PEKIN INSURANCE

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:
POLICY NUMBER:
EMPLOYEE:
SOCIAL SEC #:
MAJOR MED COVERAGE:
FAMILY COVERAGE:
EFFECTIVE DATE:
CHANGE DATE:

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.

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 of Insurance while You are Insured.

NOTICE: This certificate is not a Medicare supplement certificate. If You are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from Us.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY."

Should any complaints arise regarding this insurance, You may contact the following: Ohio Department of Insurance, Consumer Services Division, 50 W. Town St., Third Floor - Suite 300, Columbus, OH 43215.

Schedule of Benefits
PPO Network Plan

Coverage Information

Plan Type:	**Classic Choice – [Silver]**
Employer/Policyholder:	**[Company ABC]**
Employer Location State of Issue:	**Ohio**
Employee:	**[John Doe]**
Coverage Type:	**[Family or Individual]**
Certificate Number:	**[123456789]**
Effective Date:	**[1-1-2014]**
COBRA Provisions:	**[Do Apply]**
Grandfathered Status:	**Non-Grandfathered**

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.

	In-Network Providers	**Out-of-Network Providers**
Individual Deductible (per Insured per Calendar Year)	$ [250-5,000]	$ [500-10,000]
Family Deductible (per family per Calendar Year)	$ [750-12,700]	$ [1,500-30,000]

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. No one insured will be required to satisfy more than the applicable Individual Out-of-Pocket Maximum regardless of Family Coverage. See Policy for full details. The In-Network and Out-of-Network Calendar Year Out-Of-Pocket Maximums are accumulated separately.

	In-Network Providers	**Out-of-Network Providers**
Individual Out-of-Pocket Maximum (per Insured per Calendar Year)	$ [500-6,350]	$ [4,500-25,000]
Family Out-of-Pocket Maximum (per family per Calendar Year)	$ [1,500-12,700]	$ [13,500-60,000]

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.

Schedule of Benefits
PPO Network Plan

Medical Services and Supplies	In-Network Coinsurance Percentage (after In-Network Deductible)	Out-of-Network Coinsurance Percentage (after Out-of-Network Deductible)	Benefit Maximum per Insured, if any
Ambulance Services			
Emergency Ambulance Services (ground & air)	[60-100]%	[40-60]%	
Behavioral Health, Mental Health, and Substance Abuse Disorder Services			
Serious Mental Health Conditions – Inpatient *Requires Pre-Certification*	[60-100]%	[40-60]%	
Serious Mental Health Conditions – Outpatient (Does not include Partial Hospitalization & Intensive Outpatient)	[60-100]%	[40-60]%	
Substance Use Disorders – Inpatient *Requires Pre-Certification*	[60-100]%	[40-60]%	
Substance Use Disorders –Outpatient	[60-100]%	[40-60]%	
Mental Health & Substance Use Disorders-Partial Hospitalizations & Intensive Outpatient Treatment	[60-100]%	[40-60]%	
Clinical Trials			
Clinical Trials described in Certificate	[60-100]%	[40-60]%	
Dental Services			
Dental Services described in Certificate	[60-100]%	[40-60]%	
Diabetic Education, Equipment and Supplies			
Diabetic Education	[60-100]%	[40-60]%	
Diabetic Equipment and Supplies *Requires Pre-Approval*	[60-100]%	[40-60]%	
Diagnostic Services			
Outpatient Diagnostic Tests and Laboratory Tests described in Certificate	[60-100]%	[40-60]%	
Emergency and Urgent Care Services			
Emergency Room Services (Access Fee waived if insured is Hospital confined as an Inpatient immediately following the emergency room visit)	[60-100]% after $[75] Access Fee for Emergency Services	[40-60]% after $[75] Access Fee for Emergency Services	No Coverage for Non-Emergency use of an Emergency Room
Urgent Care Center Services	[60-100]%	[40-60]%	
Home Health Care Services			
Home Health Care (excluding Private Duty Nursing) Services *Requires Pre-approval*	[60-100]%	[40-60]%	100 visits per Calendar Year
Private Duty Nursing	[60-100]%	[40-60]%	90 visits per year

Schedule of Benefits
PPO Network Plan

Medical Services and Supplies	In-Network Coinsurance Percentage	Out-of-Network Coinsurance Percentage (after Out-of-Network Deductible)	Benefit Maximum per Insured, if any
Hospice Services			
Hospice Care/Respite Care *Requires Pre-approval*	[60-100]%	[40-60]%	
Inpatient Services			
Inpatient Services described in Certificate *Requires Pre-Certification*	[60-100]%	[40-60]%	
Maternity Services			
Maternity Services – Routine Prenatal	100% (Deductible Waived)	[40-60]%	
Maternity Services- Hospital Inpatient Confinement	[60-100]%	[40-60]%	
Medical Equipment, Devices, and Appliances			
Outpatient medical supplies including Durable Medical Equipment *Requires Pre-Approval*	[60-100]%	[40-60]%	
Diabetic Equipment and Supplies *Requires Pre-Approval*	[60-100]%	[40-60]%	
Outpatient Services			
Outpatient Services described in Certificate	[60-100]%	[40-60]%	
Ambulatory Surgical Facility Services	[60-100]%	[40-60]%	
Physician and Specialist Services			
Preferred Provider Office Visit Copay	$[30-40] Copay (Deductible Waived)	N/A	
Physician & Surgeon Services (including Behavioral Health, Mental Health, and Substance Abuse office visits)	[60-100]%	[40-60]%	
Prescription Drugs			
Retail Prescription Copay (per drug purchased):	Generic Drugs: [$15] Copayment Preferred Brand Drugs*: [$30] Copayment Non-Preferred Brand Drugs*: [$60] Copayment Specialty Drugs: [$100 Copayment]		
Mail Order Prescription Copay (per drug purchased):	Generic Drugs: [$45] Copayment Preferred Brand Drugs*: [$90] Copayment Non-Preferred Brand Drugs*: [$180] Copayment Specialty Drugs: [$100 Copayment]		
Preventive Care Services			
Preventive Care described in Certificate	100% (Deductible Waived)	[40-60]%	
Reconstructive Services			
Reconstructive Services described in Certificate	[60-100]%	[40-60]%	

* See 'Generic Prescription Drug Notice' on Schedule of Benefits – 5

Schedule of Benefits
PPO Network Plan

Medical Services and Supplies	In-Network Coinsurance Percentage	Out-of-Network Coinsurance Percentage (after Out-of-Network Deductible)	Benefit Maximum per Insured, if any
Skilled Nursing Facility Services			
Skilled Nursing Facility *Requires Pre Certification and Pre-Approval*	[60-100]%	[40-60]%	90 days per Calendar Year
Surgical Services			
Surgeon Services	[60-100]%	[40-60]%	
Other Surgical Services described in Certificate	[60-100]%	[40-60]%	
Therapy Services			
Inpatient Rehabilitation Services *Requires Pre Certification & Pre-approval*	[60-100]%	[40-60]%	60 days per year
Therapy – Physical, Occupational, Speech, & Pulmonary	[60-100]%	[40-60]%	20 visit Calendar Year Max for each therapy type
Therapy – Manipulative (Chiropractic)	[60-100]%	[40-60]%	12 visits per Calendar Year
Cardiac Rehabilitation Services	[60-100]%	[40-60]%	36 treatments per Calendar Year
Outpatient Radiation and Chemotherapy *Requires Pre-Approval*	[60-100]%	[40-60]%	
Habilitative Services *Requires Pre-Approval*	[60-100]%	[40-60]%	20 visit Calendar Year maximum per therapy type for Speech/Occupational Therapy; 20 hours per week maximum for clinical therapeutic intervention; 30 visit Calendar Year maximum for mental/behavioral health Outpatient Services.
Inhalation Therapy	[60-100]%	[40-60]%	
Dialysis Treatments	[60-100]%	[40-60]%	
Transplants			
Human Organ or Tissue Transplants *Requires Pre Certification (inpatient) & Pre-approval (inpatient & outpatient)*	100% (at designated Transplant Facility)	50%	
Transplant Service Lodging and Transportation Allowance when Designated Transplant Facility is used *Requires Pre-approval*	100% of Pre-approved amount	Not Applicable	$10,000 total maximum per Transplant
Unrelated Donor Search for Bone Marrow or Stem Cell Transplants for Covered Transplant	100%	Not Applicable	$30,000 total maximum per Transplant
Live Donor Medical Services *Only for Covered Expense not available to donor from any other source.*	100% (at designated Transplant Facility)	50%	

Schedule of Benefits
PPO Network Plan

Medical Services and Supplies	In-Network Coinsurance Percentage	Out-of-Network Coinsurance Percentage (after Out-of-Network Deductible)	Benefit Maximum per Insured, if any
Vision Services			
Vision Services described in Certificate	[60-100]%	[40-60]%	
Other Covered Services			
Pediatric Dental	See Pediatric Dental Care Benefit Provision		
Pediatric Vision	See Pediatric Vision Care Benefit Provision		
Reasonable and Customary Percentile Level	80th	60th	

Schedule of Benefits
PPO Network Plan

Generic Prescription Drug Notice

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 applicable retail or mail order generic Copay plus any remaining cost difference between the Brand or Preferred Brand cost in excess of the cost of the Equivalent Generic Drug. However, if your Physician writes "Dispense as Written" or "Do not Substitute" on your prescription, you will only be required to pay the applicable Brand or Preferred Brand cost.

Inpatient or Overnight Stay Notice

If an Inpatient or an overnight stay is not Pre-certified, then the first $500 in covered expenses incurred will not be covered by this policy. However, in no event will this non covered expense exceed 50% of the total charges. See Section 7 – Pre-Certification Program of the Policy.

Pre-Approval Notice

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 or services are subject to the Policy provisions, such as benefits, limitations and exclusions. Contact our Case Management Department at (800)371-9622 ext 3155 for assistance.

Artificial eyes, limbs or larynx
Chemotherapy
Clinical Trials
Durable Medical Equipment & Supplies
Home Health Care
Hospice Care
Organ and Tissue Transplants
Prosthetics
Radiation Therapy
Skilled Nursing Care in the Home
Specialty Physician Services by a Non-Preferred Provider
Therapy in excess of 20 visits per Calendar Year

TABLE OF CONTENTS

Please note that terms and phrases that are capitalized in this document are defined terms. Please see the Definitions section to find more information regarding these terms.

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 who is employed by the Policyholder on a permanent full time basis. The person must work at least 25 hours per week for an employer with 50 or fewer employees. For employers with 51 or more employees the person must work at least 30 hours per week. This includes single proprietor or partners;
- 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

Dependents are the Spouse or Child(ren) of the Employee who are not themselves insured as Employees under the Policy. A Spouse means a husband or wife of the Employee. A Child means the Employee's or Employee's Spouse's (1) natural born child, (2) legally adopted child or child placed for adoption 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, (3) step child, or (4) any other child that has been declared the legal responsibility of the Insured Employee or Insured Employee's Spouse.

To be an eligible for coverage, a Child must be one of the following:

- Under 28 years of age if an Ohio resident or a full time student; or
    - To be considered a full time student, the student must be in classroom attendance at an accredited secondary school, college or university on a full time basis that under orders of a physician, must drop below full time status as a result of an illness or injury but only when this occurs prior to age 28 and only for 12 months from the date the student drops below full time status;
- Under 26 years of age if a non-Ohio resident;
- An unmarried Child who is totally and permanently disabled, physically or mentally. The disability must have existed before the Child turned age 28.

Dependent Enrollment Eligibility is as follows:

- You may enroll Your current Dependent(s) at the same time You initially enroll; and
- 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; and
- 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

   A Newborn Child will be insured from birth for a period of 31 days, regardless of Hospital confinement if Family Coverage is in force at the time of birth.

   The Insured should apply for coverage and pay any premium due within 31 days after the Newborn Child's birth if the Insured wishes to continue coverage beyond the first 31 days

   If we are notified after the 31 day period the Newborn Child's continuation of coverage after the first 31 days will become effective on January 1st following the Policyholder's next open enrollment period, provided enrollment is received during the open enrollment period.

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

   In the case of an adopted Child or Child placed of adoption, coverage will become effective on the date of the adoption or placement for adoption, if You enroll within 30 days of the adoption or placement for adoption date. If You notify Us after that 30-day period, the adopted Child's coverage will become effective on January 1st following the Policyholder's next open enrollment period, provided You apply during the 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; or
   - Legal separation, divorce, or death.

   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.

Open Enrollment Period for Current Employees

An Employee and Employee's Dependents may enroll under the policy at any time up to January 1st, 2015. After that date, an Employee and his/her 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 date that any portion of the premium that is due is not paid;
- 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. You will be given no less than 30 days advance written notice of the rescission. Rescission means that the termination of the Employee's and Dependents' insurance has a retroactive effect to the Effective Date under the Policy; and
- The date of the Employee's death.

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 coverage 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 28 years of age and who because of a handicapped condition is incapable of self-support, may be continued under this insurance while remaining incapacitated, unmarried, 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 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. A claim may be submitted by your Preferred Provider or You. 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 at 2505 Court Street, Pekin, Illinois 61558, 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 (2505 Court Street, Pekin, IL 61558) 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 ac cepted unless evidence, satisfactory to Us, is submitted that shows it was not reasonably possible to submit proof within the time specified.

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.

PAYMENT OF CLAIMS

Clean Claims will be paid promptly upon receipt of due written Proof Of Loss. All claims payable under the terms of the policy shall be paid within 30 days following receipt by Us of due Proof Of Loss. Failure to pay within such period shall entitle the provider to interest at the lesser of 18% per annum or the rate required by Ohio Code 3901.389, from the 31st day after receipt of such Proof of Loss to the date of late payment, provided that interest amounting to less than one dollar will not be paid.

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.

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 DURING AN OFFICE VISIT AT A PREFERRED PHYSICIAN FOR PRIMARY CARE OR SPECIALIST VISIT

After the office visit Copay, We will pay 100% of Covered Expense for the office visit charge made by a Preferred Physician for Treatment of an Illness or Injury. The office visit Copay amount is shown on the Schedule of Benefits. It applies to each office visit charge by a Preferred Physician.

If, during an office visit, a Preferred Physician performs and bills for x-ray or laboratory tests, We will waive the In-Network Deductible amount, and pay the Covered Expense for those x-ray or laboratory tests at the In-Network Coinsurance percentage. The In-Network Coinsurance percentage amount is shown on the Schedule of Benefits.

Before We pay any benefit for services other than the office visit, x-ray and laboratory tests performed by the Physician in the Physician's office provided during an office visit by a Preferred Physician, Covered Expense equal to the In-Network Deductible must be incurred in a Calendar Year. We will then pay benefits for Covered Expenses provided by the Preferred Physician that are in excess of the 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. If the amount of Covered Expense You pay meets the In-Network Maximum Out of Pocket, We will then pay the Covered Expense for these services at 100% for the remainder of the Calendar Year.

Services provided in Urgent Care Centers or Facilities is not considered an office visit for the purposes of any applicable office visit copay requirements as outline in the Schedule of Benefits. Covered Expense provided in Urgent Care Centers or Facilities will be paid as outlined in the Schedule of Benefits and according to the provision in Section 5, 7. Emergency and Urgent Care Services.

BENEFIT FOR COVERED EXPENSE PROVIDED BY A PREFERRED PROVIDER

Before We pay any benefit for services other than the office visit, x-ray and laboratory tests performed by the Physician in the Physician's office 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 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 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%. However, no one covered Insured will be required to incur more than the In-Network Individual Out-of-Pocket Maximum regardless of Family Coverage.

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 Copay 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 Copay, 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 Copay.

Covered Expense for Emergency Services provided by a Non-Preferred Provider will be paid as if they had been provided by a Preferred Provider as outlined in the Benefit for Emergency Services provision.

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.

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%. However, no one covered Insured will be required to incur more than the Out-of-Network Individual Out-of-Pocket Maximum regardless of Family Coverage.

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 by Us. 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.

In the absence of Preferred Provider rates, the allowed amount will be calculated in three different ways and We will pay the greatest of the three amounts: 1) the amount We pay to Preferred Providers for the Emergency Services under this Policy; 2) the amount that would be paid using the same method We generally use to determ ine payment for services from Non-Preferred Providers under this Policy (such as the Regular, Reasonable & Customary charges), but substituting Preferred Provider copayments and coinsurance amounts; and (3) the amount that would be paid under Medicare for the services provided. All three of these amounts are calculated before application of any Preferred Provider copayments or coinsurance.

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.

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.

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. Ambulance Services

Covered Expense includes expenses for:

- Local ground emergency transportation/ambulance transportation from home, scene of Accident or medical emergency:
  - To a Hospital; or
  - Between Hospitals; or
  - Between Hospital and Skilled Nursing Facility; or
  - From Hospital or Skilled Nursing Facility to patients home; and
- Air ambulance transportation to the nearest Hospital or Skilled Nursing Facility able to provide the care.

Ambulance transportation must be made to the nearest facility that can provide appropriate care for the condition.

Non-Covered Expense includes ambulance transportation to:

- A Physician's office or clinic; or
- A morgue or funeral home.

2. Behavioral Health, Metal Health, and Substance Abuse Disorder Services

Covered Expense includes expense for:

- Behavioral/mental health Inpatient services at a Hospital;
- Behavioral/mental health services at a Residential Treatment Center;
- Behavioral/mental health outpatient services;

- Substance Abuse Disorder outpatient services;
- Substance Abuse Disorder Inpatient services;
- Partial Hospitalization;
- Intensive Outpatient Programs (partial day mental health services);
- Individual and group outpatient Treatment; and
- Electroconvulsive Therapy;

Two days of Partial Hospitalization or Intensive Outpatient Treatment are equivalent to one day of Inpatient treatment and will accumulate as such.

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

Non-Covered Expense includes expense for:

- Bereavement counseling or services (including volunteers or clergy), family counseling or treating services, marital counseling or social counseling;
- Certain disorders related to early childhood, such as academic underachievement disorder;
- Education or educational therapy other than covered education for self-management of diabetes;
- Non-pervasive developmental and learning 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;
- Sexual identification or gender disorders;
- Treatment of caffeine, gambling, computer, or similar addictions; and
- Treatment of educational, developmental, training problems or learning disorders.

3. 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 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 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; or
   - 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; or
   - 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 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.
- Either:
  - The referring health care provider has concluded that the Insured 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.

4. Dental Services

Covered Expense includes expense for:

- Oral surgery only for the following services:
  - Surgical removal of complete boney impacted teeth;
  - Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
  - Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
  - Excision of exostoses of the jaws and hard palate (provided that his procedure is not done in preparation for dentures or other prostheses);
  - Treatment of fractures of facial bone;
  - External incision and drainage of cellulitis;
  - Incision of accessory sinuses, salivary glands or ducts; and
  - Reduction of dislocation of, or excision of, the temporomandibular joints caused by Temporomandibular Joint Dysfunction and Related Disorders (TMJ) when Pre-Approval is obtained;
- Dental Treatment for injuries to whole natural teeth 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:
  - An Insured Dependent Child is age 5 or under;
  - An Insured has a chronic disability;

- 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; or
- When covered under the Pediatric Dental Care Benefit Provision;

Non-Covered Expense includes expense for:

- Any orthodontic procedure or appliance except as specified in the Pediatric Dental Care Benefit Provision;
- 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; except as provided in the Pediatric Dental Care Benefit Provision or SECTION 5 - EXPENSES COVERED BY THE PLAN, Reconstructive Services and those services listed above;
- Injuries associated with or resulting from the act of chewing;
- Maxillary or mandibular tooth implants (osseointegration); and
- 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 above.

5. Diabetic Education, Equipment and Supplies

For an Insured with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucode levels due to pregnancy or another medical condition, Covered Expense includes expense for:

- Outpatient diabetes self-management training, education and medical nutrition therapy if these services are rendered by a Physician or duly certified, registered or licensed health care professional with expertise in diabetes management;
- Medically Necessary equipment and supplies used for the management and treatment of diabetes. See "Medical Equipment, Devices, and Appliances", "Prescription Drugs", and "Preventive Care Services".

6. Diagnostic Services

Covered Expense includes, but is not limited to, expense for:

- X-ray and other radiology services (includes mammograms for any person diagnosed with breast disease);
- MRA - Magnetic Resonance Angiography;
- MRI - Magnetic Resonance Imaging;
- CAT scans;
- Laboratory and pathology services;
- Cardiographic, encephalographic, and radioisotope tests;
- Nuclear cardiology imaging studies;
- Ultrasound services;
- Allergy tests;
- EKG - Electrocardiograms;
- EMG - Electromyograms excluding surface EMG's;
- Echocardiograms;
- Bone density studies;
- PET scans;
- Diagnostic tests as an evaluation to determine the need for a covered transplant;
- Echographies;
- Doppler studies;
- BAER - Brainstem evoked potentials;
- SSEP - Somatosensory evoked potentials;
- VEP - Visual evoked potentions;
- Nerve conduction studies;
- Muscle testing;

- Electrocorticograms; and
- Genetic molecular testing (specific gene identification) and related counseling when both of the following requirements are met:
  - The Insured is an appropriate candidate for a test under medically recognized standards (for example, family background, past diagnosis, etc.); and
  - The outcome of the test is expected to determine a covered course of Treatment or prevention and is not merely informational;

Any IV tubing or dye necessary to perform these tests will be considered part of the diagnostic test and therefore be a Covered Expense.

7. Emergency and Urgent Care Services

An Emergency Medical Condition manifests itself by acute symptoms severe enough that a prudent person with average knowledge of health and medicine could reasonably expcect the absence of immediate medical attention to result in serious health consequences for an Insured. If you are experiencing an emergency, call 9-1-1 or go to the nearest hospital.

Covered Expense includes expense for:
- Emergency Services, such as medical screening examinations and other ancillary services, provided in a Hospital emergency room when used for an Emergency Medical Condition;
- For Urgent Care services provided at a Urgent Care Center;

No benefits will be paid for Treatment received in the emergency room of a Hospital, except when Emergency Services for an Emergency Medical Conditional are being rendered;

Follow-up care is not considered an Emergency Service.

8. Home Health Care Services

Covered Expense includes, but is not limited to, expense for:
- 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;
- Private duty nursing;
- Diagnostic services;
- Durable Medical Equipment;
- Medical/social services;
- Medical/surgical supplies;
- Therapy Services:
  - 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;
  - Physical Therapy;
  - Inhalation Therapy;
  - Speech Therapy
- Nutritional Guidance;
- Prescription drugs and medicines provided and billed by Home Health Care service agency; and
- Home infusion therapy, which includes a combination of nursing, Durable Medical Equipment, and prescription drug services when delivered and administered in the home. Home infusion therapy includes, but is not limited to:
  - Injections;
  - Total parenteral nutrition;
  - Enteral nutrition therapy;
  - Antibiotic therapy;
  - Pain management; and
  - Chemotherapy.

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.

See the Schedule of Benefits for visit limits that apply to Home Health Care.

Services provided as part of Home Health Care are not subject to separate limit visits for therapy.

Home Health Care limit does not apply to home infusion therapy or private duty nursing rendered in the home. Private duty nursing is accumulated separately and applied to the private duty nursing limit.

Non-Covered Expense includes expense for:

- Custodial Care;
- 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;
- Education or educational therapy other than covered education for self-management of diabetes; and
- 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.

9. Hospice Services

Hospice Services is care (generally in a home setting) for patients who are terminally ill and have a life expectancy of one year 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.

Covered Expense under the Hospice Care Program includes:

- Diagnostic services;
- Coordinated home care;
- Medical supplies and dressings;
- Medication;
- Nursing services ? skilled and non-skilled;
- Occupational Therapy;
- Pain Management Services;
- Physical, speech, and inhalation therapies if part of a treatment plan;
- Physician visits;
- Social and spiritual services; and
- Respite Care Service.

Non-Covered Expense under the Hospice Care Program includes:

- Housekeeping services;
- Services provided by volunteers.

10. Inpatient Services

Covered Expense includes expense for:

- Facility billed services while Inpatient;
- Semiprivate room and board;

- Intensive Care Unit services;
- Nursing services;
- Ancillary services and supplies;
- Physician billed services while Inpatient; and
- Rehabilitation facility services as described in the Therapy Services provision.

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

Non-Covered Expense includes expense for:

- 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.
- 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; and
- Long Term/Custodial Nursing Home Care.

11. Maternity Services

Covered Expense includes expense for:

- Prenatal and postnatal care, delivery (including covered Inpatient Services);
- Prenatal HIV testing;
- Care related to Complications of Pregnancy, which includes;
  - Extra-uterine pregnancy;
  - Severe toxemic disorders;
  - Severe puerperal sepsis;
  - Spontaneous miscarriage;
  - Severe hemorrhage;
  - Any Complications of Pregnancy requiring delivery by cesarean section.
- Maternity care;
- Maternity related check-ups;
- Delivery of baby; and
- Inpatient Services for Maternity care including 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.

Expenses incurred for a well Newborn Child's initial Hospital confinement will be considered a Covered Expense under the Insured's coverage. In the case of other insurance coverage for the mother, normal Coordination of Benefits will apply When both mother and well Newborn are Insured under the Policy, mother and well Newborn will be considered one Insured until discharge from the initial Hospital confinement. In the case of a non-well Newborn with an Illness or Injury, all usual Policy provisions apply.

Non-Covered Expense includes expense for:

- Maternity services and newborn care if the mother is a surrogate mother not insured by the Policy; and
- Services provided by a midwife that is not specifically licensed by the State to practice midwifery.

12. Medical Equipment, Devices and Appliances

Expenses incurred for prosthetic devices, orthotic devices and special appliances will be considered Covered Expenses when Pre-Approval has been obtained from Us and include:

- Required to replace all or part of an organ or tissue of the human body, including but not limited to the initial purchase of artificial eyes, limbs, and larynx;
- Required to replace all or part of the function of a permanently non-functioning or malfunctioning organ or tissue;

- A supportive device for the body or a part of the body, head, neck or extremities, including but not limited to leg, back, arm and neck braces; or
- A replacement in whole or in part, an arm or a leg including accessories essential to the effective use of the device;

Expense for Durable Medical Equipment requires Pre-Approval from Us to be considered a Covered Expense. When Pre-Approval is obtained from Us, Covered Expenses for Durable Medical Equipment include, but are not limited to:

- Internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction;
- Left Ventricular Artificial Devices (LVAD), only when used to bridge a heart transplant;
- Artificial limbs and artificial eyes, etc.;
- Intraocular lens implantation for the treatment of cataract or aphakia;
- Cochlear implant/bone-anchored hearing aid, when Pre-Approval has been obtained from Us;
- Colostomy and other ostomy supplies, when Pre-Approval has been obtained from Us;
- Restoration prosthesis;
- Wigs following cancer treatment, not to exceed one per Calendar Year; and
- The rental (but not to exceed the total cost of equipment) or purchase of Durable Medical Equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

Covered Expenses for other medical equipment, when Pre-Approval has been obtained from Us, include, but are not limited to:

- Casts,
- Splints,
- Trusses,
- Orthopedic braces,
- Crutches; and
- The purchase of one pair of the following:
  - One pair of orthopedic shoes;
  - One support stocking for each leg; and
  - One article of similar apparel-type item.

Covered Expenses will also include fitting, adjustments, repair and replacements of covered prosthetic devices, orthotic devices and special appliances when required because of wear or change in an Insured's medical or physical condition, as Medically Necessary. Devices must be purchased, not rented. Applicable taxes, shipping, and handling will also be covered.

If more than one prosthetic device can meet Your functional needs, benefits are available only for the prosthetic device that meets the minimum specifications for Your needs. If You purchase a prosthetic device that exceeds these minimum specifications, We will pay only the amount that We would have paid for the prosthetic that meets the minimum specifications, and You will be responsible for paying any difference in cost.

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.

Non-Covered Expense includes expense for:

- Foot orthotics defined as any in-shoe device designed to support the structural components of the foot during weight-bearing activities;

- Dental appliances other than intra-oral devices used in connection with the Treatment of Temporomandibular Joint Dysfunction and Related Disorders;
- Replacement of cataract lenses when a prescription change is not required; or
- Any other excluded devices as outlined in SECTION 6 - EXPENSES NOT COVERED BY THE PLAN
- Cosmetic services supplies except as outlined in SECTION 5 - EXPENSES COVERED BY THE PLAN, 15. For other services and supplies. No cosmetic services supplies will be covered for Treatment for any complications resulting from a non-covered cosmetic procedure;
- Purchase or rental of Durable Medical Equipment that has not been Pre-Approved by Us;
- Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription;
- Examinations for prescription and fitting of a prosthetic device;
- For devices used specifically as safety items or to affect performance primarily in sports-related activities;
- Hearing aids or examinations for the prescription or fitting of hearing aids, except for bone anchored hearing aids (osseointegrated auditory implants);
- Arch supports or in-shoe supports, elastic supports, and examinations to prescribe or fit such devices; Shoe inserts, casting for orthotics, and orthotics;
- The replacement of a piece of Durable Medical Equipment unless described above; and
- Wigs, hair prosthesis or hairpieces unless described above.

13. Outpatient Services

Covered Expense includes expense for:
- Outpatient facility services;
- Outpatient medical care and Treatment; and
- Outpatient facility fees.

The facility must be a licensed ambulatory surgical center or other state licensed outpatient medical facility.

Overnight stays require Pre-Certification as outlined in Section 7 - Pre-Certification Program.

14. Physician and Specialist Services (See definition of Physician for complete list of practitioners)

Covered Expense includes expense for:
- Office visits for medical care and consultations to examine, diagnose, and treat an Illness or Injury, including allergy testing and treatment and mental health disorders;
- Specialist visits and other practitioner visits;
- Hospital care;
- Surgical services, including Inpatient Physician and surgical series, outpatient surgery Physician / surgical services, postoperative care following Inpatient or outpatient surgery;
- 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;
- Injections and medication that is consumed at the Physician's office (Requires Pre-Approval by Us); and
- An additional surgical opinion following a recommendation for elective surgery limited to one consultation and related diagnostic service by a Physician. If You request, benefits will be provided for an additional consultation when the need for surgery, in Your opinion, is not resolved by the first arranged consultation.

Covered Services provided by a Physician include, but are not limited to:
- Primary care for treatment of Illness or Injury;
- Allergy testing and treatment;
- Infertility diagnosis;
- Diagnosis and Treatment of osteoporosis;
- Regular foot care examinations by a Physician for the care or Treatment of diabetes;
- Treatment of physical complications at all stages of a mastectomy including lympedemas;
- Hearing examinations to test or treat hearing loss related to an Illness or Injury; and
- Diagnosis and Treatment for obstructive sleep apnea.

Non-Covered Expense includes expense for:

- Any medical Treatment, surgical procedure (including Bariatric surgery), weight reduction programs/weight loss 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. No benefits will be provided for complications resulting from a non-covered procedure for weight reduction except for conditions including, but not limited to, myocardial infarction, excessive nausea/vomiting, pneumonia, and exacerbation of co-morbid conditions;
- Cosmetic services except as outlined specifically in SECTION 5 - EXPENSES COVERED BY THE PLAN. No cosmetic services will be covered for Treatment for any complications resulting from a non-covered cosmetic procedure except for conditions including, but not limited to, myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions;
- Education or educational therapy other than covered education for self-management of diabetes;
- 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;
- Routine hearing examinations;
- Sclerotherapy for varicose veins;
- 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;
- 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;
- Treatment for sexual transformation; and
- Treatment related to Infertility or the restoration of fertility or promotion of contraception including in vitro fertilization;

15. Prescription Drugs

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. Generic, Non Preferred, and Preferred Brand drugs listed as "Allowable Covered Prescription Expense "are covered, subject to variance in copay as described below and outlined on the Schedule of benefits.

Amount of Benefit

The Insured must pay a prescription Copay amount each time he/she places a prescription order. The amount of the Copay will vary by the type of medication purchased and the place of purchase.

Prescriptions Purchased at a Retail Pharmacy - 34 day supply

You may purchase a prescription drug order at a retail pharmacy, as long as the order does not exceed a 34 day supply or 100 unit doses. 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.

You must pay the applicable Retail Prescription Copay amount. We will then pay 100% of the amount in excess of the Retail Prescription Copay amount as shown on the Schedule of Benefits. The Copay will vary based on if the drug is Generic, Brand, Preferred Brand, or Specialty. The retail Copay tiers are outlined in the Schedule of Benefits. All drug classifications are determined by the RX Company.

When purchasing a qualified medication for greater than a 34 day supply, you must pay the applicable Retail Prescription Copay according to the schedule below:

- 1 copayment for a 30 day supply
- 2 copayments for a 60 day supply
- 3 copayments for a 90 day supply.

Prescriptions Purchased From the RX Company Mail Order Program

You may purchase a prescription drug order from the RX Company Mail Order 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. You must pay the applicable Mail Order Prescription Copay amount. We will then pay 100% of the amount in excess of the Mail Order Prescription Copay amount as shown on the Schedule of Benefits. The Copay will vary based on if the drug is Generic, Brand, Preferred Brand, or Specialty. The mail order Copay tiers are outlined in the Schedule of Benefits. 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.

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 (refer to SECTION 5 - EXPENSES COVERED BY THE PLAN and SECTION 6 - EXPENSES NOT COVERED BY THE PLAN for injectable legend drugs);
- 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; and
- 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.
- Off Label Prescription Drugs
  - For the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the United States department of health and human services under 42 U.S.C. 1395x(t)(2)
  - Medically Necessary: Off-Label Drug Use: Off-label drug use is considered medically necessary when all of the following conditions are met:
    - The drug is approved by the U.S. Food and Drug Administration (FDA).AND
    - The drug is being prescribed to treat a medical condition not listed in the product label and for which medical treatment is medically necessary.AND"
    - The prescribed drug use is supported in any one or more of the following:
      - American Hospital Formulary Service Drug Information® (AHFS®); or
      - Thomson Reuters (Healthcare) Inc. DrugPoints® meeting each of the following: Strength of Recommendation Class I or IIa; and Strength of Evidence Category A or B; and Efficacy Class I or IIa; or
      - National Comprehensive Cancer Network (NCCN) Drug & Biologics Compendium™ Category of Evidence and Consensus 1 or 2A; or
      - Two articles from major scientific or medical peer-reviewed journals (excluding case reports, letters, posters, and abstracts), or published studies having validated and uncontested data, which support the proposed use for the specific medical condition as safe and effective. Examples of accepted journals include, but are not limited to, Journal of American Medical Association, New England Journal of Medicine and Lancet.
        - Accepted study designs include, but are not limited to, randomized, double blind, placebo controlled clinical trials

- If the off-label drug use is determined to be medically necessary, its use shall also be determined to be "non-investigational" for the purposes of benefit determination.
- Orphan Drug Use-Use of an orphan drug is considered medically necessary when it receives FDA Orphan Drug designation and approval for marketing ("Designated/Approved").

- Not Medically Necessary: Off-label drug use is considered not medically necessary when the above conditions are not met. Use of an FDA designated orphan drug is considered not medically necessary when FDA has not approved the proposed orphan use for marketing.

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 applicable retail or mail order generic Copay plus 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. However, if your Physician writes "Dispense as Written" or "Do not Substitute" on your prescription, you will only be required to pay the applicable Brand or Preferred Brand cost.

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.

Prescription inhalants to enable Insureds to breathe when suffering from asthma or other life-threatening bronchial ailments will not be denied based upon any restriction on the number of days before an inhaler refill may be obtained if, contrary to those restrictions, the inhalants have been ordered or prescribed by the treating Physician and are medically appropriate.

Any expense considered under the drug card will not be considered under any other provision of the Policy.

Non-Covered Expense for Prescription Drugs

Non-Covered Expense under the Prescription Benefit, regardless of the reason they are prescribed, includes:

- 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 an 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;
- 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;
- 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 tried 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 an 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;
- Prescription drugs prescribed for cosmetic services except as outlined specifically in SECTION 5 - EXPENSES COVERED BY THE PLAN. No prescription drugs prescribed for cosmetic services will be covered for Treatment for any complications resulting from a non-covered cosmetic procedure;
- Prescription drugs prescribed for sexual transformation;
- 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;
- 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.
- 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 that is not listed above.

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 Alternative Contraceptive Coverage" from Us by calling 1-800-371-9622, ext. 2721. 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 se ction 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.

If the Insured does not have his/her prescription drug card at the time the Insured needs to purchase a prescription at the retail pharmacy, a paper claim can be filed by the Insured with the RX Company. The Insured can also file a paper claim with the RX Company for prescriptions purchased at a non-Participating Pharmacy. Prescriptions purchased in a non-emergency situation at a non-Participating Pharmacy will only be reimbursed at the quantity and rate the prescription would have been allowed at a Participating Pharmacy.

Participating Pharmacy means any pharmacy which is enrolled as a participant in the RX Company's prescription drug program.

Non-Participating Pharmacy means a pharmacy licensed in the United States to dispense prescription drugs which is not a Participating Pharmacy. It is not a pharmacy in a Physician's office, Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or similar institution.

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.

16. Preventive Care Services

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 11. 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;
- A medically recognized diagnostic examination for the detection of prostate cancer. Covered Expense includes: annual digital rectal examination, and prostate specific antigen (PSA) test for asymptomatic male Insureds 50 years of age or older, and prostate specific antigen (PSA) test for asymptomatic male Insureds 40 years of age or older (when there is family history of prostate cancer or another prostate cancer risk factor);
- 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;
- Bone mass measurement;
- Shingles vaccine;
- Human papilloma virus (HPV) vaccination;
- 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 (child health supervision services); and

- With respect to Insureds who are women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration including:
  - 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 (HPV) 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-Approval by Us;
  - Annual cervical pap smear;
  - Clinical breast examinations for the purpose of early detection and prevention of breast cancer as follows: (1) at least every 3 years for a female Insured at least 20 years of age but less than 40 years of age; and (2) annually for a female Insured 40 years of age or older;
  - Baseline mammography for female Insured 35 years of age or older;
  - An annual mammogram for female Insured 40 years of age or older;
  - A mammogram at the age and intervals considered Medically Necessary by the female Insured's health care provider for women under 40 years of age;
  - A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when Medically Necessary as determined by a Physician.

If there is no In-Network provider that can perform the services under Preventative Care, charges will be considered under the In-Network benefit. Pre-Approval for Treatment provided by an Out-of-Network Provider should be obtained to ensure care will qualify for In-Network coverage. Out-of-Network benefits will apply if there are In-Network Providers who can provide the Preventative Care.

Eligible services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations. You will be notified, at least sixty (60) days in advance, if any item or service is removed from the list of eligible services. Eligible services will be updated annually to include any new recommendations or guidelines.

You may call customer service using the number on your ID card for additional information about these services, or you may view any of the federal government's web sites regarding preventive care:

[http://www.healthcare.gov/regulations/prevention.html

http://www.ahrq.gov/clinic/uspstfix.htm

http://www.cdc.gov/vaccines/recs/acip/]

Services or supplies that are not for the diagnosis or Treatment of an existing Illness or Injury, except as outlined in this provision will not be considered a Covered Service.

17. Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Medically Necessary Treatment of congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy, including surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

18. Skilled Nursing Facility Services

Skilled Nursing Facility is a 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 Skilled Nursing Facility under applicable law.

No benefits will be provided for admissions to a Skilled Nursing Facility which are not Medically Necessary. We will reimburse You as shown in the Schedule of Benefits.

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 rates and limits shown in the Schedule of Benefits.

Covered Expense for items and services provided while inpatient at a Skilled Nursing Facility inlcude:

- Room and board (semi-private);
- Rehabilitative services;
- Drugs and supplies provided for use in the Skilled Nursing Facility; and
- Other Medically Necessary services and supplies.

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

No benefits will be paid for Long Term/Custodial Nursing Home Care.

19. Surgical Services

Covered Expense includes expense for:

- Performance of surgical and other invasive procedures;
- Anesthesia and its administration;
- Blood, blood plasma, and its administration;
- Surgical dressings for two months following surgery, when Pre-Approval has been obtained from Us;
- Fertility prevention, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only);

Charges related to surgical errors will not be considered Covered Expense and should not be billed to You or Us. Such charges include but are not limited to:

- Surgery performed on the wrong patient;
- Wrong surgical procedure performed;
- Surgery performed on the wrong body part; and
- Foreign object retained after surgery;

Non-Covered Expense includes expense for:

- Abortions, except those recommended by a Physician and is performed either: (a) to save the life or health of the mother or (b) as a result of incest or rape;
- Any surgical procedure (including Bariatric surgery), weight reduction programs/weight loss 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;
- Any surgical procedure to remove excess tissue caused by weight loss;
- Breast reduction surgery, except when performed in conjunction with reconstructive surgery following a mastectomy;
- Cosmetic surgery;
- Incidental appendectomies;
- Removal of breast implants that were implanted solely for cosmetic reasons;
- Reversal of a tubal ligation (or its equivalent) or vasectomy; and
- Sexual transformation.

20. Therapy Services

Covered Expense includes expense for:

- Inpatient rehabilitation facility services up to a maximum of 60 days of service
- Manipulative/Osteopahtic Therapy (Chiropractic Care)
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Other Therapy Services:
  - Habilitative Services, which includes:
    - Up to 20 visits per Calendar Year for each type of therapy: Speech/language Therapy and/or Occupational Therapy; and
    - 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.

    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.
  - Pulmonary rehabilitation;
  - Cardiac rehabilitation if Insured has history of acute myocardial infraction, coronary artery bypass graft surgery, percutaneous transluminalcoronary angioplasty, heart valve surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization;
  - Radiation therapy, when Pre-Approvals of the Treatment has been obtained from Us;
  - Chemotherapy or similar Treatment, provided in the Physician's 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 has been obtained from Us;
  - Inhalation Therapy, respiratory or breathing Treatments to help restore or improve breathing function; and
  - Dialysis Treatments when provided Inpatient in a Hospital setting or outpatient in a Medicare-approved dialysis center.

Therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before Treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

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. However, benefits will also be provided for preventive or Maintenance Physical Therapy when prescribed for Insureds affected by multiple sclerosis.

Up to 20 visits per Calendar Year will be considered Covered Expense for each type of therapy: Physical, Occupational, Pulmonary, and Speech Therapy. When Pulmonary rehabilitation services are rendered as a part of Physical Therapy, then the Physical Therapy limit will apply. Up to 12 visits per Calendar Year will be considered Covered Expense for Manipulative Therapy. Up to 36 visits per Calendar Year will be considered Covered Expense for cardiac rehabilitation services. In-Network and Out-Of-Network services will both count towards the Calendar Year visit limit. All services provided in one day will be considered a visit.

The 20 visit limit will not apply to Physical, Occupational or Speech therapy when Pre-Approval of the Treatment has been obtained from Us and is:

- For the treatment of burns;
- For the treatment of fractures;
- For the treatment of joint replacements;
- Immediately following surgery; or
- Immediately following a stroke

Non-Covered Expense includes expense for:

- Any Physical Therapy service that could be done as part of a home exercise program or accomplished at a health club;
- Occupational Therapy supplies;
- Physical conditioning programs such as athletic training, body-building exercises, fitness and flexibility programs; and
- The services of a massage therapist, athletic trainer, or masseuse; acupuncture or acupressure Treatment.
- Therapy provided as an Inpatient in the absence of a separate medical condition that requires Hospitalization;

Services not considered Habilitative Services include: 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.

21. Transplants

Covered transplants include, but are not limited to:

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

Medically necessary charges related to the procurement of an organ from a live donor are covered only when such benefits are not available to the donor from any other source. Medically necessary charges for the live donor can include complications from the donation procedure for up to six weeks from the date of the procurement procedure.

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.

Transplants require Pre-Approval by Us.

Non-Covered Expense includes expense for:

- Animal to human organ transplants; and
- Replacement of human organs by artificial or mechanical devices.

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 maximum benefit We will pay for food and lodging for the family member who accompanied the covered person is $10,000. We must be provided with itemized bills for all transportation, food and lodging expenses.

22. Vision Services

Covered Expense includes expense for the following when provided for the treatment of injury or disease:

- Surgical treatment of injuries and/or diseases affecting the eye;
- Routine eye examinations including determination of refraction;
- Visual functional screening for visual acuity;
- Initial contact lenses or glasses prescribed after cataract lens implantation but limited to basic lenses only;
- Initial contact lenses or glasses prescribed after loss of vision directly resulting from accidentally injury to the eye but limited to basic lenses only;

Non-Covered Expense includes expense for:

- Eye examinations for the fitting of eyewear not outlined above or in the Pediatric Vision Care Benefit Provision;
- 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 Provision and as outlined above; and
- Prescribing of corrective lenses except as specified in the Pediatric Vision Care Benefit Provision and as outlined above.

23. Other Covered Services

Covered Expense includes expense for:

- Cosmetic services, supplies, or medications provided primarily to restore function lost or impaired as the result of an Illness, Injury, or birth defect;
- Sterilization;
- Temporomandibular Joint Dysfunction and Related Disorders (TMJ);
- Coverage as described in the Pediatric Dental Benefit; and
- Coverage as described in the Pediatric Vision Benefit

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 aside from those covered complications from weight reduction or cosmetic procedures outlined in Section 5.14 - Physician and Specialist Services; or
- 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 Experimental/Investigational service, supply, or Treatment;

- 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. However, this exclusion shall not apply if the Employee is a corporate officer of any domestic or foreign corporation and is employed by the corporation and elects to withdraw from the operation of the Ohio Workers' Compensation Act according to the provisions of the Act;
- 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;
- Any service or supply not recommended or approved by a licensed medical practitioner;
- Non-medical services and supplies;
- 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;

SECTION 7 - PRE-CERTIFICATION PROGRAM

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, Substance Abuse Treatment; 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, or a Substance Abuse Treatment Facility 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

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

The Coordination of Benefits ("COB") provision applies when an Insured 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 payments from all Plans does not exceed 100% of the total Allowable Expense.

TERMINOLOGY USED IN THIS PROVISION

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.

- Plan includes: group and non-group insurance contracts, health insuring corporation ("HIC") 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.
- Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56 ; school accident type coverage; benefits for non-medical 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.

"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.

"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 another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

"Allowable Expense" is a health care expense, including deductibles, coinsurance and copayments, 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:

- The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
- If an Insured 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.
- If an Insured 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.

  If an Insured 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 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.
- 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, precertification of admissions, and preferred provider arrangements.

"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.

"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 an Insured 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 under any other Plan.

B. The following apply:
   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 coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

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

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 are as follows:
      - The Plan covering the Custodial parent;
      - The Plan covering the spouse of the Custodial parent;
      - The Plan covering the non-custodial parent; and then
      - The Plan covering the spouse of the non-custodial parent.
   v. For a dependent child covered under more than one Plan of individuals who are not 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 an Insured 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 an Insured 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 an Insured 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 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. We 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. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us 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, We 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. We 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 Us 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.

COORDINATION DISPUTES

If You believe that We have not paid a claim properly, You should first attempt to resolve the problem by contacting Us at 800-371-9622, ext. 2721 or visit Us online at www.pekininsurance.com (For health insuring corporations, reference evidence of coverage's description of appeal procedures). If You are still not satisfied, You may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at http://insurance.ohio.gov.

MEDICARE AS PRIMARY PAYER

When Medicare is primary payer, We will coordinate Our benefits with Medicare in accordance with the provisions in the Policy.

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 - OHIO STATE CONTINUATION, COBRA, AND FMLA

OHIO STATE CONTINUATION

Eligibility:

If the Insured employee's coverage stops due to an involuntary termination of employment, the Insured employee and covered dependents may be eligible to continue group coverage. The Insured employee is eligible for continuation of group benefits when, at the time of termination, he or she meets all of the following criteria:

- He/she has been Insured under the Policy, or the Former Policy for at least 3 consecutive months before his/her insurance would end; and
- He/she is not covered by Medicare; and
- He/she is not eligible for coverage under any Group Health Plan that becomes effective after his/her termination of employment date; and
- He/she has not been fired from his/her job because of a felony in connection with work, or stole from his/her employer.

Notification:

- The Insured must request this continuation of insurance in writing no later than the earlier of any of the following dates:
  - 31 days after the date on which the Insured's coverage would otherwise terminate;
  - Ten days after the date on which the Insured's coverage would otherwise terminate if the employer has notified the Insured of the right of continuation prior to such date; and
  - Ten days after the employer notifies the Insured of the right of continuation, if the notice is given after the date on which the employee's coverage would otherwise terminate.

Payment:

- The Insured must pay the entire premium to the Policyholder in advance every month.

Loss of Eligibility:

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

- The date the Insured becomes covered by Medicare.
- The date the Insured becomes covered under Group Health Plan that has an effective date after his/her termination of employment date.
- The date twelve 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.
- The date the entire group Policy terminates.

COBRA - FEDERAL CONTINUATION OF HEALTH COVERAGE AFTER TERMINATION

This provision only applies if the Policyholder employs 20 or more full time employees.

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;
   - The Insured Employee had his hours reduced;
   - Death of employee;
   - Divorce or legal separation;

- 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.

   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.

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 which does not include preexisting condition clause or which would have the preexisting condition limitation period reduced by qualifying COBRA continuation coverage;
- 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 were 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, 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. This is done 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

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:

OHIO DEPARTMENT OF INSURANCE
CONSUMER SERVICES DIVISION
50 W. TOWN ST.
THIRD FLOOR - SUITE 300
COLUMBUS, OH 43215

APPEAL PROCEDURES

You have the right to appeal an Adverse Benefit Determination made by Us. An appeal is a request made by You to Us to review and ultimately reverse Our previous decision to reduce or deny benefit.

INTERNAL CLAIM AND 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 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.

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.

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."

You must file an Appeal within 180 days after You receive notice of an Adverse Benefit Determination, You may call or write to Us to request an appeal. 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 toUs, 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 and 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 without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale and 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/EXPEDITED CLINICAL APPEALS

If Your appeal relates to an Urgent Care/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 submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. We shall render a determination on the appeal within 24 hours after it receives the requested information.

OTHER APPEALS

Upon receipt of a non-urgent pre-service or post-service appeal We shall rendered 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 days of the request. We shall render a determination of the appeal within 15 business days after it receives the requested information but in no event more than 30 days after the appeal has been received by Us.

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 health insurance consumer assistance office or ombudsman. You may contact the Ohio ombudsman program at, [1-614-644-2651] 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.

EXHAUSTION OF INTERNAL CLAIM AND APPEAL PROCESS

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.

If an appeal is not resolved to Your satisfaction, You may appeal Our decision to the Ohio Department of Insurance. The Ohio Department of Insurance will notify Us of the appeal. We will have 21 days to respond to the Ohio Department of Insurance.

The operations of Us are regulated by the Ohio Department of Insurance. Filing an appeal does not prevent You from filing a complaint with the Ohio Department of Insurance or keep the Ohio Department of Insurance from investigating a complaint.

The Ohio Department of Insurance can be contacted at:

OHIO DEPARTMENT OF INSURANCE
CONSUMER AFFAIRSDIVISION
50 W. TOWN ST.
THIRD FLOOR - SUITE 300
COLUMBUS, OH 43215

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 an Adverse Determination or Final Adverse Determination by an independent review organization (IRO).

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 the requested service or payment for the service is therefore denied, reduced, or terminated.

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 must submit a written request for an external independent review within 4 months of receiving an Adverse Determination or Final Adverse Determination. You may submit additional information or documentation to support Your request for the health care services.

A. Preliminary Review. Within 5 business days of receipt of Your request, We will complete a preliminary review of Your request to determine whether:

- You were an Insured at the time health care service was requested or provided;
- The service that is the subject of the Adverse Determination or the Final Adverse Determination is a Covered Expense under the Policy, but We have determined that the health care service does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness;
- You have exhausted Our internal grievance process (in certain urgent cases, You may be eligible for expedited external review even if You have not filed an internal appeal with Us, and , You may also be eligible for external review if You filed an internal appeal but have not received a decision from Us within 15 days after We received all required information in no case longer than 30 days after You first file the appeal or within 48 hours if You have filed a request for an expedited internal appeal); and
- You have provided all the information and forms required to process an external review.

For external reviews relating to a determination based on Treatment being Experimental/Investigational, We will complete a preliminary review to determine whether the requested service or Treatment that is the subject of the Adverse Determination or Final Adverse Determination is a Covered Expense, except

for Our determination that the service or Treatment is Experimental/Investigational for a particular medical condition and is not explicitly listed as an excluded benefit. In addition, the Physician who ordered or provided the services in question has certified that one of the following situations is applicable:

- Standard health care services or Treatments have not been effective in improving Your condition;
- Standard health care services or Treatments are not medically appropriate for You;
- There is no available standard health care services or Treatment covered by Us that is more beneficial than the recommended or requested service or Treatment;
- The health care service or Treatment is likely to be more beneficial to You, in the opinion of Your health care provider, than any available standard health care services or Treatments; or
- That scientifically valid studies, using accepted protocols, demonstrate that the health care service or Treatment requested is likely to be more beneficial to You than any available standard health care services or Treatments.

B. Notification. Within 1 business day after completion of the preliminary review, We shall notify You and Your authorized representative, if applicable, in writing whether the request is complete and eligible for an external review. If the request is not complete or not eligible for an external review, You shall be notified by Us in writing of what materials are required to make the request complete or the reason for its ineligibility. Our determination that the external review request is ineligible for review may be appealed to the Ohio Director of the Department of Insurance ("Director") by filing a complaint with the Director. The Director may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Director's decision shall be in accordance with the terms of Your Policy and shall be subject to all applicable laws.

C. Assignment of IRO. If Your request is eligible for external review, We shall, within 5 business days (a) assign an IRO from the list of approved IROs; and (b) notify You and Your authorized representative, if applicable, of the request's eligibility and acceptance for external review and the name of the IRO.

Upon assignment of an IRO, We, or the designated utilization review organization shall, within 5 business days, provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, You or Your authorized representative may, within 5 business days following the date of receipt of the notice of assignment of an IRO, submit in writing to the assigned IRO additional information that the IRO shall consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 5 business days. If We or the designated utilization review organization does not provide the documents and information within 5 business days, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. A failure by Us or designated utilization review organization to provide the documents and information to the IRO within 5 business days shall not delay the conduct of the external review. Within 1 business day after making the decision to end the external review, the IRO shall notify Us, You and, if applicable, Your authorized representative, of its decision to reverse the determination.

If You or Your authorized representative submitted additional information to the IRO, the IRO shall forward the additional information to Pekin within 1 business day of receipt from You or Your authorized representative. Upon receipt of such information, We may reconsider the Adverse Determination or Final Adverse Determination. Such reconsideration shall not delay the external review. We may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within 1 business day after making the decision to end the external review, We shall notify the IRO, You, and if applicable, Your authorized representative of its decision to reverse the determination.

D. IRO's Decision. In addition, to the documents and information provided by Us and You, or if applicable, Your authorized representative, the IRO shall also consider the following information if available and appropriate:

- Your medical records;
- Your health care provider's recommendation;
- Consulting reports from appropriate health care providers and associated records from health care providers;
- The terms of coverage under the Policy;
- The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

- Any applicable clinical review criteria developed and used by Us or its designated utilization review organization; and
- The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above, for a denial of coverage based on a determination that the health care service or Treatment recommended or requested is Experimental/Investigational, whether and to what extent (a) the recommended or requested health care service or Treatment has been approved by the federal Food and Drug Administration, (b) medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or Treatment would be substantially increased over those of available standard health care services or Treatments, or (c) the terms of coverage under Your Policy to ensure that the health care services or Treatment would otherwise be covered under the terms of coverage of the Policy.

Within 5 days after the date of receipt of the necessary information, the IRO will render its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The IRO is not bound by any claim determinations reached prior to the submission of information to the IRO. You and Your authorized representative, if applicable, will receive written notice from Us.

The written notice will include:

1. A general description of the reason for the request for external review;
2. The date the IRO received the assignment from Us;
3. The time period during which the external review was conducted;
4. References to the evidence or documentation including the evidence-based standards, considered in reaching its decision;
5. The date of its decisions, and
6. The principal reason or reasons for its decision, including, what applicable, if any, evidence-based standards that were a basis for its decisions.

If the external review was a review of Experimental/Investigational Treatments, the notice shall include the following additional information:

1. A description of Your medical condition;
2. A description of the indicators relevant to whether there is sufficient evidence to demonstrate that the recommended or requested health care service or Treatment is more likely than not to be more beneficial to You than any available standard health care services or Treatments and the adverse risks of the recommended or requested health care service or Treatments would not be substantially increased over those of available standard health care services or Treatments;
3. A description and analysis of any medical or scientific evidence considered in reaching the opinion;
4. A description and analysis of any evidence-based standards;
5. Whether the recommended or requested health care service or Treatment has been approved by the federal Food and Drug Administration;
6. Whether medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or Treatment is more likely than not to be more beneficial to You than any available standard health care services or Treatments and the adverse risks of the recommended or requested health care service or Treatment would not be substantially increased over those of available standard health care services or Treatments; and
7. The written opinion of the clinical reviewer, including the reviewer's recommendations or requested health care service or Treatment that should be covered and the rationale for the reviewer's recommendation.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, We shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the Policy even if the IRO determines that the health care services being reviewed were medically appropriate.

2. Expedited External Review

If You have a medical condition where the timeframe for completion of (a) an expedited internal review of a grievance involving an Adverse Determination; (b) a Final Adverse Determination as set forth in the Ohio Managed Care Reform and Patient Rights Act; or, (c) a standard external review as set forth in the Ohio Health Care External Review Act, would seriously jeopardize Your life or health or Your ability to regain maximum function, then You have the right to have the Adverse Determination or Final Adverse Determination reviewed by an IRO not associated with Us. In addition, if a Final Adverse Determination

concerns an admission, availability of care, continued stay or health care service for which You received Emergency Services, but have not been discharged from a facility, then You may request an expedited external review.

You may also request an expedited external review if the Treatment or service in question has been denied on the basis that it is considered Experimental/Investigational and Your health care provider certifies in writing that the Treatment or service would be significantly less effective if not started promptly.

Your request for an expedited independent external review may be submitted orally or in writing.

Notification. We shall immediately notify You and Your authorized representative, if applicable, in writing whether the expedited request is complete and eligible for an expedited external review. Our determination that the external review request is ineligible for review may be appealed to the Director by filing a complaint with the Director. The Director may determine that a request is eligible for expedited external review and require that it be referred for an expedited external review. In making such determination, the Director's decision shall be in accordance with the terms of the Policy and shall be subject to all applicable laws.

Assignment of IRO. If Your request is eligible for expedited external review, We shall immediately assign an IRO from the list of approved IROs; and notify You and Your authorized representative, if applicable, of the request's eligibility and acceptance for external review and the name of the IRO.

Upon assignment of an IRO, We or the designated utilization review organization shall, within 24 hours provide to the assigned IRO the documents and any information considered in making the Adverse Determination or Final Adverse Determination. In addition, You or Your authorized representative may submit additional information in writing to the assigned IRO. If We or the designated utilization review organization does not provide the documents and information within 24 hours, the IRO may end the external review and make a decision to reverse the Adverse Determination or Final Adverse Determination. Within 1 business day after making the decision to end the external review, the IRO shall notify Pekin, You and, if applicable, Your authorized representative, of its decision to reverse the determination.

Within 2 business days after the date of receipt of all necessary information, the expedited independent external reviewer will render a decision whether or not to uphold or reverse the Adverse Determination or Final Adverse Determination and You will receive notification from Us. The assigned IRO is not bound by any decisions or conclusions reached during Our utilization review process or Our internal grievance process. Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, We shall immediately approve the coverage that was the subject of the determination. Benefits will not be provided for services or supplies not covered under the Policy if the IRO determines that the health care services being appealed were medically appropriate.

Within 48 hours after the date of providing the notice, the assigned IRO shall provide written confirmation of the decision to You, Us and, if applicable, Your authorized representative, including all the information outlined under the standard process above.

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 and Your authorized representative may not file a subsequent request for external review involving the same Adverse Determination or Final Adverse Determination for which You have already received an external review decision.

DEFINITIONS

ABORTION

A non-therapeutic termination of a human pregnancy that is performed or induced when a life of a mother would not be endangered if the fetus were carried to term, or when the pregnancy was not a result of rape or incest.

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.

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.

CHILD, CHILDREN

1. The Insured Employee or Insured Employee's Spouse's:
   - Natural born Child;
   - Legally adopted Child or a Child placed for adoption 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 28 years of age if an Ohio resident or a full time student; or
     - To be considered a full time student, the student must be in classroom attendance at an accredited secondary school, college or university on a full time basis that under orders of a physician, must drop below full time status as a result of an illness or injury but only when this occurs prior to age 28 and only for 12 months from the date the student drops below full time status;
   - Under 26 years of age if a non-Ohio resident;
   - An unmarried Child who is totally and permanently disabled, physically or mentally. The disability must have existed before the Child turned age 28.

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

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.

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;
- Any Complications of Pregnancy requiring delivery by cesarean section.

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, Copay, and/or Deductibles.

COVERED EXPENSE

The Medically Necessary, Regular, Reasonable & Customary charge 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, 9. 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

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

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 ROOM COPAY

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.

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 working at least 25 hours per week for an employer with 50 or fewer employees. For employers with 51 or more employees the person must work 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;
- 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;
- 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 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.

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.

GROUP TYPE PLAN

Any of the following:

- Group or blanket insurance coverage;
- Prepayment plans (including Blue Cross - Blue Shield);
- Union Welfare plans;
- Plans growing out an employee-employer relationship;
- Any statutory plans;
- The medical benefits coverage in group automobile contracts, in group or individual automobile "no-fault" contracts, and in traditional "fault" type contracts; or
- Uninsured or underinsured motorist coverage.

HABILITATIVE SERVICES

Therapy and other services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.

HEALTH INSURANCE COVERAGE

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.

HOME OFFICE

The main corporate offices of Pekin Life Insurance Company. The address is 2505 Court Street, Pekin, Illinois 61558.

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; or
- 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

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, Serious 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 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.

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

INPATIENT

A confinement in a Hospital, Skilled Nursing Facility or Residential Treatment Centerthat 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.

INTENSIVE OUTPATIENT PROGRAMS

Services offered to treat Mental Health Conditions or Substance Use Conditions. Program must provide at least 3 hours of treatment per day and the program must be available at least 2-3 days per week. Treatment must be provided by Mental Health Condition professionals. It does not include services or programs provided by: school, halfway house, centers for developmentally disabled or residential programs for drug and alcohol.

INVESTIGATIONAL OR INVESTIGATIONAL SERVICES AND SUPPLIES

Procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to an Insured, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to an Insured.

MAIL ORDER PRESCRIPTION COPAY

The amount the Insured must pay for each prescription order obtained through the mail service program.

MAINTENANCE PHYSICAL THERAPY

Therapy administered to an Insured to maintain a level of function at which no demonstrable and measureable improvement of a condition will occur.

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 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, Substance Use Disorder or Serious Mental Health Condition.

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.

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-COVERED EXPENSE

Expenses for which no benefits are payable.

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.

OCCUPATIONAL THERAPY

Constructive therapeutic activity designed and adapted to promote the restoration of useful physical function.

Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

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.

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, Deductibles and Coinsurance shares. The Out-of-Pocket Maximum is shown in the Schedule of Benefits 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%.

PAIN THERAPY

Pain Therapy that is medically based and includes reasonably defined goals, including, but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the Pain Therapy against these goals.

PARTIAL HOSPITALIZATION

Intensive structured setting providing 3 or more hours of Treatment or programs per day. Services should be similar to an Inpatient setting and there should be Mental Health Condition and Substance Use Disorder Treatment available at least 5 days per week. Treatment must be provided by a multidisciplinary team of Mental Health Condition professionals. It does not include services or programs provided by: school, halfway house, centers for developmentally disabled or residential programs for drug and alcohol.

PARTICIPATING PHARMACY

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

PHYSICAL THERAPY

The Treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

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 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;
Dentists;
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.

PRE-APPROVAL

A review to determine and authorize the coverage level of Medically Necessary services the Policy will provide benefit for if approved by Us prior to receiving the services. Failure to obtain Pre-Approval may result in a reduction of the allowable amount if the amount charged exceeds Regular, Reasonable and Customary.

PRE-CERTIFICATION

The process required to obtain prior approval for Inpatient Hospital admissions and other select Hospital services. Failure to Pre-Certify could result in a Pre-Certification Penalty as well as denial of treatment for services found to not be Medically Necessary.

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.

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.

REGULAR, REASONABLE & CUSTOMARY

The lessor of:

- The actual charge;
- What the provider would accept for the same service or supply in the absence of insurance;
- The amount the providere 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;
- An 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 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;
- 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 TREATMENT CENTER

A facility, licensed as such under applicable law, whose primary function is offering therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision and structure. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Health Conditions, Serious Mental Health Conditions and/or Substance Use Disorders.

It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

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.

RETAIL PRESCRIPTION COPAY

The amount the Insured must pay for each prescription order up to a 34 day supply, obtained at a retail pharmacy. It is shown on the Policyholder's Schedule of Benefits and the Insured's Certificate of Insurance.

SCHEDULE OF BENEFITS

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

SERIOUS MENTAL HEALTH CONDTIONS

Includes:

- Schizophrenia;
- Paranoid and other psychotic disorders;

- Bipolar disorders (hypmanic, manic, depressive and mixed);
- Major depressive disorders (single episode or recurrent);
- Schizoaffective disorders (bipolar or depressive);
- Pervasive developmental disorders;
- Obsessive-compulsive disorders;
- Depression in childhood and adolescence;
- Panic disorder;
- Post-traumatic stress disorders (acute, chronic, or with delayed onset);
- Anorexia nervosa and bulimia nervosa.

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.

SKILLED 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.

SPEECH THERAPY

Treatment for the correction of a speech impairment resulting from disease including pervasive developmental disorders, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

SPOUSE

A husband or wife.

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 durin g 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 ABUSE DISORDER

Means the following mental disorders as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

- Substance abuse disorders;
- Substance dependence disorders; and
- Substance induced disorders.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS (TMJ)

Jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint-linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

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 so 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.

PEDIATRIC DENTAL BENEFIT

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

DENTAL WAITING PERIOD

The only Dental 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 BENEFIT COVERED EXPENSES

We will pay benefits as specified in this provision for covered expenses incurred by a Covered Person as defined in this provision for pediatric dental services. Pediatric dental services include the following as categorized below.

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) - 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 - Limited to 1 per tooth in 60 months
D2931 Prefabricated stainless steel crown - permanent tooth - 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 and for primary molars and cuspids.
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. - Limited to primary incisor teeth and for primary molars and cuspids.
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
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
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
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
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

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: Orthodontic Services only available for those insureds eligible for Class IV benefits who have satisfied the 24 month orthodontic Dental 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, You and/or the Covered Person or the Covered Person's dentist should submit a treatment plan to Us for review before treatment begins.

We will provide You 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 tells You 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. You and/or the Covered Person will be responsible for any amount exceeding the maximum benefit for the services performed.

If You 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. You and/or the Covered Person will be responsible for any amount exceeding the maximum benefit for the service 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 BENEFIT LIMITATIONS AND EXCLUSIONS

Refer to the "Expense Not Covered by the Plan" section for additional exclusions. Unless specifically stated otherwise, no pediatric dental 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;
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 aides 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 Dental Waiting Period re quirement.
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 Dental Charge as defined in this provision. The member is responsible for all remaining charges that exceed the allowable maximum.

PEDIATRIC DENTAL BENEFIT COVERAGE DEFINITIONS

Alternate Benefit means if We determine a service less costly than the one performed by the Covered Person's dentist could have been performed, We will pay benefits based upon the less costly service.

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

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

Dental 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 Dental Waiting Period.

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 den tal 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 Benefit Covered Expenses" provision; 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 Dental 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.

PEDIATRIC VISION BENEFIT

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 (LinedP Trifocal 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, moncular patients and patients with prescriptions > +/- 6.00 diopters. Note: All lenses include scratch resistant coating with no additional copayment.	100% after medical deductible.
Frame: Covered once every calendar year. V2020 Frame	100% after medical deductible.
Contact Lenses	
Contact Lenses: Covered once every calendar year - in lieu of eyeglasses. V2500-V2599 Contact Lenses	100% after medical deductible; subject to pre-authorization.

Benefit Description	Plan Pays for Services From
Other Vision Services	
Optional Lenses and Treatments	The insured pays an additional copay as follows:
Ultraviolet Protective Coating	No Copay
Polycarbonate Lenses (if not child, monocular or prescription >+/- 6.00 diopters)	$30
Blended Segment Lenses	$20
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

PEDIATRIC VISION BENEFIT COVERED EXPENSES

We will pay benefits as specified in this provision for covered expenses incurred by a Covered Personas defined in this provision 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; and
- 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.

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 and follow-up care - four visits in any five-year period.

PEDIATRIC VISION BENEFIT LIMITATIONS AND EXCLUSIONS

No pediatric vision benefits will be paid for:

1. Any vision service, treatment or materials not specifically listed in the schedule above;
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 provision;
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.

PEDIATRIC VISION BENEFIT DEFINITIONS

The following terms are specific to pediatric vision care benefits:

Covered Person under this benefit 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 Benefit Covered Expense" provision in this Policy for a Covered Personunder 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;
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.