PLAINTIFF'S EXHIBIT

MET-804

GROUP HOSPITAL EXPENSE INSURANCE (Non-Occupational)

NOTE: Examples in SOLID CAPITALS must be referred to Regional Supervisor.

GROUP HOSPITAL EXPENSE INSURANCE (Non-Occupational)

NOTE: Exceptions in SOLID CAPITALS must be referred to Regional Supervisor.

Amount of benefits should be consistent with local hospital charges and a flat Daily Benefit for all employees is desirable.

Benefits should not supplement existing hospital coverage.

Dependent benefits may not exceed Personal benefits.

Minimum: Daily Benefit usually $10 but if necessary may be $7 for Group with 50 or more lives. Special Services 10 times Daily Benefit. LOWER MINIMUM POSSIBLE.

Maximum: Daily Benefit $15. MAXIMUM TO $20 AVAILABLE.

Special Services may be on basis of any plan for which rates are quoted in this Rate Book. OTHER TYPES OF PLANS WILL BE CONSIDERED.

Rates:

For Daily Benefit not in even dollars, use rate for nearest dollar. ($.50 and over, next higher dollar.)

Flat rate used where plan is non-contributory, or where plan is contributory but without variation in contributions by family status or where variations but no dependent contribution exceeds premium based on flat rate.

Split rate used where contributions for dependents might exceed the premium based on the corresponding flat rate or where required by specifications of employer's plan.

Composite rates - If split rates are used, regardless of whether maternity benefits are included, a composite rate will be established based upon the distribution of dependent insurance on employees with children only, wife only, and both wife and children. This composite will be the rate charged for all employees insured for dependent insurance, regardless of the number or classification of dependents.

No composites will be calculated for a plan which includes Maternity benefits where the flat rate is applied because these rates already assume that some employees will have only children eligible for dependent hospital benefits.

Ratio group - For non-contributory plans or where contributions are the same whether or not employees are covered for dependent insurance, a ratio of total dependent benefits to total personal benefits is established at initial issue. Dependent insurance premiums are based on the application of this ratio to personal insurance in force.

Rate references:

Special Services	Max. 31 Times (or Days) Pers. & Dep. (same)	Max. 70 Times (or Days) Pers. & Dep. (same)
10%	4-3	4-8
15%	4-4	4-9
20%	4-5	4-10
$100 + 3/4 $1200	4-6	4-11
$200 + 3/4 $2400	4-7	4-12

Deductible Plan Adjustments. . . . . .Page 4-12A

Industry loadings. . . . . pages 8-1 through 8-9

Also see page 8-10 and section of page 8-11 dealing with employees age 60 and over.

GROUP HOSPITAL EXPENSE INSURANCE

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Room and Board Maximum	Special Services	Reimbursement Plans: Maternity Included	Page	Maternity Excluded
31 Times or Days	10 %	4-4		4-5
	15 %	4-6		4-7
	20 %	4-8		4-9
	$100 + 3/4 $1200	4-10		4-11
	$200 + 3/4 $2400	4-12		4-13
70 Times or Days	10 %	4-14		4-15
	15 %	4-16		4-17
	20 %	4-18		4-19
	$100 + 3/4 $1200	4-20		4-21
	$200 + 3/4 $2400	4-22		4-23
120 Times or Days	10 %	4-24		4-25
	15 %	4-26		4-27
	20 %	4-28		4-29
	$100 + 3/4 $1200	4-30		4-31
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Deductible Plan Adjustments			4-34	
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Also see page 8-10 and section of page 8-11 dealing with employees age 60 and over.

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Maximum Monthly Premiums Per Employee Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 31 TIMES the Daily Benefit Maximum Special Services 10 Times the Daily Benefit

Maximum Daily Benefit	MATERNITY BENEFITS INCLUDED* — PERSONAL COVERAGE — # of Benefits on Premium: Less than 11	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91 and over
$7	$ 1.46	$ 1.54	$ 1.61	$ 1.66	$ 1.74	$ 1.82	$ 1.87	$ 1.95	$ 2.02	$ 2.08
8	1.63	1.72	1.81	1.87	1.94	2.03	2.10	2.18	2.26	2.33
9	1.79	1.88	1.97	2.05	2.13	2.24	2.31	2.40	2.48	2.56
10	1.92	2.04	2.13	2.22	2.31	2.42	2.50	2.59	2.69	2.78
11	2.05	2.17	2.28	2.37	2.48	2.58	2.69	2.79	2.89	2.99
12	2.18	2.31	2.42	2.53	2.64	2.76	2.84	2.97	3.06	3.19
13	2.32	2.44	2.56	2.69	2.80	2.92	3.05	3.18	3.28	3.41
14	2.44	2.58	2.71	2.84	2.96	3.10	3.22	3.35	3.47	3.59
15	2.56	2.72	2.85	2.97	3.12	3.26	3.38	3.53	3.67	3.78
16	2.67	2.85	2.99	3.12	3.27	3.42	3.55	3.70	3.86	3.97
17	2.80	2.97	3.13	3.26	3.45	3.59	3.72	3.88	4.03	4.18
18	2.92	3.10	3.27	3.42	3.57	3.74	3.89	4.05	4.22	4.37
19	3.04	3.24	3.39	3.56	3.73	3.91	4.06	4.23	4.41	4.55
20	3.15	3.36	3.55	3.70	3.88	4.06	4.23	4.42	4.59	4.75
21	3.26	3.47	3.67	3.83	4.02	4.21	4.38	4.58	4.76	4.92
22	3.37	3.59	3.78	3.95	4.16	4.36	4.54	4.73	4.94	5.10
23	3.47	3.70	3.91	4.08	4.30	4.50	4.69	4.89	5.11	5.29
24	3.58	3.81	4.03	4.21	4.44	4.66	4.84	5.05	5.26	5.46
25	3.68	3.91	4.15	4.33	4.58	4.80	4.99	5.21	5.48	5.64
26	3.80	4.06	4.28	4.46	4.73	4.95	5.15	5.38	5.64	5.83
27	3.93	4.18	4.40	4.59	4.88	5.11	5.31	5.54	5.82	6.01
28	4.03	4.30	4.53	4.71	5.03	5.26	5.47	5.71	6.00	6.20
29	4.15	4.42	4.66	4.86	5.17	5.42	5.63	5.87	6.18	6.38
30	4.26	4.54	4.78	4.99	5.32	5.57	5.78	6.03	6.36	6.57

Maximum Daily Benefit	MATERNITY BENEFITS INCLUDED* — DEPENDENT COVERAGE — Flat Rates	Split Rates: (Children) Only	Wife Only	Wife & (Children)	Maximum Daily Benefit
$7	$ 3.67	$ 1.88	$2.49	$ 4.37	$7
8	4.08	2.03	2.82	4.85	8
9	4.44	2.15	3.11	5.20	9
10	4.80	2.28	3.39	5.67	10
11	5.15	2.43	3.65	6.08	11
12	5.48	2.55	3.90	6.45	12
13	5.84	2.69	4.18	6.87	13
14	6.17	2.81	4.43	7.24	14
15	6.50	2.95	4.67	7.62	15
16	6.83	3.07	4.92	7.98	16
17	7.17	3.21	5.18	8.38	17
18	7.49	3.33	5.43	8.76	18
19	7.81	3.45	5.68	9.13	19
20	8.13	3.58	5.93	9.49	20
21	8.44	3.68	6.18	9.86	21
22	8.75	3.79	6.42	10.21	22
23	9.05	3.90	6.67	10.57	23
24	9.36	4.01	6.91	10.93	24
25	9.67	4.13	7.15	11.28	25
26	9.99	4.25	7.40	11.63	26
27	10.31	4.37	7.65	12.03	27
28	10.63	4.49	7.91	12.40	28
29	10.95	4.61	8.16	12.77	29
30	11.27	4.73	8.41	13.14	30

* Includes standard maternity benefit (maximum of 10 times daily benefit) The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $ 95 per $1 00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employee Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 31 TIMES the Daily Benefit Maximum Special Services — 10 Times the Daily Benefit

MATERNITY BENEFITS EXCLUDED																	
PERSONAL COVERAGE												DEPENDENT COVERAGE					
	% of Benefits on Females												Split Rates				
Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
07	$ 1.43	$ 1.46	$ 1.49	$ 1.51	$ 1.54	$ 1.56	$ 1.60	$ 1.63	$ 1.66	$ 1.69	$ 2.00	$ 1.80	$1.71	$ 2.90	07
8	1 60	1.63	1.67	1.69	1.72	1.76	1.79	1.82	1.85	1.88	2.20	2.02	1.92	3.24	8
9	1 75	1.78	1.82	1.85	1.88	1.92	1.96	1.99	2.02	2.06	2.45	2.14	2.10	4.34	9
10	1 88	1.93	1.96	2.00	2.03	2.08	2.11	2.14	2.18	2.22	2.70	2.30	2.27	4.85	10
11	2 01	2.05	2.10	2.12	2.17	2.21	2.26	2.29	2.33	2.37	2.94	2.43	2.43	4.85	11
12	2.15	2.18	2.22	2.27	2.30	2.35	2.39	2.43	2.47	2.53	4.10	2.53	2.56	5.11	12
13	2.27	2.30	2.36	2.40	2.44	2.48	2.54	2.59	2.62	2.68	4.41	2.69	2.72	5.41	13
14	2 38	2.43	2.47	2 53	2.57	2.63	2.67	2.72	2.76	2.81	4.63	2.81	2.86	5.67	14
15	2.50	2.55	2.59	2.64	2.70	2.75	2.80	2.85	2.90	2.96	4.85	2.93	2.99	5.94	15
16	2.61	2.66	2.72	2.77	2.83	2.88	2.93	2.98	3.04	3.10	5.06	3.05	3.13	6.20	16
17	2.73	2.78	2.84	2.89	2.95	3.01	3.06	3.11	3.18	3.24	5.31	3.21	3.28	6.49	17
18	2.85	2.90	2.96	3.02	3.07	3.13	3.19	3.24	3.30	3.36	5.51	3.33	3.41	6.76	18
19	2 98	3.03	3.07	3.14	3.20	3.26	3.33	3.37	3.44	3.48	5.73	3.45	3.55	7.00	19
20	3.07	3.14	3.21	3.26	3.32	3.38	3.45	3.52	3.57	3.63	5.83	3.56	3.69	7.23	20
21	3.18	3.26	3.31	3.37	3.43	3.50	3.58	3.63	3.69	3.75	6.13	3.68	3.83	7.51	21
22	3.28	3.35	3.41	3.47	3.54	3.61	3.68	3.74	3.81	3.87	6.33	3.78	3.98	7.75	22
23	3 38	3.45	3.52	3.57	3.66	3.73	3.79	3.85	3.94	4.00	6.52	3.90	4.00	7.99	23
24	3 49	3.55	3.62	3.68	3.77	3 84	3.90	3 97	4.06	4.12	6.73	4.01	4.22	8.23	24
25	3 59	3.66	3.72	3 78	3 88	3 95	4 01	4 08	4.18	4.24	6.93	4.13	4.35	8.48	25
26	3.70	3.77	3.83	3.89	4.00	4.07	4.13	4.20	4.31	4.37	7.13	4.25	4.48	8.74	26
27	3.81	3.88	3.94	4.00	4.12	4.19	4.25	4.33	4.44	4.50	7.33	4.37	4.61	8.98	27
28	3 92	3.99	4.05	4.11	4 24	4.31	4.37	4.44	4.57	4 63	7.55	4.48	4.77	9.26	28
29	4.03	4.10	4 16	4.22	4 36	4.43	4.49	4.56	4.70	4 76	7.76	4.61	4.91	9.52	29
30	4.14	4 21	4.27	4.33	4.48	4.55	4.61	4.68	4.83	4.89	7.97	4.73	5.05	9.78	30

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GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Maximum Monthly Premiums Per Employee Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 31 TIMES the Daily Benefit Maximum Special Services 10 Times the Daily Benefit

MATERNITY BENEFITS INCLUDED*

PERSONAL COVERAGE

Maximum Daily Benefit	$ of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$7	$ 1.81	$ 1.89	$ 1.96	$ 1.82	$ 1.90	$ 1.90	$ 2.04	$ 2.13	$ 2.19	$ 2.25
8	1.79	1.88	1.97	2.04	2.11	2.21	2.37	2.36	2.45	2.53
9	1.95	2.05	2.12	2.22	2.30	2.41	2.48	2.58	2.67	2.75
10	2.07	2.19	2.29	2.38	2.47	2.57	2.66	2.76	2.87	2.96
11	2.18	2.31	2.42	2.51	2.62	2.73	2.83	2.94	3.04	3.16
12	2.33	2.45	2.56	2.68	2.78	2.88	3.01	3.13	3.20	3.35
13	2.43	2.57	2.69	2.82	2.93	3.04	3.18	3.31	3.42	3.54
14	2.56	2.70	2.83	2.95	3.09	3.23	3.34	3.46	3.61	3.73
15	2.67	2.84	2.98	3.10	3.24	3.39	3.52	3.66	3.81	3.91
16	2.79	2.98	3.11	3.25	3.40	3.57	3.69	3.83	3.98	4.11
17	2.93	3.09	3.25	3.39	3.55	3.71	3.85	4.01	4.17	4.31
18	3.02	3.22	3.37	3.53	3.69	3.85	4.00	4.18	4.35	4.49
19	3.14	3.33	3.51	3.65	3.83	4.02	4.17	4.34	4.51	4.67
20	3.24	3.44	3.63	3.80	3.97	4.16	4.32	4.51	4.68	4.85
21	3.32	3.55	3.74	3.91	4.11	4.29	4.47	4.66	4.85	5.02
22	3.44	3.65	3.85	4.02	4.20	4.43	4.61	4.81	5.01	5.19
23	3.53	3.76	3.96	4.15	4.36	4.57	4.75	4.96	5.17	5.36
24	3.63	3.86	4.08	4.26	4.50	4.71	4.90	5.10	5.34	5.53
25	3.73	3.97	4.19	4.38	4.63	4.85	5.04	5.26	5.51	5.70
26	3.83	4.07	4.32	4.51	4.78	5.00	5.20	5.43	5.68	5.88
27	3.90	4.21	4.41	4.61	4.87	5.11	5.32	5.56	5.81	6.01
28	4.07	4.33	4.57	4.78	5.00	5.31	5.52	5.76	6.05	6.26
29	4.19	4.45	4.70	4.91	5.22	5.47	5.68	5.92	6.23	6.45
30	4.30	4.57	4.82	5.04	5.37	5.63	5.83	6.08	6.41	6.63

MATERNITY BENEFITS INCLUDED*

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$ 3.90	$ 1.96	$2.67	$ 4.63	$7
4.31	2.11	3.01	5.13	8
4.68	2.28	3.29	5.64	9
5.04	2.38	3.35	6.03	10
5.37	2.52	3.82	6.34	11
5.71	2.65	3.98	6.71	12
6.05	2.78	4.32	7.11	13
6.37	2.93	4.56	7.49	14
6.71	3.06	4.81	7.87	15
7.03	3.18	5.07	8.26	16
7.36	3.30	5.31	8.61	17
7.67	3.41	5.56	8.97	18
7.98	3.53	5.80	9.33	19
8.29	3.68	6.04	9.69	20
8.60	3.78	6.28	10.04	21
8.91	3.87	6.53	10.39	22
9.21	3.99	6.77	10.78	23
9.53	4.10	7.01	11.11	24
9.83	4.21	7.26	11.47	25
10.13	4.28	7.51	11.81	26
10.47	4.45	7.75	12.21	27
10.79	4.57	8.02	12.59	28
11.11	4.69	8.27	12.96	29
11.43	4.81	8.53	13.33	30

* Includes standard maternity benefit (maximum of 10 times daily benefit) The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance on ADDITIONAL SINGLE PREMIUM OF $ 95 per $1 00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan – Schedule of Minimum Monthly Premiums Per Employee – Non-Occupational – No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board — 31 TIMES the Daily Benefit. Maximum Special Services — 10 Times the Daily Benefit.

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

Maximum Daily Benefit	Ages of Insureds on Premium									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
01	$ 1.58	$ 1.81	$ 1.84	$ 1.87	$ 1.76	$ 1.74	$ 1.77	$ 1.80	$ 1.83	$ 1.86
08	1.78	1.79	1.83	1.86	1.88	1.94	1.98	2.00	2.04	2.08
09	1.81	1.85	1.87	1.92	2.05	2.10	2.13	2.17	2.21	2.25
10	2.03	2.06	2.12	2.10	2.19	2.23	2.27	2.31	2.36	2.40
11	2.14	2.19	2.23	2.27	2.31	2.36	2.40	2.44	2.48	2.54
12	2.27	2.30	2.36	2.40	2.44	2.48	2.54	2.58	2.65	2.68
13	2.36	2.43	2.47	2.53	2.57	2.62	2.67	2.72	2.78	2.81
14	2.46	2.55	2.58	2.64	2.70	2.75	2.79	2.85	2.90	2.94
15	2.61	2.67	2.72	2.77	2.82	2.88	2.93	2.98	3.04	3.07
16	2.72	2.78	2.83	2.88	2.93	2.99	3.05	3.11	3.16	3.21
17	2.85	2.90	2.96	3.02	3.07	3.13	3.19	3.25	3.30	3.36
18	2.95	3.02	3.06	3.13	3.19	3.24	3.30	3.37	3.43	3.48
19	3.06	3.13	3.19	3.23	3.30	3.37	3.43	3.48	3.54	3.61
20	3.16	3.22	3.28	3.36	3.41	3.48	3.54	3.61	3.67	3.73
21	3.25	3.32	3.38	3.45	3.52	3.58	3.65	3.71	3.78	3.84
22	3.37	3.43	3.48	3.54	3.62	3.68	3.75	3.82	3.88	3.96
23	3.46	3.51	3.57	3.64	3.72	3.78	3.85	3.92	4.00	4.07
24	3.53	3.60	3.67	3.73	3.83	3.88	3.96	4.02	4.12	4.18
25	3.63	3.69	3.78	3.83	3.93	4.00	4.06	4.13	4.23	4.30
26	3.73	3.80	3.87	3.94	4.03	4.10	4.18	4.23	4.34	4.43
27	3.83	3.91	3.98	4.05	4.13	4.20	4.28	4.34	4.45	4.52
28	3.88	4.02	4.09	4.16	4.29	4.30	4.42	4.48	4.62	4.69
29	4.07	4.13	4.20	4.27	4.41	4.48	4.54	4.61	4.75	4.82
30	4.18	4.24	4.31	4.38	4.53	4.60	4.66	4.73	4.88	4.95

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Maximum Daily Benefit	Flat Rates	Split Rates		
		Child(ren) Only	Wife Only	Wife & Child(ren)
07	$ 3.13	$ 1.00	$1.00	$ 2.05
8	3.43	2.11	2.11	2.22
9	3.68	2.25	2.28	2.33
10	3.94	2.38	2.43	2.01
11	4.26	2.53	2.58	2.11
12	4.38	2.65	2.72	2.37
13	4.62	2.79	2.86	2.05
14	4.83	2.93	2.99	2.92
15	5.06	3.06	3.13	3.19
16	5.22	3.18	3.28	3.37
17	5.39	3.31	3.41	3.51
18	5.60	3.41	3.54	3.65
19	5.80	3.53	3.67	3.78
20	6.00	3.65	3.80	3.93
21	6.20	3.76	3.92	4.07
22	6.39	3.87	4.06	4.19
23	6.60	3.99	4.19	4.33
24	6.80	4.10	4.32	4.43
25	7.00	4.21	4.46	4.57
26	7.20	4.33	4.60	4.73
27	7.35	4.45	4.72	4.85
28	7.71	4.57	4.86	5.05
29	7.92	4.69	5.02	5.21
30	8.13	4.81	5.16	5.37

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Maximum Monthly Premiums Per Employee Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 31 TIMES the Daily Benefit Maximum Special Services 20 Times the Daily Benefit

MATERNITY BENEFITS INCLUDED*

PERSONAL COVERAGE

Maximum Daily Benefit	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
07	$ 1.73	$ 1.85	$ 1.89	$ 1.95	$ 2.04	$ 2.11	$ 2.18	$ 2.27	$ 2.33	$ 2.46
8	1.88	1.96	2.07	2.14	2.22	2.31	2.39	2.48	2.53	2.66
9	2.03	2.13	2.23	2.31	2.39	2.50	2.58	2.68	2.78	2.85
10	2.18	2.27	2.37	2.47	2.56	2.67	2.78	2.87	2.90	3.06
11	2.27	2.39	2.50	2.61	2.73	2.82	2.93	3.05	3.18	3.26
12	2.48	2.52	2.64	2.76	2.88	2.98	3.10	3.22	3.34	3.46
13	2.58	2.62	2.77	2.89	3.01	3.13	3.26	3.38	3.51	3.66
14	2.62	2.78	2.91	3.03	3.15	3.29	3.43	3.55	3.68	3.86
15	2.73	2.89	3.03	3.19	3.30	3.44	3.57	3.72	3.86	3.98
16	2.83	3.00	3.15	3.29	3.44	3.59	3.72	3.88	4.03	4.17
17	2.93	3.12	3.28	3.42	3.59	3.72	3.88	4.05	4.20	4.34
18	3.05	3.25	3.41	3.56	3.72	3.89	4.05	4.20	4.36	4.54
19	3.17	3.36	3.53	3.70	3.86	4.04	4.20	4.39	4.53	4.71
20	3.27	3.48	3.65	3.81	4.00	4.18	4.36	4.53	4.71	4.87
21	3.38	3.57	3.76	3.93	4.13	4.31	4.49	4.68	4.88	5.06
22	3.48	3.69	3.87	4.05	4.27	4.45	4.65	4.85	5.04	5.21
23	3.58	3.78	3.98	4.17	4.39	4.58	4.77	4.98	5.20	5.38
24	3.68	3.88	4.09	4.28	4.52	4.73	4.92	5.12	5.37	5.54
25	3.78	3.99	4.21	4.39	4.66	4.88	5.08	5.28	5.54	5.71
26	3.87	4.11	4.34	4.52	4.81	5.03	5.23	5.43	5.72	5.90
27	3.96	4.21	4.45	4.64	4.93	5.17	5.38	5.58	5.88	6.06
28	4.10	4.35	4.59	4.79	5.11	5.32	5.54	5.70	6.00	6.27
29	4.22	4.47	4.72	4.93	5.25	5.48	5.70	5.94	6.26	6.46
30	4.33	4.59	4.84	5.05	5.40	5.63	5.85	6.10	6.44	6.64

MATERNITY BENEFITS INCLUDED*

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$ 4.07	$ 2.00	$3.03	$ 4.82	07
4.44	2.13	3.12	5.25	8
4.81	2.27	3.40	5.87	9
5.15	2.42	3.66	6.00	10
5.50	2.55	3.91	6.46	11
5.85	2.85	4.15	6.84	12
6.15	2.92	4.40	7.22	13
6.47	3.06	4.63	7.59	14
6.78	3.09	4.90	7.97	15
7.10	3.21	5.11	8.32	16
7.42	3.35	5.35	8.70	17
7.73	3.47	5.58	9.06	18
8.04	3.58	5.83	9.41	19
8.35	3.70	6.06	9.78	20
8.68	3.82	6.29	10.12	21
8.98	3.93	6.54	10.47	22
9.27	4.04	6.78	10.83	23
9.58	4.15	7.03	11.18	24
9.86	4.27	7.27	11.54	25
10.20	4.39	7.46	11.81	26
10.52	4.51	7.77	12.28	27
10.84	4.63	8.02	12.66	28
11.16	4.75	8.28	13.03	29
11.48	4.87	8.53	13.40	30

* Includes standard maternity benefit (maximum of 10 times daily benefit) The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $ 95 per $1.00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan — Schedule of Minimum Monthly Premiums Per Employee — Non-Occupational — No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board — 31 TIMES the Daily Benefit — Maximum Special Services — 20 Times the Daily Benefit

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

Maximum Daily Benefit	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$7	$ 1.76	$ 1.74	$ 1.77	$ 1.80	$ 1.84	$ 1.87	$ 1.91	$ 1.95	$ 1.97	$ 2.02
8	1.85	1.88	1.93	1.98	2.00	2.04	2.08	2.12	2.14	2.19
9	1.99	2.03	2.08	2.11	2.14	2.18	2.23	2.27	2.30	2.38
10	2.12	2.18	2.20	2.25	2.28	2.33	2.37	2.42	2.45	2.50
11	2.23	2.27	2.31	2.37	2.42	2.45	2.50	2.55	2.58	2.63
12	2.35	2.39	2.44	2.48	2.54	2.59	2.63	2.68	2.72	2.77
13	2.45	2.51	2.56	2.60	2.65	2.70	2.75	2.79	2.85	2.90
14	2.56	2.61	2.67	2.72	2.76	2.81	2.87	2.92	2.97	3.03
15	2.67	2.72	2.77	2.83	2.88	2.93	2.98	3.04	3.09	3.14
16	2.77	2.83	2.88	2.93	2.99	3.05	3.10	3.16	3.21	3.27
17	2.88	2.93	2.98	3.05	3.11	3.16	3.22	3.28	3.34	3.39
18	2.98	3.04	3.10	3.16	3.23	3.28	3.34	3.39	3.46	3.53
19	3.08	3.15	3.21	3.28	3.35	3.39	3.45	3.51	3.58	3.65
20	3.18	3.24	3.31	3.37	3.44	3.50	3.56	3.63	3.69	3.76
21	3.29	3.34	3.40	3.47	3.54	3.60	3.67	3.73	3.81	3.88
22	3.37	3.45	3.52	3.58	3.65	3.71	3.77	3.84	3.92	3.98
23	3.47	3.53	3.59	3.68	3.75	3.81	3.87	3.94	4.03	4.09
24	3.56	3.63	3.68	3.75	3.85	3.91	3.98	4.04	4.15	4.20
25	3.68	3.71	3.78	3.84	3.96	4.01	4.08	4.15	4.26	4.31
26	3.77	3.82	3.88	3.93	4.06	4.12	4.20	4.27	4.38	4.44
27	3.88	3.93	3.98	4.04	4.16	4.23	4.30	4.38	4.49	4.57
28	3.98	4.04	4.11	4.17	4.32	4.37	4.44	4.51	4.63	4.70
29	4.09	4.14	4.21	4.28	4.40	4.48	4.56	4.63	4.76	4.83
30	4.22	4.26	4.32	4.39	4.50	4.61	4.68	4.75	4.91	4.96

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

First Dates	Split Dates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$ 3.35	$ 3.85	$3.84	$ 4.84	$7
3.86	3.13	3.22	3.35	8
3.82	3.27	3.30	4.84	9
4.05	3.42	3.84	4.86	10
4.29	3.55	3.48	5.33	11
4.98	3.89	3.81	5.35	12
4.72	3.83	3.94	5.76	13
4.93	3.96	3.82	6.02	14
5.14	3.99	3.28	6.28	15
5.34	4.11	3.38	6.53	16
5.54	4.25	3.37	6.79	17
5.75	4.37	3.37	7.04	18
5.96	4.58	3.70	7.28	19
6.15	4.70	3.82	7.53	20
6.35	4.83	3.93	7.77	21
6.54	4.95	4.05	8.01	22
6.74	4.06	4.81	8.25	23
6.94	4.15	4.34	8.49	24
7.13	4.27	4.47	8.74	25
7.34	4.38	4.41	8.98	26
7.53	4.51	4.75	9.22	27
7.76	4.63	4.89	9.46	28
7.97	4.75	5.03	9.70	29
8.16	4.87	5.11	10.05	30

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employee Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 31 DAYS Maximum Special Services -- $100 in full plus 3/4 of next $1200 with a maximum combined benefit of $1000

MATERNITY BENEFITS INCLUDED*

PERSONAL COVERAGE

Maximum Daily Benefit	$ of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
07	$ 1.86	$ 1.94	$ 2.05	$ 2.06	$ 2.17	$ 2.25	$ 2.33	$ 2.41	$ 2.48	$ 2.55
8	1.87	2.06	2.15	2.22	2.32	2.39	2.48	2.57	2.66	2.73
9	2.06	2.18	2.27	2.37	2.45	2.54	2.63	2.74	2.83	2.92
10	2.18	2.30	2.40	2.49	2.58	2.70	2.79	2.89	2.98	3.18
11	2.30	2.41	2.54	2.63	2.74	2.84	2.96	3.07	3.17	3.27
12	2.46	2.53	2.64	2.74	2.86	2.96	3.10	3.22	3.34	3.44
13	2.58	2.65	2.77	2.88	3.01	3.14	3.26	3.38	3.51	3.63
14	2.81	2.75	2.89	3.01	3.14	3.28	3.41	3.53	3.67	3.79
15	2.78	2.87	3.01	3.13	3.28	3.41	3.55	3.70	3.83	3.96
16	2.88	2.97	3.12	3.25	3.41	3.56	3.68	3.84	4.00	4.13
17	2.98	3.09	3.25	3.38	3.55	3.71	3.85	4.01	4.17	4.31
18	3.01	3.22	3.37	3.52	3.68	3.84	3.99	4.17	4.33	4.48
19	3.13	3.31	3.47	3.63	3.81	4.00	4.13	4.32	4.50	4.66
20	3.21	3.43	3.60	3.76	3.94	4.13	4.30	4.48	4.65	4.81
21	3.30	3.52	3.73	3.88	4.08	4.28	4.45	4.65	4.81	4.98
22	3.41	3.62	3.84	4.01	4.21	4.41	4.60	4.78	4.97	5.15
23	3.50	3.72	3.96	4.14	4.33	4.54	4.75	4.94	5.14	5.32
24	3.61	3.83	4.09	4.26	4.47	4.68	4.91	5.09	5.30	5.49
25	3.70	3.95	4.21	4.39	4.60	4.83	5.06	5.26	5.47	5.66
26	3.81	4.07	4.33	4.52	4.73	4.97	5.22	5.43	5.65	5.83
27	3.93	4.19	4.46	4.65	4.90	5.13	5.38	5.60	5.83	6.02
28	4.04	4.31	4.59	4.79	5.05	5.28	5.54	5.76	6.01	6.22
29	4.16	4.43	4.72	4.92	5.19	5.44	5.70	5.92	6.19	6.41
30	4.27	4.55	4.84	5.05	5.34	5.59	5.85	6.08	6.37	6.59

MATERNITY BENEFITS INCLUDED*

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$ 4.30	$ 2.18	$2.00	$ 5.00	07
4.60	2.22	3.23	5.43	8
4.82	2.35	3.46	5.81	9
5.26	2.47	3.71	6.18	10
5.55	2.60	3.94	6.54	11
5.85	2.75	4.15	6.88	12
6.17	2.88	4.40	7.28	13
6.48	3.00	4.63	7.61	14
6.78	3.11	4.84	7.97	15
7.08	3.23	5.08	8.31	16
7.40	3.37	5.31	8.69	17
7.70	3.48	5.55	9.03	18
7.99	3.60	5.77	9.37	19
8.28	3.71	5.99	9.70	20
8.58	3.83	6.21	10.06	21
8.88	3.93	6.41	10.38	22
9.19	4.05	6.67	10.72	23
9.48	4.18	6.88	11.05	24
9.78	4.28	7.12	11.39	25
10.10	4.40	7.36	11.76	26
10.35	4.53	7.61	12.13	27
10.74	4.64	7.87	12.51	28
11.06	4.78	8.12	12.88	29
11.30	4.88	8.37	13.25	30

* Includes standard maternity benefit (maximum of 10 times daily benefit) The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $ 95 per 31 00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employee -- Non-Occupational No Industry Loading

(Not applicable to Medicare Security Plans)

Maximum Room and Board 31 DAYS Maximum Special Services -- $100 in full plus 3/4 of next $1200 with a maximum combined benefit of $1000

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

Maximum Daily Benefit	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$7	$ 1.83	$ 1.86	$ 1.91	$ 1.94	$ 1.97	$ 2.01	$ 2.06	$ 2.09	$ 2.12	$ 2.16
8	1.94	1.97	2.01	2.05	2.10	2.13	2.17	2.21	2.25	2.28
9	2.04	2.09	2.12	2.17	2.20	2.25	2.28	2.33	2.37	2.42
10	2.14	2.19	2.23	2.27	2.31	2.36	2.40	2.44	2.48	2.54
11	2.36	2.39	2.35	2.38	2.43	2.47	2.53	2.57	2.61	2.65
12	2.35	2.38	2.44	2.48	2.54	2.58	2.63	2.68	2.72	2.77
13	2.45	2.51	2.55	2.60	2.65	2.70	2.75	2.79	2.83	2.90
14	2.55	2.60	2.65	2.72	2.75	2.82	2.86	2.90	2.94	3.01
15	2.64	2.70	2.75	2.83	2.86	2.93	2.98	3.02	3.06	3.13
16	2.74	2.79	2.85	2.90	2.96	3.03	3.09	3.13	3.18	3.25
17	2.83	2.90	2.96	3.03	3.07	3.15	3.19	3.25	3.30	3.37
18	2.94	3.01	3.06	3.13	3.18	3.25	3.30	3.36	3.42	3.49
19	3.04	3.10	3.15	3.21	3.28	3.35	3.39	3.46	3.52	3.59
20	3.13	3.20	3.26	3.33	3.38	3.45	3.53	3.58	3.63	3.70
21	3.23	3.29	3.37	3.43	3.49	3.55	3.63	3.68	3.74	3.81
22	3.33	3.38	3.47	3.53	3.59	3.66	3.73	3.78	3.83	3.92
23	3.41	3.48	3.57	3.63	3.69	3.76	3.85	3.90	3.97	4.03
24	3.51	3.57	3.66	3.73	3.80	3.87	4.01	4.06	4.13	4.15
25	3.60	3.67	3.78	3.84	3.90	3.97	4.08	4.13	4.18	4.26
26	3.71	3.78	3.88	3.93	4.02	4.08	4.18	4.23	4.32	4.38
27	3.81	3.88	4.00	4.04	4.14	4.21	4.32	4.37	4.45	4.53
28	3.93	4.00	4.11	4.17	4.26	4.33	4.46	4.49	4.58	4.65
29	4.04	4.11	4.23	4.28	4.38	4.45	4.58	4.61	4.71	4.78
30	4.15	4.22	4.33	4.39	4.50	4.57	4.68	4.73	4.84	4.91

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$ 2.52	$ 2.18	$2.20	$ 4.20	$7
2.72	2.22	2.33	4.35	8
2.94	2.25	2.45	4.60	9
4.14	2.47	2.59	5.00	10
4.34	2.80	2.71	5.31	11
4.53	2.93	2.81	5.54	12
4.74	3.06	2.94	5.80	13
4.94	3.11	3.05	6.05	14
5.13	3.17	3.15	6.25	15
5.33	3.23	3.27	6.51	16
5.52	3.37	3.41	6.70	17
5.72	3.48	3.53	7.01	18
5.90	3.60	3.64	7.24	19
6.08	3.71	3.73	7.40	20
6.28	3.83	3.86	7.69	21
6.47	3.95	3.98	7.92	22
6.66	4.06	4.09	8.14	23
6.84	4.18	4.20	8.36	24
7.03	4.30	4.31	8.59	25
7.24	4.42	4.45	8.81	26
7.45	4.53	4.59	9.11	27
7.66	4.64	4.73	9.32	28
7.87	4.76	4.87	9.63	29
8.08	4.88	5.01	9.89	30

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Maximum Monthly Premiums Per Employee Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 31 DAYS Maximum Special Services $100 in full plus 3/4 of cost $1200 with a maximum combined benefit of $1000

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

Maximum Daily Benefit	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$7	$ 1.83	$ 1.86	$ 1.91	$ 1.94	$ 1.97	$ 2.01	$ 2.06	$ 2.09	$ 2.12	$ 2.16
8	1.94	1.97	2.01	2.05	2.10	2.13	2.17	2.21	2.25	2.28
9	2.04	2.08	2.12	2.17	2.20	2.25	2.28	2.33	2.37	2.42
10	2.14	2.18	2.23	2.27	2.31	2.36	2.40	2.44	2.48	2.54
11	2.26	2.30	2.35	2.39	2.43	2.47	2.53	2.57	2.61	2.65
12	2.35	2.39	2.44	2.48	2.54	2.58	2.63	2.66	2.75	2.77
13	2.45	2.51	2.56	2.60	2.65	2.70	2.75	2.79	2.83	2.90
14	2.55	2.60	2.65	2.70	2.75	2.80	2.86	2.92	2.96	3.01
15	2.64	2.70	2.75	2.80	2.86	2.90	2.96	3.02	3.06	3.13
16	2.73	2.78	2.85	2.90	2.96	3.02	3.08	3.13	3.19	3.23
17	2.83	2.89	2.95	3.02	3.07	3.13	3.19	3.25	3.30	3.36
18	2.94	3.01	3.08	3.13	3.18	3.23	3.29	3.36	3.42	3.47
19	3.04	3.10	3.16	3.21	3.28	3.35	3.39	3.46	3.53	3.58
20	3.13	3.20	3.26	3.32	3.38	3.45	3.52	3.58	3.63	3.69
21	3.22	3.28	3.37	3.43	3.49	3.55	3.62	3.68	3.74	3.81
22	3.32	3.38	3.47	3.53	3.58	3.66	3.72	3.79	3.85	3.92
23	3.41	3.48	3.57	3.63	3.69	3.76	3.85	3.90	3.97	4.03
24	3.51	3.57	3.68	3.73	3.80	3.86	3.97	4.01	4.08	4.15
25	3.60	3.67	3.78	3.84	3.90	3.97	4.08	4.13	4.19	4.26
26	3.71	3.78	3.88	3.93	4.02	4.08	4.18	4.24	4.30	4.38
27	3.82	3.89	4.00	4.06	4.11	4.21	4.31	4.37	4.43	4.51
28	3.93	4.00	4.11	4.17	4.26	4.33	4.44	4.49	4.56	4.63
29	4.04	4.11	4.22	4.28	4.38	4.45	4.56	4.61	4.71	4.78
30	4.15	4.22	4.33	4.39	4.50	4.57	4.68	4.73	4.84	4.91

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$ 3.53	$ 2.10	$2.30	$ 4.35	$7
3.73	2.22	2.33	4.55	8
3.84	2.35	2.45	4.60	9
4.16	2.47	2.58	5.06	10
4.34	2.60	2.71	5.31	11
4.53	2.73	2.81	5.54	12
4.74	2.86	2.94	5.80	13
4.95	2.97	3.02	6.02	14
5.15	3.11	3.18	6.20	15
5.32	3.22	3.29	6.52	16
5.53	3.37	3.41	6.78	17
5.72	3.48	3.53	7.01	18
5.90	3.60	3.64	7.24	19
6.08	3.71	3.75	7.46	20
6.28	3.83	3.88	7.69	21
6.47	3.94	3.98	7.92	22
6.66	4.06	4.09	8.14	23
6.84	4.16	4.20	8.36	24
7.03	4.28	4.31	8.58	25
7.24	4.40	4.45	8.83	26
7.45	4.53	4.58	9.11	27
7.65	4.64	4.73	9.37	28
7.87	4.78	4.87	9.53	29
8.08	4.88	5.01	9.99	30

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employee Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 31 DAYS Maximum Special Services $200 in full plus 3/4 of next $2400 with a maximum combined benefit of $2000

MATERNITY BENEFITS INCLUDED*

PERSONAL COVERAGE

Maximum Daily Benefit	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$7	$ 1.91	$ 2.03	$ 2.09	$ 2.17	$ 2.25	$ 2.34	$ 2.40	$ 2.49	$ 2.57	$ 2.64
8	2.05	2.15	2.25	2.31	2.40	2.49	2.58	2.66	2.76	2.83
9	2.16	2.27	2.36	2.46	2.54	2.65	2.73	2.84	2.92	3.01
10	2.27	2.38	2.48	2.59	2.70	2.79	2.89	3.00	3.10	3.18
11	2.38	2.50	2.62	2.71	2.84	2.94	3.05	3.17	3.27	3.38
12	2.48	2.61	2.73	2.85	2.98	3.08	3.20	3.31	3.43	3.54
13	2.58	2.72	2.85	2.97	3.09	3.22	3.35	3.47	3.59	3.71
14	2.68	2.83	2.97	3.09	3.23	3.37	3.49	3.62	3.76	3.88
15	2.78	2.95	3.10	3.22	3.37	3.52	3.65	3.78	3.93	4.05
16	2.89	3.07	3.22	3.36	3.51	3.65	3.80	3.93	4.11	4.23
17	3.01	3.20	3.35	3.50	3.66	3.81	3.95	4.10	4.27	4.40
18	3.12	3.31	3.48	3.63	3.79	3.97	4.11	4.28	4.45	4.61
19	3.22	3.42	3.59	3.75	3.92	4.11	4.27	4.44	4.62	4.76
20	3.31	3.52	3.71	3.87	4.05	4.24	4.41	4.58	4.77	4.94
21	3.41	3.62	3.82	3.99	4.18	4.38	4.55	4.75	4.93	5.11
22	3.51	3.73	3.93	4.10	4.31	4.52	4.70	4.87	5.10	5.27
23	3.61	3.83	4.04	4.22	4.44	4.65	4.84	5.07	5.26	5.44
24	3.71	3.94	4.15	4.34	4.57	4.80	4.98	5.23	5.42	5.61
25	3.80	4.05	4.27	4.45	4.70	4.93	5.13	5.39	5.59	5.78
26	3.91	4.17	4.38	4.58	4.83	5.07	5.28	5.54	5.77	5.97
27	4.03	4.28	4.52	4.71	4.96	5.21	5.45	5.72	5.95	6.15
28	4.14	4.41	4.65	4.85	5.15	5.39	5.61	5.89	6.13	6.34
29	4.26	4.53	4.78	4.98	5.29	5.55	5.77	6.05	6.31	6.53
30	4.37	4.65	4.90	5.11	5.44	5.70	5.92	6.21	6.49	6.71

MATERNITY BENEFITS INCLUDED*

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$ 4.41	$ 2.16	$3.06	$ 5.22	$7
4.74	2.28	3.33	5.61	8
5.05	2.42	3.56	5.98	9
5.38	2.54	3.80	6.34	10
5.69	2.67	4.03	6.70	11
6.00	2.80	4.24	7.06	12
6.32	2.94	4.50	7.44	13
6.63	3.08	4.72	7.78	14
6.94	3.20	4.96	8.16	15
7.26	3.33	5.18	8.51	16
7.57	3.45	5.43	8.88	17
7.88	3.56	5.68	9.24	18
8.17	3.68	5.90	9.58	19
8.47	3.80	6.13	9.92	20
8.77	3.91	6.33	10.28	21
9.07	4.04	6.57	10.59	22
9.36	4.16	6.80	10.94	23
9.66	4.25	7.02	11.27	24
9.96	4.36	7.25	11.61	25
10.28	4.48	7.50	11.98	26
10.60	4.60	7.71	12.35	27
10.92	4.72	8.01	12.73	28
11.24	4.84	8.24	13.19	29
11.56	4.96	8.51	13.47	30

* Includes standard maternity benefit (maximum of 10 times daily benefit) The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance on ADDITIONAL SINGLE PREMIUM OF $ 95 per $1 00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Maximum Monthly Premiums Per Employee Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board - 31 DAYS Maximum Special Services - $200 in full plus 3/4 of next $2400 with a maximum combined benefit of $2000

MATERNITY BENEFITS EXCLUDED										
PERSONAL COVERAGE										
Maximum Daily Benefit	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$7	$ 1.91	$ 1.95	$ 1.97	$ 2.02	$ 2.05	$ 2.10	$ 2.13	$ 2.17	$ 2.21	$ 2.25
8	2.02	2.06	2.11	2.13	2.18	2.22	2.27	2.30	2.35	2.38
9	2.12	2.17	2.21	2.28	2.28	2.34	2.38	2.43	2.46	2.51
10	2.23	2.27	2.31	2.37	2.43	2.49	2.50	2.55	2.59	2.63
11	2.34	2.38	2.43	2.47	2.53	2.57	2.62	2.67	2.71	2.78
12	2.45	2.48	2.53	2.58	2.63	2.68	2.73	2.77	2.83	2.87
13	2.53	2.59	2.63	2.68	2.73	2.78	2.84	2.88	2.92	2.98
14	2.62	2.68	2.73	2.78	2.84	2.88	2.94	2.99	3.03	3.10
15	2.72	2.78	2.84	2.88	2.95	3.01	3.08	3.11	3.16	3.21
16	2.81	2.87	2.93	2.98	3.05	3.11	3.18	3.23	3.28	3.35
17	2.92	2.97	3.03	3.08	3.15	3.21	3.28	3.33	3.39	3.47
18	3.05	3.11	3.18	3.22	3.29	3.36	3.41	3.47	3.53	3.60
19	3.16	3.21	3.27	3.33	3.39	3.46	3.53	3.58	3.65	3.72
20	3.23	3.30	3.37	3.43	3.49	3.56	3.63	3.69	3.75	3.83
21	3.32	3.38	3.46	3.52	3.58	3.67	3.72	3.81	3.86	3.93
22	3.43	3.49	3.55	3.62	3.69	3.77	3.84	3.92	3.98	4.04
23	3.52	3.58	3.65	3.71	3.80	3.87	3.94	4.02	4.08	4.15
24	3.61	3.68	3.74	3.81	3.90	3.98	4.04	4.13	4.20	4.27
25	3.70	3.77	3.84	3.90	4.00	4.08	4.15	4.24	4.31	4.38
26	3.81	3.88	3.95	4.01	4.12	4.19	4.27	4.36	4.44	4.51
27	3.90	3.98	4.05	4.13	4.21	4.30	4.38	4.47	4.55	4.63
28	4.03	4.10	4.17	4.23	4.36	4.44	4.51	4.63	4.70	4.77
29	4.14	4.21	4.28	4.34	4.48	4.56	4.63	4.76	4.83	4.90
30	4.25	4.32	4.39	4.45	4.60	4.68	4.75	4.88	4.98	5.03

MATERNITY BENEFITS EXCLUDED				
DEPENDENT COVERAGE				
	Split Rates			Maximum Daily Benefit
Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	
$ 3.64	$ 2.10	$2.30	$ 4.44	$ 07
3.88	2.28	2.43	4.71	8
4.08	2.43	2.85	4.97	9
4.28	2.54	2.98	5.22	10
4.48	2.67	2.80	5.47	11
4.68	2.80	2.93	5.72	12
4.88	2.94	3.04	5.98	13
5.08	3.06	3.15	6.21	14
5.28	3.20	3.28	6.48	15
5.48	3.33	3.48	6.73	16
5.68	3.45	3.53	6.98	17
5.88	3.58	3.66	7.23	18
6.08	3.69	3.77	7.48	19
6.27	3.80	3.96	7.68	20
6.46	3.91	4.08	7.81	21
6.65	4.03	4.11	8.13	22
6.83	4.14	4.22	8.36	23
7.03	4.26	4.33	8.56	24
7.21	4.38	4.43	8.81	25
7.43	4.50	4.58	9.07	26
7.63	4.62	4.73	9.33	27
7.84	4.75	4.87	9.58	28
8.05	4.86	5.01	9.85	29
8.26	4.98	5.18	10.11	30

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan — Schedule of Minimum Monthly Premiums For Employee — Non-Occupational — No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board — 70 TIMES the Daily Benefit — Maximum Special Services — 10 Times the Daily Benefit

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

Maximum Daily Benefit	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
97	$ 1.32	$ 1.35	$ 1.38	$ 1.41	$ 1.44	$ 1.48	$ 1.70	$ 1.73	$ 1.77	$ 1.79
8	1.70	1.73	1.77	1.80	1.83	1.87	1.88	1.94	1.97	2.00
9	1.86	1.89	1.94	1.97	2.00	2.05	2.06	2.13	2.18	2.19
10	2.06	2.05	2.08	2.13	2.16	2.21	2.24	2.30	2.33	2.36
11	2.14	2.18	2.23	2.28	2.31	2.35	2.40	2.46	2.48	2.52
12	2.27	2.32	2.38	2.41	2.45	2.50	2.54	2.59	2.63	2.68
13	2.41	2.45	2.51	2.55	2.60	2.64	2.70	2.75	2.79	2.83
14	2.53	2.59	2.63	2.69	2.73	2.79	2.84	2.88	2.94	2.99
15	2.66	2.71	2.76	2.81	2.87	2.93	2.97	3.03	3.08	3.13
16	2.78	2.84	2.88	2.95	3.00	3.08	3.10	3.17	3.23	3.27
17	2.88	2.96	3.02	3.07	3.14	3.20	3.25	3.31	3.38	3.43
18	3.03	3.08	3.15	3.21	3.27	3.33	3.39	3.45	3.51	3.57
19	3.15	3.22	3.27	3.34	3.40	3.47	3.53	3.59	3.66	3.71
20	3.27	3.34	3.41	3.47	3.53	3.60	3.67	3.74	3.80	3.86
21	3.38	3.45	3.53	3.58	3.65	3.73	3.79	3.86	3.93	3.99
22	3.49	3.56	3.63	3.69	3.77	3.84	3.91	3.98	4.06	4.13
23	3.60	3.67	3.74	3.80	3.89	3.96	4.03	4.10	4.18	4.25
24	3.71	3.78	3.85	3.91	4.01	4.08	4.15	4.22	4.30	4.38
25	3.83	3.89	3.96	4.03	4.13	4.20	4.27	4.34	4.43	4.51
26	3.93	4.00	4.07	4.14	4.23	4.31	4.39	4.46	4.55	4.64
27	4.04	4.11	4.18	4.25	4.37	4.44	4.51	4.59	4.68	4.77
28	4.15	4.22	4.29	4.35	4.49	4.56	4.63	4.70	4.84	4.90
29	4.26	4.33	4.40	4.48	4.61	4.68	4.75	4.83	4.97	5.03
30	4.37	4.44	4.51	4.57	4.73	4.80	4.87	4.94	5.10	5.16

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$ 3.00	$ 3.00	$1.83	$ 3.82	97
3.00	3.15	3.04	4.19	8
3.07	3.28	3.23	4.31	9
3.04	3.43	3.41	4.04	10
4.10	3.38	3.57	5.12	11
4.03	3.77	3.72	5.43	12
4.00	3.90	3.89	5.75	13
4.03	3.90	3.04	6.03	14
5.10	3.14	3.10	6.32	15
5.20	3.37	3.33	6.60	16
5.30	3.51	3.48	6.80	17
5.00	3.64	3.63	7.17	18
6.00	3.87	3.78	7.45	19
6.31	3.70	3.93	7.73	20
6.52	3.91	4.07	7.90	21
6.73	4.03	4.21	8.14	22
6.04	4.15	4.35	8.50	23
7.15	4.27	4.49	8.70	24
7.36	4.39	4.63	8.02	25
7.37	4.51	4.77	9.20	26
7.70	4.63	4.91	9.54	27
7.90	4.75	5.05	9.80	28
8.20	4.87	5.19	10.06	29
8.41	4.99	5.33	10.33	30

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GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Maximum Monthly Premiums Per Employee Non Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 70 TIMES the Daily Benefit Maximum Special Services 15 Times the Daily Benefit

MATERNITY BENEFITS INCLUDED*

PERSONAL COVERAGE

Maximum Daily Benefit	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
07	$ 1.71	$ 1.79	$ 1.86	$ 1.93	$ 2.01	$ 2.09	$ 2.15	$ 2.23	$ 2.31	$ 2.37
8	1.90	1.89	2.00	2.10	2.23	2.33	2.40	2.49	2.58	2.66
9	2.07	2.17	2.25	2.35	2.43	2.54	2.62	2.72	2.81	2.88
10	2.30	2.32	2.42	2.52	2.61	2.71	2.81	2.91	3.03	3.11
11	2.32	2.45	2.56	2.66	2.77	2.88	2.98	3.10	3.20	3.28
12	2.48	2.58	2.71	2.81	2.94	3.05	3.17	3.29	3.40	3.52
13	2.58	2.72	2.85	2.98	3.09	3.23	3.35	3.48	3.60	3.73
14	2.72	2.86	3.00	3.13	3.26	3.41	3.53	3.66	3.79	3.91
15	2.86	3.01	3.15	3.28	3.42	3.57	3.71	3.85	4.00	4.11
16	3.00	3.14	3.29	3.42	3.58	3.74	3.87	4.02	4.18	4.30
17	3.15	3.29	3.44	3.58	3.75	3.91	4.06	4.22	4.38	4.51
18	3.31	3.41	3.57	3.73	3.89	4.06	4.21	4.39	4.57	4.71
19	3.33	3.43	3.71	3.86	4.04	4.22	4.38	4.56	4.74	4.88
20	3.44	3.62	3.84	4.01	4.19	4.38	4.54	4.73	4.92	5.06
21	3.56	3.78	3.96	4.13	4.33	4.52	4.70	4.90	5.08	5.23
22	3.65	3.87	4.07	4.25	4.47	4.67	4.85	5.05	5.26	5.41
23	3.75	3.98	4.19	4.38	4.60	4.81	5.00	5.21	5.43	5.60
24	3.86	4.09	4.31	4.50	4.74	4.96	5.15	5.36	5.60	5.78
25	3.96	4.21	4.43	4.62	4.88	5.10	5.30	5.52	5.78	5.97
26	4.07	4.33	4.56	4.75	5.02	5.25	5.46	5.68	5.95	6.14
27	4.19	4.45	4.68	4.88	5.16	5.41	5.63	5.85	6.11	6.31
28	4.30	4.57	4.81	5.02	5.33	5.56	5.78	6.02	6.33	6.53
29	4.42	4.69	4.94	5.15	5.47	5.72	5.94	6.18	6.50	6.72
30	4.53	4.81	5.06	5.28	5.62	5.87	6.09	6.34	6.66	6.90

MATERNITY BENEFITS INCLUDED*

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$ 1.10	$ 2.00	$2.70	$ 4.80	07
1.53	2.24	3.14	5.38	8
1.92	2.30	3.44	5.83	9
2.20	2.53	3.71	6.26	10
2.64	2.68	3.96	6.66	11
5.00	2.82	4.23	7.06	12
6.34	2.97	4.50	7.47	13
6.68	3.12	4.75	7.87	14
7.03	3.35	5.01	8.30	15
7.37	3.40	5.28	8.67	16
7.71	3.61	5.53	9.04	17
8.03	3.83	5.79	9.42	18
8.38	3.79	6.02	9.78	19
8.68	3.84	6.25	10.16	20
9.00	4.00	6.53	10.53	21
9.33	4.15	6.76	10.90	22
9.66	4.34	7.04	11.30	23
9.96	4.36	7.30	11.65	24
10.28	4.60	7.54	12.03	25
10.60	4.66	7.78	12.30	26
10.93	4.92	7.96	12.76	27
11.24	4.84	8.20	13.16	28
11.56	4.98	8.55	13.51	29
11.88	5.00	8.80	13.80	30

* Includes standard maternity benefit (maximum of 10 times daily benefit) The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $ 95 per 01 00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employee -- Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board -- 70 TIMES the Daily Benefit Maximum Special Services -- 15 Times the Daily Benefit

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

Maximum Daily Benefit	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
07	$ 1.68	$ 1.71	$ 1.74	$ 1.78	$ 1.81	$ 1.85	$ 1.88	$ 1.91	$ 1.95	$ 1.98
8	1.87	1.90	1.93	1.98	2.01	2.06	2.09	2.13	2.17	2.21
9	2.03	2.07	2.10	2.15	2.18	2.23	2.27	2.31	2.35	2.39
10	2.18	2.21	2.25	2.30	2.33	2.37	2.43	2.46	2.51	2.55
11	2.30	2.33	2.37	2.40	2.46	2.51	2.55	2.60	2.64	2.70
12	2.41	2.45	2.51	2.55	2.60	2.64	2.70	2.75	2.79	2.85
13	2.53	2.59	2.63	2.69	2.72	2.79	2.84	2.89	2.94	2.99
14	2.66	2.71	2.76	2.81	2.87	2.93	2.97	3.03	3.08	3.13
15	2.78	2.84	2.89	2.95	3.00	3.06	3.12	3.17	3.23	3.27
16	2.88	2.96	3.02	3.07	3.14	3.20	3.25	3.31	3.36	3.42
17	3.03	3.08	3.13	3.21	3.27	3.33	3.39	3.45	3.51	3.57
18	3.16	3.21	3.28	3.35	3.39	3.45	3.51	3.58	3.65	3.70
19	3.28	3.33	3.39	3.46	3.51	3.58	3.63	3.70	3.77	3.84
20	3.36	3.43	3.50	3.57	3.63	3.70	3.77	3.84	3.90	3.97
21	3.48	3.53	3.60	3.67	3.74	3.81	3.88	3.95	4.02	4.08
22	3.54	3.63	3.70	3.77	3.85	3.92	3.99	4.06	4.14	4.21
23	3.66	3.73	3.80	3.87	3.96	4.03	4.10	4.17	4.26	4.33
24	3.78	3.83	3.90	3.97	4.07	4.14	4.21	4.28	4.38	4.45
25	3.86	3.93	4.00	4.07	4.18	4.25	4.32	4.39	4.50	4.57
26	3.97	4.04	4.11	4.18	4.29	4.37	4.44	4.51	4.63	4.70
27	4.06	4.15	4.22	4.28	4.42	4.48	4.56	4.63	4.75	4.83
28	4.18	4.26	4.33	4.40	4.54	4.61	4.69	4.75	4.89	4.96
29	4.30	4.37	4.44	4.51	4.66	4.73	4.80	4.87	5.02	5.09
30	4.41	4.48	4.55	4.63	4.78	4.85	4.92	4.99	5.15	5.22

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$ 2.33	$ 2.00	$2.01	$ 4.10	07
2.65	2.26	2.26	4.48	8
2.83	2.39	2.43	4.82	9
4.19	2.53	2.66	5.12	10
4.43	2.68	2.75	5.43	11
4.87	2.82	2.89	5.71	12
4.91	2.97	3.04	6.01	13
5.14	3.12	3.18	6.30	14
5.38	3.25	3.33	6.58	15
5.61	3.39	3.48	6.85	16
5.84	3.51	3.63	7.14	17
6.06	3.63	3.77	7.40	18
6.27	3.76	3.90	7.66	19
6.48	3.88	4.04	7.92	20
6.69	4.00	4.18	8.18	21
6.90	4.13	4.32	8.44	22
7.11	4.26	4.46	8.70	23
7.32	4.38	4.60	8.96	24
7.53	4.48	4.74	9.22	25
7.74	4.60	4.88	9.48	26
7.95	4.73	5.01	9.74	27
8.16	4.84	5.18	10.00	28
8.37	4.96	5.32	10.26	29
8.58	5.08	5.44	10.52	30

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GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Maximum Monthly Premiums Per Employee Non Occupational No Industry Loading
(Not applicable to Modern Security Plans)

Maximum Room and Board 70 TIMES the Daily Benefit Maximum Special Services 20 Times the Daily Benefit

MATERNITY BENEFITS INCLUDED*

PERSONAL COVERAGE

Maximum Daily Benefit	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$7	$ 1.84	$ 1.93	$ 2.00	$ 2.07	$ 2.16	$ 2.23	$ 2.30	$ 2.38	$ 2.46	$ 2.53
8	2.08	2.18	2.19	2.27	2.35	2.44	2.52	2.61	2.70	2.78
9	2.16	2.26	2.36	2.44	2.53	2.64	2.72	2.82	2.91	3.00
10	2.29	2.41	2.51	2.61	2.71	2.82	2.91	3.02	3.12	3.22
11	2.41	2.54	2.65	2.76	2.86	2.98	3.08	3.21	3.32	3.42
12	2.55	2.67	2.80	2.86	3.04	3.16	3.27	3.39	3.51	3.63
13	2.66	2.81	2.83	3.06	3.18	3.31	3.42	3.56	3.69	3.81
14	2.78	2.93	3.08	3.20	3.33	3.47	3.60	3.74	3.87	4.00
15	2.90	3.06	3.21	3.33	3.48	3.63	3.76	3.91	4.06	4.18
16	3.01	3.18	3.33	3.48	3.63	3.78	3.92	4.08	4.24	4.38
17	3.13	3.31	3.47	3.61	3.78	3.94	4.08	4.25	4.41	4.56
18	3.24	3.44	3.61	3.76	3.93	4.10	4.26	4.43	4.60	4.78
19	3.37	3.56	3.74	3.91	4.07	4.26	4.43	4.61	4.78	4.94
20	3.47	3.67	3.86	4.03	4.22	4.40	4.57	4.78	4.95	5.11
21	3.57	3.78	3.98	4.15	4.36	4.54	4.72	4.92	5.13	5.29
22	3.68	3.89	4.09	4.27	4.50	4.68	4.87	5.07	5.28	5.46
23	3.78	4.00	4.21	4.40	4.63	4.82	5.02	5.23	5.44	5.64
24	3.89	4.11	4.33	4.52	4.77	4.96	5.17	5.38	5.63	5.81
25	3.99	4.23	4.45	4.64	4.91	5.13	5.33	5.54	5.81	5.99
26	4.10	4.35	4.58	4.77	5.04	5.27	5.48	5.71	5.98	6.18
27	4.22	4.47	4.70	4.91	5.17	5.41	5.64	5.87	6.17	6.36
28	4.33	4.59	4.83	5.04	5.36	5.60	5.80	6.04	6.35	6.55
29	4.45	4.71	4.96	5.17	5.50	5.74	5.95	6.20	6.53	6.74
30	4.56	4.83	5.08	5.30	5.65	5.88	6.11	6.36	6.72	6.93

MATERNITY BENEFITS INCLUDED*

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$ 4.20	$ 2.13	$3.05	$ 5.00	$7
4.87	2.27	3.26	5.33	8
5.65	2.42	3.53	5.97	9
6.41	2.57	3.82	6.39	10
8.77	2.71	4.06	3.70	11
8.11	2.86	4.33	7.19	12
8.45	3.00	4.59	7.59	13
8.78	3.15	4.83	7.88	14
7.12	3.30	5.08	8.37	15
7.46	3.44	5.32	8.76	16
7.78	3.58	5.57	9.15	17
8.10	3.69	5.82	9.51	18
8.42	3.81	6.07	9.88	19
8.74	3.94	6.30	10.36	20
9.06	4.06	6.55	10.81	21
9.38	4.18	6.84	10.96	22
9.70	4.30	7.00	11.36	23
10.02	4.42	7.31	11.73	24
10.34	4.54	7.54	12.10	25
10.66	4.66	7.81	12.47	26
10.98	4.78	8.04	12.84	27
11.30	4.90	8.32	13.22	28
11.62	5.02	8.57	13.60	29
11.94	5.14	8.82	13.96	30

* Includes standard maternity benefit (maximum of 10 times daily benefit). The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF 8.85 per 81.00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Maximum Monthly Premiums Per Employee Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 70 TIMES the Daily Benefit Maximum Special Services 20 Times the Daily Benefit

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

Maximum Daily Benefit	Ages of Beneficiaries on Premium: Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$7	$ 1.81	$ 1.85	$ 1.89	$ 1.92	$ 1.96	$ 1.99	$ 2.03	$ 2.07	$ 2.10	$ 2.14
8	1.97	2.01	2.05	2.09	2.13	2.17	2.21	2.25	2.28	2.33
9	2.13	2.16	2.21	2.24	2.28	2.33	2.37	2.41	2.45	2.50
10	2.25	2.30	2.36	2.39	2.43	2.48	2.52	2.57	2.61	2.66
11	2.37	2.42	2.46	2.52	2.57	2.61	2.66	2.71	2.76	2.80
12	2.50	2.53	2.60	2.64	2.70	2.75	2.80	2.85	2.90	2.95
13	2.62	2.67	2.71	2.77	2.82	2.87	2.93	2.97	3.03	3.08
14	2.72	2.78	2.84	2.89	2.94	2.99	3.05	3.11	3.16	3.22
15	2.84	2.89	2.95	3.00	3.06	3.12	3.17	3.23	3.29	3.34
16	2.95	3.00	3.06	3.13	3.18	3.24	3.30	3.36	3.42	3.48
17	3.06	3.12	3.18	3.24	3.31	3.36	3.42	3.49	3.55	3.61
18	3.17	3.24	3.30	3.36	3.43	3.49	3.54	3.61	3.68	3.74
19	3.29	3.35	3.42	3.49	3.56	3.61	3.68	3.75	3.81	3.88
20	3.39	3.45	3.52	3.59	3.66	3.72	3.79	3.86	3.93	3.99
21	3.49	3.55	3.62	3.69	3.77	3.83	3.90	3.97	4.05	4.11
22	3.59	3.65	3.72	3.79	3.88	3.94	4.01	4.08	4.17	4.23
23	3.69	3.75	3.82	3.89	3.99	4.05	4.12	4.19	4.29	4.35
24	3.79	3.85	3.92	3.99	4.10	4.16	4.23	4.30	4.41	4.47
25	3.89	3.95	4.02	4.09	4.21	4.27	4.34	4.41	4.53	4.59
26	4.00	4.05	4.13	4.20	4.32	4.38	4.46	4.53	4.65	4.72
27	4.11	4.17	4.25	4.31	4.45	4.51	4.58	4.65	4.78	4.84
28	4.22	4.28	4.35	4.42	4.57	4.63	4.70	4.77	4.92	4.98
29	4.33	4.39	4.46	4.53	4.69	4.75	4.82	4.89	5.05	5.11
30	4.44	4.50	4.57	4.64	4.81	4.87	4.94	5.01	5.18	5.24

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Maximum Daily Benefit	Flat Rates	Split Rates: (Children) Only	Wife Only	Wife & Child(ren)
$7	$ 3.31	$ 2.13	$2.17	$ 4.30
8	3.79	2.27	2.36	4.83
9	4.00	2.62	2.54	4.96
10	4.31	2.57	2.70	5.27
11	4.56	2.71	2.85	5.56
12	4.78	2.86	2.99	5.85
13	5.02	3.00	3.13	6.13
14	5.26	3.15	3.26	6.41
15	5.47	3.29	3.40	6.69
16	5.68	3.42	3.53	6.95
17	5.91	3.56	3.67	7.23
18	6.11	3.69	3.81	7.48
19	6.33	3.81	3.94	7.75
20	6.54	3.94	4.06	8.00
21	6.75	4.06	4.20	8.26
22	6.96	4.18	4.34	8.52
23	7.17	4.30	4.48	8.78
24	7.38	4.42	4.62	9.04
25	7.59	4.54	4.76	9.30
26	7.87	4.66	4.80	9.56
27	8.07	4.78	5.04	9.82
28	8.32	4.90	5.18	10.08
29	8.42	5.02	5.32	10.34
30	8.64	5.14	5.46	10.60

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Maximum Monthly Premiums Per Employee Non-Contributory Per Industry Practice

(Not applicable to Modern Security Plans)

Maximum Room and Board 70 DAYS Maximum Special Services $100 in full plus 3 4 of next $1200 with a maximum combined benefit of $1000

MATERNITY BENEFITS INCLUDED*

PERSONAL COVERAGE

Unit Benefits on Females

Maximum Daily Benefit	Less than 11	11 21	21 31	31 41	41 51	51 61	61 71	71 81	81 91	91 and over
$7	$ 1 88	$ 2 06	$ 2 15	$ 2 21	$ 2 30	$ 2 38	$ 2 45	$ 2 54	$ 2 62	$ 2 69
8	2 09	2 19	2 28	2 36	2 45	2 53	2 62	2 71	2 80	2 88
9	2 21	2 32	2 41	2 51	2 59	2 70	2 78	2 89	2 98	3 07
10	2 32	2 44	2 54	2 64	2 74	2 85	2 94	3 05	3 15	3 26
11	2 44	2 56	2 69	2 78	2 89	3 00	3 12	3 23	3 34	3 44
12	2 55	2 67	2 80	2 90	3 04	3 16	3 27	3 38	3 51	3 63
13	2 66	2 81	2 93	3 06	3 18	3 31	3 44	3 56	3 69	3 81
14	2 77	2 92	3 06	3 18	3 32	3 46	3 59	3 72	3 86	3 98
15	2 87	3 04	3 19	3 31	3 46	3 60	3 74	3 89	4 03	4 16
16	2 97	3 15	3 30	3 44	3 60	3 75	3 89	4 05	4 20	4 34
17	3 10	3 27	3 44	3 58	3 75	3 91	4 05	4 22	4 38	4 52
18	3 20	3 40	3 56	3 72	3 88	4 05	4 20	4 38	4 54	4 70
19	3 31	3 51	3 67	3 84	4 02	4 21	4 35	4 54	4 72	4 87
20	3 41	3 62	3 81	3 97	4 16	4 35	4 52	4 69	4 88	5 05
21	3 51	3 72	3 94	4 10	4 30	4 49	4 68	4 86	5 05	5 23
22	3 62	3 84	4 06	4 23	4 44	4 64	4 84	5 02	5 22	5 40
23	3 72	3 95	4 19	4 37	4 57	4 78	5 00	5 19	5 39	5 58
24	3 83	4 06	4 32	4 50	4 71	4 93	5 16	5 35	5 56	5 75
25	3 93	4 18	4 45	4 63	4 85	5 07	5 32	5 52	5 74	5 93
26	4 04	4 29	4 57	4 76	5 00	5 22	5 48	5 69	5 92	6 12
27	4 14	4 40	4 70	4 89	5 15	5 38	5 64	5 85	6 10	6 30
28	4 27	4 54	4 83	5 03	5 30	5 53	5 80	6 02	6 28	6 49
29	4 39	4 66	4 96	5 16	5 44	5 69	5 96	6 18	6 45	6 68
30	4 50	4 78	5 08	5 29	5 57	5 84	6 11	6 35	6 64	6 86

MATERNITY BENEFITS INCLUDED*

SUPPLEMENTAL COVERAGE

Split Rates

Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$ 4 52	$ 2 23	$3 12	$ 3 35	$7
4 84	2 36	3 30	3 74	8
5 18	2 50	3 62	4 12	9
5 50	2 63	3 87	4 50	10
5 83	2 77	4 11	4 88	11
6 14	2 90	4 33	5 23	12
6 47	3 04	4 59	5 63	13
6 79	3 17	4 82	7 99	14
7 11	3 31	5 06	8 37	15
7 42	3 46	5 28	8 73	16
7 75	3 58	5 53	9 11	17
8 07	3 70	5 78	9 48	18
8 37	3 83	6 00	9 83	19
8 68	3 95	6 23	10 18	20
8 99	4 07	6 46	10 52	21
9 30	4 19	6 69	10 86	22
9 61	4 31	6 93	11 24	23
9 92	4 43	7 16	11 59	24
10 23	4 55	7 39	11 94	25
10 55	4 67	7 64	12 31	26
10 87	4 78	7 85	12 68	27
11 19	4 91	8 05	13 06	28
11 51	5 03	8 30	13 43	29
11 81	5 15	8 65	13 80	30

* Includes standard maternity benefit (maximum of 10 times daily benefit). The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance on ADDITIONAL SINGLE PREMIUM OF $ 95 per $1 00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Maximum Monthly Premiums Per Employee Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 70 DAYS Maximum Special Services $100 in full plus 3/4 of next $1200 with a maximum combined benefit of $1000

MATERNITY BENEFITS EXCLUDED																	
	PERSONAL COVERAGE											DEPENDENT COVERAGE					
	Cost Benefits on Females											Split Rates					
Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	Flat Rates	Children(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$7	$ 1.95	$ 1.98	$ 2.03	$ 2.08	$ 2.10	$ 2.14	$ 2.16	$ 2.22	$ 2.26	$ 2.36	$ 2.25	$ 2.23	$2.26	$ 2.37	$7
8	2.06	2.10	2.14	2.18	2.23	2.26	2.31	2.35	2.39	2.43	2.96	2.96	2.48	2.84	8
9	2.17	2.22	2.26	2.31	2.34	2.39	2.43	2.48	2.52	2.57	4.10	2.50	2.61	3.11	9
10	2.28	2.33	2.37	2.42	2.46	2.51	2.55	2.60	2.64	2.70	4.60	2.83	2.75	3.38	10
11	2.40	2.44	2.50	2.54	2.58	2.63	2.68	2.73	2.78	2.82	4.82	2.77	2.80	3.45	11
12	2.50	2.54	2.60	2.64	2.70	2.75	2.80	2.85	2.90	2.95	4.82	2.96	2.98	3.68	12
13	2.61	2.67	2.71	2.77	2.82	2.87	2.93	2.97	3.03	3.08	5.04	3.04	3.12	3.97	13
14	2.71	2.77	2.82	2.87	2.93	2.98	3.04	3.09	3.15	3.20	5.25	3.17	3.25	4.12	14
15	2.81	2.87	2.93	2.98	3.04	3.09	3.15	3.21	3.26	3.32	5.46	3.31	3.38	4.29	15
16	2.91	2.97	3.03	3.09	3.15	3.21	3.26	3.32	3.38	3.44	5.67	3.44	3.50	4.44	16
17	3.03	3.08	3.15	3.21	3.27	3.33	3.38	3.45	3.51	3.57	5.88	3.58	3.63	4.61	17
18	3.13	3.20	3.25	3.32	3.38	3.44	3.50	3.57	3.63	3.69	6.09	3.70	3.76	4.76	18
19	3.23	3.30	3.35	3.42	3.49	3.56	3.61	3.68	3.75	3.81	6.30	3.83	3.89	4.93	19
20	3.33	3.40	3.47	3.53	3.60	3.67	3.74	3.78	3.86	3.93	6.48	3.93	3.99	5.06	20
21	3.43	3.50	3.58	3.64	3.71	3.78	3.85	3.91	3.98	4.05	6.68	4.07	4.11	5.18	21
22	3.53	3.60	3.68	3.75	3.82	3.89	3.98	4.03	4.10	4.17	6.88	4.18	4.23	5.42	22
23	3.63	3.70	3.80	3.86	3.93	4.00	4.10	4.15	4.22	4.29	7.08	4.31	4.35	5.66	23
24	3.73	3.80	3.91	3.97	4.04	4.11	4.22	4.27	4.34	4.41	7.28	4.43	4.47	5.90	24
25	3.83	3.90	4.02	4.08	4.15	4.22	4.34	4.39	4.46	4.53	7.48	4.55	4.59	6.14	25
26	3.94	4.01	4.13	4.19	4.27	4.34	4.46	4.51	4.59	4.66	7.69	4.67	4.72	6.40	26
27	4.05	4.12	4.25	4.30	4.38	4.46	4.58	4.63	4.72	4.79	7.90	4.79	4.87	6.64	27
28	4.16	4.23	4.35	4.41	4.51	4.58	4.70	4.75	4.85	4.92	8.11	4.91	5.01	6.92	28
29	4.27	4.34	4.46	4.52	4.63	4.70	4.82	4.87	4.98	5.05	8.32	5.03	5.15	10.18	29
30	4.38	4.45	4.57	4.63	4.75	4.82	4.94	4.99	5.11	5.18	8.53	5.15	5.29	10.44	30

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Maximum Monthly Premiums Per Employee Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 70 DAYS Maximum Special Services $200 on full plus 3/4 of next $2400 with a maximum combined benefit of $2000

MATERNITY BENEFITS INCLUDED*

PERSONAL COVERAGE

Cost Quarterly per Member

Maximum Daily Benefit	Less than 11	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91 and over
$7	$ 2.06	$ 2.15	$ 2.22	$ 2.30	$ 2.38	$ 2.47	$ 2.54	$ 2.61	$ 2.71	$ 2.78
8	2.18	2.28	2.36	2.45	2.54	2.63	2.72	2.81	2.91	2.98
9	2.30	2.41	2.50	2.60	2.69	2.80	2.88	2.99	3.08	3.17
10	2.41	2.53	2.63	2.74	2.85	2.95	3.05	3.16	3.27	3.36
11	2.53	2.65	2.78	2.87	3.00	3.10	3.22	3.34	3.44	3.56
12	2.64	2.77	2.89	3.01	3.13	3.26	3.37	3.49	3.61	3.72
13	2.76	2.89	3.02	3.14	3.26	3.40	3.53	3.65	3.78	3.90
14	2.85	3.00	3.14	3.27	3.41	3.55	3.68	3.81	3.95	4.08
15	2.96	3.13	3.28	3.40	3.56	3.71	3.84	3.99	4.13	4.26
16	3.08	3.25	3.41	3.53	3.70	3.85	4.00	4.16	4.32	4.46
17	3.20	3.38	3.55	3.68	3.86	4.02	4.18	4.33	4.50	4.64
18	3.31	3.51	3.69	3.82	4.00	4.18	4.33	4.49	4.67	4.85
19	3.42	3.62	3.80	3.96	4.14	4.33	4.49	4.67	4.85	5.00
20	3.52	3.73	3.92	4.09	4.27	4.47	4.64	4.83	5.01	5.18
21	3.62	3.84	4.04	4.21	4.41	4.61	4.79	5.00	5.18	5.36
22	3.73	3.95	4.15	4.33	4.55	4.76	4.94	5.16	5.35	5.53
23	3.83	4.06	4.27	4.46	4.68	4.90	5.09	5.33	5.52	5.71
24	3.94	4.17	4.39	4.58	4.82	5.05	5.24	5.49	5.69	5.88
25	4.04	4.29	4.51	4.71	4.96	5.19	5.39	5.66	5.87	6.06
26	4.15	4.41	4.64	4.83	5.13	5.34	5.55	5.81	6.05	6.25
27	4.27	4.53	4.76	4.96	5.26	5.50	5.71	5.99	6.23	6.43
28	4.38	4.65	4.89	5.10	5.41	5.65	5.87	6.16	6.41	6.62
29	4.50	4.77	5.02	5.23	5.55	5.81	6.03	6.32	6.59	6.81
30	4.61	4.89	5.14	5.36	5.70	5.96	6.18	6.48	6.77	6.99

MATERNITY BENEFITS INCLUDED*

DEPENDENT COVERAGE

Cost Quarterly per Member

Split Rates				Maximum Daily Benefit
Flat Rates	Wife (Children) Only	Wife Only	Wife & Children	
$ 4.64	$ 2.30	$3.21	$ 5.51	$7
4.99	2.43	3.48	5.91	8
5.31	2.57	3.72	6.29	9
5.65	2.70	3.97	6.67	10
5.98	2.84	4.21	7.05	11
6.30	2.98	4.45	7.43	12
6.63	3.13	4.69	7.82	13
6.95	3.26	4.92	8.18	14
7.28	3.40	5.17	8.57	15
7.61	3.53	5.41	8.94	16
7.93	3.67	5.65	9.32	17
8.26	3.78	5.91	9.70	18
8.56	3.92	6.14	10.06	19
8.87	4.04	6.37	10.41	20
9.18	4.16	6.60	10.76	21
9.49	4.28	6.83	11.11	22
9.80	4.40	7.07	11.47	23
10.11	4.52	7.30	11.83	24
10.42	4.64	7.53	12.17	25
10.74	4.76	7.78	12.54	26
11.06	4.88	8.02	12.91	27
11.38	5.00	8.29	13.29	28
11.70	5.12	8.54	13.66	29
12.02	5.24	8.79	14.02	30

* Includes standard maternity benefit (maximum of 10 times daily benefit) The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $ 95 per $1 00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Maximum Monthly Premiums Per Employee Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 70 DAYS Maximum Special Services $200 in full plus 3/4 of next $2400 with a maximum combined benefit of $2000

MATERNITY BENEFITS INCLUDED

PERSONAL COVERAGE

Maximum Daily Benefit	Age of Beneficiary on Premium Date									
	less than 11	11 21	21 31	31 41	41 51	51 61	61 71	71 81	81 91	91 and over
$7	$ 2 03	$ 2 07	$ 2 10	$ 2 15	$ 2 18	$ 2 23	$ 2 27	$ 2 31	$ 2 35	$ 2 39
8	2 15	2 19	2 24	2 27	2 32	2 36	2 41	2 45	2 50	2 53
9	2 26	2 31	2 35	2 40	2 44	2 49	2 53	2 58	2 62	2 67
10	2 37	2 42	2 46	2 52	2 57	2 61	2 66	2 71	2 76	2 80
11	2 49	2 53	2 59	2 63	2 69	2 73	2 79	2 84	2 88	2 94
12	2 59	2 64	2 69	2 75	2 79	2 85	2 85	2 85	5 66	5 85
13	2 69	2 75	2 80	2 85	2 90	2 96	3 02	3 06	3 12	3 17
14	2 79	2 85	2 90	2 96	3 02	3 07	3 13	3 18	3 24	3 30
15	2 90	2 96	3 02	3 07	3 14	3 20	3 25	3 31	3 38	3 42
16	3 02	3 07	3 14	3 20	3 25	3 31	3 38	3 44	3 50	3 56
17	3 13	3 20	3 25	3 32	3 38	3 44	3 50	3 57	5 82	5 85
18	3 24	3 31	3 36	3 43	3 50	3 57	3 63	3 69	3 76	3 83
19	3 36	3 41	3 48	3 54	3 61	3 68	3 75	3 81	3 88	3 96
20	3 46	3 51	3 58	3 65	3 71	3 79	3 86	3 93	3 99	4 06
21	3.28	3.81	3.68	3.75	3.82	3.90	3.97	4 05	4 11	4.18
22	3 66	3 71	3 78	3 85	3 93	4 01	4 08	4 17	4 23	4 30
23	3 74	3 81	3 88	3 95	4 04	4 12	4.19	4 29	4 35	4 42
24	3 84	3 91	3 98	4 05	4 15	4 23	4 30	4 41	4 47	4 54
25	3 94	4 01	4 08	4 15	4 26	4 34	4 41	4 53	4 59	4 66
26	4 02	4 12	4 19	4 26	4 38	4 46	4 53	4 65	4 72	4 79
27	4 16	4 23	4 30	4 37	4 50	4 58	4 77	4 77	4 85	4 92
28	4 27	4 34	4 41	4 48	4 62	4 70	4 77	4 89	4 98	5 05
29	4 38	4 45	4 52	4 59	4 74	4 82	4 89	5 01	5 11	5 18
30	4 49	4 56	4 63	4 70	4 86	4 94	5 01	5 13	5 24	5 31

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$ 2 07	$ 2 30	$2.43	$ 4 73	$7
2 11	2 43	2.58	5 01	8
2 32	2.57	2 71	5 28	9
2 55	2 70	2.85	5 55	10
2 77	2 84	2 98	5.82	11
2 98	3 11	3 11	6 06	12
3 20	3 13	3 23	6 26	13
3 41	3 26	3 35	6 61	14
3 63	3 40	3 49	6 89	15
3 85	3 53	3 62	7 15	16
4 06	3.67	3 76	7 43	17
4 28	3 79	3 89	7 68	18
4 47	3 92	4 01	7 93	19
4 67	4 04	4.13	8.17	20
4 87	4.18	4.22	8.41	21
5 07	4 28	4.37	8 65	22
5 27	4 40	4.49	8 89	23
5 47	4 52	4 61	9 13	24
5 67	4 64	4 73	9 37	25
5 88	4 76	4 87	9 62	26
6 08	4 88	5 01	9 86	27
6 30	5 00	5 15	10 15	28
6 51	5 12	5 29	10 41	29
6 72	5 24	5 43	10 67	30

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Premiums Per Employee Non Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 120 DAYS Maximum Special Services 10 Times the Daily Benefit

MATERNITY BENEFITS INCLUDED* — PERSONAL COVERAGE											MATERNITY BENEFITS INCLUDED* — DEPENDENT COVERAGE				
	% of Benefits on Females											Split Rates			
Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$ 7	$1.60	$1.66	$1.75	$1.81	$1.89	$1.97	$2.03	$2.10	$2.18	$2.23	$3.94	$2.06	$2.65	$4.11	$ 7
8	1.70	1.87	1.96	2.03	2.10	2.20	2.27	2.36	2.44	2.51	4.36	2.21	3.00	5.21	8
9	1.90	2.05	2.13	2.23	2.31	2.42	2.49	2.58	2.67	2.76	4.77	2.35	3.31	5.66	9
10	2.10	2.22	2.31	2.41	2.50	2.62	2.70	2.80	2.90	2.99	5.16	2.50	3.60	6.10	10
11	2.24	2.37	2.48	2.57	2.68	2.78	2.86	2.97	3.11	3.22	5.58	2.75	4.14	6.65	11
12	2.39	2.52	2.63	2.75	2.86	2.95	3.04	3.15	3.31	3.43	6.00	2.95	4.44	7.20	12
13	2.53	2.66	2.81	2.93	3.04	3.16	3.29	3.42	3.53	3.67	6.42	3.08	4.70	7.70	13
14	2.67	2.83	2.95	3.06	3.20	3.35	3.48	3.61	3.74	3.86	6.86	3.23	4.96	8.19	14
15	2.80	2.96	3.10	3.22	3.38	3.53	3.65	3.80	3.94	4.06	7.31	3.37	5.22	8.72	15
16	2.93	3.11	3.25	3.39	3.54	3.68	3.83	3.98	4.15	4.27	7.68	3.51	5.46	9.06	17
17	3.06	3.24	3.40	3.53	3.71	3.88	4.01	4.18	4.33	4.47	8.02	3.65	5.76	9.41	18
18	3.19	3.37	3.55	3.71	3.87	4.09	4.19	4.38	4.54	4.69	8.36	3.78	6.02	9.90	19
19	3.33	3.53	3.69	3.86	4.03	4.22	4.38	4.56	4.74	4.88	8.78	3.90	6.29	10.19	20
20	3.45	3.66	3.85	4.01	4.20	4.39	4.56	4.75	4.93	5.10	9.03	4.03	6.34	10.67	21
21	3.58	3.78	3.98	4.15	4.35	4.54	4.72	4.93	5.12	5.28	9.35	4.15	6.60	10.95	22
22	3.68	3.91	4.11	4.28	4.50	4.71	4.89	5.09	5.30	5.47	9.88	4.27	7.06	11.33	23
23	3.80	4.03	4.24	4.42	4.65	4.86	5.05	5.28	5.49	5.67	10.00	4.40	7.31	11.71	24
24	3.92	4.15	4.38	4.56	4.80	5.02	5.21	5.43	5.67	5.85	10.33	4.52	7.57	12.09	25
25	4.03	4.29	4.51	4.69	4.95	5.18	5.38	5.60	5.86	6.05	10.65	4.66	7.81	12.46	26
26	4.14	4.41	4.64	4.82	5.10	5.33	5.54	5.77	6.04	6.24	10.97	4.78	8.07	12.85	27
27	4.26	4.53	4.76	4.95	5.25	5.49	5.70	5.93	6.22	6.42	11.20	4.90	8.33	13.21	28
28	4.37	4.65	4.89	5.09	5.40	5.64	5.86	6.10	6.40	6.61	11.61	5.00	8.58	13.58	29
29	4.49	4.77	5.02	5.22	5.54	5.80	6.02	6.28	6.58	6.80	11.93	5.13	8.83	13.95	30
30	4.60	4.89	5.14	5.35	5.69	5.95	6.17	6.42	6.76	6.98					

* Includes standard maternity benefit (maximum of 10 times daily benefit). The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $ 95 per $1.00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

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GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan -- Schedule of Minimum Premiums For Employee - Non-Occupational - No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board - 120 DAYS — Maximum Special Services — 10 Times the Daily Benefit

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

Maximum Daily Benefit	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$ 7	$1.57	$1.60	$1.63	$1.66	$1.69	$1.73	$1.75	$1.78	$1.82	$1.84
8	1.75	1.78	1.82	1.85	1.88	1.93	1.96	2.00	2.03	2.06
9	1.92	1.95	2.00	2.03	2.06	2.11	2.14	2.19	2.21	2.26
10	2.08	2.11	2.14	2.19	2.23	2.28	2.31	2.39	2.39	2.43
11	2.20	2.25	2.30	2.33	2.38	2.42	2.47	2.51	2.55	2.60
12	2.34	2.39	2.43	2.46	2.52	2.58	2.62	2.67	2.71	2.76
13	2.48	2.53	2.58	2.63	2.68	2.72	2.78	2.83	2.87	2.94
14	2.61	2.67	2.71	2.77	2.81	2.87	2.93	2.98	3.03	3.08
15	2.74	2.78	2.84	2.89	2.96	3.02	3.06	3.12	3.17	3.22
16	2.86	2.93	2.98	3.04	3.08	3.15	3.21	3.27	3.33	3.37
17	2.99	3.05	3.11	3.18	3.23	3.30	3.35	3.41	3.48	3.53
18	3.12	3.17	3.26	3.31	3.37	3.43	3.48	3.55	3.63	3.68
19	3.24	3.32	3.37	3.44	3.50	3.57	3.64	3.70	3.77	3.83
20	3.37	3.44	3.51	3.57	3.64	3.71	3.78	3.85	3.91	3.98
21	3.48	3.55	3.62	3.68	3.76	3.83	3.90	3.98	4.05	4.11
22	3.59	3.67	3.73	3.80	3.88	3.96	4.03	4.10	4.18	4.25
23	3.71	3.78	3.85	3.91	4.01	4.08	4.15	4.22	4.33	4.38
24	3.83	3.89	3.97	4.03	4.13	4.20	4.27	4.35	4.45	4.51
25	3.93	4.01	4.08	4.14	4.25	4.33	4.40	4.47	4.58	4.65
26	4.04	4.12	4.19	4.25	4.37	4.45	4.53	4.61	4.71	4.78
27	4.15	4.23	4.30	4.36	4.49	4.57	4.64	4.73	4.84	4.91
28	4.30	4.34	4.41	4.47	4.61	4.69	4.76	4.85	4.97	5.04
29	4.37	4.45	4.53	4.58	4.73	4.81	4.88	4.96	5.10	5.17
30	4.48	4.56	4.63	4.69	4.85	4.93	5.00	5.07	5.23	5.30

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$3.17	$2.04	$1.07	$3.03	$ 7
3.80	2.31	2.10	4.21	8
3.78	2.29	2.30	4.65	9
4.06	2.50	2.48	4.98	10
4.32	2.68	2.63	5.21	11
4.50	2.70	2.80	5.50	12
4.83	2.85	2.98	5.92	13
5.00	3.06	3.12	6.21	14
5.31	3.33	3.30	6.81	15
5.53	3.37	3.43	6.80	16
5.81	3.51	3.59	7.10	17
6.04	3.63	3.74	7.39	18
6.27	3.78	3.89	7.67	19
6.50	3.96	4.05	7.95	20
6.73	4.03	4.19	8.23	21
6.93	4.15	4.34	8.46	22
7.15	4.27	4.48	8.75	23
7.36	4.40	4.62	9.02	24
7.58	4.53	4.77	9.29	25
7.78	4.64	4.91	9.55	26
8.00	4.78	5.04	9.81	27
8.21	4.88	5.19	10.07	28
8.43	5.06	5.33	10.33	29
8.63	5.13	5.47	10.60	30

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Premiums Per Employee Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 120 DAYS Maximum Special Services 15 Times the Daily Benefit

Maximum Daily Benefit	MATERNITY BENEFITS INCLUDED* PERSONAL COVERAGE % of Benefits on Females										MATERNITY BENEFITS INCLUDED* DEPENDENT COVERAGE				
												Split Rates			Maximum Daily Benefit
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	
$ 7	$1.76	$1.84	$1.91	$1.98	$2.06	$2.15	$2.21	$2.29	$2.37	$3.43	$4.20	$2.15	$2.85	$5.00	$ 7
8	1.96	2.05	2.15	2.22	2.29	2.39	2.46	2.55	2.65	2.72	4.64	2.31	3.21	5.52	8
9	2.13	2.23	2.31	2.41	2.50	2.61	2.69	2.79	2.88	3.08	5.04	2.46	3.51	5.97	9
10	2.26	2.39	2.49	2.58	2.68	2.78	2.88	2.98	3.10	3.10	5.42	2.61	3.79	6.40	10
11	2.39	2.53	2.63	2.73	2.84	2.95	3.06	3.18	3.28	3.28	5.77	2.75	4.06	6.82	11
12	2.53	2.65	2.78	2.88	3.02	3.13	3.25	3.37	3.48	3.81	6.13	2.90	4.33	7.25	12
13	2.66	2.81	2.93	3.06	3.17	3.31	3.44	3.57	3.69	3.81	6.49	3.04	4.59	7.65	13
14	2.80	2.94	3.08	3.20	3.35	3.50	3.63	3.75	3.88	4.00	6.83	3.21	4.85	8.06	14
15	2.92	3.10	3.24	3.37	3.51	3.66	3.80	3.95	4.10	4.21	7.18	3.35	5.11	8.46	15
16	3.05	3.23	3.38	3.51	3.68	3.84	3.97	4.13	4.28	4.43	7.54	3.49	5.38	8.87	16
17	3.18	3.36	3.53	3.68	3.83	4.01	4.15	4.33	4.48	4.65	7.89	3.63	5.64	9.26	17
18	3.30	3.51	3.67	3.83	3.99	4.16	4.33	4.50	4.68	4.82	8.21	3.76	5.90	9.64	18
19	3.43	3.63	3.81	3.96	4.15	4.34	4.50	4.67	4.85	5.02	8.55	3.87	6.15	10.02	19
20	3.54	3.75	3.95	4.12	4.30	4.48	4.66	4.86	5.04	5.21	8.87	4.00	6.40	10.40	20
21	3.66	3.87	4.07	4.24	4.44	4.63	4.82	5.02	5.21	5.38	9.20	4.13	6.66	10.78	21
22	3.78	3.98	4.18	4.36	4.58	4.78	4.99	5.19	5.38	5.57	9.53	4.26	6.91	11.16	22
23	3.88	4.09	4.30	4.50	4.72	4.93	5.13	5.34	5.56	5.75	9.85	4.37	7.17	11.54	23
24	3.97	4.20	4.43	4.62	4.86	5.08	5.30	5.49	5.73	5.92	10.18	4.49	7.43	11.92	24
25	4.08	4.32	4.55	4.74	5.01	5.23	5.43	5.65	5.92	6.11	10.51	4.61	7.68	12.29	25
26	4.18	4.43	4.67	4.88	5.14	5.38	5.60	5.82	6.10	6.30	10.83	4.73	7.93	12.66	26
27	4.31	4.57	4.85	5.00	5.31	5.54	5.75	5.98	6.26	6.46	11.15	4.86	8.18	13.02	27
28	4.42	4.69	4.93	5.14	5.46	5.69	5.91	6.15	6.44	6.67	11.47	4.97	8.44	13.41	28
29	4.54	4.81	5.06	5.27	5.60	5.85	8.07	6.31	6.64	6.86	11.79	5.09	8.69	13.78	29
30	4.65	4.93	5.18	5.40	5.75	6.00	6.22	6.47	6.83	7.04	12.11	5.21	8.94	14.15	30

* Includes standard maternity benefit (maximum of 10 times daily benefit). The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $.05 per $1.00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Premiums Per Employee Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 120 DAYS Maximum Special Services 15 Times the Daily Benefit

MATERNITY BENEFITS EXCLUDED																		
PERSONAL COVERAGE																		
	% of Benefits on Premium										DEPENDENT COVERAGE							
												Split Rates						
Maximum Daily Benefit	Less than 31	31-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit			
$ 7	$1.73	$1.76	$1.79	$1.83	$1.86	$1.91	$1.94	$1.97	$2.01	$2.04	$3.43	$2.15	$2.07	$4.22	$ 7			
8	1.93	1.96	2.01	2.04	2.07	2.12	2.15	2.19	2.24	2.28	3.76	2.31	2.31	4.62	8			
9	2.09	2.13	2.16	2.21	2.25	2.30	2.34	2.38	2.42	2.46	4.05	2.48	2.50	4.96	9			
10	2.22	2.28	2.32	2.37	2.40	2.44	2.49	2.53	2.58	2.63	4.32	2.61	2.67	5.28	10			
11	2.33	2.40	2.44	2.49	2.53	2.58	2.62	2.68	2.72	2.78	4.56	2.78	2.82	5.58	11			
12	2.48	2.53	2.58	2.63	2.68	2.73	2.78	2.83	2.87	2.94	4.81	2.96	2.98	5.94	12			
13	2.61	2.67	2.71	2.77	2.81	2.87	2.93	2.98	3.03	3.08	5.06	3.08	3.13	6.19	13			
14	2.74	2.79	2.84	2.89	2.96	3.02	3.08	3.12	3.17	3.22	5.29	3.21	3.28	6.49	14			
15	2.86	2.93	2.98	3.04	3.09	3.15	3.21	3.27	3.33	3.37	5.54	3.35	3.42	6.78	15			
16	2.98	3.05	3.11	3.16	3.23	3.28	3.35	3.41	3.46	3.52	5.78	3.48	3.56	7.08	16			
17	3.13	3.19	3.26	3.31	3.37	3.43	3.50	3.55	3.62	3.68	6.03	3.63	3.71	7.38	17			
18	3.23	3.31	3.36	3.43	3.49	3.56	3.62	3.69	3.76	3.81	6.22	3.76	3.86	7.62	18			
19	3.35	3.42	3.49	3.54	3.62	3.69	3.76	3.81	3.88	3.96	6.48	3.87	4.02	7.89	19			
20	3.46	3.53	3.61	3.68	3.74	3.81	3.88	3.96	4.02	4.09	6.67	4.00	4.16	8.16	20			
21	3.56	3.64	3.71	3.78	3.85	3.92	4.00	4.07	4.14	4.21	6.87	4.12	4.31	8.43	21			
22	3.67	3.74	3.81	3.88	3.97	4.04	4.11	4.18	4.26	4.34	7.11	4.24	4.45	8.69	22			
23	3.77	3.84	3.91	3.99	4.08	4.15	4.22	4.30	4.39	4.46	7.32	4.37	4.59	8.93	23			
24	3.87	3.96	4.02	4.09	4.19	4.26	4.34	4.41	4.51	4.58	7.54	4.49	4.74	9.23	24			
25	3.98	4.05	4.12	4.19	4.31	4.38	4.45	4.52	4.64	4.71	7.76	4.61	4.88	9.49	25			
26	4.08	4.16	4.23	4.30	4.43	4.50	4.57	4.64	4.77	4.85	7.97	4.72	5.02	9.75	26			
27	4.20	4.27	4.34	4.41	4.55	4.62	4.69	4.76	4.90	4.97	8.18	4.85	5.16	10.01	27			
28	4.31	4.38	4.45	4.52	4.67	4.74	4.81	4.88	5.03	5.10	8.39	4.97	5.30	10.27	28			
29	4.42	4.49	4.56	4.63	4.79	4.86	4.93	5.00	5.16	5.23	8.60	5.09	5.44	10.53	29			
30	4.53	4.60	4.67	4.74	4.91	4.98	5.05	5.12	5.29	5.36	8.81	5.21	5.58	10.79	30			

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan — Schedule of Minimum Premiums Per Employee — Non-Occupational — No Industry Limitations

(Not applicable to Modern Security Plans)

Maximum Hours and Hazard: 120 DAYS — Maximum Special Accounts: 20 Times the Daily Benefit

Maximum Daily Benefit	MATERNITY BENEFITS INCLUDED* — PERSONAL COVERAGE — % of Benefits on Females: Less than 11	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91 and over	MATERNITY BENEFITS INCLUDED* — DEPENDENT COVERAGE — Flat Rates	Split Rates: Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$7	$1 89	$1 99	$2 06	$2 13	$2 22	$2 29	$2 36	$2 45	$2 52	$2 59	$4 39	$2 19	$3 02	$5 21	$7
8	2 06	2 16	2 25	2 33	2 41	2 51	2 58	2 68	2 76	2 85	4 78	2 34	3 23	5 47	8
9	2 22	2 32	2 43	2 51	2 60	2 71	2 79	2 89	2 98	3 08	5 17	2 49	3 43	6 12	9
10	2 36	2 48	2 58	2 68	2 78	2 89	2 99	3 10	3 20	3 30	5 54	2 65	3 90	6 55	10
11	2 48	2 61	2 72	2 81	2 92	3 04	3 15	3 26	3 37	3 48	5 91	2 78	4 12	7 37	11
12	2 63	2 75	2 88	2 98	3 12	3 24	3 35	3 45	3 58	3 69	6 28	2 95	4 37	7 77	12
13	2 74	2 89	3 01	3 14	3 26	3 40	3 53	3 65	3 78	3 90	6 60	3 09	4 60	8 17	13
14	2 86	3 01	3 17	3 29	3 42	3 56	3 69	3 83	3 96	4 10	6 99	3 26	4 93	8 57	14
15	2 99	3 15	3 30	3 42	3 57	3 72	3 86	4 01	4 16	4 30	7 38	3 39	5 18	8 97	15
16	3 10	3 27	3 43	3 57	3 72	3 88	4 03	4 18	4 34	4 49	7 66	3 57	5 44	9 35	16
17	3 22	3 40	3 57	3 71	3 89	4 04	4 19	4 36	4 52	4 67	8 05	3 70	5 69	9 73	17
18	3 34	3 54	3 71	3 86	4 03	4 20	4 37	4 53	4 71	4 87	8 28	3 88	5 93	10 11	18
19	3 47	3 66	3 84	4 01	4 18	4 37	4 53	4 72	4 89	5 06	8 61	3 92	6 19	10 11	19
20	3 57	3 77	3 97	4 14	4 33	4 51	4 68	4 88	5 07	5 23	8 94	4 06	6 42	10 48	20
21	3 67	3 88	4 08	4 26	4 47	4 65	4 84	5 04	5 24	5 41	9 20	4 19	6 60	10 86	21
22	3 78	4 00	4 20	4 38	4 60	4 79	4 99	5 19	5 39	5 56	9 59	4 31	6 85	11 24	22
23	3 89	4 11	4 32	4 52	4 75	4 95	5 14	5 36	5 59	5 77	9 97	4 43	7 09	11 62	23
24	4 00	4 23	4 45	4 64	4 89	5 10	5 30	5 51	5 77	5 94	10 24	4 55	7 45	12 00	24
25	4 11	4 35	4 57	4 76	5 04	5 25	5 44	5 67	5 95	6 13	10 57	4 68	7 70	12 38	25
26	4 22	4 47	4 70	4 88	5 19	5 40	5 61	5 84	6 13	6 32	10 88	4 80	7 93	12 75	26
27	4 34	4 58	4 82	5 01	5 33	5 56	5 77	6 00	6 31	6 48	11 21	4 93	8 18	13 13	27
28	4 45	4 71	4 95	5 16	5 49	5 71	5 93	6 17	6 49	6 69	11 53	5 06	8 40	13 50	28
29	4 57	4 83	5 08	5 29	5 63	5 87	6 09	6 33	6 67	6 88	11 85	5 16	8 71	13 87	29
30	4 68	4 95	5 20	5 42	5 78	6 02	6 24	6 49	6 83	7 06	12 17	5 28	8 96	14 24	30

* Includes standard maternity benefit (maximum of 10 times daily benefit) The *personal* rates provide immediate maternity benefits for female employees becoming insured on or within 31 days *after* the issue date of the Group Policy The dependent rates exclude *benefits for pregnancy* existing on the issue date of the dependent insurance To include standard *maternity benefits for pregnancy* existing on the issue date of the dependent insurance as ADDITIONAL SINGLE PREMIUM OF $ 95 per $1 00 will be charged for all employees with dependent wives becoming *insured* on or within 31 days after the issue date.

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan – Schedule of Minimum Premiums Per Employee – Non-Occupational – No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 120 DAYS — Maximum Special Services 20 Times the Daily Benefit

MATERNITY BENEFITS EXCLUDED												MATERNITY BENEFITS EXCLUDED				
PERSONAL COVERAGE												DEPENDENT COVERAGE				
	% of Benefits as Premium												Split Rates			
Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over		Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$7	$1.86	$1.91	$1.94	$1.98	$2.02	$2.05	$2.09	$2.13	$2.16	$2.20		$3.62	$2.19	$2.24	$4.42	$7
8	2.03	2.07	2.11	2.15	2.19	2.24	2.28	2.33	2.35	2.40		3.90	2.34	2.43	4.77	8
9	2.16	2.22	2.28	2.31	2.35	2.40	2.44	2.48	2.53	2.58		4.18	2.48	2.62	5.11	9
10	2.33	2.37	2.41	2.46	2.50	2.55	2.60	2.65	2.69	2.74		4.46	2.68	2.78	5.43	10
11	2.46	2.48	2.52	2.60	2.65	2.69	2.74	2.78	2.84	2.88		4.70	2.78	2.94	5.73	11
12	2.58	2.62	2.66	2.72	2.78	2.83	2.88	2.94	2.98	3.04		4.93	2.85	3.08	6.03	12
13	2.69	2.75	2.79	2.85	2.90	2.96	3.03	3.06	3.13	3.17		5.17	2.89	3.22	6.31	13
14	2.80	2.86	2.93	2.98	3.03	3.08	3.14	3.20	3.25	3.32		5.40	3.24	3.36	6.60	14
15	2.93	2.98	3.04	3.09	3.15	3.21	3.27	3.33	3.39	3.46		5.63	3.39	3.50	6.89	15
16	3.04	3.07	3.15	3.22	3.28	3.34	3.40	3.46	3.53	3.59		5.83	3.53	3.64	7.16	16
17	3.15	3.21	3.28	3.34	3.41	3.46	3.53	3.59	3.67	3.73		6.06	3.67	3.78	7.45	17
18	3.27	3.34	3.40	3.46	3.53	3.58	3.67	3.72	3.79	3.86		6.30	3.80	3.91	7.71	18
19	3.39	3.45	3.52	3.59	3.65	3.72	3.78	3.86	3.93	4.00		6.52	3.93	4.06	7.98	19
20	3.49	3.55	3.63	3.70	3.77	3.83	3.89	3.98	4.05	4.11		6.74	4.06	4.18	8.24	20
21	3.58	3.65	3.73	3.80	3.88	3.91	4.02	4.09	4.17	4.23		6.93	4.18	4.29	8.51	21
22	3.70	3.76	3.83	3.90	4.00	4.06	4.13	4.20	4.30	4.36		7.17	4.31	4.41	8.76	22
23	3.80	3.86	3.93	4.01	4.11	4.17	4.24	4.32	4.42	4.48		7.38	4.43	4.61	9.04	23
24	3.90	3.97	4.04	4.11	4.22	4.28	4.36	4.43	4.54	4.60		7.60	4.55	4.76	9.31	24
25	4.01	4.07	4.14	4.21	4.34	4.40	4.47	4.54	4.67	4.73		7.83	4.68	4.90	9.58	25
26	4.13	4.18	4.25	4.32	4.45	4.52	4.59	4.66	4.80	4.86		8.03	4.80	5.04	9.84	26
27	4.23	4.28	4.36	4.43	4.56	4.63	4.71	4.78	4.93	4.99		8.26	4.93	5.18	10.12	27
28	4.34	4.40	4.47	4.54	4.70	4.76	4.83	4.90	5.06	5.13		8.45	5.04	5.32	10.36	28
29	4.45	4.51	4.58	4.65	4.82	4.88	4.95	5.02	5.19	5.25		8.66	5.16	5.46	10.62	29
30	4.56	4.62	4.69*	4.76	4.94	5.00	5.07	5.14	5.32	5.38		8.87	5.28	5.60	10.88	30

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Premiums Per Employee Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 120 DAYS Maximum Special Services $100 in full plus 3/4 of next $1200 with a maximum combined benefit of $1000

MATERNITY BENEFITS INCLUDED*

PERSONAL COVERAGE

Maximum Daily Benefit	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$ 7	$2.04	$2.12	$2.21	$2.27	$2.36	$2.44	$2.52	$2.61	$2.69	$2.76
8	2.15	2.25	2.34	2.43	2.52	2.60	2.69	2.78	2.87	2.95
9	2.28	2.39	2.48	2.58	2.66	2.77	2.85	2.96	3.06	3.15
10	2.39	2.51	2.61	2.71	2.81	2.93	3.02	3.12	3.23	3.34
11	2.51	2.63	2.77	2.86	2.98	3.08	3.20	3.31	3.42	3.53
12	2.63	2.75	2.88	2.98	3.12	3.24	3.35	3.48	3.60	3.71
13	2.74	2.89	3.01	3.14	3.26	3.40	3.53	3.65	3.78	3.90
14	2.85	3.00	3.14	3.27	3.41	3.55	3.68	3.81	3.95	4.08
15	2.95	3.13	3.28	3.40	3.55	3.69	3.83	3.99	4.13	4.25
16	3.06	3.24	3.39	3.53	3.68	3.83	3.98	4.14	4.29	4.44
17	3.18	3.36	3.53	3.68	3.85	4.01	4.15	4.33	4.49	4.65
18	3.29	3.50	3.66	3.82	3.98	4.15	4.31	4.49	4.65	4.81
19	3.41	3.61	3.77	3.94	4.13	4.32	4.46	4.65	4.83	4.98
20	3.51	3.72	3.91	4.08	4.27	4.46	4.63	4.80	5.00	5.17
21	3.61	3.84	4.05	4.21	4.41	4.60	4.80	4.98	5.17	5.33
22	3.73	3.95	4.17	4.35	4.55	4.75	4.94	5.13	5.34	5.53
23	3.83	4.06	4.28	4.49	4.69	4.90	5.10	5.31	5.52	5.71
24	3.94	4.17	4.40	4.62	4.83	5.05	5.28	5.48	5.69	5.88
25	4.06	4.28	4.51	4.75	4.97	5.20	5.45	5.65	5.87	6.07
26	4.15	4.39	4.62	4.88	5.12	5.35	5.61	5.82	6.05	6.26
27	4.27	4.51	4.74	5.01	5.27	5.51	5.77	5.98	6.23	6.43
28	4.38	4.64	4.85	5.13	5.42	5.66	5.93	6.15	6.41	6.63
29	4.50	4.78	5.00	5.28	5.56	5.82	6.09	6.31	6.58	6.82
30	4.61	4.89	5.20	5.41	5.71	5.97	6.24	6.47	6.77	7.00

MATERNITY BENEFITS INCLUDED*

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$4.62	$2.30	$3.19	$5.49	$ 7
4.96	2.43	3.45	5.88	8
5.31	2.58	3.70	6.28	9
5.63	2.71	3.95	6.66	10
5.97	2.86	4.20	7.06	11
6.36	2.98	4.43	7.41	12
6.62	3.13	4.68	7.81	13
6.95	3.27	4.92	8.19	14
7.27	3.41	5.16	8.57	15
7.60	3.56	5.40	8.96	16
7.93	3.70	5.64	9.33	17
8.25	3.81	5.89	9.70	18
8.58	3.94	6.13	10.06	19
8.87	4.07	6.35	10.42	20
9.18	4.19	6.58	10.77	21
9.51	4.32	6.82	11.14	22
9.83	4.44	7.06	11.50	23
10.14	4.56	7.29	11.85	24
10.45	4.69	7.53	12.22	25
10.77	4.81	7.78	12.58	26
11.09	4.93	8.02	12.98	27
11.41	5.05	8.28	13.34	28
11.73	5.17	8.54	13.71	29
12.05	5.29	8.79	14.08	30

* Includes standard maternity benefit (maximum of 10 times daily benefit). The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $.05 per $1.00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employer Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 120 DAYS Maximum Special Services $100 in full plus 3/4 of next $1200 with a maximum combined benefit of $1000

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

Maximum Daily Benefit	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71 81	81-91	91 and over
$7	$ 2 01	$ 2 04	$ 2 09	$ 2 12	$ 2 16	$ 2 20	$ 2 25	$ 2 29	$ 2 33	$ 2 37
8	2 12	2 16	2 20	2 25	2 30	2 33	2 38	2 42	2 46	2 50
9	2 24	2 28	2 33	2 38	2 41	2 46	2 50	2 55	2 60	2 65
10	2 35	2 40	2 44	2 49	2 53	2 58	2 63	2 68	2 72	2 78
11	2 47	2 51	2 58	2 63	2 67	2 71	2 77	2 81	2 86	2 90
12	2 58	2 62	2 68	2 72	2 78	2 83	2 88	2 94	2 98	3 04
13	2 69	2 75	2 79	2 85	2 90	2 96	3 02	3 06	3 12	3 17
14	2 79	2 85	2 90	2 96	3 02	3 07	3 13	3 18	3 24	3 30
15	2 89	2 96	3 02	3 07	3 13	3 18	3 24	3 31	3 36	3 41
16	3 00	3 06	3 12	3 18	3 24	3 31	3 36	3 42	3 48	3 54
17	3 12	3 17	3 24	3 31	3 37	3 43	3 48	3 55	3 62	3 66
18	3 22	3 30	3 35	3 42	3 48	3 54	4 01	4 08	4 13	4 20
19	3 33	3 40	3 45	3 52	3 59	4 07	4 13	4 19	4 26	4 32
20	3 43	3 50	3 57	4 04	4 11	4 18	4 25	4 30	4 38	4 45
21	3 53	3 61	4 09	4 15	4 22	4 29	4 36	4 42	4 50	4 57
22	4 04	4 11	4 20	4 28	4 35	4 42	4 49	4 56	5 03	5 09
23	4 14	4 21	4 31	4 38	4 45	4 52	4 59	5 07	5 14	5 21
24	4 24	4 31	4 41	4 49	4 56	5 03	5 11	5 18	5 25	5 33
25	4 34	4 42	4 52	4 59	5 07	5 15	5 22	5 29	5 37	5 44
26	4 45	4 52	5 02	5 10	5 18	5 25	5 33	5 41	5 48	5 56
27	4 55	5 03	5 13	5 21	5 29	5 37	5 45	5 52	6 00	6 08
28	5 05	5 13	5 23	5 32	5 40	5 48	5 56	6 04	6 12	6 20
29	5 15	5 24	5 34	5 43	5 51	5 59	6 07	6 15	6 23	6 31
30	5 25	5 34	5 44	5 53	6 01	6 10	6 18	6 26	6 34	6 43

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Flat Rate	Split Rate			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$ 3 84	$ 5 30	$ 2 41	$ 6 71	$7
4 00	5 43	2 55	6 98	8
4 32	5 98	2 69	7 23	9
4 53	6 21	2 83	7 56	10
4 74	6 46	2 96	8 03	11
4 86	6 90	3 06	8 47	12
5 10	7 13	3 22	8 75	13
5 31	7 37	3 35	9 02	14
5 52	7 61	3 48	9 29	15
5 84	7 94	3 61	9 75	16
6 06	8 20	3 76	10 03	17
6 27	8 41	3 87	10 30	18
6 47	8 94	3 99	10 93	19
6 67	9 07	4 11	11 10	20
6 88	9 19	4 23	11 42	21
7 09	9 32	4 36	11 68	22
7 29	9 44	4 48	11 92	23
7 50	9 56	4 60	12 16	24
7 70	9 69	4 73	12 42	25
7 91	9 81	4 87	12 68	26
8 12	9 93	5 01	12 94	27
8 33	10 05	5 15	13 20	28
8 54	10 17	5 29	13 46	29
8 75	10 29	5 43	13 72	30

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employee - Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board - 120 DAYS Maximum Special Services - $200 in full plus 3/4 of next $2400 with a maximum combined benefit of $2000

MATERNITY BENEFITS INCLUDED* — PERSONAL COVERAGE — % of Benefits on Females											MATERNITY BENEFITS INCLUDED* — DEPENDENT COVERAGE — Split Rates				
Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
07	$ 2.13	$ 2.21	$ 2.28	$ 2.36	$ 2.45	$ 2.54	$ 2.61	$ 2.70	$ 2.78	$ 2.85	$ 4.76	$ 2.37	$3.28	$ 5.65	07
08	2.24	2.35	2.45	2.52	2.61	2.70	2.79	2.88	2.99	3.06	5.11	2.50	3.56	6.06	08
09	2.37	2.48	2.57	2.67	2.76	2.87	2.96	3.07	3.18	3.25	5.46	2.65	3.80	6.45	09
10	2.48	2.60	2.70	2.82	2.93	3.03	3.13	3.24	3.35	3.44	5.79	2.78	4.06	6.84	10
11	2.60	2.73	2.84	2.95	3.08	3.18	3.30	3.43	3.53	3.65	6.12	2.93	4.30	7.23	11
12	2.72	2.85	2.97	3.08	3.21	3.35	3.46	3.58	3.70	3.81	6.45	3.07	4.54	7.61	12
13	2.82	2.97	3.10	3.23	3.35	3.49	3.63	3.74	3.87	4.00	6.78	3.22	4.79	8.01	13
14	2.93	3.08	3.22	3.36	3.50	3.64	3.77	3.91	4.05	4.18	7.11	3.36	5.02	8.38	14
15	3.05	3.22	3.37	3.49	3.65	3.81	3.94	4.09	4.23	4.36	7.45	3.50	5.27	8.77	15
16	3.17	3.34	3.50	3.65	3.80	3.95	4.10	4.26	4.42	4.57	7.79	3.64	5.52	9.16	16
17	3.28	3.46	3.64	3.78	3.98	4.13	4.27	4.45	4.60	4.75	8.11	3.78	5.77	9.55	17
18	3.41	3.61	3.79	3.93	4.11	4.29	4.44	4.61	4.79	4.95	8.45	3.90	6.03	9.93	18
19	3.53	3.72	3.91	4.07	4.25	4.44	4.60	4.78	4.97	5.12	8.78	4.04	6.26	10.30	19
20	3.62	3.84	4.03	4.20	4.38	4.58	4.76	4.95	5.13	5.30	9.07	4.18	6.49	10.85	20
21	3.73	3.95	4.15	4.32	4.52	4.73	4.91	5.12	5.30	5.49	9.38	4.28	6.73	11.01	21
22	3.84	4.06	4.26	4.45	4.67	4.88	5.08	5.28	5.48	5.66	9.75	4.41	6.96	11.37	22
23	3.94	4.17	4.39	4.58	4.80	5.02	5.22	5.46	5.65	5.84	10.02	4.53	7.20	11.72	23
24	4.06	4.29	4.51	4.70	4.94	5.18	5.37	5.62	5.82	6.02	10.33	4.66	7.44	12.10	24
25	4.16	4.41	4.63	4.82	5.09	5.33	5.53	5.80	6.01	6.20	10.65	4.78	7.67	12.45	25
26	4.27	4.52	4.74	4.95	5.21	5.47	5.68	5.97	6.18	6.38	10.97	4.90	7.92	12.82	26
27	4.38	4.63	4.86	5.07	5.34	5.61	5.82	6.13	6.37	6.57	11.30	5.02	8.17	13.19	27
28	4.50	4.77	5.01	5.22	5.54	5.78	6.00	6.30	6.55	6.76	11.61	5.14	8.43	13.57	28
29	4.62	4.89	5.14	5.35	5.68	5.96	6.16	6.46	6.73	6.95	11.93	5.26	8.68	13.94	29
30	4.73	5.01	5.26	5.48	5.83	6.09	6.31	6.62	6.91	7.13	12.25	5.38	8.93	14.31	30

* Includes standard maternity benefit (maximum of 10 times daily benefit) The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $ 95 per $1 00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan – Schedule of Minimum Monthly Premiums Per Employee – Non-Occupational – No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board – 120 DAYS Maximum Special Services – $200 in full plus 3/4 of next $2400 with a maximum combined benefit of $2000

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

Maximum Daily Benefit	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$ 7	$ 2.09	$ 2.13	$ 2.18	$ 2.21	$ 2.25	$ 2.30	$ 2.34	$ 2.38	$ 2.42	$ 2.46
8	2.21	2.26	2.31	2.34	2.39	2.43	2.48	2.52	2.56	2.61
9	2.33	2.38	2.43	2.47	2.51	2.56	2.61	2.66	2.70	2.75
10	2.44	2.49	2.53	2.60	2.65	2.69	2.74	2.79	2.84	2.88
11	2.56	2.61	2.67	2.71	2.77	2.81	2.87	2.93	2.97	3.03
12	2.67	2.72	2.77	2.83	2.87	2.94	2.98	3.04	3.08	3.14
13	2.77	2.83	2.88	2.94	2.99	3.05	3.11	3.15	3.21	3.27
14	2.87	2.94	2.99	3.05	3.11	3.18	3.22	3.28	3.34	3.40
15	2.99	3.05	3.11	3.16	3.23	3.30	3.35	3.41	3.48	3.53
16	3.11	3.16	3.23	3.30	3.35	3.41	3.48	3.54	3.61	3.67
17	3.23	3.28	3.35	3.42	3.48	3.54	3.61	3.68	3.73	3.80
18	3.34	3.41	3.48	3.53	3.61	3.68	3.74	3.80	3.87	3.94
19	3.46	3.51	3.59	3.65	3.72	3.79	3.86	3.92	4.00	4.06
20	3.54	3.62	3.69	3.76	3.82	3.90	3.98	4.05	4.11	4.18
21	3.65	3.72	3.79	3.86	3.93	4.02	4.09	4.17	4.25	4.31
22	3.75	3.82	3.89	3.97	4.05	4.13	4.20	4.30	4.38	4.43
23	3.85	3.92	4.00	4.07	4.16	4.24	4.32	4.42	4.48	4.55
24	3.96	4.03	4.10	4.17	4.27	4.36	4.43	4.54	4.60	4.68
25	4.06	4.13	4.20	4.27	4.39	4.47	4.54	4.67	4.73	4.80
26	4.17	4.24	4.31	4.38	4.51	4.58	4.66	4.79	4.85	4.93
27	4.28	4.35	4.42	4.49	4.63	4.71	4.78	4.91	4.98	5.05
28	4.39	4.46	4.53	4.60	4.75	4.83	4.90	5.03	5.13	5.18
29	4.50	4.57	4.64	4.71	4.87	4.95	5.02	5.15	5.25	5.32
30	4.61	4.68	4.75	4.82	4.99	5.07	5.14	5.27	5.38	5.45

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$ 5.09	$ 3.37	$ 3.50	$ 4.07	$ 7
4.33	2.50	2.66	5.18	8
4.45	2.65	2.78	5.44	9
4.69	2.78	2.94	5.72	10
4.91	2.93	3.07	6.00	11
5.15	3.07	3.20	6.27	12
5.38	3.22	3.33	6.55	13
5.57	3.36	3.45	6.81	14
5.80	3.50	3.59	7.09	15
6.03	3.64	3.73	7.37	16
6.22	3.78	3.87	7.65	17
6.47	3.90	4.01	7.91	18
6.66	4.04	4.13	8.17	19
6.87	4.18	4.25	8.41	20
7.06	4.28	4.38	8.66	21
7.28	4.41	4.50	8.91	22
7.49	4.53	4.62	9.15	23
7.69	4.66	4.75	9.41	24
7.90	4.78	4.87	9.65	25
8.11	4.90	5.01	9.91	26
8.32	5.03	5.13	10.17	27
8.53	5.16	5.28	10.43	28
8.74	5.26	5.43	10.69	29
8.95	5.38	5.57	10.95	30

GROUP HOSPITAL EXPENSE INSURANCE

Reduction in Premium Rates for "Deductible" Hospital Expense Insurance Plans

(Not applicable to Modern Security Plans)

If the Hospital Expense Plan includes a "deductible" arrangement whereby the employee is to pay the first $25 or $50 of the charges for room and board and special services otherwise payable under the Plan, the monthly premium per employee for the basic Plan is reduced in accordance with the following table:

PERSONAL COVERAGE

	% of Benefits on Females									
Deductible	Less than 11	11 - 21	21 - 31	31 - 41	41 - 51	51 - 61	61 - 71	71 - 81	81 - 91	91 and over
$25	$ .51	$ .53	$ .54	$ .55	$ .57	$ .59	$ .60	$ .62	$ .63	$ .65
$50	1.07	1.11	1.16	1.19	1.24	1.28	1.32	1.36	1.40	1.43

DEPENDENT COVERAGE

Deductible	FLAT RATE	SPLIT RATES		
		Child(ren) Only	Wife Only	Wife & Child(ren)
$25	$1.35	$1.07	$.68	$1.75
$50	2.81	2.14	1.46	3.60

GROUP DIAGNOSTIC X-RAY AND LABORATORY EXAMINATION INSURANCE

(Non-Occupational)

Coverage:

Benefits may cover employees only or employees and dependents.

Reimbursement, up to the maximum specified in the plan, for the cost of Diagnostic X-Rays and Laboratory Examinations when such examinations are made outside a hospital or if in a hospital when time spent in hospital is not sufficient to qualify for reimbursement of such charges under Hospital Expense Insurance.

Plan may include both X-Ray and Laboratory reimbursement or may be limited to reimbursement for X-Ray Examination only.

Plan may provide a maximum for each type of examination performed (scheduled basis) or may provide an overall maximum for all examinations (unscheduled basis).

Limitations:

Benefits are not payable for examination of the urine or X-Ray therapy treatment nor for any examination:

(a) which is not made or recommended by a physician licensed to practice medicine;

(b) which is made during hospital confinement and for which a charge is made by the hospital;

(c) in connection with dental work or treatment;

(d) because of pregnancy or resulting childbirth or complications;

(e) if reimbursement for such examination is otherwise payable under the Group Plan.

Underwriting:

Written only in conjunction with Metropolitan Hospital Expense Insurance. (If less than 50 lives, Life or Accident and Sickness must also be included.)

Maximum Benefit:

On a scheduled basis

$50 for examinations due to any one accident.
$50 for all examinations during any 12 consecutive months due to sickness.

For schedule of reimbursement, see reverse side.

On an unscheduled basis

$25 or $50 for all examinations due to any one accident;
$25 or $50 for all examinations during any 12 consecutive months due to sickness.

Rates:

Minimum table. . . . . .pages 4-37 and 4-38

Industry loadings. . . . . .pages 8-1 through 8-9

Also see page 8-10 and section of page 8-11 dealing with employees age 60 and over.

GROUP DIAGNOSTIC X-RAY AND LABORATORY EXAMINATION INSURANCE

(Non-Occupational)

Schedule of Diagnostic X-Ray and Laboratory Examinations

X-Ray Examination	Maximum Payment	Laboratory Examinations	Maximum Payment
Abdominal Region		Electrocardiogram	
Gastro-intestinal series - barium meal	$25.00	With interpretation	$10.00
Colon - barium enema	15.00	Without interpretation	7.50
Gall Bladder, dye method	15.00	Sugar tolerance test, involving two or more blood sugar determinations and accompanying urinary sugar determinations	10.00
Flat film	10.00	All other laboratory examinations (except urine examinations)	5.00
Kidney, ureter or bladder:			
dye method - intravenous	10.00		
dye method - retrograde pyelogram	20.00		
Arm or Leg	5.00		
Chest region			
Heart and lungs	10.00		
Stereoscopic	15.00		
Head - skull, sinuses or lower jaw (except dental X-Ray)	10.00		
Pelvis, hip, spine or shoulder	10.00		
Ribs - one side	10.00		

NOTE: When X-Ray only is written only the examinations in the left hand column above are applicable.

GROUP PERSONAL GROUP DIAGNOSTIC X-RAY AND LABORATORY EXAMINATION INSURANCE
AND
GROUP PERSONAL DIAGNOSTIC X-RAY (ONLY) EXAMINATION INSURANCE

(Non-Occupational)

SCHEDULE OF MINIMUM MONTHLY PREMIUMS

(Not applicable to Modern Security Plans)

Basis of: (a) Payments on an unscheduled basis up to specified maximums or in accordance with a schedule of maximum payments up to $25 for certain examinations.
(b) Specified maximums for examinations due to any one accident and for all examinations during any 12 consecutive months due to illness.

PLAN	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
X-Ray and Laboratory Examinations:										
Scheduled - $50 maximum	$ .28	$.29	$.31	$.33	$.35	$.36	$.37	$.38	$.39	$.41
Unscheduled - $25 maximum	.24	.25	.26	.27	.28	.29	.30	.31	.32	.34
50 maximum	.36	.37	.39	.41	.43	.45	.46	.47	.49	.51
X-Ray Only:										
Scheduled - $50 maximum	.18	.19	.20	.21	.22	.23	.24	.25	.26	.27
Unscheduled - $25 maximum	.16	.16	.17	.17	.18	.19	.20	.20	.21	.22
50 maximum	.24	.25	.26	.27	.28	.29	.30	.31	.32	.34

GROUP DEPENDENT GROUP DIAGNOSTIC X-RAY AND LABORATORY EXAMINATION INSURANCE
AND
GROUP DEPENDENT DIAGNOSTIC X-RAY (ONLY) EXAMINATION INSURANCE

(Non-Occupational)

SCHEDULE OF MINIMUM MONTHLY PREMIUMS

(Not applicable to Modern Security Plans)

Basis of: (a) Payments on an unscheduled basis up to specified maximums or in accordance with a schedule of maximum payments up to $25 for certain examinations.

(b) Specified Maximums for examinations due to any one accident and for all examinations during any 12 consecutive months due to illness.

PLAN	Flat Rate	Split Rates		
		Child(ren) Only	Wife Only	Wife and Child(ren)
X-Ray and Laboratory Examinations:				
Scheduled - $50 maximum	$ .70	$ .47	$ .42	$ .89
Unscheduled - $25 maximum	.60	.40	.36	.76
50 maximum	.90	.60	.54	1.14
X-Ray Only:				
Scheduled - $50 maximum	.45	.30	.27	.57
Unscheduled - $25 maximum	.40	.27	.24	.51
50 maximum	.60	.40	.36	.76

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan — Schedule of Maximum Monthly Premiums Per Employee — Non-Occupational — No Industry Deadline

(Not applicable to Modern Security Plans)

Maximum Room and Board — 120 DAYS — Maximum Special Services — 10 Times the Daily Benefit

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

Full Benefits on Females

Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$7	$1.57	$1.60	$1.63	$1.66	$1.69	$1.73	$1.75	$1.78	$1.82	$1.84
8	1.75	1.78	1.82	1.85	1.88	1.93	1.96	2.00	2.03	2.06
9	1.92	1.95	2.00	2.03	2.06	2.11	2.14	2.18	2.21	2.26
10	2.06	2.11	2.14	2.19	2.22	2.28	2.31	2.35	2.39	2.43
11	2.20	2.25	2.30	2.33	2.38	2.42	2.47	2.51	2.55	2.60
12	2.34	2.39	2.43	2.48	2.52	2.58	2.62	2.67	2.71	2.76
13	2.48	2.52	2.59	2.63	2.68	2.72	2.78	2.84	2.87	2.93
14	2.61	2.67	2.71	2.77	2.83	2.87	2.93	2.98	3.03	3.08
15	2.74	2.79	2.84	2.89	2.96	3.02	3.06	3.12	3.17	3.22
16	2.86	2.93	2.98	3.04	3.09	3.15	3.21	3.27	3.31	3.37
17	2.99	3.05	3.11	3.16	3.23	3.30	3.35	3.41	3.46	3.52
18	3.12	3.17	3.24	3.31	3.37	3.43	3.49	3.55	3.62	3.68
19	3.24	3.32	3.37	3.44	3.50	3.57	3.64	3.70	3.77	3.82
20	3.37	3.44	3.51	3.57	3.64	3.71	3.78	3.85	3.91	3.98
21	3.48	3.55	3.64	3.69	3.76	3.84	3.90	3.98	4.05	4.11
22	3.59	3.67	3.74	3.80	3.88	3.96	4.03	4.10	4.18	4.24
23	3.71	3.78	3.85	3.91	4.01	4.08	4.15	4.22	4.32	4.38
24	3.82	3.89	3.97	4.03	4.13	4.20	4.27	4.35	4.44	4.51
25	3.93	4.01	4.08	4.14	4.25	4.33	4.40	4.47	4.56	4.65

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Maximum Daily Benefit	Flat Rates	Split Rates: Children(-only) Units	Split Rates: Wife-Only	Split Rates: Wife & Children(-only)	Maximum Daily Benefit
$7	$3.17	$2.06	$1.87	$3.93	$7
8	3.50	2.21	2.10	4.31	8
9	3.78	2.35	2.30	4.65	9
10	4.06	2.50	2.48	4.90	10
11	4.32	2.66	2.65	5.31	11
12	4.56	2.79	2.80	5.59	12
13	4.83	2.95	2.98	5.91	13
14	5.08	3.08	3.13	6.21	14
15	5.31	3.23	3.26	6.51	15
16	5.55	3.37	3.43	6.80	16
17	5.81	3.51	3.59	7.10	17
18	6.04	3.65	3.74	7.39	18
19	6.27	3.78	3.89	7.67	19
20	6.50	3.90	4.05	7.95	20
21	6.72	4.03	4.19	8.22	21
22	6.93	4.15	4.34	8.49	22
23	7.15	4.27	4.48	8.75	23
24	7.36	4.40	4.62	9.02	24
25	7.58	4.52	4.77	9.29	25

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan — Schedule of Maximum Monthly Premiums Per Employee — Non-Occupational — Per Industry Grades

(Not applicable to Modern Security Plans)

Maximum Room and Board — 120 DAYS — Maximum Special Services — 15 Times the Daily Benefit

Maximum Daily Benefit	MATERNITY BENEFITS INCLUDED* PERSONAL COVERAGE — Cost of Benefits on Females											MATERNITY BENEFITS INCLUDED* DEPENDENT COVERAGE — Spouse Rates				
	Less than 11	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91 and over		Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$7	$1.76	$1.84	$1.91	$1.98	$2.06	$2.15	$2.21	$2.29	$2.37	$2.43		$4.20	$2.15	$2.85	$5.00	$7
8	1.96	2.05	2.15	2.22	2.29	2.39	2.46	2.55	2.65	2.73		4.64	2.31	3.21	5.52	8
9	2.13	2.23	2.31	2.41	2.50	2.61	2.69	2.79	2.88	2.96		5.04	2.46	3.51	5.97	9
10	2.26	2.39	2.49	2.59	2.68	2.78	2.88	2.98	3.10	3.19		5.42	2.61	3.79	6.40	10
11	2.39	2.52	2.63	2.73	2.84	2.96	3.06	3.18	3.28	3.40		5.77	2.76	4.06	6.82	11
12	2.53	2.65	2.79	2.89	3.02	3.13	3.25	3.37	3.48	3.61		6.13	2.90	4.32	7.22	12
13	2.66	2.81	2.93	3.06	3.17	3.31	3.43	3.57	3.69	3.81		6.49	3.06	4.59	7.65	13
14	2.80	2.94	3.08	3.20	3.35	3.50	3.61	3.75	3.88	4.00		6.83	3.21	4.85	8.06	14
15	2.92	3.10	3.21	3.37	3.51	3.66	3.80	3.95	4.10	4.21		7.19	3.35	5.11	8.46	15
16	3.05	3.23	3.36	3.51	3.68	3.84	3.97	4.13	4.28	4.42		7.53	3.49	5.36	8.87	16
17	3.19	3.36	3.53	3.68	3.85	4.01	4.15	4.32	4.49	4.63		7.89	3.62	5.64	9.26	17
18	3.30	3.51	3.67	3.83	3.99	4.16	4.32	4.50	4.68	4.82		8.21	3.74	5.90	9.61	18
19	3.43	3.63	3.81	3.96	4.15	4.34	4.50	4.67	4.85	5.02		8.55	3.87	6.15	10.02	19
20	3.54	3.75	3.95	4.12	4.30	4.49	4.66	4.86	5.01	5.21		8.87	4.00	6.40	10.40	20
21	3.68	3.87	4.07	4.24	4.44	4.63	4.82	5.02	5.21	5.39		9.20	4.12	6.66	10.78	21
22	3.78	3.98	4.18	4.36	4.59	4.79	4.97	5.17	5.38	5.57		9.53	4.24	6.91	11.15	22
23	3.86	4.09	4.30	4.50	4.72	4.93	5.12	5.31	5.50	5.75		9.85	4.37	7.17	11.54	23
24	3.97	4.20	4.43	4.62	4.86	5.08	5.28	5.49	5.73	5.92		10.18	4.49	7.43	11.92	24
25	4.08	4.31	4.55	4.74	5.01	5.23	5.41	5.65	5.92	6.11		10.51	4.61	7.68	12.29	25

* Includes standard maternity benefit maximum of 10 times daily benefit. The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an Additional Single Premium of $ .05 per $1.00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Maximum Monthly Premiums Per Employee Non-Occupational No Industry Limiting

(Not applicable to Modern Security Plans)

Maximum Room and Board 120 DAYS Maximum Special Services 15 Times the Daily Benefit

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

Cost Rates for Females

Maximum Daily Benefit	Less than 11	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91 and over
$7	$1.73	$1.76	$1.79	$1.84	$1.86	$1.91	$1.94	$1.97	$2.01	$2.01
8	1.93	1.96	2.01	2.04	2.07	2.12	2.15	2.19	2.23	2.28
9	2.09	2.13	2.16	2.21	2.25	2.30	2.34	2.38	2.42	2.46
10	2.22	2.28	2.32	2.37	2.40	2.46	2.49	2.53	2.59	2.63
11	2.35	2.40	2.44	2.49	2.53	2.59	2.63	2.68	2.72	2.78
12	2.46	2.52	2.59	2.63	2.68	2.72	2.78	2.83	2.87	2.94
13	2.61	2.67	2.71	2.77	2.81	2.87	2.93	2.98	3.03	3.08
14	2.74	2.79	2.84	2.89	2.96	3.02	3.06	3.12	3.17	3.23
15	2.86	2.93	2.98	3.04	3.09	3.15	3.21	3.27	3.33	3.37
16	2.99	3.05	3.11	3.18	3.23	3.30	3.35	3.41	3.46	3.52
17	3.12	3.17	3.24	3.31	3.37	3.43	3.49	3.55	3.62	3.68
18	3.23	3.31	3.36	3.43	3.49	3.55	3.62	3.69	3.76	3.81
19	3.35	3.42	3.49	3.54	3.62	3.69	3.76	3.81	3.88	3.96
20	3.46	3.53	3.61	3.68	3.74	3.81	3.88	3.96	4.02	4.09
21	3.56	3.61	3.71	3.78	3.85	3.92	4.00	4.07	4.14	4.21
22	3.67	3.74	3.84	3.88	3.97	4.04	4.11	4.18	4.26	4.34
23	3.77	3.84	3.91	3.99	4.08	4.15	4.22	4.30	4.39	4.46
24	3.87	3.94	4.02	4.09	4.19	4.26	4.34	4.41	4.51	4.58
25	3.98	4.05	4.12	4.19	4.31	4.38	4.45	4.52	4.64	4.71

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Spouse Rates

Plan Rates	Husband and Wife	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$3.13	$2.15	$2.07	$1.22	$7
3.76	2.30	2.31	4.62	8
4.05	2.46	2.50	1.90	9
4.32	2.61	2.67	5.28	10
4.56	2.76	2.83	5.59	11
4.81	2.90	2.98	5.88	12
5.06	3.06	3.13	6.19	13
5.29	3.21	3.28	6.49	14
5.51	3.34	3.43	6.78	15
5.78	3.49	3.59	7.08	16
6.02	3.62	3.74	7.36	17
6.23	3.78	3.88	7.62	18
6.46	3.87	4.02	7.89	19
6.67	4.00	4.16	8.16	20
6.89	4.12	4.31	8.43	21
7.11	4.24	4.45	8.69	22
7.32	4.37	4.59	8.96	23
7.54	4.49	4.74	9.23	24
7.76	4.61	4.88	9.49	25

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employee Non-Occupational No Industry Loading

(Not applicable to Modern Security Plans)

Maximum Room and Board 120 DAYS Maximum Special Services 20 Times the Daily Benefit

Maximum Daily Benefit	MATERNITY BENEFITS INCLUDED* PERSONAL COVERAGE Age Brackets on Females: Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	MATERNITY BENEFITS INCLUDED* DEPENDENT COVERAGE Special Rates: Flat Rates	Children only	Wife only	Wife & Children	*Maximum Daily Benefit
$7	$1.89	$1.99	$2.06	$2.14	$2.22	$2.29	$2.36	$2.15	$2.52	$2.59	$1.39	$1.19	$3.02	$5.21	$7
8	2.06	2.16	2.25	2.33	2.41	2.51	2.59	2.68	2.76	2.85	1.78	2.31	3.33	5.07	8
9	2.22	2.32	2.43	2.51	2.60	2.71	2.79	2.89	2.98	3.08	5.17	2.49	3.63	6.12	9
10	2.36	2.48	2.58	2.68	2.78	2.89	2.99	3.10	3.20	3.30	5.51	2.65	3.90	6.55	10
11	2.48	2.61	2.72	2.84	2.96	3.06	3.17	3.29	3.40	3.50	5.91	2.79	4.17	6.98	11
12	2.63	2.75	2.88	2.98	3.12	3.24	3.35	3.48	3.60	3.71	6.25	2.95	4.42	7.37	12
13	2.74	2.89	3.01	3.14	3.26	3.40	3.53	3.65	3.78	3.90	6.60	3.09	4.68	7.77	13
14	2.86	3.01	3.17	3.29	3.42	3.56	3.69	3.83	3.96	4.10	6.94	3.24	4.93	8.17	14
15	2.99	3.15	3.30	3.42	3.57	3.72	3.86	4.01	4.16	4.28	7.28	3.39	5.18	8.57	15
16	3.10	3.27	3.42	3.57	3.73	3.88	4.02	4.18	4.31	4.48	7.61	3.52	5.42	8.95	16
17	3.22	3.40	3.57	3.71	3.89	4.04	4.19	4.36	4.50	4.67	7.96	3.67	5.68	9.35	17
18	3.34	3.51	3.71	3.86	4.03	4.20	4.37	4.53	4.71	4.87	8.28	3.80	5.93	9.73	18
19	3.47	3.66	3.84	4.01	4.18	4.37	4.53	4.72	4.89	5.06	8.61	3.92	6.19	10.11	19
20	3.57	3.77	3.97	4.14	4.33	4.51	4.68	4.88	5.07	5.23	8.91	4.06	6.32	10.48	20
21	3.67	3.89	4.09	4.26	4.47	4.65	4.84	5.04	5.24	5.41	9.26	4.18	6.68	10.88	21
22	3.79	4.00	4.20	4.38	4.62	4.81	4.99	5.19	5.42	5.59	9.59	4.31	6.93	11.24	22
23	3.89	4.11	4.32	4.52	4.75	4.95	5.14	5.36	5.59	5.77	9.92	4.43	7.19	11.62	23
24	4.00	4.23	4.45	4.64	4.89	5.10	5.30	5.51	5.77	5.91	10.24	4.55	7.45	12.00	24
25	4.11	4.35	4.57	4.76	5.01	5.25	5.44	5.67	5.95	6.13	10.57	4.69	7.70	12.38	25

* Includes standard maternity benefit (maximum of 10 times daily benefit) The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $.05 per $1.00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date

COMBINED DISABILITY PREMIUM $1.000 OR LESS
GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan — Schedule of Minimum Monthly Premiums Per Employee — Non-Occupational — No Industry Loading

Maximum Room and Board — 31 TIMES the Daily Benefit — Maximum Special Services — 10 Times the Daily Benefit

MATERNITY BENEFITS INCLUDED*

PERSONAL COVERAGE

% of Benefits on Females

Age	Less than 21	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61 and over
1	$1.365	$1.449	$1.522	$1.596	$1.659	$1.732	$1.785	$1.858	$1.932	$1.995
2	1.533	1.617	1.711	1.785	1.858	1.912	2.016	2.089	2.163	2.247
3	1.680	1.774	1.869	1.953	2.037	2.142	2.215	2.299	2.373	2.478
4										
5										
6	1.806	1.921	2.020	2.121	2.205	2.310	2.394	2.499	2.583	2.688
7	1.932	2.037	2.173	2.257	2.362	2.478	2.572	2.677	2.772	2.887
8	2.058	2.173	2.310	2.415	2.520	2.646	2.751	2.856	2.961	3.076
9										
10	2.173	2.289	2.457	2.572	2.677	2.803	2.929	3.045	3.150	3.286
11	2.289	2.436	2.583	2.709	2.835	2.971	3.087	3.213	3.339	3.486
12	2.404	2.551	2.709	2.845	2.971	3.129	3.255	3.391	3.517	3.654
13										
14										
15										
16	2.520	2.667	2.835	2.992	3.129	3.276	3.423	3.559	3.706	3.843
17	2.625	2.793	2.982	3.118	3.276	3.411	3.591	3.727	3.874	4.032
18	2.740	2.908	3.118	3.265	3.423	3.591	3.748	3.906	4.053	4.221
19										
20	2.856	3.045	3.234	3.402	3.559	3.748	3.916	4.074	4.242	4.420
	2.961	3.160	3.381	3.549	3.706	3.906	4.074	4.242	4.420	4.599

MATERNITY BENEFITS INCLUDED*

DEPENDENT COVERAGE

Flat Rates	Split Rates: Individual Only	Split Rates: Wife Only	Split Rates: Wife & Individual	Maximum Daily Benefit
$3.150	$1.771	$2.394	$1.108	$ 7
3.885	1.900	2.698	4.599	8
4.231	2.026	2.971	4.998	9
4.578	2.152	3.214	5.397	10
4.924	2.289	3.507	5.796	11
5.229	2.404	3.748	6.153	12
5.575	2.530	4.011	6.511	13
5.901	2.656	4.252	6.909	14
6.216	2.782	4.491	7.276	15
6.531	2.898	4.735	7.633	16
6.846	3.024	4.967	8.011	17
7.161	3.139	5.229	8.368	18
7.465	3.255	5.460	8.715	19
7.780	3.360	5.712	9.072	20

* Includes standard maternity benefit maximum of 10 times daily benefit. The flat rates provide benefits, subject to limits for female employees becoming insured on or within 31 days after the issue date of the group policy. The split rates exclude benefits for persons insured on the issue date of the group insurance. To include maternity benefits for persons insured on the issue date of the dependent insurance, an ADDITIONAL SINGLE PREMIUM OF $ 995 per $1.000 will be charged for persons with dependent wives becoming insured on or within 30 days after the issue date.

COMBINED DISABILITY PREMIUM $1,000 OR LESS
GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Maximum Monthly Premiums Per Employee Non-Occupational No Industry Loading

Maximum Room and Board 31 Times the Daily Benefit Maximum Special Services 10 Times the Daily Benefit

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

Age at Nearest Birthday

Maximum Daily Benefit	Less than 21	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61 and over
$ 7	$1 344	$1 375	$1 406	$1 438	$1 469	$1 500	$1 501	$1 533	$1 564	$1 595
8	1 501	1 533	1 564	1 596	1 627	1 659	1 690	1 721	1 753	1 784
9	1 688	1 680	1 711	1 743	1 774	1 806	1 848	1 879	1 900	1 942
10	1 771	1 816	1 848	1 890	1 911	1 953	1 984	2 026	2 058	2 100
11	1 900	1 932	1 974	2 005	2 047	2 089	2 121	2 163	2 194	2 236
12	2 016	2 058	2 100	2 131	2 173	2 215	2 257	2 299	2 331	2 373
13	2 131	2 173	2 226	2 268	2 299	2 341	2 394	2 436	2 478	2 520
14	2 247	2 299	2 331	2 383	2 425	2 478	2 509	2 562	2 604	2 656
15	2 352	2 404	2 446	2 499	2 541	2 593	2 635	2 688	2 730	2 772
16	2 467	2 509	2 562	2 614	2 667	2 709	2 761	2 814	2 866	2 898
17	2 572	2 625	2 677	2 719	2 782	2 835	2 887	2 929	2 982	3 014
18	2 677	2 730	2 793	2 845	2 898	2 950	3 003	3 066	3 108	3 161
19	2 793	2 856	2 898	2 961	3 014	3 076	3 129	3 181	3 233	3 297
20	2 898	2 961	3 021	3 076	3 129	3 192	3 255	3 307	3 370	3 423

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$2 740	$1 774	$1 617	$3 391	$ 7
3 003	1 900	1 806	3 706	8
3 255	2 026	1 974	4 000	9
3 486	2 152	2 131	4 284	10
3 717	2 289	2 278	4 567	11
3 927	2 404	2 415	4 819	12
4 158	2 530	2 562	5 092	13
4 368	2 656	2 698	5 355	14
4 578	2 782	2 824	5 607	15
4 777	2 898	2 950	5 848	16
4 998	3 024	3 097	6 121	17
5 197	3 139	3 223	6 361	18
5 397	3 255	3 349	6 604	19
5 596	3 360	3 486	6 846	20

COMBINED DISABILITY PREMIUM $1.000 OR LESS

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employee - Non-Occupational - - No Industry Loading

Maximum Room and Board – 31 TIMES the Daily Benefit Maximum Special Services - 15 Times the Daily Benefit

MATERNITY BENEFITS INCLUDED* — PERSONAL COVERAGE											MATERNITY BENEFITS INCLUDED* — DEPENDENT COVERAGE				
	% of Benefits on females											Split Rates			
Maximum Daily Benefit	Less than 11	11 21	21 31	31 41	41-51	51 61	61-71	71-81	81-91	91 and over	Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$ 7	$1.512	$1.585	$1.669	$1.743	$1.806	$1.890	$1.953	$2.026	$2.089	$2.163	$3.717	$1.858	$2.562	$4.420	$ 7
8	1.690	1.774	1.869	1.942	2.016	2.110	2.184	2.268	2.341	2.425	4.105	1.984	2.877	4.861	8
9	1.827	1.932	2.026	2.110	2.194	2.299	2.383	2.467	2.562	2.646	4.462	2.110	3.150	5.260	9
10	1.942	2.058	2.173	2.268	2.362	2.457	2.551	2.656	2.751	2.856	4.809	2.247	3.412	5.659	10
11	2.058	2.173	2.299	2.394	2.499	2.614	2.719	2.814	2.919	3.045	5.134	2.373	3.664	6.037	11
12	2.173	2.289	2.436	2.551	2.646	2.772	2.887	2.992	3.108	3.223	5.428	2.499	3.895	6.394	12
13	2.289	2.425	2.562	2.688	2.803	2.940	3.045	3.171	2.286	3.423	5.775	2.636	4.147	6.783	13
14	2.394	2.541	2.698	2.824	2.950	3.087	3.213	3.339	2.465	3.601	6.090	2.761	4.378	7.140	14
15	2.520	2.656	2.824	2.961	3.097	3.244	3.381	3.517	3.654	3.780	6.405	2.887	4.620	7.507	15
16	2.625	2.782	2.961	3.097	3.244	3.402	3.549	3.675	3.822	3.979	6.741	3.003	4.882	7.885	16
17	2.740	2.898	3.097	3.244	3.391	3.559	3.706	3.864	4.000	4.168	7.024	3.108	5.113	8.221	17
18	2.845	3.024	3.223	3.370	3.528	3.706	3.853	4.011	4.178	4.347	7.339	3.223	5.344	8.568	18
19	2.950	3.129	3.339	3.496	3.654	3.813	4.021	4.179	4.336	4.525	7.633	3.328	5.575	8.904	19
20	3.045	3.244	3.454	3.633	3.801	4.000	4.158	4.338	4.515	4.693	7.927	3.444	5.806	9.250	20

* Includes standard maternity benefit (maximum of 10 times daily benefit). The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $ 945 per $1.00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

COMBINED DISABILITY PREMIUM $1.000 OR LESS

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employee - Non-Occupational - No Industry Loading

Maximum Room and Board -- 31 TIMES the Daily Benefit Maximum Special Services -- 15 Times the Daily Benefit

	MATERNITY BENEFITS EXCLUDED											MATERNITY BENEFITS EXCLUDED				
	PERSONAL COVERAGE											DEPENDENT COVERAGE				
	$ of Benefits on Females												Split Rates			
Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over		Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$ 7	$1.491	$1.512	$1.543	$1.575	$1.606	$1.638	$1.669	$1.701	$1.722	$1.753		$2.961	$1.858	$1.785	$3.643	$ 7
8	1.659	1.690	1.722	1.753	1.785	1.827	1.858	1.890	1.921	1.953		3.234	1.984	1.984	3.969	8
9	1.795	1.837	1.869	1.900	1.932	1.974	2.016	2.047	2.089	2.110		3.486	2.110	2.152	4.263	9
10	1.911	1.953	1.995	2.037	2.068	2.100	2.142	2.184	2.226	2.268		3.717	2.247	2.299	4.546	10
11	2.026	2.068	2.100	2.142	2.184	2.226	2.268	2.299	2.341	2.394		3.927	2.373	2.436	4.809	11
12	2.131	2.173	2.226	2.268	2.299	2.341	2.394	2.436	2.478	2.520		4.137	2.499	2.562	5.061	12
13	2.247	2.289	2.331	2.383	2.425	2.478	2.509	2.562	2.604	2.656		4.357	2.635	2.698	5.334	13
14	2.352	2.404	2.446	2.499	2.541	2.593	2.635	2.688	2.730	2.772		4.567	2.761	2.824	5.586	14
15	2.467	2.509	2.562	2.614	2.667	2.709	2.761	2.814	2.866	2.888		4.767	2.887	2.950	5.838	15
16	2.572	2.625	2.677	2.719	2.782	2.835	2.887	2.929	2.982	3.034		4.987	3.003	3.097	6.100	16
17	2.688	2.730	2.793	2.845	2.898	2.950	3.003	3.066	3.108	3.160		5.176	3.108	3.223	6.331	17
18	2.782	2.845	2.898	2.950	3.003	3.066	3.108	3.171	3.234	3.286		5.365	3.223	3.339	6.562	18
19	2.887	2.940	3.003	3.055	3.108	3.171	3.234	3.286	3.339	3.402		5.554	3.328	3.465	6.793	19
20	2.982	3.045	3.097	3.160	3.223	3.286	3.339	3.402	3.465	3.517		5.743	3.444	3.580	7.024	20

COMBINED DISABILITY PREMIUM $1.000 OR LESS

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan – Schedule of Minimum Monthly Premiums Per Employee -- Non-Occupational -- No Industry Loading

Maximum Room and Board — 21 TIMES the Daily Benefit Maximum Special Services — 20 Times the Daily Benefit

MATERNITY BENEFITS INCLUDED*														
PERSONAL COVERAGE											DEPENDENT COVERAGE			
	% of Benefits on Females											Split Rates		
Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$ 7	$1.627	$1.711	$1.795	$1.869	$1.932	$2.016	$2.078	$2.162	$2.236	$2.310	$3.874	$1.890	$2.698	$4.588	$ 7
8	1.774	1.869	1.963	2.047	2.121	2.205	2.278	2.373	2.446	2.541	4.262	2.016	2.882	5.008	8
9	1.911	2.005	2.110	2.194	2.280	2.384	2.467	2.551	2.646	2.751	4.588	2.142	3.255	5.397	9
10	2.026	2.142	2.257	2.341	2.446	2.551	2.646	2.751	2.835	2.940	4.914	2.278	3.507	5.785	10
11	2.131	2.247	2.383	2.488	2.593	2.698	2.803	2.918	3.024	3.139	5.230	2.404	3.748	6.153	11
12	2.257	2.373	2.509	2.625	2.740	2.866	2.982	3.076	3.202	3.318	5.544	2.530	3.990	6.520	12
13	2.352	2.488	2.635	2.761	2.877	3.002	3.129	3.244	3.370	3.496	5.860	2.667	4.221	6.888	13
14	2.457	2.604	2.761	2.887	3.013	3.150	3.276	3.402	3.538	3 685	6.184	2.793	4.452	7.245	14
15	2.562	2.709	2.877	3.013	3.139	3.297	3.433	3.570	3.696	3.843	6.478	2.908	4.683	7.591	15
16	2.667	2.824	2 992	3 150	3.286	3 444	3.580	3.727	3.874	4.032	6.793	3.034	4.914	7.948	16
17	2.761	2.920	3.129	3.276	3.423	3 591	3.748	3.895	4.042	4.210	7.077	3.150	5.145	8.295	17
18	2.877	3.035	3.244	3.402	3.570	3.738	3.895	4.042	4.210	4.378	7.402	3.276	5.376	8.652	18
19	2.971	3.160	3 370	3.538	3.685	3.874	4.053	4.210	4.378	4.567	7.696	3 381	5.607	8.988	19
20	3.066	3.265	3.475	3.654	3.822	4.011	4.178	4.357	4.536	4.714	7.990	3.496	5 827	9.324	20

MATERNITY BENEFITS INCLUDED*
DEPENDENT COVERAGE

* Includes standard maternity benefit (maximum of 10 times daily benefit). The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $.945 per $1.00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

COMBINED DISABILITY PREMIUM $1.000 OR LESS
GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employee - Non-Occupational — No Industry Loading

Maximum Room and Board - 31 TIMES the Daily Benefit Maximum Special Services 20 Times the Daily Benefit

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

Maximum Daily Benefit	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$ 7	$1.606	$1.638	$1.669	$1.707	$1.752	$1.784	$1.795	$1.837	$1.869	$1.900
8	1.743	1.785	1.816	1.858	1.890	1.921	1.953	1.995	2.026	2.068
9	1.879	1.911	1.953	1.984	2.026	2.068	2.100	2.131	2.173	2.215
10	1.995	2.037	2.079	2.110	2.152	2.194	2.236	2.278	2.310	2.352
11	2.100	2.142	2.184	2.236	2.278	2.310	2.352	2.404	2.446	2.488
12	2.215	2.257	2.299	2.341	2.394	2.436	2.488	2.520	2.572	2.614
13	2.310	2.362	2.404	2.457	2.499	2.541	2.593	2.635	2.688	2.730
14	2.415	2.467	2.509	2.562	2.604	2.656	2.698	2.751	2.803	2.856
15	2.509	2.562	2.614	2.667	2.709	2.761	2.814	2.866	2.908	2.961
16	2.614	2.667	2.709	2.772	2.824	2.877	2.919	2.982	3.034	3.087
17	2.709	2.761	2.824	2.877	2.929	2.982	3.045	3.097	3.150	3.202
18	2.814	2.877	2.919	2.982	3.045	3.097	3.150	3.202	3.265	3.318
19	2.908	2.971	3.034	3.097	3.139	3.202	3.265	3.318	3.381	3.444
20	3.003	3.066	3.118	3.181	3.244	3.297	3.360	3.423	3.486	3.538

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$3.108	$1.890	$1.921	$3.811	$ 7
3.370	2.016	2.100	4.116	8
3.601	2.142	2.257	4.389	9
3.822	2.278	2.394	4.672	10
4.032	2.404	2.520	4.924	11
4.252	2.530	2.656	5.187	12
4.452	2.667	2.772	5.439	13
4.651	2.793	2.898	5.691	14
4.840	2.908	3.013	5.922	15
5.040	3.034	3.129	6.163	16
5.239	3.150	3.255	6.405	17
5.428	3.276	3.370	6.646	18
5.628	3.381	3.496	6.877	19
5.806	3.496	3.601	7.098	20

COMBINED DISABILITY PREMIUM $1.000 OR LESS

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan - Schedule of Minimum Monthly Premiums Per Employee Non-Occupational No Industry Loading

Maximum Room and Board - 31 DAYS Maximum Special Services - $100 in full plus 3/4 of next $1,200 with a maximum combined benefit of $1,000

MATERNITY BENEFITS INCLUDED*															
PERSONAL COVERAGE											DEPENDENT COVERAGE				
	% of Benefits on Females											Split Rates			
Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$ 7	$1.743	$1.827	$1.921	$1.995	$2.068	$2.152	$2.215	$2.289	$2.373	$2.446	$4.084	$1.974	$2.856	$4.830	$ 7
8	1.858	1.953	2.047	2.121	2.205	2.289	2.373	2.467	2.530	2.625	4.389	2.100	3.087	5.187	8
9	1.953	2.058	2.163	2.257	2.341	2.436	2.520	2.614	2.709	2.814	4.683	2.215	3.307	5.523	9
10	2.058	2.173	2.278	2.373	2.478	2.583	2.677	2.772	2.866	2.982	4.998	2.331	3.549	5.880	10
11	2.152	2.268	2.415	2.509	2.614	2.719	2.835	2.940	3.045	3.150	5.302	2.457	3.780	6.237	11
12	2.257	2.373	2.509	2.625	2.740	2.866	2.982	3.076	3.202	3.318	5.575	2.572	3.990	6.562	12
13	2.352	2.488	2.635	2.761	2.877	3.003	3.129	3.244	3.370	3.496	5.880	2.698	4.221	6.919	13
14	2.446	2.593	2.751	2.866	3.003	3.139	3.276	3.391	3.528	3.664	6.184	2.814	4.441	7.255	14
15	2.551	2.688	2.856	2.992	3.129	3.276	3.412	3.549	3.685	3.822	6.478	2.929	4.662	7.591	15
16	2.635	2.793	2.971	3.118	3.255	3.412	3.550	3.685	3.832	4.000	6.772	3.055	4.882	7.938	16
17	2.740	2.898	3.097	3.244	3.391	3.559	3.706	3.864	4.000	4.168	7.066	3.171	5.113	8.284	17
18	2.835	3.013	3.213	3.360	3.517	3.696	3.843	4.000	4.158	4.336	7.371	3.286	5.334	8.620	18
19	2.929	3.108	3.307	3.475	3.643	3.822	3.990	4.158	4.315	4.504	7.644	3.391	5.544	8.935	19
20	3.013	3.213	3.433	3.601	3.769	3.969	4.126	4.294	4.473	4.662	7.927	3.496	5.764	9.261	20

* Includes standard maternity benefit (maximum of 10 times daily benefit). The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $ 945 per $1.00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

COMBINED DISABILITY PREMIUM $1.000 OR LESS
GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan — Schedule of Minimum Monthly Premiums Per Employee — Non-Occupational — No Industry Loading

Maximum Room and Board 31 DAYS — Maximum Special Services $100 in full plus 3/4 of next $1,200 with a maximum combined benefit of $1,000

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

% of Benefits on Females

Maximum Daily Benefit	Less than 21	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91 and over
$ 7	$1 722	$1 753	$1 795	$1 827	$1 868	$1 900	$1 932	$1 963	$2 005	$2 037
8	1 827	1 869	1 900	1 932	1 974	2 005	2 047	2 089	2 110	2 152
9	1 921	1 963	2 005	2 047	2 079	2 110	2 152	2 194	2 236	2 278
10	2 026	2 068	2 100	2 142	2 184	2 226	2 268	2 299	2 341	2 391
11	2 121	2 163	2 215	2 257	2 299	2 331	2 383	2 425	2 467	2 499
12	2 215	2 257	2 299	2 341	2 394	2 436	2 488	2 520	2 572	2 614
13	2 310	2 362	2 404	2 457	2 499	2 541	2 593	2 635	2 688	2 730
14	2 404	2 457	2 499	2 541	2 593	2 646	2 698	2 740	2 793	2 835
15	2 499	2 541	2 593	2 646	2 698	2 740	2 793	2 845	2 898	2 940
16	2 583	2 635	2 688	2 740	2 793	2 845	2 898	2 950	2 992	3 045
17	2 688	2 730	2 793	2 845	2 898	2 950	3 003	3 066	3 108	3 160
18	2 772	2 835	2 887	2 940	2 992	3 055	3 097	3 160	3 213	3 276
19	2 866	2 919	2 971	3 034	3 097	3 150	3 202	3 265	3 318	3 381
20	2 950	3 013	3 076	3 129	3 192	3 255	3 307	3 360	3 423	3 486

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Maximum Daily Benefit	Flat Rates	Spouse Rates: Spouse only	Spouse & Child(ren)	Maximum Daily Benefit
$3 318	$1 974	$2 079	$4 053	$ 7
3 517	2 100	2 194	4 294	8
3 706	2 215	2 310	4 525	9
3 906	2 331	2 436	4 767	10
4 095	2 457	2 551	5 008	11
4 273	2 572	2 656	5 229	12
4 473	2 698	2 772	5 470	13
4 662	2 814	2 887	5 701	14
4 840	2 929	2 992	5 922	15
5 019	3 055	3 097	6 153	16
5 218	3 171	3 223	6 394	17
5 397	3 286	3 328	6 615	18
5 586	3 391	3 433	6 825	19
5 785	3 496	3 538	7 035	20

COMBINED DISABILITY PREMIUM $1.000 OR LESS
GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan - Schedule of Minimum Monthly Premiums Per Employee Non-Occupational No Industry Loading

Maximum Room and Board - 31 DAYS **Maximum Special Services - $200 in full plus 3/4 of next $2,400 with a maximum combined benefit of $2,000**

	MATERNITY BENEFITS INCLUDED*										MATERNITY BENEFITS INCLUDED*				
	PERSONAL COVERAGE										DEPENDENT COVERAGE				
	% of Benefits on Females											Split Rates			
Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$ 7	$1 816	$1 911	$1.995	$2 068	$2 131	$2.228	$2.299	$2 373	$2.457	$2.520	$4.200	$2 037	$2 929	$4 966	$ 7
8	1 932	2.026	2 131	2 205	2.289	2 383	2 457	2 551	2 635	2.719	4 515	2 152	3 101	5 334	8
9	2 037	2 142	2 247	2 331	2.425	2 530	2 614	2.709	2 793	2 898	4 819	2 278	3 402	5 680	9
10	2 131	2 247	2 362	2 467	2 572	2 667	2 761	2 877	2 971	3 076	5 113	2 394	3 633	6 027	10
11	2 236	2 352	2 499	2 583	2 698	2 814	2.929	3 024	3 129	3 255	5 428	2 509	3 874	6 384	11
12	2 341	2 457	2 593	2.719	2 824	2 950	3.066	3 171	3 297	3 402	5 712	2 646	4 084	6 730	12
13	2 425	2 562	2 719	2 824	2 950	3 087	3.213	3 318	3 444	3 580	6 037	2 772	4 315	7 087	13
14	2.520	2 656	2 824	2 950	3 087	3 213	3 349	3 475	3 612	3 738	6 321	2 898	4 525	7 423	14
15	2.625	2 772	2 940	3 066	3 213	3 370	3 507	3 633	3 769	3 916	6 636	3 013	4.767	7 780	15
16	2 730	2 877	3 066	3 213	3 339	3 507	3 654	3 801	3 947	4 095	6 930	3 129	4 998	8 127	16
17	2 824	3 003	3 192	3 339	3 486	3 664	3 801	3 958	4 105	4 263	7 224	3 255	5 218	8 473	17
18	2.929	3 097	3 297	3 454	3 622	3 790	3 948	4 105	4 263	4 441	7 518	3 360	5.439	8 799	18
19	3 024	3 213	3 423	3 580	3 748	3 937	4 105	4 273	4 441	4 620	7 801	3 475	5 650	9 135	19
20	3.118	3 307	3 528	3 706	3 874	4 074	4.262	4 420	4 588	4 777	8 106	3 580	5 890	9 471	20

* Includes standard maternity benefit (maximum of 10 times daily benefit). The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $.500 per $1.00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

- 1958 - Printed in U S A (7 59)

COMBINED DISABILITY PREMIUM $1.000 OR LESS
GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan · Schedule of Minimum Monthly Premiums Per Employee · Non-Occupational · No Industry Loading

Maximum Room and Board 31 DAYS · Maximum Special Services $200 in full plus 3/4 of next $2,400 with a maximum combined benefit of $2,000

MATERNITY BENEFITS EXCLUDED															
PERSONAL COVERAGE											DEPENDENT COVERAGE				
	% of Benefits on Females											Split Rates			
Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$ 7	$1.785	$1.837	$1.889	$1.940	$1.992	$1.974	$2.016	$2.047	$2.089	$2.110	$3.433	$2.037	$2.152	$4.189	$ 7
8	1.900	1.942	1.984	2.026	2.058	2.100	2.131	2.173	2.215	2.247	3.643	2.152	2.289	4.441	8
9	2.005	2.047	2.089	2.121	2.163	2.205	2.247	2.289	2.320	2.362	3.832	2.278	2.404	4.683	9
10	2.100	2.142	2.184	2.236	2.278	2.310	2.352	2.404	2.446	2.488	4.021	2.394	2.520	4.914	10
11	2.205	2.247	2.299	2.331	2.383	2.425	2.478	2.509	2.551	2.604	4.221	2.509	2.646	5.155	11
12	2.299	2.341	2.383	2.436	2.478	2.520	2.572	2.614	2.667	2.698	4.420	2.646	2.751	5.397	12
13	2.383	2.436	2.488	2.520	2.572	2.625	2.677	2.709	2.761	2.814	4.609	2.772	2.866	5.638	13
14	2.478	2.520	2.572	2.625	2.677	2.719	2.772	2.824	2.877	2.919	4.798	2.898	2.971	5.869	14
15	2.572	2.625	2.677	2.719	2.782	2.835	2.887	2.929	2.982	3.034	4.998	3.013	3.097	6.111	15
16	2.677	2.719	2.782	2.835	2.887	2.940	2.992	3.055	3.097	3.150	5.187	3.129	3.213	6.342	16
17	2.772	2.835	2.887	2.940	2.992	3.055	3.097	3.160	3.213	3.276	5.376	3.255	3.328	6.583	17
18	2.866	2.919	2.971	3.034	3.097	3.150	3.202	3.265	3.318	3.381	5.566	3.360	3.433	6.793	18
19	2.961	3.024	3.087	3.139	3.202	3.265	3.318	3.381	3.444	3.496	5.703	3.475	3.549	7.024	19
20	3.055	3.108	3.171	3.234	3.297	3.360	3.423	3.486	3.538	3.601	5.922	3.580	3.664	7.245	20

COMBINED DISABILITY PREMIUM $1.000 OR LESS
GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan -- Schedule of Minimum Monthly Premiums Per Employee - Non-Occupational - No Industry Loading

Maximum Room and Board -- 70 TIMES the Daily Benefit — Maximum Special Services - 10 Times the Daily Benefit

	MATERNITY BENEFITS INCLUDED*										MATERNITY BENEFITS INCLUDED*				
	PERSONAL COVERAGE										DEPENDENT COVERAGE				
	$ of Benefits on Females											Split Rates			
Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	Flat Rates	Child(ren) Only	Male Only	Male & Child(ren)	Maximum Daily Benefits
$ 7	$1.438	$1.522	$1.596	$1.669	$1.732	$1.818	$1.869	$1.942	$2.016	$2.079	$3.843	$1.869	$2.478	$4.347	$ 7
8	1.617	1.701	1.785	1.869	1.942	2.026	2.100	2.184	2.257	2.341	4.042	2.005	2.783	4.798	8
9	1.764	1.858	1.963	2.047	2.131	2.236	2.310	2.394	2.478	2.583	4.389	2.131	3.076	5.208	9
10	1.900	2.016	2.121	2.215	2.310	2.415	2.489	2.604	2.688	2.793	4.767	2.268	3.360	5.628	10
11	2.026	2.142	2.278	2.362	2.467	2.583	2.688	2.793	2.887	3.003	5.113	2.404	3.622	6.027	11
12	2.163	2.278	2.415	2.530	2.635	2.761	2.866	2.971	3.087	3.202	5.428	2.530	3.874	6.405	12
13	2.289	2.415	2.572	2.688	2.803	2.929	3.055	3.171	3.286	3.423	5.796	2.667	4.147	6.814	13
14	2.404	2.551	2.709	2.835	2.961	3.087	3.223	3.349	3.475	3.622	6.121	2.793	4.389	7.182	14
15	2.530	2.677	2.835	2.971	3.108	3.245	3.391	3.528	3.664	3.801	6.457	2.929	4.641	7.570	15
16	2.648	2.803	2.982	3.129	3.265	3.423	3.570	3.706	3.853	4.000	6.783	3.055	4.893	7.948	16
17	2.761	2.929	3.118	3.265	3.423	3.591	3.738	3.885	4.032	4.200	7.088	3.181	5.145	8.326	17
18	2.887	3.055	3.265	3.412	3.580	3.748	3.906	4.063	4.221	4.389	7.444	3.307	5.397	8.704	18
19	3.003	3.192	3.391	3.559	3.717	3.906	4.084	4.242	4.410	4.588	7.749	3.423	5.638	9.061	19
20	3.118	3.318	3.538	3.706	3.874	4.074	4.242	4.420	4.599	4.777	8.074	3.538	5.890	9.439	20

* Includes standard maternity benefit (maximum of 10 times daily benefit). The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $.945 per $1.00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

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COMBINED DISABILITY PREMIUM $1.000 OR LESS
GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employee Non-Occupational No Industry Loading

Maximum Room and Board 70 TIMES the Daily Benefit Maximum Special Services 10 Times the Daily Benefit

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

% of Benefits on Females

Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$ 7	$1.417	$1.449	$1.470	$1.501	$1.533	$1.564	$1.585	$1.617	$1.648	$1.669
8	1.585	1.617	1.648	1.680	1.711	1.743	1.774	1.806	1.837	1.869
9	1.732	1.764	1.806	1.837	1.869	1.911	1.942	1.974	2.005	2.047
10	1.869	1.911	1.942	1.984	2.016	2.058	2.089	2.131	2.163	2.205
11	1.995	2.037	2.079	2.110	2.152	2.194	2.236	2.278	2.310	2.352
12	2.121	2.163	2.205	2.247	2.289	2.331	2.373	2.415	2.457	2.499
13	2.247	2.289	2.341	2.383	2.425	2.467	2.520	2.562	2.604	2.656
14	2.362	2.415	2.457	2.509	2.551	2.604	2.646	2.698	2.740	2.793
15	2.478	2.530	2.572	2.625	2.677	2.730	2.772	2.824	2.877	2.919
16	2.593	2.646	2.698	2.751	2.803	2.856	2.908	2.961	3.013	3.055
17	2.709	2.761	2.814	2.866	2.929	2.982	3.034	3.087	3.139	3.192
18	2.824	2.877	2.940	2.992	3.055	3.108	3.160	3.223	3.276	3.328
19	2.940	3.003	3.055	3.118	3.171	3.234	3.297	3.349	3.412	3.465
20	3.055	3.118	3.181	3.234	3.297	3.360	3.423	3.486	3.549	3.601

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Maximum Daily Benefit	Flat Rates	Split Rates: Child(ren) Only	Split Rates: Wife Only	Split Rates: Wife & Child(ren)
$ 7	$2.077	$1.869	$1.701	$3.570
8	3.171	2.005	1.900	3.906
9	3.423	2.131	2.079	4.210
10	3.675	2.268	2.247	4.515
11	3.906	2.404	2.394	4.798
12	4.137	2.530	2.541	5.071
13	4.378	2.667	2.698	5.365
14	4.599	2.793	2.835	5.628
15	4.819	2.929	2.971	5.901
16	5.029	3.055	3.108	6.163
17	5.260	3.181	3.255	6.436
18	5.470	3.307	3.391	6.699
19	5.680	3.423	3.528	6.951
20	5.890	3.538	3.664	7.203

COMBINED DISABILITY PREMIUM $1.000 OR LESS

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employee Non-Occupational No Industry Loading

Maximum Room and Board 70 TIMES the Daily Benefit Maximum Special Services 15 Times the Daily Benefit

Maximum Daily Benefit	MATERNITY BENEFITS INCLUDED* PERSONAL COVERAGE $ of Benefits on Females										MATERNITY BENEFITS INCLUDED* DEPENDENT COVERAGE				
												Split Rates			
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$ 7	$1.585	$1.669	$1.753	$1.837	$1.890	$1.974	$2.037	$2.110	$2.184	$2.257	$3.878	$1.953	$2.656	$1.609	$ 7
8	1.774	1.858	1.963	2.037	2.110	2.205	2.278	2.362	2.446	2.530	4.281	2.089	2.982	5.071	8
9	1.921	2.026	2.121	2.215	2.299	2.404	2.488	2.572	2.667	2.761	4.631	2.226	3.265	5.491	9
10	2.047	2.163	2.278	2.373	2.467	2.572	2.667	2.772	2.866	2.971	4.998	2.362	3.528	5.890	10
11	2.163	2.278	2.415	2.509	2.614	2.730	2.835	2.940	3.045	3.171	5.341	2.499	3.790	6.289	11
12	2.289	2.404	2.551	2.667	2.772	2.898	3.013	3.118	3.234	3.360	5.659	2.635	4.032	6.667	12
13	2.404	2.541	2.688	2.814	2.929	3.066	3.181	3.307	3.423	3.559	6.006	2.772	4.284	7.056	13
14	2.520	2.667	2.824	2.950	3.087	3.223	3.349	3.475	3.612	3.748	6.331	2.908	4.525	7.434	14
15	2.646	2.793	2.961	3.097	3.234	3.391	3.528	3.664	3.801	3.937	6.657	3.034	4.777	7.812	15
16	2.761	2.919	3.097	3.244	3.391	3.549	3.696	3.832	3.979	4.137	6.993	3.160	5.040	8.200	16
17	2.877	3.015	3.244	3.391	3.549	3.717	3.864	4.021	4.168	4.336	7.297	3.276	5.281	8.557	17
18	2.992	3.171	3.370	3.528	3.685	3.864	4.021	4.179	4.347	4.515	7.623	3.391	5.523	8.914	18
19	3.097	3.286	3.496	3.654	3.822	4.011	4.189	4.347	4.515	4.704	7.917	3.507	5.754	9.261	19
20	3.202	3.402	3.622	3.801	3.969	4.168	4.338	4.515	4.693	4.882	8.232	3.622	5.995	9.618	20

* Includes standard maternity benefit (maximum of 10 times daily benefit). The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $ 94 per $1.00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

COMBINED DISABILITY PREMIUM $1.000 OR LESS

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employee Non-Occupational No Industry Loading

Maximum Room and Board - 70 TIMES the Daily Benefit Maximum Special Services 15 Times the Daily Benefit

MATERNITY BENEFITS EXCLUDED															
PERSONAL COVERAGE											DEPENDENT COVERAGE				
	% of Benefits on Females											Split Rates			
Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$ 7	$1.564	$1.596	$1.627	$1.659	$1.690	$1.722	$1.753	$1.785	$1.816	$1.848	$3.108	$1.953	$1.879	$3.832	$ 7
8	1.743	1.774	1.816	1.848	1.879	1.921	1.953	1.984	2.026	2.058	3.462	2.089	2.089	4.179	8
9	1.890	1.932	1.963	2.005	2.037	2.079	2.121	2.152	2.194	2.226	3.864	2.226	2.268	4.494	9
10	2.016	2.058	2.100	2.142	2.173	2.215	2.257	2.299	2.341	2.383	3.906	2.362	2.415	4.777	10
11	2.131	2.173	2.215	2.257	2.299	2.341	2.383	2.425	2.467	2.520	4.137	2.499	2.562	5.061	11
12	2.247	2.289	2.341	2.383	2.425	2.467	2.520	2.562	2.604	2.656	4.357	2.635	2.698	5.334	12
13	2.362	2.415	2.457	2.509	2.551	2.604	2.646	2.698	2.740	2.793	4.578	2.772	2.835	5.607	13
14	2.478	2.530	2.572	2.625	2.677	2.730	2.772	2.824	2.877	2.919	4.798	2.908	2.971	5.880	14
15	2.593	2.646	2.698	2.751	2.803	2.856	2.908	2.961	3.013	3.055	5.019	3.034	3.108	6.142	15
16	2.709	2.761	2.814	2.866	2.929	2.982	3.034	3.087	3.139	3.192	5.239	3.160	3.255	6.415	16
17	2.824	2.877	2.940	2.992	3.055	3.108	3.160	3.223	3.276	3.328	5.449	3.276	3.391	6.687	17
18	2.929	2.992	3.045	3.108	3.160	3.223	3.276	3.339	3.402	3.454	5.649	3.391	3.517	6.909	18
19	3.034	3.097	3.160	3.213	3.276	3.339	3.402	3.454	3.517	3.580	5.848	3.507	3.643	7.150	19
20	3.139	3.202	3.265	3.328	3.391	3.454	3.517	3.580	3.643	3.706	6.048	3.622	3.769	7.392	20

COMBINED DISABILITY PREMIUM $1.000 OR LESS
GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employee - Non-Occupational - No Industry Loading

Maximum Room and Board — 70 TIMES the Daily Benefit Maximum Special Services — 20 Times the Daily Benefit

MATERNITY BENEFITS INCLUDED* — PERSONAL COVERAGE — % of Benefits on Females											MATERNITY BENEFITS INCLUDED* — DEPENDENT COVERAGE				
												Split Rates			
Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$ 7	$1.711	$1.795	$1.879	$1.963	$2.026	$2.110	$2.173	$2.257	$2.331	$2.404	$4.042	$1.984	$2.883	$4.788	$ 7
8	1.869	1.963	2.058	2.142	2.215	2.310	2.383	2.478	2.551	2.646	4.620	2.121	3.097	5.218	8
9	2.005	2.110	2.215	2.299	2.394	2.499	2.583	2.667	2.761	2.866	4.767	2.257	3.370	5.628	9
10	2.131	2.247	2.362	2.457	2.562	2.667	2.761	2.866	2.961	3.066	5.113	2.394	3.633	6.027	10
11	2.247	2.362	2.499	2.604	2.709	2.824	2.929	3.045	3.150	3.265	5.449	2.530	3.885	6.415	11
12	2.373	2.488	2.635	2.751	2.866	2.992	3.108	3.213	3.339	3.454	5.764	2.667	4.126	6.793	12
13	2.478	2.614	2.761	2.887	3.013	3.139	3.265	3.381	3.507	3.643	6.100	2.803	4.368	7.171	13
14	2.583	2.730	2.898	3.024	3.150	3.286	3.423	3.549	3.685	3.822	6.415	2.940	4.599	7.539	14
15	2.698	2.845	3.013	3.150	3.286	3.444	3.580	3.717	3.853	4.000	6.741	3.066	4.840	7.906	15
16	2.803	2.961	3.139	3.297	3.433	3.591	3.738	3.885	4.032	4.189	7.056	3.192	5.082	8.274	16
17	2.908	3.076	3.276	3.423	3.580	3.748	3.906	4.053	4.210	4.378	7.350	3.318	5.313	8.631	17
18	3.024	3.202	3.402	3.559	3.727	3.895	4.063	4.210	4.378	4.557	7.686	3.444	5.554	8.998	18
19	3.129	3.318	3.528	3.696	3.853	4.042	4.221	4.389	4.557	4.746	7.980	3.559	5.785	9.345	19
20	3.223	3.423	3.643	3.822	3.990	4.189	4.357	4.536	4.714	4.903	8.284	3.675	6.016	9.691	20

* Includes standard maternity benefit (maximum of 10 times daily benefit). The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $.945 per $1.00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

COMBINED DISABILITY PREMIUM $1.000 OR LESS
GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employee Non-Occupational No Industry Loading

Maximum Room and Board — 70 TIMES the Daily Benefit Maximum Special Services — 20 Times the Daily Benefit

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

% of Benefits on Females

Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$ 7	$1.690	$1.722	$1.753	$1.785	$1.817	$1.858	$1.890	$1.932	$1.963	$1.995
8	1.837	1.879	1.911	1.953	1.984	2.026	2.058	2.100	2.131	2.173
9	1.974	2.016	2.058	2.089	2.131	2.173	2.215	2.247	2.289	2.331
10	2.100	2.142	2.184	2.226	2.268	2.310	2.352	2.394	2.436	2.478
11	2.215	2.257	2.299	2.352	2.394	2.436	2.478	2.520	2.572	2.614
12	2.331	2.373	2.425	2.467	2.520	2.562	2.614	2.656	2.709	2.751
13	2.436	2.488	2.530	2.583	2.635	2.677	2.720	2.772	2.824	2.877
14	2.541	2.593	2.646	2.698	2.740	2.793	2.845	2.898	2.950	3.002
15	2.646	2.698	2.751	2.803	2.856	2.908	2.961	3.013	3.066	3.118
16	2.751	2.803	2.856	2.919	2.971	3.024	3.076	3.139	3.192	3.244
17	2.856	2.908	2.971	3.024	3.087	3.139	3.202	3.255	3.318	3.370
18	2.961	3.024	3.076	3.139	3.202	3.255	3.318	3.370	3.433	3.496
19	3.066	3.128	3.192	3.255	3.307	3.370	3.433	3.496	3.559	3.622
20	3.160	3.223	3.286	3.349	3.412	3.475	3.538	3.601	3.664	3.727

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Maximum Daily Benefit	Flat Rates	Split Rates: Child(ren) Only	Split Rates: Wife Only	Split Rates: Wife & Child(ren)
$ 7	$3 276	$1.984	$2 026	$4 011
8	3 538	2.121	2 205	4 326
9	3 780	2.257	2 373	4 630
10	4 021	2.394	2.520	4.914
11	4 252	2 530	2 656	5 187
12	4 473	2 667	2.793	5.460
13	4 683	2.803	2 919	5.722
14	4 893	2 940	3 045	5 985
15	5 103	3.066	3 171	6.237
16	5 302	3 192	3 297	6.489
17	5 512	3 318	3.423	6 741
18	5 712	3 444	3.549	6.993
19	5 911	3 570	3.675	7.234
20	6 100	3.675	3.780	7.465

COMBINED DISABILITY PREMIUM $1.000 OR LESS
GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan - Schedule of Minimum Monthly Premiums Per Employee Non-Occupational No Industry Loading

Maximum Room and Board 70 DAYS Maximum Special Services $100 in full plus 3/4 of next $1,200 with a maximum combined benefit of $1,000

MATERNITY BENEFITS INCLUDED*											MATERNITY BENEFITS INCLUDED*				
PERSONAL COVERAGE											DEPENDENT COVERAGE				
	% of Benefits on Females											Split Rates			
Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$ 7	$1.837	$1.931	$2.016	$2.089	$2.163	$2 247	$2 320	$2.394	$2.478	$2.551	$1.252	$2 079	$2 961	$5.040	$ 7
8	1.953	2.047	2 142	2 226	2 310	2 394	2 478	2.572	2 646	2.740	4 578	2 205	3 202	5 407	8
9	2.058	2.163	2 268	2 362	2 446	2 551	2.635	2.730	2.824	2.929	4 882	2.331	3 433	5.764	9
10	2 163	2.278	2 394	2 488	2 593	2 698	2.793	2 898	2.992	3.108	5 197	2.457	3 675	6.132	10
11	2 268	2.383	2 530	2 625	2 730	2 845	2.961	3 066	3 171	3 286	5 523	2 583	3 916	6 499	11
12	2 373	2.488	2 635	2.751	2 866	2 992	3.108	3.213	3.339	3 454	5 796	2.709	4 126	6.835	12
13	2 478	2.814	2.761	2 887	3 013	3 139	3.265	3.381	3 507	3.643	6 121	2 835	4.368	7 203	13
14	2.572	2 719	2 887	3 003	3.139	3 276	3 412	3.538	3 675	3 811	6 426	2 961	4 588	7 549	14
15	2.677	2 824	2 992	3 129	3 265	3 423	3 559	3 696	3 832	3 979	6 730	3 087	4 819	7.906	15
16	2.772	2 929	3 108	3 265	3 402	3 559	3 706	3 843	3 990	4 158	7 035	3 213	5 050	8.263	16
17	2.877	3 045	3 244	3 391	3 549	3 717	3 864	4 021	4 168	4 336	7 339	3 339	5 281	8.620	17
18	2 982	3.160	3 360	3 517	3.675	3 853	4 011	4.168	4.326	4 504	7 654	3 454	5 512	8 967	18
19	3 076	3 265	3 465	3 633	3 801	3 990	4.158	4 326	4 494	4 683	7 927	3 570	5 722	9 292	19
20	3.171	3 370	3 591	3 769	3 937	4 137	4 305	4 473	4 651	4 840	8 232	3 685	5 953	9 639	20

* Includes standard maternity benefit (maximum of 10 times daily benefit). The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SUM OF PREMIUM OF $ 945 per $1.00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

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COMBINED DISABILITY PREMIUM $1.000 OR LESS
GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan Schedule of Minimum Monthly Premiums Per Employee Non-Occupational No Industry Loading

Maximum Room and Board 70 DAYS Maximum Special Services $100 in full plus 3/4 of next $1,200 with a maximum combined benefit of $1,000

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

Total Benefits as Indicated

Maximum Daily Benefit	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$ 7	$1.816	$1.848	$1.880	$1.921	$1.963	$1.995	$2.037	$2.068	$2.110	$2.142
8	1.921	1.963	1.995	2.037	2.079	2.110	2.152	2.194	2.226	2.268
9	2.026	2.068	2.110	2.152	2.184	2.226	2.268	2.310	2.352	2.394
10	2.131	2.173	2.215	2.257	2.299	2.341	2.383	2.425	2.467	2.520
11	2.236	2.278	2.331	2.373	2.415	2.457	2.509	2.551	2.593	2.635
12	2.331	2.373	2.425	2.467	2.520	2.562	2.614	2.656	2.709	2.751
13	2.436	2.488	2.530	2.583	2.635	2.677	2.730	2.772	2.824	2.877
14	2.530	2.583	2.635	2.677	2.730	2.782	2.835	2.887	2.940	2.982
15	2.625	2.677	2.730	2.782	2.835	2.887	2.940	2.992	3.045	3.097
16	2.719	2.772	2.824	2.887	2.940	2.992	3.045	3.097	3.150	3.213
17	2.824	2.877	2.930	2.992	3.055	3.108	3.160	3.223	3.276	3.328
18	2.919	2.982	3.034	3.097	3.150	3.213	3.265	3.328	3.381	3.444
19	3.013	3.076	3.129	3.192	3.255	3.318	3.370	3.433	3.496	3.559
20	3.108	3.171	3.234	3.297	3.360	3.423	3.486	3.538	3.601	3.664

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Flat Rates	Split Rates: (Children) Only	Split Rates: Wife Only	Split Rates: Wife & Child(ren)	Maximum Daily Benefit
$3.496	$2.079	$2.184	$4.263	$ 7
3.696	2.205	2.310	4.515	8
3.906	2.331	2.436	4.767	9
4.105	2.457	2.562	5.019	10
4.315	2.583	2.688	5.271	11
4.494	2.709	2.793	5.502	12
4.704	2.835	2.919	5.754	13
4.903	2.961	3.034	5.995	14
5.092	3.087	3.150	6.237	15
5.292	3.213	3.265	6.478	16
5.491	3.339	3.391	6.730	17
5.680	3.454	3.507	6.961	18
5.859	3.570	3.612	7.182	19
6.048	3.685	3.727	7.413	20

COMBINED DISABILITY PREMIUM $1.000 OR LESS
GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan -- Schedule of Minimum Monthly Premiums Per Employee Non-Occupational No Industry Loading

Maximum Room and Board 70 DAYS Maximum Special Services $200 in full plus 3/4 of next $2,400 with a maximum combined benefit of $2,000

MATERNITY BENEFITS INCLUDED* — PERSONAL COVERAGE											MATERNITY BENEFITS INCLUDED* — DEPENDENT COVERAGE				
	% of Benefits on Females											Split Rates			
Maximum Daily Benefit:	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over	Flat Rates	Child(ren) Only	Wife Only	Wife & Child(ren)	Maximum Daily Benefit
$ 7	$1.911	$2.005	$2.089	$2.173	$2.236	$2.331	$2.404	$2.478	$2.562	$2 635	$4 378	$2 142	$3.045	$5 187	$ 7
8	2 037	2.131	2.236	2 310	2.394	2.488	2.572	2 667	2.751	2 835	4 704	2 288	3 297	5 565	8
9	2.142	2.247	2 352	2.446	2.541	2.646	2.730	2 824	2.919	3 024	5 019	2.394	3 528	5 922	9
10	2 247	2.362	2.478	2 583	2.688	2.793	2.887	3.003	3.097	3.202	5 334	2.520	3.769	6 289	10
11	2.352	2.467	2 614	2.709	2.824	2.940	3.055	3.160	3.265	3.391	5.649	2.646	4 011	6 657	11
12	2.457	2.583	2.719	2.845	2.950	3.087	3.202	3.307	3.433	3.548	5.943	2.782	4 231	7 014	12
13	2.551	2.688	2.845	2.961	3.087	3.223	3.349	3 465	3.591	3.727	6 268	2 919	4.462	7 381	13
14	2.646	2 793	2 961	3 087	3.223	3 360	3.496	3.622	3.759	3 906	6.573	3.045	4 683	7 728	14
15	2.761	2.908	3.076	3.213	3.360	3.517	3.654	3.790	3.927	4.074	6.888	3.171	4 924	8.095	15
16	2.866	3.024	3.213	3.360	3.496	3.664	3 811	3.958	4 105	4.263	7 203	3.297	5.166	8 463	16
17	2.971	3.150	3 339	3 496	3.643	3 822	3.969	4 126	4.273	4 452	7 507	3.423	5 397	8 820	17
18	3.087	3.265	3 475	3.622	3.790	3 969	4.137	4.284	4 452	4.630	7.833	3 538	5 638	9 177	18
19	3.181	3.370	3.580	3.748	3.916	4.105	4 284	4.452	4 620	4 798	8 106	3.654	5.848	9 502	19
20	3.276	3.475	3 696	3.874	4 042	4.252	4.420	4.599	4 777	4 968	8 410	3.769	6 079	9 849	20

* Includes standard maternity benefit (maximum of 10 times daily benefit). The personal rates provide immediate maternity benefits for female employees becoming insured on or within 31 days after the issue date of the Group Policy. The dependent rates exclude benefits for pregnancy existing on the issue date of the dependent insurance. To include standard maternity benefits for pregnancy existing on the issue date of the dependent insurance an ADDITIONAL SINGLE PREMIUM OF $.945 per $1.00 will be charged for all employees with dependent wives becoming insured on or within 31 days after the issue date.

COMBINED DISABILITY PREMIUM $1,000 OR LESS

GROUP HOSPITAL EXPENSE INSURANCE

Reimbursement Plan — Schedule of Minimum Monthly Premiums Per Employee — Non-Occupational — No Industry Loading

Maximum Room and Board — 70 DAYS Maximum Special Services — $200 in full plus 3/4 of next $2,400 with a maximum combined benefit of $2,000

MATERNITY BENEFITS EXCLUDED

PERSONAL COVERAGE

Maximum Daily Benefit	% of Benefits on Females									
	Less than 11	11-21	21-31	31-41	41-51	51-61	61-71	71-81	81-91	91 and over
$ 7	$1.890	$1.932	$1.983	$2.005	$2.037	$2.079	$2.121	$2.152	$2.194	$2.226
8	2.005	2.047	2.089	2.121	2.163	2.205	2.247	2.289	2.331	2.363
9	2.110	2.152	2.194	2.236	2.278	2.320	2.362	2.404	2.446	2.488
10	2.215	2.257	2.299	2.352	2.394	2.436	2.478	2.530	2.572	2.614
11	2.320	2.362	2.415	2.457	2.509	2.551	2.604	2.646	2.688	2.740
12	2.415	2.467	2.509	2.562	2.604	2.656	2.709	2.751	2.803	2.845
13	2.509	2.562	2.614	2.656	2.709	2.761	2.814	2.856	2.908	2.961
14	2.604	2.656	2.709	2.761	2.814	2.866	2.919	2.971	3.024	3.076
15	2.709	2.761	2.814	2.866	2.929	2.982	3.034	3.087	3.139	3.192
16	2.814	2.866	2.929	2.982	3.034	3.087	3.150	3.213	3.265	3.318
17	2.919	2.982	3.034	3.097	3.150	3.213	3.265	3.328	3.381	3.444
18	3.034	3.087	3.150	3.202	3.265	3.328	3.391	3.444	3.507	3.570
19	3.118	3.181	3.244	3.307	3.370	3.433	3.496	3.559	3.622	3.675
20	3.213	3.276	3.339	3.402	3.465	3.538	3.601	3.664	3.727	3.790

MATERNITY BENEFITS EXCLUDED

DEPENDENT COVERAGE

Flat Rates	Split Rates			Maximum Daily Benefit
	Child(ren) Only	Wife Only	Wife & Child(ren)	
$3.612	$2.142	$3.268	$4.410	$ 7
3.822	2.268	3.404	4.672	8
4.032	2.394	3.530	4.924	9
4.242	2.520	3.656	5.176	10
4.452	2.646	3.782	5.428	11
4.651	2.782	3.898	5.680	12
4.851	2.919	3.913	5.932	13
5.050	3.045	3.129	6.174	14
5 250	3.171	3.255	6.426	15
5.460	3.297	3.381	6.678	16
5.630	3.433	3.507	6.930	17
6.090	3.538	3.633	7.171	18
6.037	3.654	3 738	7.382	19
6.236	3.769	3.853	7.623	20

COMBINED DISABILITY PREMIUM $1,000 OR LESS
GROUP HOSPITAL EXPENSE INSURANCE

Reduction in Premium Rates for "Deductible" Hospital Expense Insurance Plans.

If the Hospital Expense Plan includes a "deductible" arrangement whereby the employee is to pay the first $25 or $50 of the charges for room and board and special services otherwise payable under the Plan, the monthly premium per employee for the basic Plan is reduced in accordance with the following table:

PERSONAL COVERAGE

% of Benefits on Females

Deductible	Less than 11	11 - 21	21 - 31	31 - 41	41 - 51	51 - 61	61 - 71	71 - 81	81 - 91	91 and over
$25	$ .472	$ .493	$ .504	$ .514	$ .535	$ .546	$ .556	$ .577	$ .588	$ .609
$50	.997	1.039	1.061	1.113	1.155	1.197	1.228	1.270	1.302	1.333

DEPENDENT COVERAGE

Deductible	FLAT RATE	SPLIT RATES		
		Child(ren) Only	Wife Only	Wife & Child(ren)
$25	$ 1.260	$ .997	$ .630	$ 1.627
$50	2.625	1.995	1.365	3.360

GROUP HOSPITAL EXPENSE INSURANCE

Reduction in Premium Rates for "Deductible" Hospital Expense Insurance Plans.

If the Hospital Expense Plan includes a "deductible" arrangement whereby the employee is to pay the first $25 or $50 of the charges for room and board and special services otherwise payable under the Plan, the monthly premium per employee for the basic Plan is reduced in accordance with the following table:

PERSONAL COVERAGE

Deductible	% of Benefits on Females									
	less than 11	11 - 21	21 - 31	31 - 41	41 - 51	51 - 61	61 - 71	71 - 81	81 - 91	91 and over
$25	$.30	$.31	$.32	$.34	$.35	$.36	$.38	$.39	$.40	$.41
$50	.72	.75	.78	.81	.84	.87	.90	.93	.96	.99

DEPENDENT COVERAGE

Deductible	FLAT RATE	SPLIT RATES		
		Child(ren) Only	Wife Only	Wife & Child(ren)
$25	$ .82	$ .67	$ .42	$1.09
$50	1.90	1.48	1.02	2 50

GROUP DIAGNOSTIC X-RAY AND LABORATORY EXAMINATION INSURANCE

(Non-Occupational)

Coverage:

Benefits may cover employees only or employees and dependents.

Reimbursement, up to the maximum specified in the plan, for the cost of Diagnostic X-Rays and Laboratory Examinations when such examinations are made outside a hospital or if in a hospital when time spent in hospital is not sufficient to qualify for reimbursement of such charges under Hospital Expense coverage.

Plan may include both X-Ray and Laboratory reimbursement or may be limited to reimbursement for X-Ray Examination only.

Plan may provide a maximum for each type of examination performed (scheduled basis) or may provide an overall maximum for all examinations (unscheduled basis).

Exclusions:

Benefits are not payable for examination of the urine or X-Ray therapy treatment nor for any examination which is made:

(a) during hospital confinement and for which a charge is made by the hospital;

(b) in connection with dental work or treatment;

(c) because of pregnancy or resulting childbirth or complications;

(d) if reimbursement for such examination is otherwise payable under the Group Plan.

Underwriting:

Written only in conjunction with Metropolitan Hospital Expense Insurance. (If less than 50 lives, Life or Accident and Sickness must also be included.)

Maximum benefit:

On a scheduled basis

$50 for examinations due to any one accident.
$50 for all examinations during any 12 consecutive months due to sickness.

For schedule of reimbursement, see reverse side of [illegible]

On an unscheduled basis

$25 or $50 for all examinations due to any one accident;
$25 or $50 for all examinations during any 12 consecutive months due to sickness.

Rates:

Minimum table [illegible]

Industry loadings [illegible]

Also see page 8-10 and [illegible] page 8-11 [illegible] employees age 60 and over.

GROUP DIAGNOSTIC X-RAY AND LABORATORY EXAMINATION INSURANCE

(Non-Occupational)

Schedule of Diagnostic X-Ray and Laboratory Examinations

X-Ray Examinations	Maximum Payment	Laboratory Examinations	Maximum Payment
Abdominal Region		Electrocardiogram	
Gastro-intestinal series - barium meal	$25.00	With interpretation	$10.00
Colon - barium enema	15.00	Without interpretation	7.50
Gall Bladder, dye method	15.00	Sugar tolerance test, involving two or more blood sugar determinations and accompanying urinary sugar determinations	10.00
Flat film	10.00	All other laboratory examinations (except urine examinations)	5.00
Kidney, ureter or bladder:			
dye method - intravenous	10.00		
dye method - retrograde pyelogram	20.00		
Arm or Leg	5.00		
Chest region			
Heart and lungs	10.00		
Fluoroscopic	15.00		
Head - skull, sinuses or lower jaw (except dental X-Ray)	10.00		
Pelvis, hip, spine or shoulder	10.00		
Ribs - one side	10.00		

NOTE: When X-Ray only is written only the examinations in the left hand column above are applicable.