SECTION I: DEFINITIONS

The definition of psychiatric care is deleted and replaced with the following:

**Psychiatric Care** is treatment by a physician for psychiatric or psychological conditions. These conditions include: neurosis, psychoneurosis, psychopathy, psychosis, treatment of eating disorders or, except as noted below, mental, nervous, or emotional disease or disorder of any kind listed in DSM-III, the medical code reference book for psychiatric disorders.

SECTION III: THE HEALTH CARE CERTIFICATION PROGRAM

Subsection: Penalty

The first paragraph is hereby deleted and replaced with the following:

There is a penalty if treatment is not certified due to the lack of Notification to the Health Care Certification Program Cost Watch. The penalty is an exclusion from eligible expenses of 20% of all charges related to the treatment up to a $10,000 maximum.

SECTION IV: BENEFITS

Subsection: Eligible Expenses

The **OUTPATIENT PSYCHIATRIC CARE CHARGES** provision is hereby deleted and replaced with the following:

**OUTPATIENT PSYCHIATRIC CARE CHARGES.** Services for outpatient psychiatric care up to $550 per calendar year. Services shall be legally performed by or under the clinical supervision of a physician or licensed psychologist whether performed in an office in a hospital or in a community mental health facility so long as the hospital or community mental health facility is approved by the Joint Commission on Health Care Organizations or certified by the department of mental health.
The following provisions are hereby added:

**ALCOHOLISM TREATMENT CHARGES** for outpatient, *hospital confined* and intermediate primary care benefits up to $550 per *calendar year*. Services shall be legally performed by or under the clinical supervision of a *physician* or a licensed psychologist whether performed in an office, a *hospital*, in a community mental health facility or in an alcoholism treatment facility so long as the *hospital*, community mental health facility or alcoholism treatment facility is approved by the Joint Commission on Accreditation of Hospitals or certified by the department of health.

**CHILD HEALTH SUPERVISION SERVICES** for children from the moment of birth until age nine. Child health supervision services means periodic review of a child’s physical and emotional status performed by a *physician* or by a health care professional under the supervision of a *physician* in accordance with the recommendations of the American Academy of Pediatrics. The periodic review includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests. *Benefits* for child health supervision services that are provided to a child during the period from birth to age one shall not exceed a maximum limit of $500. *Benefits* provided to a child during any year thereafter shall not exceed a maximum limit of $150 per year. Coinsurance and deductible apply.

**SECTION V: EXCLUSIONS AND LIMITATIONS**

**Subsection: Exclusions**

The eighteenth (18) bullet for drug addiction is hereby deleted and replaced with the following:

- Any treatment of drug addiction, substance abuse or chemical dependency.

**SECTION VII: TERMINATION OF COVERAGE**

**Subsection: Coverage Terminates**

The *Coverage Terminates* provision is hereby deleted and replaced with the following:

All coverage terminates for an *insured person* at 12:01 a.m. on the first day of the month following the month in which any of these circumstances occurs:

- The *insured person* gives prior written notice of termination;
- The *insured person* fails to make any required premium payments; or
- Coverage is terminated for a line of business or class of eligible *insured persons*.

If there are losses for charges *incurred* in connection with a disability or medical condition that began while coverage was in force, this certificate does not provide *benefits* after the *insured person's* coverage terminates and any Continuation or Extension ends.
SECTION VIII: CLAIM PAYMENT PROVISIONS
Subsection: Arbitration

The last paragraph of the Arbitration provision is hereby deleted and replaced with the following:

In any arbitration dispute or controversy that conflicts with this certificate this certificate shall govern. The parties agree that the arbitration award and any decision by the arbitration panel shall be confidential. It is understood and agreed that the parties are waiving their right to seek remedies in court (except for judicial injunctive relief, as stated above), including the right to a jury trial; and that an arbitration award may not be set aside in later litigation except upon the limited circumstances set forth in the Federal Arbitration Act. Judgment upon the award rendered by the arbitration panel may be entered in any court having jurisdiction thereof.

SECTION IX: GENERAL PROVISIONS
Subsection: Coordination of Benefits

The Coordination of Benefits provision is hereby deleted and replaced with the following:

"Coordination of benefits" is the procedure used to pay health care expenses when a person is covered by more than one plan. Celtic Life follows rules established by Ohio law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family members are covered by another group plan in addition to this one, we will follow Ohio coordination of benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

Celtic Life pays for health care only when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

Plans that do not Coordinate

Celtic Life will pay benefits without regard to benefits paid by the following kinds of coverage.

- Individual (not group) policies or contracts
- Medicaid
- Group hospital indemnity plans which pay less than $100 per day
- School accident coverage
- Some supplemental sickness and accident policies

How Celtic Life Pays as Primary Plan

- When we are primary, we will pay the full benefit allowed by your contract as if you had no other coverage.

How Celtic Life Pays as Secondary Plan

- When we are secondary, our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will we pay more than we would have paid had we been primary.

- We will pay only for health care expenses that are covered by Celtic Life.

- We will pay only if you have followed all of our procedural requirements, including (care obtained from or arranged by your primary care physician, pre-certification, etc.).

- We will pay no more than the reasonable and customary charge for the health care involved. If our reasonable and customary charge is lower than the primary plan's, we will use the primary plan's reasonable and customay charge. That may be less than the actual bill.

Which Plan is Primary?

To decide which plan is primary, we have to consider the coordination provisions of the other plan. The Primary Plan will be determined by the first of the following which applies:

1. Non-coordinating Plan

   If you have another group plan which does not coordinate benefits, it will always be primary.

2. Employee

   The plan which covers you as an Employee (neither laid off nor retired) is always primary.
3. Children (Parents Divorced or Separated)

If the court decree makes one parent responsible for health care expenses, that parent's plan is primary.

If the court decree gives joint custody and does not mention health care, we follow the birthday rule.

If neither of those rules applies, the order will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

4. Children and the Birthday Rule

When your children's health care expenses are involved, we follow the "birthday rule." The plan of the parent with the first birthday in a calendar year is always primary for the children. If your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children.

However, if your spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

5. Other Situations

For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686-1526.

Subsection: Plan Determination

This subsection is hereby deleted in its entirety.
CONDITIIONS
This rider does not otherwise enlarge, amend, or diminish the certificate except as stated herein. This rider
is subject to all the terms, conditions, limitations and exceptions of your certificate except where changed
by this rider.

CELTIC LIFE INSURANCE COMPANY

James P. Daly
Chief Operating Officer and Executive Vice President