OPTIONAL ENDORSEMENT

TO

Certificate Form Nos. MTWPMACERT (1/99)

The foregoing certificate forms are hereby amended as follows:

Schedule of Benefits

A. **COMPREHENSIVE MAJOR MEDICAL EXPENSE PLAN:** The following services and treatments are covered at the benefit levels set forth below subject to the terms, limitations, and exclusions of the policy.

1. **Individual Annual Deductible and Annual Out-of-Pocket Benefits:**

* * *

(b) **Individual Annual Maximum Out-of-Pocket Payout:**

150 Plan:	~~**$1,000**~~	**$2,000**
300 Plan:	~~**$1,200**~~	**$2,400**
500 Plan:	~~**$1,500**~~	**$3,000**
1000 Plan:	~~**$2,000**~~	**$4,000**

* * *

2. **Percentage payable after satisfaction of Deductible and prior to the satisfaction of the Out-of-Pocket maximum amounts for eligible Inpatient Hospital, Outpatient Hospital, Surgical and Medical services, non-Severe Mental Illness and Severe Mental Illness as defined in the Policy:**

(a) **PPO Network Percentage Payable after Deductible** (unless otherwise specified in the Policy or in this Schedule of Benefits): ~~**90%**~~ **80%**

(b) **Non-PPO Network Percentage Payable after Deductible** (unless otherwise specified in the Policy or in this Schedule of Benefits): ~~**80%**~~ **60%**

* * *

(c) **Laboratory Charges and X-rays:**
Inside PPO Network: ~~**90%**~~ **80%**
Outside PPO Network: ~~**80%**~~ **60%**

* * *

(f) **Ambulance services:**
Inside PPO Network: ~~**90%**~~ **80%**
Outside PPO Network: ~~**80%**~~ **60%**

* * *

(j) **Mammograms:**
Inside PPO Network: ~~**90%**~~ **80%**
Outside PPO Network: ~~**80%**~~ **60%**

* * *

(l) **Office visits:**
Inside PPO Network: ~~**90%**~~ **80%**
Outside PPO Network: ~~**80%**~~ **60%**

* * *

(o) **Colonoscopy:**

Inside PPO Network:	**~~90%~~ 80%**
Outside PPO Network:	**~~80%~~ 60%**

* * *

3. **Routine Physical Examinations and Check-ups** (if your Policy contains the Optional Co-Payment Endorsement, and the following services qualify as a Physician Office Visit, refer to the endorsement for Benefit information)**:**

(a) Well baby/Child benefit: Office visits for routine check-ups for children up to and including age eighteen (18) are covered subject to the following guidelines:

(1) From the moment of birth through two (2) years of age, the Policy covers office visits for routine check-ups, including medical history, physical examination, developmental assessment, anticipatory guidance and laboratory tests, at the following benefit levels:

Inside PPO Network:	**~~90%~~ 80%**
Outside PPO Network:	**~~80%~~ 60%**

This Benefit is not subject or applicable to the Calendar Year Deductible.

(2) For children ages two (2) through and including eighteen (18), the Policy covers one (1) office visit per Calendar Year for routine check-ups:

Inside PPO Network:	**~~90%~~ 80%**
Outside PPO Network:	**~~80%~~ 60%**

* * *

(b) For Insureds and Dependents age nineteen (19) or older, all Deductible Plans cover routine physical examinations and check-ups, including routine lab work required for the routine physical examination to an annual maximum Benefit of **$300**. This Benefit does not include mammograms and influenza immunizations, which are covered elsewhere in the Policy. Routine adult immunizations are covered for Insureds and Dependents age nineteen (19) or older as determined in accordance with the most recent guidelines of the Centers for Disease Control. On the 150 & 300 Deductible Plans, this Benefit is not subject to the Calendar Year Deductible and amounts paid by the Insured for these procedures are not applicable to the satisfaction of the Deductible. On the 500 & 1000 Deductible Plans, this Benefit is subject to the Calendar Year Deductible, and the annual maximum Benefit will either be paid by the Company (if the Deductible has been satisfied) or applied to the Calendar Year Deductible (if the Deductible has not been satisfied). Amounts in excess of the $300 maximum are neither payable by the Company nor applicable to the Deductible.

Inside PPO Network:	**~~90%~~ 80%**
Outside PPO Network:	**~~80%~~ 60%**

* * *

4. **Routine childhood immunizations and influenza immunizations: ~~90%~~ 80%.** This Benefit is not subject to the Calendar Year Deductible and amounts paid by the Insured for these procedures are not applicable to the satisfaction of the Deductible. Routine childhood immunizations shall be determined in accordance with the most recent guidelines of the Centers for Disease Control.

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6. **Family Deductible and Out-of-Pocket Benefits:**

* * *

(b) **Annual Family Out-of-Pocket:**

150 Plan:	**~~$2,000~~**	**$4,000**
300 Plan:	**~~$2,400~~**	**$4,800**
500 Plan:	**~~$3,000~~**	**$6,000**
1000 Plan:	**~~$4,000~~**	**$8,000**