CERTIFICATE OF INSURANCE

The following states the name of the Insured Employee, whether Dependent coverage is provided, the Employee's original Effective Date, the date of the most recent change, and the types of insurance in effect for the Insured.

POLICYHOLDER:	[Company ABC]
POLICY NUMBER:	[LP00123450]
EMPLOYEE:	[John Doe]
SOCIAL SEC #:	[123-45-6789]
MAJOR MED COVERAGE:	[YES]
FAMILY COVERAGE:	[NO]
EFFECTIVE DATE:	[01/01/2014]
CHANGE DATE:	[01/01/2014]

SAMPLE

PEKIN INSURANCE

SCHEDULE OF BENEFITS
PPO Network Plan

Coverage Information

Plan Type:

Employer/Policyholder:

Employer Location State of Issue:

Employee:

Coverage Type:

Certificate Number:

Effective Date:

COBRA Provisions:

Grandfathered Status:

Calendar Year Deductible

The amount of the Covered Expenses an Insured is responsible to pay each Calendar Year. The In-Network and Out-of-Network Calendar Year Deductibles are accumulated separately. No one insured will be required to satisfy more than the applicable Individual Deductible regardless of Family Coverage. See Policy for full details. The Deductibles are subject to annual adjustments as may be required by law.

	In-Network Providers	**Out-of-Network Providers**
Individual Deductible (per Insured per Calendar Year)		
Family Deductible (per Family per Calendar Year)		

Out-of-Pocket Maximum

The maximum amount of Covered Expenses an Insured must pay per Calendar Year before We begin to pay benefits for Covered Expenses at 100% for such Calendar Year. The In-Network and Out-of-Network Calendar Year Out-Of-Pocket Maximums are accumulated separately. No one insured will be required to satisfy more than the applicable Individual Out-of-Pocket Maximum regardless of Family Coverage. The Out-of-Pocket Maximum is subject to annual adjustments as may be required by law.

	In-Network Providers	**Out-of-Network Providers**
Individual Out-of-Pocket Maximum (per Insured per Calendar Year)		
Family Out-of-Pocket Maximum (per Family per Calendar Year)		

Coinsurance and Benefit Maximums for Covered Expenses Per Insured

In Network and Out-of-Network Coinsurance percentages are the percentages of Covered Expenses paid by Us. Benefit Maximum is the limit on the Covered Expenses that We will pay on behalf of any Insured per Calendar Year. Expenses must be eligible under the Policy, Medically Necessary and the most cost-effective medically appropriate care. See the Policy for full details of coverages, exclusion, limitations and provisions.

SAMPLE

SCHEDULE OF BENEFITS
PPO Network Plan

Medical Services and Supplies	In-Network Coinsurance Percentage (after In-Network Deductible)	Out-of-Network Percentage (after Out-of-Network Deductible)	Benefit Maximum per Insured, if any
Physician Office Visit	%	%	
In-Patient Confinement	%	%	
Semi-private Hospital Room & Board	%	%	
Phsycian& Surgeon Services	%	%	
Reasonable and Customary Percentile Level	80th	60th	
Urgent Care Facility	%	%	
Emergency Room (Access Fee waived if insured is Hospital confined as an Inpatient immediately following the emergency room visit) *No coverage for Non-Emergency use of an Emergency Room*	% after $75 Access Fee for Emergency Services	% after $75 Access Fee for Emergency Services	
Skilled Nursing Facility	%	%	90 days maximum per calendar year
Ambulatory Surgical Center Facility	%	%	
Emergency Ambulance Services (ground & air)	%	%	
Outpatient Diagnostic Tests and Laboratory Tests	%	%	
Outpatient Radiation and Chemotherapy *Requires Pre-approval*	%	%	
Outpatient medical supplies including Durable Medical Equipment *Requires Pre-approval*	%	%	
Preventive Care	100% (Deductible Waived)	Not Covered	
Maternity Services - Prenatal & first post-partnum	%	%	
Maternity Services - Hospital Inpatient Confinement	%	%	
Diabetic Equipment and Supplies	%	%	
Durable Medical Equipment *Requires Pre Authorization*	%	%	
Inpatient Rehabilitation Services	%	%	
Outpatient Habilitative Services	%	%	
Human Organ or Tissue Transplants *Requires Pre Certification (inpatient) & Pre-approval (inpatient & outpatient)*	100% (at designated Transplant Facility)	90% of first $100,000. No coverage thereafter	$30,000 total maximum per Transplant for unrelated donor searches. See certificate.

SAMPLE

SCHEDULE OF BENEFITS
PPO Network Plan

Medical Services and Supplies	In-Network Coinsurance Percentage (after In-Network Deductible)	Out-of-Network Percentage (after Out-of-Network Deductible)	Benefit Maximum per Insured, if any
Transplant Service Lodging and Transportation Allowance when Designated Transplant Facility is used *Requires Pre-approval*	$200 daily maximum	Not Applicable	$10,000 total maximum
Mental Health Conditions-Inpatient *Requires PreCertification*	%	%	
Mental Health Conditions-Outpatient	70%	%	
Chemical Dependency Treatment and Substance Use Disorders - Inpatient *Requires PreCertification*	%	%	
Chemical Dependency Treatment and Substance Use Disorders - Outpatient		%	
Hospice Care/Respite Care *Requires Pre Authorization*	%	%	15 days per lifetime inpatient and 15 days per lifetime outpatient. Respite Care must be used in increments of not more than 5 days at a time.
Home Health Care (excluding Private Duty Nursing) *Requires Pre Authorization*	%	%	
Private Duty Nursing	%	%	90 visits per Calendar Year
Therapy - Physical, Manipulative, Occupational & Speech	%	%	20 visit Calendar Year Max for each therapy type
Injectible Medications, excluding insulin *Requires Pre-approval*	%	%	
Retail Prescription Drugs	% (Participating Pharmacy)	N/A	
Mail Order Prescription Drugs	% (Participating Pharmacy)	N/A	
Pediatric Dental	See Pediatric Dental Care Benefit Amendment		
Pediatric Vision	See Pediatric Vision Care Benefit Amendment		

SAMPLE

SCHEDULE OF BENEFITS
PPO Network Plan

There is a penalty of $500 for failure to obtain Pre-Certification for Inpatient and overnight stays, but in no event will the penalty exceed 50% of the total charges. Penalty payments do not apply toward any Deductible or any Out-Of-Pocket maximum amounts. See Section 7 - Pre-Certification Program of the Policy.

The following are subject to Pre-Approval by Our case management prior to obtaining services: If Pre-Approval is approved for a particular treatment or service, that authorization applies only to the Medical Necessity of that treatment or service. All treatments are subject to the Policy provisions, such as benefits, limitation and exclusions. Contact our Case Management Department at (800)371-9622 ext 3155 for assistance.

Artificial eyes, limbs or larynx
Bariatric Surgery
Chemotherapy
Durable Medical Equipment & Supplies
Habilitative Services
Home Health Care
Hospice Care
Organ and Tissue Transplants
Prosthetics
Radiation Therapy
Self-Injectible Medications (except insulin)
Skilled Nursing Care

SAMPLE

YOUR PREFERRED PROVIDER PLAN

YOUR CERTIFICATE OF INSURANCE LISTS THE BENEFITS THAT YOU ARE INSURED FOR.
ANY BENEFITS OR PROVISIONS SHOWN TO BE "EXCLUDED" IN YOUR CERTIFICATE OF INSURANCE ARE NOT PART OF YOUR PLAN AND DO NOT APPLY TO YOU.

This certificate booklet summarizes the group insurance benefits of the policy. It outlines what You must do to be Insured. It explains how to file claims. It is Your certificate while You are Insured.

SAMPLE

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SECTION 1 – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

Eligibility for Insurance

To be Eligible for coverage under the policy, an individual must either meet the definition of Employee or meet the definition of Dependent.

Employee Enrollment Eligibility

To become an Insured Employee, an individual must:

- Be an Employee;
- Complete and submit, through the Policyholder, an enrollment form, during an enrollment period;
- Provide any additional information We need to determine eligibility, if requested by Us; and
- Agree to pay Your portion of the required premium, if required by the Policyholder.

Dependent Enrollment Eligibility

- You may enroll Your current Dependent(s) at the same time You initially enroll.
- You may enroll any new Dependent who meets the definition of Dependent, after Your Enrollment Date, by completing and submitting an enrollment form to Us the Policyholder.

Enrollment for Employees and Dependents

To have the insurance provided by the policy, all Eligible Employees and Dependents must enroll by completing and submitting an enrollment form. The insurance becomes effective as follows:

- If You enroll on or before the date You are Eligible, You will become insured on the date You are Eligible. If You enroll for Your Dependents on or before the date they are Eligible, they will become Insured on the date they are Eligible;
- If You enroll within 30 days after the date You are Eligible, You will become Insured on the premium due date following the date You enrolled. If You enroll Your Dependents within 30 days after the date they are Eligible, they will become Insured on the premium due date following the date You enrolled.

Initial Enrollment Period For New Employees And Dependents Eligible After The Policy Effective Date

An initial enrollment period is the period of time during which a new Employee and his or her Dependents are first Eligible to enroll under the policy. Your initial date of eligibility to enroll is the first day of Your Service Waiting Period which is typically the date on which employment starts. If You and Your Dependents are enrolling during the initial enrollment period, You must enroll for coverage during Your servicing waiting period. Your coverage and coverage for Your Dependents will be effective on the premium due date following the last day of the Service Waiting Period except that Your and Your Dependents' Effective Date will not be longer than 90 calendar days from Your initial date of eligibility to enroll.

Dependent Enrollment Periods

1. Special Enrollment Period for Newborn Children

   Coverage of a Newborn Child will be automatic for the first 60 days following the birth of Your Newborn Child. For coverage to continue beyond this time, You must notify Us within 60 days of birth and pay any required premium within that 60-day period. Coverage will become effective on the date of birth. If We are notified after that 60-day period, the Newborn Child's coverage will become effective on January 1st following the Policyholder's next open enrollment period.

2. Special Enrollment Period for Adopted Children or Children Placed for Adoption

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Coverage of an adopted Child or Child placed for adoption will be automatic for the first 60 days following the adoption or date on which the Child is placed for adoption. For coverage to continue beyond this time, We must receive notice and the required premium within the 60-day period. Coverage will become effective on the date of adoption or date on which the Child is placed for adoption. If You notify Us after that 60-day period, the Child's coverage will become effective on January 1st following the Policyholder's next open enrollment period.

3. Court Ordered Dependent Children

Coverage is provided to a Child in the court ordered custody of an Employee on the same basis and to the same extent, and in the same manner, as for a newborn Dependent Child.
We must receive notification within 31 days of the date on which the court order establishing custody of the Child by the Employee was issued and any additional premiums that are due for the coverage of the Child must be paid. In order to establish court ordered custody, the Employee must send to Us a copy of the court order that establishes that the Employee has full legal custody of such Child. If an Employee notifies Us after the 31-day period, the Dependent Child's coverage will become effective on January 1st following the Policyholder's next open enrollment period.

Special Enrollment Periods

1. For Persons Who Previously Declined Coverage

A person who previously declined coverage in writing because they were covered under another Group Health Plan or Health Insurance Coverage may have a 30 day special enrollment period if they lose that coverage.

The 30 day special enrollment period will begin for that person on the day the person loses his/her coverage under another Group Health Plan or Health Insurance Coverage because of:

- A reduction in the number of hours of employment;
- Termination of employment;
- Termination of employer contributions;
- The COBRA continuation provision that they were covered under is exhausted under the other Group Health Plan or Health Insurance Coverage;
- Legal separation, divorce, or death; or
- Cessation of dependent status.

Coverage will become effective on the premium due date following the date the person enrolls.

2. For Persons Having a Family Status Change

A person will have a 30 day special enrollment period to enroll for coverage beginning on the date a Family Status Change occurs.

In the case of a Family Status Change due to marriage, coverage will begin on the earlier of the next premium due date or the first day of the month, after the completed enrollment form is received.

3. Change in CHIP or Medicaid Coverage

If an Employee's or an Employee's Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or an Employee or Dependent becomes Eligible for a subsidy (state premium assistance program) under Medicaid or CHIP and the Employee previously declined coverage under the policy, the Employee or an Employee and his Dependent may request special enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If the enrollment form is received within the 60 day period, the Employee or Employee's Dependent's coverage will be effective on the first day of the month following receipt of the enrollment form by Us.

4. Loss of minimum essential coverage

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If You or Your eligible dependents lose minimum essential coverage (a failure to pay premium or a rescission of coverage allowed under federal law do not qualify as a loss of minimum essential coverage), You and Your eligible dependents must enroll within 60 days of this event.
Minimum essential coverage can consist of either (a) government-sponsored coverage, such as Medicare or Medicaid; (b) an "eligible employer-sponsored plan"; (c) a plan "offered" in the individual market within a State"; (d) a "grandfathered health plan" or (e) anything else that the Secretary of Health and Human Services deems appropriate.

5. If an Employee or an Employee's Dependent(s) become a citizen, national or lawfully present individual in the U.S., You are eligible to enroll within 60 days of the event.

6. If You are qualified, but experience an error in enrollment, You and Your eligible Dependents must enroll within 60 days of the event.

Open Enrollment Period for Current Employees

An Employee and his Dependents may enroll under the policy during an open enrollment period that runs from [November 15 to December 15] of each year. If an Employee and his/her Dependents do not enroll when Eligible on the policy Effective Date, during the initial enrollment period or during a special enrollment period as described above, an Employee or the Employee's Dependents must wait until the next annual open enrollment period to enroll. If an Employee or his/her Dependents enroll during an open enrollment period, the Employee's coverage and Employee's Dependent's coverage will be effective on January 1st next following the end of the open enrollment period.

SECTION 2 - TERMINATION OF INSURANCE OF INSUREDS

Insured Employee - The insurance of an Insured Employee will end on the earliest of the following dates:

- The last day of the coverage month when any portion of the premium due is not paid by 31 days following the first day of the coverage month;
- The premium due date following the date he/she is no longer an Employee;
- The date the policy terminates;
- If You have performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing in order to obtain coverage for a service, Your coverage will terminate on the premium due date following written notice of termination delivered by Us to You. However, if an Employee commits fraud or makes an intentional misrepresentation of material fact in writing on his/her enrollment form, We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying Us for the amount We paid for previously received services not to include any Copayments made or Premium paid for such services. Rescission means that the termination of the Employee's and Dependents' insurance has a retroactive effect to the Effective Date under the policy;
- The date of the Employee's death; and
- If an insured can provide proof of other coverage, the last day of coverage under this policy is the day before such coverage begins.

Insured Dependent - The insurance of an Insured Dependent will end on the earliest of the following dates:

- The date the Insured Employee's insurance terminates. If the Insured Employee's insurance terminates because he/she dies, Dependent health coverage will remain in effect until the premium due date following 90 days after the Insured Employee's death. Extension of this overage is subject to premium and any other applicable provisions of the policy;
- The premium due date following the date he/she no longer meets the definition of a Dependent as defined in the policy. An Insured Dependent Child who is losing coverage because he/she is turning 26 years of age, and who because of a handicapped condition is incapable of self-support, may be continued under this insurance while remaining incapacitated, and Dependent on his or her parents or other care providers for lifetime care and supervision. We may request Proof of Incapacity from time to time, but not

SAMPLE

before 2 months prior to the date his/her insurance would otherwise end. If Proof of Incapacity is not received within 31 days after it is requested, the Child will not be considered an Insured Dependent. If We do not request proof of incapacity, coverage for this Child shall extend through the term of the policy, or any extension or renewal of the policy; and

- The date that any portion of the premium that is due is not paid.

SECTION 3 - CLAIMS

NOTICE OF CLAIMS

We must receive written notice of claims. It must be given within 20 days after the date the loss began or as soon as reasonably possible. It may be given at Our Home Office or to one of Our agents. It must contain enough information to identify You.

CLAIM FORMS

We will provide claim forms within 15 days after We receive notice of claim. If We do not provide the forms, a claim may be filed without using them. Such claims must contain written Proof of Loss. It must cover the occurrence, type, and extent of loss.

PROOF OF LOSS

Written Proof of Loss must be sent to Our Home Office within 90 days after the loss or as soon as reasonably possible. It may include medical records, supplier invoices for supplies and other supporting documentation to determine coverage. Proof provided more than one year late will not be accepted unless evidence, satisfactory to Us, is submitted that shows it was not reasonably possible to submit proof within the time specified.

TIMING OF CLAIM DECISIONS

We will provide notice, in accordance with the provisions set forth below, of any Adverse Benefit Determination or a decision that a claim is payable in full within the following timeframes:

- Urgent Care Concurrent and Pre-Service Claims:
  - If the Insured has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
  - If the Insured has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
  - The Insured will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:
    - Receipt of the specified information; or
    - The end of the period afforded the Insured to provide the information for which the period will not be less than 48 hours.

If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Insured. All necessary information may be transmitted by telephone, facsimile, or other similarly expeditious method. Alternatively, the Insured may request an expedited review under the external review process.

- Non-Urgent Care Concurrent Pre-Service Claims:
  - If the Insured has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period. If an extension is necessary due to circumstances beyond Our control, notice of the additional extension will be provided prior to the end of the initial 15-day period.
  - If the Insured has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, The Insured must provided the specific information needed within 45 days from receipt of the notice.

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- Post-Service Claims:
  - If the Insured has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period. If an extension is necessary due to circumstances beyond Our control, notice of the additional extension will be provided prior to the end of the initial 30-day period.
  - If the Insured has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Insured will be notified of a determination of benefits prior to the end of the extension period, The Insured must provided the specific information needed within 45 days from the receipt of the notice.

PAYMENT OF CLAIMS

We will either accept or deny a clean claim within 30 days after We receive it. If the Clean Claim is not paid within 30 days, We will pay interest at the current rate determined by the State of Iowa for delayed claim payments on any benefit due beginning on the 31st day after We receive all information necessary to establish a clean claim.

All accident and health benefits are payable to the Insured Employee. However, We reserve the right to pay benefits directly to the Hospital or other provider of medical services. These payments will satisfy Our responsibility to the extent of the payments.

If any benefit remains payable after the death of the Insured or while he/she is not competent to give a valid release, We may pay a benefit up to $1,000.00 to any relative of his/hers who We decide is justly entitled to it. Any payment made to his/her relatives in good faith will fully release Us of Our responsibility to the extent of the payment.

PHYSICAL EXAMINATION AND AUTOPSY

We, at Our expense, have the right to examine the Insured when and as often as We may reasonably require while a claim is pending or during any period in which We are paying benefits. In the case of death, We have the right to have an autopsy performed.

LEGAL ACTIONS

No suit at law or in equity may be brought to recover under the policy:

- any earlier than 60 days after written Proof of Loss has been sent to Us as required by the terms of the policy; or
- any later than three years after the time such proof must be sent.

SECTION 4 - MAJOR MEDICAL BENEFIT PROVISIONS

AMOUNT OF BENEFIT

We will pay the amount of benefit shown on the Schedule of Benefits for Covered Expense after Your Cost-Sharing shown on the Schedule of Benefits has been met. Our payments are subject to the policy's definitions, provisions, limitations, and exclusions.

BENEFIT FOR COVERED EXPENSE PROVIDED BY A PREFERRED PROVIDER

Before We pay any benefit for other services provided by a Preferred Provider, Covered Expense equal to the applicable In-Network Deductible must be incurred in a Calendar Year. For Individual Coverage, the applicable In-Network Individual Deductible must be met. For Family Coverage, the applicable In-Network Family Deductible must be met. However, no one covered Insured will be required to incur more than the applicable In-Network Individual Deductible regardless of Family Coverage.

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After the applicable In-Network Deductible is satisfied, We will then pay benefits for Covered Expense provided by a Preferred Provider that are in excess of the applicable In-Network Deductible for the remainder of the Calendar Year. These benefits will be paid at the In-Network Coinsurance Percentage shown on the Schedule of Benefits.

Once the applicable In-Network Out-of-Pocket Maximum amount has been met as shown for In-Network Providers on the Schedule of Benefits, We will pay the Covered Expenses at 100% for the remainder of the Calendar Year. For Individual Coverage, the Individual In-Network Out-of-Pocket Maximum must be met before benefit is paid at 100%. For Family Coverage, the In-Network Family Out-of-Pocket Maximum must be met before benefit is paid at 100%.

Covered Expenses by a Preferred Provider are combined with Covered Expenses for prescriptions purchased at a Participating Pharmacy with the drug card to satisfy the In-Network Deductible.

BENEFITS FOR PRESCRIPTIONS PURCHASED AT A PARTICPATING PHARMACY

Before We pay any benefit for covered prescriptions purchased with the drug card at a Participating Pharmacy, Covered Expense equal to the applicable In-Network Deductible must be incurred in a Calendar Year. For Individual Coverage, the In-Network Individual Deductible must be met. For Family Coverage, the In-Network Family Deductible must be met. However, no one covered Insured will be required to incur more than the In-Network Individual Deductible regardless of Family Coverage.

After the applicable In-Network Deductible is satisfied, We will then pay benefits for Covered Expense provided by a Participating Pharmacy that are in excess of the applicable In-Network Deductible for the remainder of the Calendar Year. These benefits will be paid at the In-Network Coinsurance Percentage shown on the Schedule of Benefits.

Once the applicable In-Network Out-of-Pocket Maximum amount has been met as shown for In-Network Providers on the Schedule of Benefits, We will pay the Covered Expenses at 100% for the remainder of the Calendar Year. For Individual Coverage, the Individual In-Network Out-of-Pocket Maximum must be met before benefit is paid at 100%. For Family Coverage, the In-Network Family Out-of-Pocket Maximum must be met before benefit is paid at 100%.

Covered Expenses for prescriptions purchased at a Participating Pharmacy with the drug card are combined with Covered Expenses by a Preferred Provider to satisfy the In-Network Deductible.

BENEFIT FOR COVERED EXPENSE FOR EMERGENCY SERVICES PROVIDED IN A HOSPITAL EMERGENCY ROOM

When You incur Covered Expense for Emergency Services provided in a Hospital emergency room, You must pay an emergency room Access Fee as outlined in the Schedule of Benefits. This amount must be paid anytime You receive Emergency Services in a Hospital emergency room, and are not directly admitted to the Hospital as an Inpatient. This amount is in addition to any Deductible amounts.

After You pay the emergency room Access Fee, We will pay other Covered Expense as outlined above in the section titled "Benefit for Covered Expense Provided by a Preferred Provider."

If You are directly admitted to the Hospital as an Inpatient following an emergency room visit, You will not be required to pay the emergency room Access Fee.

BENEFIT FOR COVERED EXPENSE PROVIDED BY A NON-PREFERRED PROVIDER

Before We can pay any benefit for other services provided by a Non-Preferred Provider, Covered Expense equal to the applicable Out-of-Network Deductible must be incurred in a Calendar Year. For Individual Coverage, the Out-of-Network Individual Deductible must be met. For Family Coverage, the Out-of-Network Family Deductible must be met. However, no one covered Insured will be required to incur more than the Out-of-Network Individual Deductible regardless of Family Coverage.

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After the applicable Out-of-Network Deductible is satisfied, We will then pay benefits for Covered Expense provided by a Non-Preferred Provider that are in excess of the applicable Out-of-Network Deductible for the remainder of the Calendar Year. These benefits will be paid at the Out-of-Network Coinsurance Percentage shown on the Schedule of Benefits.

Once the applicable Out-of-Network Out-of-Pocket Maximum amount has been met as shown for Out-of-Network Providers on the Schedule of Benefits, We will pay the Covered Expenses at 100% for the remainder of the Calendar Year. For Individual Coverage, the Individual Out-of-Network Out-of-Pocket Maximum must be met before benefit is paid at 100%. For Family Coverage, the Out-of-Network Family Out-of-Pocket Maximum must be met before benefit is paid at 100%.

USE OF NON-PREFERRED PROVIDERS

When You use a Non-Preferred Provider:

- The amount of payment is based upon a reduced allowable amount, and not the actual billed charge; and
- You may be expected to pay a larger portion of the bill, even after We have paid the percentage of Covered Expense provided under the policy.

BENEFIT FOR SPECIALTY PHYSICIAN SERVICES BY A NON-PREFERRED PROVIDER

If care by a specialist is Medically Necessary and appropriate, and there is no Preferred Provider of the required specialty In-Network, the Plan will consider Covered Expenses by the Out-of Network provider to be considered as if services were provided by a Preferred Provider. Use of Out-of-Network specialty Physicians due to convenience, Physician preference or patient/family preference does not qualify for extension of In-Network coverage. All covered health expenses from other providers resulting from use of a specialty provider will be considered Out-of-Network unless there are no In-Network providers available for use by the specialty provider. Consideration of covering Non-Preferred services as Preferred requires Pre-Approval. Use of specialty providers for Treatment of an Emergency Medical Condition is covered under BENEFIT FOR EMERGENCY SERVICES.

BENEFIT FOR EMERGENCY SERVICES

Sometimes situations occur that require an Insured to receive care from a Non-Preferred Provider, instead of Preferred Providers. When an Insured requires Emergency Services as defined by the Policy, benefits will be calculated as if the services were provided by a Preferred Provider, even when the services are from a Non-Preferred Provider. The In-Network Deductible and In-Network Coinsurance percentage amounts will apply as long as emergency care is being rendered. Once it has been established that the Insured can safely transfer to the care of a Preferred Provider, We will only pay In-Network benefits for Preferred Providers. If the Insured chooses to continue to receive care from Non-Preferred Providers once the Insured is Stabilized and a safe transfer to a Preferred Provider can be made, benefit for expense from Non-Preferred Providers will be calculated using the Out-of-Network Deductible and Out-of-Network Coinsurance percentage amounts.

Medically Necessary and appropriate care provided outside of the United States due to an Emergency Medical Condition are also Covered Expenses.

DEDUCTIBLE CREDIT PROVISION

An Insured's Deductible for the first Calendar Year can be reduced by any expense that:

- Was applied to his/her Deductible under the Former Policy for this Calendar Year; or
- Was incurred during the 90 day period prior to the date the Policy became effective, and was applied to the Deductible under the Former Policy.

This provision only applies to persons insured under the Former Policy on the day before the Policy became effective, and who have been continuously insured under the Policy since the Policy's Effective Date.

To receive credit under this provision, each Insured must provide Us with proof of the amount of credit earned under the Former Policy. This proof should be submitted at the same time or prior to the Insured filing the first claim under the Policy.

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MATERIAL MODIFICATION OF COVERAGE

In the event of a material modification of the Covered Expenses under the Policy, You will be given no less than 60 days notice of the change, including changes to Preventive Care Covered Expenses.

SECTION 5 - EXPENSES COVERED BY THE PLAN

Benefits are payable as outlined on the Schedule of Benefits for Covered Expense. Covered Expenses are charges for the following, subject to all other Policy provisions:

1. By a Hospital for:

- Semiprivate room and board;
- Care in the Intensive Care Unit;
- Hospital services and supplies which are to be used while in the Hospital;
- Emergency Services in a Hospital emergency room, including a voluntary HIV test performed while receiving emergency medical services in a Hospital emergency room;
- Outpatient medical care and Treatment.

Inpatient and overnight stays require Pre-Certification as outlined in Section 7 – Pre-Certification Program.

2. For outpatient surgery

Performed in a licensed ambulatory surgical facility.

3. By a Chemical Dependency Treatment Facility

Treatment facility that provides Treatment of Substance Use Disorders. This type of facility must be licensed under applicable law.

Inpatient and overnight stays require Pre-Certification as outlined in Section 7 – Pre-Certification Program.

4. By a Community Mental Health Center

Mental health center that provides outpatient Treatment of Mental Health Conditions. This type of facility must be licensed under applicable law.

5. By a Nursing Facility

That provides continuous skilled nursing services as ordered and certified by an Insured's attending Physician on an Inpatient basis. A registered nurse (R.N.) must supervise services and supplies on a 24 hour basis. The facility must be licensed as a Nursing Facility under applicable law.

Skilled nursing care in a Hospital is included if the level of care needed by the Insured has been reclassified from acute care to skilled nursing care and no designated skilled nursing care beds or swing beds are available in the Hospital or in another Hospital or health care facility within a thirty-mile radius of the Hospital. We will reimburse You based on the Skilled Nursing Facility rate shown in the Schedule of Benefits.

Inpatient and overnight stays require Pre-Certification as outlined in Section 7 – Pre-Certification Program.

6. By a Psychiatric Medical Institution for Children (PMIC)

This type of facility provides Inpatient psychiatric services to Children and is licensed as a PMIC under Iowa Code Chapter 135H.

SAMPLE

Inpatient and overnight stays require Pre-Certification as outlined in Section 7 – Pre-Certification Program.

7. By a Physician for:

- Office visits;
- Hospital care;
- Surgical services, including postoperative care following Inpatient or outpatient surgery; for multiple surgical procedures performed during the same operative session, Covered Expense will include 100% of the Regular, Reasonable and Customary amount for the first surgical procedure, 50% of the Regular, Reasonable and Customary amount for the second surgical procedure, and 25% of the Regular, Reasonable and Customary amount for each additional surgical procedure;
- Services of an assistant surgeon when Medically Necessary to perform the surgery, but no more than 20% of the amount allowed for the primary surgeon's fee; and
- Injections and medication that is consumed at the Physician's office. Requires Pre-Approval by Us.

8. Substance Use Disorder Services

Treatment for a condition with physical or physiological symptoms produced by Alcoholism or Chemical Dependency as described in the most current *Diagnostic and Statistical Manual of Mental Disorders*.

Inpatient and overnight stays require Pre-Certification as out lined in Section 7 – Pre-Certification Program.

9. Home Health Care Services

- Home health aide services – when provided in conjunction with a Medically Necessary skilled service also received in the home;
- Home skilled nursing – Treatment must be given by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) and/or a Medicare-certified agency. The daily benefit for home skilled nursing services will not exceed the Regular, Reasonable and Customary charge;
- Inhalation therapy;
- Medical equipment;
- Medical social services;
- Medical supplies;
- Occupational Therapy – but only for services to treat the upper extremities, which means the arms from the shoulder to the fingers. Occupational therapy supplies are not covered under this benefit;
- Oxygen and equipment for its administration;
- Parenteral and enteral nutrition;
- Physical Therapy;
- Prescription drugs and medicines administered in the vein or muscle;
- Prosthetic devices and braces;
- Speech therapy; and
- Private duty nursing.

All of the following requirements must be met in order for a home health services to be a Covered Expense:

- The Insured requires a Medically Necessary skilled service such as skilled nursing, physical therapy, or speech therapy;
- Services are received from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) and/or a Medical-certified agency;
- Services are prescribed by a Physician for the Treatment of Illness or Injury;
- Services are not more costly than alternative services that would be effective for diagnosis and Treatment of the Insured's condition; and
- Pre-Approval was obtained.

10. Hospice Services

SAMPLE

Care (generally in a home setting) for patients who are terminally ill and have a life expectancy of six months or less. Hospice Care covers the same services as described under Home Health Services, as well as Hospice Respite Care from a facility approved by Medicare or by the Joint Commission for Accreditation of Health Care Organizations (JCAHO). Hospice Respite Care offers rest and relief help for the family caring for a terminally ill patient. Inpatient Respite Care can take place in a nursing home, Skilled Nursing Facility or Hospital. Services require Pre-Approval by Us.

11. Maternity Services

- Prenatal and postnatal care, delivery, including Complications of Pregnancy; and
- Maternity services include a minimum of:
  - 48 hours of Inpatient care (in addition to the day of delivery) following a vaginal delivery; or
  - 96 hours of Inpatient care (in addition to the day of delivery) following a cesarean section.

The attending practitioner, in consultation with the mother, may discharge the mother or newborn prior to 48 or 96 hours, as applicable. If the Inpatient Hospital stay is shorter, coverage includes a follow-up postpartum home visit by an approved provider competent to perform postpartum care.

For a covered pregnancy, including surrogate pregnancy, of an Insured mother under the Policy, expenses incurred for a well Newborn Child's initial Hospital confinement will be considered a covered expense under the Insured mother's coverage. In the case of other insurance coverage for the mother, normal Coordination of Benefits will apply as if the charges for the well Newborn are for the mother. No benefits are provided for the well Newborn initial Hospital confinement when the mother is not insured under the Policy. Mother and well Newborn will be considered one Insured until discharge from the initial Hospital confinement and therefore the Mother must be eligible for coverage for the Newborn's initial Hospital confinement to be eligible. In the case of a non-well Newborn with an illness or injury, all usual policy provisions apply.

12. Mental Health Condition Services

Treatment for a Mental Health Condition. Coverage includes diagnosis and Treatment of a Mental Health Condition.

Inpatient and overnight stays require Pre-Certification as outlined in Section 7 – Pre-Certification Program.

13. Preventive Care

The following preventive care services are covered without regard to any Cost-Sharing requirements such as Deductible, Copay or Coinsurance requirements that would otherwise apply when received from an In-Network provider. Refer to the Schedule of Benefits for Out-of-Network coverage, if applicable.

- Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention will be considered the most current other than those issued in or around November 2009. Except oral medications that meet these requirements are covered under the 15. Prescription Benefit of this section;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Insured involved. Reimbursement for immunizations containing no more than trace amounts of mercury as defined by the United States food and drug administration shall be at the acquisition cost rate for immunizations containing no more than trace amounts of mercury;
- With respect to Insureds who are infants, Children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- With respect to Insureds who are women, such additional preventive care and screenings not described in paragraph (A) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration including:

SAMPLE

    - One well-woman preventive care visit per Calendar Year for an adult woman to obtain the recommended preventive screening services that are age appropriate and developmentally appropriate, including preconception and one visit for prenatal care. More than one visit may be needed to obtain all the recommended preventive screening services, depending on a woman's health status, health needs and other risk factors. Additional well-woman visits will be covered if the Physician determines they are necessary to help establish what preventive screening services are appropriate and to set up a plan to help the woman get the care she will need to be healthy;
    - One screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be high risk for diabetes;
    - High-risk human papilloma virus DNA testing in women with normal cytology results. One screening is covered for females 30 years of age and over and will be covered no more frequently than once every 3 years;
    - One counseling session per Calendar Year for counseling on sexually transmitted infections for all sexually active women;
    - One counseling session and screening per Calendar Year for human immune-deficiency virus infection for all sexually active women;
    - Female contraceptive methods, female sterilization procedures, and patient education and counseling for all women with reproductive capacity. Reasonable medical cost management measures such as, but not limited to, requirement of Equivalent Generic Drug when available and appropriate will apply. Covered oral contraceptives must be processed using the prescription drug card. one screening and counseling for interpersonal and domestic violence per Calendar Year;
    - Breastfeeding support, supplies and counseling in conjunction with each birth: Covered Expense includes comprehensive lactation support and counseling by a trained provider during Pregnancy and/or in the postpartum period. Coverage includes the costs of renting or purchase of one breast pump per pregnancy for the duration of the breast feeding. Supplies and equipment are considered Durable Medical Equipment and require pre authorization by Us;
    - Annual cervical pap smear;
    - Mammography;
    - One baseline mammogram examination for each female Insured who is at least 35, but less than 40 years of age;
    - One mammogram examination every 2 years or more frequently if ordered by a Physician for a female Insured who is at least 40 but less than 50 years of age;
    - One mammogram examination every year for a female Insured age 50 and over;
    - Human papilloma virus vaccination as defined by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
- Prostate cancer screening. A medically recognized diagnostic examination for the detection of prostate cancer. Covered Expense includes:
    - A physical examination for the detection of prostate cancer; and
    - A prostate-specific antigen test used for the detection of prostate cancer for each male who:
        - Is at least 50 years of age and is asymptomatic; or
        - Is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor; and
- Colorectal cancer screening as prescribed by a Physician in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College Gastroenterology;

14. Transplants

- Certain bone marrow/stem cell transfers from a living donor;
- Heart;
- Heart and lung;
- Kidney;

SAMPLE

- Liver;
- Lung;
- Pancreas;
- Simultaneous pancreas/kidney; and
- Small bowel.

Expenses for an unrelated donor search for bone marrow or stem cell transplants for a transplant covered under this provision will be covered up to a maximum amount of $30,000 per transplant.

Charges related to the donation of an organ are usually covered by the recipient's medical benefits plan. However, if donor charges are excluded by the recipient's plan, and You are a donor, the charges will be covered under the Policy.

Travel/Lodging Benefit

When a covered organ transplant is performed at a Designated Transplant Facility, We will provide:

- Transportation for the Insured patient and one member of the Insured patient's Immediate Family to accompany the Insured patient to and from the Designated Transplant Facility; and
- Lodging at or near the Designated Transplant Facility for the family member who accompanied the Insured patient, while the covered person is confined at the Designated Transplant Facility.

We will arrange the transportation and lodging at no cost to the Insured patient; except that the daily maximum benefit We will pay for food and lodging for the family member who accompanied the covered person is $200.00 with a total maximum of $10,000. We must be provided with itemized bills for all transportation, food and lodging expenses.

Transplants require Pre-Approval by Us.

15. Prescription Benefits

The prescription benefits are facilitated through a drug card administered by the prescription drug card company, hereafter referred to as the RX Company. Benefit is provided for Covered expense incurred for drugs which require a written prescription and which are dispensed by a licensed pharmacist. The prescription benefit also provides benefit for expense for insulin, syringes for administration of insulin, test strips for glucose monitors, and glucagon emergency kits, when prescribed by a Physician and dispensed by a licensed pharmacist.

Prescriptions Purchased at a Retail Pharmacy – 34 day supply

You may purchase a prescription drug order at a retail Participating Pharmacy, as long as the order does not exceed the lesser of a 34 day supply. An exception will be made for non-Specialty medication once a 30 day supply has been covered under this Policy. In such cases, You may purchase up to a 90 day supply at a retail Participating Pharmacy. All drug classifications are determined by the RX Company.

Prescriptions Purchased From the RX Company Mail Order Program – 90 day supply

You may purchase a prescription drug order from the RX Company Mail Order Participating Pharmacy, as long as the order does not exceed a 90 day supply for all classifications other than Specialty drugs. Specialty drugs may not be purchased in quantities larger than a 34 day supply. All drug classifications are determined by the RX Company.

Allowable Covered Prescription Expense

A prescription drug order is a request for each separate prescription drug and/or each authorized refill, if ordered by a Physician.

SAMPLE

Expense incurred for a prescription drug order for the following items will be considered allowable covered prescription expense:

- Self-injectable and Non-injectable legend drug;
- Insulin and epipens on prescription;
- Disposable insulin needles/syringes;
- Test strips for glucose monitors;
- Lancets for diabetic blood monitoring;
- Glucagon emergency kits;
- Tretinoin, all dosage forms (Retin-A), when Medically Necessary;
- Oral contraceptives and female contraceptive devices, (at no Cost-Share) see Special Handling in this section;
- Evidenced-based preventative oral medications that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force, (at no Cost Share) see also Special Handling in this section;
- Erectile dysfunction medications but limited to 6 pills per month;
- Compound medications if at least one ingredient is a legend drug;
- Any other oral drug which, under the applicable state laws, may be only dispensed upon a written prescription of a Physician or other lawful prescriber; and
- Covered Expense for drugs considered Non-Formulary are covered at the applicable Brand or Specialty Copay level.

When You purchase a Brand or Preferred Brand drug that has a FDA-approved generic equivalent, We will pay only what We would have paid for the Equivalent Generic Drug. You will be responsible for the any remaining cost difference between the Brand or Preferred Brand cost in excess of the cost of the Equivalent Generic Drug. This remaining cost You will incur is a non Covered Expense and will not accumulate towards any limits including Your Maximum Out of Pocket.

Most prescription drugs are limited to a maximum quantity You may receive in a single prescription. Limits are determined by the RX Company and Federal regulations that limit the quantity that may be dispensed for certain medications. If Your prescription is so regulated, it may not be available in the amount prescribed by Your Physician.

In addition, coverage for certain drugs is limited to specific quantities per day, month, year, or lifetime based on medical guidelines determined by the RX Company and/or the FDA. Amounts in excess of medically appropriate quantity limitations are not covered.

Non Covered Prescription Expense

The following are not Covered Expenses under the Prescription Benefit, regardless of the reason they are prescribed:

- The amount of expense for a medication that is in excess of the amount agreed upon between the RX Company and Us;
- The difference between the cost of a brand or preferred brand drug and a generic drug, if the generic drug has been designated as and Equivalent Generic Drug;
- Duplicate prescriptions or prescriptions refilled more frequently than the prescribed dosage indicates (to be eligible for coverage under the prescription benefit, a prescription purchased at retail pharmacy cannot be filled until the patient has used 75% of the medication as prescribed and a prescription purchased at mail order cannot be refilled until the patient has used 60% of the medication as prescribed);
- Any prescription drug that is not intended to be self administered;
- Medication which is to be taken or administered to an individual, in whole or in part, while he or she is a patient in a Hospital, rest home, sanitarium, Skilled Nursing Facility, convalescent care facility, nursing home, or similar institution which operates on its premises or allows to be operated on its premise, a facility for dispensing pharmaceuticals;
- Drugs dispensed by a Physician;
- Fluoride supplements;

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- Hematinics;
- Immunization agents, biological sera, blood or blood plasma;
- Minerals;
- Minoxidil (Rogaine) or other similar medications for the Treatment of alopecia;
- Nicorette or any other medication containing nicotine or other smoking deterrent medications;
- Anorexiants or any drugs used for the purpose of weight loss or weight control;
- Non-legend drugs, other than insulin;
- Tretinoin, all dosages forms (Retin A), for individuals 26 years of age or older;
- Vitamins, singly or in combination, except for legend prenatal vitamins or as outlined in Allowable Covered Prescription Expense;
- Therapeutic devices or appliances, including needles, syringes, support garments and other non-medical substances, regardless of intended use, except those listed under Allowable Covered Prescription Expense;
- Charges for administration or injection of any drug;
- Prescriptions which an Eligible person is entitled to receive without charge under any Worker's Compensation law;
- Drugs labeled "Caution-limited by federal laws to investigational use" or Experimental/Investigational drugs. Except as outlined in SECTION 5 - EXPENSES COVERED BY THE PLAN, 16. Clinical Trials;
- Prescriptions refilled in excess of the number ordered by the Physician;
- Prescriptions refilled after one year from the Physician's original order;
- Prescriptions to replace lost, stolen or damaged prescriptions;
- Prescriptions for the Treatment of Infertility;
- Prescription legend drugs when multiple drug options are available and the least expensive is not tired first according to the RX Company's step therapy requirements;
- Any charge for a prescription drug dosage that exceeds the RX Company's optimum dosage limits;
- Any charge for more than a 90 day supply;
- Female brand and preferred brand contraceptive medications and devices when a Equivalent Generic is available (unless Medically Necessary to use brand or preferred brand);
- Any contraceptive medication or device in which benefits were previously provided under another section of the Policy;
- Prescription drugs prescribed for cosmetic reasons;
- Drugs used primarily for cosmetic purposes, regardless of intended use;
- Convenience packaging when the cost exceeds the cost of the drug when purchased in its normal container;
- Drugs abused or otherwise misused by an Insured; or
- Most prescription and non-prescription nutritional and dietary supplements are not Covered Expenses under this benefit including, but not limited to:
    - Special dietary formulas;
    - Herbal products;
    - Fish oil products;
    - Minerals;
    - Supplementary vitamin preparations;
    - Multivitamins;
    - Most over-the-counter products, including nutritional dietary supplements;
    - Prescription drugs that are not FDA-approved; and
    - Self-help or self-cure products or drugs.

Special Handling of Medications Provided at No Cost Share

Certain medications outlined in this Prescription Benefit section are provided at no Cost Share. However, there may be a Cost Share when a brand or preferred brand medications is used and an Equivalent Generic Drug is available and use of the brand or preferred brand is not Medically Necessary.

If your Physician determines that a Food and Drug Administration-approved contraceptive method is Medically Necessary but is not typically covered under this Policy, You may request a form, 'Request for

SAMPLE

Alternative Contraceptive Coverage' from Us by calling 1-800-371-9622, ext. 3281. This form must be completed by Your attending Physician and returned to Us at 2505 Court Street, Pekin, IL 61558. Once We receive the completed form, We will make a determination of coverage and notify You of Our decision within 30 days.

Special Handling of Medications for Cancer

Your Cost Share for Covered Expense for oral chemotherapy medications under the Prescription Benefits section will never exceed the Cost Share You would pay for any other type of cancer Treatment provided under other sections of the Policy.

How to File a Claim for Prescription Benefits

To file a claim at a retail pharmacy, an Insured must present his/her prescription drug card to the Participating Pharmacy. The pharmacist will use the card to file the claim with the RX Company. The RX Company will then submit claims for Covered Expenses to Us for application of Your In-Network benefits.

To file a claim under through Mail Order, an Insured must submit the original prescription and any necessary mail order forms to the RX Company's Mail Order facility. The necessary forms and instructions can be obtained from Us or the RX Company's Mail Order provider. The RX Company's Mail Order provider will then submit claims for Covered Expenses to Us for application of Your In-Network benefits.

16. Clinical Trials

Covered Expense includes routine patient costs incurred by a qualified individual who participates in an approved clinical trial. A qualified individual who wishes to participate in an approved clinical trial must obtain Pre-Approval by Us and use an In-Network Provider if an In-Network Provider is participating in the trial and the In-Network Provider accepts the qualified individual as a participant in the trial. However, if the approved clinical trial is either conducted outside the state in which the qualified individual resides by an Out-of-Network Provider or there is no In-Network provider conducting the approved clinical trial and accepting the qualified individual in the individual's state of residence, then routine patient costs will be covered as if provided by an In-Network provider and subject to Regular, Reasonable and Customary.

For the purpose of this Benefit, the following definitions apply:

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV Clinical Trial that is

1. Conducted in relation to the prevention, detection, or Treatment of cancer or other life-threatening disease or condition; and
2. Is one of the following:
   - Federally funded trials
   - The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
     - The National Institutes of Health.
     - The Centers for Disease Control and Prevention.
     - The Agency for Health Care Research and Quality.
     - The Centers for Medicare & Medicaid Services.
     - A bona fide Clinical Trial Cooperative group or center of any of the entities described in clauses 1) through 4) above or the Department of Defense or the Department of Veterans Affairs.
     - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   - In any of the following clauses below if the following conditions are met: The study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations

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used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
    - The Department of Veterans Affairs
    - The Department of Defense
    - The Department of Energy; or
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- The study or investigation is a drug trial that is exempt from the investigational new drug application requirements.

Life-threatening condition

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Qualified Individual

An Insured who meets the following conditions:

- The individual is eligible to participate in an approved Clinical Trial according to the trial protocol with respect to Treatment of cancer or other life-threatening diseases or conditions; and
- Either:
    - The referring health care provider has concluded that the Insured's participation in the clinical trial would be appropriate based upon the Insured meeting the conditions described in paragraph a. above; or
    - The Insured provides medical and scientific information establishing that participation in such trial would be appropriate based upon the Insured meeting the conditions described above.

Routine Patient Costs

All items and services that are typically covered by the Policy for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include:

- The investigational item, device, or service, itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Clinical Trial participation requires Pre-Approval by Us.

17. Therapy – Physical, Manipulative, Occupational, Speech, and Habilitative Services

Expenses incurred for the following therapies will be considered Covered Expenses:

- Physical Therapy;
- Manipulative Therapy;
- Occupational Therapy; and
- Speech Therapy.

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time. The expense must not be for supervised exercise. Up to 20 visits per calendar year will be considered Covered Expense. In-Network and Out-Of-Network services will both count towards the 20 visit Calendar Year limit. All services provided in one day will be considered a visit.

For children ages 0 to 21 with a medical diagnosis of Autism Spectrum Disorder the following Habilitative Services can be considered Covered Expenses:

- Up to 20 visits per Calendar Year for each type of therapy: Speech/language Therapy and/or Occupational Therapy; and

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- When it is in accordance with a treatment plan, up to 20 hours per week of clinical therapeutic intervention that is supported by empirical evidence, which includes, but is not limited to applied behavioral analysis; and
- Mental/behavioral health outpatient services performed by a licensed psychologist, psychiatrist, or Physician to provide consultation, assessment, development and oversight of treatment plans.

For Habilitative Services to be considered a Covered Expense, the following conditions must be met:

- Treatment must be administered by a licensed speech−language pathologist, audiologist, occupational therapist, physical therapist, Physician, licensed nurse, optometrist, licensed nutritionist, clinical social worker, psychiatrist or psychologist upon the referral of a Physician;
- Treatment must be Medically Necessary, therapeutic, and not Experimental/Investigational; and
- Pre-Approval must be obtained from Us.

18. For other services and supplies for:

- Anesthesia and its administration;
- X-rays and major diagnostics, including MRI, MRA, and nuclear medicine;
- Laboratory tests;
- Allergy testing and Treatment;
- Infertility diagnosis;
- Radiation therapy, when Pre-Approval of the Treatment is obtained from Us;
- Chemotherapy, or similar Treatment, provided in the office or the home, but the Covered Expense for chemotherapy provided through a Physician's office will not exceed the Regular, Reasonable, and Customary fees for home chemotherapy (when Pre-Approval of the Treatment is obtained from Us);
- Electroshock therapy, when Pre-Approved of the Treatment has been obtained by Us;
- The initial purchase of artificial eyes, limbs and larynx, when Pre-Approval has been obtained from Us;
- Blood, blood plasma, and its administration;
- Casts, splints, trusses, orthopedic braces, and crutches, when Pre-Approval has been obtained from Us;
- Ostomy supplies, when Pre-Approval has been obtained from Us;
- Durable Medical Equipment, when Pre-Approval has been obtained from Us;
- Surgical dressings for two months following surgery, when Pre-Approval has been obtained from Us;
- The purchase of one pair of the following while Insured when Pre-Approval has been obtained from Us:
  - One pair of orthopedic shoes;
  - One support stocking for each leg;
  - One article of similar apparel-type item;
- Local ground ambulance transportation to the nearest Hospital able to provide the care;
- Air ambulance transportation to the nearest Hospital or Skilled Nursing Facility able to provide the care;
- Urgent Care services provided at an Urgent Care Center;
- Diabetic self-management training and education program for up to ten hours in a 12 month period under the following conditions:
  - The treating Physician certifies that such services are necessary;
  - The program is certified by the Iowa department of public health;
  - It is for a new onset of diabetes; or
    - The patient has poor glycemic control as evidenced by a glycosylated hemoglobin of 9.5 or more in the ninety days before attending the training; or
    - There has been a change in Treatment regimen from no diabetes medications to any diabetes medication, or from oral diabetes medication to insulin; or
    - The patient is high risk for complication based on poor glycemic control, with documented evidence of problems in the past year; or
    - The patient is high risk for lack of feeling in the foot, foot ulcer or amputation, diabetic related retina problems, or kidney complications;
- One follow-up diabetic self-management training and education session of up to two hours each year for an individual who has received the initial training and education;
- Breast prosthesis or reconstructive surgery following a mastectomy, including surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Physical complications at all stages of a mastectomy including lympedemas;

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- Mastectomy bra following a mastectomy;
- Dental Treatment for injuries when Treatment is completed within 12 months of the Injury;
- Anesthesia (general) and Hospital or ambulatory surgical facility services related to covered Dental services if:
  - o The Insured is under age 14 and, based on a determination by a licensed dentist and the Insured's treating Physician, the Insured has a Dental or developmental condition for which patient management in the Dental office has been ineffective and requires Dental Treatment in a Hospital or ambulatory surgical facility; or
  - o Based on a determination by a licensed dentist and the Insured's treating Physician, the Insured has one or more medical conditions that would create significant or undue medical risk in the course of delivery of any necessary Dental Treatment or surgery if not rendered in a Hospital or ambulatory surgical facility.
- Impacted teeth removal (surgical) as an Inpatient or ambulatory surgical outpatient of a facility; but only when the Insured has one or more medical conditions that would create significant or undue medical risk in the course of the impacted teeth removal if not rendered in a Hospital or ambulatory surgical facility or when covered under the Pediatric Dental Care Benefit Amendment;
- Facial bone fracture reduction;
- Incisions of accessory sinus, mouth, salivary glands, or ducts;
- Jaw dislocation manipulation;
- Orthodontic services required for surgical management of cleft palate;
- Treatment of abnormal changes in the mouth due to Injury or Illness;
- Removal of toxic substances from the blood when the kidneys are unable to do so when provided as an Inpatient in a Hospital setting or as an outpatient in a Medicare-approved dialysis center.
- Fertility prevention, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only);
- Genetic molecular testing (specific gene identification) and related counseling when both of the following requirements are met:
  - o The Insured is an appropriate candidate for a test under medically recognized standards (for example, family background, past diagnosis, etc.)
  - o The outcome of the test is expected to determine a covered course of Treatment or prevention and is not merely informational.
- Hearing examinations, but only to test or treat hearing loss related to an Illness or Injury;
- Inhalation therapy, respiratory or breathing Treatments to help restore or improve breathing function;
- Non-experimental, Medically Necessary bariatric surgical procedure when performed to treat Morbid Obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption when:
  - Morbid Obesity has persisted for a t least five (5) years; and
  - For which nonsurgical Treatment that is supervised by a Physician has been unsuccessful for at least six (6) consecutive months; and
  - The Insured is over the age of 21, unless the insured is under 21 and two (2) authorized Physicians determine that the surgery is necessary to:
    - o Save the life of the Insured; or
    - o Restore the Insured's ability to maintain a major life activity

  Each Physician must document in the Insured's medical record the reason for the Physician's determination. Requires Pre-Approval by Us;
- Prosthetic devices used as artificial substitutes to replace a missing natural part of the body or to improve, aid, or increase the performance of a natural function. Also covered are braces, which are rigid or semi-rigid devices commonly used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. Braces do not include elastic stocking, elastic bandages, garter belts, arch supports, orthodontic devices or other similar items. Prosthetic devices must be pre-approved by Us. See SECTION 6 – EXPENSES NOT COVERED BY THE PLAN for excluded devices;
- Obstructive sleep apnea diagnosis and Treatments;
- Temporomandibular joint disorder (TMJ);
- Vision examinations but only when related to an Illness or Injury or covered under the Pediatric Vision Care Benefit Amendment;
- Medication management office visits for Mental Health Disorders and Chemical Dependency Disorders.

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SECTION 6 - EXPENSES NOT COVERED BY THE PLAN

These exclusions apply to all benefits of the Policy:

1. **This insurance does not cover loss caused by:**
   - An act of war;
   - Service in the armed forces;
   - Complications arising from excluded Treatment;
   - Commission of a felony or illegal activities.

2. **This insurance does not pay any benefit for expense for:**
   - Services that aren't Medically Necessary;
   - Services for which no benefit is defined or described in the Policy;
   - Any surgical procedure to remove excess tissue caused by weight loss;
   - Incidental appendectomies;
   - Treatment of educational, developmental, training problems or learning disorders, expect those considered Habilitative Services;
   - Bereavement counseling or services (including volunteers or clergy), family counseling or treating services, marital counseling or social counseling;
   - Impulse control disorders, such as pathological gambling;
   - Non-pervasive developmental and learning disorders;
   - Sensitivity, shyness and social withdrawal disorders;
   - Services provided by an Employee of a school district, or a person contracted to provide services for a school district, or services available through a school system;
   - Any Experimental/Investigational service, supply, or Treatment. Except as outlined in SECTION 5 - EXPENSES COVERED BY THE PLAN, 16. Clinical Trials;
   - The use of any services or facilities of a federal, Veteran's administration, state, county or municipal Hospital, except where We or the Insured are legally required to pay the expenses;
   - Treatment of an Injury or Illness, if the Illness or Injury is recognized as a compensable loss by the provisions of any worker's compensation act, employer liability law, occupational disease law, or any similar law of a state or federal government, or other governmental subdivision, under which the person is or could be protected on a mandatory basis, whether or not such protection is afforded; or would have been recognized had the Insured made claim within the appropriate time limits. If the worker's compensation type coverage has denied a claim, but the Insured is still pursuing coverage with the worker's compensation type coverage through a state or federal commission or agency, or other legal entity, benefits will not be payable under the Policy until the Insured certifies he/she no longer intends to pursue coverage through the worker's compensation type coverage;
   - Any service or supply not recommended or approved by a licensed medical practitioner;
   - Services or supplies that are not for the diagnosis or Treatment of an existing Illness or Injury, except as provided under Preventive Care as outlined in SECTION 5 – EXPENSES COVERED BY THE PLAN, 13. Preventive Care and 15. Prescription Benefits;
   - Abortions, except where the mother's life is threatened;
   - Any orthodontic procedure or appliance except as specified in the Pediatric Dental Care Benefit Amendment;
   - Nonmedical services and supplies;
   - Durable Medical Equipment unless Pre-Approval has been obtained from Us for the purchase or rental of the equipment;
   - Any service or supply that the Insured is not legally required to pay for, including any forgiveness of Deductible, Coinsurance or Copay by a provider;
   - Eye surgery to correct a refractive error (i.e., when the shape of Your eye does not bend light correctly resulting in blurred images);
   - Eyeglasses or contact lenses, including charges related to their fitting except as specified in the Pediatric Vision Care Benefit Amendment;
   - Prescribing of corrective lenses except as specified in the Pediatric Vision Care Benefit Amendment;

SAMPLE

- Eye examinations for the fitting of eyewear except as specified in the Pediatric Vision Care Benefit Amendment;
- Routine vision examinations except as specified in the Pediatric Vision Care Benefit Amendment;
- Treatment received in the emergency room of a Hospital, except when Emergency Services are being rendered;
- Any Physical Therapy service that could be done as part of a home exercise program or accomplished at a health club;
- The replacement of a piece of Durable Medical Equipment;
- Custodial Care;
- Services furnished by the Insured or a member of his/her or his/her Spouse's Immediate Family, or by a person who regularly lives in his/her home;
- Hospital charges for the first weekend in the Hospital if the Insured is admitted to a Hospital on a Friday, Saturday, or Sunday, except when the admission is for Emergency Services, or when surgery is performed the next morning.
- Treatment related to the restoration of fertility or promotion of conception;
- Nutritional supplements;
- Animal to human organ transplants;
- Replacement of human organs by artificial or mechanical devices;
- Treatment of caffeine, gambling, computer, or similar addictions;
- Any medical Treatment, weight reduction programs or supplies (including dietary supplements, foods, equipment, lab testing, examinations, and prescription drugs), whether or not weight reduction is medically appropriate, membership dues, or clinic fees for the Treatment of obesity, including Morbid Obesity. Except as outlined in SECTION 5 – EXPENSES COVERED BY THE PLAN;
- Any surgical procedure to remove excess tissue caused by weight loss.
- Services provided by a midwife, except where specifically licensed by the State to practice midwifery;
- Sclerotherapy for varicose veins;
- For devices used specifically as safety items or to affect performance primarily in sports-related activities;
- Medical or surgical Treatment of upper or lower jaw alignment conditions or malformations, including orthognathic surgery, except for
  - Direct Treatment of acute traumatic Injury or cancer; or
  - As may be provided in the Policy under the "Temporomandibular Joint Disorder" benefit in SECTION 5 – EXPENSES COVERED BY THE PLAN;
- Wigs, hair prosthesis or hairpieces;
- Routine foot care related to corns, calluses, flat feet, fallen arches, weak feet, or chronic foot strain, except that routine foot care for patients with diabetes will be covered;
- Shoe inserts, casting for orthotics, and orthotics;
- Physical conditioning programs such as athletic training, body-building exercises, fitness and flexibility programs;
- The services of a massage therapist, athletic trainer, or masseuse; acupuncture or acupressure Treatment;
- Sexual transformation;
- Breast reduction surgery, except when performed in conjunction with reconstructive surgery following a mastectomy;
- Treatment performed outside the United States, except when an emergency;
- Removal of breast implants that were implanted solely for cosmetic reasons;
- Residential Facility services;
- Growth hormone Treatment except when such Treatment is medically proven to be effective for the Treatment of documented growth retardation due to growth hormone deficiency, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such Treatment must be likely to result in a significant improvement of the Insured's condition;
- Any oral medication intended to be self administered except as outlined in SECTION 5 – EXPENSES COVERED BY THE PLAN, 15. Prescription Benefits;

SAMPLE

- Over the counter medications except as outlined in SECTION 5 – EXPENSES COVERED BY THE PLAN, 15. Prescription Benefits;
- Prescription legend drugs when multiple drug options are available and the least expensive is not tried first;
- Cosmetic services, supplies, or drugs unless provided primarily to restore function lost or impaired as the result of an Illness, Injury or a birth defect including Treatment for any complications resulting from a non-covered cosmetic procedure;
- Education or educational therapy other than covered education for self management of diabetes;
- General dentistry including, but not limited to, diagnostic and preventive services, restorative services, endodontic services, periodontal services, indirect fabrications, dentures and bridges, and orthodontic services unrelated to accidental injuries or surgical management of cleft palate; except as provided in the Pediatric Dental Care Benefit Amendment or the Dental benefit in SECTION 5 – EXPENSES COVERED BY THE PLAN;
- Injuries associated with or resulting from the act of chewing;
- Maxillary or mandibular tooth implants (osseointegration);
- Infertility Treatment, including but not limited to:
  - Collection or purchase of donor semen (sperm) or oocytes (eggs)
  - Freezing of sperm, oocytes, or embryos
  - Surrogate parent services;
  - Artificial insemination, in vitro fertilization, or any related Infertility Treatment or transfer procedures.
- Reversal of a tubal ligation (or its equivalent) or vasectomy;
- Hearing aids;
- Routine hearing examinations;
- Custodial home care services and supplies, which help an Insured with their daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of Custodial Care are assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding, and other forms of assistance with normal bodily functions; preparation of special diets; and supervision of medication that can usually be self-administered. An Insured is not covered for sanitaria care or rest cures.
- Maternity services and newborn care if the mother is a surrogate mother not covered by the Policy;
- Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription;
- Certain disorders related to early childhood, such as academic underachievement disorder;
- Communication disorders, such as stuttering and stammering;
- Sexual identification or gender disorders;
- Telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, charges for medical information, recreational therapy, and any services or supplies that are nonmedical;
- Occupational Therapy supplies;
- Therapy provided as an Inpatient in the absence of a separate medical condition that requires Hospitalization;
- Orthotic foot devices such as arch supports or in-shoe supports, orthopedic shoes, elastic supports, or examinations to prescribe or fit such devices;
- Examinations for prescription and fitting of a prosthetic device

- . All charges related to surgical errors to include but not limited to
  - Surgery performed on the wrong patient
  - Wrong surgical procedure performed
  - Surgery performed on the wrong body part
  - Foreign object retained after surgery
- Any charges for hospital acquired conditions as defined by the most current listing by The Centers for Medicare & Medicaid Services (CMS). No charges or days associated with the hospital acquired condition should be billed to You or Us.

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SECTION 7 - PRE-CERTIFICATION PROGRAM

SAMPLE

To qualify for full benefits under the Policy, You must call the Pre-Certification Hotline (1-800-245-3005) if:

- You are going to be admitted as an Inpatient to a Hospital, Skilled Nursing Facility, Chemical Dependency Treatment Facility, Community Mental Health Center or Psychiatric Medical Institute for Children; or
- You are going to have an overnight stay at any facility.

You can make the phone call, or You can have a relative or Your Physician make the phone call. However, You are responsible for making sure that someone calls the Pre-Certification Hotline.

NON-EMERGENCY HOSPITALIZATIONS OR SURGERIES

The Pre-Certification Hotline must be called at least 72 hours before an Insured is admitted to a Hospital, Skilled Nursing Facility, Chemical Dependency Treatment Facility, Community Mental Health Center or Psychiatric Medical Institute for Children for an Inpatient stay and at least 72 hours before an Insured is scheduled for an overnight stay at any facility.

MEDICAL EMERGENCY

The Pre-Certification Hotline must be called within 2 business days (or as soon as reasonably possible if the Insured's condition prevents them from calling within that time frame) following emergency surgery or emergency admission to a Hospital or Skilled Nursing Facility.

PREGNANCY

The Hotline must also be called if a Hospital stay exceeds:

- 48 hours following a vaginal delivery (not including the day of delivery); or
- 96 hours following a cesarean birth (not including the day of delivery).

If discharge from the Hospital occurs earlier, a post-discharge visit will be provided to the mother and newborn by providers competent in postpartum care and newborn assessment if determined medically appropriate by the attending Physician.

INFORMATION NEEDED

When a person calls the Hotline, he/she should have the following information available:

- The Insured patient's name, date of birth, sex, and the certificate number of the Insured;
- The proposed (or actual) date and reason for admission or stay;
- The name and phone number of the facility and admitting Physician;
- Any information regarding any other insurance plans.

PRE-CERTIFICATION PROCESS

When a call is made to the Pre-Certification Hotline, the caller will be given a Pre-Certification number along with the reviewer's recommendations. The reviewer will assign a length of stay to the admission.

If Your stay exceeds the recommended length of stay, the facility or Your Physician should contact the reviewer, who will again review Your case.

MEDICAL NECESSITY

No benefits will be payable for any confinement that is not approved by the reviewer as being Medically Necessary. The fact that a Physician or another health care provider has prescribed or ordered an admission, or continued stay, does not necessarily mean the stay is Medically Necessary. Benefits are only payable if the Pre-Certification reviewer determines the admission, or continued stay, is Medically Necessary.

RIGHT TO APPEAL

SAMPLE

The Physician or Insured may, at any time, initiate a request for reevaluation or extension of a reviewer's decision, by calling the Pre-Certification Hotline.

FAILURE TO PRE-CERTIFY

If an Insured fails to have his/her admission or overnight Pre-Certified, then the first $500 of Covered Expense incurred as a result of the admission or overnight stay will not be covered under the Policy, in addition to any medically unnecessary expense. However, this provision will not apply to an expectant mother's admission for pregnancy.

SECTION 8 - COORDINATION OF BENEFITS

COORDINATION OF THIS PLAN'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payment from all Plans does not exceed 100% of the total allowable expense.

DEFINITIONS

A. A plan is any of the following that provides benefits or services for medical or Dental care or Treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident-type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under (1) or (2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as Dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.

   When this plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of

SAMPLE

another plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total allowable expense.

D. Allowable expense is a health care expense, including Deductibles, Coinsurance and Copay, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

   The following are examples of expenses that are not allowable expenses:
   1. The difference between the cost of a semiprivate Hospital room and a private Hospital room is not an allowable expense, unless one of the plans provides coverage for private Hospital room expenses;
   2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense;
   3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense;
   4. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and by another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits; and
   5. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, Pre-Certification of admissions, and Preferred Provider arrangements.

E. Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Child resides more than one-half of the Calendar Year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plan.

B. 1. Except as provided in Paragraph (2), a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary. 2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverage that are superimposed over base plan Hospital and surgical benefits, and insurance-type coverage that are written in connection with a closed panel plan to provide out-of-network benefits.

SAMPLE

C. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

D. Each plan determines its order of benefits using the first of the following rules that apply:
   1. Non-Dependent or Dependent. The plan that covers the person other than as a Dependent, for example as an Employee, member, Policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent; and primary to the plan covering the person as other than a Dependent (e.g., a retired Employee); then the order of benefits between the two Plans is reversed so that the plan covering the person as an Employee, member, Policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.

   2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one plan the order of benefits is determined as follows:
      a) For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:
         i. The plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan**;** or
         ii. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
      b) For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         i. If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
         ii. If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
         iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of subparagraph (a) above shall determine the order of benefits; or
         iv. If there is no court decree allocating responsibility for the Dependent Child's health care expenses or health care coverage, the order of benefits for the Child is as follows:
            - The plan covering the custodial parent;
            - The plan covering the Spouse of the custodial parent;
            - The plan covering the noncustodial parent; and then
            - The plan covering the Spouse of the noncustodial parent.
      c) For a Dependent Child covered under more than one Plan of individuals who are the parents of the Child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Child.

   3. Active Employee or Retired or Laid-Off Employee. The plan that covers a person as an active Employee, that is, an Employee who is neither laid off nor retired, is the primary plan**.** The plan covering that same person as a retired or laid-off Employee is the secondary plan**.** The same would hold true if a person is a Dependent of an active Employee and that same person is a Dependent of a retired or laid-off Employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

   4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an Employee, member, subscriber or retiree or covering the person as a Dependent of an Employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have

SAMPLE

this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The plan that covered the person as an Employee, member, Policyholder, subscriber or retiree longer is the primary plan and the Plan that covered the person the shorter period of time is the secondary plan.

6. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. [Organization responsibility for COB administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. [Organization responsibility for COB administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give [Organization responsibility for COB administration] any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this plan. If it does, [organization responsibility for COB administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. [organization responsibility for COB administration] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by [Organization responsibility for COB administration] is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

MEDICARE AS PRIMARY PAYER

When Medicare is primary payer, We will coordinate Our benefits with Medicare in accordance with the "Coordination of Benefits" provision in the Policy.

SAMPLE

If an Insured is Eligible for Medicare as primary payer, but does not enroll or apply for it on time, We will estimate what Medicare would have paid if the Insured had made timely application.

SECTION 9 -RIGHT OF REIMBURSEMENT

If an Insured incurs expenses for Illness or Injury that occurred due to the negligence of a third party:

- We have the right to reimbursement for all benefits We paid from any and all damages collected from the third party for those same expenses whether by action of law, settlement, or compromise, by the Insured, the Insured's parents if the Insured is a minor, or the Insured's legal representative, as a result of that Illness or Injury; and
- We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits We paid for that Illness or Injury.

We shall have the right to first reimbursement out of all funds the Insured, the Insured's parents if the Insured is a minor, or the Insured's legal representative, is or was able to obtain for the same expenses We have paid as a result of the Illness or Injury.

You are required to furnish any information or assistance or provide any documents that We may reasonably require in order to obtain Our rights under this provision. This provision applies whether or not the third party admits liability.

SECTION 10 – IOWA STATE CONTINUATION

CONTINUATION OF HEALTH INSURANCE COVERAGE AFTER TERMINATION OF EMPLOYMENT, DEATH, OR DISSOLUTION OR ANNULMENT OF MARRIAGE

The insurance of Insured Employee and Dependents ends when an Insured Employee terminates his/her employment. An Insured whose insurance ends for this reason may elect to continue the health insurance coverage that was in force for himself/herself, and any Insured Dependents, if:

- He/she has been insured under this group Policy, or the Former Policy for three consecutive months before his/her insurance would end; and
- He/she is not covered by Medicare; and
- He/she is not Eligible to be covered, or covered, under any group health policy that becomes effective after his/her termination of employment date.

The Policyholder must provide written notice of the continuation right no later than 10 days after termination.

The Insured must request continuation of this insurance in writing within 10 days after the later of:

- The date insurance would end due to termination of employment; or
- The date the Insured is given written notice of the right to continuation by the Policyholder;

In no event later than 31 days after insurance would otherwise end. The Insured Employee must pay the entire premium due to the Policyholder in advance every month.

An Insured Dependent may also continue coverage if they are losing health insurance due to dissolution or annulment of marriage or death of the Employee. The person Eligible for continuation, who shall be the Spouse or the custodial parent or legal guardian on behalf of a Dependent Child, must notify the Policyholder of the occurrence of the event within 30 days after the event occurs. Within ten days of receipt of that notice, the Policyholder must provide the person Eligible for continuation with notice of the continuation right. The person must request continuation in writing within 10 days after receipt of the notice of the continuation right.

All health insurance benefits provided under this provision are subject to this Policy's provisions, exclusions, and limitations.

SAMPLE

The insurance provided under this provision will end on the earliest of the following dates:

- The date the Insured becomes Eligible for Medicare;
- The date the Insured becomes covered under group health insurance that has an Effective Date after his/her termination of employment date;
- The date nine months from the date his/her insurance would have ended due to termination of employment;
- The date he/she fails to pay any premium due;
- If the continuing Insured is a former Spouse, the date the former Spouse remarries; or
- The date this entire group Policy terminates.

FEDERAL CONTINUATION OF HEALTH COVERAGE AFTER TERMINATION

If this continuation provision is included in the Policy, it will be indicated on the Schedule of Benefits.

Federal law requires that most Group Health Plans give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the Group Health Plan, the covered employee's spouse, and the dependent Children of the covered employee.

Continuation coverage is the same coverage that the plan gives to other Insureds or beneficiaries under the plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including open enrollment and special enrollment rights.

CONTINUATION RIGHTS

1. An Insured's Health Insurance Coverage can be continued for a maximum period of 18 months, if it is ending because:
   - The Insured Employee's employment terminated for reasons other than gross misconduct; or
   - The Insured Employee had his hours reduced; or
   - Death of employee; or
   - Divorce or legal separation; or
   - Entitlement to Medicare; or
   - Loss of dependent child status.

   If an Insured does not wish to continue coverage for himself/herself, his/her Insured Spouse and/or Insured Children may elect to continue the coverage on their own for a maximum of 18 months.

2. There may be other coverage options for You and Your family to buy coverage through the Health Insurance Marketplace. In the Marketplace, You could be eligible for a new kind of tax credit that lowers Your monthly premiums right away, and You can see what your premium, Deductibles, and out-of-pocket costs will be before You make a decision to enroll. Being eligible for COBRA does not limit Your eligibility for coverage for a tax credit through the Marketplace. Additionally, You may qualify for a special enrollment opportunity for another group health plan for which You are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if You request enrollment within 30 days

3. An Insured's Health Insurance Coverage may be extended beyond the 18 month continuation period, to a maximum period of 29 months, for himself/herself and/or his/her Insured Dependents, if:
   - His/her insurance is ending because of one of the reasons listed above; and
   - He/she qualifies as disabled for Social Security purposes at the time his/her employment ends or at any time during the first 60 days of COBRA continuation; and
   - He/she notifies the Policyholder of a determination of total disability by the Social Security Administration within 60 days of the determination, but before the end of the first 18 months of continuation.

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However, an Insured's extended continuation will end the premium due date that is at least 30 days after a final determination under the Social Security Act that he/she is no longer disabled. Premiums during the additional 11 months of coverage will be at a substantially higher rate than for the initial 18 month period.

4. An Insured Dependent's Health Insurance Coverage can be continued for a maximum period of 36 months, if his/her insurance is ending because:
   - The Insured Employee dies;
   - A divorce or legal separation has occurred;
   - The Insured Dependent Child no longer meets the Policy's definition of a Dependent Child; or
   - The Insured Employee became covered by Medicare.

5. An Insured Dependent's health coverage can be continued for at least 3 6 months from the date the Insured Employee became covered by Medicare, if his/ her insurance ends for any of the above-listed reasons.

6. An Insured can continue his/her insurance for 36 months, if:
   - He/she has lost coverage or had his/her coverage substantially reduced within one year before or after the date his/her employer began proceedings in a Ch. 11 bankruptcy proceeding; and
   - He/she retired after the Ch. 11 bankruptcy proceeding; or
   - He/she is an Insured Dependent of a retiree who died after a Ch. 11 bankruptcy proceeding.

7. An Insured can continue his/her insurance for his/her lifetime, if:
   - He/she has lost coverage or had his/her insurance substantially reduced within one year before or after his/her employer began proceedings in a Ch. 11 bankruptcy case; and
   - He/she is a retiree who retired before the Ch. 11 bankruptcy proceeding; or
   - He/she is a widow or widower of a retiree who died before the bankruptcy proceeding.

NOTIFICATION RESPONSIBILITIES OF THE POLICYHOLDER

The Policyholder must notify an Insured of his/her right to continue within 14 days after the Policyholder becomes aware that one of the events listed above has occurred. The notification must be in writing.

RESPONSIBILITIES OF AN INSURED

1. An Insured must notify the Policyholder if any of the following events occur:
   - A divorce or legal separation;
   - An Insured Child no longer meets the Policy's definition of an Insured Dependent Child.

   This notice must be given to the Policyholder within 60 days of the occurrence of one of these events.

2. An Insured must notify the Policyholder if he/she wants to continue coverage. He/she must give notice within 60 days after the date a COBRA qualifying event occurs, or within 60 days after the Policyholder provides him/her with notification of this right to continue, whichever is the longer period of time. The notice the Insured must provide must be in writing, by using the COBRA Continuation of Coverage Election form that the Policyholder provides him/her.

3. If an Insured decides to continue this coverage, the first premium payment is due 45 days following the date he/she returns the election form. Coverage is provided only when the full premium for the applicable period is received. The Insured must pay any premiums after that within 30 days of the date the premium is due. Premium payments must be made to the Policyholder. Coverage is not in force for any period for which premium is not paid.

INSUREDS WHO CANNOT CONTINUE

An Insured cannot continue this coverage if at the time of his/her termination, he/she is a nonresident alien with no earned income from sources within the United States, or the Dependent of such person.

SAMPLE

TERMINATION

Continued coverage will end on the earliest of the following dates:
- The date the maximum continuation period has been exhausted;
- The date the employer ceases to maintain any Group Health Plan for any Employee;
- The date the Insured is covered by another Group Health Plan;
- The date the Insured becomes covered by Medicare; and
- The date any premium that is due is not paid within the time allowed.

An Insured's continuation will terminate anytime the Policy is terminated.

FAMILY AND MEDICAL LEAVE ACT (FMLA) CONTINUATION PROVISION

An Employee receiving a leave of absence qualifying under the FMLA will continue to receive Health Insurance Coverage as if he/she was not on leave.

All other benefits, such as any life insurance, accidental death and dismemberment, disability and dental insurance will terminate in accordance with the other policy continuation and termination provisions.

TERMINATION OF HEALTH INSURANCE COVERAGE

Health Insurance Coverage will end on the earliest of the following dates:
- The date that any portion of the health premium that is due is not paid;
- The premium due date following the date the Employee no longer qualifies under this or another policy continuation provision;
- The date the Policy terminates; and
- The premium due date following the date the Employee gives notice of an intent not to return to work.

If coverage is terminated for any reason other than nonpayment of premium, or the termination of the entire Policy, then the Employee may be able to continue his/her Health Insurance Coverage for an additional period of time. Please see the section titled "Federal Continuation of Health Insurance Coverage After Termination" to determine if any additional continuation is available.

REINSTATEMENT OF BENEFITS

An Employee returning from a FMLA leave of absence can reinstate coverage under the Policy for Health Insurance Coverage by applying within 31 days from the date he/she returned from the leave of absence. The benefits will be reinstated on the date the Employee returned from the leave. No waiting periods or benefit limitations for preexisting conditions will apply.

Employees applying more than 31 days from the date of return from the leave will be considered late enrollees.

SECTION 11 - APPEALS

An **"Adverse Benefit Determination"** means:
1. A determination made by Us that, based upon the information provided, a request for a benefit does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be Investigational. Due to this determination, the requested benefit is denied, reduced, terminated, or payment is not provided or made, in whole or in part, for the benefit; or
2. A service, treatment, supply or device which is determined to be experimental/investigational; or
3. A rescission of coverage determination. This does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

SAMPLE

A **“Final Internal Adverse Benefit Determination”** means an Adverse Benefit Determination that has been upheld by Us at the completion of Our internal review/appeal process.

CLAIM APPEAL PROCEDURES

If You have received an Adverse Benefit Determination, You may have Your claim reviewed on appeal. We will review its decision in accordance with the following procedures. Claim reviews are commonly referred to as “appeals.”

Within 180 days after You receive notice of an Adverse Benefit Determination, You may call or write to Us to request a claim review. We will need to know the reasons why You do not agree with the Adverse Benefit Determination. You may call 1-800-371-9622 or send Your request to:

MAIL: Pekin Insurance
Health Claim Appeals
2505 Court Street
Pekin, Illinois 61558-0001

FAX: (309)346-8265
EMAIL: HealthClaimAppeal@pekininsurance.com

In support of Your claim review, You have the option of presenting evidence and testimony to Us. The evidence may be presented by phone or in person at a location of Our choice. You and Your authorized representative may ask to review Your file and any relevant documents. You or Your authorized representative may submit written issues, comments and additional medical information within 180 days after You receive notice of an Adverse Benefit Determination or at any time during the claim review process.

We will provide You or Your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of Your claim. This information will be provided without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such evidence or information will be provided to You or Your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give You a chance to respond. The appeal will be conducted by individuals associated with Us and/or by external advisors, but who were not involved in making the initial denial of Your claim. Before You or Your authorized representative may bring any action to recover benefits, the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by Us.

URGENT CARE PRE-SERVICE/EXPEDITED CLINICAL APPEALS

If Your appeal relates to an Urgent Care pre-service/expedited clinical claim, or health care services, including, but not limited to, procedures or Treatments ordered by a health care provider, the denial of which could significantly increase the risk to the claimant’s health, then You may be entitled to an appeal on an expedited basis. Before authorization of benefits for an ongoing course of Treatment is terminated or reduced, We will provide You with notice and an opportunity to appeal. For the ongoing course of Treatment, coverage will continue during the appeal process.

Upon receipt of an Urgent Care/expedited pre-service or concurrent clinical appeal, We will notify the party filing the appeal, as soon as possible, but no more than 24 hours after the submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 48 hours of the request. We shall render a determination on the appeal and provide notice within 48 hours after receiving the additional information.

NON-URGENT PRE-SERVICE APPEALS

Upon receipt of a non-urgent pre-service appeal We shall render a determination of the appeal within 3 business days if additional information is needed to review the appeal. Additional information must be submitted within 5

SAMPLE

days of the request. We shall render a decision and provide notice of the determination of the appeal within 30 days after the appeal has been received by Us.

ALL OTHER APPEALS

For all other post service appeals, We shall render a determination of the appeal and provide notice of the determination within 30 days for most appeal requests and within 60 days for all appeal requests.

IF YOU NEED ASSISTANCE

If You have any questions about the claims procedures or the review procedure, call Us at [1-800-371-9622] or contact Us by:

MAIL: Pekin Insurance
Health Claim Appeals
2505 Court Street
Pekin, Illinois 61558-0001

FAX: (309)346-8265
EMAIL: HealthClaimAppeal@pekininsurance.com

If You need assistance with the internal claims and appeals or the external review processes that are described below. You may contact the Iowa Insurance Division at 515-281-6348 or call the number on the back of Your ID card for contact information. In addition, for questions about Your appeal rights or for assistance, You can contact the Employee Benefits Security Administration at [1-866-444-EBSA (3272)].

NOTICE OF APPEAL DETERMINATION

We will notify the party filing the appeal, You, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

The written notice will include:
1. The reasons for the determination;
2. A reference to the benefit plan provisions, on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and information about how to obtain diagnosis, Treatment and denial codes with their meanings;
4. An explanation of Our external review processes (and how to initiate an external review) and a statement of Your right, if any, to bring a civil action under Section 502(a) of ERISA following a final decision on external appeal;
5. In certain situations, a statement in non-English language(s) that future notices of claim denials and certain other benefit information may be available in such non-English language(s);
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request; and
9. A description of the standard that was used in denying the claim and a discussion of the decision.

If Our decision is to continue to deny or partially deny Your claim or You do not receive timely decision, You may be able to request an external review of Your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the INDEPENDENT EXTERNAL REVIEW section below.

SAMPLE

You must exercise the right to internal appeal as a precondition to taking any action against Us, either at law or in equity. If You have an adverse appeal determination, You may file civil action in a state or federal court.

INDEPENDENT EXTERNAL REVIEW

You or Your authorized representative may make a request for a standard external or expedited external review of a Final Adverse Determination by an independent review organization (IRO). You must first exhaust the internal appeal process described earlier in this section. However, if You have not received a decision regarding the adverse benefit determination within 30 days following the date of Your request of an appeal, You are considered to have satisfied the requirement to exhaust the internal appeal process.

An **"Adverse Determination"** means a determination by Us or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a Covered Expense has been reviewed and, based upon the information provided, does not meet Our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and/or if determined to be experimental/investigational, and therefore, the requested service or payment for the service is denied, reduced, or terminated.
An adverse determination eligible for external review does not include a denial of coverage for a service or treatment specifically excluded under the policy.

A **"Final Adverse Determination"** means an Adverse Determination involving a Covered Expense that has been upheld by Us or its designated utilization review organization, at the completion of Our internal grievance process procedures.

1. Standard External Review

You or Your authorized representative may request an external review through the Iowa Insurance Division by completing an External Review Request Form and submitting the form as described in this section. You may obtain this request form by calling the Customer Service number on Your ID card, by visiting Our website at www.pekininsurance.com, by contacting the Iowa Insurance Division or by visiting the Iowa Insurance Divisions' website at www.iid.state.ia.us.

You will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on Your request for external review.

Requests must be filed in writing at the following address, no later than four months after You receive notice of the final adverse benefit determination:

Iowa Insurance Division
330 Maple Street
Des Moines, Iowa 50319-0065
Fax: 515-281-3059
E-mail: iid.marketingregulation@iid.iowa.gov

Preliminary Review Upon notification that an external review request has been filed, We will make a preliminary review of the request to determine whether the request may proceed to external review. Following that review, the Iowa Insurance Division will decide whether Your request is eligible for an external review, and if it is the Iowa Insurance Division will assign an IRO to conduct the external review. You will be advised of the name of the IRO and will then have five business days to provide new information to the IRO. The IRO will make a decision within 45 days of the date the Iowa Insurance Division receives Your request for an external review.

You may contact the Iowa Insurance Division at 515-281-348 at any time for assistance with the external review process.

2. Expedited External Review

SAMPLE

You do not need to exhaust the internal appeal process to request an external review of an adverse determination or a final adverse determination if You have a medical condition for which the time frame for competing and internal appeal or for completing a standard external review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function.

You may also have the right to request an expedited external review of a final adverse determination that concerns an admission, availability of care, concurrent review, or service for which You received Emergency Services, and You have not been discharged from a facility.

If Our adverse benefit determination is that the service or Treatment is experimental or investigational and Your treating Physician has certified in writing that delaying the service or Treatment would render it significantly less effective, You may also have the right to request an expedited external review.

You or Your authorized representative may submit an oral or written expedited external review request to the Iowa Insurance Division by contacting the Iowa Insurance Division at 515-281-6348.

If the Insurance Division determines the request is eligible for an expedited external review, the Division will immediately assign an IRO to conduct the review and a written decision will be made within 4 business days from the receipt of the request. If the IRO provides its decision orally, it must provide this decision in writing within 48 hours of the oral notification.

3. External Review Decision

An external review decision is binding on Us. An external review decision is binding on You, except to the extent You have other remedies available under applicable federal or state law. You or Your authorized representative may not file a subsequent request for external review involving the same Adverse Determination of Final Adverse Determination for which You have already received an external review decision.

LEGAL ACTION

You shall not start legal action against Us until You have exhausted the appeal procedure described in this section.

DEFINITIONS

ACCESS FEE

The amount You must pay each time you incur Covered Expense for Emergency Services provided in a Hospital emergency room. The amount is outlined in the Schedule of Benefits. This amount must be paid anytime You receive Emergency Services in a Hospital emergency room, and are not directly admitted to the Hospital as an inpatient. This amount is in addition to any Deductible and coinsurance amounts.

ALCOHOLISM

A chronic disorder or Illness in which the Insured is unable, for psychological or physical reasons, or both, to refrain from the frequent consumption of alcohol in quantities sufficient to produce intoxication and, ultimately, Injury to health and effective functioning.

APPROVED TRANSPLANT SERVICES

Services and supplies for organ transplants when provided at or arranged by a Designated Transplant Facility. Such services include, but are not limited to, Hospital charges, Physician charges, organ procurement and tissue typing, and ancillary services related to the organ transplant.

SAMPLE

CALENDAR YEAR

January 1 through December 31.

CERTIFICATE OF INSURANCE

A list which states the benefits an Insured Employee is insured for under the Policy.

CHEMICAL DEPENDENCY

The abuse of or psychological or physical dependency on or addiction to a controlled substance.

CHEMICAL DEPENDENCY TREATMENT FACILITY

A place which:
- Provides Treatment of Chemical Dependency; and
- Is legally licensed for the Treatment of Chemical Dependency.

It does not include a Residential Facility.

CHILD, CHILDREN

1. The Insured Employee or Insured Employee's Spouse's:
    - Natural born Child;
    - Legally adopted Child who is in the custody of the Insured pursuant to an interim court order of adoption vesting temporary care of the Child to the Insured;
    - Step Child; or
    - Any other Child that has been declared the legal responsibility of the Insured Employee or Insured Employee's Spouse.

2. The Child must be one of the following:
    - Under 26 years of age;
    - An unmarried full-time student enrolled in an accredited educational institution. Full-time student status continues during:
        - Regularly-scheduled school vacations; and
        - Medically Necessary leaves of absence until the earlier of one year from the first day of leave or the date coverage would otherwise end; or
    - An unmarried Child who is totally and permanently disabled, physically or mentally. The disability must have existed before the Child turned age 26, or while the Child was a full-time student.

A Medically Necessary leave of absence means an absence that:
- Commences while the Child is suffering from a serious Illness or Injury;
- Is Medically Necessary; and
- Causes the Child to lose student status for purposes of Health Insurance Coverage under the terms of the Policy.

CLEAN CLAIM

A properly completed paper or electronic billing instrument containing all reasonably necessary information that does not involve coordination of benefits for third-party liability, preexisting condition investigations, or subrogation, and that does not involve the existence of particular circumstances requiring special Treatment that prevents a prompt payment from being made.

COINSURANCE

SAMPLE

The designated percentage that We will pay per Insured per Calendar Year in excess of any applicable Deductibles for Covered Expense. The Coinsurance percentage for different types of services is shown on the Schedule of Benefits.

COMMUNITY MENTAL HEALTH CENTER

A place which:
- Provides outpatient Treatment of Mental Health Conditions; and
- Is legally licensed for the Treatment of Mental Health Conditions

It does not include a Residential Facility.

COMPLICATIONS OF PREGNANCY

Pregnancy complicated by concurrent disease or abnormal conditions significantly affecting usual medical management, such as, but not limited to:
- Extra-uterine pregnancy;
- Severe toxemic disorders;
- Severe puerperal sepsis;
- Spontaneous miscarriage;
- Severe hemorrhage; and
- Any Complications of Pregnancy requiring delivery by cesarean section.

Complication of pregnancy does not include:
- False labor;
- Occasional spotting;
- Physician prescribed rest;
- Morning sickness;
- Induced abortion;
- Elective cesarean section;
- Maternal age; or
- Repeat cesarean section, unless necessary because of existing medical complications.

COPAY

The amount required to be paid by an Insured each time a specific service is provided, as set forth in the Schedule of Benefits. Services requiring Copay amounts are shown in the Schedule of Benefits.

COST-SHARING

The amounts an Insured must pay for Covered Expenses, expressed as Coinsurance, Access Fees, Copay, and/or Deductibles.

COVERED EXPENSE

The Medically Necessary, Regular, Reasonable & Customary charges for medical services and supplies that are incurred:
- By an Insured while the Insured's coverage under the Policy is in force; and
- For the Treatment of an Illness or Injury except for Preventive Care as specified in SECTION 5 – EXPENSES COVERED BY THE PLAN, 13.Preventative Care; and
- Are not in excess of Regular, Reasonable and Customary charges; and
- Are not excluded from coverage by the terms of the Policy.

CUSTODIAL CARE

SAMPLE

Care which is primarily for the purpose of meeting personal needs. It can be provided by persons without professional skills or training. Examples are help in walking, getting in and out of bed, bathing, eating, dressing, taking medicine. Custodial Care also includes supervision of the patient for safety reasons.

DENTAL

Any care or Treatment or surgery relating to the teeth or gums, including but not limited to preventative Dental care, extractions, restorations, endodontics, periodontics, prosthodontics, oral surgery for any condition which is caused by or related to a problem of the teeth, or any appliances which rest upon or are attached to the teeth. For the purposes of the Policy, all care, surgery, or Treatment of this type will be considered Dental Treatment or surgery, regardless of the origin of the condition which caused the Treatment or surgery.

DEPENDENT

The Spouse and the Child or Children of the Employee, who are not themselves insured as Employees under the Policy.

DESIGNATED TRANSPLANT FACILITY

A facility which has entered into an agreement through a national organ transplant network to render Approved Transplant Services to Our Insureds. The Designated Transplant Facility may or may not be located within the Insured's geographic area. A list of designated transplant facilities is available from Us.

DURABLE MEDICAL EQUIPMENT (DME)

Durable Medical Equipment is medical equipment:

- Which You have received Pre-Approval from Us;
- Which is ordered or prescribed by a Physician;
- Durable enough to withstand repeated usage;
- Primarily and customarily manufactured to serve a medical purpose;
- Would not be useful to a person without an Injury or Illness; and
- Is appropriate for treating an Illness or Injury in the home.

DME includes, but is not limited to, wheelchairs, walkers, Hospital beds, oxygen and oxygen equipment, monitors, nebulizers, blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, lancets, and lancing devices.

The following items are not considered DME, and are not covered under the Policy:

- Air purifiers or cleaners, air conditioners, humidifiers, dehumidifiers, vaporizers, or heaters;
- Any equipment which provides comfort or convenience;
- Structure or vehicle alterations, ramps, or elevators;
- Whirlpools, exercise machines of any type, swimming pools, hot tubs;
- Computers or communication devices;
- Heating pads, heat lamps, duplicate equipment; or
- Similar types of items or equipment.

EFFECTIVE DATE

The date the Policy is put in force or the date the Insured is added to the Policy.

ELIGIBLE

Meets the qualifications to apply for insurance.

EMERGENCY MEDICAL CONDITION

SAMPLE

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- Serious disfigurement of the individual.

EMERGENCY SERVICES

With respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate such Emergency Medical Condition, and such further medical examination and Treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to Stabilize the patient.

EMPLOYEE

A person employed by the Policyholder on a permanent full-time basis, at least 30 hours per week. The person must meet the requirements described in the Policyholder's Policy Schedule of Benefits. It does not mean temporary, part-time, or seasonal Employees.

ENROLLMENT DATE

The earlier of the date of enrollment of the individual in the Policy, or the first day of the Service Waiting Period for enrollment.

EQUIVALENT GENERIC DRUG

A drug that has been classified by the Food and Drug Administration (FDA) as safe, equivalent to, and as effective as the brand name drug that would otherwise be prescribed.

EXPERIMENTAL/INVESTIGATIONAL

Means any drug, biologic, device, diagnostic service, product, equipment, procedure, Treatment, service or supply used in or directly related to the diagnosis, evaluation, or Treatment of an Injury or Illness if one or more of the following criteria apply. The drug, biologic, device, diagnostic service, product, equipment, procedure, Treatment, service or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use; or
- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, Treatment, service or supply(Except as outlined in SECTION 5 - EXPENSES COVERED BY THE PLAN, 16. Clinical Trials); or
- Is subject to review and approval of an Institutional Review Board or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, Treatment, service, or supply as Experimental/Investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, Treatment, service, or supply is under evaluation.

It also means any service, supply, or Treatment that is not commonly and customarily recognized by the physician's profession and within the United States as appropriate Treatment of the patient's diagnosed illness or

SAMPLE

injury and determined to be of proven effectiveness by the appropriate National Scientific Organization related to the diagnosed Illness or Injury.

It also means any procedures, drugs, or devices with unproven efficacy. Unproven efficacy means that the procedures, drugs, or devices have not been used with sufficient frequency or have not achieved the requisite success rates to establish their safety and efficacy in the medical community. A procedure, drug, or device may be considered Experimental/Investigational for certain diagnoses and conditions, and considered established therapies for other diagnoses and conditions.

A medical Treatment, procedure, drug or device that is approved through clinical trials will be considered experimental or investigational if reliable evidence shows it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its safety, efficacy, or its efficacy as compared with the standard means of Treatment or diagnosis, and reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its safety, efficacy or efficacy as compared with the standard means of Treatment or diagnosis, and/or approval has not been given by the United States Food and Drug Administration at the time it is furnished.(Except as outlined in SECTION 5 - EXPENSES COVERED BY THE PLAN, 16. Clinical Trials)

The fact that a procedure, drug, or device is the only available Treatment for a condition will not make it eligible for coverage if it is Experimental/Investigational according to this definition.

FAMILY COVERAGE

The Insured Employee and/or Spouse and/or Children of the Insured Employee, who are Insured as a family unit under the Insured Employee's certificate number.

FAMILY STATUS CHANGE

Any of the following events:

- Marriage;
- Divorce;
- Birth;
- Adoption; or
- Child being placed for adoption.

FORMER POLICY

The Policyholder's terminated Group Health Plan that was replaced by this coverage.

GROUP HEALTH PLAN

An Employee welfare benefit plan that provides medical care to Employees or their Dependents directly or through insurance, reimbursement, or otherwise.

HABILITATIVE SERVICES

Medically Necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not Habilitative Services include, but are not limited to, Respite Care, day care, recreational care, residential Treatment, social services, Custodial Care or education services of any kind, including but not limited to vocational training. Habilitative Services are covered under the same terms and conditions applied to rehabilitative Services under the Policy.

HEALTH INSURANCE COVERAGE

SAMPLE

Benefits consisting of medical care under any Hospital or medical service policy or certificate, Hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

HEALTH INSURANCE MARKETPLACE

Is a set of government-regulated and standardized health care plans that may be available for purchase.

HOME HEALTH CARE

Care and Treatment of an Insured under a plan of care established by his/her Physician. The plan must be submitted to Us in writing, and Pre-Approval has been obtained from Us. The plan of care must be reviewed at least every two months by Your Physician.

It consists of the Medically Necessary services for:

- Part-time or intermittent home nursing care by or under the supervision of a registered nurse (R.N.);
- Part-time or intermittent home health aide services, which solely consist of caring for the patient, and which are provided under the supervision of a R.N. or medical social worker;
- Physical, respiratory, Occupational or Speech Therapy;
- Nutrition counseling provided by or under the supervision of a registered dietitian; and
- Evaluation and development of a home health plan by a R.N., Physician extender or medical social worker, when approved or requested by the primary care Physician.

The Home Health Care services must be provided or coordinated by a state-licensed or Medicare-certified home health agency or rehabilitation agency.

HOSPICE

An agency that provides a coordinated program of home and Inpatient care for the special physical, psychological, and social needs of terminally ill persons and their families. The Hospice agency must:

- Be certified or licensed as a Hospice by the state in which they are operating;
- Operate under the direct supervision of a Physician;
- Provide services 24 hours a day, seven days a week; and
- Maintain medical records on each patient.

HOSPICE CARE

Care and Treatment provided by a Hospice for a terminally ill person and the Immediate Family members of the person if they are covered under the Policy.

HOSPITAL

A place which:

- Is legally operated for the Inpatient care and Treatment of ill or injured persons;
- Has surgical or diagnostic facilities on the premises or in facilities available to it;
- Has continuous 24 hour nursing services; and
- Has a staff of one or more Physicians available at all times.

It does not mean:

- A rest, nursing, or convalescent home;
- A facility or institution mainly for the Treatment of alcoholics or drug addicts;
- A facility primarily affording custodial or educational care for persons suffering from mental diseases or disorders; or
- A free-standing ambulatory surgical facility that arranges for overnight stays within the facility.

ILLNESS

SAMPLE

A disease process that causes the abnormal function of:

- An organ;
- A system of the body; or
- The whole body.

It must be caused by:

- A pathogenic change; or
- A psychological disturbance.

It is also a pregnancy, complication of pregnancy, Mental Health Condition or a Substance Use Disorder.

IMMEDIATE FAMILY

The Insured's Spouse, Children, parents, brothers and sisters.

INDIVIDUAL COVERAGE

Only a single person is covered for Health Insurance Coverage benefits under the Insured's Certificate of Insurance.

INJURY

Bodily Injury caused by an accident which occurs while Insured under the Policy.

INFERTILITY

The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

IN-NETWORK

Covered Expense provided by a Preferred Provider.

IN-NETWORK DEDUCTIBLE

The amount of Covered Expense for services provided by a Preferred Provider that must be incurred in a Calendar Year by an Insured before any Covered Expense is paid by Us. It is equal to the lesser of:

- amount specified under the In-Network Individual Deductible amount shown on the Schedule of Benefits
- amount specified under the In-Network Family Deductible amount shown on the Schedule of Benefits

Out-of-Network Deductible amounts will not be used to satisfy any In-Network Deductible amount.

IN-NETWORK FAMILY DEDUCTIBLE

The maximum amount of Deductible a family insured under one Certificate of Insurance must pay in a Calendar Year for services provided by Preferred Providers. This amount is shown on the Schedule of Benefits. The In-Network Family Deductible may be satisfied by combining all In-Network Deductible amounts applied to Covered Expenses for the Insured Employee and the Insured Employee's Dependents for the Calendar Year. However, only Covered Expense incurred in a Calendar Year and applied to that same Calendar Year's In-Network Individual Deductible can be used to satisfy the In-Network Family Deductible.

Out-of-Network Deductible amounts will not be used to satisfy any In-Network Deductible amounts.

IN- NETWORK INDIVIDUAL DEDUCTIBLE

The maximum amount of Deductible that an individual Insured must pay in a Calendar Year for services by a Preferred Provider. This amount is shown on the Schedule of Benefits.

SAMPLE

Out-of-Network Deductible amounts will not be used to satisfy any In-Network Deductible amounts.

INPATIENT

A confinement in a Hospital, Chemical Dependency Treatment Facility, Community Mental Health Center, Skilled Nursing Facility or Psychiatric Medical Institution for Children that results in the facility making a room and board charge. An overnight stay in an observation unit of a Hospital or licensed ambulatory surgical facility will be considered an inpatient stay for Pre-Certification purposes.

INSURED

Any Insured Employee or Insured Dependent who is covered for benefits under the Policy.

INTENSIVE CARE

A separate area in a Hospital for the inpatient care of patients who are critically ill, which:
- Provides constant nursing care which is not usual in other rooms and wards;
- Has special lifesaving equipment which is immediately available at all times; and
- Has at least one R.N. on duty at all times.

MEDICALLY NECESSARY

Treatment that is:
- Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on:
  - Creditable scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
  - Physician specialty society recommendations and the views of Physicians practicing in the relevant clinical area; and
  - Any other relevant factors;
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
- Not provided primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or Treatment of the Illness, Injury or disease..

MEDICARE

Title XVIII of the Social Security Act as amended.

MENTAL HEALTH CONDITION

Includes:
- The following biologically based mental Illness: Schizophrenia, Bipolar disorder, Major Depressive disorder, Schizo-affective disorder, Obsessive-Compulsive disorders, Pervasive developmental disorders, Autistic disorders; and
- Disorders listed only as a Mental Health Condition in the most current "ICD-9-CM" or "ICD-10-cm" and not dually listed elsewhere in the "ICD-9-CM" or "ICD-10-cm".

It does not include Chemical Dependency.

MORBID OBESITY

- A body mass index of at least thirty-five (35) kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- A body mass index of at least forty (40) kilograms per meter squared without comorbidity.

SAMPLE

For purposes of this definition, body mass index is equal to weight in kilograms divided by height in meters squared.

NEWBORN CHILD

A Dependent Child born to the Employee while he/she is Insured under the Policy.

NON-DESIGNATED TRANSPLANT FACILITY

A facility that has not entered into a specific national organ transplant network agreement that We designate to provide Approved Transplant Services for Our Insureds.

NON-PREFERRED PROVIDER

Any medical provider who has not entered into a written agreement with Us or a Preferred Provider Organization under contract with Us to provide services to Our Insureds at a negotiated rate. However, if the nearest Preferred Provider is more than 50 miles from the Insured's residence, then a Non-Preferred Provider within 50 miles of the Insured's residence will be paid as if the service was provided by a Preferred Provider.

NURSING FACILITY

A legally operated institution or a part of an institution for the Treatment of inpatients. Treatment must be under the supervision of a Physician. It must provide 24 hour nursing service under the supervision of a R.N. It must maintain daily medical records of each patient. This definition does not include:

- A rest home or home for the aged;
- An institution, nor a unit of an institution, used for custodial or educational care; or
- An institution, nor a unit of an institution, used for the Treatment of alcoholics, drug addicts, or the mentally ill.

OUT-OF-NETWORK

Covered Expense provided by a Non-Preferred Provider.

OUT-OF-NETWORK DEDUCTIBLE

The amount of Covered Expense for services provided by a Non-Preferred Provider that must be incurred in a Calendar Year by an Insured before any Covered Expense is paid by Us. It is equal to the lesser of:

- amount specified under the Out-of-Network Individual Deductible amount shown on the Schedule of Benefits.
- amount specified under the Out-of-Network Family Deductible amount shown on the Schedule of Benefits

Out-of-Network Deductible amounts will not be used to satisfy any In-Network Deductible amount.

OUT-OF-NETWORK FAMILY DEDUCTIBLE

The maximum amount of Deductible a family Insured under one Certificate of Insurance must pay in a Calendar Year for services provided by Non-Preferred Providers. This amount is shown on the Schedule of Benefits. The Out-of-Network Family Deductible may be satisfied by combining all Out-of-Network Deductible amounts applied to Covered Expenses for the Insured Employee and the Insured Employee's Dependents for the Calendar Year. However, only Covered Expense incurred in a Calendar Year and applied to that same Calendar Year's Out-of-Network Individual Deductible can be used to satisfy the Out-of-Network Family Deductible.

In-Network Deductible amounts will not be used to satisfy any Out-of-Network Deductible amounts.

SAMPLE

OUT-OF-NETWORK INDIVIDUAL DEDUCTIBLE

The maximum amount of Deductible that an individual Insured must pay in a Calendar Year for services by a Non-Preferred Provider. This amount is shown on the Schedule of Benefits.

In-Network Deductible amounts will not be used to satisfy any Out-of-Network Deductible amounts.

OUT-OF-POCKET MAXIMUM

The maximum amount of Covered Expenses You will pay in a Calendar Year. The Out-of-Pocket Maximum includes applicable Copays, Access Fees, Deductibles and Coinsurance shares. The Out-of-Pocket Maximum is shown in the Schedule of Benefits. Except that any type of Copay under the Prescription Drugs benefit does not count towards this maximum unless mandated by state or federal law. After the Out-of-Pocket Maximum is reached, We will pay the remainder of the Covered Expenses incurred by an Insured during the rest of that Calendar Year at 100%.

PARTICIPATING PHARMACY

Any pharmacy which is enrolled as a participant in the RX Company's prescription drug program

PHYSICIAN

A practitioner of the healing arts licensed by the state he/she practices in. He/she must be performing only those services he/she is licensed to perform. Physician includes, but is not limited to, the following:

- Advanced Registered Nurse Practitioners (ARNP) registered with the Iowa Board of Nursing to practice in an advanced role with a specialty designation of certified clinical nurse specialist, certified nurse midwife, certificate nurse practitioner, or certified registered nurse anesthetist;
- Audiologists;
- Chiropractors;
- Doctors of Osteopathy (D.O.);
- Licensed Independent Social Workers;
- Medical Doctors (M.D.);
- Occupational Therapists;
- Optometrists;
- Oral Surgeons;
- Physical Therapists;
- Physician Assistants;
- Podiatrists;
- Psychologists. Psychologists must have a doctorate degree in psychology with two years' clinical experience and meet the standards of a national register; and
- Speech Pathologists.

POLICY

The entire contract between the Policyholder and Us consisting of: the Group Insurance Policy, the Certificate of Insurance, Schedule of Benefits, Policyholder Application, Employee enrollment forms, and any other riders, amendments or endorsements.

POLICYHOLDER

The employer listed as the Policyholder on the face page of the Policy.

POST-SERVICE CLAIM

SAMPLE

A claim for benefit under the Policy after the service has been rendered.

PRE-APPROVAL

A review to determine and authorize the coverage level of Medically Necessary services the Policy will provide benefit for if Pre-Approved by Us prior to receiving the services.

PRE-CERTIFCATION

The process required to obtain prior approval for inpatient Hospital admissions and other select Hospital services.

PREFERRED PHYSICIAN

A Physician who is entered into a written agreement to provide services to Our Insureds at a negotiated rate through a direct contact with Us or through a Preferred Provider Organization under contract with Us. We recommend that You verify with Us that the Physician You are using or considering is currently a Preferred Provider.

PREFERRED PROVIDER

A medical provider who has entered into a written agreement to provide services to Our Insureds at a negotiated rate through a direct contract with Us, or through a Preferred Provider Organization under contract with Us. We recommend that You verify with Us that the provider You are using or considering is currently a Preferred Provider.

It also means a provider accessed under the qualifications outlined in BENEFIT FOR SPECIALTY PHYSICIAN SERVICES BY A NON-PREFERRED PROVIDER or BENEFIT FOR EMERGENCY SERVICES. However, rates for reimbursement will be at the Regular, Reasonable & Customary rate due to lack of a negotiated Preferred Provider direct contract.

PRE-SERVICE CLAIM

A claim for benefit under the Policy where the Policy conditions the receipt of the benefit, in whole or in part, on obtaining pre-approval for the medical care or service.

PROOF OF INCAPACITY

Medical proof that a dependent Child is incapable of self-support and solely dependent on the Insured for maintenance and support due to mental retardation or physical handicap.

PROOF OF LOSS

Consists of:

- A properly completed claim form, if applicable for determining benefits; and
- Any other information We need to determine benefits and process the claim.

PSHYCIATRIC MEDICAL INSTITUTION FOR CHILDREN (PMIC)

A place which:

- Provides inpatient psychiatric services to Children; and
- Is licensed as a PMIC under Iowa Code Chapter 135H.

It does not include a Residential Treatment Facility

REGULAR, REASONABLE & CUSTOMARY

The lesser of:

SAMPLE

- the actual charge;
- what the provider would accept for the same service or supply in the absence of insurance;
- the amount the provider has agreed to charge under a Preferred Provider agreement with Pekin Life Insurance Company;
- the amount the provider has agreed to accept under the terms of a negotiated agreement with Pekin Life Insurance Company;
- a reasonable amount determined by Pekin Life Insurance Company by comparing charges made by other medical professionals and/or facilities with similar credentials, for similar services and supplies, adjusted to the geographic locale, and based upon the Regular, Reasonable & Customary percentile level purchased by the Policyholder and/or factors deemed appropriate by Pekin Life Insurance Company (Reasonable & Customary percentile is listed on the Schedule of Benefits);
- an amount based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services for the same services or supplies; or
- an amount based on accepted industry standard or a commercially available database using factors such as, but not limited to the:
  - complexity or severity of the treatment;
  - level of skill and experience required for the treatment;
  - cost and quality data;
  - comparable fees and costs for the treatment;
  - reimbursement amounts paid by Centers for Medicare and Medicaid Services for the same services or supplies;
  - generally accepted billing practices; and/or
  - industry standard cost, reimbursement, and utilization data.

Regular, Reasonable & Customary for certain surgical charges will be determined as follows:

- for multiple surgical procedures performed at the same operative session, We will allow up to 100% of the Regular, Reasonable & Customary amount for the first surgical procedure, 50% of the Regular, Reasonable & Customary amount for the second surgical procedure, and 25% of the Regular, Reasonable & Customary amount for each additional surgical procedure;
- for charges by an assistant surgeon, We will allow up to 20% of the amount allowed for the primary surgical procedure when an assistant is deemed Medically Necessary.

We reserve the right to take into consideration all of the above means of determining the Regular, Reasonable & Customary rate and in some instances an allowable amount may not be the lesser of.

RESIDENTIAL FACILITY

A place which:

- Provides Treatment for severe, persistent or chronic Mental Health Conditions or Chemical Dependency; and
- Meets all the following criteria:
  - Is a residential setting;
  - Provides Treatment that involves therapeutic intervention and specialized programs with a high degree of structure and supervision;
  - Provides Treatment that includes training in basic skills such as social skills and activities of daily living; and
  - Provides Treatment that does not require direct daily supervision by a Physician

SAMPLE

RESPITE CARE

Short-term care given to a Hospice patient by another care-giver so that the patient's care-giver can rest or take time off.

SCHEDULE OF BENEFITS

A list which states those benefits the Policyholder has decided to offer to his/her Insured Employees.

SERVICE WAITING PERIOD

A period of time 90 days or less that must pass with respect to an Employee before the Employee is Eligible to be covered for benefits under the terms of the Policy. The Service Waiting Period is shown in the Policyholders' application.

SPOUSE

A husband, wife or same sex partner as the result of a marriage that is legally recognized in Iowa.

STABILIZE

To provide the medical Treatment of an Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another Hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn Child), "Stabilize" means to deliver the Newborn Child (including the placenta).

SUBSTANCE USE DISORDER

Alcoholism or Chemical Dependency.

TREATMENT

Means:

- Any examination, diagnostic test, or actual Treatment by a Physician of an Illness or Injury or symptoms of an Illness or Injury; or
- Any medication or other service or supply dispensed in regard to an Illness or Injury or symptoms of an Illness or Injury.

URGENT CARE

Medical care for an Illness or Injury serious enough that a reasonable person would seek care right away, but not as severe as to require Hospital emergency department care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

URGENT CARE CENTER

A licensed facility that provides Urgent Care.

WE, US, OUR

Pekin Life Insurance Company

YOU, YOUR

An Insured Employee or Insured Dependent.

SAMPLE

SAMPLE

APPEALS/COMPLAINTS

It is Our policy to treat each claim submission fairly. If, however, You are not satisfied with Our decision on a matter, You have the right to file an appeal or a complaint asking Us to reconsider Our decision.

Requests for reconsideration can be made by contacting Us by phone, fax or letter at:

LIFE & HEALTH CLAIM COMMITTEE
PEKIN LIFE INSURANCE COMPANY
2505 COURT STREET
PEKIN, IL 61558
Ph.: 800-371-9622, ext. 2721
Fax: 309-346-8265

We will also include specific instructions on how to file an appeal with any negative decision regarding a claim or request for benefits.

You can also write to the State Insurance Department at:

IOWA INSURANCE DIVISION
CONSUMER AFFAIRS BUREAU
330 MAPLE STREET
DES MOINES, IA 50319-0065

SAMPLE

PEKIN INSURANCE COMPANY

PEDIATRIC DENTAL CARE BENEFIT AMENDMENT

This amendment is attached to and made part of the policy and certificate to which it is attached. Except as modified below, all terms, conditions, exclusions, and limitations of the policy apply.

Notwithstanding any other provisions of the policy, covered expenses under this amendment are not covered under any other provision of the policy. Any amount in excess of the maximum amount provided under this amendment, if any, is not covered under any other provision in the policy.

All terms used in this amendment have the same meaning given to them in the policy, unless otherwise specifically defined in this amendment. Refer to the "Pediatric Dental Care Limitations and Exclusions" provision in this amendment and the "Expense Not Covered by the Plan" section of the certificate for pediatric dental care expenses not covered by the policy. All other terms and provisions of the policy are applicable to covered expenses for pediatric dental care.

Schedule of Benefits

Covered expenses for pediatric dental care apply toward the medical deductible and medical out-of-pocket maximum amount.

Covered Expense	Plan Pays
Class I services	100% after medical deductible
Class II services	70% after medical deductible
Class III services	50% after medical deductible
Orthodontia	50% after medical deductible

Waiting Period

The only waiting period is for orthodontic services. To meet this requirement, the dependent child receiving orthodontia services must be covered under the policy for an entire and continuous 24 month waiting period to receive orthodontic coverage.

Pediatric Dental Care Covered Expenses

We will pay benefits as specified in the schedule of benefits in this amendment for covered expenses incurred by a covered person as defined in this amendment for pediatric dental services. Pediatric dental services include the following as categorized below.

SAMPLE

Class I Services

Diagnostic and Treatment Services
D0120 Periodic oral evaluation - Limited to 1 every 6 months
D0140 Limited oral evaluation - problem focused - Limited to 1 every 6 months
D0150 Comprehensive oral evaluation - Limited to 1 every 6 months
D0180 Comprehensive periodontal evaluation - Limited to 1 every 6 months
D0210 Intraoral – complete series (including bitewings) 1 every 60 (sixty) months
D0220 Intraoral – periapical first film
D0230 Intraoral – periapical – each additional film
D0240 Intraoral – occlusal film
D0270 Bitewing – single film – 1 set every 6 months
D0272 Bitewings – two films – 1 set every 6 months
D0274 Bitewings – four films – 1 set every 6 months
D0277 Vertical bitewings – 7 to 8 films – 1 set every 6 months
D0330 Panoramic film – 1 film every 60 (sixty) months
D0340 Cephalometric x-ray
D0350 Oral / Facial Photographic Images
D0470 Diagnostic Models
Note: Diagnostic procedures of: D0330, D0340, D0350 and D0470 are covered as Type I benefit and applied toward the Non-Ortho annual maximum for a non-vested orthodontia insured.
Preventative Services
D1120 Prophylaxis – Limited to 1 every 6 months
D1203 Topical application of fluoride (excluding prophylaxis) – Limited to 2 every 12 months
D1204 Topical application of fluoride (excluding prophylaxis) – Age 15 to 19 – 2 every 12 months
D1206 Topical fluoride varnish – 2 in 12 months
D1351 Sealant – per tooth – unrestored permanent molars – 1 sealant per tooth every 36 months
D1352 Preventative resin restorations in a moderate to high caries risk patient – permanent tooth – 1 sealant per tooth every 36 months.
D1510 Space maintainer – fixed – unilateral
D1515 Space maintainer – fixed – bilateral
D1520 Space maintainer – removable – unilateral
D1525 Space maintainer – removable – bilateral
D1550 Re-cementation of space maintainer
Additional Procedures covered as Basic Services
D9110 Palliative treatment of dental pain – minor procedure

Class II Services

Minor Restorative Services
D2140 Amalgam - one surface, primary or permanent
D2150 Amalgam - two surfaces, primary or permanent
D2160 Amalgam - three surfaces, primary or permanent
D2161 Amalgam - four or more surfaces, primary or permanent
D2330 Resin–based composite - one surface, anterior
D2331 Resin-based composite - two surfaces, anterior
D2332 Resin-based composite - three surfaces, anterior
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior)
D2910 Re-cement inlay
D2920 Re-cement crown
D2930 Prefabricated stainless steel crown - primary tooth – Under age 15 - Limited to 1 per tooth in 60

SAMPLE

months

D2931 Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months

D2940 Protective Restoration

D2951 Pin retention - per tooth, in addition to restoration

Endodontic Services

D3220 Therapeutic pulpotomy (excluding final restoration) - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.

D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.

D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for insureds up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.

D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. - Limited to primary incisor teeth for insureds up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.

Periodontal Services

D4341 Periodontal scaling and root planning-four or more teeth per quadrant – Limited to 1 every 24 months

D4342 Periodontal scaling and root planning-one to three teeth, per quadrant – Limited to 1 every 24 months

Prosthodontic Services

D5410 Adjust complete denture – maxillary

D5411 Adjust complete denture – mandibular

D5421 Adjust partial denture – maxillary

D5422 Adjust partial denture - mandibular

D5510 Repair broken complete denture base

D5520 Replace missing or broken teeth - complete denture (each tooth)

D5610 Repair resin denture base

D5620 Repair cast framework

D5630 Repair or replace broken clasp

D5640 Replace broken teeth - per tooth

D5650 Add tooth to existing partial denture

D5660 Add clasp to existing partial denture

D5710 Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5720 Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5721 Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5730 Reline complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5731 Reline complete mandibular denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5740 Reline maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5741 Reline mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5750 Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation

Oral Surgery

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth

D7220 Removal of impacted tooth - soft tissue

SAMPLE

D7230 Removal of impacted tooth – partially bony
D7240 Removal of impacted tooth - completely bony
D7241 Removal of impacted tooth - completely bony with unusual surgical complications
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7251 Coronectomy - intentional partial tooth removal
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Surgical access of an unerupted tooth
D7310 Alveoloplasty in conjunction with extractions - per quadrant
D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions - per quadrant
D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7471 Removal of exostosis
D7510 Incision and drainage of abscess - intraoral soft tissue
D7910 Suture of recent small wounds up to 5 cm
D7971 Excision of pericoronal gingiva

Class III Services

Major Restorative Services
Note: When dental services that are subject to a frequency limitation were performed prior to an insured's effective date of coverage the date of the prior service may be counted toward the time, frequency limitations and/ or replacement limitations under the policy. (For example, if a crown, partial bridge, etc was not placed while covered by us, the frequency limitations may apply).
D0160 Detailed and extensive oral evaluation - problem focused, by report
D2510 Inlay - metallic – one surface – An alternate benefit will be provided
D2520 Inlay - metallic – two surfaces – An alternate benefit will be provided
D2530 Inlay - metallic – three surfaces – An alternate benefit will be provided
D2542 Onlay - metallic - two surfaces – Limited to 1 per tooth every 60 months
D2543 Onlay - metallic - three surfaces – Limited to 1 per tooth every 60 months
D2544 Onlay - metallic - four or more surfaces – Limited to 1 per tooth every 60 months
D2740 Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months
D2750 Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months
D2751 Crown - porcelain fused to predominately base metal – Limited to 1 per tooth every 60 months
D2752 Crown - porcelain fused to noble metal – Limited to 1 per tooth every 60 months
D2780 Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months
D2781 Crown - 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months
D2783 Crown - 3/4 porcelain/ceramic – Limited to 1 per tooth every 60 months
D2790 Crown - full cast high noble metal– Limited to 1 per tooth every 60 months
D2791 Crown - full cast predominately base metal – Limited to 1 per tooth every 60 months
D2792 Crown - full cast noble metal– Limited to 1 per tooth every 60 months
D2794 Crown – titanium– Limited to 1 per tooth every 60 months
D2950 Core buildup, including any pins– Limited to 1 per tooth every 60 months
D2954 Prefabricated post and core, in addition to crown– Limited to 1 per tooth every 60 months
D2980 Crown repair, by report
Endodontic Services
D3310 Anterior root canal (excluding final restoration)
D3320 Bicuspid root canal (excluding final restoration)
D3330 Molar root canal (excluding final restoration)
D3346 Retreatment of previous root canal therapy-anterior
D3347 Retreatment of previous root canal therapy-bicuspid
D3348 Retreatment of previous root canal therapy-molar

SAMPLE

D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352 Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
D3353 Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
D3354 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration
D3410 Apicoectomy/periradicular surgery - anterior
D3421 Apicoectomy/periradicular surgery - bicuspid (first root)
D3425 Apicoectomy/periradicular surgery - molar (first root)
D3426 Apicoectomy/periradicular surgery (each additional root)
D3450 Root amputation - per root
D3920 Hemisection (including any root removal) - not including root canal therapy
Periodontal Services
D4210 Gingivectomy or gingivoplasty – four or more teeth - Limited to 1 every 36 months
D4211 Gingivectomy or gingivoplasty – one to three teeth
D4240 Gingival flap procedure, four or more teeth – Limited to 1 every 36 months
D4249 Clinical crown lengthening-hard tissue
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
D4270 Pedicle soft tissue graft procedure
D4271 Free soft tissue graft procedure (including donor site surgery)
D4273 Subepithelial connective tissue graft procedures (including donor site surgery)
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis – Limited to 1 per lifetime
Prosthodontic Services
D5110 Complete denture - maxillary – Limited to 1 every 60 months
D5120 Complete denture - mandibular – Limited to 1 every 60 months
D5130 Immediate denture - maxillary – Limited to 1 every 60 months
D5140 Immediate denture - mandibular – Limited to 1 every 60 months
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)– Limited to 1 every 60 months
D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth) – Limited to 1 every 60 months
Note: An **implant** is a covered procedure only if determined to be a dental necessity. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.
D6010 Endosteal Implant - 1 every 60 months
D6012 Surgical Placement of Interim Implant Body - 1 every 60 months
D6040 Eposteal Implant – 1 every 60 months
D6050 Transosteal Implant, Including Hardware – 1 every 60 months
D6053 Implant supported complete denture
D6054 Implant supported partial denture
D6055 Connecting Bar – implant or abutment supported - 1 every 60 months
D6056 Prefabricated Abutment – 1 every 60 months

SAMPLE

D6058 Abutment supported porcelain ceramic crown -1 every 60 months
D6059 Abutment supported porcelain fused to high noble metal - 1 every 60 months
D6060 Abutment supported porcelain fused to predominately base metal crown - 1 every 60 months
D6061 Abutment supported porcelain fused to noble metal crown - 1 every 60 months
D6062 Abutment supported cast high noble metal crown - 1 every 60 months
D6063 Abutment supported cast predominately base metal crown - 1 every 60 months
D6064 Abutment supported cast noble metal crown - 1 every 60 months
D6065 Implant supported porcelain/ceramic crown - 1 every 60 months
D6066 Implant supported porcelain fused to high metal crown - 1 every 60 months
D6067 Implant supported metal crown - 1 every 60 months
D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 months
D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
D6070 Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months
D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 months
D6072 Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months
D6073 Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months
D6074 Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 months
D6075 Implant supported retainer for ceramic fixed partial denture - 1 every 60 months
D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
D6077 Implant supported retainer for cast metal fixed partial denture - 1 every 60 months
D6078 Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months
D6079 Implant/abutment supported fixed partial denture for partially edentulous arch - 1 every 60 months
D6080 Implant Maintenance Procedures -1 every 60 months
D6090 Repair Implant Prosthesis -1 every 60 months
D6091 Replacement of Semi-Precision or Precision Attachment -1 every 60 months
D6095 Repair Implant Abutment -1 every 60 months
D6100 Implant Removal -1 every 60 months
D6190 Implant Index -1 every 60 months
D6210 Pontic - cast high noble metal – Limited to 1 every 60 months
D6211 Pontic - cast predominately base metal – Limited to 1 every 60 months
D6212 Pontic - cast noble metal– Limited to 1 every 60 months
D6214 Pontic – titanium – Limited to 1 every 60 months
D6240 Pontic - porcelain fused to high noble metal – Limited to 1 every 60 months
D6241 Pontic - porcelain fused to predominately base metal – Limited to 1 every 60 months
D6242 Pontic - porcelain fused to noble metal – Limited to 1 every 60 months
D6245 Pontic - porcelain/ceramic – Limited to 1 every 60 months
D6519 Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months
D6520 Inlay – metallic – two surfaces – Limited to 1 every 60 months
D6530 Inlay – metallic – three or more surfaces - Limited to 1 every 60 months
D6543 Onlay – metallic – three surfaces - 1 every 60 months
D6544 Onlay – metallic – four or more surfaces -1 every 60 months
D6545 Retainer - cast metal for resin bonded fixed prosthesis -1 every 60 months
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months
D6740 Crown - porcelain/ceramic -1 every 60 months
D6750 Crown - porcelain fused to high noble metal - 1 every 60 months
D6751 Crown - porcelain fused to predominately base metal - 1 every 60 months
D6752 Crown - porcelain fused to noble metal - 1 every 60 months
D6780 Crown - 3/4 cast high noble metal - 1 every 60 months
D6781 Crown - 3/4 cast predominately base metal - 1 every 60 months
D6782 Crown - 3/4 cast noble metal - 1 every 60 months

D6783 Crown - 3/4 porcelain/ceramic - 1 every 60 months
D6790 Crown - full cast high noble metal - 1 every 60 months
D6791 Crown - full cast predominately base metal - 1 every 60 months
D6792 Crown - full cast noble metal - 1 every 60 months
D6973 Core buildup for retainer, including any pins - 1 every 60 months
D9940 Occlusal guard, by report - 1 in 12 months for patients age 13 to 19

Class IV Services

Orthodontic Services
D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8050 Interceptive orthodontic treatment of the primary dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8210 Removable appliance therapy
D8220 Fixed appliance therapy
D8660 Pre-orthodontic treatment visit
D8670 Periodic orthodontic treatment visit (as part of contract)
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)
Note: Benefits for codes D0330, D0340, D0350, and D0470 will be applied to the lifetime orthodontia maximum when performed as part of orthodontia treatment; for those insureds eligible for Class IV benefits who have satisfied the 24 month orthodontic waiting period.

Integral service

Integral services are additional charges related to materials or equipment used in the delivery of dental care. The following services are considered integral to the dental service and will not be paid separately:

1. Local anesthetics;
2. Bases;
3. Pulp testing;
4. Pulp caps;
5. Study models/diagnostic casts;
6. Treatment plans;
7. Occlusal (biting or grinding surfaces of molar and bicuspid teeth) adjustments;
8. Nitrous oxide;
9. Irrigation; and
10. Tissue preparation associated with impression or placement of a restoration.

Pretreatment plan

We suggest that if dental treatment is expected to exceed $300, a covered person or their dentist should submit a treatment plan to us for review before treatment begins.

We will provide the employee and/or the covered person and the dentist with an estimate for benefits payable based on the submitted treatment plan. This estimate is not a guarantee of what we will pay. It

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tells the employee and/or the covered person and the dentist in advance about the benefits payable for the pediatric dental services in the treatment plan. An estimate for services is not necessary for a dental emergency.

Alternate services

If two or more services are acceptable to correct a dental condition, we will base the benefits payable on the least expensive pediatric dental service that produces a professionally satisfactory result, as determined by us. We will pay up to the maximum benefit for the least costly pediatric dental service subject to any applicable medical deductible and/or coinsurance. The covered person will be responsible for any amount exceeding the maximum benefit for the services performed.

If the employee and/or the covered person and the dentist decide on a more costly service, payment will be limited to the reimbursement limit for the least costly service and will be subject to any medical deductible and/or coinsurance. The covered person will be responsible for any amount exceeding the maximum benefit for the services performed.

Continuation of Coverage

We will pay benefits for a 31 day period after the covered person's insurance ends if before coverage ends the dentist:
1. prepared the abutment teeth for the completion of installation of prosthetic devices;
2. made an impression;
3. prepared the tooth for cast restoration; or
4. the covered person's dentist opened the pulp chamber before the covered person's insurance ended and the device was installed or treatment was finished within 31 days after the termination of coverage.

Pediatric Dental Care Limitations and Exclusions

Refer to the "Expense Not Covered by the Plan" section of the certificate for additional exclusions. Unless specifically stated otherwise, no benefit will be provided for, or on account of, the following items:
1. Services and treatment not prescribed by or under the direct supervision of a dentist;
2. Services and treatment which are experimental or investigational;
3. Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;
4. Services and treatment performed prior to your effective date of coverage;
5. Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
6. Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice.
7. Services and treatment resulting from failure to comply with professionally prescribed treatment;
8. Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
9. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
10. Office infection control charges;
11. Charges for copies of records, charts or x-rays, or any costs associated with forwarding/mailing copies of records, charts or x-rays;
12. State or territorial taxes on dental services performed;

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13. Those submitted by a dentist, which are for the same services performed on the same date for the same insured by another dentist;
14. Those which are for specialized procedures and techniques;
15. Those performed by a dentist who is compensated by a facility for similar covered services performed for insureds;
16. Duplicate, provisional and temporary devices, appliances, and services;
17. Plaque control programs, oral hygiene instruction, and dietary instructions;
18. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
19. gold foil restorations;
20. Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
21. Adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
22. Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
23. Sealants for teeth other than permanent molars;
24. Precision attachments, personalization, precious metal bases and other specialized techniques;
25. Replacement of dentures that have been lost, stolen or misplaced;
26. Orthodontic services provided to an insured who has not met the 24 month waiting period requirement.
27. Repair of damaged orthodontic appliances;
28. Replacement of lost or missing appliances;
29. Fabrication of athletic mouth guard;
30. Internal bleaching;
31. Nitrous oxide;
32. Oral sedation;
33. Topical medicament center
34. Bone grafts when done in connection with extractions, apicoetomies or non-covered/non eligible implants.
35. When two or more services are submitted and the services are considered part of the same service to one another, we will pay the most comprehensive service (the service that includes the other non benefited service).
36. When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), we will pay for the service that represents the final treatment.
37. All services are subject to the usual and customary charge as defined in this amendment. The member is responsible for all remaining charges that exceed the allowable maximum.

Definitions

Alternate Benefit means if we determine a service less costly than the one preformed by the covered person's dentist could have been performed, we will pay benefits based upon the less costly service.

Annual Benefit Maximum means the maximum annual benefit that you can receive per person.

Class I Services means the basic services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.

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Class II Services means intermediate services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.

Class III Services means major services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.

Class IV Services means orthodontic services.

Covered person under this amendment means a person under the age of 19 who is eligible and enrolled for benefits provided under this policy/certificate.

Dentally Necessary means that a dental service or treatment is performed in accordance with generally accepted dental standards, as determined from multiple sources including but not limited to relevant clinical dental research from various research organizations including dental schools, current recognized dental school standard of care curriculums and organized dental groups including the American Dental Association, which is necessary to treat decay, disease or injury of teeth, or essential for the care of teeth and supporting tissues of the teeth.

Expense incurred date means the date on which:
1. The teeth are prepared for fixed bridges, crowns, inlays or onlays;
2. The final impression is made for dentures or partials;
3. The pulp chamber of a tooth is opened for root canal therapy;
4. A periodontal surgical procedure is performed; or
5. The service is performed for services not listed above.

Pediatric dental services mean the following services:
1. Ordered by a dentist;
2. Described in the "Pediatric Dental Care Covered Expenses" provision in this amendment; and
3. Incurred when a covered person is insured for that benefit under the policy on the expense incurred date.

Treatment plan means a written report on a form and completed by the dentist that includes:
1. A list of the services to be performed, using the American Dental Association terminology and codes;
2. The dentist's written description of the proposed treatment for the covered person;
3. Pretreatment x-rays supporting the services to be performed;
4. Itemized cost of the proposed treatment; and
5. Any other appropriate diagnostic materials (may include x-rays, chart notes, treatment records, etc.) as requested by us.

Usual and Customary Charge means the lowest of:
- the dentist's actual charge for the services or supplies (or, if the provider of the service or supplies is not a dentist, such other provider's actual charge for the services or supplies); or
- the usual charge by the dentist or other provider of the services or supplies for the same or similar services or supplies; or
- the usual allowance for an area is the usual charge made by most dentists in the same geographic area for the same or similar service or supply. Pekin's claim payment system uses data compiled from industry claim processing to establish procedure code specific customary allowance within a geographic area. We use the 80th percentile charge to establish a customary allowance. Using the 80th percentile recognizes that even within a geographically contiguous area, charges for a procedure may vary based on location, provider qualifications, or the nature of the specific case. At the same time, payment for charges far in excess of the prevailing fee will be reduced to the 80th percentile amount for benefit payment purposes. The 80th percentile is felt to be a fair level since full payment is allowed not only for average charges, but also for fees somewhat about the average rate.

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Waiting Period means the amount of time that a covered person must be enrolled in this Plan before the covered person can receive orthodontic services. Benefits are prorated if the treatment began prior to satisfying the waiting period.

Signed at PEKIN LIFE INSURANCE COMPANY
2505 Court Street, Pekin, Illinois 61558

[Daniel V. Connell] [Scott A. Martin]

Secretary President

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PEKIN INSURANCE COMPANY

PEDIATRIC VISION CARE BENEFIT AMENDMENT

This amendment is attached to and made part of the policy and certificate to which it is attached. Except as modified below, all terms, conditions, exclusions, and limitations of the policy apply.

Notwithstanding any other provisions of the policy, covered expenses under this amendment are not covered under any other provision of the policy. Any amount in excess of the maximum amount provided under this amendment, if any, is not covered under any other provision in the policy.

All terms used in this amendment have the same meaning given to them in the policy, unless otherwise specifically defined in this amendment. Refer to the "Pediatric Vision Care Limitations and Exclusions" provision in this amendment and the “Expense Not Covered by the Plan” section of the certificate for pediatric vision care expenses not covered by the policy. All other terms and provisions of the policy are applicable to covered expenses for pediatric vision care.

Schedule of Benefits

Covered expenses for pediatric vision care apply toward the medical deductible and medical out-of-pocket maximum amount.

Benefit Description	Plan Pays for Services From
Diagnostic	
Eye exam: covered in full every calendar year. Includes dilation, if professionally indicated. 92002/92004 New patient exams 92012/92014 Established patient exams S0620 Routine ophthalmologic exam w/refraction - new patient S0621 Routine ophthalmologic exam w/refraction - established patient	100% after medical deductible
Eyewear	
A covered person may choose prescription glasses or contacts.	
Lenses: one pair covered in full every calendar year. V2100-2199 Single Vision V2200-2299 Conventional (Lined) Bifocal V2300-2399 Conventional (Lined) Trifocal	100% after medical deductible

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V2121, V2221, V2321 Lenticular [Note: Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses. Note: Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions > +/- 6.00 diopters. Note: All lenses include scratch resistant coating with no additional copayment. There may be an additional charge at Walmart and Sam's Club.]	
Frame: Covered once every calendar year. V2020 Frame [*Note: Additional discounts are available from participating providers except Walmart and Sam's Club.] [Note: "Collection" frames with retail values up to $225 are available at no cost at most participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.]	[Collection Frame]: 100% after medical deductible [Non-Collection Frame:] 100% up to $150 after medical deductible. A 20% discount applies to any amount over $150
Contact Lenses	
Contact Lenses: Covered once every calendar year – in lieu of eyeglasses. V2500-V2599 Contact Lenses [Note: In some instances, participating providers may charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the Contact Lenses received is less than the allowance, you may submit a claim for the remaining balance (the combined reimbursement will not exceed the total allowance). *Note: Additional discounts are available from participating providers except Walmart and Sam's Club.]	100% up to $150 after medical deductible. [Expenses in excess of $150 (may be applied toward the cost of evaluation, materials, fitting and follow-up care)]. A 15% discount applies to any amount over $150. 100% up to $600 for medically necessary contact lenses, after medical deductible; subject to pre-authorization.
Other Vision Services	
Optional Lenses and Treatments: Ultraviolet Protective Coating Polycarbonate Lenses (if not child, monocular or prescription >+/-6.00 diopters) Blended Segment Lenses	The insured pays an additional copay as follows: No Copay $30 $20

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Intermediate Vision Lenses	$30
Standard Progressives	No Copay
Premium Progressives (Varilux®, etc.)	$90
Photochromic Glass Lenses	$20
Plastic Photosensitive Lenses (Transitions®)	No Copay
Polarized Lenses	$75
Standard Anti-Reflective (AR) Coating	$35
Premium AR Coating	$48
Ultra AR Coating	$60
Hi-Index Lenses	$55
Extra Discounts and Savings	
Prescription glasses • Optional Lens Treatments - **Progressive Lens Options:** Insureds may receive a discount on additional progressive lens options:	
Select Progressive Lenses	
Ultra Progressive Lenses	$70
	$195

Pediatric Vision Care Covered Expenses

We will pay benefits as specified in the schedule of benefits in this amendment for covered expenses incurred by a covered person as defined in this amendment for pediatric vision care. Covered expenses for pediatric vision care include: One routine eye examination every calendar year, one pair of standard eyeglass lenses or contact lenses every calendar year and one frame every calendar year. Contact lenses are available in lieu of eyeglasses.

Copayment - There are no copayments for covered eye examinations, standard eyeglass lenses, plan frames, or contact lenses in lieu of eyeglasses. There may be copayments for optional lens types and treatments as specified in the schedule of benefits.

Pre-authorization is required for:

- Medically necessary contact lenses in the treatment of certain eye health conditions and is obtained by the participating provider.
- The treatment of low vision and is obtained by the participating provider.
- Discounts for laser vision correction and is obtained by the insured.

Additional Benefits

Medically Necessary Contact Lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions:

Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism.

Medically necessary contact lenses are dispensed in lieu of other eyewear.

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Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for insureds with low vision. After pre-authorization, covered low vision services will include one comprehensive low vision evaluation every 5 years, with a maximum benefit of $300; maximum low vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period, with a maximum charge of $100 each visit.

Pediatric Vision Care Limitations and Exclusions

We do not cover the following:

1. Any vision service, treatment or materials not specifically listed in the schedule of benefits in this amendment;
2. Services and materials that are experimental or investigational;
3. Services and materials not meeting accepted standards of optometric practice;
4. Services and materials resulting from failure to comply with professionally prescribed treatment;
5. Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
6. Office infection control charges;
7. State or territorial taxes on vision services performed;
8. Medical treatment of eye disease or injury;
9. Visual therapy;
10. Special lens designs or coatings other than those described in this amendment;
11. Replacement of lost/stolen eyewear;
12. Non-prescription (Plano) lenses;
13. Two pairs of eyeglasses in lieu of bifocals;
14. Services not performed by licensed personnel;
15. Prosthetic devices and services;
16. Insurance of contact lenses.

Definitions

The following terms are specific to pediatric vision care benefits:

Covered person under this amendment means a person under the age of 19 who is eligible and enrolled for benefits provided under the policy.

Low vision means severe vision problems as diagnosed by an Ophthalmologist or Optometrist that cannot be corrected with regular prescription lenses or contact lenses and reduces a person's ability to function at certain or all tasks.

Materials mean frames, and lenses and lens options, and/or contact lenses.

Pediatric vision care means the services and materials specified in the "Pediatric Vision Care Covered Expense" provision in this amendment for a covered person under the age of 19.

Severe vision problems mean the best-corrected acuity is:
1. 20/200 or less in the better eye with best conventional spectacle or contact lens prescription;

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2. A demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point; or
3. The widest diameter subtends an angle less than 20 degrees in the better eye.

Signed at PEKIN LIFE INSURANCE COMPANY
2505 Court Street, Pekin, Illinois 61558

[Daniel V. Connell] [Scott A. Martin]

Secretary President

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