o Female
Medicare ID Number: *(found on your Medicare ID Card)*	_____	_____
Desired future effective month:	_____ Month/Year	_____ Month/Year

G[**Or** -Please attach a copy of your Medicare ID card with this application to expedite electronic filing and speed the processing of your Part B Claim.]

PLEASE READ AND COMPLETE THE OTHER SIDE ,

[AMA-MSAPP 00/00]

MS9000GAT.AR

[I am a member of _____] **G**
Other Applicants
Name: _____ Relationship: _____
Address: _____ Sex: DOB: __/___/__
City/State: _____ Telephone: _____
Medicare ID Number: _____(*found on your Medicare ID Card)*
1b

IF YOU ARE UNDER AGE 65 AND COVERED UNDER MEDICARE PARTS A and B,
YOU MAY APPLY FOR COVERAGE UNDER PLANS [[A, B OR C] [A][A or B] [A, B, C, or F] [A through J] [A through N]] ONLY. 2a

CHECK BOX FOR DESIRED COVERAGE:

F [Physician/Member/Customer/Applicant/Employee/Cardholder] [Applicant I]
[• Plan A • Plan B • Plan C • Plan D • Plan F • Plan G • Plan K • Plan L,• Plan M, • Plan N]]**2b**
[• Other __] **2f**
H [Spouse/Other Applicant] [Applicant II]
[• Plan A • Plan B • Plan C • Plan D • Plan F • Plan G • Plan K • Plan L • Plan M • Plan N]**2b** [• Other _____] **2f**

[(Monthly Rate) (based on current age of XX)]

$XX.XX	$XX.XX	$XX.XX	$XX.XX	$XX.XX
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXXX	XXXXXXXXXXX

2c

[[PLEASE BILL] [• Please bill me at home]
[Mode of Payment] [Choose one] [• Monthly] [• Quarterly] [• Semi-annual] [• Annual][EFT Monthly (Electronic Funds Transfer)]]**2d**
[Payment Method][• Direct Bill • EFT Monthly (Electronic Funds Transfer) • AMPO (Automatic Monthly Payment Option) • Credit Card] Please note: Effective date will be disclosed on the Certificate Schedule Page.
[First premium payment enclosed in the amount of [Member/Physician] $_____ Spouse $_____.] **2e**
[Total premium enclosed for [Member/Physician] and Spouse $_____.]
[Please note: Effective date will be disclosed on the Certificate Schedule Page.] **G**
[Desired Future Effective Date of Coverage: ____/____/_____] **G**
[Be sure to select your payment preference and enclose your first premium payment [Member/Physician] $___ Spouse $____.]
[Total premium enclosed for [Member/Physician] and Spouse $_____.]
[Please make your check payable to the [AMA Insurance Agency, Inc.]] **G**

EFT Authorization Agreement: I authorize [AMA Insurance Agency, Inc.] to instruct my financial institution to make my monthly bill payments on the dates due from account listed. This authority remains in effect until [AMA Insurance Agency] has received written notification from me of termination in time to allow reasonable opportunity to act on it, or until [AMA Insurance Agency, Inc.] has sent me written notice of termination of this agreement.
_____ [Physician][Customer] signature
_____ [Spouse] signature
_____Account Number _____ Routing Number **2e**

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE AND BELIEF

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS

	[Physician] F / [Applicant I] F	[Spouse] H / [Applicant II] H
1) Your Acceptance May be Guaranteed.		
a) Did you turn age 65 in the last 6 months?	o Yes o No	o Yes o No
b) Did you enroll in Medicare Part B in the last 6 months?	o Yes o No	o Yes o No
If Yes, what is the effective date?	___/___/___ mo day yr	___/___/___ mo day yr
2) Premium Assistance Questions (Questions we are required to ask)		
a) Are you covered for medical assistance through the state Medicaid program: (NOTE TO APPLICANT): If you are participating in a "Spend-Down Program" and have not met your "Share of Cost"; please answer NO to this question.) Will Medicaid pay your premiums for this Medicare Supplement policy?	o Yes o No	o Yes o No
b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	o Yes o No o Yes o No	o Yes o No o Yes o No
3) Replacement Questions. (Answer only if you are replacing coverage)		
Ÿ **Medicare Advantage:**		
a) If you had coverage from any Medicare plan other than the original Medicare within the past 63 days (for example, a Medicare Advantage Plan, or Medicare HMO or PPO) fill in your start and end dates. If you are still covered under this plan leave "END" blank.	Start_____ End_____	Start_____ End_____
b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	o Yes o No	o Yes o No
Ÿ **Medicare Supplement:**		
a) Was this your first time in this type of Medicare plan?	o Yes o No	o Yes o No
b) Did you drop a Medicare Supplement policy to enroll in this Medicare Plan?	o Yes o No	o Yes o No
c) Do you have another Medicare Supplement policy in force?	o Yes o No	o Yes o No
d) If so, with what company, and what plan do you have? Company: _____ Plan: _____		
e) If so, do you intend to replace your current Medicare Supplement policy with this policy?	o Yes o No	o Yes o No
Ÿ **Other:**		
a) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)	o Yes o No	o Yes o No
b) If so, with what company and what kind of policy? Company: _____ Plan: _____	o Yes o No	o Yes o No
c) What are your dates of coverage under the other policy? (If you are still covered by the other policy, leave 'END" blank.)	Start_____ End_____	Start_____ End_____
f) List policies sold to you by the company which are still in force. _____		
g) List policies sold to you by the company in the last 5 years that are no longer in force. _____		

MEDICARE SUPPLEMENT INFORMATION TO CONSIDER

- You do not need more than one Medicare Supplement policy or certificate.
- If you purchase this Certificate you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy or certificate.
- If, after purchasing this certificate, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement certificate can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement certificate (or, if that is no longer available, a substantially equivalent policy or certificate) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstituted certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare Supplement certificate or policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement certificate or policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement certificate or policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent certificate or policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement certificate or policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB).

[FL Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.] **3a**

[PA Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.] **3b**

[Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.] **3c**

[Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information, concerning any fact material thereto commits a fraudulent insurance act, which is a crime.] **3d**

[New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]**3e**

[Nebraska Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a crime and may be subject to fines or confinement in prison.]**3f**

[Tennessee Residents; It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.] **3g**

[Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.] **3h**

IMPORTANT – PLEASE READ AND SIGN

I hereby apply for Medicare Supplement coverage issued by Transamerica Life Insurance Company. I understand that this coverage will not pay benefits for conditions for which I have received medical treatment or advice within the last 6 months (3 months in WA) prior to the effective date until I have been insured for 6 (3 months in WA) consecutive months. If I had creditable health insurance coverage within 63 (90 days in ME and WY) calendar days of applying for this plan, or if I am an Eligible Person enrolled within 63 days of termination, then this pre-existing conditions limitation will be waived to the extent that it was satisfied under the replaced coverage. This waiver will apply only to prior creditable coverage which includes, but is not limited to, coverage under a group health plan, health insurance coverage, Medicare Supplement, Medicare Parts A and B, Medicaid, TRICARE, a state health benefits risk pool or the Federal Employees Health Benefits Plan (FEHB).

[PLEASE NOTE: If you are currently enrolled in a Medicare Risk HMO plan, you are responsible for terminating your HMO coverage once you apply for this plan. Any unpaid claims resulting from failure to disenroll from your HMO plan will be your responsibility.] G

I understand that my acceptance into this [D AMA]-[C sponsored/endorsed] Plan is GUARANTEED with no medical information required and that the pre-existing conditions limitation is not applicable if 1.) I apply within 6 months of being age 65 (or older) and] [I am] enrolled in Medicare Parts A and B or, 2.) if I have been covered by [a/the] [D AMA- C sponsored] [Catastrophic Major Medical] or [Hospital Income Plan] for at least the [12] 4c months prior to the date this Medicare Supplement takes effect. or [3.) I replace other primary hospital or medical reimbursement coverage with this plan.]

4a

[If you are [age 65 or older], enrolled in Medicare Parts A and B and your premium is paid when due, your coverage will be effective on the first day of the month [after] your application is received[.] [by AMA Insurance Agency, Inc.] [(or on the first day of the following month if received on the 11th of the month or later).] 4b

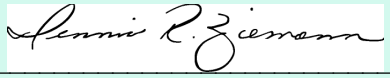
Please read and complete the other side

I acknowledge that I have read all statements.

[Physician's][Member's][Customer's][Employee's] [Signature] X _____ **Date** _____

[Applicant's]

[Spouse's/Other Applicant's] [Applicant] Signature X _____ **Date** _____

Licensed Resident Agent (where required by law):  4d

[Dennis R. Ziemann]

Your 30-Day Right To Return Your Certificate Takes The Risk Out Of Applying Now

Apply today. When your Certificate arrives, examine it carefully. Take up to 30 days, if you like, to discuss it with your family, friends, lawyer, accountant or advisor. If, for any reason, you decide during the 30 days that you do not need this supplemental protection, write "cancel" across the face of your Certificate and mail it back to [AMA Insurance Agency, Inc.]B Any premium paid will be refunded in full and your Certificate will be considered never issued. G

1-800-458-5736 B

To apply by phone call [1-800-xxx-xxxx from [8:00 a.m. to 5:00 p.m.], [Central Time], [Monday through Friday].] [To apply online visit our website [www.abcdefghijk]. B

B For more information, call this toll-free number for prompt, courteous service. [Experienced, knowledgeable service specialists will gladly assist you.] G

Underwritten by Transamerica Life Insurance Company under Group Policy No. MS9000GPT

Transamerica Life Insurance Company
Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

This chart show the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Plans E, H, I and J are no longer available for sale.

Basic Benefits:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B coinsurance or copayments.

Blood: First three pints of blood each year.

Plan A	Plan B	Plan C	Plan D	Plan F or F*	Plan G	Plan K	Plan L	Plan M	Plan N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance *	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $[4,620]; paid at 100% after limit reached	Out-of-pocket limit $[2,310]; paid at 100% after limit reached		

Monthly Age Rate									
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]
Monthly Age Rate with [8%] [Electronic Funds Transfer Payment] Discount									
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	]$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as plan F after one has paid a calendar year [$2,000] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed [$2,000]. Out-of pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible. Please note: High Deductible Plan F is currently not available as part of this program.

Transamerica Life Insurance Company

Medicare Supplement Plans

About Your Certificate

Premium Information

Your premium is based on your age at the time coverage is issued (not applicable to residents of AR, CT, GA, ME and WA). We, Transamerica Life Insurance Company, can only raise your premium if we raise the premium for all certificates like yours in this state.

Disclosures

Use this outline to compare benefits and premiums among policies

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I and J are no longer available for sale.

Read Your Certificate Very Carefully

This is only an outline describing your Certificate's most important features. The Group Policy is the insurance contract. You must read the Certificate itself to understand all of the rights and duties of both you and Transamerica Life Insurance Company.

Right To Return Certificate

If you find that you are not satisfied with your Certificate, you may return it to Transamerica Life Insurance Company, through its authorized agent, [AMA Insurance Agency Inc.], [515 N. State St., Chicago, IL 60654-9687].

If you send the Certificate back to [us][the agency] within 30 days after you receive it, we will treat the Certificate as if it had never been issued and return all of your payments.

Certificate Replacement

If you are replacing another health insurance Certificate, do NOT cancel it until you have actually received your new Certificate and are sure you want to keep it.

Notice

- The Certificate may not fully cover all of your medical costs.
- Transamerica Life Insurance Company is not connected with Medicare.
- This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare and You" for more details.

Complete Answers Are Very Important

When you fill out the application for the new Certificate, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your Certificate and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Plan A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	$0	[$1,068] (Part A deductible)
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	$0	Up to [$133.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.,			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible]
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Plan B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1,068]	[$1,068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare – approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	$0	Up to [$133.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan B

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:,			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible]
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Plan C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1,068]	[$1,068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days (lifetime)	$0	100% of Medicare Eligible Expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare – approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan C

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
First [$135] of Medicare-Approved Amounts*	$0	[$135] (Part B Deductible]	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	[$1,068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare – approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan D

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:,			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible]
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services: Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1,068]	[$1,068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days (lifetime)	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare – approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES –I N OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:,			
First [$135] of Medicare-Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
First [$135] of Medicare-Approved Amounts*	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services: Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First [$135] of Medicare-Approved Amounts*	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1,068]	[$1,068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days (lifetime)	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare – approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR*

*Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:,			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible]
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [$4,620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (•) in the chart below. Once your reach the annual limit, the plans pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY *
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	[$534](50% of Part A deductible)	[$534](50% of Part A deductible)•
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days (lifetime)	$0	100% of Medicare Eligible Expenses	$0***
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare – approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$66.75] a day	Up to [$66.75] a day•
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%•
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of copayment/ coinsurance•

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan K

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR*

****Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY *
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:,			
First [$135] of Medicare-Approved Amounts****	$0	$0	[$135] (Part B deductible)****•
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10%•
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	$0	All Costs(and they do not count toward annual out-of-pocket limit of [$4,620])*
BLOOD			
First 3 pints	$0	50%	50%•
First [$135] of Medicare-Approved Amounts****	$0	$0	[$135] (Part B Deductible]****•
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10% •
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approve amounts to [$4620] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called " Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service**.**

Plan K

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
First [$135] of Medicare-Approved Amounts*****	$0	$0	[$135] (Part B Deductible) •
Remainder of Medicare-Approved Amounts	80%	10%	10% •

***** Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

Plan L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [$2,310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (•) in the chart below. Once you reach the annual limit, the plans pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1,068]	[$801](75% of Part A deductible)	[$267](25% of Part A deductible) •
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days (lifetime)	$0	100% of Medicare Eligible Expenses	$0***
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare – approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$100.13] a day	Up to [$33.38] •a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25% •
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/ coinsurance	25% of copayment/ coinsurance•

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan L

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR*

****Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY *
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:,			
First [$135] of Medicare-Approved Amounts****	$0	$0	[$135] (Part B deductible)**** •
Preventive Benefits for Medicare covered services	Generally 75% or mor e of Medicare approved amounts	Remainder of Medicare approved amounts	$All cost above Medicare approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5%
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	$0	All costs (and they do not count toward out-of-pocket limit of [$2,310])*
BLOOD			
First 3 pints	$0	75%	25% •
First [$135] of Medicare-Approved Amounts****	$0	$0	[$135] (Part B Deductible]
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	Generally 5% •
CLINICAL LABORATORY SERVICES			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to [$2,310] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called " Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Plan L

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
Medically necessary skilled care services			
And medical supplies	100%	$0	$0
Durable medical equipment:			
First [$135] of Medicare-Approved Amounts******	$0	$0	[$135] (Part B Deductible) •
Remainder of Medicare-Approved Amounts	80%	15%	5% •

***** Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

Plan M

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1,068]	[$534](50% of Part A deductible)	[$534](50% of Part A deductible)
61st thru 90th day	All but [$267] a day	[$267] a day	
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days (lifetime)	$0	100% of Medicare Eligible Expenses	$0
Beyond the Additional 365 days	$0	$0	$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare -approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to[$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan M

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR*

*Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:,			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible]
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
Medicare Approved Services:			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime maximum

** Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

Plan N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1,068]	[$1,068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days (lifetime)	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare -approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR*

*Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUT –PATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First [$135] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	$0 Generally 80%	$0 Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	[$135] (Part B deductible) Up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	$0	All Costs
BLOOD First 3 pints First [$135] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	$0 $0 80%	All costs $0 20%	$0 [$135] (Part B Deductible] $0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE- APPROVED SERVICESL Medically necessary skilled care services and medical supplies Durable medical equipment: First [$135] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% $0 80%	$0 $0 20%	$0 [$135] (Part B Deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA: First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

**Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT [CERTIFICATE SCHEDULE][SCHEDULE PAGE]
Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan A

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of

any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:

(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:

(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;

(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN A

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you

are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31 days**]** before the date of change. Premiums may be changed: when the terms of the Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. **[**If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.**]**

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time

written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermeer
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT [CERTIFICATE SCHEDULE][SCHEDULE PAGE]
Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	**[**JOSEPHINE SAMPLE**]**
[Policy:	**[**MZ0000000H0000A**]]**
[Certificate Number:	**[**SAMPPROD**]]**
[Policyholder:	**[**ABC ASSOCIATION**]]**
[Effective Date of Coverage:	**[**January 01, 2010**]]**
[[Semi-Annual**]** Premium:	**[**$50.00**]]**
[Covered Person's Age At Issue:	**[**65**]]**

Supplemental Medicare Expense Benefits
Plan B

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:

(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;

(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN B

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium

mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31 days**]** before the date of change. Premiums may be changed: when the terms of the Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. **[**If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.**]**

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermeer
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT [CERTIFICATE SCHEDULE][SCHEDULE PAGE]
Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan C

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Medicare Part B Deductible Benefit	• This Plan pays 100% of the Medicare Part B Deductible per Calendar Year.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;

(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN C

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT
You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B DEDUCTIBLE BENEFIT
You will receive benefits when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part B Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Calendar Year, is the Medicare Part B Deductible.

FOREIGN COUNTRY TRAVEL BENEFIT
You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the **[**Certificate Schedule**][**Schedule Page**]**, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the **[**Certificate Schedule**][**Schedule Page**]**. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the **[**Certificate Schedule**][**Schedule Page**]**.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under

Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
   (a) provide continuation of benefits contained in the Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31 days**]** before the date of change. Premiums may be changed: when the terms of the Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. **[**If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.**]**

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof

of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermeer
Secretary

Brenda Cleary
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT SCHEDULE PAGE
Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	**[**JOSEPHINE SAMPLE**]**
[Policy:	**[**MZ0000000H0000A**]]**
[Certificate Number:	**[**SAMPPROD**]]**
[Policyholder:	**[**ABC ASSOCIATION**]]**
[Effective Date of Coverage:	**[**January 01, 2010**]]**
[[Semi-Annual**]** Premium:	**[**$50.00**]]**
[Covered Person's Age At Issue:	**[**65**]]**

Supplemental Medicare Expense Benefits
Plan D

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;

(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN D

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS PART A
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B
You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A

Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the **[**Certificate Schedule**][**Schedule Page**]**, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and

(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the **[**Certificate Schedule**][**Schedule Page**]**. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the **[**Certificate Schedule**][**Schedule Page**]**.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may

also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least [31 days] before the date of change. Premiums may be changed: when the terms of the Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. [If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.]

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT SCHEDULE PAGE
Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan F

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Medicare Part B Deductible Benefit	• This Plan pays 100% of the Medicare Part B Deductible per Calendar Year.
Medicare Part B Excess Benefit	• This Plan pays 100% of the difference between the Medicare Part B billed amount and the Medicare Eligible Expense.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Schedule Page who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for

Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which **[**first**]** manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN F

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B
You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part B Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Calendar Year, is the Medicare Part B Deductible.

MEDICARE PART B EXCESS BENEFIT

You will receive an additional benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. We will pay 100% of the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law) and the Medicare Part B Eligible Expense. Benefits will not be paid if your Physician or medical provider accepts the Medicare Eligible Expenses as the total amount due.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the **[**Certificate Schedule**][**Schedule Page**]**, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the **[**Certificate Schedule**][**Schedule Page**]**.

Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the **[**Certificate Schedule**][**Schedule Page**]**.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of the application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or less than **[**6**]**

months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:

  (a) provide continuation of benefits contained in the Policy; or

  (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
(a) the conversion coverage provided under item (1) above; or
(b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to all Covered Persons covered under the Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least [31 days] before the date of change. Premiums may be changed: when the terms of the Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. [If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.]

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]**(referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT SCHEDULE PAGE
Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	**[**JOSEPHINE SAMPLE**]**
[Policy:	**[**MZ0000000H0000A**]]**
[Certificate Number:	**[**SAMPPROD**]]**
[Policyholder:	**[**ABC ASSOCIATION**]]**
[Effective Date of Coverage:	**[**January 01, 2010**]]**
[[Semi-Annual**]** Premium:	**[**$50.00**]]**
[Covered Person's Age At Issue:	**[**65**]]**

Supplemental Medicare Expense Benefits
Plan G

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Medicare Part B Excess Benefit	• This Plan pays 100% of the difference between the Medicare Part B billed amount and the Medicare Eligible Expense.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN G

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B EXCESS BENEFIT

You will receive an additional benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. We will pay 100% of the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law) and the Medicare Part B Eligible Expense. Benefits will not be paid if your Physician or medical provider accepts the Medicare Eligible Expenses as the total amount due.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the **[**Certificate Schedule**][**Schedule Page**]**, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and

(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the **[**Certificate Schedule**][**Schedule Page**]**. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the **[**Certificate Schedule**][**Schedule Page**]**.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under

Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
   (a) provide continuation of benefits contained in the Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31 days**]** before the date of change. Premiums may be changed: when the terms of the Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. **[**If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.**]**

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof

of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Linda Clarey
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT SCHEDULE PAGE
Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	**[**JOSEPHINE SAMPLE**]**
[Policy:	**[**MZ0000000H0000A**]]**
[Certificate Number:	**[**SAMPPROD**]]**
[Policyholder:	**[**ABC ASSOCIATION**]]**
[Effective Date of Coverage:	**[**January 01, 2010**]]**
[[Semi-Annual**]** Premium:	**[**$50.00**]]**
[Covered Person's Age At Issue:	**[**65**]]**

Supplemental Medicare Expense Benefits
Plan K

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 50% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Blood Benefit
Part A & B

- This Plan pays 50% of the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Medical Benefits
Part B

- This Plan pays 50% of the cost sharing of Medicare Eligible Expenses, for Part B Medical Services, other than Part B preventive medical services, after payment of the Medicare Part B Deductible, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Additional Benefits

Medicare Part A Deductible Benefit	• This Plan pays 50% of the Medicare Part A Deductible per Benefit Period, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Skilled Nursing Facility Benefit	• This Plan pays 50% of the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Part B Preventive Services Benefit	• This Plan pays 100% of the coinsurance amount for Medicare Eligible Expenses for Part B preventive medical services, subject to the Medicare Part B Deductible.
Out of Pocket Limit	• $**[**4,140**]** per Calendar Year. Once this Out of Pocket Limit has been met, this Plan pays 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year.

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for

Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN K

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 50% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare until the Out of Pocket Limit has been met, then 100%.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense. We will pay 50% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense. We will pay 50% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

MEDICAL BENEFITS – PART B
You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses other than Part B preventive medical services. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay 50% of the cost sharing for Part B Medicare Eligible Expenses which are not paid by Medicare for you, until the Out of Pocket Limit has been met, then 100%.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 50% of the Medicare Part A Deductible until the Out of Pocket Limit has been met, then 100%.

SKILLED NURSING FACILITY BENEFIT
You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement. We will pay 50% of the Actual Expenses, subject to the above, until the Out of Pocket Limit has been met, then 100%.

PART B PREVENTIVE SERVICES BENEFIT
You will receive a benefit when we receive proof that, while insured, you incurred expenses for Part B preventive services, as defined by Medicare. We will pay 100% of the cost sharing for Medicare Part B preventive services, subject to the Medicare Part B Deductible.

COST SHARING AFTER OUT OF POCKET LIMIT
After you have reached the Out of Pocket Limit shown on the **[**Certificate Schedule**][**Schedule Page**]**, you will receive benefits when we receive proof that, while insured, you incurred eligible expenses. We will pay 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year. The Out of Pocket Limit is shown on the **[**Certificate Schedule**][**Schedule Page**]** and will be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under

Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
   (a) provide continuation of benefits contained in the Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31 days**]** before the date of change. Premiums may be changed: when the terms of the Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. **[**If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.**]**

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof

of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT SCHEDULE PAGE
Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan L

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 75% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Blood Benefit
Part A & B

- This Plan pays 75% of the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Medical Benefits
Part B

- This Plan pays 75% of the cost sharing of Medicare Eligible Expenses, for Part B Medical Services, other than Part B preventive medical services, after payment of the Medicare Part B Deductible, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Additional Benefits

Medicare Part A Deductible Benefit	• This Plan pays 75% of the Medicare Part A Deductible per Benefit Period, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Skilled Nursing Facility Benefit	• This Plan pays 75% of the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Part B Preventive Services Benefit	• This Plan pays 100% of the coinsurance amount for Medicare Eligible Expenses for Part B preventive medical services, subject to the Medicare Part B Deductible.
Out of Pocket Limit	• $**[**2,070**]** per Calendar Year. Once this Out of Pocket Limit has been met, this Plan pays 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year.

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for

Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN L

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 75% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare until the Out of Pocket Limit has been met, then 100%.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense. We will pay 75% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense. We will pay 75% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

MEDICAL BENEFITS – PART B
You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses other than Part B preventive medical services. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay 75% of the cost sharing for Part B Medicare Eligible Expenses which are not paid by Medicare for you, until the Out of Pocket Limit has been met, then 100%.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 75% of the Medicare Part A Deductible until the Out of Pocket Limit has been met, then 100%.

SKILLED NURSING FACILITY BENEFIT
You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement. We will pay 75% of the Actual Expenses, subject to the above, until the Out of Pocket Limit has been met, then 100%.

PART B PREVENTIVE SERVICES BENEFIT
You will receive a benefit when we receive proof that, while insured, you incurred expenses for Part B preventive services, as defined by Medicare. We will pay 100% of the cost sharing for Medicare Part B preventive services, subject to the Medicare Part B Deductible.

COST SHARING AFTER OUT OF POCKET LIMIT
After you have reached the Out of Pocket Limit shown on the **[**Certificate Schedule**][**Schedule Page**]**, you will receive benefits when we receive proof that, while insured, you incurred eligible expenses. We will pay 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year. The Out of Pocket Limit is shown on the **[**Certificate Schedule**][**Schedule Page**]** and will be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under

Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
   (a) provide continuation of benefits contained in the Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31 days**]** before the date of change. Premiums may be changed: when the terms of the Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. **[**If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.**]**

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof

of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermeer
Secretary

Brenda Cleary
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT SCHEDULE PAGE
Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan M

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 50% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;

(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN M

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B
You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A

Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 50% of the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the **[**Certificate Schedule**][**Schedule Page**]**, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the **[**Certificate Schedule**][**Schedule Page**]**. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the **[**Certificate Schedule**][**Schedule Page**]**.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may

also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least [31 days] before the date of change. Premiums may be changed: when the terms of the Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. [If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.]

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for two years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT SCHEDULE PAGE
Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan N

Hospital Benefits **Part A**	• This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150. • Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.
Blood Benefit **Part A & B**	• This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.
Medical Benefits **Part B**	• This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, other than the co-payment amounts shown below, subject to the Medicare Part B Deductible.
• **Office Visit Co-Payment**	• $[20] per office visit
• **Emergency Room Co-Payment**	• $[50] per emergency room visit (waived if you are admitted to the Hospital and the emergency

visit is subsequently covered as a Medicare Part A Eligible Expense)

Additional Benefits

Medicare Part A Deductible Benefit	• This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.
Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN N

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you, except as provided in items (3) and (4) that follows.

(3) You must pay the lesser of $**[**20**]** or the Medicare Part B coinsurance or co-payment, shown in the **[**Certificate Schedule**][**Schedule Page**]**, for each covered health care provider office visit, including visits to medical specialist.

(4) You must pay the lesser of $**[**50**]** or the Medicare Part B coinsurance or co-payment, shown in the **[**Certificate Schedule**][**Schedule Page**]**, for each visit to an emergency room of a Hospital. This emergency room co-payment will be waived if you are admitted to the Hospital and the emergency visit is subsequently covered as a Medicare Part A Eligible Expense.

If you discontinue or lapse Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 100% of the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT
You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT
You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the **[**Certificate Schedule**][**Schedule Page**]**, before expenses are payable under this benefit. This benefit is subject to the following conditions:
(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the **[**Certificate Schedule**][**Schedule Page**]**. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the **[**Certificate Schedule**][**Schedule Page**]**.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of

termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31 days**]** before the date of change. Premiums may be changed: when the terms of the Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. **[**If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.**]**

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible.

The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan A

Core Benefits

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person’s application and the first premium. The Effective Date of Coverage will be shown on the Covered Person’s certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN A

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will

be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code

(Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs

and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least [31] days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least [31] days before the date of change. Premiums may be changed: when the terms of this Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. [If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.]

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within [30 days] after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan B

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Persons' application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN B

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will

be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or **]**is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. Premiums may be changed: when the terms of this Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. **[**If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.**]**

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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[Pre-Existing Condition Limitation .....**]**
Individual Termination of Insurance .....
Premiums .....
General Provisions .....
Claim Provisions .....

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan C

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Medicare Part B Deductible Benefit	• This Plan pays 100% of the Medicare Part B Deductible per Calendar Year.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of

any person described in **[**(a)**] [**or**] [**(b)**]** above**][**;**][** and**] [**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**] [**(b)**] [**or**] [**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:

(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:

(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist,

occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN C

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part B Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Calendar Year, is the Medicare Part B Deductible.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be

entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date

of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. Premiums may be changed: when the terms of this Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. **[**If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.**]**

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after three years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan D

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Foreign Country Travel Benefit

• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian

Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN D

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay

100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a

Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and

(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code

(Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. Premiums may be changed: when the terms of this Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. **[**If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.**]**

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and

not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan F

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Medicare Part B

- This Plan pays 100% of the Medicare Part B

Deductible Benefit	Deductible per Calendar Year.
Medicare Part B Excess Benefit	• This Plan pays 100% of the difference between the Medicare Part B billed amount and the Medicare Eligible Expense.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC

Association's**][**Federation**]** Directory**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which **[**first**]** manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE

Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN F

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365

days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B DEDUCTIBLE BENEFIT
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part B Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Calendar Year, is the Medicare Part B Deductible.

MEDICARE PART B EXCESS BENEFIT
The Covered Person will receive an additional benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. We will pay 100% of the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law) and the Medicare Part B Eligible Expense. Benefits will not be paid if the Covered Person's Physician or medical provider accepts the Medicare Eligible Expenses as the total amount due.

FOREIGN COUNTRY TRAVEL BENEFIT
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:
(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of the application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses his entitlement to such medical assistance, within the 24 month period, his coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
(a) the conversion coverage provided under item (1) above; or
(b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. Premiums may be changed: when the terms of this Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. **[**If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.**]**

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person’s death, the benefit will be paid as follows: to the Covered Person’s spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan G

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Medicare Part B Excess Benefit	• This Plan pays 100% of the difference between the Medicare Part B billed amount and the Medicare Eligible Expense.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of

any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist,

occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE

Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN G

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B EXCESS BENEFIT

The Covered Person will receive an additional benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. We will pay 100% of the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law) and the Medicare Part B Eligible Expense. Benefits will not be paid if the Covered Person's Physician or medical provider accepts the Medicare Eligible Expenses as the total amount due.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to

exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if he provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date

of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. Premiums may be changed: when the terms of this Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. **[**If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.**]**

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan K

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 50% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Blood Benefit Part A & B

- This Plan pays 50% of the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Medical Benefits Part B

- This Plan pays 50% of the cost sharing of Medicare Eligible Expenses for Part B Medical Services, other than Part B preventive medical services, after payment of the Medicare Part B Deductible, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 50% of the Medicare Part A Deductible per Benefit Period, until the Out of Pocket Limit has

been met, then this Plan pays 100%.

Skilled Nursing Facility Benefit	• This Plan pays 50% of the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Part B Preventive Services Benefit	• This Plan pays 100% of the coinsurance amount for Medicare Eligible Expenses for Part B preventive medical services, subject to the Medicare Part B Deductible.
Out of Pocket Limit	• $**[**4,140**]** per Calendar Year. Once this Out of Pocket Limit has been met, this Plan pays 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year.

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]**

Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][;][** and**] [**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**] [**or**] [**(b)**]** above**][**;**][** and**] [**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**] [**(b)**] [**or**] [**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:

(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:

(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities,

Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN K

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 50% of the cost sharing for all Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare until the Out of Pocket Limit has been met, then 100%.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense. We will pay 50% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense. We will pay 50% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses other than Part B preventive medical services. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay 50% of the cost sharing for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person, until the Out of Pocket Limit has been met, then 100%.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 50% of the Medicare Part A Deductible until the Out of Pocket Limit has been met, then 100%.

SKILLED NURSING FACILITY BENEFIT
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement. We will pay 50% of the Actual Expenses, subject to the above, until the Out of Pocket Limit has been met, then 100%.

PART B PREVENTIVE SERVICES BENEFIT
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for Part B preventive services, as defined by Medicare. We will pay 100% of the cost sharing for Medicare Part B preventive services, subject to the Medicare Part B Deductible.

COST SHARING AFTER OUT OF POCKET LIMIT
After the Covered Person has reached the Out of Pocket Limit shown on the Schedule, the Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred eligible expenses. We will pay 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year. The Out of Pocket Limit is shown on the Schedule and will be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by

a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered

Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date

of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. Premiums may be changed: when the terms of this Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. **[**If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.**]**

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan L

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 75% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Blood Benefit Part A & B

- This Plan pays 75% of the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Medical Benefits Part B

- This Plan pays 75% of the cost sharing of Medicare Eligible Expenses for Part B Medical Services, other than Part B preventive medical services, after payment of the Medicare Part B Deductible, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 75% of the Medicare Part A Deductible per Benefit Period, until the Out of Pocket Limit has

been met, then this Plan pays 100%.

Skilled Nursing Facility Benefit	• This Plan pays 75% of the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Part B Preventive Services Benefit	• This Plan pays 100% of the coinsurance amount for Medicare Eligible Expenses for Part B preventive medical services, subject to the Medicare Part B Deductible.
Out of Pocket Limit	• $**[**2,070**]** per Calendar Year. Once this Out of Pocket Limit has been met, this Plan pays 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year.

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]**

Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][;][** and**] [**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**] [**or**] [**(b)**]** above**][**;**][** and**] [**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**] [**(b)**] [**or**] [**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:

(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:

(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities,

Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN L

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 75% of the cost sharing for all Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare until the Out of Pocket Limit has been met, then 100%.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense. We will pay 75% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense. We will pay 75% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses other than Part B preventive medical services. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay 75% of the cost sharing for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person, until the Out of Pocket Limit has been met, then 100%.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 75% of the Medicare Part A Deductible until the Out of Pocket Limit has been met, then 100%.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement. We will pay 75% of the Actual Expenses, subject to the above, until the Out of Pocket Limit has been met, then 100%.

PART B PREVENTIVE SERVICES BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for Part B preventive services, as defined by Medicare. We will pay 100% of the cost sharing for Medicare Part B preventive services, subject to the Medicare Part B Deductible.

COST SHARING AFTER OUT OF POCKET LIMIT

After the Covered Person has reached the Out of Pocket Limit shown on the Schedule, the Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred eligible expenses. We will pay 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year. The Out of Pocket Limit is shown on the Schedule and will be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by

a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered

Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date

of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. Premiums may be changed: when the terms of this Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. **[**If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.**]**

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan M

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 50% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Foreign Country Travel Benefit

• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian

Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN M

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay

100% of the cost sharing for all Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 50% of the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a

Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and

(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code

(Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. Premiums may be changed: when the terms of this Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. **[**If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.**]**

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

Deleted: We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan N

Core Benefits

Hospital Benefits Part A	• This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150. • Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.
Blood Benefit Part A & B	• This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.
Medical Benefits Part B	• This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, other than the co-payment amounts shown below, subject to the Medicare Part B Deductible.
• **Office Visit Co-Payment**	• $**[**20**]** per office visit
• **Emergency Room Co-Payment**	• $**[**50**]** per emergency room visit (waived if the Covered Person is admitted to the Hospital and the emergency visit is subsequently covered as a Medicare Part A Eligible Expense)

Additional Benefits

Medicare Part A Deductible Benefit	• This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.
Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
•	
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated

organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][;][** and**] [**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**] [**or**] [**(b)**]** above**][**;**][** and**] [**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**] [**(b)**] [**or**] [**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE

Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN N

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other

appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the cost sharing for all Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person, except as provided in items (3) and (4) that follows.

(3) The Covered Person must pay the lesser of $**[**20**]** or the Medicare Part B coinsurance or co-payment, shown in the Schedule, for each covered health care provider office visit, including visits to medical specialist.

(4) The Covered Person must pay the lesser of $**[**50**]** or the Medicare Part B coinsurance or co-payment, shown in the Schedule, for each visit to an emergency room of a Hospital. This emergency room co-payment will be waived if the Covered Person is admitted to the Hospital and the emergency visit is subsequently covered as a Medicare Part A Eligible Expense.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 100% of the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person’s

certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:

(a) the conversion coverage provided under item (1) above; or
(b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

Deleted: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. Premiums may be changed: when the terms of this Policy are changed; or, to coincide with changes in applicable Medicare deductible, copayment and coinsurance amounts. **[**If such premium change becomes effective during a period for which premium has already been paid, any increased premium due from the date of change must be paid.**]**

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to

us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

Medicare Supplement Insurance Plans sponsored by the American Medical Association (AMA)

+ { 2 Valuable Discounts
Guaranteed Acceptance
Professional Service

4 Top Reasons to Choose

AMA INSURANCE AGENCY

AMA Insurance Agency, Inc.
A subsidiary of the American Medical Association

AMAT409

AMA-sponsored Medicare Supplement Insurance Plans

2 Valuable Discounts

Save [2%]! With EFT billing option.

You have the option to sign-up for Monthly Electronic Funds Transfer (EFT) with AMA Insurance Agency, Inc. to automatically deduct your premium payment from your bank savings or checking account. When you select the EFT option you save a full [2%] on your premium. If your premium is [$100] a month, that's a [$24] a year savings. Both you and your spouse are eligible for this discount.

New! Save an Extra [5%] with the Spouse Discount

When both you and your spouse are covered under an AMA- sponsored Medicare Supplement Insurance Plan issued after June, 2010, you can both receive a [5%] premium discount. This spouse discount is in addition to the EFT discount savings and is available as long as you keep your certificate inforce. With both discounts you and your spouse can make a significant impact on your insurance costs year after year.

Guaranteed Acceptance

You are guaranteed acceptance into any Medicare Supplement Insurance Plan sponsored by the American Medical Association (AMA) that is available in your state. This sets the AMA-sponsored plans apart, as many companies provide guaranteed acceptance only during limited open or special enrollment periods.

Professional Service

AMA Insurance Agency, Inc. (a subsidiary of the American Medical Association) is the administrator of these plans. Service is our number one priority. For over twenty-five years we have been dedicated to serving physicians and their families. We understand your concerns when it comes to your medical insurance and have unique expertise in providing Medicare Supplement Insurance Plans to physicians.

Because we insure medical professionals exclusively, you will be a part of a select group and not lost among millions of certificate holders. By limiting participation to physicians and spouses, the AMA Insurance Agency is able to provide the fast, efficient and personal service you deserve. We understand you and that makes all the difference.

We know you have choices when it comes to your Medicare Supplement coverage. We are here to help you with the plan that's right for you.

Call the AMA Insurance Agency Inc. at [800-458-5736] [Monday through Friday], [8:00 am to 5:00 p. m. Central Time] or visit [doctormedsupp.com].

AMAT409

[AMA Insurance Agency, Inc.
A subsidiary of the American Medical Association]
[515 N. State Street
Chicago, Illinois 60654]

[AMA]-Sponsored Medicare Supplement Plans offered in ARKANSAS

for zip codes [beginning with] [900-918]

AFFORDABLE PREMIUMS

Plan	A	B	C	D	F	G	K	L	M	N
Monthly EFT	[XXX.XX]	[XXX.XX]	[XXX.XX]	[XXX.XX]	[XXX.XX]	[XXX.XX]	[XXX.XX]	[XXX.XX]	[XXX.XX]	[XXX.XX]

Bold = Recommended plans

Rates effective as of [01/01/2009] with current [2009] monthly rates per person for age [65]

2 Discounts Available EFT [2]% and Spouse [5]% = Total [7]% Discount

Combine your discounts and get a total [7]% discount. A monthly discount with the [2]% for billing discount for prepaying your premium through monthly Electronic Funds Transfer (EFT). Or for both the [2]% EFT discount plus the [5]% discount if your spouse is also enrolled. You get the [7]% discount for each person insured. That can really add up every month, especially for a couple. And you keep these discounts for your lifetimes.

For example with a [$100.00] dollar monthly premium
[$ 2.00] EFT Discount
[$ 5.00] Spouse Discount
Total [$ 7.00] Total Discount
Times 12 month = [$84.00] Yearly

And for a Couple that's a [$168.00] Savings Every Year!

[2]% EFT Discount -Convenience and Savings with the Monthly Electronic Funds Transfer

If you prefer the budgeting ease and convenience of having your premiums electronically transferred from your savings or checking account, you may elect the Electronic Funds Transfer Payment Option. Simply complete the enclosed EFT Authorization Agreement. By choosing the EFT payment option shown above, you will save [2%] annually … with no checks to write… no stamps to buy … no trips to the mailbox.

[5]% Discounts Available To Physician and Spouse

And choose the [5]% discount for each of you if you and your spouse are both enrolled. This discount is for certificates effective on or after 6/1/10. The discount is applied for all billing methods and continues for your lifetimes.

Have a spouse that needs coverage?
Call us toll-free at [1-800-458-5736] for a quick, no obligation rate quote.

For other payment options and discounts, please see reverse side

Please See Reverse

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Your Choice of Payment Options
Depending upon your preference, you may be billed quarterly, semi-annually, annually or through monthly Electronic Funds Transfer (EFT). You save [2]% off the quarterly rate (not shown) by choosing to be billed monthly EFT or annually, ([1]% if you choose semi-annual billing). These savings are possible because we pass on to you reduced administrative costs associated with these options.

To calculate the quarterly, semi-annual and annual premium, divide the EFT monthly premium shown by [.98], then multiply by 3 for the quarterly premium, by [5.76] for the semi-annual premium or by [11] for the annual premium. For example, if the EFT monthly premium is $73.60 ($73.60 divided by [.98] = [$75.10] x 3 = [$225.30] quarterly) or ([$75.10] x [5.76] = [$432.58] semi-annual) or ([$75.10] x 11 = [$826.10] annual).
Note: monthly premium payment is only available through Electronic Funds Transfer (EFT).

Plus the Spouse Discount of [5]% per year per person. This will be applied to all modes of payment, monthly, quarterly, semi-annual or annual.

[No portion of [AMA] membership dues is used by [AMA Insurance Agency, Inc.] to support the marketing efforts of the [AMA]-sponsored Medicare Supplement Insurance Program.]

Underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa.

[AMA Insurance Agency, Inc.
A subsidiary of the American Medical Association]
[515 N. State Street
Chicago, Illinois 60654]

[AMA]-Sponsored Medicare Supplement Plans offered in ARKANSAS

for zip codes [beginning with] [900-918]

AFFORDABLE PREMIUMS

Plan	A	B	C	D	F	G	K	L	M	N
Monthly EFT	[XXX.XX]	[XXX.XX]	[XXX.XX]	[XXX.XX]	[XXX.XX]	[XXX.XX]	[XXX.XX]	[XXX.XX]	[XXX.XX]	[XXX.XX]

Bold = Recommended plans
Rates effective as of [01/01/2009] with current [2009] monthly rates per person for age [65]

2 Discounts Available EFT [2]% and Spouse[5]% = Total [7]% Discount

Combine your discounts and get a total [7]% discount. A monthly discount with the [2]% for billing discount for prepaying your premium through monthly Electronic Funds Transfer (EFT). Or for both the [2]% EFT discount plus the [5]% discount if your spouse is also enrolled. You get the [7]% discount for each person insured. That can really add up every month, especially for a couple. And you keep these discounts for your lifetimes.

For example with a [$100.00] dollar monthly premium
[$2.00] EFT Discount
[$5.00] Spouse Discount
Total [$ 7.00] Total Discount
Times 12 month = [$84.00] Yearly

And for a Couple that's a [$168.00] Savings Every Year!

[2]% EFT Discount -Convenience and Savings with the Monthly Electronic Funds Transfer
If you prefer the budgeting ease and convenience of having your premiums electronically transferred from your savings or checking account, you may elect the Electronic Funds Transfer Payment Option. Simply complete the enclosed EFT Authorization Agreement. By choosing the EFT payment option shown above, you will save [2]% annually … with no checks to write… no stamps to buy … no trips to the mailbox.

[5]% Discounts Available To Physician and Spouse
And choose the [5]% discount for each of you if you and your spouse are both enrolled. This discount is for certificates effective on or after 6/1/10. The discount is applied for all billing methods and continues for your lifetimes.

Have a spouse that needs coverage?
Call us toll-free at [1-800-458-5736] for a quick, no obligation rate quote.

For other payment options and discounts, please see reverse side Please See Reverse
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Be sure to check with AMA Insurance Agency, Inc. for a current premium rate if you are applying after the 'Respond By' date. Application received after the "Respond By" date or coverage issued with a future Effective Date will be based on the rate in your state as of the Effective Date of your Certificate.

Your Choice of Payment Options

Depending upon your preference, you may be billed quarterly, semi-annually, annually or through monthly Electronic Funds Transfer (EFT). You save [2]% off the quarterly rate (not shown) by choosing to be billed monthly EFT or annually, ([1]% if you choose semi-annual billing). These savings are possible because we pass on to you reduced administrative costs associated with these options.

To calculate the quarterly, semi-annual and annual premium, divide the EFT monthly premium shown by [.98], then multiply by 3 for the quarterly premium, by [5.76] for the semi-annual premium or by [11] for the annual premium. For example, if the EFT monthly premium is $73.60 ($73.60 divided by [.98] = [$75.10] x 3 = [$225.30] quarterly) or ([$75.10] x [5.76] = [$432.58] semi-annual) or ([$75.10] x [11] = [$826.10] annual).

Note: monthly premium payment is only available through Electronic Funds Transfer (EFT).

Plus the Spouse Discount of [5]% per year per person. This will be applied to all modes of payment, monthly, quarterly, semi-annual or annual.

[No portion of [AMA] membership dues is used by [AMA Insurance Agency, Inc.] to support the marketing efforts of the [AMA]-sponsored Medicare Supplement Insurance Program.]

Underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa.

AMA Insurance Agency, Inc.
A Subsidiary of the American Medical Association

515 N. State Street
Chicago, Illinois 60654

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Even if you already have a Medicare Supplement Plan...

It's easy to step up to a higher level of value, service, and choice of plan options with the [AMA][2]-sponsored Medicare Supplement Insurance Program.

Dear [Physician,] [Medicare Beneficiary,][3]

You've probably come to expect a certain level of excellence in many areas of your life. And rightly so. You've earned it.

So if you want to be sure your Medicare Supplement protection is also providing a higher level of value, service, and choice of plan options – we'd like to tell you about the Medicare Supplement Program sponsored by the [American Medical Association][AMA][2]-, now available to [physicians and spouses.][member's parents.][physicians' and spouses' parents.][3]

IMPORTANT: Your pre-existing health conditions may be covered immediately if you switch from another Medicare Supplement Plan.

If this plan replaces any creditable coverage, such as any primary hospital and medical reimbursement coverage, or if you apply within 63 calendar days [90 days in ME and WY][6] of canceling your other coverage, you will not have a new waiting period for any pre-existing health conditions as long as you have satisfied at least a 6 month pre-existing health conditions period [3 months WY][6] with your current policy. Creditable coverage includes: coverage under a group health plan, health insurance coverage, Medicare Parts A and B, TRICARE, a state health benefits risk pool or Federal Employees Health Benefit Plan. This makes it easy to switch coverage regardless of your health or the plan you select. [There are other instances when your pre-existing conditions period will be waived. Please refer to the enclosed brochure for details.][9]

[[Keep in mind] [And remember][9], with all [AMA][2]-sponsored Medicare Supplement Insurance coverage you will still have the ability to choose your own physicians and specialists, since this is not an HMO or PPO program.][9]

[The enclosed rates may be very competitive depending on your age and state of residence when your Certificate is issued – so we can provide a better value to you.][9]

We're also proud to offer rates [to physicians and spouses][3] which may be more affordable than the competition, based on your age and state of residence. Please refer to the enclosed [yellow][5] rate sheet for rates on every plan available in your state.

[We provide a high level of customer service to our [physician and spouse][3]customers.][9]

[And][9] when it comes to customer service, we go above and beyond for our valued [physician and spouse][3] Medicare Supplement customers. We know that Medicare Supplement Insurance coverage can be confusing [(even for physicians)][3] so we're here to answer any questions you may have and to make sure your claims are handled quickly. [In fact, most covered claims are paid within [4][7] days of the date we receive them (based on [2009] claims payment experience)!][9][And with [Electronic Claim Filing for [Part A] [and Part B][11] claims] [simplified claims procedure][11], there are no claim forms for you to complete (unless you are in the pre-existing conditions period).][9]

[We provide a choice of [10][9] standard
Medicare Supplement Insurance Plans [available in your state]

Unlike many other Medicare Supplement Programs, with [AMA][2]-sponsored coverage you have a choice of [standard] plans available in your state[9]. In addition, you can select any plan, even the higher benefit plans. [A waiting period of up to six months for coverage of pre-existing health conditions may apply.][9]

We recommend special consideration of plan[s] [A], [C], [and] [F][8] which [is a] [are] popular plan choice[s] [among physicians][3]. Plans [C] [and F] are the most popular [.] [, and Plan F of course provides the maximum level of Medicare Supplement protection.][8] You can refer to the enclosed Outline of Coverage for details on the Medicare Supplement Insurance Plans now available to you. [As all] [Remember, since][9] Medicare Supplement Insurance Plans have been standardized by Federal law, the plan benefits are the same regardless of the insurance company.

[We have selected Transamerica Life Insurance Company to underwrite the [AMA][2]-Sponsored Medicare Supplement Insurance Program because of their excellent ratings and reputation.][9]

You'll be glad to know that the underwriter of this Medicare Supplement Program – Transamerica Life Insurance Company, [an AEGON company][9] [member of the AEGON Insurance Group][9] – is currently rated ["A" (Excellent)][10] by the A.M. Best Company, for their financial strength and operating performance, and ["AA-" (Very Strong)] [10]by Standard & Poor for their financial strength. These are some of the highest ratings attainable. Transamerica is also an experienced provider of Medicare Supplement coverage to many thousands of seniors across the nation.

Apply now with no risk — your acceptance is guaranteed.

You risk nothing when you apply for the [AMA][2] sponsored Medicare Supplement Plan of your choice. Just complete, sign, date, and return the enclosed [Physician][3] [Physician and Spouse][3] Application in the postage-paid envelope [(have your spouse complete the Spouse Application if also applying)][3]. [Send no money at this time.][9] Once you receive your Certificate in the mail, you'll have a full 30 days to review it and decide if this coverage is right for you. If you're not completely satisfied during this period, just return the Certificate and you will owe nothing. No questions asked. [And don't forget,] [And keep in mind,][9] your acceptance is guaranteed in any [standard plan][9] you select. you can select any [standard] plan.

If you would like additional information on a plan not featured in the enclosed Outline of Coverage, or if you have any questions, just call us at [1-800-458-5736], [Monday through Friday] [8:00 a.m. to 5:00 p.m]., [Central Time] [or visit us at our web site: [www.doctormedsupp.com]].[1]

Sincerely,

[J. Christopher Burke, FLMI]
[President]
[AMA Insurance Agency, Inc.][1]

P.S. Why not step up to a higher level of value, service, and choice of plan options with the [AMA][2]-sponsored Medicare Supplement Program? You deserve it! And remember, your pre-existing health conditions may be waived under certain circumstances as described in this package. So apply now.

[No portion of [AMA][2] membership dues is used by the [AMA Insurance Agency, Inc.][2] to support the marketing efforts of the [AMA][2] sponsored Insurance Program.][6]

To [enroll] [apply] by phone call [1-800-xxx-xxxx from [8:00 a.m. to 5:00 p.m.], [Central Time], [Monday through Friday][1]. To [enroll] [apply] online visit our website [www.abcdefghijk].[1]

[Note: This Medicare Supplement Insurance Plan is not connected with or endorsed by the U. S. Government or the Federal Medicare Program.][6]

[Neither Transamerica nor its agents are endorsed by Medicare or connected to the U. S. Government.][6]

AMA Insurance Agency, Inc.
A Subsidiary of the American Medical Association

515 N. State Street
Chicago, Illinois 60654

If you're thinking of switching your Medicare Supplement Insurance Plan...you're not alone. **Thousands [of physicians][3] have already switched to the [AMA][2]-Sponsored Medicare Supplement Insurance Program.**

Dear [Physician,] [Medicare Beneficiary,][3]

You may be wondering why so many [people] [physicians and their spouses] have already switched their Medicare Supplement coverage to the Program sponsored by the [American Medical Association (AMA)][2]. We think it's for a few very good reasons a higher level of value, a higher level of service and a higher level of plan options. Many [physicians][3] are also glad that they have the ability to choose their own physicians and specialists with these plans.

If you switch your Medicare Supplement coverage, your pre-existing health conditions may be covered immediately.

Like many [physicians][3], you may be considering replacing an existing Medicare Supplement Plan. If so, you can rest assured, because we've made it easy to switch coverage regardless of your health or the plan you select.

When you replace any creditable coverage, such as Medicare Supplement insurance or any primary hospital and medical reimbursement coverage, or if you apply within 63 calendar days [90 days in ME and WY][6] of canceling your other coverage, you will not have a new waiting period for any pre-existing health conditions as long as you have satisfied at least a 6 month pre-existing health conditions period [3 months in WY] [6] with your current policy. Creditable coverage includes: coverage under a group health plan, health insurance coverage, Medicare Parts A and B, TRICARE, a state health benefits risk pool or Federal Employees Health Benefit Plan. There are other instances when your pre-existing conditions period will be waived. Please refer to the enclosed brochure for details.

[Compare our very competitive rates with what you may be paying now ... and we think you'll find a better value.][9]

Here's another excellent reason to consider [AMA][2]-sponsored Medicare Supplement coverage ... depending on your age and state of residence, our rates [for physicians and spouses][3] may often be more affordable than the competition's rates. Just take a look at the [yellow][5] rate sheet enclosed for the competitive rates on every standard plan available in your state.

[Experience a high level of customer service exclusively for physicians and their spouses.][9]

[The plan administrator, [AMA Insurance Agency, Inc., a licensed insurance subsidiary of the American Medical Association (AMA)][2] understands your insurance needs.][9] When you need to file a claim, or to get quick answers to your questions, you'll have the confidence in knowing we're right here, ready to assist you in

any way possible. Our courteous and professional customer service specialists are dedicated to providing the best service possible to our [physician and spouse][3] customers. We understand Medicare Supplement coverage, and we'll help you get your claims settled quickly [and without hassles][9]. [With our Electronic Claim Filing for [Part A] [and B]][11] [The majority of covered claims are paid within [4][7] days of receipt. (based on [2009] claims payment experience)][7] Each question, each concern, each claim receives personal attention. [Because this plan insures physicians and their families only,][3] [you are always treated as an individual][9].

Select [any of the [10] Standard] Medicare Supplement Insurance Plans [available in your state].

The underwriter not only offers [a choice of] [10] [standard] plans available in your state. This special advantage allows you to apply with confidence, regardless of your health (a waiting period of up to six months [3 months in WY][6] for coverage of preexisting health conditions may apply). Many Medicare Supplement programs will not make all standard plans available.

Our recommended plans include [A], [C], and [F.][8], which are popular standard plan choices among our [physician] [insureds] [customers][3]. The most popular Plans are [C] [and] [F][8] . [and Plan F of course provides the maximum level Medicare Supplement protection.][8] Please refer to the enclosed Outline of Coverage for details on the Medicare Supplement Plans now available to you. Keep in mind, since all Medicare Supplement Insurance Plans have been standardized by Federal law, the plan benefits are the same regardless of the insurance company.

[You'll have the added confidence that comes with a highly-rated underwriter.][9]

Transamerica Life Insurance Company,[an AEGON company] [a member of the AEGON Insurance Group][9], is the underwriter of this program. We've selected Transamerica because of their experience in providing Medicare Supplement coverage to seniors across the United States, and because of their excellent standing. Transamerica is currently rated ["A" (Excellent)][10] by the A.M. Best Company, for their financial strength and operating performance, and ["AA-" (Very Strong)][10] by Standard & Poor for their financial strength.

Don't delay. Apply now with no risk — you'll have a 30-day no-obligation review period.

If a higher level of value is important to you, that may be reason enough to apply now. But when you combine this money-saving value with a higher level of service and plan options, you'll find it's hard to find such an offer elsewhere. Plus you are guaranteed acceptance in any plan you select. So apply now with no risk. Just complete, sign, date and return the enclosed [Physician] [Physician and Spouse][3] Application in the postage-paid envelope. Be sure to have your spouse complete the [Spouse][3] Application if also applying. [Send no money at this time.][9] Once you receive your Certificate in the mail, you'll have a full 30 days to review it.

[Sincerely,]

[J. Christopher Burke, FLMI]
[President]
[AMA Insurance Agency, Inc.]1

P.S. If you've already responded to our initial mailing for Medicare Supplement coverage, we thank you. You will be receiving your Certificate of Insurance in the mail soon. If you haven't responded for this high level of value, service, and choice of plan options, I urge you to apply now.

Any questions? Call us at [1-800-458-5736], [Monday through Friday] [8:00 a.m. to 5:00 p.m.], [Central Time] [or visit us at our web site: [www.doctormedsupp.com].][1]

[No portion of [AMA][2] membership dues is used by the [AMA Insurance Agency, Inc.][2] to support the marketing efforts of the [AMA][2]-sponsored Insurance Program.][6]

To [enroll][apply] by phone call [**1-800-xxx-xxxx** from [8:00 a.m. to 5:00 p.m.], [Central Time], [Monday through Friday][1]. To [enroll][apply] online visit our website [www.abcdefghijk].[1]

[Note: This Medicare Supplement Insurance Plan is not connected with or endorsed by the U. S. Government or the Federal Medicare Program.][6]

[Neither Transamerica nor its agents are endorsed by Medicare or connected to the U. S. Government.][6]

AMA Insurance Agency, Inc.
A Subsidiary of the American Medical Association

515 N. State Street
Chicago, Illinois 60654

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FINAL NOTIFICATION [FOR 2009][4] [2009][4]

Don't miss this opportunity to REPLACE your current Medicare Supplement Protection,

Application Deadline: [Dec. 31,2009][4]

Dear [Physician,] [Medicare Beneficiary,][3]

[As the New Year draws near,] [At this time,] [Spring is a time of renewal, and][9] you may be thinking of how to make the most of your time and money. If so, we suggest that you consider how the Medical Supplement Insurance Program sponsored by the [American Medical Association (AMA)][2] can save you both if you [and your spouse] haven't returned your application[s].

Save time with no new waiting period!
When you replace your Medicare Supplement coverage, your pre-existing health conditions may be covered immediately.

We know that time is of the essence when it comes to your health care. We've made it even easier to replace existing coverage with [AMA][2]-sponsored Medicare Supplement protection, regardless of your health or the plan you select.

When this plan replaces creditable coverage, such as Medicare Supplement insurance (or any primary hospital and medical reimbursement coverage) or if you apply within 63 calendar days [90 days in ME and WY][6] of canceling your other coverage, you will have no new waiting period for any pre-existing health conditions to the extent satisfied under the prior plan. Creditable coverage includes: coverage under a group plan, health insurance coverage, Medicare Parts A and B, TRICARE, a state health benefits risk pool or Federal Employees Health Benefit Plan. There are other instances when your pre-existing conditions period will be waived. Please refer to the enclosed brochure for details.

[Save money with these very competitive rates! When you take a moment to compare, we think you may find that we offer a better value [to physicians and spouses][3].][9]

[Although][9] saving money on premiums may not be a number one priority, [but][9] it can be an added bonus to get the quality coverage you want, at a more affordable cost. And this coverage

[exclusively for physicians and spouses][3] is available at very affordable rates which [are often] [may be][9] less than the competition, depending on your age and state of residence. Please refer to the enclosed [yellow][5] rate sheet for rates on every plan available [in your state][9].

[Keep in mind, our high level of customer service will be here for you every step of the way.][9]

[The plan administrator, [AMA Insurance Agency, Inc., a licensed insurance subsidiary of the American Medical Association (AMA)] understands your insurance needs.][2] From the moment you call with any questions about this coverage, and throughout your entire relationship as a valued customer, you'll receive the level of service you deserve. Our professional customer service specialists value the opportunity to serve [your] [you and your spouse's][3] Medicare Supplement coverage needs with quick answers to your questions and simplified claims. [In fact, unless you are in a pre-existing conditions period, no claim forms are needed and most covered claims are paid within [4][7] days of receipt (based on [2009] claims payment experience).]. [And with Electronic Claim Filing for [Part A] [and Part B][11] claims, your filing process is hassle-free.][11]

Plus, you can select any Medicare Supplement Plan available [in your state].

To provide the highest level of plan options, you can select from every plan available [in your state]. So you can apply with confidence, regardless of your health. A waiting period of up to six months for coverage of pre-existing health conditions may apply.

Although you can select any plan available, we recommend special consideration of plan[s] [A], [C], and [F]. Plans [C] [and F][8] are the most popular [among physicians,][3] [and Plan F of course provides the maximum level of Medicare Supplement protection.][8]. You can refer to the enclosed Outline of Coverage for details on the Medicare Supplement [Standard][8] Plans available. The plan benefits are the same regardless of the insurance company, as all Medicare Supplement Insurance Plans have been standardized by Federal law.

[The plan underwriter – Transamerica Life Insurance Company– has some of the highest ratings attainable.][9]

[You'll be glad to know Transamerica Life Insurance Company– [an AEGON Company] [a member of the AEGON Insurance Group] – is the underwriter of this program. Transamerica is currently rated ["A" (Excellent)][10] by the A.M. Best Company, for their financial strength and operating performance, and ["AA-" (Very Strong)][10] by Standard & Poor for their financial strength. They also have vast experience in providing Medicare Supplement coverage to many thousands of seniors across the country.][9]

[APPLY NOW WITH NO RISK.][9]

Don't miss out on this valuable protection opportunity if you have yet to apply for [AMA][2]-sponsored Medicare Supplement Insurance coverage. You'll have a 30-day no-risk review period. So just complete and return the application[s] today.

Sincerely,

[J. Christopher Burke, FLMI]

[President]
[AMA Insurance Agency, Inc.][1]

P.S. If you should have any questions, simply call us at [1-800-458-5736,] [Monday through Friday] [8:00 a.m. to 5:00 p.m.], [Central Time] [or visit us at our web site: www.doctormedsupp.com].[1] If you haven't responded for this high level of value, service and choice of plan options, I urge you to apply now.

[No portion of [AMA][2] membership dues is used by [AMA insurance Agency, Inc.][2] to support the marketing efforts of the [AMA][2]- Sponsored Insurance Program.][6]

To [enroll] [apply] by phone call [1-800-xxx-xxxx from [8:00 a.m. to 5:00 p.m.], [Central Time], [Monday through Friday][1]. To [enroll] [apply] online visit our website [www.abcdefghijk].[1]

[Note: This Medicare Supplement Insurance Plan is not connected with or endorsed by the U. S. Government or the Federal Medicare Program.][6]

[Neither Transamerica nor its agents are endorsed by Medicare or connect to the U. S. Government.][6]

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Chicago, Illinois 60654

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[As you near your [65th][9] birthday, keep in mind ... you need more than just Medicare and] [9]

You're in good company with the [AMA][2]- sponsored Medicare Supplement Insurance Program (dedicated to serving [physicians][3] for over [25][1] years).

Dear [Physician,] [Medicare Beneficiary,][3]

A

You've probably come to expect a certain level of excellence in many areas of your life. And rightly so. You've earned it. [And now that you are nearing age [65] [9], you have even more reason to expect excellence <u>in your health care coverage.]</u>[9] You may soon qualify for Medicare coverage and already know that Medicare was not intended to cover all of your health care costs, and it doesn't. The fact is, with Medicare coverage alone you could be left with thousands of dollars a year in health care expenses to pay out of your own pocket.

B

As you approach your retirement years, your lifestyle, interests, passions, and activities will probably continue, but your health may change. To manage your healthcare needs, [AMA Insurance Agency, Inc.][2] is a trusted source and a valuable planning tool to help you sort through the complexities of Medicare and Medicare Options. [If you are retired from your job or plan to retire (and will be using Medicare when you turn age [65] [9]), you will want to make sure to <u>learn about what kind of policies will provide the health care coverage you need.]</u>[9] You most likely know that Medicare was not intended to cover all of your health care costs, and it doesn't. The fact is, with Medicare coverage alone you could be left with thousands of dollars a year in health care expenses to pay out of your own pocket.

C

As you near the age of [65] [9], you want to protect your assets and maintain control over your own health care. [If you are retired from your practice or plan to retire and will be using Medicare when you turn age [65][9], you have a major decision to make before the end of your 6 month open enrollment period. This decision could affect your future health and health care.] [9] You already know that Medicare was not intended to cover all of your health care costs, and it doesn't. The fact is, with Medicare coverage alone you could be left with thousands of dollars a year in health care expenses to pay out of your own pocket.

We'd like to introduce the Medicare Supplement Insurance Program sponsored by the [American Medical Association (AMA)][2], available exclusively [.][to] [Physicians and Spouses.] [Physician's Parents][3] Keep in mind that all insurance companies provide the same Medicare Supplement Plans as recommended by Federal law. When choosing a Medicare Supplement Plan, there are <u>three</u> aspects you need to consider: 1) cost 2) service level, and 3) choice of [10] [standard] [9] plan options. You can be assured that the AMA-sponsored Medicare Supplement Plan excels in each of these key areas by providing competitive rates, a wide array of standard plans to choose from and a dedicated staff of experienced professionals available to assist you.

<u>IMPORTANT: Apply Now to Assure Your Pre-existing Health Conditions will be covered immediately</u>

If you or your spouse apply during your Medicare Open Enrollment Period which lasts 6 months from the date you are enrolled in Medicare Part A and B and you are age 65 or older, or if this plan replaces prior creditable coverage, such as primary hospital and medical reimbursement coverage that has been in force within the past sixty-three (63) calendar days [90 days in ME and WY][6], then your pre-existing health conditions limitation will be waived. [Please refer to the enclosed brochure for details.][9]

[And] [Keep in mind][9] with all [AMA][2] -sponsored Medicare Supplement Insurance coverage you will have the ability to choose your own physicians and specialists, since this is not an HMO or PPO program.

Courteous, Professional Customer Service and Claim Payment

When it comes to service, our Customer Care staff located in [Chicago, IL] [1] go above and beyond expectations for valued [physician and spouse][3] Medicare Supplement insureds. We know that Medicare Supplement Insurance coverage can be confusing [(even for physicians)][3] so we're here to answer any questions you may have and to make sure your claims are handled quickly. In fact, most covered claims are paid within [4][7] days of the date we receive them (based on [2009] claims payment experience). And with our [Electronic Claim Filing for [Part A] [and Part B][11] claims,] [simplified claims procedures][11], there are no claim forms for you to complete.

This Plan provides a choice of [10][9]standard Medicare Supplement Insurance Plans [available in your state].[9]

Unlike many other Medicare Supplement Programs, with [AMA][2] -sponsored coverage you have a choice of plans available in your state. [A waiting period of up to six months for coverage of pre-existing health conditions may apply.] [9]

We recommend that you consider plan[s] [A],[C], or [F] [8], which [is a][are] popular plan choice[s] [among physicians].[3] [Plan F of course provides the maximum level of Medicare Supplement protection.][8] You can refer to the enclosed Outline of Coverage for details on the Medicare Supplement Insurance Plans now available to you. Remember, since Medicare Supplement Insurance Plans have been standardized by Federal law, the plan benefits are the same regardless of the insurance company.

You'll be glad to know that the underwriter of this Medicare Supplement Program – Transamerica Life Insurance Company, an AEGON company – is currently rated ["A" (Excellent)][10] by the A.M. Best Company, for their financial strength and operating performance, and ["AA-" (Very Strong)][10] by Standard & Poor for their financial strength. [These are some of the highest ratings attainable.][9] Transamerica is also an experienced provider of Medicare Supplement coverage to many thousands of seniors across the nation.

[We have selected Transamerica Life Insurance Company to underwrite the [AMA][2]- sponsored Medicare Supplement Insurance Program because of their excellent ratings and reputation.][9]

Apply [by Phone][9] With No Risk – [call [800xxx-xxxx][1]][9]\

A Customer Care Specialist is standing by to assist you. You risk nothing when you apply for the [AMA][2] -sponsored Medicare Supplement Plan of your choice. [Simply call us] [Just][9] or complete, sign, date, and return the enclosed [Physician][Physician and Spouse][3] Application in the postage-paid envelope [(be sure to complete the spouse sections and have your spouse sign if also applying)][3]. [Send no money at this time.][9] Once you receive your Certificate in the mail, you'll have a full 30 days to review it and decide if this coverage is right for you. If you're not completely satisfied during this period, just return the Certificate and you will owe nothing. No questions asked. And don't forget, [And keep in mind,][9] you can select any [standard][8] plan

If you would like additional information on a plan not featured in the enclosed Outline of Coverage, or if you have any questions, just call [us][9] at [1-800-xxx-xxxx], [Monday through Friday 8:00 a.m. to 5:00 p.m., Central Time] [or visit us at our web site: [www.doctormedsupp.com]][1].

Sincerely,

[J. Christopher Burke, FLMI]
[President]
[AMA Insurance Agency, Inc.][1]

A P.S. As you turn [65] [9], why not start off with a higher level of value, service, and choice of [10][8] standard plan options with the [AMA][2] sponsored Medicare Supplement Program? You deserve it! Remember, your acceptance is guaranteed into the plan of your choice and pre-existing health conditions will be waived if you apply within 6 months of your [65th][9] birthday. So apply now.

B P.S. As you near the age of [65][9], the [AMA] [2] understands that few things may be as important to you as your health and health care. You will learn from these materials, the [AMA Insurance Agency][2] has made it easy and convenient for [physicians][and their spouses] [3] to secure solid Medicare Supplement protection from a reliable source. Remember, your acceptance is guaranteed into the plan of your choice and pre-existing health conditions will be waived if you apply within 6 months of your [65th][9] birthday. So apply now.

C P.S. One of the main reasons physicians choose the [AMA] [2] sponsored Medicare Supplement coverage is to take advantage of physicians-only group rates and dedicated service from [AMA Insurance Agency][2]. You can trust [AMA Insurance Agency, Inc.] [2] to provide expert assistance with this important decision. Remember, your acceptance is guaranteed into the plan of your choice and pre-existing health conditions will be waived if you apply within 6 months of your [65th][9] birthday. So apply now.

[3 Ways to [enroll] [apply]][9]

) Call [1-800-xxx-xxxx from [8:00 a.m. to 5:00 p.m.], [Central Time], [Monday through Friday]][1]	8 Visit our website [www.abcdefghijk][1]	* Mail your completed [application][enrollment][9] form in the enclosed envelope.

[No portion of [AMA][2] membership dues is used by [AMA Insurance Agency, Inc.][2] to support the marketing efforts of the [AMA][2]-Sponsored Insurance Program.][6]

[Note: This Medicare Supplement Insurance Plan is not connected with or endorsed by the U. S. Government or the Federal Medicare Program.][6]

[Neither Transamerica nor its agents are endorsed by Medicare or connected to the U. S. Government.] [6]

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As your birthday draws closer...you may be thinking of selecting a quality Medicare Supplement Insurance Plan to supplement your Medicare coverage...and you're quite wise.

Thousands [of physicians][3] have selected the [AMA][2]-Sponsored Medicare Supplement Insurance Program.

Dear [Physician,] [Medicare Beneficiary,][3]

A

By now you know the facts: even when you qualify for Medicare when you turn [65][9] it's simply not enough. Because with Medicare coverage alone, you could be left to pay numerous health care costs (perhaps thousands a year) out of your own pocket or your savings.

B

As you near age [65][9], a major factor in your lifestyle, whether or not it includes retirement, may be your eligibility for Medicare and how it will impact your health care and your financial needs. There are definite limits to what Medicare covers and you'll want to get the most comprehensive coverage, without limits on your freedom to choose your own doctors and hospitals. And these days life should be about getting more, not less.

C

As you approach age [65][9] and become eligible for Medicare you will need to consider what Medicare covers and what it does not. Many healthcare expenses such as Medicare's deductible, co-insurance and co-payments fall on you unless you secure the right insurance. While it is nearly impossible to predict all your medical needs for future years ahead, you'll want to make sure the insurance you choose provides the costs, benefits, convenience and quality you need and deserve.

So perhaps you're thinking about a Medicare Supplement Insurance Plan to help fill in the gaps in coverage. And if you're considering the Medicare Supplement Insurance Program sponsored by [the American Medical Association (AMA)] [2], you're not alone.

In fact, thousands [of physicians and their spouses][3] have already selected the [AMA][2] sponsored Program to supplement their Medicare coverage. We think it's for a few very good reasons: 1) a higher level of value, 2) a higher level of service and, 3) a higher level of [10] [9] plan options. Many [physicians][3] are also glad they have the ability to choose their own physicians and specialists since this is not an HMO or PPO program. That's a feature some Medicare Supplement health plan options restrict.

REMEMBER: Your pre-existing health conditions may be covered immediately.

If you or your spouse apply during your Medicare Open Enrollment Period which lasts 6 months from the date you are enrolled in Medicare Parts A and B, you are age 65 or older, or if this plan replaces any prior creditable coverage that has been in force within the past sixty-three (63) calendar days [90 days in ME and WY][6], then your pre-existing health conditions limitation will be waived. Creditable coverage includes: coverage under a group health plan, health insurance coverage,

Medicare Parts A and B, TRICARE, a state health benefits risk pool or Federal Employees Health Benefit Plan. With these conditions, you'll have immediate coverage regardless of your health or the plan you select. There are other instances when your pre-existing conditions period may be waived. Please refer to the enclosed brochure for details.

Here's another excellent reason to consider [AMA][2]-sponsored Medicare Supplement coverage...depending on your age and state of residence, these rates [for physicians and spouses][3] may often be more affordable than the competition's rates. Just take a look at the [yellow][5] rate sheet enclosed for the competitive rates on every [standard][9] plan available in your state.

[The plan administrator, [AMA Insurance Agency, Inc., a licensed insurance subsidiary of the American Medical Association (AMA)] [2] understands your insurance needs.][2] When you need to file a claim, or to get quick answers to your questions, you'll have the confidence in knowing we're right here, ready to assist you in any way possible. Our courteous and professional customer care specialists are dedicated to providing the best service possible to our [physician and spouse][3] customers. We understand Medicare Supplement Insurance, and we'll help you get your claims settled quickly. [With our Electronic Claim Filing for [Part A] [and B] claims,][11] [the majority of covered claims are paid within [4][7] days of receipt (based on [2009] claims payment experience).][9] Each question, each concern, each claim receives personal attention. [Because this plan insures physicians and their families only, you are always treated as an individual.][9]

Select [any of the [10] [9] Standard] Medicare Supplement Insurance Plans available in your state.

The underwriter offers [a choice of] [10] [all] [9] standard plans available in your state. This special advantage allows you to apply with confidence, regardless of your health (a waiting period of up to six months [3 months in WA and WY][6] for coverage of pre-existing health conditions may apply). Many Medicare Supplement programs do not make all standard plans available.

Our recommended plans include [A], [C], and [F] [8], which are popular [standard][9] plan choices among our [physician] [insureds][customers][3]. The most popular Plans are [C] [and] [F][8]. [and Plan F of course provides the maximum level of Medicare Supplement protection.][8] Please refer to the enclosed Outline of Coverage for details on the Medicare Supplement Plans now available to you. Keep in mind, since all Medicare Supplement Insurance Plans have been standardized by Federal law, the plan benefits are the same regardless of the insurance company.

Transamerica Life Insurance Company, [an AEGON company] [a member of the AEGON Insurance Group][9], is the underwriter of this program. We've selected Transamerica because of their experience in providing Medicare Supplement coverage to seniors across the United States, and because of their excellent standing. Transamerica is currently rated ["A" (Excellent)][10] by the A.M. Best Company, for their financial strength and operating performance, and ["AA-" (Very Strong)][10]by Standard & Poor for their financial strength.

Don't delay. Apply now with no risk — you'll have a 30-day no-obligation review period.

If a higher level of value is important to you, that may be reason enough to apply now. But when you combine this money-saving value with a higher level of service and broad plan options, you'll find it's hard to find such an offer elsewhere. So apply now with no risk. Just complete, sign, date, and return the enclosed

[Physician] [Physician & Spouse][3] Application in the postage-paid envelope [Be sure to have your spouse complete the [Spouse][3] Application if also applying][9]. [Send no money at this time.][9] Once you receive your Certificate in the mail, you'll have a full 30 days to review it.

Sincerely,

[J. Christopher Burke, FLMI]
[President]
[AMA Insurance Agency, Inc.][1]

P.S. If you've already responded to our initial mailing for Medicare Supplement coverage, we thank you. You will be receiving your Certificate of Insurance in the mail soon. If you haven't responded for this high level of value, service, and choice. I urge you to apply [now] [before you turn age [65]][9] .

Any questions? Call us at [1-800-458-5736], [Monday through Friday 8:00 a.m. to 5:00 p.m., Central Time] [or visit us at our web site: [www.doctormedsupp.com].][1]

[No portion of [AMA][2] membership dues is used by the [AMA Insurance Agency, Inc.][2] to support the marketing efforts of the [AMA][2] Sponsored Insurance Programs.][6]

To [enroll] [apply] by phone call [1-800-xxx-xxxx from [8:00 a.m. to 5:00 p.m.], [Central Time], [Monday through Friday][1]. To [enroll] [apply] online visit our website [www.abcdefghijk].[1]

[Note: This Medicare Supplement Insurance Plan is not connected with or endorsed by the U. S. Government or the Federal Medicare Program.][6]

[Neither Transamerica nor its agents are endorsed by Medicare or connected to the U. S. Government] [6]

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Application Deadline: [Dec. 31, 2009][The 1st Of The Month Of Your Birthday][9]

FINAL PRE-BIRTHDAY NOTIFICATION [FOR 2009][4]

[Application Deadline] [The 1st of the month of your birthday]. [December 31, 2009][9]

Dear [Physician,] [Medicare Beneficiary,][3]

A

[The date you turn age [65][9] is drawing nearer.] [The New Year is drawing nearer, and so is the date you turn age [65][9].][9] So if you and your spouse haven't returned your application(s) for the Medicare Supplement Insurance Program sponsored by the [American Medical Association (AMA)][2], please take a moment to consider [this important protection] [how we can save you time and money] [in the new year][9], as well as provide the important protection you need] to help supplement the many gaps in coverage that Medicare's deductibles, copayments and limitations could otherwise require you to pay out-of-pocket.

B

You may be ready to sign up for Medicare coverage, perhaps very soon. If you and your spouse haven't returned your application for the Medicare Supplement Insurance Program sponsored by [American Medical Association (AMA)][2] please let us know if we can provide any additional information or help at this time as your Medicare open enrollment period comes to an end. Our trained professional customer service representative are here for you as you decide to move forward with your decision and will work to help you enroll promptly to meet this critical deadline.

C

You still have time to get your Medicare Supplement Insurance sponsored by [American Medical Association (AMA)][2]. If you haven't sent in your application, please consider the plan that will make all the difference in controlling your medical expenses once you are enrolled in Medicare. A Medicare Supplement plan will cover many of your out-of-pocket costs that Medicare doesn't cover like deductibles, and copayments – and they can really add up quickly.

Save time with no waiting period! Your pre-existing health conditions may be covered immediately if you apply within 6 months of turning age [65][9].

[We know that continuity of health care coverage is important. And, as you transition to Medicare Benefits, it's important that the coverage you select to fill the coverage gaps is in place. That's why we've made applying for [AMA-sponsored] Medicare Supplement easy][9]

If you or your spouse apply during your Medicare Open Enrollment Period which lasts 6 months from the date you are enrolled in Medicare Part A and B and you are age 65 or older, or if this plan replaces any creditable coverage, such as a primary hospital and medical reimbursement coverage that has been in force

for the past sixty-three (63) calendar days [90 days in ME and WY][6], then your pre-existing health conditions limitation will be waived. Creditable coverage includes: coverage under a group health plan, health insurance coverage, Medicare Parts A and B, TRICARE, a state health benefits risk pool or Federal Employees Health Benefit Plan. With these conditions, you'll have immediate coverage regardless of your health or the plan you select. There are other instances when your pre-existing conditions period will be waived. Please refer to the enclosed brochure for details.

Saving money on premiums may not be a number one priority, but it can be an added bonus to get the quality coverage you want, at an affordable cost. And this coverage [exclusively for physicians and spouses][3] is available at affordable rates which may be less than the competition, depending on your age and state of residence. Please refer to the enclosed [yellow][5] rate sheet for rates on every Plan available in your state.

[And] from the moment you call with any questions about our coverage, and throughout your entire relationship as a valued customer, you'll have the [highest] [9] level of service [you deserve][9]. Our professional customer care specialists value the opportunity to serve [your] [you and your spouse's] Medicare Supplement coverage needs with quick answers to your questions and simplified claims. [In fact, [unless you are in a pre-existing conditions period,] no claim forms are needed, and most covered claims are paid within [4][7] days of receipt (based on [2009] claims payment experience).] [And with our Electronic Claim Filing for [Part A] [and Part B][11] claims, your filing process is hassle-free.][11]

Plus, you can select any Medicare Supplement Plan [available in your state] [And no medical underwriting is required] [9]

To provide the highest level of plan options, you can select from every plan available [in your state]. So you can apply with confidence, regardless of your health. A waiting period of up to six months for coverage of pre-existing health conditions may apply.

Although you can select any plan available, [we recommend special consideration of plan[s] [A], [C], and [F]].[8] Plans [C] [and] [F][8] are the most popular [among physicians].[3] [and plan F or course provides the maximum level of Medicare Supplement protection.][8]. You can refer to the enclosed Outline of Coverage for details on the Medicare Supplement Standard Plans available. Benefits are the same regardless of the insurance company, as all Medicare Supplement Insurance Plans have been standardized by Federal law.

You'll be glad to know Transamerica Life Insurance Company [an AEGON company] [a member of the AEGON Insurance Group][9] – is the underwriter of this program. Transamerica is currently rated ["A" (Excellent)][10] by the A.M. Best Company, for their financial strength and operating performance, and ["AA-" (Very Strong)][10] by Standard & Poor for their financial strength. They also have vast experience in providing Medicare Supplement coverage to many thousands of seniors across the country.

[APPLY NOW WITH NO RISK.] [9]

Don't miss out on this valuable protection opportunity if you have yet to apply for [AMA][3] -sponsored Medicare Supplement Insurance coverage. You'll have a 30-day no-risk review period. So just complete and return the application[s] today.

Sincerely,

[J. Christopher Burke, FLMI]
[President]
[AMA Insurance Agency, Inc.][1]

P.S. [Remember, with Medicare coverage alone, you could be left with thousands in health care costs to pay on your own. The [AMA][2] sponsored Medicare Supplement Insurance Plans provide coverage to help fill in the out-of-pocket gaps in Medicare's deductibles and copayments, and you can still choose your own physicians and specialists (unlike some other Medicare health plan options). [If you should have any questions simply] call us at [1-800-458-5736], [Monday through Friday (8:00 a.m. to 5:00 p.m., Central Time] with any questions [or visit us at our website: www.doctormedsupp.com]. [If you haven't yet responded to this offer of high level of value, service and choice, I urge you to apply now.][9]

[No portion of [AMA][2] membership dues is used [by the AMA Insurance Agency, Inc.] to support the marketing efforts of the [AMA] [2] sponsored Insurance Program.][6]

To [enroll][apply] by phone call [1-800-xxx-xxxx from [8:00 a.m. to 5:00 p.m.], [Central Time], [Monday through Friday][1]. To [enroll][apply] online visit our website [www.abcdefghijk].[1]

[Note: This Medicare Supplement Insurance Plan is not connected with or endorsed by the U. S. Government or the Federal Medicare Program.][6]

[Neither Transamerica nor its agents are endorsed by or connected to the U. S. Government.] [6]

Here's what just a few insureds [with AMA Insurance Agency] have to say about the high level of service we provide [to physicians and their spouses]:

"We value your services and have been pleased to have your help."

— John T. Hurly, M.D.

"The service is evidently so good. I haven't yet had a reason to contact your claim representative. Thank you so much."

— M. Michael Strober, M.D.

"I have never experienced a delay or other problem with my Medicare Supplement."

— Josephine D. Trujillo, M.D.

"You have been just great — have been with you almost from your beginning and hope I never have to change."

— Anne N. Quillian

Remember:

You keep your ability to choose your own physicians and specialists with [AMA]-sponsored Medicare Supplement coverage, since this is not an HMO or PPO program.

Why accept less than you deserve?

Get a higher level of excellence with the [AMA]-sponsored Medicare Supplement Insurance Program!

- A Better Value With Our Competitive Rates
- Superior Service [For Physicians And Their Spouses]
- Choice of [Standard] Plan Options With Guaranteed Acceptance

Any questions?

Just call [1-800-458-5736]

[Monday through Friday
8:00 a.m. to 5:00 p.m., Central Time]
[or visit us at our web site:
[www.doctormedsupp.com]]

AMA INSURANCE AGENCY

[A subsidiary of the American Medical Association (AMA)]

This brochure is a description only. Full details will be found in the Certificate of Insurance. Plans available may vary or may not be available in some states.

Note: Medicare Supplement plans are available in some states for residents on Medicare due to disability. Please see your outline of coverage for details.

[AMA]-sponsored Medicare Supplement Insurance meets the requirements of your state insurance department state laws, and the federal government. However it is not connected with the Federal Medicare Program or the U.S. Government in any way.

[No portion of [AMA] membership dues is used by [AMA Insurance Agency, Inc.] to support the marketing efforts of the [AMA]-sponsored Medicare Supplement Insurance Program.]

Your Coverage Cannot Be Canceled Individually: Once insured, your protection cannot be canceled individually as long as your premiums are paid when due. [And a covered spouse may continue in the program even after the death of the physician.]

Do not terminate your existing coverage until your [AMA]-sponsored Medicare Supplement Insurance goes into effect.

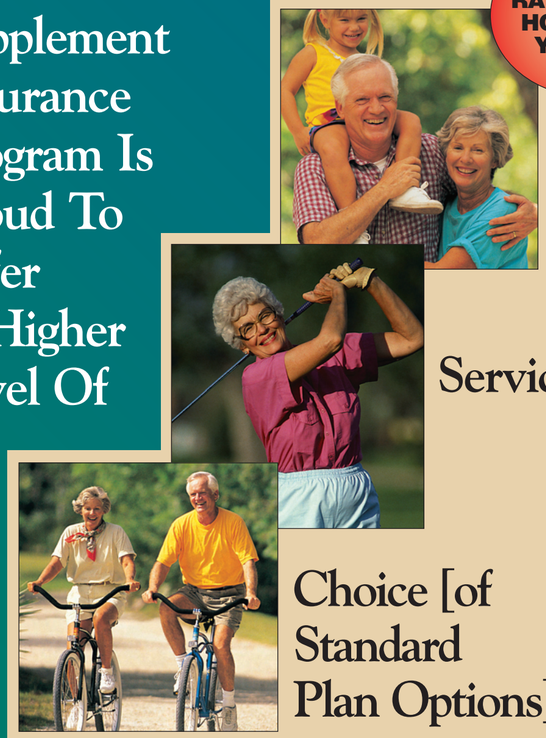
Your rates cannot be increased individually, no matter how many claims you file. Your rates can only increase if they are increased for the entire group in your state. In most states, your premium is based on Issue Age. This means your premium will not increase because you have grown older and have entered a new age category. (See the enclosed rate chart for information in your state.)

Transamerica Life Insurance Company - Policy # MS9000GPT
Transamerica Financial Life Insurance Company - Policy # (for New York residents only)
Monumental Life Insurance Company - Policy #

AMA INSURANCE AGENCY [A Subsidiary of the American Medical Association]

The [AMA]-sponsored Medicare Supplement Insurance Program Is Proud To Offer A Higher Level Of Value Service & Choice [of Standard Plan Options]

COMPARE RATES & SEE HOW MUCH YOU CAN SAVE!



- **[If you switch to the [AMA]-sponsored Medicare Supplement Insurance Protection, you may qualify for immediate coverage of pre-existing health conditions!]**
- **ACCEPTANCE GUARANTEED**
- **[All [Physicians & Spouses]/[Persons] [Age 65 Or Older] [Covered Under Medicare Parts A and B] Are Invited To Apply]**

MSAMAMIPPATLICBR [MS AMA TLIC BROCHURE DATE]

You deserve a higher level of value, service and choice in your Medicare Supplement Insurance Protection. And it's easy to step up to the [AMA]-sponsored Medicare Supplement Insurance Program.

You may qualify for immediate coverage of any pre-existing health conditions.

[It's easy for you to switch and step up to a higher level of Medicare Supplement protection [sponsored by the American Medical Association (AMA)]. For example, **if this plan replaces any currently in force Medicare Supplement coverage** (or any primary hospital and medical reimbursement coverage) or if you apply within 63 calendar days (90 days in ME and WY) of canceling your other coverage, **you will have no new waiting period for any pre-existing health conditions, to the extent satisfied under the prior plan.]**

You can also qualify for immediate coverage of pre-existing health conditions if you are enrolled in Medicare Parts A and B and you have been covered by an [AMA]-sponsored [Catastrophic Major Medical Plan] or [Hospital Income Plan] for the 12 months immediately prior to your effective date of coverage in one of these plans.

SWITCH & SAVE!

You'll receive an excellent value for your Medicare Supplement dollar.

The [AMA]-sponsored Medicare Supplement Insurance Program was developed to provide a superior value [to those] [to physicians and their spouses] [age 65 and over][covered under Medicare Parts A and B]. Once you review the rate sheet enclosed, you may see a better value than any protection you may have now. That may be one of the reasons thousands [of physicians] have switched to [AMA]-sponsored coverage.

Remember: You keep your ability to choose your own physicians and specialists with [AMA]-sponsored Medicare Supplement coverage, since this is not an HMO or PPO program.

You'll have superior service and simplified claims.

[AMA Insurance Agency, Inc., a subsidiary of the American Medical Association, is the plan Administrator.] At [AMA Insurance Agency, Inc.], we specialize in providing excellent customer service to our [physician and spouse] Medicare Supplement customers. We consider it a pleasure to serve your Medicare Supplement coverage needs, and we've been told by many [physicians] [insureds] that our positive attitude shows!

Our dedicated, professional customer service specialists thoroughly understand Medicare Supplement coverage, and we're available to answer your questions and assist our customers with quick, simplified claims payment. Simply put, we want to help you make the most of your plan benefits. [No claim forms are needed for payment, and most covered claims are paid within [8] days of receipt.**]

[And with our electronic claims filing for Part B Claims, you have an automatic exchange of information from Medicare to us. There's no paperwork for you or your health care provider, and you're also assured that you or your provider will quickly receive all eligible benefit dollars due to you.]

You can select from any of the [AMA]-sponsored plans available in your state, with the advantage of guaranteed acceptance.

Two more distinct advantages of [AMA]-sponsored Medicare Supplement Insurance coverage are the availability of a choice of plans in your state, and your guarantee of acceptance in the plan you select. Many Medicare Supplement programs only make certain plans available, and most do not offer the plans on a guaranteed acceptance basis. But we believe [physicians and their spouses] [you] should have the advantage of a wider selection, and should not have to worry about plan acceptance, regardless of health.

Although you can select from all plans available in your state, we recommend careful consideration of the plans highlighted in the section at right.This coverage will not pay benefits for conditions for which you have received medical treatment or advice within the last 6 months (3 months in MN, WA and WY) prior to the effective date until you have been insured for 6 consecutive months (3 months in WA and WY). If during your Open Enrollment Period this plan replaces creditable health insurance coverage within 63 days (90 days in ME and WY) of applying for the plan, then this pre-existing conditions limitation will be waived to the extent satisfied under the prior plan. This waiver will apply only to prior creditable coverage.* (The open enrollment period of New York State residents lasts indefinitely.) (MA residents - the pre-existing condition limitation does not apply.)

*Creditable coverage includes but is not limited to: coverage under a group health plan, health insurance coverage, Medicare Parts A and B, TRICARE, a state health benefits risk pool or Federal Employees Health Benefits Plan (FEHB).

Have any questions?

Just give us a call at

[1-800-458-5736],

[Monday through Friday 8:00 a.m. to 5:00 p.m., Central Time.]

[**Based on [2009] claims payment experience.]

Plus...

You'll have the added assurance that the [AMA]-sponsored Medicare Supplement Insurance Program is underwritten by a financially strong insurance company, with some of the highest ratings attainable.

Program Underwriters:	Ratings: A.M. Best	Moody's	Standard & Poor
Transamerica Financial Life Insurance Company (in NY only)	[A+] [(Superior)]	[Aa3] [(Excellent)]	[AA] [(Very Strong)]
Transamerica Life Insurance Company	[A+ (Superior)]	[Aa3 (Excellent)]	[AA (Very Strong)]
Monumental Life Insurance Company	[A+ (Superior)]	[Aa3 (Excellent)]	[AA (Very Strong)]

(A.M. Best's rating is for financial strength and operating performance. Moody's Investors Service's rating is for financial strength. Standard & Poor's rating is for financial strength.) Ratings as of [2006]

Which supplemental plan makes the most sense for you?

We recommend Plans [A], [C] [and] [F]. Here's why:

Although you can select from all of the [AMA]-sponsored Medicare Supplement Insurance Plans which are available in your state, we recommend consideration of these plans, for the reasons mentioned below: (Please refer to your enclosed Outline of Coverage for details on plan coverage).

PLAN A:

Plan A provides the most basic coverage, at the most economical cost. It includes basic insurance copayments (but not the deductible) for Medicare Part A, Medicare Part B, and Blood expenses. Plan A may make sense for you if you have a limited amount you want to spend on supplemental protection, or if you have substantial means and can afford to self-insure some of your health care expenses.

PLAN C:

Plan C is a popular choice [among physicians], and provides coverage beyond the "basics" plus skilled nursing and foreign travel benefits.

PLAN F:

Plan F is also a popular Plan [among physicians,] and it includes the Part B Excess (100%) doctor charges benefit, paying the difference between the doctor's actual charges and the Medicare-approved amount. It may be an especially appropriate choice if you see doctors who do not accept Medicare assignment. (Doctors who accept *assignment* take the Medicare-approved amount as full payment.)

Top Physician Choices: Plans [C] and [F]

EXCLUSIONS

Benefits will not be paid for any expenses which are not determined to be Medicare-eligible expenses by the Federal Medicare Program or its administrators.

Don't miss your chance to get the level of value, service, and choice of standard plan options you deserve!
Apply today with NO RISK.

Here's what just a few insureds [with AMA Insurance Agency] have to say about the high level of service we provide to physicians and their spouses:

"We value your services and have been pleased to have your help."

– John T. Hurly, M.D.

"The service is evidently so good. I haven't yet had a reason to contact your claim representative. Thank you so much."

– M. Michael Strober, M.D.

"I have never experienced a delay or other problem with my Medicare Supplement."

– Josephine D. Trujillo, M.D.

"You have been just great — have been with you almost from your beginning and hope I never have to change."

– Anne N. Quillian

Why A Medicare Supplement Insurance Plan?

If you're just turning 65, you have some important choices to make about your health care coverage. Because as you probably know by now, **Medicare alone does not cover all of your health care costs**. In fact, **it was never intended to cover everything**. That's why many people choose to supplement their basic Medicare coverage with a Medicare Supplement Insurance Plan.

Since all Medicare Supplement Plans are now standardized by Federal law, **each plan offers the same benefits regardless of the insurance provider**. So it makes shopping for coverage easier. You can concentrate on evaluating **the value** or cost of the plan, **the service provided,** and **the choice of Plans which are offered.** (In most states, Medicare Supplement Insurance companies are not required to make all plans available). **With an [AMA-]Sponsored Medicare Supplement Plan, you also have the complete freedom to select your own physicians and specialists, unlike some other Medicare health plan options which restrict this freedom.** That's a freedom many [physicians and their spouses] appreciate.

Why The [AMA-]Sponsored Plans?

If you are comparing different Medicare Supplement Insurance Plans, you'll be pleased to see what [AMA Insurance Agency] provides. In short, a higher level of value, service, and choice. And you can rest assured that [AMA] sponsorship is not easily earned. Each insurance program offered [to physicians and spouses] is carefully evaluated for quality, value, financial soundness of the underwriter, and numerous other aspects before sponsorship is received. So it's one more assurance which makes selecting a plan that's right for you even easier.]

Why accept less than you deserve?

Get a higher level of excellence with the [AMA]-sponsored Medicare Supplement Insurance Program!

- A Better Value With Our Competitive Rates
- Superior Service [For Physicians And Their Spouses]
- Choice of [Standard] Plan Options With Guaranteed Acceptance

Any questions?

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[Monday through Friday 8:00 a.m. to 5:00 p.m., Central Time] [or visit us at our web site: [www.doctormedsupp.com]]

AMA INSURANCE AGENCY

[A subsidiary of the American Medical Association (AMA)]

This brochure is a description only. Full details will be found in the Certificate of Insurance. Plans available may vary or may not be available in some states.

Note: Medicare Supplement plans are available in some states for residents on Medicare due to disability. Please see your outline of coverage for details.

[AMA]-sponsored Medicare Supplement Insurance meets the requirements of your state insurance department state laws, and the federal government. However it is not connected with the Federal Medicare Program or the U.S. Government in any way.

No portion of [AMA] membership dues is used by [AMA Insurance Agency, Inc.] to support the marketing efforts of the [AMA]-sponsored Medicare Supplement Insurance Program.

Your Coverage Cannot Be Canceled Individually: Once insured, your protection cannot be canceled individually as long as your premiums are paid when due. [And a covered spouse may continue in the program even after the death of the physician.]

Do not terminate your existing coverage until your [AMA]-sponsored Medicare Supplement Insurance goes into effect.

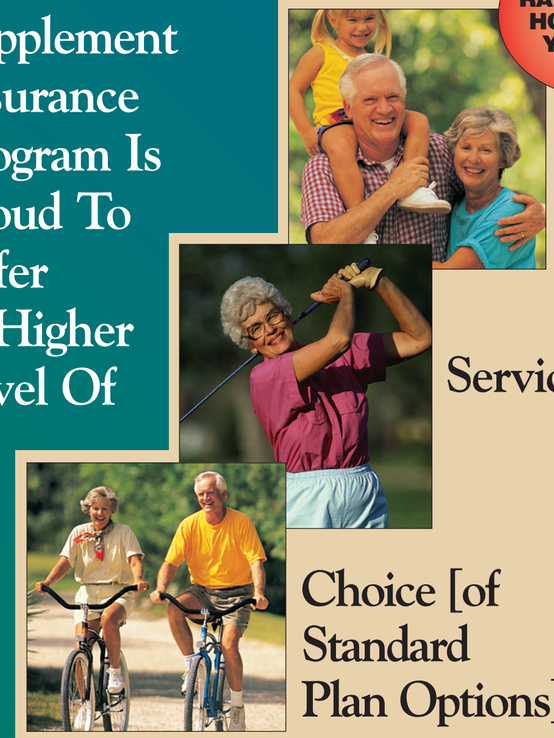
Your rates cannot be increased individually, no matter how many claims you file. Your rates can only increase if they are increased for the entire group in your state. In most states, your premium is based on Issue Age. This means your premium will not increase because you have grown older and have entered a new age category. (See the enclosed rate chart for information in your state.)

Transamerica Life Insurance Company - Policy # MS9000GPT
Transamerica Financial Life Insurance Company - Policy # (for New York residents only)
Monumental Life Insurance Company - Policy #

AMA INSURANCE AGENCY [A Subsidiary of the American Medical Association]

The [AMA]-sponsored Medicare Supplement Insurance Program Is Proud To Offer A Higher Level Of Value Service & Choice [of Standard Plan Options]

COMPARE RATES & SEE HOW MUCH YOU CAN SAVE!



- **[SPECIAL PRE-BIRTHDAY OPPORTUNITY: If you apply within 6 months of your 65th birthday, you qualify for immediate coverage of pre-existing health conditions.]**
- **ACCEPTANCE GUARANTEED**
- **[All [Physicians & Spouses]/[Persons] [Turning Age 65 Or Older][Covered Under Medicare Parts A and B] Are Invited To Apply]**

MSAMAMIPPATLICBR-T65 [MSAMATLICBR-T65]

You deserve a higher level of value, service and choice in your Medicare Supplement Insurance Protection. And it's easy to step up to the [AMA]-sponsored Medicare Supplement Insurance Program.

You may qualify for immediate coverage of any pre-existing health conditions.

[If you or your spouse apply during Medicare's Open Enrollment Period which lasts 6 months from the date you are enrolled in Medicare Parts A and B and you are age 65 or older, or if this plan replaces prior creditable* coverage that has been in force for 6 months and within the past sixty-three (63) calendar days (90 days in ME and WY), then your pre-existing health conditions limitation will be waived.]

You can also qualify for immediate coverage of pre-existing health conditions if you are enrolled in Medicare Parts A and B and you have been covered [by the Catastrophic Major Medical] or [Hospital Income Plan] sponsored by the American Medical Association (AMA)] for the 12 months immediately prior to your effective date of coverage in one of these Medicare Supplement plans.

[SPECIAL NOTE: **If this plan replaces any currently inforce creditable Medicare Supplement coverage** (or any primary hospital and medical reimbursement coverage) or if you apply within 63 calendar days (90 days in ME and WY) of cancelling your other coverage, **you will have no new waiting period for any pre-existing health conditions as long as you have satisfied the 6-month pre-existing health conditions period with your current policy**. You can't have any breaks in health coverage that are longer than 63 calendar days (90 days in ME and WY) for this coverage to be credited toward the pre-existing conditions restrictions.]

[**Remember:** You'll have the ability to choose your own physicians and specialists with [AMA-]Sponsored Medicare Supplement coverage, since this is not an HMO or PPO program.]

You'll receive an excellent value for your Medicare Supplement dollar.

The [AMA]-sponsored Medicare Supplement Insurance Program was developed to provide [an excellent value][.] [to physicians and their spouses] [age 65 over] [and covered by Medicare Parts A and B.]. Once you review the rate sheet enclosed, you may see a better value than any protection you may be considering. That may be one of the reasons thousands [of physicians] have switched to [AMA]-sponsored coverage.

And when you apply for coverage, you will also be securing a **one-year rate guarantee**. Just apply by the 1st of the month of your birthday, and your rates are **guaranteed not to increase for one full year** from your effective date.

You'll have superior service and simplified claims.

[AMA Insurance Agency, Inc., a subsidiary of the American Medical Association, is the plan administrator.] At [AMA Insurance Agency, Inc.], we specialize in providing excellent customer service to our [physician and spouse] Medicare Supplement customers. We consider it a pleasure to serve your Medicare Supplement coverage needs, and we've been told by many [physicians] [insureds] that our positive attitude shows!

Our dedicated, professional customer service specialists thoroughly understand Medicare Supplement coverage, and we're available to answer your questions and assist our customers with quick, simplified claims payment. Simply put, we want to help you make the most of your plan benefits. [No claim forms are needed for payment, and most covered claims are paid within [8] days of receipt.**] [And with our electronic claims filing for Part B Claims, you have an automatic exchange of information from Medicare to us. There's no paperwork for you or your health care provider, and you're also assured that you or your provider will quickly receive all eligible benefit dollars due to you.]

You can select from any of the [AMA]-sponsored plans available in your state, with the advantage of guaranteed acceptance.

Two more distinct advantages of [AMA]-sponsored Medicare Supplement Insurance coverage are the availability of a choice of plans in your state, and your guarantee of acceptance in the plan you select. Many Medicare Supplement programs only make certain plans available, and most do not offer the plans on a guaranteed acceptance basis. But we believe [physicians and their spouses] [you] should have the advantage of a wider selection, and should not have to worry about plan acceptance, regardless of health.

Although you can select from all of the [AMA]-sponsored plans in your state, we recommend careful consideration of the plans highlighted in the section at right. This coverage will not pay benefits for conditions for which you have received medical treatment or advice within the last 6 months (3 months in MN, WA and WY) prior to the effective date until you have been insured for 6 consecutive months (3 months in WA and WY). If during your Open Enrollment Period this plan replaces creditable health insurance coverage within 63 days (90 days in ME and WY) of applying for the plan, then this pre-existing conditions limitation will be waived to the extent satisfied under the prior plan. This waiver will apply only to prior creditable coverage.* (The open enrollment period of New York State residents lasts indefinitely.) (MA residents - the pre-existing condition limitation does not apply.)

*Creditable coverage includes but is not limited to: coverage under a group health plan, health insurance coverage, Medicare Parts A and B, TRICARE, a state health benefits risk pool or Federal Employees Health Benefits Plan (FEHB).

Have any questions?
Just give us a call at

[1-800-458-5736],

[Monday through Friday 8:00 a.m. to 5:00 p.m., Central Time.]

[**Based on [2009] claims payment experience.]

Plus...

You'll have the added assurance that the [AMA]-sponsored Medicare Supplement Insurance Program is underwritten by a financially strong insurance company, with some of the highest ratings attainable.

Program Underwriters:	Ratings: A.M. Best	Moody's	Standard & Poor
Transamerica Financial Life Insurance Company (in NY only)	[A+] [(Superior)]	[Aa3] [(Excellent)]	[AA] [(Very Strong)]
Transamerica Life Insurance Company	[A+ (Superior)]	[Aa3 (Excellent)]	[AA (Very Strong)]
Monumental Life Insurance Company	[A+ (Superior)]	[Aa3 (Excellent)]	[AA (Very Strong)]

(A.M. Best's rating is for financial strength and operating performance. Moody's Investors Service's rating is for financial strength. Standard & Poor's rating is for financial strength.) Ratings as of [2006]

Which supplemental plan makes the most sense for you?

We recommend Plans [A], [C] and [F]. Here's why:

Although you can select from all of the [AMA]-sponsored Medicare Supplement Insurance Plans which are available in your state, we recommend consideration of these plans, for the reasons mentioned below: (Please refer to your enclosed Outline of Coverage for details on plan coverage).

PLAN A:

Plan A provides the most basic coverage, at the most economical cost. It includes basic insurance copayments (but not the deductible) for Medicare Part A, Medicare Part B, and Blood expenses. Plan A may make sense for you if you have a limited amount you want to spend on supplemental protection, or if you have substantial means and can afford to self-insure some of your health care expenses.

PLAN C:

Plan C is a popular choice [among physicians], and provides coverage beyond the "basics" plus skilled nursing and foreign travel benefits.

PLAN F:

Plan F is also a popular plan [among physicians,] and it includes the Part B Excess (100%) doctor charges benefit, paying the difference between the doctor's actual charges and the Medicare-approved amount. It may be an especially appropriate choice if you see doctors who do not accept Medicare assignment. (Doctors who accept *assignment* take the Medicare-approved amount as full payment.)

Top Physician Choices: **Plans [C] and [F]**

EXCLUSIONS
Benefits will not be paid for any expenses which are not determined to be Medicare-eligible expenses by the Federal Medicare Program or its administrators.

Don't miss your chance to get the level of value, service, and choice of standard plan options you deserve!
Apply today with NO RISK.

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
Company Tracking Number:	*HM AR0050707C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Rate Information

Rate data applies to filing.

Filing Method:	Prior Approval
Rate Change Type:	%
Overall Percentage of Last Rate Revision:	%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Transamerica Life Insurance Company	%	%				%	%

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
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Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved 09/17/2009	Arkansas Rate Sheet	MS9000GPT	New		Arkansas Rate Sheet.PDF

Exhibit A

Transamerica Life Insurance Company

Standard Group Medicare Supplement
State of Arkansas
Monthly Premium Rates

Guaranteed Issue

Composite	Plan A-2010	Plan B-2010	Plan C-2010	Plan D-2010	Plan F-2010	Plan G-2010	Plan K-2010	Plan L-2010	Plan M-2010	Plan N-2010
Under 65	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65 & up	113	153	180	167	183	170	84	124	153	144

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
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Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	09/17/2009

Comments:
See Forms Schedule Tab

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	09/17/2009

Comments:
Attachment:
AR MS9000 Readability Certification.PDF

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved	09/17/2009

Comments:
See Forms Schedule Tab

		Item Status:	Status Date:
Satisfied - Item:	AR - NAIC TRANSMITTAL DOCUMENT	Accepted for Informational Purposes	09/17/2009

Comments:
Attachment:
AR - NAIC TRANSMITTAL DOCUMENT.PDF

		Item Status:	Status Date:
Satisfied - Item:	AR Cover Letter	Accepted for Informational	09/17/2009

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
Company Tracking Number:	*HM AR0050707C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Purposes

Comments:

Attachment:

AR Cover Letter.PDF

		Item Status:	**Status Date:**
Satisfied - Item:	Explanation of Variables MS9000	Accepted for Informational Purposes	09/17/2009

Comments:

Attachment:

Explanation of Variables MS9000.PDF

		Item Status:	**Status Date:**
Satisfied - Item:	Explanation of Variables - MS9000GAT	Accepted for Informational Purposes	09/17/2009

Comments:

Attachment:

Explanation of Variables - MS9000GAT.PDF

		Item Status:	**Status Date:**
Satisfied - Item:	Explanation of Variables - Letters	Accepted for Informational Purposes	09/17/2009

Comments:

Attachment:

Explanation of Variables - Letters.PDF

TRANSAMERICA LIFE INSURANCE COMPANY

Administrative Office | 520 Park Avenue | Baltimore | Maryland 21201-4500

READABILITY CERTIFICATION

This will certify that the submitted forms meet the requirements of the Life and Health Policy Language Simplification Act. The Flesch Reading Ease Score for the forms are shown below:

Group Policies	**Score**
MS9000GPT-A.SD - Group Medicare Supplement Insurance Policy Plan A	41
MS9000GPT-B.SD - Group Medicare Supplement Insurance Policy Plan B	41
MS9000GPT-C.SD - Group Medicare Supplement Insurance Policy Plan C	41
MS9000GPT-D.SD - Group Medicare Supplement Insurance Policy Plan D	41
MS9000GPT-F.SD - Group Medicare Supplement Insurance Policy Plan E	42
MS9000GPT-G.SD - Group Medicare Supplement Insurance Policy Plan F	41
MS9000GPT-K.SD - Group Medicare Supplement Insurance Policy Plan G	42
MS9000GPT-L.SD - Group Medicare Supplement Insurance Policy Plan H	42
MS9000GPT-M.SD - Group Medicare Supplement Insurance Policy Plan I	41
MS9000GPT-N.SD - Group Medicare Supplement Insurance Policy Plan J	41

Group Certificates of Insurance	**Score**
MS9000GCT-A.SD - Group Medicare Supplement Certificate of Insurance Plan A	42
MS9000GCT-B.SD - Group Medicare Supplement Certificate of Insurance Plan B	42
MS9000GCT-C.SD - Group Medicare Supplement Certificate of Insurance Plan C	41
MS9000GCT-D.SD - Group Medicare Supplement Certificate of Insurance Plan D	41
MS9000GCT-F.SD - Group Medicare Supplement Certificate of Insurance Plan E	41
MS9000GCT-G.SD - Group Medicare Supplement Certificate of Insurance Plan F	41
MS9000GCT-K.SD - Group Medicare Supplement Certificate of Insurance Plan G	42
MS9000GCT-L.SD - Group Medicare Supplement Certificate of Insurance Plan H	42
MS9000GCT-M.SD - Group Medicare Supplement Certificate of Insurance Plan I	41
MS9000GCT-N.SD - Group Medicare Supplement Certificate of Insurance Plan J	41
MS9000GAT.SD - Application Form	40

July 31, 2009
Date

Edward G. Weigand
Assistant Secretary

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	**Prepared for the State of**	Arkansas

2.	**Department Use Only**
	State Tracking ID

3. **Insurer Name & Address**	**Domicile**	**Insurer License Type**	**NAIC Group #**	**NAIC #**	**FEIN #**	**State #**
Transamerica Life Insurance Company 4333 Edgewood Road, N.E. Cedar Rapids IA 52499	IA		468	86231	39-0989781	

4. **Contact Name & Address**	**Telephone #**	**Fax #**	**E-mail Address**
Cindy K. Hammonds, FLMI, CCP, AIRC, ACS 2700 W Plano Parkway Plano TX 75075	877-527-6444 Ext. 6783	972-881-4097	chammon1@aegonusa.com

5.	**Requested Filing Mode**	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	**Company Tracking Number**	HM AR0050707C01	
7.	☒ **New Submission** ☐ **Resubmission**	Previous file # _____	
8.	**Market**	☐ Individual ☐ Franchise	
		Group	☐ Small ☒ Large ☐ Small and Large ☐ Employer ☒ Association ☐ Blanket ☒ Discretionary ☒ Trust ☐ Other: _____
9.	**Type of Insurance**	MS08G Group Medicare Supplement - Standard Plans 2010	
10.	**Product Coding Matrix Filing Code**	MS08G.001 Plan A 2010	
11.	**Submitted Documents**	☒ **FORMS** ☒ Policy ☒ Outline of Coverage ☒ Certificate ☒ Application/Enrollment ☐ Rider/Endorsement ☒ Advertising ☐ Schedule of Benefits ☐ Other: _____ ☒ **RATES** ☒ New Rate ☐ Revised Rate ☒ **FILING OTHER THAN FORM OR RATE:** Please explain: Advertising **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreement ☐ Statement of Variability ☒ Certifications ☒ Actuarial Memorandum ☐ Other: _____	

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12.	**Filing Submission Date**	8/3/2009
13.	**Filing Fee (If required)**	Amount _____ Check Date _____ Retaliatory ☐ Yes ☐ No Check Number _____
14.	**Date of Domiciliary Approval**	Pending
15.	**Filing Description:**	

NAIC #468-86231
Forms, Rates and Advertising Filing

RE: MS9000GPT-A.DE et al. - Medicare Supplement Insurance Program
Company Filing#: HM AR0050707C01

The above referenced forms are being submitted for your review and approval. These forms are new and in compliance with the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) will replace previously approved forms MS5000GPT-A.AR et al which were approved by your department on November 17, 2007 under Insurance Department File # 36902. Upon approval, these forms will only be issued with an effective date of June 1, 2010 or later.

Other than the changes required to comply with MIPPA, these forms are the same as those filed and approved for form MS5000GPT-A.AR et al. As with our previously approved filing, the group policy will be issued direct in Delaware or marketed through an out-of-state trust policy and coverage will be marketed to sponsored association groups and financial institutions on a direct response, mass marketed basis.

Included in this submission are: the 10 Standardized Medicare Supplement Insurance Plans A through D, Plans F and G and Plans K through N (we will not offer high Deductible Plan F), the required outline of coverage, application, rates and actuarial materials, and the 2 advertising kits that will be used with this product. One kit will be mailed to applicants turning age 65 and the other to those over the age of 65.

These forms are being filed concurrently in our domicile state of Iowa.

We trust with the enclosed information, you will be able to review our filing and grant an approval. If you have any questions, please contact the undersigned. Thank you in advance for your help and attention to this matter.

Forms including in Filing:
Group Medicare Supplement Insurance Program
Group Policies:
MS9000GPT-A.AR - Group Medicare Supplement Insurance Policy Plan A
MS9000GPT-B.AR - Group Medicare Supplement Insurance Policy Plan B
MS9000GPT-C.AR - Group Medicare Supplement Insurance Policy Plan C
MS9000GPT-D.AR - Group Medicare Supplement Insurance Policy Plan D
MS9000GPT-F.AR - Group Medicare Supplement Insurance Policy Plan F
MS9000GPT-G.AR - Group Medicare Supplement Insurance Policy Plan G
MS9000GPT-K.AR - Group Medicare Supplement Insurance Policy Plan K
MS9000GPT-L.AR - Group Medicare Supplement Insurance Policy Plan L
MS9000GPT-M.AR - Group Medicare Supplement Insurance Policy Plan M
MS9000GPT-N.AR - Group Medicare Supplement Insurance Policy Plan N

Group Certificates of Insurance:
MS9000GCT-A.AR - Group Medicare Supplement Insurance Certificate Plan A
MS9000GCT-B.AR - Group Medicare Supplement Insurance Certificate Plan B
MS9000GCT-C.AR - Group Medicare Supplement Insurance Certificate Plan C
MS9000GCT-D.AR - Group Medicare Supplement Insurance Certificate Plan D
MS9000GCT-F.AR - Group Medicare Supplement Insurance Certificate Plan F
MS9000GCT-G.AR - Group Medicare Supplement Insurance Certificate Plan G
MS9000GCT-K.AR - Group Medicare Supplement Insurance Certificate Plan K
MS9000GCT-L.AR - Group Medicare Supplement Insurance Certificate Plan L

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MS9000GCT-M.AR - Group Medicare Supplement Insurance Certificate Plan M
MS9000GCT-N.AR - Group Medicare Supplement Insurance Certificate Plan N

MS9000GOTCS - Outline of Coverage, Group Plans, A-D, F, G, K-N

MS9000GAT - Application Form

Advertising Forms:
Kit One - for those turning age 65
MSAMAMIPPATLICBR - T65 - Turning 65 Brochure
MPLTR1 - Turning 65 Solicitation Letter Effort 1
MPLTR2 - Turning 65 Solicitation Letter Effort 2
MPLTR3 - Turning 65 Solicitation Letter Effort 3
MP T65 RS - Turning 65 Rate Sheet
Kit Two - for those age 65 and over
MSAMAMIPPATLICBR -Brochure
MPLTRR1 - Solicitation Letter Effort 1
MPLTRR2 - Solicitation Letter Effort 2
MPLTRR3 - Solicitation Letter Effort 3
MP Resol RS - Turning 65 Rate Sheet
Material available for both Kits
AMAT409 - Discount Flyer

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Cindy K. Hammonds, FLMI, CCP, AIRC, ACS Title Compliance System Specialist

Signature Cindy Hammonds Date 8/3/2009

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TRANSAMERICA LIFE INSURANCE COMPANY

AN IOWA STOCK COMPANY I ADMINISTRATIVE OFFICES: BALTIMORE, MARYLAND 21201

August 3, 2009

Insurance Commissioner Jay Bradford
Compliance - Life and Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

NAIC #468-86231; FEIN#: 39-0989781

RE: MS9000GPT-A.DE et al. - Medicare Supplement Insurance Program
Company Filing#: HM AR0050707C01
See Attached List of Forms

Dear Commissioner Bradford:

The above referenced forms are being submitted for your review and approval. These forms are new and in compliance with the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) will replace previously approved forms MS5000GPT-A.AR et al which were approved by your department on November 17, 2007 under Insurance Department File # 36902. Upon approval, these forms will only be issued with an effective date of June 1, 2010 or later.

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These forms are being filed concurrently in our domicile state of Iowa.

We trust with the enclosed information, you will be able to review our filing and grant an approval. If you have any questions, please contact the undersigned. Thank you in advance for your help and attention to this matter.

Sincerely,

Edward G. Weigand
Director, Product Filing & Compliance
(800) 233-4624, ext. 5265
(410) 209-5910 (Fax)
eweigand@aegonusa.com (E-mail)

List of Forms
Group Medicare Supplement Insurance Program

Group Policies:

MS9000GPT-A.AR - Group Medicare Supplement Insurance Policy Plan A
MS9000GPT-B.AR - Group Medicare Supplement Insurance Policy Plan B
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- MPLTRR3 – Solicitation Letter Effort 3
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Material available for both Kits
- AMAT409 – Discount Flyer

EXPLANATION OF VARIABLES
Medicare Supplement Insurance Program - MIPPA Compliant Forms

Group Policy Form Series MS9000-GPT, Plans A, B, C, D, F, G, K, L, M, N

Schedule of Benefits

- *Group Policy Number*, *Effective Date*, *Anniversary Date*, and *Policyholder* will change case by case to reflect Policyholder specific data.
- Plan N - Schedule of Benefits will reflect appropriate Medical Benefits Part B Office Visit Co-Payment and Emergency Room Co-Payment amounts. This information will also be reflected in the Plan Benefits provision.

Definitions

- In the definitions of Hospital, Nurse, Physician, and Skilled Nursing Facility, "Christian Science" references will be included if appropriate for and selected by the Policyholder.
- In the definition of Member, information will be included that reflects data and/or description specific to the Policyholder.
- The definition of Policy Month, the period of time may begin on the 1st through the 31st day of the month and may end on the 25th through the last day of the month as agreed to by the Policyholder and us.

Eligibility and Effective Date

- The use of the deferred effective date in the event of hospitalization paragraphs may be deleted as agreed to by the Policyholder and us.

Pre-Existing Condition Limitation

- For selected case issues, the Pre-Existing Condition Limitation may be omitted, as agreed to by the Policyholder and us.
- Other Pre-Existing Condition Limitation time periods are 3/6, 6/3 and 3/3, as agreed to by the Policyholder and us

Individual Termination of Insurance

- In the Conversion provision, reference to "terminates membership with the Policyholder" in item (2) will be omitted for any Policyholder that does not "terminate" its members.

Premiums

- In the Premium Changes provision, prior written notice of premium change must be at least 31 days and may be more, as agreed to by the Policyholder and us. And the statement regarding payment of the increased premium for premium which has already been paid may be omitted, as agreed to by the Policyholder and us.
- The Unpaid Premium provision may be omitted, as agreed to by the Policyholder and us.

General Provisions

- In the Certificates provision, the time to return the certificate will be at least 30 days and may be more, as agreed to by the Policyholder and us.
- In the Right to Terminate provision, prior written notice of termination must be at least 31 days and may be more, as agreed to by the Policyholder and us.

- The Time Limit on Certain Defenses provision will be removed of there is no Pre-Existing Condition Limitation. And the limitation time period will reflect the Pre-Existing Condition time period (but in no case greater than 6 months), as agreed to by the Policyholder and us.

Group Certificate Form Series MS9000-GCT, Plans A, B, C, D, F, G, K, L, M, N

First Page

- The use of the deferred effective date in the event of hospitalization paragraphs may be deleted as agreed to by the policyholder and us.

Schedule of Benefits

- *Covered Person's Name*, *Policy Number*, *Certificate Number*, *Policyholder*, *Effective Date of Coverage*, [*Mode*] *Premium*, and *Covered Person's Age At Issue* will change case by case to reflect Covered Person specific data.
- Plan N - Schedule of Benefits will reflect appropriate Medical Benefits Part B Office Visit Co-Payment and Emergency Room Co-Payment amounts. This information will also be reflected in the Plan Benefits provision.

Definitions

- In the definitions of Hospital, Nurse, Physician, and Skilled Nursing Facility, "Christian Science" references will be included if appropriate for and selected by the Policyholder.
- The definition of Policy Month, the period of time may begin on the 1st through the 31st day of the month and may end on the 25th through the last day of the month as agreed to by the Policyholder and us.

Pre-Existing Condition Limitation

- For selected case issues, the Pre-Existing Condition Limitation may be omitted, as agreed to by the Policyholder and us.
- Other Pre-Existing Condition Limitation time periods are 3/6, 6/3 and 3/3, as agreed to by the Policyholder and us

Individual Termination of Insurance

- In the Conversion provision, reference to "terminates membership with the Policyholder" in item (2) will be omitted for any Policyholder that does not "terminate" its members.

Premiums

- In the Premiums provision, the change in premium mode may be omitted.
- In the Premium Changes provision, prior written notice of premium change must be at least 31 days and may be more, as agreed to by the Policyholder and us. And the statement regarding payment of the increased premium for premium which has already been paid may be omitted, as agreed to by the Policyholder and us.
- The Unpaid Premium provision may be omitted, as agreed to by the Policyholder and us.

General Provisions

- The Time Limit on Certain Defenses provision will be removed of there is no Pre-Existing Condition Limitation. And the limitation time period will reflect the Pre-

Existing Condition time period (but in no case greater than 6 months), as agreed to by the Policyholder and us.

Explanation of Variability
For Group Application - Form No. MS9000GAT
Transamerica Life Insurance Company

Found on All Pages of Application

A Association Logo will vary.

B Administration name, address and phone number will vary

C Depending on the wishes of the association, either the term “Endorsed” or “Sponsored” will be used.

D Will vary by association.

E personalized name and address

F Will vary depending on how the line of business addresses their customers.

G Will either be included or removed, depending upon the wishes of the association.

H Depending on who is being solicited, “spouse “or Other Applicant” may be used. Other applicant may only be used if eligibility is approved in the state.

I Future services we plan to develop

1a Depending on the wishes of the association, either “It’s easy to apply:” or “To Apply:” will be used.

1b Will be included if the state has approved eligibility of other applicants and they are being solicited.

1c Depending on who is being solicited statement could read “This Medicare Supplement Application for both [Physician/Member/Applicant/Employee/Customer &Spouse.” Or “This Medicare Supplement Application for Physician/Member/Applicant/Employee/Customer, Spouse & Other Applicant.” Other Applicant will only be used if the state has approved eligibility.

1d Depending on the wishes of the association this may or may not be included. If included, the date to respond by will change depending on when the information is mailed.

1e Included or deleted depending on administrator

1f Included or deleted depending on administrator

1g Included or deleted depending on administrator

1h Included for Credit Card customers only

2a Plans available for persons under age 65 may vary per state.

2b Depending on the wishes of the association plans shown may vary

2c Depending on the wishes of the association this section may or may not be included. If included, rate information for the plans shown in 2c will vary by age and state.

2d Depending on the wishes of the association, this may or may not be shown. If included, either “Please Bill” or “Mode of Payment” will be used. Payment modes offered are variable depending upon the administrator. “Choose One” will be included or removed.

2e Depending on the wishes of the association, “Payment Method” may or may not be used. Payment methods shown are variable depending upon the administrator.

2f In or out depending if allowed in the state.

3a To be included for Florida

3b To be included for Pennsylvania

3c To be included for Colorado

3d To be included for Kentucky

3e To be included for New Jersey

3f To be included for Nebraska

3g To be included for Tennessee

3h Standard fraud statement

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4a Will be included or removed. **For states where under 65 coverage not required**, bracketed information will read "...1.) I apply within 6 months of being age 65 or older and enrolled in Medicare Parts A and B or, 2.) if I have been covered by [a/the][AMA-sponsored] Catastrophic Major Medical, Hospital Indemnity Plan or other primary hospital or medical reimbursement coverage for at least [12] months within 63 days prior to the date this Medicare Supplement takes effect.
If under age 65 coverage is required bracketed information will read "...1.) I am enrolled in Medicare Parts A and B or, 2.) if I have been covered by [a/the][AMA-sponsored] Catastrophic Major Medical, Hospital Indemnity Plan or other primary hospital or medical reimbursement coverage for at least [12] months within 63 days prior to the date this Medicare Supplement takes effect..

4b Section will either be included or removed depending on the administrator. **If included in states where under age 65 coverage is required** section will not include bracketed wording "age 65 or older". Other bracketed information is variable by administrator.

4c Number of months may change by administrator

4d Included for states where licensed agent signature is required.

7/8/09

AMA – TLIC MIPPA
Letter Variability

Turning 65 letters
MPLTRT1
MPLTRT2
MPLTRT3

Resolicitation Letters
MPLTRR1
MPLTRR2
MPLTRR3

1. Association/ Group logo, title, signature, address, phone number, website information may change.

2. All references to the association or group may change.

3. Description of persons will vary by association or group for example, physician, spouse, member,

4. Reference to year will be updated

5. Creative changes to kit may change for example color of rate sheet,

6. State regulations may change for number of days for creditable coverage, waiting periods etc.

7. Claim days will be updated as needed.

8. Recommended plans may vary by association or group.

9. Creative copy changes for group, for seasonality, end of year. Paragraphs may be added or deleted to lengthen or shorten the letter.

10. Rating will be updated as needed.

11. Claims processing and billing processing may vary by association or group.

Based on different target groups (segments) within the membership, we will use one of the following sets of copy in the letter:

A. Standard copy that is default for all segments.
B. Copy for segment/cluster 3 (young at heart).
C. Copy for segment/cluster 6 (senior days) and segment/cluster 7 (bingo bunch).

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
Company Tracking Number:	*HM AR0050707C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/03/2009	Supporting Document	Explanation of Variables - MS9000GAT	09/14/2009	Explanation of Variables - MS9000GAT.PDF (Superceded)
08/03/2009	Form	Plan N Master Policy	09/14/2009	MS9000GPT-N_AR.PDF (Superceded)
08/03/2009	Form	Plan M Master Policy	09/14/2009	MS9000GPT-M_AR.PDF (Superceded)
08/03/2009	Form	Plan L Master Policy	09/14/2009	MS9000GPT-L_AR.PDF (Superceded)
08/03/2009	Form	Plan K Master Policy	09/14/2009	MS9000GPT-K_AR.PDF (Superceded)
08/03/2009	Form	Plan G Master Policy	09/14/2009	MS9000GPT-G_AR.PDF (Superceded)
08/03/2009	Form	Plan F Master Policy	09/14/2009	MS9000GPT-F_AR.PDF (Superceded)
08/03/2009	Form	Plan D Master Policy	09/14/2009	MS9000GPT-D_AR.PDF (Superceded)

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
Company Tracking Number:	*HM AR0050707C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

08/03/2009	Form	Plan C Master Policy	09/14/2009	MS9000GPT-C_AR.PDF (Superceded)
08/03/2009	Form	Plan B Master Policy	09/14/2009	MS9000GPT-B_AR.PDF (Superceded)
08/03/2009	Form	Plan A Master Policy	09/14/2009	MS9000GPT-A_AR.PDF (Superceded)
08/03/2009	Form	Plan N Certificate	09/14/2009	MS9000GCT-N_AR.PDF (Superceded)
08/03/2009	Form	Plan M Certificate	09/14/2009	MS9000GCT-M_AR.PDF (Superceded)
08/03/2009	Form	Plan L Certificate	09/14/2009	MS9000GCT-L_AR.PDF (Superceded)
08/03/2009	Form	Plan K Certificate	09/14/2009	MS9000GCT-K_AR.PDF (Superceded)
08/03/2009	Form	Plan G Certificate	09/14/2009	MS9000GCT-G_AR.PDF (Superceded)
08/03/2009	Form	Plan F Certificate	09/14/2009	MS9000GCT-F_AR.PDF (Superceded)
08/03/2009	Form	Plan D Certificate	09/14/2009	MS9000GCT-D_AR.PDF (Superceded)
08/03/2009	Form	Plan C Certifcate	09/14/2009	MS9000GCT-C_AR.PDF (Superceded)

SERFF Tracking Number:	*AEGX-126252428*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43112*
Company Tracking Number:	*HM AR0050707C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050707C01*		

08/03/2009	Form	Plan B Certificate	09/14/2009	MS9000GCT-B_AR.PDF (Superceded)
08/03/2009	Form	Plan A Certificate	09/14/2009	MS9000GCT-A_AR.PDF (Superceded)
08/03/2009	Form	Application	09/14/2009	MS9000GAT.PDF (Superceded)

7/8/09

AMA – TLIC MIPPA
Letter Variability

Turning 65 letters
MPLTRT1
MPLTRT2
MPLTRT3

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MPLTRR1
MPLTRR2
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TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan N

Core Benefits

Hospital Benefits **Part A**	• This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150. • Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.
Blood Benefit **Part A & B**	• This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.
Medical Benefits **Part B**	• This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, other than the co-payment amounts shown below, subject to the Medicare Part B Deductible.
• **Office Visit Co-Payment**	• $**[**20**]** per office visit
• **Emergency Room Co-Payment**	• $**[**50**]** per emergency room visit (waived if the Covered Person is admitted to the Hospital and the emergency visit is subsequently covered as a Medicare Part A Eligible Expense)

Additional Benefits

Medicare Part A Deductible Benefit	• This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.
Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
•	
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**] [**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**] [**and**] [**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated

organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][**;**][** and**] [**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**] [**or**] [**(b)**]** above**][**;**][** and**] [**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**] [**(b)**] [**or**] [**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE

Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN N

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other

appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the cost sharing for all Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person, except as provided in items (3) and (4) that follows.

(3) The Covered Person must pay the lesser of $**[**20**]** or the Medicare Part B coinsurance or co-payment, shown in the Schedule, for each covered health care provider office visit, including visits to medical specialist.

(4) The Covered Person must pay the lesser of $**[**50**]** or the Medicare Part B coinsurance or co-payment, shown in the Schedule, for each visit to an emergency room of a Hospital. This emergency room co-payment will be waived if the Covered Person is admitted to the Hospital and the emergency visit is subsequently covered as a Medicare Part A Eligible Expense.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 100% of the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person’s

certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
    (a) provide continuation of the benefits contained in this Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:

(a) the conversion coverage provided under item (1) above; or
(b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to

us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person’s death, the benefit will be paid as follows: to the Covered Person’s spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan M

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 50% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian

Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN M

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay

100% of the cost sharing for all Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 50% of the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a

Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and

(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code

(Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan L

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 75% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Blood Benefit Part A & B

- This Plan pays 75% of the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Medical Benefits Part B

- This Plan pays 75% of the cost sharing of Medicare Eligible Expenses for Part B Medical Services, other than Part B preventive medical services, after payment of the Medicare Part B Deductible, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 75% of the Medicare Part A Deductible per Benefit Period, until the Out of Pocket Limit has

	been met, then this Plan pays 100%.
Skilled Nursing Facility Benefit	• This Plan pays 75% of the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Part B Preventive Services Benefit	• This Plan pays 100% of the coinsurance amount for Medicare Eligible Expenses for Part B preventive medical services, subject to the Medicare Part B Deductible.
Out of Pocket Limit	• $**[**2,070**]** per Calendar Year. Once this Out of Pocket Limit has been met, this Plan pays 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year.

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]**

Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][;][** and**] [**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**] [**or**] [**(b)**]** above**][;][** and**] [**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**] [**(b)**] [**or**] [**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:

(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:

(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities,

Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE

Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN L

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 75% of the cost sharing for all Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare until the Out of Pocket Limit has been met, then 100%.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense. We will pay 75% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense. We will pay 75% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses other than Part B preventive medical services. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay 75% of the cost sharing for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person, until the Out of Pocket Limit has been met, then 100%.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 75% of the Medicare Part A Deductible until the Out of Pocket Limit has been met, then 100%.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement. We will pay 75% of the Actual Expenses, subject to the above, until the Out of Pocket Limit has been met, then 100%.

PART B PREVENTIVE SERVICES BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for Part B preventive services, as defined by Medicare. We will pay 100% of the cost sharing for Medicare Part B preventive services, subject to the Medicare Part B Deductible.

COST SHARING AFTER OUT OF POCKET LIMIT

After the Covered Person has reached the Out of Pocket Limit shown on the Schedule, the Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred eligible expenses. We will pay 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year. The Out of Pocket Limit is shown on the Schedule and will be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by

a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered

Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date

of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person’s death, the benefit will be paid as follows: to the Covered Person’s spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan K

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 50% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Blood Benefit Part A & B

- This Plan pays 50% of the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Medical Benefits Part B

- This Plan pays 50% of the cost sharing of Medicare Eligible Expenses for Part B Medical Services, other than Part B preventive medical services, after payment of the Medicare Part B Deductible, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 50% of the Medicare Part A Deductible per Benefit Period, until the Out of Pocket Limit has

	been met, then this Plan pays 100%.
Skilled Nursing Facility Benefit	• This Plan pays 50% of the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Part B Preventive Services Benefit	• This Plan pays 100% of the coinsurance amount for Medicare Eligible Expenses for Part B preventive medical services, subject to the Medicare Part B Deductible.
Out of Pocket Limit	• $**[**4,140**]** per Calendar Year. Once this Out of Pocket Limit has been met, this Plan pays 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year.

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]**

Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][;][** and**] [**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**] [**or**] [**(b)**]** above**][;][** and**] [**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**] [**(b)**] [**or**] [**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:

(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:

(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities,

Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE

Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN K

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 50% of the cost sharing for all Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare until the Out of Pocket Limit has been met, then 100%.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense. We will pay 50% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense. We will pay 50% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses other than Part B preventive medical services. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay 50% of the cost sharing for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person, until the Out of Pocket Limit has been met, then 100%.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 50% of the Medicare Part A Deductible until the Out of Pocket Limit has been met, then 100%.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement. We will pay 50% of the Actual Expenses, subject to the above, until the Out of Pocket Limit has been met, then 100%.

PART B PREVENTIVE SERVICES BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for Part B preventive services, as defined by Medicare. We will pay 100% of the cost sharing for Medicare Part B preventive services, subject to the Medicare Part B Deductible.

COST SHARING AFTER OUT OF POCKET LIMIT

After the Covered Person has reached the Out of Pocket Limit shown on the Schedule, the Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred eligible expenses. We will pay 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year. The Out of Pocket Limit is shown on the Schedule and will be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by

a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered

Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date

of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person’s death, the benefit will be paid as follows: to the Covered Person’s spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan G

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Medicare Part B Excess Benefit	• This Plan pays 100% of the difference between the Medicare Part B billed amount and the Medicare Eligible Expense.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of

any person described in **[**(a)**] [**or**] [**(b)**]** above**][**;**][** and**] [**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**] [**(b)**] [**or**] [**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist,

occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN G

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B EXCESS BENEFIT

The Covered Person will receive an additional benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. We will pay 100% of the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law) and the Medicare Part B Eligible Expense. Benefits will not be paid if the Covered Person's Physician or medical provider accepts the Medicare Eligible Expenses as the total amount due.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to

exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if he provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date

of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person’s death, the benefit will be paid as follows: to the Covered Person’s spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan F

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Medicare Part B

- This Plan pays 100% of the Medicare Part B

Deductible Benefit	Deductible per Calendar Year.
Medicare Part B Excess Benefit	• This Plan pays 100% of the difference between the Medicare Part B billed amount and the Medicare Eligible Expense.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC

Association's**][**Federation**]** Directory**]][;][** and**] [**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**] [**or**] [**(b)**]** above**][;][** and**] [**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**] [**(b)**] [**or**] [**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which **[**first**]** manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE

Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN F

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365

days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B DEDUCTIBLE BENEFIT
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part B Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Calendar Year, is the Medicare Part B Deductible.

MEDICARE PART B EXCESS BENEFIT
The Covered Person will receive an additional benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. We will pay 100% of the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law) and the Medicare Part B Eligible Expense. Benefits will not be paid if the Covered Person's Physician or medical provider accepts the Medicare Eligible Expenses as the total amount due.

FOREIGN COUNTRY TRAVEL BENEFIT
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:
(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of the application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses his entitlement to such medical assistance, within the 24 month period, his coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
    (a) provide continuation of the benefits contained in this Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person’s death, the benefit will be paid as follows: to the Covered Person’s spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan D

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian

Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE

Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN D

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay

100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a

Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and

(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code

(Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and

not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan C

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Medicare Part B Deductible Benefit	• This Plan pays 100% of the Medicare Part B Deductible per Calendar Year.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**] [**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**] [**and**] [**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][**;**][** and**] [**(c) the lawful spouse**[**, unless legally separated,**]** of

any person described in **[**(a)**] [**or**] [**(b)**]** above**][**;**][** and**] [**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**] [**(b)**] [**or**] [**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist,

occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE

Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN C

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part B Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Calendar Year, is the Medicare Part B Deductible.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be

entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date

of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after three years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person’s death, the benefit will be paid as follows: to the Covered Person’s spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan B

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person’s immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person’s immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Persons' application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN B

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will

be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or **]**is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

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MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan A

Core Benefits

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) **[**a member of **[**or physician who is eligible for membership in**]** **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**]][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]** or of constituent or state associations or of component societies (as these terms are defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time) or of **[**ABC Association's**]** affiliated organizations or of those **[**national **[**medical specialty**]** societies**]** recognized by **[**ABC Association**]** for purposes of representation in the **[**ABC Association's**]** House of Delegates and as listed in the **[**ABC Association's**][**Federation**]** Directory**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

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

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person’s application and the first premium. The Effective Date of Coverage will be shown on the Covered Person’s certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN A

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will

be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code

(Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs

and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person **[**terminates membership with the Policyholder or**]** is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT SCHEDULE PAGE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan N

Hospital Benefits **Part A**	• This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150. • Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.
Blood Benefit **Part A & B**	• This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.
Medical Benefits **Part B**	• This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, other than the co-payment amounts shown below, subject to the Medicare Part B Deductible.
• **Office Visit Co-Payment**	• $[20] per office visit
• **Emergency Room Co-Payment**	• $[50] per emergency room visit (waived if you are admitted to the Hospital and the emergency

visit is subsequently covered as a Medicare Part A Eligible Expense)

Additional Benefits

Medicare Part A Deductible Benefit	• This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.
Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN N

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you, except as provided in items (3) and (4) that follows.

(3) You must pay the lesser of $**[**20**]** or the Medicare Part B coinsurance or co-payment, shown in the **[**Certificate Schedule**][**Schedule Page**]**, for each covered health care provider office visit, including visits to medical specialist.

(4) You must pay the lesser of $**[**50**]** or the Medicare Part B coinsurance or co-payment, shown in the **[**Certificate Schedule**][**Schedule Page**]**, for each visit to an emergency room of a Hospital. This emergency room co-payment will be waived if you are admitted to the Hospital and the emergency visit is subsequently covered as a Medicare Part A Eligible Expense.

If you discontinue or lapse Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 100% of the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the **[**Certificate Schedule**][**Schedule Page**]**, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the **[**Certificate Schedule**][**Schedule Page**]**. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the **[**Certificate Schedule**][**Schedule Page**]**.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
    (a) provide continuation of benefits contained in the Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
    (a) the conversion coverage provided under item (1) above; or
    (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of

termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible.

The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT SCHEDULE PAGE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan M

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 50% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;

(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN M

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A

Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 50% of the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the **[**Certificate Schedule**][**Schedule Page**]**, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and

(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the **[**Certificate Schedule**][**Schedule Page**]**. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the **[**Certificate Schedule**][**Schedule Page**]**.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
    (a) provide continuation of benefits contained in the Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
    (a) the conversion coverage provided under item (1) above; or
    (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may

also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for two years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT SCHEDULE PAGE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan L

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 75% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Blood Benefit
Part A & B

- This Plan pays 75% of the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Medical Benefits
Part B

- This Plan pays 75% of the cost sharing of Medicare Eligible Expenses, for Part B Medical Services, other than Part B preventive medical services, after payment of the Medicare Part B Deductible, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Additional Benefits

Medicare Part A Deductible Benefit	• This Plan pays 75% of the Medicare Part A Deductible per Benefit Period, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Skilled Nursing Facility Benefit	• This Plan pays 75% of the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Part B Preventive Services Benefit	• This Plan pays 100% of the coinsurance amount for Medicare Eligible Expenses for Part B preventive medical services, subject to the Medicare Part B Deductible.
Out of Pocket Limit	• $**[**2,070**]** per Calendar Year. Once this Out of Pocket Limit has been met, this Plan pays 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year.

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for

Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN L

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 75% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare until the Out of Pocket Limit has been met, then 100%.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense. We will pay 75% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense. We will pay 75% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses other than Part B preventive medical services. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay 75% of the cost sharing for Part B Medicare Eligible Expenses which are not paid by Medicare for you, until the Out of Pocket Limit has been met, then 100%.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 75% of the Medicare Part A Deductible until the Out of Pocket Limit has been met, then 100%.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement. We will pay 75% of the Actual Expenses, subject to the above, until the Out of Pocket Limit has been met, then 100%.

PART B PREVENTIVE SERVICES BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for Part B preventive services, as defined by Medicare. We will pay 100% of the cost sharing for Medicare Part B preventive services, subject to the Medicare Part B Deductible.

COST SHARING AFTER OUT OF POCKET LIMIT

After you have reached the Out of Pocket Limit shown on the **[**Certificate Schedule**][**Schedule Page**]**, you will receive benefits when we receive proof that, while insured, you incurred eligible expenses. We will pay 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year. The Out of Pocket Limit is shown on the **[**Certificate Schedule**][**Schedule Page**]** and will be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under

Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
    (a) provide continuation of benefits contained in the Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
    (a) the conversion coverage provided under item (1) above; or
    (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof

of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT SCHEDULE PAGE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan K

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 50% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Blood Benefit
Part A & B

- This Plan pays 50% of the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Medical Benefits
Part B

- This Plan pays 50% of the cost sharing of Medicare Eligible Expenses, for Part B Medical Services, other than Part B preventive medical services, after payment of the Medicare Part B Deductible, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Additional Benefits

Medicare Part A Deductible Benefit	• This Plan pays 50% of the Medicare Part A Deductible per Benefit Period, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Skilled Nursing Facility Benefit	• This Plan pays 50% of the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Part B Preventive Services Benefit	• This Plan pays 100% of the coinsurance amount for Medicare Eligible Expenses for Part B preventive medical services, subject to the Medicare Part B Deductible.
Out of Pocket Limit	• $**[**4,140**]** per Calendar Year. Once this Out of Pocket Limit has been met, this Plan pays 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year.

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for

Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN K

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 50% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare until the Out of Pocket Limit has been met, then 100%.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense. We will pay 50% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense. We will pay 50% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses other than Part B preventive medical services. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay 50% of the cost sharing for Part B Medicare Eligible Expenses which are not paid by Medicare for you, until the Out of Pocket Limit has been met, then 100%.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 50% of the Medicare Part A Deductible until the Out of Pocket Limit has been met, then 100%.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement. We will pay 50% of the Actual Expenses, subject to the above, until the Out of Pocket Limit has been met, then 100%.

PART B PREVENTIVE SERVICES BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for Part B preventive services, as defined by Medicare. We will pay 100% of the cost sharing for Medicare Part B preventive services, subject to the Medicare Part B Deductible.

COST SHARING AFTER OUT OF POCKET LIMIT

After you have reached the Out of Pocket Limit shown on the **[**Certificate Schedule**][**Schedule Page**]**, you will receive benefits when we receive proof that, while insured, you incurred eligible expenses. We will pay 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year. The Out of Pocket Limit is shown on the **[**Certificate Schedule**][**Schedule Page**]** and will be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under

Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
    (a) provide continuation of benefits contained in the Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
    (a) the conversion coverage provided under item (1) above; or
    (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof

of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]**(referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT SCHEDULE PAGE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan G

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Medicare Part B Excess Benefit	• This Plan pays 100% of the difference between the Medicare Part B billed amount and the Medicare Eligible Expense.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN G

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B EXCESS BENEFIT

You will receive an additional benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. We will pay 100% of the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law) and the Medicare Part B Eligible Expense. Benefits will not be paid if your Physician or medical provider accepts the Medicare Eligible Expenses as the total amount due.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the **[**Certificate Schedule**][**Schedule Page**]**, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the **[**Certificate Schedule**][**Schedule Page**]**. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the **[**Certificate Schedule**][**Schedule Page**]**.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under

Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
    (a) provide continuation of benefits contained in the Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
    (a) the conversion coverage provided under item (1) above; or
    (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof

of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT SCHEDULE PAGE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan F

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Medicare Part B Deductible Benefit	• This Plan pays 100% of the Medicare Part B Deductible per Calendar Year.
Medicare Part B Excess Benefit	• This Plan pays 100% of the difference between the Medicare Part B billed amount and the Medicare Eligible Expense.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Schedule Page who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for

Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which **[**first**]** manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN F

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part B Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Calendar Year, is the Medicare Part B Deductible.

MEDICARE PART B EXCESS BENEFIT

You will receive an additional benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. We will pay 100% of the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law) and the Medicare Part B Eligible Expense. Benefits will not be paid if your Physician or medical provider accepts the Medicare Eligible Expenses as the total amount due.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the **[**Certificate Schedule**][**Schedule Page**]**, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the **[**Certificate Schedule**][**Schedule Page**]**.

Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the **[**Certificate Schedule**][**Schedule Page**]**.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of the application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or less than **[**6**]**

months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:

  (a) provide continuation of benefits contained in the Policy; or

  (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to all Covered Persons covered under the Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT SCHEDULE PAGE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan D

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;

(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN D

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A

Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the **[**Certificate Schedule**][**Schedule Page**]**, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and

(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the **[**Certificate Schedule**][**Schedule Page**]**. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the **[**Certificate Schedule**][**Schedule Page**]**.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may

also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT [CERTIFICATE SCHEDULE][SCHEDULE PAGE]
Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	**[**JOSEPHINE SAMPLE**]**
[Policy:	**[**MZ0000000H0000A**]]**
[Certificate Number:	**[**SAMPPROD**]]**
[Policyholder:	**[**ABC ASSOCIATION**]]**
[Effective Date of Coverage:	**[**January 01, 2010**]]**
[[Semi-Annual**]** Premium:	**[**$50.00**]]**
[Covered Person's Age At Issue:	**[**65**]]**

Supplemental Medicare Expense Benefits
Plan C

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Medicare Part B Deductible Benefit	• This Plan pays 100% of the Medicare Part B Deductible per Calendar Year.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;

(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN C

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part B Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Calendar Year, is the Medicare Part B Deductible.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the **[**Certificate Schedule**][**Schedule Page**]**, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the **[**Certificate Schedule**][**Schedule Page**]**. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the **[**Certificate Schedule**][**Schedule Page**]**.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under

Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof

of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT [CERTIFICATE SCHEDULE][SCHEDULE PAGE]
Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	**[**JOSEPHINE SAMPLE**]**
[Policy:	**[**MZ0000000H0000A**]]**
[Certificate Number:	**[**SAMPPROD**]]**
[Policyholder:	**[**ABC ASSOCIATION**]]**
[Effective Date of Coverage:	**[**January 01, 2010**]]**
[[Semi-Annual**]** Premium:	**[**$50.00**]]**
[Covered Person's Age At Issue:	**[**65**]]**

Supplemental Medicare Expense Benefits
Plan B

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:

(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;

(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN B

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium

mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the **[**Certificate Schedule**][**Schedule Page**]** (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the **[**Certificate Schedule**][**Schedule Page**]**. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

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MEDICARE SUPPLEMENT [CERTIFICATE SCHEDULE][SCHEDULE PAGE]

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	**[**JOSEPHINE SAMPLE**]**
[Policy:	**[**MZ0000000H0000A**]]**
[Certificate Number:	**[**SAMPPROD**]]**
[Policyholder:	**[**ABC ASSOCIATION**]]**
[Effective Date of Coverage:	**[**January 01, 2010**]]**
[[Semi-Annual**]** Premium:	**[**$50.00**]]**
[Covered Person's Age At Issue:	**[**65**]]**

Supplemental Medicare Expense Benefits
Plan A

Hospital Benefits **Part A**	• This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150. • Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.
Blood Benefit **Part A & B**	• This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.
Medical Benefits **Part B**	• This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of

any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the **[**Certificate Schedule**][**Schedule Page**]** who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**][**Schedule Page**]**.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;

(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN A

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you

are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you **[**terminate membership with the Policyholder or if you**]** are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**][**Schedule Page**]**. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time

written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

AMA

A American Medical Association

TRANSAMERICA LIFE INSURANCE COMPANY G
[A TRANSAMERICA COMPANY] G
DIRECT RESPONSE DIVISION • BALTIMORE, MARYLAND
Medicare Supplement Insurance Program
C [Sponsored/Endorsed] by the [American Medical Association] D

1c

[THIS Medicare Supplement Application for [both] [PHYSICIAN/Member /applicant/employee/customer] [and/&/OR] [spouse] [& other applicant][Spouse may also be a partner in a civil union]

1a [It's easy to apply:] [To Apply:]

1. Please complete, date and sign this form, and check the Plan you want. Make sure you answer all the questions and read all the statements.
2. 1e [Send NO MONEY at this time. You will be billed when your Insurance Certificate is mailed.] 1f [Be sure to complete the Monthly Deduction Authorization enclosed.] 1g [Send no money now. Your premiums will be automatically deducted from your checking account.] 1h [Send no money now. Your premium will be conveniently billed to your credit card.]
3. Return this application (be sure to have your spouse sign if also applying) in the postage-paid envelope provided[.] [, to: B [AMA Insurance Agency, Inc., 515 North State St., Chicago IL 60654-9687.]

B

Administered by:
AMA Insurance Agency, Inc.
515 North State Street, Chicago, Illinois 6054-9687
(In California, d/b/a:
AMA of Illinois Insurance Agency)
A Subsidiary of the American Medical Association (AMA)

Underwritten by: Transamerica Life Insurance Company, Cedar Rapids, Iowa

1d

[Response Requested by:]
[Month XX, XXXX]

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
Sample A. Sample
Apt. 1-A
123 Main Street
Suite 123
Anytown, US 12345-6789 E

Please check if above address is o Home o Office
If not indicated above, please provide your primary home address here: _____
Street Address

_____
City State Zip

G

PLEASE COMPLETE

o I wish to apply
[Phone No: (_____)_____ [Work Phone: (_____)_____]G
[Name of [physician/member/customer/employee/other applicant] F
[whose spouse is applying for coverage]]_ G

_____
H [Spouse][Other Applicant's] Name (if applying)

_____
E-mail address _____

[Physician/Member/Customer/Cardholder/Employee/Applicant]F:
F [Physician] [Spouse (if applying)]
H [Applicant I] [Other Applicant]

Social Security Number:	_____	_____
Date of Birth:	____-____-____ Month Day Year	____-____-____ Month Day Year
Sex:	o Male o Female	o Male o Female
Medicare ID Number: *(found on your Medicare ID Card)*	_____	_____
Desired future effective month:	_____ Month/Year	_____ Month/Year

G[**Or** -Please attach a copy of your Medicare ID card with this application to expedite electronic filing and speed the processing of your Part B Claim.]

PLEASE READ AND COMPLETE THE OTHER SIDE ,

MS9000GAT

[I am a member of _____] **G**
Other Applicants
Name: _____ Relationship: _____
Address: _____ Sex: DOB: __/___/__
City/State: _____ Telephone: _____
Medicare ID Number: _____ *(found on your Medicare ID Card)*
1b

IF YOU ARE UNDER AGE 65 AND COVERED UNDER MEDICARE PARTS A and B,
YOU MAY APPLY FOR COVERAGE UNDER PLANS [[A, B OR C] [A][A or B] [A, B, C, or F] [A through J] [A through N]] ONLY. 2a

CHECK BOX FOR DESIRED COVERAGE:

F [Physician/Member/Customer/Applicant/Employee/Cardholder] [Applicant I]
[• Plan A • Plan B • Plan C • Plan D • Plan F • Plan G • Plan K • Plan L,• Plan M, • Plan N]]**2b**
[• Other __] **2f**
H [Spouse/Other Applicant] [Applicant II]
[• Plan A • Plan B • Plan C • Plan D • Plan F • Plan G • Plan K • Plan L • Plan M • Plan N]**2b** [• Other _____] **2f**

[(Monthly Rate) (based on current age of XX)]

$XX.XX	$XX.XX	$XX.XX	$XX.XX	$XX.XX
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXXX	XXXXXXXXXXX

2c

[[PLEASE BILL] [• Please bill me at home]
[Mode of Payment] [Choose one] [• Monthly] [• Quarterly] [• Semi-annual] [• Annual][EFT Monthly (Electronic Funds Transfer)]]**2d**
[Payment Method][• Direct Bill • EFT Monthly (Electronic Funds Transfer) • AMPO (Automatic Monthly Payment Option) • Credit Card] Please note: Effective date will be disclosed on the Certificate Schedule Page.
[First premium payment enclosed in the amount of [Member/Physician] $_____ Spouse $_____.] **2e**
[Total premium enclosed for [Member/Physician] and Spouse $_____.]
[Please note: Effective date will be disclosed on the Certificate Schedule Page.] **G**
[Desired Future Effective Date of Coverage: ____/_____/_____] **G**
[Be sure to select your payment preference and enclose your first premium payment [Member/Physician] $___ Spouse $____.]
[Total premium enclosed for [Member/Physician] and Spouse $_____.]
[Please make your check payable to the [AMA Insurance Agency, Inc.]] **G**

EFT Authorization Agreement: I authorize [AMA Insurance Agency, Inc.] to instruct my financial institution to make my monthly bill payments on the dates due from account listed. This authority remains in effect until [AMA Insurance Agency] has received written notification from me of termination in time to allow reasonable opportunity to act on it, or until [AMA Insurance Agency, Inc.] has sent me written notice of termination of this agreement.
_____ [Physician][Customer] signature
_____ [Spouse] signature
_____Account Number _____ Routing Number **2e**

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE AND BELIEF

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS

	[Physician] F [Applicant I] F	[Spouse] H [Applicant II] H
1) Your Acceptance May be Guaranteed.		
a) Did you turn age 65 in the last 6 months?	o Yes o No	o Yes o No
b) Did you enroll in Medicare Part B in the last 6 months?	o Yes o No	o Yes o No
If Yes, what is the effective date?	___/___/___ mo day yr	___/___/___ mo day yr
2) Premium Assistance Questions (Questions we are required to ask)		
a) Are you covered for medical assistance through the state Medicaid program: (NOTE TO APPLICANT): If you are participating in a "Spend-Down Program" and have not met your "Share of Cost"; please answer NO to this question.) Will Medicaid pay your premiums for this Medicare Supplement policy?	o Yes o No	o Yes o No
b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	o Yes o No o Yes o No	o Yes o No o Yes o No
3) Replacement Questions. (Answer only if you are replacing coverage)		
Ÿ **Medicare Advantage:**		
a) If you had coverage from any Medicare plan other than the original Medicare within the past 63 days (for example, a Medicare Advantage Plan, or Medicare HMO or PPO) fill in your start and end dates. If you are still covered under this plan leave "END" blank.	Start_____ End_____	Start_____ End_____
b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	o Yes o No	o Yes o No
Ÿ **Medicare Supplement:**		
a) Was this your first time in this type of Medicare plan?	o Yes o No	o Yes o No
b) Did you drop a Medicare Supplement policy to enroll in this Medicare Plan?	o Yes o No	o Yes o No
c) Do you have another Medicare Supplement policy in force?	o Yes o No	o Yes o No
d) If so, with what company, and what plan do you have? Company: _____ Plan: _____		
e) If so, do you intend to replace your current Medicare Supplement policy with this policy?	o Yes o No	o Yes o No
Ÿ **Other:**		
a) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)	o Yes o No	o Yes o No
b) If so, with what company and what kind of policy? Company: _____ Plan: _____	o Yes o No	o Yes o No
c) What are your dates of coverage under the other policy? (If you are still covered by the other policy, leave 'END" blank.)	Start_____ End_____	Start_____ End_____

MEDICARE SUPPLEMENT INFORMATION TO CONSIDER

- You do not need more than one Medicare Supplement policy or certificate.
- If you purchase this Certificate you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy or certificate.
- If, after purchasing this certificate, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement certificate can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement certificate (or, if that is no longer available, a substantially equivalent policy or certificate) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstituted certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare Supplement certificate or policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement certificate or policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement certificate or policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent certificate or policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement certificate or policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB).

[FL Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.] **3a**

[PA Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.] **3b**

[Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.] **3c**

[Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information, concerning any fact material thereto commits a fraudulent insurance act, which is a crime.] **3d**

[New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]**3e**

[Nebraska Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a crime and may be subject to fines or confinement in prison.]**3f**

[Tennessee Residents; It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.] **3g**

[Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.] **3h**

IMPORTANT – PLEASE READ AND SIGN

I hereby apply for Medicare Supplement coverage issued by Transamerica Life Insurance Company. I understand that this coverage will not pay benefits for conditions for which I have received medical treatment or advice within the last 6 months (3 months in WA) prior to the effective date until I have been insured for 6 (3 months in WA) consecutive months. If I had creditable health insurance coverage within 63 (90 days in ME and WY) calendar days of applying for this plan, or if I am an Eligible Person enrolled within 63 days of termination, then this pre-existing conditions limitation will be waived to the extent that it was satisfied under the replaced coverage. This waiver will apply only to prior creditable coverage which includes, but is not limited to, coverage under a group health plan, health insurance coverage, Medicare Supplement, Medicare Parts A and B, Medicaid, TRICARE, a state health benefits risk pool or the Federal Employees Health Benefits Plan (FEHB).

[PLEASE NOTE: If you are currently enrolled in a Medicare Risk HMO plan, you are responsible for terminating your HMO coverage once you apply for this plan. Any unpaid claims resulting from failure to disenroll from your HMO plan will be your responsibility.] G

I understand that my acceptance into this [D AMA]-[C sponsored/endorsed] Plan is GUARANTEED with no medical information required and that the pre-existing conditions limitation is not applicable if 1.) I apply within 6 months of being age 65 (or older) and] [I am] enrolled in Medicare Parts A and B or, 2.) if I have been covered by [a/the] [D AMA- C sponsored] [Catastrophic Major Medical] or [Hospital Income Plan] for at least the [12] **4c** months prior to the date this Medicare Supplement takes effect. or [3.) I replace other primary hospital or medical reimbursement coverage with this plan.]

4a

[If you are [age 65 or older], enrolled in Medicare Parts A and B and your premium is paid when due, your coverage will be effective on the first day of the month [after] your application is received[.] [by AMA Insurance Agency, Inc.] [(or on the first day of the following month if received on the 11th of the month or later).] **4b**

Please read and complete the other side

I acknowledge that I have read all statements.

[Physician's][Member's][Customer's][Employee's] [Signature] X _____ **Date** _____

[Applicant's]

[Spouse's/Other Applicant's] [Applicant] Signature X _____ **Date** _____

Licensed Resident Agent (where required by law): Dennis R. Ziemann **4d**

[Dennis R. Ziemann]

Your 30-Day Right To Return Your Certificate Takes The Risk Out Of Applying Now

Apply today. When your Certificate arrives, examine it carefully. Take up to 30 days, if you like, to discuss it with your family, friends, lawyer, accountant or advisor. If, for any reason, you decide during the 30 days that you do not need this supplemental protection, write "cancel" across the face of your Certificate and mail it back to [AMA Insurance Agency, Inc.]**B** Any premium paid will be refunded in full and your Certificate will be considered never issued. **G**

1-800-458-5736 **B**

To apply by phone call [1-800-xxx-xxxx from [8:00 a.m. to 5:00 p.m.], [Central Time], [Monday through Friday].] [To apply online visit our website [www.abcdefghijk]. **B**

B For more information, call this toll-free number for prompt, courteous service. [Experienced, knowledgeable service specialists will gladly assist you.] **G**

Underwritten by Transamerica Life Insurance Company under Group Policy No. MS9000GPT