TRANSAMERICA®
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office, Cedar Rapids, Iowa

Administrative Office:
Boon Administrative Services, Inc.
P.O. Box 559017
Austin, TX 78755
866-868-4139

Dear Participant:

Thank you for choosing Transamerica Life Insurance Company to help meet your insurance needs.

Please look over your documents carefully, and if you find anything that is not correct, notify us immediately.

Enclosed are your Certificates of Insurance and Claim Forms for each product. On the back of this letter is our Notice of Privacy Policy.

If you need additional information or have any other questions, we encourage you to write us at the address listed in our letterhead or call us at 1-866-868-4139.

Once again, we would like to say thank you for choosing Transamerica.

Sincerely,

Dave Paulsen, Chief Distribution Officer
Transamerica

Enclosures: As stated

NOTICE OF PRIVACY POLICY
Information Only – No Response Necessary

Protecting your privacy is very important to us. We want you to understand what information we collect and how we use it. We collect and use nonpublic personal information in order to provide our customers with a broad range of financial products and services. We treat your information with the utmost respect and in accordance with our Privacy Policy.

What Information We Collect and From Whom We Collect It
We may collect nonpublic personal information about you from the following sources:

* Information we receive from you on applications or other forms;
* Information about your transactions with us, our affiliates, or others; and
* Information we receive from non-affiliated third parties, including consumer reporting agencies and insurance support organizations.

Nonpublic personal information is nonpublic information about you that we obtain in connection with providing a financial product or service to you. In some states, personal information may also include your name, address and medical record information but not privileged information. This information may be collected in person, by mail, fax, or by other electronic means as permitted by law or as expressly authorized by you.

What Information We Disclose and To Whom We Disclose It
Depending upon the product or service offered, we may disclose nonpublic personal information we collect to:

* Persons or companies that perform services on our behalf.
* Other financial institutions with which we have joint marketing agreements as permitted by law. In Vermont this includes only your name, contact information, policy coverage and information about your transactions with us or our affiliates.
* A medical professional for the purpose of disclosing a medical problem of which you may not be aware.
* Other insurance support organizations for use in connection with an insurance transaction or to prevent fraud.
* An insurance regulatory authority.
* A law enforcement or other governmental authority to prevent or prosecute fraud or other unlawful activities.
* Organizations conducting actuarial research studies.
* If applicable, a group policyholder for reporting claims experience or conducting an audit.

We do not disclose any nonpublic personal information about you to either our affiliates or non-affiliates, except as permitted by law. Our affiliates are companies with which we share common ownership. They offer life and health insurance and pension and savings products. Nonpublic personal information about you that we obtain from a report prepared by an insurance support organization may be retained by that organization and disclosed to other persons.

Your Right to Verify Accuracy of Information We Collect
Keeping your information accurate and up to date is very important to us. You have the right to write to us to request reasonable access to your nonpublic personal information (this includes a record of any subsequent disclosures of medical record information). You may not access your personal information that relates to and is collected in connection with or in reasonable anticipation of a claim or a criminal or civil proceeding. If you believe the information we collected about you is inaccurate, you have the right to request in writing that we amend, correct or delete it. We will notify you of our decision, give you our reasons and you will have the right to file a concise statement of dispute with us if you do not agree. Your statement will be made a part of our file and sent to persons or organizations that received your information in the past and in the future as required by law. For a copy of our more detailed Notice of Insurance Information Practices as applicable to your product or service, please send a written request to 6300 Bridgepoint Parkway, Building 3, Suite 500, Austin, Texas 78730 or call 1-866-868-4139.

Our Security Procedures
We restrict access to nonpublic personal information and only allow disclosures to persons and companies as permitted or required by law to assist in providing products or services to you. We maintain physical, electronic, and procedural safeguards to protect your nonpublic personal information. Should your relationship with us end, we will maintain and only disclose your nonpublic personal information in accordance with this Privacy Policy.

This Notice applies to the following companies and any separate accounts established for the products they may offer.

Transamerica Advisors Life Insurance Company
Transamerica Capital, Inc.
Transamerica Casualty Insurance Company
Transamerica Financial Life Insurance Company
Transamerica Investors Securities Corporation
Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company
Transamerica Retirement Advisors, Inc.
Transamerica Retirement Insurance Agency, Inc.
Transamerica Retirement Solutions Corporation
Stonebridge Benefit Services, Inc.
Stonebridge Life Insurance Company

HIPAA NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") covers an Affiliated Covered Entity ("ACE"). When this Notice refers to the Transamerica ACE or "we", "our" or "us", it is referring to the health care components of the following affiliated entities; Transamerica Financial Life Insurance Company, Transamerica Life Insurance Company, and Transamerica Premier Life Insurance. Each of the companies listed above is a hybrid covered entity under the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively, "HIPAA"). The combined companies listed are designated as a single covered entity for purposes of compliance with HIPAA and certain covered health care components of such companies. The single covered entity shall be known as the Transamerica Affiliated Covered Entity or the "Transamerica ACE." This designation may be amended from time-to-time to add new covered entities that are under common control and ownership to the Transamerica ACE.

The Transamerica ACE is required under HIPAA to protect the privacy of your protected health information ("PHI"), provide you with notice of our legal duties and privacy practices with respect to PHI and abide by the terms of the Notice currently in effect for the Transamerica ACE. This Notice describes how the Transamerica ACE may use and disclose your PHI and your rights to access and amend your PHI.

This notice is effective September 23, 2013 and provided to you in connection with your health plan from the Transamerica ACE. In some cases, this may include product riders purchased with a product that is not considered a health plan subject to HIPAA. Health plans include, but are not limited to: Dental, Long Term Care, Medicare Supplement, Prescription Drug Coverage, Supplemental Medical Expense, Medical Expense, and TRICARE.

Our Commitment to Your Privacy

We are committed to maintaining the privacy of your PHI. This notice will tell you about the ways in which we may use and disclose your PHI for payment, health care operations, and other circumstances as either required or permitted by law. Permitted uses and disclosures may include use and disclosure between the affiliates within the Transamerica ACE. **Except as outlined below, we will not use or disclose your PHI without your written authorization, which you may revoke as described in the "Your Privacy Rights" section below.** For example, use or disclosure of your PHI for marketing, or any disclosure that would constitute a sale of your PHI, would require your authorization.

We are required by law to: safeguard your PHI; give you this Notice of our duties and privacy practices; notify you in the event of a breach of your unsecured PHI; and abide by the terms of the Notice of Privacy Practices currently in effect. **The laws of your state may provide additional privacy rights.**

We reserve the right to change any of our privacy practices and the terms of this Notice, and to make the new notice effective for all PHI maintained by us. In the event of a material change, a revised notice will be sent to all of our policyholders.

USES AND DISCLOSURES OF YOUR PHI

1. **Treatment.** We do not make treatment decisions, but we may disclose your information to those who do. For example, we may disclose information regarding your benefits to doctors, hospitals, long term care facilities, and other health care providers involved in your care.

2. **Payment**. We may use and disclose your PHI as necessary for benefit verification and claims processing purposes. For instance, we may use information regarding health care services you receive from service providers such as physicians, hospitals, pharmacies, nursing homes, assisted living facilities, and home health care agencies to process and pay claims, to determine whether services are medically necessary or to otherwise pre-authorize or certify services as covered under your health plan. We may also forward such information to another health plan, which may also have an obligation to process and pay claims on your behalf. Examples of our payment related purposes also include our collection of premiums, coordinating reinsurance, and care coordination activities.

3. **Health Care Operations.** We will use and disclose your PHI as necessary, and as permitted by law to operate our business including performing quality improvement and assurance, conducting cost-management and business planning, enrollment, underwriting, reinsurance, compliance, auditing, rating, customer service, fraud prevention and reporting, research purposes, specialized government functions, payment of agent commissions, and other functions related to your health plan. With the exception of long-term care insurance underwriting, we are prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes. If our long-term care insurance underwriting uses genetic information it will only be used in a manner allowed by law.

4. **Family and Friends Involved in Your Care.** We may disclose your PHI to certain family, friends, and others who are involved in your care or in the payment for your care in order to not hinder that person's involvement. If you are unavailable, incapacitated, or facing an emergency medical situation, or if we have determined, based on our professional judgment and review of the circumstances, that you would not object and that a limited disclosure may be in your best interest, we may share limited PHI without your approval. If you have designated a person to help

prevent the unintentional lapse of your coverage, we will inform that person prior to terminating the policy for nonpayment of premium. We may also disclose limited PHI to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you. You have the right to stop or limit these disclosures by contacting us at the address shown at the end of this notice.

5. **Business Associates**. Certain services are performed through contracts with outside persons or organizations, such as auditing, accreditation, actuarial services, legal services, claims investigation and adjudication, underwriting support services, care coordination services, etc. We may disclose your PHI to one or more of these outside persons or organizations that assist us with our health care operations. We obligate business associates to appropriately safeguard the privacy of your PHI.

6. **Collection of Information.** To properly underwrite, rate, and administer your health plan, we may collect health and non-health personal information such as your age, occupation, physical condition, and health history, including drug and alcohol usage. You are our most important source of information; however, with your authorization, we may also collect or verify information by contacting information sources such as: insurance support organizations (like Medical Information Bureau, Inc.); insurance companies to which you have applied for coverage; and medical professionals and facilities which have provided services to you.

7. **Agents.** Your agent is our business associate. For customer service purposes, your agent may be notified of certain coverage-related matters and information necessary to assist in servicing your coverage. For example, your agent may be notified if we: decline your application, offer you coverage at a higher than standard rate, or offer to accept the application with modifications to the benefits you requested. We may also notify your agent when there is a change in premium paying status, when we receive notice of a claim, or notice of the cancellation or replacement of your policy. Your agent may be notified on their commission statement that your policy remains in force for as long as you continue to pay your premium.

8. **Plan Sponsors.** We may also use or disclose PHI to the plan sponsor of a group health plan, if applicable, provided that any such plan sponsor certifies that the information provided will be maintained in a confidential manner and not used for employment related decisions or for other employee benefit determinations or in any other manner not permitted by law.

9. **Health-Related Benefits and Services.** We or our business associates may contact you regarding health-related benefits and services that may be of interest to you.

10. **Mergers and Acquisitions.** Your PHI may also be disclosed as a part of a potential sale, merger or acquisition involving our business.

USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

Your PHI may be used or disclosed as applicable without your authorization in the following circumstances:

- for any purpose when required by law;
- for public health and/or law enforcement activities consistent with law if we suspect child abuse, elder abuse, or neglect or believe you to be a victim of abuse, neglect, domestic violence, or other crimes;
- as required by law for governmental oversight agency conducting audits, investigations (such as investigations in to consumer complaints), or civil or criminal proceedings;
- if required by a court or an administrative ordered subpoena or discovery request;
- as required by law for certain law enforcement purposes; about deceased persons to coroners, health examiners, and funeral directors consistent with law;
- if necessary for organ and tissue donation or transplant;
- for certain government-approved research purposes;
- upon reasonable belief to avert a serious threat to health or safety;
- for specialized government functions (such as military personnel and inmates in correctional facilities);
- for national security or intelligence activities;
- to workers' compensation agencies if necessary to make a benefit determination;
- to Non-affiliated organizations or persons, such as other insurance institutions, agents, insurance support organizations (such as Medical Information Bureau, Inc.), or law enforcement and governmental authority as necessary to prevent or investigate criminal activity, fraud, material misrepresentation or material non-disclosure in connection with your coverage or application for coverage;
- to our parent company and affiliates in conjunction with health care operation purposes.

Your Privacy Rights

Your rights are explained below. ***Any written requests to exercise those rights should be directed to the address provided at the end of this notice.***

1. **Restrictions.** You have the right to request restrictions on certain of our uses and disclosures of your PHI for treatment, payment, or health care operations by notifying us in writing. Your request must describe in detail the restriction you are requesting. We will evaluate all requests; however, we are not required to agree to the restriction and we retain the right to terminate a restriction if we believe such termination is appropriate. In the event of a termination by us, you will be notified. You also have the right to terminate a restriction, in writing. You may obtain a Request for Restriction form by contacting us at the phone number listed at the end of this notice.

2. **Confidential Communications.** You may request that we send communications of health information to you by alternative means or to alternative locations, if all or part of that information could endanger you. For example, you may ask that we contact you at work, rather than at home. We will try to accommodate reasonable requests. You may obtain a Request for Confidential

Communication form by contacting us at the phone number listed at the end of this notice.

3. **Access.** You have a right to access much of the PHI that we retain on your behalf. All requests must be made in writing and signed by you or your representative. We may charge a reasonable fee for copies, postage, labor and supplies and, in certain cases, may deny your request. You may obtain a Request for Access form by contacting us at the phone number listed at the end of this notice.

4. **Amendment.** You have the right to request that PHI we maintain about you be amended or corrected. We will give each request consideration; however we are not obligated to make requested amendments. All amendment requests must be in writing, signed by you or your representative and state the reason(s) for the request. If an amendment or correction is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain a Request for Amendment form by contacting us at the phone number listed at the end of this notice.

5. **Accounting.** You have the right to receive an accounting of certain disclosures made by us of your PHI within the six (6) calendar years immediately preceding such a request. Requests must be made in writing and signed by you or your representative. The first accounting in any 12-month period is free; but we may charge you for additional accountings within the same 12-month period. You will be notified in advance of any fee. You may obtain a Request for Accounting of Disclosure form by contacting us at the phone number listed at the end of this notice.

6. **Revocation of Authorization**. If you have signed an authorization for uses and disclosures not related to payment or health care operations, you have the right to revoke that authorization in writing at any time, except to the extent that we have taken action in reliance on such authorization, or if other law provides us with the right to contest a claim under the policy or the policy itself. Note: your revocation will not prevent us from using collected information in conjunction with our fraud prevention program.

7. **Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy upon request.

NOTE: The rights granted to you do not extend to information about you relating to or in anticipation of a claim or civil or criminal proceeding.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with us by sending your written complaint to our Consumer Affairs Department at the address given below. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. within 180 days of a violation of your rights. We will not retaliate against you for filing a complaint.

Contacting Us

To file a complaint or to make a request as described in the section entitled "Your Privacy Rights," please send your written request to the company at: 4333 Edgewood Road NE, Cedar Rapids, IA 52499. Requests should be directed to our Customer Service Department and Complaints should be sent to the attention of our Consumer Affairs Department. Please be sure to include the following information:

- Your full name
- Address
- Date of Birth
- Last four digits of your Social Security Number
- Policy number
- The nature of your request or complaint

FOR FURTHER INFORMATION regarding our HIPAA Notice of Health Information Privacy Practices or our general privacy practices, please write to us at the address shown above or call 1-866-512-7495.

THIS NOTICE IS REQUIRED BY FEDERAL LAW. WE MAKE IT AVAILABLE TO THE GENERAL PUBLIC, APPLICANTS AND POLICYHOLDERS. YOUR RECEIPT OF THIS NOTICE IS NOT EVIDENCE OF COVERAGE.

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499
A Stock Company

About Your Insurance – This Certificate explains benefits provided under the Group Master Policy ("Policy") issued to the Policyholder named on the Schedule of Benefits. Read it closely to become familiar with your coverage.

Terms important to understanding this Certificate are defined in the Definitions section or in separate Certificate provisions and are capitalized.

Important Notice – Benefits are payable only as described in this Certificate for a covered loss that occurs while the Covered Person is insured under the Policy.

The Policy may be amended or canceled as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person. Premiums are subject to change.

The benefits for Dependents described in this Certificate, if available under the Policy, are applicable only if you are insured, apply for Dependent coverage, receive our approval of such Dependents, and pay the premium required for each Dependent.

This Certificate is signed for us at our Home Office to take effect on the same date coverage becomes effective.

General Counsel and Secretary

President

Group Certificate for Hospital Indemnity Insurance

THIS CERTIFICATE PROVIDES LIMITED BENEFITS – READ IT CAREFULLY

THIS CERTIFICATE IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT. IF YOU PURCHASE THIS CERTIFICATE ONLY, YOU WILL NOT SATISFY THE FEDERAL REQUIREMENT THAT YOU HAVE HEALTH COVERAGE, WHICH IS IN EFFECT BEGINNING JANUARY 1, 2014.

Administrative Office:
6300 Bridgepoint Parkway, Building 3, Suite 500, Austin, Texas 78730
Customer Service: 1-866-868-4139

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

POLICYHOLDER:	The Hertz Corporation
GROUP POLICY NUMBER:	11344F
POLICY EFFECTIVE DATE:	July 01, 2018
GOVERNING JURISDICTION:	Florida

Y1F28
Benefits per Covered Person

Daily In-Hospital Indemnity Benefit per day Maximum of 31 days per confinement	$250
Hospital Confinement Indemnity Benefit per day Maximum of 1 day per confinement Maximum number of confinements per calendar year	$2,500 1
Outpatient Diagnostic Laboratory Test Indemnity Benefit per day Maximum of 2 days per calendar year	$15
Outpatient Select Diagnostic Test Indemnity Benefit per day Maximum of 1 day per calendar year	$75
Outpatient Advanced Studies Diagnostic Test Indemnity Benefit per day Maximum of 1 day per calendar year	$300
Outpatient Physician Office Visit Indemnity Benefit per day Maximum of 6 days per calendar year	$80
Surgical and Anesthesia Indemnity Benefit Inpatient surgical benefit per day Outpatient surgical benefit per day Outpatient minor surgical benefit per day Maximum of 1 day per surgical benefit per calendar year Anesthesia Indemnity Benefit per day	 $1,000 $500 $100 30%
Prescription Drug Indemnity Benefit Generic Prescription Benefit Amount per day Brand Name Prescription Benefit Amount per day Combined total maximum number of days per calendar month Maximum number of days per calendar year	 $20 $40 2 24
Off-The-Job Accidental Injury Indemnity Benefit per day Maximum of 1 day per accident and 5 accidents per calendar year	$500
Inpatient Drug and Alcohol Addiction Indemnity Benefit per day Maximum of 31 days per calendar year Lifetime maximum of 60 days	$200
Inpatient Mental and Nervous Disorder Indemnity Benefit per day Maximum of 31 days per calendar year Lifetime maximum of 60 days	$200
Waiver of Preexisting Condition Limitation	

DEFINITIONS

Terms important to understanding this Certificate are defined below and are capitalized in this Certificate.

Accidental Bodily Injury – An injury for which benefits are provided, The injury must be:
1. Sustained by a Covered Person; and
2. The direct cause of loss, independently of disease, bodily infirmity or other cause.

All such injuries, with any complications and any recurrences of complications arising from any one Accident, will be deemed to be a single injury. Such injury or injuries must occur while this Certificate is in force.

Active Service – Performing in the usual manner all of the regular duties of your occupation on a scheduled work day at the normal place of business or other location as directed by your employer.

You are considered to be in Active Service on a day which is not a scheduled work day only if you would meet the requirements above if it were a scheduled work day and you were in Active Service on the last preceding regular work day.

Active Service does not apply if employment is not an eligibility requirement.

Amendment, Endorsement, or Rider – Any form issued by us which adds, modifies, changes, or deletes any Policy or Certificate provision or benefit.

Application – The form completed and signed to apply for this insurance coverage.

Calendar Year – The period from January 1 through December 31 of the same year.

Child – A Child of yours who is under the age of 26 and is:
1. A natural Child of yours or of your covered Dependent Child (Coverage for a child born to your covered Dependent Child will terminate 18 months after the birth of the newborn child.); or
2. A legally adopted Child or a Child who has been placed for adoption with you; or
3. A stepchild or foster Child; or
4. A Child for whom you have been appointed legal guardian; or
5. A Child for whom you are legally required to provide support.

If applicable, Child will also include children of your Other Adult Dependent in the same manner as a stepchild.

Child also includes a Child who meets the criteria described above, but who is age 25 or older, if the Child is any Child for whom coverage would otherwise terminate while the Child is and continues to be incapable of self-sustaining employment because of mental retardation or physical handicap. We will continue the Child's coverage under the following conditions:
1. The Child must be incapacitated;
2. We must receive proof of incapacity within 31 days after coverage would otherwise terminate;
3. We may require additional proof of such incapacity from time to time, but not more often than once a year after the Child attains age 26; and
4. Your coverage must remain in force.

If a claim is denied because of a Child having reached the attained age, we will establish that the child is and has continued to be handicapped.

Confinement or Confined - That period of time the Covered Person is admitted into a Hospital as a resident bed patient. Confinement does not include that period of time during which a Covered Person is in a Hospital emergency room, an observation room, a freestanding surgical facility or an outpatient facility.

Covered Person - You and your Dependents who have been accepted for coverage.

Dependent – Your Spouse or Other Adult Dependent or Child covered under this Certificate.

Evidence of Insurability – The correct and complete answers to the questions in the Application and medical history, if necessary, which will be used by us to base our acceptance of any proposed Covered Person who enrolls at a time other than during stated enrollment periods.

Hospital –
1. Is an institution licensed as a Hospital and operated pursuant to law;
2. Is primarily and continuously engaged in providing and operating, either on its premises or in facilities controlled by the Hospital, under the supervision of a staff of duly licensed Physicians, medical, diagnostic and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
3. Provides 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).
4. Is accredited by the Joint Commission on Accreditation of Health Care Organizations.

We will consider a Government or Charity Hospital as any other Hospital.

The term "Hospital" does not include an institution or that part of an institution operated as:
1. A convalescent home, convalescent, rest, or nursing facilities;
2. A facility for the aged, drug addicts, or alcoholics;
3. A facility primarily affording custodial, educational, or rehabilitory care;
4. A facility primarily affording care for mental and nervous disorders;
5. A long-term nursing unit or geriatrics ward; or
6. An Extended Care Facility for the care of convalescent, rehabilitative, or ambulatory patients

Immediate Family Member – Anyone related to a Covered Person in the following manner: spouse, daughter, son, stepchild, father, mother, stepparent, sister, brother, stepsister, stepbrother, grandchild, grandparent, father-in-law, mother-in-law, or the spouse of any of these. The term "spouse" includes a common law marriage partner, domestic partner, or civil union partner, if legally recognized in the governing jurisdiction.

Insured, **you, or your –** The employee or member covered for this insurance.

Observation Unit – A specialized area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a Physician. Such a unit must:
1. Be under the direct supervision of a Physician or registered nurse;
2. Be staffed by nurses assigned specifically to that unit; and
3. Provide care seven days per week, 24 hours per day.

Other Adult Dependent – Your common law marriage partner, domestic partner, or civil union partner.

Physician - A person who is providing services within the scope of his or her license, and is either:
1. Licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
2. Legally qualified and licensed as a medical practitioner and is required to be recognized, according to the insurance statutes or the insurance regulations of the governing jurisdiction.

Such person must not be an Immediate Family Member of any Covered Person. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible Physicians under the Policy.

Policy – The complete contract of insurance, which includes the Policy as issued to the Policyholder, the Policyholder Application, the Certificate Provisions, and any Amendments, Endorsements, and Riders.

Policyholder – The entity named on the Schedule of Benefits to whom the Policy is issued.

Preexisting Condition – A Covered Person's Sickness or physical condition for which medical advice or treatment was recommended by or received from a Physician within 12 months before of the date the Covered Person's coverage became effective or for which the Covered Person incurred expense or took medication within 12 months before the Covered Person's coverage became effective.

Preexisting Condition will also include a condition that manifests itself in a way that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 12-month period before the Covered Person's coverage became effective.

Sickness – Illness or disease which first manifests itself while the Covered Person's coverage is in force and is the direct cause of the loss.

Spouse – Your legally married Spouse.

Transamerica Life Insurance Company, the Company, we, us, or our – The insurer that underwrites this coverage.

ELIGIBILITY AND EFFECTIVE DATE

Coverage will take effect at 12:01 a.m. at the main place of business of the Policyholder.

Employee or Member Eligibility – To be eligible for coverage under the Policy, you must:
1. Meet the eligibility requirements listed on the Policyholder Application;
2. Be in Active Service; and
3. Provide satisfactory Evidence of Insurability to us, if required.

Employee or Member Effective Date - Your insurance will take effect on the later of: (1) the Policy Effective Date; or (2) the first day of the calendar month which coincides with or next follows the date you are accepted for coverage; provided you are: (a) an eligible employee or member on such date; and (b) we have received your first premium payment.

If you do not meet the eligibility requirements on the date your coverage is to take effect, your coverage will take effect on the first day of the calendar month which coincides with or next follows the date you satisfy the requirements.

Dependent Eligibility, if available under the Policy – To be eligible under the Policy, a Dependent must:
1. Meet the definition of an eligible Dependent;
2. Be able to perform a majority of the normal activities of a person of like age in good health;
3. Not be eligible as an employee or member under the Policy; and
4. Provide satisfactory Evidence of Insurability to us, if required.

Dependent Effective Date – Insurance on each Dependent will take effect on the later of: (1) the date your coverage becomes effective; or (2) the first day of the calendar month which coincides with or next follows the date the Dependent is accepted for coverage, provided that: (a) the Dependent is an eligible Dependent on such date; and (b) we have received any additional premium.

If a Dependent does not meet the eligibility requirements on the date his or her coverage is to take effect, coverage on that Dependent will take effect on the first day of the calendar month which coincides with or next follows the date the Dependent satisfies the requirements.

If you and your Spouse or Other Adult Dependent are both eligible as an employee or member, any Children may be insured as a Dependent of either you or your Spouse or Other Adult Dependent, but not both.

Newborn or Newly-Adopted or Foster Child Effective Date – Coverage for a newborn will become effective automatically on the day he or she is born. Coverage for an adopted or foster Child under the age of 18 will become effective from the moment of placement in your residence or the day a court enters an order appointing you the legal guardian of the Child. In the case of a newborn adopted Child, coverage begins at the moment of birth if a written agreement to adopt the Child has been entered into by the Insured prior to the birth of the Child, whether or not the agreement is enforceable.

The newly born or adopted or foster Child's coverage will continue without any additional premium as long as you have either Single Parent Family or Family coverage in force on that date. You must notify us of the addition of this Child within 30 days of the birth, placement for adoption or guardianship appointment.

If you have Individual coverage or Individual and Spouse/Other Adult Dependent coverage, the Child will be automatically covered for the first 31 days following birth, adoption or placement of the Child in your home. In order to continue the Child's coverage:
1. You must notify us by the end of the 31-day period of the addition of such Child; and
2. You must elect either Single Parent Family or Family coverage, and pay any applicable additional premium.

If timely notice is given, we may not charge an additional premium for coverage of the child for the notice period. If timely notice is not given, we may charge an additional premium from the date of birth or placement. If notice is given within 60 days of the birth or placement of the child, we may not deny coverage for the child due to your failure to timely notify us of the birth or placement of the child.

Coverage for a newly born or newly adopted Child will consist of coverage for Accident and Sickness including confinements for medically diagnosed congenital defects and birth abnormalities within the scope of the Policy.

DAILY IN-HOSPITAL INDEMNITY BENEFIT

We will pay the Daily In-Hospital Indemnity Benefit amount shown in the Schedule of Benefits for each day the Covered Person is Confined to a Hospital as the result of a covered Accident or Sickness. This benefit is limited to any maximums shown in the Schedule of Benefits.

We will not pay this benefit for an emergency room stay, an outpatient stay, or a stay in an Observation Unit.

Confinement for the same or related condition within 30 days of discharge will be treated as a continuation of the prior Confinement. Successive Confinements separated by more than 30 days will be treated as a new and separate Confinement.

EXCLUSIONS AND LIMITATIONS

With respect to benefits provided under this Certificate, no benefits will be payable as the result of:

1. A Covered Person's suicide or attempted suicide, while sane or insane.
2. A Covered Person's intentionally self-inflicted injury.
3. Rest care or rehabilitative care and treatment.
4. Immunization shots and routine examinations such as: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings. This exclusion does not apply to coverage under the optional Wellness Indemnity Benefit Rider, if attached as part of the contract.
5. Routine newborn care. This exclusion does not apply to coverage under the optional Wellness Indemnity Benefit Rider, if attached as part of the contract.
6. A Covered Person's abortion, except for medically necessary abortions performed to save the mother's life.
7. The treatment of:
   a. A Covered Person's mental or emotional disorder. This exclusion does not apply to coverage under the optional Inpatient Mental and Nervous Disorder Indemnity Benefit Rider, if attached as part of the contract.
   b. A Covered Person's alcoholism or drug addiction. This exclusion does not apply to coverage under the optional Inpatient Drug and Alcohol Addiction Indemnity Benefit Rider, if attached as part of the contract.
8. A Covered Person's participation in a riot, or insurrection.
9. Dental care or treatment, except for such care or treatment due to Accidental Injury to sound natural teeth within 12 months of the Accident and except for dental care or treatment necessary due to congenital disease or anomaly.
10. Any Accident caused by the participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician or taken according to the Physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the Accident occurred).
11. A Covered Person's sex change, reversal of tubal ligation or reversal of vasectomy.
12. Artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or Physician's services, unless required by law.
13. Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation.
14. Traveling in or descending from any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip.
15. Any loss incurred while a Covered Person is on active duty status in the armed forces. (If you notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as a result of this exception.)
16. An Accident or Sickness arising out of or in the course of any occupation for compensation, wage or profit or for which benefits may be payable under an Occupational Disease Law or similar law, whether or not application for such benefits has been made.
17. A Covered Person's involvement in any war or act of war, whether declared or undeclared.

Preexisting Condition Limitation - No benefits are provided during the first 12 months this coverage is in force for a Preexisting Condition. After this 12-month period, loss due to such Preexisting condition will be payable unless specifically excluded from coverage. This 12-month period is measured from the date coverage becomes effective for each Covered Person.

PREMIUMS

All premiums are payable on or before the date they are due.

Premium Changes - We have the right to change the premium rates on any premium due date in accordance with the terms of the Policy. If the rates are changed, we will give at least a 60-day advance written notice to the Policyholder.

If the premiums increase because a change in benefits increases our liability, premium rates may be changed on the date that our liability is increased, without regard to any premium rate guarantee. If the premiums should increase because of a change in benefits, we will give at least a 45 day written notice of such increase and any premium rate guarantees will be null. If such premium increase takes place on a date other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due, the coverage will automatically be terminated as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

Premium Refunds - If your Spouse or Other Adult Dependent is covered and you divorce or legally terminate the Other Adult Dependent relationship or such Dependent dies and we are notified in writing at our Administrative Office, we will refund premiums for the period of time following the date of divorce/dissolution or death of such Dependent. Any unearned premium will be refunded.

If your Children are covered and coverage for all Children ends, we will refund premiums for the period of time following the last day of coverage. We must be notified in writing at our Administrative Office. Any unearned premium will be refunded.

Unpaid Premiums - Any premium due and unpaid may be deducted from a claim payment.

TERMINATION OF INSURANCE

Subject to the Portability Option, your insurance will cease on the earliest of:
1. The date the Policy terminates, subject to the Portability Option;
2. The date you cease to be eligible for coverage;
3. The date of your death;
4. The premium due date on which we fail to receive your premium, subject to the Grace Period provision; or
5. The date you send us a written notice that you want to cancel coverage.

The insurance on a Dependent will cease on the earliest of:
1. The date your coverage terminates;
2. The premium due date on which we fail to receive your premium, subject to the Grace Period provision;
3. The date the Dependent Child no longer meets the definition of Child;
4. The date a Covered Spouse or Other Adult Dependent no longer meets the definition of same;
5. The date the Policy is modified so as to exclude Dependent coverage; or
6. The date you send us a written notice that you want to cancel coverage on your Dependent.

We will have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

Termination of your insurance will not affect any claim which begins before the date of termination.

We may end the Policy on any premium due date. We must provide a 45-day advance written notice to your last known address of any such termination. If we fail to provide the 45-day notice, your coverage will remain in force with the existing rates until after the 45-day notice is given or replacement coverage is obtained whichever occurs first.

Extension of Benefits – If a Covered Person is Disabled on the date his or her coverage is to terminate, such termination will be without prejudice to any Hospital Confinement which began while coverage was in force, with respect to Daily In-Hospital Indemnity Benefits.

However, the Covered Person must continue to be Hospital Confined or Disabled.

If benefits are extended under this provision, such Extension of Benefits will continue until the earlier of:
1. 30 days from the date that coverage was to have terminated; or
2. The date on which the Covered Person is no longer disabled.

As it pertains to this provision, **Disability** has the following meaning:

Disability or Disabled – The inability, due to an Injury or Sickness, to perform all of the substantial and material duties of your regular occupation.

For a Dependent Child, Spouse, or Other Adult Dependent, "Disabled" means the inability to perform a majority of the normal activities of a person of like age in good health.

PORTABILITY OPTION

If you lose eligibility for this insurance for any reason other than nonpayment of premiums, you will have the option to continue this Certificate (including any Riders, if applicable) by paying the premiums directly to us at our Administrative Office within 31 days after this insurance terminates. We will bill you for these premiums after you notify us to continue this coverage. The premiums you pay directly to us may exceed the premiums that were paid through the Policyholder due to increased administrative costs for direct billing. If you stop paying the premiums under this option, this coverage will cease, subject to the terms of the Grace Period.

This Portability Option is only available for the Insured and the Insured's Dependents; it is not available for the Insured's Dependents without the Insured.

CLAIM PROVISIONS

Notice of Claim – Written notice of claim must be given to us at our Administrative Office, or to our agent. Such notice should be made within 30 days after any loss covered by the contract. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay, so long as notice is given as soon as reasonably possible.

Claim Forms – Claim forms should be used for filing Proof of Loss. We will send such form to the claimant within 15 days of receipt of notice of claim. If we fail to supply the proper claim forms within 15 days, you can give proof in writing, setting forth the nature and extent of the loss within the time stated in the Proof of Loss provision. You or a personal representative may obtain a claim form by calling our toll-free telephone number listed on the cover page.

Proof of Loss – Due written Proof of Loss must be given to us at our Administrative Office. In case of a claim for loss for which a periodic payment is provided contingent upon continuing loss, such satisfactory written Proof of Loss must be sent within 90 days after the termination of the period for which we are liable. For any other loss, proof must be sent within 90 days after the date of such loss.

Failure to furnish such proof within such time will not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof and it was furnished as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time of loss, unless the claimant was legally incapacitated.

Payment of Claim Benefits – All benefits payable under your Certificate will be paid to you, unless you have assigned such benefits. Any benefits that are not paid at your death will be paid to your Spouse or Other Adult Dependent or if there is no Spouse or Other Adult Dependent, then to your estate.

If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to $3,000 to someone related to you or beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

Physical Examinations And Autopsy - We have the right to have a Covered Person examined by a Physician of our choice as often as reasonably necessary while a claim is pending. In case of death, we may request an autopsy where it is not forbidden by law. We will pay for such examination or autopsy.

Time of Payment of Claims – Benefits for a covered loss will be paid as soon as we receive due written Proof of Loss.

GENERAL PROVISIONS

Clerical Error – A clerical error by us will not invalidate insurance otherwise in force, nor continue insurance otherwise not validly in force.

Conformity with State Laws – Any provision of the Policy or this Certificate which, on coverage effective date, is in conflict with the statutes of the state in which you reside on such date is hereby amended to conform to the minimum requirements of such statutes.

Entire Contract; Changes – The Entire Contract consists of the Policy as issued to the Policyholder, the Policyholder Application, the Certificate Provisions, and any attached Amendments, Endorsements, and Riders. Only our President, Vice President, Secretary, or an Assistant Secretary may make any changes to the Policy or this Certificate and then only in writing. No agent or Policyholder has authority to change the Policy or this Certificate or to waive any of its provisions. Any changes are subject to the laws of the governing jurisdiction.

Grace Period – A Grace Period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy and/or Certificate will terminate at the end of the Grace Period if the premium has not been paid. You must still pay all unpaid premium. This includes the premium due for the Grace Period.

If coverage is canceled on a premium due date and the premium has been paid through that date, the Grace Period will not apply. If cancellation is during the Grace Period, you will be liable for any unpaid premium including the pro rata premium for that part of the Grace Period during which coverage was in force. Benefits may be reduced by the amount of any due but unpaid premiums.

Legal Action –
No legal action may be brought to recover under this Certificate:
1. Within 60 days after written Proof of Loss has been furnished as required; or
2. After the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

Misstatement of Age – If the Covered Person's age has been misstated, all amounts payable under this Certificate will be such as the premium paid would have purchased at the correct age.

Other Insurance With Us - If you have more than one hospital indemnity policy, certificate, or similar coverage with us, only the one chosen by you will remain in effect. We will refund all premiums paid for any other such coverage.

Time Limit on Certain Defenses
Misstatements in the Application - We will not use any statement, except fraudulent statements, to void or reduce benefits after coverage has been in effect for two years. Any such statement would have to be in a signed form. This also applies to all Riders. Any increase in benefit amounts is subject to a new two year contestable period for the increased amount only.

All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to you.

Notices Given by Us – Any notice to you will be sent to your last known address.

TELEPHONE NUMBER FOR POLICYHOLDER INQUIRIES – Our Customer Service toll-free telephone number is shown on Page 1 of this Certificate. This toll-free number is provided to assist you in making inquiries or obtaining information regarding your coverage under this Certificate or to assist in resolving complaints.

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: 6300 Bridgepoint Parkway, Building 3, Suite 500, Austin, Texas 78730
(Hereinafter called "the Company," "we," "us," or "our")

HOSPITAL CONFINEMENT INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

BENEFIT

We will pay the Hospital Confinement Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person is Confined to a Hospital as the result of a covered Accident or Sickness. Confinement must begin while this Rider is in force and must last a minimum of 24 continuous hours from time of admission as a resident bed patient. Each stay in a Hospital must meet the definition of Confinement. Benefits are limited to the maximums shown in the Schedule of Benefits.

We will not pay this benefit for an emergency room stay, an outpatient stay, or a stay in an Observation Unit.

Confinement for the same or related condition within 30 days of discharge will be treated as a continuation of the prior Confinement. Successive Confinements separated by more than 30 days will be treated as a new and separate Confinement.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary

President

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: 6300 Bridgepoint Parkway, Building 3, Suite 500, Austin, Texas 78730
(Hereinafter called "the Company," "we," "us," or "our")

OUTPATIENT DIAGNOSTIC LABORATORY TEST INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

BENEFIT

We will pay the Outpatient Diagnostic Laboratory Test Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person undergoes a diagnostic laboratory test, on an outpatient basis, for the purpose of diagnosing a covered Accident or Sickness. Benefits are subject to the maximums shown in the Schedule of Benefits.

This Rider does not pay a benefit for any tests covered by any other Rider attached to the contract.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at Our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary

President

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: 6300 Bridgepoint Parkway, Building 3, Suite 500, Austin, Texas 78730
(Hereinafter called "the Company," "we," "us," or "our")

OUTPATIENT SELECT DIAGNOSTIC TEST INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

In addition to the definitions contained in the contract, the following definition applies to this Rider.

Select Diagnostic Test – Includes the following tests performed on an outpatient basis.

1. X-rays;
2. Ultrasound;
3. Electroencephalogram (EEG); and
4. Sleep Studies

BENEFIT

We will pay the Outpatient Select Diagnostic Test Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person undergoes a Select Diagnostic Test for the purpose of diagnosing a covered Accident or Sickness. Benefits are subject to the maximums shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary

President

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: 6300 Bridgepoint Parkway, Building 3, Suite 500, Austin, Texas 78730
(Hereinafter called "the Company," "we," "us," or "our")

OUTPATIENT ADVANCED STUDIES DIAGNOSTIC TEST INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

In addition to the definitions contained in the contract, the following definition applies to this Rider.

Advance Studies Diagnostic Test - Includes the following tests performed on an outpatient basis.

1. Computer tomography scan (CT);
2. Magnetic resonance imaging (MRI);
3. Myelogram;
4. Positron emission tomography (PET);
5. Angiogram;
6. Arteriogram; and
7. Thallium stress test.

BENEFIT

We will pay the Outpatient Advance Studies Diagnostic Test Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person undergoes an Advance Studies Diagnostic Test for the purpose of diagnosing a covered Accident or Sickness. Benefits are subject to the maximums shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary

President

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: 6300 Bridgepoint Parkway, Building 3, Suite 500, Austin, Texas 78730
(Hereinafter called "the Company," "we," "us," or "our")

OUTPATIENT PHYSICIAN OFFICE VISIT INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

In addition to the definitions contained in the contract, the following definition applies to this Rider.

Urgent Care Center – An ambulatory care facility that provides immediate medical care by a Physician on an unscheduled, walk-in basis to patients for extended hours. The center must have on-site diagnostic X-ray and laboratory equipment and can be located within a Hospital or as a freestanding facility. Emergency rooms and walk-in primary care offices are not considered Urgent Care Centers.

BENEFIT

We will pay the Outpatient Physician Office Visit Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person receives outpatient treatment in a Physician's office or Urgent Care Facility as the result of a covered Accident or Sickness. Benefits are subject to the maximums shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at Our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary

President

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: 6300 Bridgepoint Parkway, Building 3, Suite 500, Austin, Texas 78730
(Hereinafter called "the Company," "we," "us," or "our")

SURGICAL AND ANESTHESIA INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

Outpatient Minor Surgical Procedure – Those surgical procedures performed on an outpatient basis that are in the following CPT Code ranges:

- Skin – Debridement, Biopsy, Excisions/Removals (10021 - 11001); (11042 - 11313); (11400 - 11442)
- Nails (11719 – 11740)
- Injection – Intralesional, Intradermal, Subcutaneous (11900 - 11954)
- Destruction Of Lesions (17000 - 17286)
- Injection, Removal, Aspiration (20500 - 20612)
- Casts And Strapping (29000 – 29750)
- Venous, Arterial (36430 - 36680)
- Bone Marrow, Stem Cell (38204 - 38221)
- Mouth – Incision, Excision, Destruction (40800 – 40820)
- Tongue, Floor Of Mouth (41000 - 41010)
- Tongue, Floor Of Mouth – Incisioin/Excision (41100 - 41110)
- Dentoalveolar – Incisions/Excisions (41800 - 42106)
- Excision/Endoscopy (46320 - 46615)
- Destruction, Lesions Of Anus & Liver Needle Biopsy (46900 – 47001)
- Antepartum & Fetal Invasive Services (59000 – 59051)
- Nerve Blockers (64400 – 64550)
- Eyelids – Incisions, Excisions, Closure (67700 – 67875)
- External Ear – Incisions/Excision (69000 – 69105)
- Middle Ear – Incision (69400 – 69436)

Venipuncture, CPT codes 36400 – 36425, is NOT considered surgery.

All other surgical procedures performed on an outpatient basis will be covered under the "Outpatient Surgical Indemnity Benefit" described below.

BENEFITS

The following benefits are limited to the maximums shown in the Schedule of Benefits.

Surgical Indemnity Benefit

We will pay the **Inpatient Surgical Benefit** amount shown on the Schedule of Benefits for each day a Covered Person undergoes surgery while Confined to a Hospital as the result of a covered Accident or Sickness.

We will pay the **Outpatient Surgical Benefit** amount shown in the Schedule of Benefits for each day a Covered Person undergoes surgery, on an outpatient basis, as the result of a covered Accident or Sickness. This benefit is not payable for an Outpatient Minor Surgical Procedure.

We will pay the **Outpatient Minor Surgical Benefit** amount shown in the Schedule of Benefits for each day a Covered Person undergoes an Outpatient Minor Surgical Procedure as the result of a covered Accident or Sickness.

Anesthesia Indemnity Benefit

For each day a surgical benefit, as outlined above, is paid and anesthesia is administered, we will also pay the **Anesthesia Indemnity Benefit** amount shown in the Schedule of Benefits

EXCLUSIONS AND LIMITATIONS

The Exclusions listed in the Contract will apply to this rider; however, the following exception applies to exclusion 10 of the Contract with regards to this Rider:

Benefits under this Rider will be paid for the following dental or oral surgery procedures:

- Excision of impacted third molars; or
- Closed or open reduction of fractures or dislocation of the jaw.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:

1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary

President

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: 6300 Bridgepoint Parkway, Building 3, Suite 500, Austin, Texas 78730
(Hereinafter called "the Company," "we," "us," or "our")

PRESCRIPTION DRUG INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

BENEFIT

We will pay the Prescription Drug Indemnity Benefit amount specified in the Schedule of Benefits when a Covered Person fills a prescription for drugs as a result of a covered Accident or Sickness. Such drugs must be prescribed by a Physician. This benefit will be limited to the maximum number of prescriptions shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary President

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: 6300 Bridgepoint Parkway, Building 3, Suite 500, Austin, Texas 78730
(Hereinafter called "the Company," "we," "us," or "our")

OFF-THE-JOB ACCIDENTAL INJURY INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

In addition to the definitions contained in the contract, the following definition applies to this Rider.

Off-the-Job Accidental Injury - An injury which is caused by an Accident that does not occur while in the course of any legal or illegal occupation, activity, or employment for pay, benefit or profit.

BENEFIT

We will pay the Off-the-Job Accidental Injury Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person receives treatment for a covered Accident. Treatment must be provided by a Physician in the Physician's office, clinic, urgent care facility or Hospital emergency room within 96 hours of the Accident. Benefits are limited to the maximums shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary

President

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: 6300 Bridgepoint Parkway, Building 3, Suite 500, Austin, Texas 78730
(Hereinafter called "the Company," "we," "us," or "our")

INPATIENT DRUG AND ALCOHOL ADDICTION INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

BENEFIT

We will pay the Inpatient Drug and Alcohol Addiction Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person is confined, on an inpatient basis, to a Hospital or residential treatment facility as the result of alcohol or drug addiction. Confinement must begin while this Rider is in force and last for a minimum of 24 continuous hours. Benefits are subject to the maximums shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary

President

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: 6300 Bridgepoint Parkway, Building 3, Suite 500, Austin, Texas 78730
(Hereinafter called "the Company," "we," "us," or "our")

INPATIENT MENTAL AND NERVOUS DISORDER INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

In addition to the definitions contained in the contract, the following definition applies to this Rider.

Mental or Nervous Disorder - Includes neurosis, psychoneurosis, psychopathy, psychosis, or other mental or emotional disease or disorder of any kind.

BENEFIT

We will pay the Inpatient Mental and Nervous Disorder Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person is confined, on an inpatient basis, to a Hospital or mental health facility as the result of a Mental or Nervous Disorder. Confinement must begin while this Rider is in force and last for a minimum of 24 continuous hours. Benefits are subject to the maximums shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:

1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary

President

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499
Administrative Office: P.O. Box 998, Covington, LA 70434-0998
(Hereinafter called "the Company," "We," "Us," or "Our")

WAIVER OF PREEXISTING CONDITION LIMITATION AMENDATORY RIDER

This Rider is attached to and made a part of the contract to which it is attached. It is issued in consideration of the Application and payment of any required initial premium. The contract is amended as follows:

EXCLUSIONS AND LIMITATIONS

The **Preexisting Condition Limitation** provision in the **Exclusions and Limitations** section of the contract is hereby deleted in its entirety. Benefits relating to a Preexisting Condition will be paid the same as any other benefits payable under the contract.

This Amendatory Rider does not waive, alter or extend any condition or provision of the contract, except to the extent shown above. It is subject to all the terms and limitations of the contract. This Amendatory Rider takes effect and expires concurrently with the contract to which it is attached.

This Rider is signed for the Company at Our Home Office to take effect on the contract Effective Date.

General Counsel and Secretary

President

TRANSAMERICA®
Employee Benefits

Transamerica Life Insurance Company *("insurer")*
Administered By: Boon Administrative Services, Inc.
P.O. Box 559017, Austin, TX 78755

TransChoice® Claim Form

By furnishing this form, the Company does not admit that there is any insurance in force and does not waive any of it's rights and defenses

To file a claim: Complete Sections 1 and 2. Attach an itemized statement or have the Provider/Attending Physician complete Section 3. Submit the Claim Form with the itemized statement attached (if applicable) to the address above.

SECTION 1 – INSURED'S INFORMATION

1. Insured's Full Name	2. Date of Birth	3. Social Security Number	4. Certificate Number
5. Address (*include city, state and zip code)*			
6. Phone Number	7. Group Number (6-10 characters) _ _ _ _ _ _ _ _ _ _	8. Marital Status: ❒Married ❒Single ❒Other	9. Gender: ❒Male ❒Female

SECTION 2 – PATIENT'S INFORMATION Please attach itemized statement, CMS 1500 or UB92

1. Patient's Full Name	2. Date of Birth	3. Social Security Number
4. Relationship to Insured: ❒Self ❒Spouse ❒Child ❒Stepchild ❒Other	5. Date of Accident (if applicable)	
6. If auto accident, was patient: ❒Driver ❒Passenger ❒Unknown	7. Is this accident/illness covered by Worker's Compensation? ❒Yes ❒No	

If the health care provider is in your PPO network, payment will be made directly to the provider. Any remaining amount up to your indemnity benefit will be paid to you. If the provider is not in your PPO network, payment will be made directly to you.

Please attach an itemized statement: CMS 1500 or UB92 with itemization or have Section 3 completed by the Attending Physician.

SECTION 3 – ATTENDING PHYSICIAN'S STATEMENT To be completed by physician only if no itemized statement

Persons signing may receive a copy of this authorization. Any copy of this authorization shall have the same authority as the original.

I hereby request and authorize you to furnish to Transamerica Life Insurance Company or its representative any and all medical information concerning any illness or injury I may have suffered.

Signature of Patient (If minor, parent/guardian must sign) _____ Date _____

If signed on behalf of another, indicate your relationship (Only if patient is unable to sign) _____

(Expires six months from this date unless indicated or revoked earlier.)

1. Name and Address of Facility where Services Rendered

2. If auto accident, was patient: ❒Driver ❒Passenger ❒Unknown | 3. Is this accident/illness covered by Worker's Compensation? ❒Yes ❒No

4. Diagnosis or Nature of Illness or Injury. Relate Diagnosis to Procedure in Column D by Reference to Number 1, 2, 3, Etc. or DX Code

A Date of Service	B Place of Service	C Fully Describe Procedures, Medical Services or Supplies Furnished for each Date Given: Procedure Code (Identify)	C: Explain Unusual Services or Circumstances	D Diagnosis Code	E Charges	F

Your Patient's Account Number	Total Charge	Amount Paid	Balance Due

Physician's Name (please print)	Signature	Date	Tax ID Number or SSN
Street Address	City	State	Zip / Phone Number

REQUIRED FRAUD WARNING STATEMENTS

Claimants are required to acknowledge receipt of fraud warnings. Please refer to the fraud warning statement for your state as indicated below. Sign, date and return with claim documents.

FOR RESIDENTS OF ALASKA or TEXAS: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, or misleading information may be prosecuted under state law.

_____
Claimant's signature Date

FOR RESIDENTS OF ARIZONA: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

_____
Claimant's signature Date

FOR RESIDENTS OF CALIFORNIA: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

_____
Claimant's signature Date

FOR RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from the insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

_____
Claimant's signature Date

FOR RESIDENTS OF DELAWARE, IDAHO or INDIANA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

_____
Claimant's signature Date

FOR RESIDENTS OF DISTRICT OF COLUMBIA, LOUISIANA or RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____
Claimant's signature Date

FOR RESIDENTS OF FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

_____
Claimant's signature Date

FOR RESIDENTS OF HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both

_____
Claimant's signature Date

FOR RESIDENTS OF MAINE, TENNESSEE or VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

_____
Claimant's signature Date

FOR RESIDENTS OF MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____
Claimant's signature Date

FOR RESIDENTS OF MINNESOTA: A person who files a claim with intent to defraud or help commit a fraud against an insurer is guilty of a crime.

_____
Claimant's signature Date

FOR RESIDENTS OF NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided by RSA 638:20.

_____
Claimant's signature Date

FOR RESIDENTS OF NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

_____
Claimant's signature Date

FOR RESIDENTS OF OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

_____
Claimant's signature Date

FOR RESIDENTS OF PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

_____
Claimant's signature Date

FOR RESIDENTS OF ALL OTHER STATES: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

_____
Claimant's signature Date