



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.

YOUR PREFERRED PROVIDER PLAN

THERE MAY BE BENEFITS DESCRIBED IN THIS PLAN THAT ARE NOT INCLUDED IN YOUR PLAN. YOU ARE ONLY INSURED FOR THOSE INSURANCE BENEFITS CHOSEN BY YOUR EMPLOYER. THE SCHEDULE OF BENEFITS LISTS THE BENEFITS THAT YOUR EMPLOYER CHOSE TO OFFER YOU. YOUR CERTIFICATE OF INSURANCE LISTS THE BENEFITS THAT YOU ARE INSURED FOR. ANY BENEFITS OR PROVISIONS SHOWN TO BE "EXCLUDED" ON THE SCHEDULE OF BENEFITS OR YOUR CERTIFICATE OF INSURANCE ARE NOT PART OF YOUR PLAN AND DO NOT APPLY TO YOU.

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

TABLE OF CONTENTS

Certificate of Insurance	Insert
Definitions	5-14
Dates of Eligibility for this Insurance	15
Effective Date of Insurance	15-16
Termination of Insurance of Insureds	16-17
Claims	17-18
Major Medical Benefit Provisions	
Benefit for Covered Expense Provided by a Preferred Provider	18
Benefit for Covered Expense for Emergency Services Provided in a Hospital Emergency Room	18
Benefit for Covered Expense provided by a Non-Preferred Provider	18-19
Benefit for Emergency Care	19
Expense Covered by the Plan	19-21
Transplant Benefit	22
Optional Benefits	22
Wellness Benefit for Preventive Health Care	22-23
Hospital Benefits for Dental Surgery	23
Pregnancy Like Any Illness	23
Infertility & In Vitro Fertilization Benefit	23
Mental Health Parity Benefit	23-24
Limitations to Health Benefits Provided by This Policy	24
Mental Illness/Nervous Disorders & Chemical Dependency	24
Manipulative Therapy	24
Sterilization Procedures	24
Benefit Limitations for Preexisting Conditions	24-25
Expense Not Covered by the Plan	25-27
Pre-certification Program	27-28
Discontinuance & Replacement Provisions	28-29
Deductible Credit Provision	28
Coinsurance Credit Provision	28
Medicare as Primary Payer	29
Coordination of Benefits	29-30
Right of Reimbursement	30

Benefits Available Upon Termination	
Benefit Extension after Termination	30
Illinois Continuation of Health Insurance Coverage After Termination of Employment	30-31
Illinois Spousal and Dependent Continuation	31-32
Federal Continuation of Health Insurance Coverage After Termination	33-34
Conversion Privilege - Changing to an Individual Health Policy	35
Family and Medical Leave Act (FLMA) Continuation Provision	35
Complaints	36

DEFINITIONS

ALLOWABLE EXPENSE

Any medically necessary, regular, reasonable & customary item of expense of health care, when the item is covered at least in part by one of the group-type plans. The difference between the cost of a private hospital room and a semiprivate hospital room is only considered an allowable expense when the patient's stay in a private room is certified as medically necessary by the patient's physician.

APPROVED TRANSPLANT SERVICES

Means 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 this policy.

CHILD, CHILDREN

1. The insured employee or insured employee's spouse's:
 - a. natural born child;
 - b. legally adopted child who is in the custody of the insured pursuant to an interim court order of adoption vesting temporary care of the child to the insured;
 - c. step child; or
 - d. any other child that has been declared the legal responsibility of the insured employee or insured employee's spouse.
2. The child must be unmarried, depend on the insured for full maintenance and support, not be eligible for group insurance as an employee, and be:
 - a. under 26 years of age;
 - b. incapable of self-sustaining support because of a handicapped condition. The child must have become incapable before he/she became 26 years of age.
 - c. Military veteran under 30 years of age who is: an Illinois resident, is not married, has served in the active or reserve component of the United States Armed Forces (including the National Guard) and has received a release or discharge other than dishonorable; or
 - d. a student under the age of 26 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 26 and only for 12 months from the date the student drops below full time status.

CIVIL UNION

A legal relationship between two persons, of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

COINSURANCE

Means 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:

1. extra-uterine pregnancy;
2. severe toxemic disorders;

3. severe puerperal sepsis;
4. spontaneous miscarriage;
5. severe hemorrhage;
6. any complications of pregnancy requiring delivery by cesarean section;
7. Hyperemesis Gravidarum; or
8. Pre-Eclampsia.

Complication of pregnancy does not include:

1. false labor;
2. occasional spotting;
3. physician prescribed rest;
4. morning sickness;
5. induced abortion;
6. elective cesarean section;
7. maternal age;
8. repeat cesarean section, unless necessary because of existing medical complications.

COVERED EXPENSES

The medically necessary, regular, reasonable & customary charges for medical services and supplies that are incurred:

1. by an insured while this policy is in force; and
2. before this insurance ends; and
3. for the treatment of an illness or injury.

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 this 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

Means 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

Durable medical equipment is medical equipment:

1. which is preauthorized by us;
2. is used repeatedly;
3. serves a medical purpose;
4. would not be useful to a person without an injury or illness; and
5. is appropriate for treating an illness or injury in the home.

It includes 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 durable medical equipment, and are not covered under this policy:

1. air purifiers or cleaners, air conditioners, humidifiers, dehumidifiers, vaporizers, or heaters;
2. any equipment which provides comfort or convenience;
3. structure or vehicle alterations, ramps, or elevators;
4. whirlpools, exercise machines of any type, swimming pools, hot tubs;
5. computers or communication devices;
6. heating pads, heat lamps, duplicate equipment; or
7. similar types of items or equipment.

EFFECTIVE DATE

The date this policy is put in force or the date the insured is added to this policy.

ELIGIBLE

Meets the qualifications to apply for insurance.

EMERGENCY CARE

Means covered expense for services for treatment of an injury or emergency medical condition that reasonably requires the insured to seek immediate medical care, under circumstances, or at locations which preclude the insured from obtaining needed medical care from a Preferred Provider.

It does not mean covered expense for services provided by a non-preferred provider once a referral can be made to safely transfer the patient to the care of a preferred provider.

EMERGENCY SERVICES

Means those medical and health services provided to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such 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:

1. 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; or
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

EMPLOYEE

A person employed by the Policyholder on a permanent full-time basis. He/she must meet the qualifications described in the Policyholder's Policy Schedule. 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 waiting period for enrollment.

EQUIVALENT GENERIC DRUG

Means a drug that our discount drug card company has classified as safe, equivalent to, and as effective as the brand name drug that would otherwise be prescribed.

EXPERIMENTAL/INVESTIGATIONAL

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.

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 understudy 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 approval has not been given by the United States Food and Drug Administration at the time it is furnished.

EVIDENCE OF INSURABILITY

Evidence of good health acceptable to us.

FAMILY COVERAGE

Means, 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

A marriage, a birth, an adoption, or a child being placed for adoption.

FORMER POLICY

The Policyholder's terminated group health policy that was replaced by this policy.

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

1. Group or blanket insurance coverage;
2. Prepayment plans (including Blue Cross-Blue Shield plans);
3. Union welfare plans;
4. Plans growing out of an employee-employer relationship;
5. Any statutory plans;
6. The medical benefits coverage in group automobile contracts, in group or individual automobile "no-fault" contracts, and in traditional automobile "fault" type contracts.

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.

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 be pre-approved by us. The plan of care must be reviewed at least every two months by your physician.

It consists of the medically necessary services for:

1. part-time or intermittent home nursing care by or under the supervision of a registered nurse (R.N.).
2. 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.
3. physical, respiratory, occupational or speech therapy.
4. nutrition counseling provided by or under the supervision of a registered dietitian.
5. 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.

Up to 4 consecutive hours of care will be considered one home health care visit.

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:

1. be certified or licensed as a hospice by the state in which they are operating;
2. operate under the direct supervision of a physician;
3. provide services 24 hours a day, seven days a week; and
4. 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 this policy.

HOSPITAL

Means a place which:

1. is legally operated for the inpatient care and treatment of ill or injured persons;
2. has surgical or diagnostic facilities on the premises or in facilities available to it;
3. has continuous 24 hour nursing services; and
4. has a staff of one or more physicians available at all times.

It does not mean:

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

ILLNESS

A disease process that causes the abnormal function of:

1. an organ;
2. a system of the body; or
3. the whole body.

It must be caused by:

1. a pathogenic change; or
2. a psychological disturbance.

It is also a pregnancy or complication of pregnancy.

IMMEDIATE FAMILY

The insured's spouse, children, parents, brothers and sisters.

INDIVIDUAL COVERAGE

Means that only a single person is covered for health insurance benefits under the insured's certificate.

INJURY

Bodily injury caused by an accident which occurs while insured under this policy.

INFERTILITY

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

IN-NETWORK

Means covered expense provided by a preferred provider.

IN-NETWORK FAMILY COVERAGE COINSURANCE SHARE

The amount of covered expense that insureds with family coverage must pay for services provided by a preferred provider, after we have paid the coinsurance amount. In-Network family coverage coinsurance share does not include:

1. any deductible amounts;
2. expense an insured would pay because of our payment of 50% benefit under any "Limitations to Health Benefits Provided by This Policy";
3. any penalty for noncompliance with plan requirements;
4. any out of network coinsurance share; or
5. expense an insured would pay as a result of an organ transplant at a non-designated transplant facility.

The In-Network family coverage coinsurance share for a calendar year is shown on the Schedule of Benefits.

IN-NETWORK INDIVIDUAL COVERAGE COINSURANCE SHARE

The amount of covered expense that an insured with individual coverage must pay for services provided by a preferred provider, after we have paid the coinsurance amount. In-Network individual coinsurance share does not include:

1. any deductible amounts;
2. expense an insured would pay because of our payment of 50% benefit under any "Limitations to Health Benefits Provided by This Policy";
3. any penalty for noncompliance with plan requirements;
4. any out of network coinsurance share; or
5. expense an insured would pay as a result of an organ transplant at a non-designated transplant facility.

The In-Network Individual Coverage Coinsurance Share for a calendar year is shown on the Schedule of Benefits.

IN-NETWORK INDIVIDUAL COVERAGE DEDUCTIBLE

The amount of covered expense for services provided by a preferred provider that must be incurred in a calendar year by an insured with individual coverage before any covered expense is paid by us. It is equal to the amount specified under the In-Network Individual Coverage 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 COVERAGE DEDUCTIBLE

The amount of deductible insureds with family coverage 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 Coverage Deductible must be satisfied by combining all in-network amounts applied to deductibles for the insured employee and the insured employee's dependents for the calendar year. Out of Network deductible amounts will not be used to satisfy any In-Network deductible amounts.

INPATIENT

Means a confinement in a hospital that results in the hospital 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

Means any insured employee or insured dependent who is covered for benefits under this policy.

INTENSIVE CARE

Means a separate area in a hospital for the inpatient care of patients who are critically ill, which:

1. provides constant nursing care which is not usual in other rooms and wards;

2. has special lifesaving equipment which is immediately available at all times; and
3. has at least one R.N. on duty at all times.

LATE ENROLLEE

Means an eligible employee or dependent who applies more than 30 days after:

1. the date he/she became eligible under this policy; or
2. a special enrollment period.

MANIPULATIVE THERAPY

Treatment consisting primarily of manipulation, heat, ultrasound, diathermy, acupuncture or similar types of treatment. It includes all tests, x-rays, examinations, office visits, medications, or similar services provided in conjunction with this type of treatment.

MAXIMUM BENEFIT

The maximum amount of benefit that will be paid for all covered expense for each insured while he/she is insured under this policy. It is shown on the Schedule of Benefits.

On January 1 of each year, each insured person who has benefits charged to his/her maximum benefit will automatically have an amount reinstated for future use. The amount to be reinstated each year will be \$1000.00 or the amount the insured has received in benefit during the preceding calendar year, whichever is less. There will be no reinstatement of the maximum benefit for any benefits paid under "Benefit Extension After Termination".

If the insured employee's insurance terminates solely because his/her maximum benefit is exhausted, his/her insurance will be considered to continue in order to determine if his/her dependents are eligible for this policy.

MEDICALLY NECESSARY

Means treatment that:

1. is not experimental/investigational in nature;
2. is not done mainly as a convenience to the patient or provider;
3. is commonly accepted as proper care or treatment of the condition by the American medical community;
4. is performed solely for the benefit of the patient; and
5. meets professionally recognized national standards of quality.

MEDICARE

Title XVIII of the Social Security Act as amended.

MENTAL ILLNESS/NERVOUS DISORDER

Includes:

1. neuroses, psycho neuroses, psychopathy, psychosis or other emotional disorder;
2. affective disorders (including bipolar disorder and major depression);
3. Tourette's disorder;
4. attention deficit disorder;
5. conduct disorder;
6. adjustment disorder;
7. serious mental illness, including schizophrenia, paranoid and other psychotic disorders, bipolar disorders (hypomanic, 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; and
8. similar conditions or illnesses.

MINOR

A person who is under the legal age of competence.

NEWBORN CHILD

A dependent child born to the employee while he/she is insured under this policy.

NEW ENROLLEE

Means an eligible employee or dependent who applies for insurance within 30 days of his/her date of eligibility under this policy.

NON-DESIGNATED TRANSPLANT FACILITY

Means 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

Means 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.

OUT OF NETWORK

Means covered expense provided by a non-preferred provider.

OUT OF NETWORK FAMILY COINSURANCE SHARE

The amount of covered expense that insureds with family coverage must pay for services provided by a non-preferred provider, after we have paid the coinsurance amount. Out of Network family coverage coinsurance share does not include:

1. any deductible amounts;
2. expense an insured would pay because of our payment of 50% benefit under any "Limitations to Health Benefits Provided by This Policy";
3. any penalty for noncompliance with plan requirements;
4. any In-Network coinsurance share; or
5. expense an insured would pay as a result of an organ transplant at a non-designated transplant facility.

The Out of Network Family Coverage Coinsurance Share is shown on the Schedule of Benefits.

OUT OF NETWORK FAMILY COVERAGE DEDUCTIBLE

The amount of deductible insureds with family coverage must pay in a calendar year for services provided by a non-preferred provider. This amount is shown on the Schedule of Benefits. The Out of Network Family Coverage Deductible must be satisfied by combining all out of network amounts applied to deductibles for the insured employee and the insured employee's dependents for the calendar year. In-Network deductible amounts will not be used to satisfy the Out of Network deductible amounts.

OUT OF NETWORK INDIVIDUAL COVERAGE COINSURANCE SHARE

The amount of covered expense that an insured with individual coverage must pay for services provided by a non-preferred provider after we have paid the coinsurance amount. Out of Network Individual Coverage Coinsurance share does not include:

1. any deductible amounts;
2. expense an insured would pay because of our payment of 50% benefit under any "Limitations to Health Benefits Provided by This Policy";
3. any penalty for noncompliance with plan requirements;
4. any In-Network coinsurance share; or
5. expense an insured would pay as a result of an organ transplant at a non-designated transplant facility.

The Out of Network Individual Coverage Coinsurance Share is shown on the Schedule of Benefits.

OUT OF NETWORK INDIVIDUAL COVERAGE 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 with individual coverage before any covered expense is paid by us. It is equal to the amount specified under the Out of Network Individual Coverage Deductible amount shown on the Schedule of Benefits. In-Network deductible amounts will not be used to satisfy the Out of Network deductible amounts.

PHYSICIAN

Means 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.

Treatment by an Optometrist is considered Treatment by a Physician and will be considered for benefits the same as any physician licensed to practice medicine in all branches

POLICYHOLDER

The employer listed as the policyholder on the face page of the policy.

PREFERRED PROVIDER

Means 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 that the provider you are using or considering is currently a preferred provider.

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:

1. a properly completed claim form; and
2. any other information we need to process the claim.

QUALIFYING CREDITABLE COVERAGE

Coverage by an individual under:

1. a group health plan, including church or governmental plans;
2. individual or group health insurance coverage;
3. Medicaid or Medicare;
4. state health risk pools;
5. Military sponsored health care;
6. Public health benefits; or
7. the Federal Employees Health Benefit Plans.

Days of creditable coverage that occur before a significant break in coverage will not be counted as qualifying creditable coverage.

Days in a waiting period are not counted as creditable coverage.

REGULAR, REASONABLE & CUSTOMARY

The lesser of:

1. the actual charge;
2. what the provider would accept for the same service or supply in the absence of insurance;
3. the reasonable charge as determined by Pekin Life Insurance Company, based upon the Regular, Reasonable & Customary percentile level purchased by the Policyholder and factors deemed appropriate by Pekin Life Insurance Company;
4. the amount the provider has agreed to charge under a preferred provider agreement with Pekin Life Insurance Company.

Reasonable and customary for surgery will be determined as follows:

1. 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;
2. 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.

SALARY

The basic salary of the insured employee. It does not include commission, overtime or bonuses.

SCHEDULE OF BENEFITS

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

SIGNIFICANT BREAK IN COVERAGE

A period of 63 consecutive days during all of which an individual did not have any qualifying creditable coverage. Waiting periods are not taken into account in determining if a significant break in coverage has occurred.

SKILLED NURSING FACILITY

Means 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:

1. a rest home or home for the aged;
2. an institution, nor a unit of an institution, used for custodial or educational care;
3. an institution, nor a unit of an institution, used for the treatment of alcoholics, drug addicts, or the mentally ill.

SPOUSE

Wife , husband, or a party to a Civil Union.

TERMINALLY ILL PERSON

A person who has been diagnosed by a physician as having a life expectancy of six months or less.

TOTAL DISABILITY

Continuous inability to perform any and all duties of the insured's job. For a dependent insured who does not work, it means inability to perform all of the normal activities of a person of the same age or sex. Total disability must be certified by a physician. The person must be receiving treatment by a physician.

TREATMENT

Means:

1. any examination, diagnostic test, or actual treatment by a physician of an illness or injury or symptoms of an illness or injury; or
2. any medication or other service or supply dispensed in regard to an illness or injury or symptoms of an illness or injury.

WE, US

Pekin Life Insurance Company

YOU, YOUR

An insured employee or insured dependent.

DATES OF ELIGIBILITY FOR THIS INSURANCE

Only eligible employees and dependents are entitled to the insurance provided by this policy.

A person who is an employee will be eligible for insurance after he/she has satisfied any waiting period (not to exceed 90 days) specified on the Policyholder's Policy Schedule. His/her dependents will be eligible on that date also.

An employee is considered as having eligible dependents on the date:

1. he/she is legally married, or a Civil Union is established; or
2. when his/her first child is born; or
3. the court orders coverage be provided under this policy for a spouse, minor, or dependent.

EFFECTIVE DATE OF INSURANCE

To have the insurance provided by this policy, all eligible employees and dependents must apply by submitting an application completed in writing. The insurance becomes effective as follows:

1. NEW ENROLLEES

- a. If an employee applies on or before the date he/she is eligible, the employee will become insured on the date that he/she is eligible. If the employee applies for his/her dependents on or before the date they are eligible, they will become insured on the date they are eligible.
- b. If an employee applies within 30 days after the date he/she is eligible, the employee will become insured on the premium due date following the date he/she applies. If an employee applies for his/her dependents within 30 days after the date they are eligible, they will become insured on the premium due date following the date the employee applies.

2. LATE ENROLLEES

A late enrollee will become insured on the January 1st, following the date he/she applies. He/she should apply between November 15th and December 15th of the year prior to the January 1st he/she wants to become insured.

3. NEWBORN CHILDREN

A newborn child will be insured from birth, regardless of hospital confinement if:

- a. all other eligible children of the insured employee are insured under the employee's certificate under this policy at the time of the newborn's birth; or
- b. the insured applies for coverage and pays any premium due within 31 days after the newborn's birth.

4. SPECIAL ENROLLMENT PERIOD

A. 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:

1. the day the person loses his/her coverage under another group health plan or health insurance coverage because of:
 - a. a reduction in the number of hours of employment;
 - b. termination of employment;
 - c. termination of employer contributions;
 - d. the COBRA continuation provision that they were covered under is exhausted under the other group health plan or health insurance coverage; or
 - e. legal separation, divorce, or death.

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

B. For Persons Having a Family Status Change

A person will have a 30 day special enrollment period to apply 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 application is received.

In the case of a family status change due to the birth of a dependent child, coverage will begin on the child's date of birth, if application is made during the special enrollment period.

In the case of a family status change due to adoption or placement for adoption, coverage will begin on the date of the adoption or placement for adoption, if application is made during the special enrollment period.

5. DEFERRED EFFECTIVE DATES

An employee must be at work on the date insurance begins. If the employee is not at work and it is for a reason that is not health status related, insurance does not begin until he/she returns to work. If insurance is to be effective on a non-work day, the employee must have worked the previous scheduled work day unless the absence was approved or it was health status related.

6. BENEFIT CHANGES

An insured employee must be at work on the date a benefit change occurs. If the employee is not at work and it is for a reason that is not health status related, the benefit change will not occur until he/she returns to work. If the benefit change is to occur on a non-work day, the employee must have worked the previous scheduled work day unless the absence was approved or it was health status related.

TERMINATION OF INSURANCE OF INSURED

1. The insurance of an insured employee will end on the earliest of the following dates:
 - a. the date that any portion of the premium that is due is not paid;
 - b. the premium due date following the date he/she is no longer an employee;
 - c. the date that this entire policy terminates;
 - d. 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 immediately upon written notice of termination delivered by Us to You. However, if an Employee commits fraud or makes an intentional misrepresentation of material fact in writing on his/her enrollment form, We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of the Employee's and Dependents' insurance has a retroactive effect to the Effective Date under the policy.
2. The insurance of an insured dependent will end on the earliest of the following dates:
 - a. 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;
 - b. the premium due date following the date he/she no longer meets the definition of a dependent as defined in this policy. An insured dependent child who is losing coverage because he/she is turning 19 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.
 - c. the date that any portion of the premium that is due is not paid.

Uniform Termination of Coverage

In the event that We no longer offer the type of coverage provided in the Policy, the Policyholder will be notified no later than 90 days prior to the date of the discontinuation. Such discontinuation would be made uniformly, without regard to claims experience or health-related factors of current Insureds and anyone who may become eligible for the coverage.

In the event that We discontinue all group health insurance coverage in the small group or large group markets in the State of Illinois, the Policyholder will be notified no later than 180 days prior to the date of the discontinuation. In such cases, all coverage issued or delivered in the affected group market would be discontinued.

If We uniformly modify, uniformly terminate or discontinue coverage in accordance with Section 30 or 50 of Act 97, We will notify the Illinois Department of Insurance by certified mail at least 90 days prior to the notification of the Policyholder.

CLAIMS

NOTICE OF CLAIMS

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

CLAIM FORMS

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

PROOF OF LOSS

Written proof of loss must be sent to our Home Office within 90 days after the loss or as soon as reasonably possible. Proof provided more than one year late will not be accepted unless evidence, satisfactory to us, is submitted that shows it was not reasonably possible to submit proof within the time specified.

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 on this policy:

1. any earlier than 60 days after written proof of loss has been sent to us as required by the terms of the policy; or
2. any later than three years after the time such proof must be sent.

ASSIGNMENT OF BENEFITS

You may assign the benefits provided by this certificate. We are not bound by any assignment unless it is received in written form at our home office. We are not responsible for the validity of any assignment. An assignment may limit the interest of the Insured Employee.

Unless otherwise specified by You, any assignment will take effect on the date the notice of assignment is signed by You, subject to any payments made or actions taken by us prior to receipt of the written notice of assignment.

PAYMENT OF CLAIMS

After we receive proof of loss, we will pay benefits as they become due. 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 Insured to interest at the rate of 9% per annum 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.

MAJOR MEDICAL BENEFIT PROVISIONS

AMOUNT OF BENEFIT

We will pay the amount of benefit shown on the Schedule of Benefits for covered expense after the deductible has been met. Our payments will not exceed the maximum benefit shown on the Schedule of Benefits. Our payments are subject to this policy's definitions, provisions, limitations, and exclusions.

BENEFIT FOR COVERED EXPENSE PROVIDED BY A PREFERRED PROVIDER

Before we can pay any benefit for services provided by a Preferred Provider, covered expense equal to the applicable In-Network deductible must be incurred in a calendar year. An insured who has Individual Coverage must meet the In-Network Individual Coverage Deductible. For those insureds with Family Coverage, the In-Network Family Coverage Deductible must first be met.

We will then pay benefits for covered expenses provided by a preferred provider that are in excess of the applicable In-Network deductible for the remainder of that calendar year. These benefits will be paid at the In-Network coinsurance percentage shown on the Schedule of Benefits (or at the coinsurance percentages listed in the section titled "Limitations to Health Benefits Provided by this Policy".)

Benefit for In-Network covered expense will be paid at 100% once the applicable In-Network coinsurance share amount has been met. An insured with Individual Coverage will have to meet the In-Network Individual Coverage Coinsurance Share amount before benefit is paid at 100%. For those insureds with Family Coverage, the In-Network Family Coverage Coinsurance Share amount must be met before benefit is paid at 100%.

Covered expense provided by a preferred provider and paid at 50% under the section titled "Limitations to Health Benefits Provided by this Policy" will not be applied to any In-Network Individual Coverage Coinsurance Share, or In-Network Family Coverage Coinsurance Share. Covered expense paid at 90% under the section titled "Transplant Benefit" will not be applied to any In-Network Individual Coverage Coinsurance Share, or In-Network Family Coverage Coinsurance Share.

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 a \$50 emergency room access fee. 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 deductibles and coinsurance share amounts.

After you pay the first \$50 of covered expense, 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 \$50 emergency room access fee.

BENEFIT FOR COVERED EXPENSE PROVIDED BY A NON-PREFERRED PROVIDER

Before we can pay any benefit for services provided by a Non-Preferred Provider, covered expense equal to the applicable Out of Network deductible must be incurred in a calendar year. An insured who has Individual Coverage must meet the Out of Network Individual Coverage Deductible. For those insureds with Family Coverage, the Out of Network Family Coverage Deductible must first be met. We will then pay benefits for covered expenses provided by a non-preferred provider that are in excess of the applicable Out of Network deductible for the remainder of that calendar year. These benefits will be paid at the Out of Network coinsurance percentage shown on the Schedule of Benefits (or at the coinsurance percentages listed in the section titled "Limitations to Health Benefits Provided by this Policy".)

Benefit for Out of Network covered expense will be paid at 100% once the applicable Out of Network coinsurance share amount has been met. An insured with Individual Coverage will have to meet the Out of Network Individual Coverage Coinsurance Share amount before benefit is paid at 100%. For those insureds with Family Coverage, the Out of Network Family Coverage Coinsurance Share amount must be met before benefit is paid at 100%.

Covered expense provided by a non-preferred provider and paid at 50% under the section titled "Limitations to Health Benefits Provided by this Policy" will not be applied to any Out of Network Individual Coverage Coinsurance Share, or Out of Network Family Coverage Coinsurance Share. Covered expense paid at 90% under the section titled "Transplant Benefit" will not be applied to any Out of Network Individual Coverage Coinsurance Share, or Out of Network Family Coverage Coinsurance Share.

USE OF NON-PREFERRED PROVIDERS

When you use a non-preferred provider:

1. the amount of payment is based upon a reduced allowable amount, and not the actual billed charge; and
2. you may be expected to pay a larger portion of the bill, even after we have paid the percentage of eligible expense provided under the policy.

BENEFIT FOR EMERGENCY CARE

Sometimes situations occur that require an insured to receive care from a non-preferred provider, instead of preferred providers. When an insured requires emergency care as defined by the policy, benefits will be calculated as if the expense was provided by a preferred provider, even when the expense is from a non-preferred provider. The In-Network deductible, In-Network coinsurance percentage, and In-Network coinsurance share amounts will apply as long as emergency care is being rendered. Once it has been established that the insured can safely transfer to the care of a preferred provider, we will only pay In-Network benefits for preferred providers. If the insured chooses to continue to receive care from non-preferred providers once 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, Out of Network coinsurance percentage, and Out of Network coinsurance share amounts.

EXPENSE COVERED BY THE PLAN

Benefits are payable for covered expense. Covered expenses are charges:

1. by a hospital for:
 - semiprivate room and board;
 - care in the Intensive Care Unit;
 - hospital services and supplies which are to be used while in the hospital;
 - emergency services in a hospital emergency room;
 - outpatient medical care and treatment.
2. for outpatient surgery performed in a licensed ambulatory surgical facility.
3. by a physician for:
 - office visits;
 - hospital care;
 - surgical services, including postoperative care following inpatient or outpatient surgery; for multiple surgical procedures performed during the same operative session, covered expense will include 100% of the regular, reasonable and customary amount for the first surgical procedure, 50% of the regular, reasonable and customary amount for the second surgical procedure, and 25% of the regular, reasonable and customary amount for each additional surgical procedure;
 - services of an assistant surgeon when medically necessary to perform the surgery, but no more than 20% of the amount allowed for the primary surgeon's fee;
 - injections, and medication that is consumed at the physician's office.
4. for other services and supplies for:
 - anesthesia and its administration;
 - medications requiring a written prescription that are self-injected, when pre-approved by us;

- x-rays, and radiation therapy;
- chemotherapy, or similar treatment, provided in the office or the home, but the covered expense for chemotherapy provided through a physician's office will not exceed the regular, reasonable, and customary fees for home chemotherapy;
- outpatient physical therapy;
- occupational therapy;
- outpatient speech therapy by a licensed or certified speech therapist to restore speech loss or correct an impairment due to a congenital defect for which corrective surgery has been performed, or an injury or illness except for a mental, nervous or emotional disorder;
- laboratory tests;
- the initial purchase of artificial limbs, eyes, and larynx;
- blood, blood plasma, and its administration;
- casts, splints, trusses, braces, and crutches;
- ostomy supplies;
- allergens dispensed by a physician;
- durable medical equipment, when we have pre-authorized the purchase or rental;
- surgical dressings for two months following surgery;
- the purchase of one pair of the following while insured:
 - one pair of orthopedic shoes;
 - one support stocking for each leg;
 - one article of similar apparel-type item;
- local ground ambulance transportation to the nearest preferred provider hospital able to provide the care;
- air ambulance transportation to the nearest preferred provider hospital able to provide the care;
- drugs requiring a written prescription, including oral contraceptives, which are purchased using the discount drug card we provide, and submitted electronically to us by the discount drug card company;
- insulin, diabetic syringes and needles, test strips for glucose monitors and glucagon emergency kits;
- diabetes self-management training including medical nutrition education, but no more than:
 - a total of 3 medically necessary visits to a physician or a certified, registered or licensed health care professional with expertise in diabetes management upon the initial diagnosis of diabetes;
 - or a total of 2 medically necessary visits to a physician or a certified, registered or licensed health care professional with expertise in diabetes management, upon a determination by the patient's physician that a significant change in the patient's symptoms or medical condition has occurred;
 - regular foot exams for patient with diabetes;
- breast prosthesis or reconstructive surgery following a mastectomy, including surgery and reconstruction of the other breast to produce a symmetrical appearance;
- fibrocystic breast conditions;
- a baseline mammogram for women age 35 or older with no out of pocket expense when obtained performed by a Preferred Provider;
- an annual mammogram for women 40 years of age or older with no out of pocket expense when performed by a Preferred Provider;
- 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 with no out of pocket expense when performed by a Preferred Provider;

- a comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, or when Medically Necessary as determined by a Physician with no out of pocket expense when performed by a Preferred Provider;
 - a Physician office visit or in-home nurse visit within 48 hours of discharge from the hospital following a covered mastectomy;
 - 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 for asymptomatic male Insureds 40 years of age or older when there is family history of prostate cancer or another prostate cancer risk factor;
 - injections for contraceptive purposes, including depo-provera and norplant; and for contraceptive devices which require a written prescription before dispensing.
 - Examination and testing of sexual criminal assault victim (services covered with no out of pocket);
 - Temporomandibular Joint Disorder/Craniomandibular Disorder.
 - the laboratory work for an annual cervical smear or pap smear for female insureds;
 - an annual digital rectal examination and a prostate-specific antigen test, for male insureds age 40 and over, upon the recommendation of a physician;
 - outpatient contraceptive services and prescription contraceptive devices, including Levonorgestrel (Norplant);
 - examinations and laboratory tests for the detection of colorectal cancer as prescribed by a physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening.
5. for home health care visits not to exceed:
 - a. the number of visits shown on the Schedule of Benefits during one calendar year; and
 - b. the cost for such care in an inpatient facility.
 6. for care in a licensed skilled nursing facility when pre-approved by us, but not for longer than the number of days shown on the Schedule of Benefits during one calendar year.
 7. for hospice care when pre-approved by us;
 8. Cancer Research Trial Coverage

Expense incurred for medically appropriate associated routine patient care will be considered covered expense for insureds who have a life threatening terminal condition related to cancer, and who are participating in an approved cancer research trial.

TRANSPLANT BENEFIT

We will pay for covered expense for pre-approved organ transplants according to the following schedule:

Designated Transplant Facility	Non-Designated Transplant (Considered Out of Network) Facility
100% of Approved Transplant Services	90% of the Covered Expense in excess of the Out of Network deductible for hospital charges, physician charges, tissue typing and other ancillary services organ transplant. Once the insured has paid 10% of \$100,000 of covered expense for the transplant services listed above, then we will pay 100% of the covered expense for those services for the rest of the calendar year during which the organ transplant occurred.
Coverage as outlined in Travel/Lodging Benefit	No coverage for transportation and lodging
Organ Procurement and Acquisition covered in full	No coverage for organ procurement and acquisition

TRAVEL/LODGING BENEFIT

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

1. 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
2. Lodging at or near the Designated Transplant Facility for the family member who accompanied the insured patient, while the covered person is confined at the Designated Transplant Facility.

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

OPTIONAL BENEFITS - Please refer to the Schedule of Benefits to determine if you are covered for these benefits.

WELLNESS BENEFIT FOR PREVENTIVE HEALTH CARE

If this policy contains this benefit, the maximum wellness benefit for each insured in a calendar year will be shown on the Schedule of Benefits.

We will pay 100% of the reasonable and customary charge for expense incurred for preventative health care, consisting of a history and general physical examination, immunizations and the following tests when ordered in conjunction with the wellness exam:

1. mammogram;
2. pap smear;
3. blood screening tests, such as screening tests for cholesterol level, diabetes, sexually transmitted disease, PSA test and liver function;
4. chest x-rays, electrocardiograms, and stress tests;
5. screening tests for colon cancer;

6. tuberculosis skin test; and
7. routine vision exams.

We will only pay for expense for preventive health care exams and immunizations when provided by a Preferred Physician. We will only pay for preventive health care tests when ordered by a Preferred Physician, and provided by a Preferred Provider.

We will not pay more than the maximum wellness benefit for each insured in a calendar year for expense incurred for preventive health care.

HOSPITAL BENEFITS FOR DENTAL SURGERY

If this policy contains this benefit, it will be shown on the Schedule of Benefits.

Expense incurred to monitor or treat an existing illness or injury will not be covered under this provision.

We will consider expenses charged by a hospital for dental surgery as covered expenses. It must be medically necessary that the surgery be performed as an outpatient or inpatient in a hospital.

The expense will be subject to all policy provisions.

PREGNANCY LIKE ANY ILLNESS

If this policy contains this benefit, it will be shown on the Schedule of Benefits.

Expenses incurred as a result of a normal pregnancy will be considered covered expenses under this policy.

If we pay benefits for the pregnancy, then expense incurred for a well newborn child's initial confinement will be considered covered expense. The expense will be subject to all major medical policy provisions.

For a covered pregnancy, hospital services for inpatient care provided to the mother and the dependent newborn child will be covered for:

1. a minimum of 48 hours following a vaginal delivery; or
2. a minimum of 96 hours following a cesarean section;

unless the following applies:

1. post-discharge office visit to the physician or in-home nurse visit is provided in the first 48 hours after discharge; or
2. earlier discharge is consented to by the mother and the attending physician.

INFERTILITY & IN VITRO FERTILIZATION BENEFIT

If this policy contains this benefit, it will be shown on the Schedule of Benefits.

Expenses incurred for the treatment of infertility and in vitro fertilization will be considered covered expenses under the policy. The expense will be subject to all major medical policy provisions.

Items covered shall include, but not be limited to:

1. uterine embryo lavage, embryo transfer, artificial insemination, and low tubal ovum transfer; and
2. in vitro fertilization, gamete intra fallopian tube transfer, and zygote intra fallopian tube transfer, but only if:
 - a. the insured has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments;
 - b. the insured has not undergone 4 completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then 2 more completed oocyte retrievals will be covered;
 - c. and the procedures are performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

MENTAL HEALTH PARITY BENEFIT

This benefit is only available to employers with 50 or more employees. If this policy contains this benefit, it will be shown on the Schedule of Benefits.

Item 1. under the section titled "Limitations to Health Benefits Provided by this Policy" shall read as follows:

1. Mental Illness/Nervous Disorders & Chemical Dependency
 - a. Expense incurred as a result of mental illness/nervous disorders will be considered covered expenses under this policy, except that, during a calendar year, we will not pay for more than:
 1. 45 days of inpatient treatment; or
 2. 35 visits for outpatient treatment for group and individual therapy.

The expense is subject to all other policy provisions.

- b. The benefit payable for the treatment of chemical dependency including alcoholism and drug addiction, is limited to 50% of the covered expenses in excess of the deductible amount. (END OF OPTIONAL BENEFITS)

LIMITATIONS TO HEALTH BENEFITS PROVIDED BY THIS POLICY

These limitations apply to all health benefits provided by this policy.

Covered expenses incurred for certain types of medical treatment are limited. When an insured receives any of the following types of treatment, the benefits will be paid as explained below:

1. Mental Illness/Nervous Disorders & Chemical Dependency
 - a. The benefit payable for all treatment of mental illness/nervous disorders is limited to 50% of all covered expenses in excess of the deductible amount.
 - b. The benefit payable for all treatment of chemical dependency including alcoholism and drug addiction, is limited to 50% of the covered expenses in excess of the deductible amount.
2. Manipulative Therapy
 - a. The benefit payable for outpatient treatment consisting primarily of manipulative therapy is limited to 50% of all covered expenses in excess of the deductible amount.
3. Sterilization Procedures

The benefit payable for all sterilization procedures is limited to 50% of all covered expenses incurred as a result of the procedure which are in excess of the deductible amount. However, no benefit will be payable for a sterilization procedure performed during the insured patient's first 12 months of coverage under this policy or the former policy.

BENEFIT LIMITATIONS FOR PREEXISTING CONDITIONS

Benefit limitations for preexisting conditions will only apply until the Policy's renewal date in 2014. The Group Master Policy will reflect the renewal date. After the renewal date in 2014, there are no benefit limitations for preexisting conditions.

If an insured, over the age 19, is not a late enrollee, any expense incurred for treatment of a preexisting condition during the insured's first 12 months of coverage under this policy will not be considered a covered expense. We begin counting the 12 month period from the enrollment date. The 12 month period will be reduced by the number of days of qualifying creditable coverage the insured has as of the enrollment date.

If an insured, over the age 19, is a late enrollee, any expense incurred for treatment of a preexisting condition during the insured's first 18 months of coverage under this policy will not be considered a covered expense. We begin counting the 18 month period from the enrollment date. The 18 month period will be reduced by the number of days of creditable coverage the insured has as of the enrollment date.

Preexisting condition means any illness or injury, whether physical or mental, for which medical advice, care, or treatment was recommended for or received by the insured within the six month period before his/her enrollment date. However, a pregnancy will not be considered a preexisting condition.

For the purposes of this section, treatment means:

1. any examination, diagnostic test, or actual treatment by a physician, which demonstrates the presence of an illness or injury, or symptoms of an illness or injury;

2. any medication or other service or supply dispensed in regard to an illness or injury or symptoms of an illness or injury;
3. any checkup or examination to determine if a previously existing illness or injury is recurring.

If an insured was covered under the former policy when this policy replaced it, and he/she became insured on this policy's effective date, his/her benefits for a preexisting condition will be the lesser of:

1. the benefits of this policy without the application of the preexisting condition limitation; or
2. the benefits of the former policy.

EXPENSE NOT COVERED BY THE PLAN

These exclusions apply to all health benefits of this policy.

1. This insurance does not cover loss caused by:
 - an act of war;
 - service in the armed forces;
 - suicide, attempted suicide, or intentionally self-inflicted injury, whether sane or insane;
 - complications arising from excluded treatment, except for complications of pregnancy;
 - commission of a felony or illegal occupation; This does not include emergency or other medical, hospital or surgical expenses, which would otherwise be a Covered Expense, if Treatment is incurred as a result of an injury sustained while an Insured is either intoxicated or under the influence of a narcotic, regardless of the condition under which the substance was administered. Intoxication will be defined by the state where the accident occurred.
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 this policy;
 - incidental appendectomies;
 - treatment of educational or training problems, learning disorders, marital counseling, or social counseling;
 - services provided by an employee of a school district, or a person contracted to provide services for a school district, or services available through a school system;
 - any experimental/investigational service, supply, or treatment;
 - the use of any services or facilities of a federal, Veteran's Administration, state, county or municipal hospital, except where we or the insured are legally required to pay the expenses;
 - treatment of an injury or illness caused by or resulting from an illness or injury of the insured, 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 this policy until the insured certifies he/she no longer intends to pursue coverage through the worker's compensation type coverage;
 - hearing aids, eyeglasses, frames, contact lenses, dentures;
 - any dental treatment, dental surgery, or extractions, except for the treatment of injuries to whole natural teeth. The injury must have occurred while the insured was covered under this policy or the former policy. The treatment must be performed during the first 12 months after the date of injury;
 - any service or supply not recommended or approved by a licensed medical practitioner;
 - any treatment or surgery that results in the improvement of appearance, except for that which is the result of an injury. The injury must have occurred while the insured was covered under this policy or the former policy. The treatment must be performed during the first 12 months after the date of injury;

- services or supplies that are not for the diagnosis or treatment of an existing illness or injury, except as provided under any Wellness Benefit for Preventive Care;
- eye examinations for the correction of vision or fitting of glasses or contact lenses, immunizations or vaccinations, including Synagis or similar immunization agents, except as provided under any Wellness Benefit for Preventive Care;
- abortions, except where the mother's life is threatened;
- normal pregnancy or childbirth, including expense incurred for a well newborn's initial hospital confinement, except as may be provided in this policy under a specific provision titled "Pregnancy Like Any Illness". However, expense that is in excess of the amount incurred for a normal delivery, and that is incurred for a complication of pregnancy, will be considered covered expense;
- any orthodontic procedure or appliance;
- more than one ultrasound examination for a normal pregnancy;
- amniocentesis, except for the diagnosis or treatment of an existing complication of pregnancy;
- reversal of sterilization procedures;
- nonmedical services and supplies;
- durable medical equipment unless we have pre-authorized the purchase or rental of the equipment;
- any service or supply that the insured is not legally required to pay for, including any forgiveness of deductible, or coinsurance by a provider;
- any surgery for the correction of a refractive error;
- treatment received in the emergency room of a hospital, except when emergency services are being rendered;
- the replacement of a piece of durable medical equipment or a prosthesis;
- custodial care;
- services furnished by the insured or a member of his/her or his/her spouse's immediate family, or by a person who regularly lives in his/her home;
- hospital charges for the first weekend in the hospital if the insured is admitted to a hospital on a Friday, Saturday, or Sunday, except when the admission is for emergency services, or when surgery is performed the next morning.
- treatment related to the restoration of fertility or promotion of conception including in vitro fertilization, except as may be provided in this policy under the provision titled "Infertility Benefit/In Vitro Fertilization Benefit";
- nutritional supplements;
- animal to human organ transplants;
- replacement of human organs by artificial or mechanical devices;
- treatment of nicotine, caffeine, gambling, computer, or similar addictions;
- any medical treatment, surgical procedure, weight reduction program, membership dues, or clinic fees for the treatment of obesity, including morbid obesity; any surgical procedure to remove excess tissue caused by weight loss;
- services provided by a midwife, except where specifically licensed by the State to practice midwifery;
- a sterilization procedure performed during the insured patient's first 12 months of coverage under this policy or the former policy;
- by a registered nurse (RN) for private duty professional nursing services;
- sclerotherapy for varicose veins;
- for devices used specifically as safety items or to affect performance primarily in sports-related activities;

- medical or surgical treatment of upper or lower jaw alignment conditions or malformations, including orthognathic surgery, except for:
 - direct treatment of acute traumatic injury or cancer; or
 - as may be provided in this policy under the provision titled "Temporomandibular Joint Disorder/Craniomandibular Disorder";
- wigs or hair prosthesis;
- routine foot care related to corns, calluses, flat feet, fallen arches, weak feet, or chronic foot strain, except that routine foot care for patients with diabetes will be covered; shoe inserts, casting for orthotics, and orthotics;
- physical conditioning programs such as athletic training, body-building exercises, fitness and flexibility programs;
- surrogate parenting;
- the services of a massage therapist, athletic trainer, or masseuse; acupuncture or acupressure treatment;
- sexual transformation;
- breast reduction surgery, except when performed in conjunction with reconstructive surgery following a mastectomy;
- treatment performed outside the United States, except when an emergency;
- removal of breast implants that were implanted solely for cosmetic reasons;
- 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;
- self-injected prescription medications, except when pre-approved by us;
- any oral prescription medication that was purchased without using the discount drug card that we provide;
- over the counter medications;
- the difference between the cost of a Brand name drug and an Equivalent Generic drug;
- duplicate prescriptions or prescriptions refilled more frequently than the prescribed dosage indicates;
- fluoride supplements, minerals, Minoxidil for the treatment of alopecia, or vitamins.

PRE-CERTIFICATION PROGRAM

To qualify for full benefits under the policy, you must call the Pre-certification Hotline if:

1. you are going to be admitted as an inpatient to a hospital or skilled nursing facility; or
2. you are going to have surgery performed outside of your primary care physician's office.

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 scheduled for non-emergency surgery outside of the primary care physician's office or admitted to a hospital or skilled nursing facility for an inpatient stay.

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 Pre-certification Hotline must be called 2 months before the expected date of delivery. The Hotline must be called again the day of delivery.

INFORMATION NEEDED

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

1. the insured patient's name, date of birth, sex, and the social security number of the insured;
2. the policy number;
3. the proposed (or actual) date and reason for admission or surgery;
4. the name and phone number of the hospital (or skilled nursing facility) and admitting physician;
5. 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 hospital (skilled nursing facility) or your physician should contact the reviewer, who will again review your case.

MEDICAL NECESSITY

No benefits will be payable for any confinement or surgery 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, surgery, 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 Precertification Hotline.

FAILURE TO PRECERTIFY

If an insured fails to have his/her admission or surgery pre-certified, then the first \$500 of covered expense incurred as a result of the admission or surgery will not be covered under this policy, in addition to any medically unnecessary expense.

DISCONTINUANCE & REPLACEMENT PROVISIONS

The provisions listed on this page only apply to persons insured under the former policy on the day before this policy became effective, and who have been continuously insured under this policy since this policy's effective date.

DEDUCTIBLE CREDIT PROVISION

An insured's deductible for the first calendar year this policy is in force can be reduced by any expense that:

1. was applied to his/her deductible under the former policy for this calendar year; or
2. was incurred during the 90 day period prior to the date this policy became effective, and was applied to the deductible under the former policy.

COINSURANCE CREDIT PROVISION

An insured's coinsurance share amount for the first calendar year this policy is in force can be reduced by the amount of expense that was applied to his/her coinsurance share amount under the former policy for the same calendar year.

RECEIVING CREDIT

To receive credit under these provisions, each insured must provide us with proof of the amount of credit earned under the former policy. This proof must be acceptable to us. It must be submitted at the same time he/she files his/her first claim under this policy.

MEDICARE AS PRIMARY PAYER

When Medicare is primary payer, we will coordinate our benefits with Medicare in accordance with the "Coordination of Benefits" provision in the policy.

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.

COORDINATION OF BENEFITS

If an insured has medical or dental coverage under another group-type plan, we will coordinate our benefits with those of that plan. One plan is primary. One plan is secondary. The primary plan pays its regular benefits. The secondary plan pays a reduced amount, which when added to the benefits paid by the primary plan, will normally equal 100% of the allowable expense. The benefits payable under the secondary plan cannot exceed the benefit that would be payable if there was no other group-type plan.

RULES FOR ORDER OF PAYMENT

The primary plan is:

1. the plan which does not coordinate its benefits with any other plan.
2. the plan which covers the person as an employee or student, rather than as a dependent. (However, if a person is also a Medicare beneficiary, 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, for example a retired employee.)
3. the plan of the parent whose birthday (excluding year of birth) occurs earlier in a calendar year, if both parents are living together. If both parents have the same birthday, the plan that has covered a parent the longest is primary. If the other plan does not have this provision in their policy, then the plan which insures the father as an employee will be primary, rather than the plan which insures the mother as an employee.
4. the plan of the parent with custody of the child, if the parents are divorced or separated. The secondary plan will be the plan of the spouse of the parent with custody. The final plan will be the plan of the parent without custody.
5. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, then the plan of the parent who has responsibility will be primary over the other parent or stepparent's plan. This provision does not apply until we have been informed of the terms of the court decree. Any benefits paid prior to our knowledge of the terms of the court decree will be subject to the other sections of this provision.
6. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, then the plan of the parent whose birthday occurs earlier in the calendar year is primary.
7. the plan which covers a person as an active employee, rather than the plan which covers the person as a laid-off or retired employee. The primary plan is the plan which covers the person as a dependent of an active employee, rather than the plan which covers the person as a dependent of a laid-off or retired employee.
8. the plan which insures the person as an employee, or the dependent of an employee, rather than the plan which insures the person under any continuation coverage. If the other plan does not have a rule regarding continuation coverage, and as a result, the plans do not agree on which plan is primary, then this rule will be ignored.
9. If none of the above rules apply, then the plan which has covered the insured person the longest is the primary plan. The length of time a person has been covered under a plan is measured from the claimant's first date of continuous coverage with the Policyholder.

BENEFIT CREDIT AS SECONDARY PLAN

If the amount we pay as the secondary plan is less than the amount that we would have paid as the primary plan, a benefit credit will exist. We, as the secondary plan, can use this benefit credit to pay other allowable expenses incurred by the same insured during the same calendar year as the benefit credit occurred.

RIGHT TO RECEIVE AND RELEASE INFORMATION

We have the right to seek and to release any necessary information to any other insurance company or organization, for the purpose of implementing this provision. We can do this without consent or notice to any concerned person. Any person claiming benefits under this policy must provide us with any necessary information to implement this provision.

REIMBURSING THE OTHER PLAN

If another plan has paid their benefit in error according to this provision, we can make payment directly to them to satisfy the intent of this provision. Any payment made by us for this reason will fully discharge us of any liability under this plan.

RIGHT TO RECOVERY

If we made a payment in error, we can recover our payment from the other plan, the insured, or anyone else to whom we have made payment, so as to satisfy the intent of this provision.

RIGHT OF REIMBURSEMENT

If an insured incurs expenses for illness or injury that occurred due to the negligence of a third party:

1. 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 at 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
2. 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.

BENEFIT EXTENSION AFTER TERMINATION

If an insured is totally disabled at the time this entire policy ends, then the major medical insurance provided by this policy will continue only for the illness or injury which caused the total disability. It will continue only for that illness or injury until the earliest of the following dates:

1. 12 months after termination;
2. the date the maximum benefit is paid;
3. the date the insured is no longer totally disabled;
4. the date the succeeding carrier's plan provides coverage for the illness or injury.

ILLINOIS CONTINUATION OF HEALTH INSURANCE COVERAGE AFTER TERMINATION OF EMPLOYMENT

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

1. he/she has been insured under this group policy, or the former policy for three consecutive months before his/her insurance would end; and
2. he/she is not covered by Medicare; and
3. he/she is not covered under any group health insurance that becomes effective after his/her termination of employment date; and
4. he/she does not exercise his/her conversion privilege upon termination of employment; and
5. he/she has not been fired from his/her job because:

- a. he/she committed a felony in connection with work; or
- b. he/she stole from his/her employer.

His/her employer must not have been responsible for his/her actions in any way. He/she must have either admitted his/her guilt or been convicted by a court for the act.

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

1. the date insurance would end due to termination of employment; or
2. the date the insured is given written notice of the right to continuation by the Policyholder;

but in no event later than 60 days after insurance would otherwise end.

The insured employee must pay the entire premium to the Policyholder in advance every month.

Any dental, vision care, or weekly income benefits will not be continued under this provision. All health insurance benefits provided under this provision are subject to this policy's provisions, exclusions, and limitations.

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

1. the date the insured becomes eligible for Medicare;
2. the date the insured becomes covered under group health insurance that has an effective date after his/her termination of employment date;
3. the date 12 months from the date his/her insurance would have ended due to termination of employment;
4. the date he/she fails to pay any premium due; or
5. the date this entire group policy terminates.

RIGHTS FOLLOWING CONTINUATION

An insured may be able to convert his/her insurance to an individual conversion policy if his/her continuation is ending because his/her insurance has been continued for the maximum period allowed by law. An insured's conversion rights are outlined under the provisions regarding conversion of health benefits in this policy.

ILLINOIS SPOUSAL AND DEPENDENT CONTINUATION

An insured employee's spouse may continue this policy beyond when it would usually terminate, if it should terminate because:

1. the insured employee dies; or
2. the insured employee and insured spouse legally dissolve their marriage; or
3. the insured employee retires, and the spouse is at least age 55 at the time of retirement.

The insurance of any insured dependent children may also be continued. In addition, an insured employee's dependent child may continue this policy beyond when it would usually terminate, if it should terminate because the insured employee dies and the child is not eligible for coverage as a dependent under the Spousal Continuation or has attained the maximum age for eligibility for children under this policy.

If the insured spouse wishes to continue his/her insurance, he/she must provide both the Policyholder and us with written notice of the divorce, or the death or retirement of the employee. The notice must be provided within 30 days after the date of divorce, death, or retirement. In the event of the death of the employee, if the dependent child wishes to continue his/her insurance, the dependent child or a responsible adult acting on behalf of the dependent child must provide the Policyholder or us written notice of the death of the employee within 30 days of the date the coverage terminates.

After the Policyholder receives the notice from the spouse or the dependent child, the Policyholder has 15 days to provide us with written notice of the dissolution of the employee's marriage, the retirement of the employee, or the death of the employee, and that former spouse's or retired employee's residence address or the dependent child's residence address. The Policyholder must send the spouse or the dependent child a copy of the notice that is sent to us. The copy must be sent to the spouse's or child's residence address.

After we receive notice from the spouse or the Policyholder, or from the dependent child or responsible adult acting on behalf of the dependent child, we will send the spouse, the dependent child, or responsible adult at the child's residence information that the insurance may be continued for that retired employee's spouse or former spouse and covered dependents, or for the dependent child. This information will be sent within 30 days after we receive the notice. It will be sent by certified mail, return receipt requested. The information will include:

1. a form for election to continue the insurance coverage;
2. the amount of the premium;
3. the method and place of premium payments; and
4. instructions for returning the election form within 30 days after the date it is received from the insurance company.

The spouse, dependent child or responsible adult acting on behalf of the dependent child must return the election form and the first premium to us within 30 days after we send the form. If we do not receive it, the continuation coverage and the right to continuation benefits terminates.

If we do not send the information within 30 days after we receive notice, then:

1. coverage will automatically continue until the information is sent; and
2. all premium will be waived until we send the information.

However, if this entire policy is terminated before we can send the information, then the former spouse's or dependent child's insurance will not be continued beyond this policy's termination date.

TERMINATION OF COVERAGE UNDER THIS PROVISION

1. If a former spouse was under age 55 when his/her coverage began under this continuation provision, his/her insurance will end on the earliest of the following dates:
 - a. the date he/she fails to pay any premium when it is due;
 - b. the date his/her insurance would have ended (except due to the retirement of the insured employee) under the terms of this policy if the spouse and the insured employee were still married to each other. However, coverage under this provision will not terminate during the first 120 days after it begins, except when this entire policy is terminated;
 - c. the date he/she first becomes an insured employee under any other group health plan that he/she was not covered under on the date his/her insurance began under this provision;
 - d. the date he/she remarries;
 - e. the date two years after his/her insurance was continued under this provision; or
 - f. the date this entire policy terminates.
2. If a retired employee's spouse or a former spouse was age 55 or over when his/her coverage began under this continuation provision, his/her insurance will end on the earliest of the following dates:
 - a. the date he/she fails to pay any premium when it is due;
 - b. the date his/her insurance would have ended (except due to the retirement of the insured employee) under the terms of this policy if the spouse and the insured employee were still married to each other. However, coverage under this provision will not terminate during the first 120 days after it begins, except when this entire policy is terminated;
 - c. the date he/she first becomes an insured employee under any other group dental plan that he/she was not covered under on the date his/her insurance began under this provision;
 - d. the date he/she remarries;
 - e. the date he/she reaches the qualifying age or otherwise establishes eligibility under the Medicare program;
 - f. the date this entire policy terminates.
3. The dependent child's insurance will end on the earliest of the following dates:
 - a. the date he/she fails to pay any premium when it is due;

- b. when coverage would terminate under the terms of this policy if the dependent child was still an eligible dependent of the employee;
- c. the date on which the dependent child first becomes, after the date of election, an insured employee under any other group health plan; or
- d. the expiration of 2 years from the date continuation coverage began.

RIGHTS FOLLOWING SPOUSAL OR DEPENDENT CONTINUATION COVERAGE

An insured spouse or the insured dependent child may be able to convert the insurance to an individual conversion policy, if his/her continuation is ending because his/her insurance has continued for the maximum period allowed by this provision. Conversion rights are outlined under the provision "Conversion Privilege - Changing to an Individual Health Policy".

FEDERAL CONTINUATION OF HEALTH COVERAGE AFTER TERMINATION

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

Under certain circumstances, an insured has the right to continue his/her health insurance beyond the date that it would normally end. The health insurance coverage that can be continued is the same coverage that is provided to insureds whose coverage has not ended. However, any weekly income benefits for total disability cannot be continued.

CONTINUATION RIGHTS

1. An insured's health insurance can be continued for a maximum period of 18 months, if it is ending because:
 - a. the insured employee's employment terminated for reasons other than gross misconduct; or
 - b. the insured employee had his hours reduced.

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. An insured's health insurance 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:
 - a. his/her insurance is ending because of one of the reasons listed above; and
 - b. 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
 - c. 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.

3. An insured dependent's health insurance can be continued for a maximum period of 36 months, if his/her insurance is ending because:
 - a. the insured employee dies;
 - b. a divorce or legal separation has occurred;
 - c. the insured dependent child no longer meets this policy's definition of a dependent child;
 - d. the insured employee became covered by Medicare.
4. An insured dependent's health coverage can be continued for at least 36 months from the date the insured employee became covered by Medicare, if his/her insurance ends for any of the above-listed reasons.
5. An insured can continue his/her insurance for 36 months, if:
 - a. 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

- b. he/she retired after the Ch. 11 bankruptcy proceeding; or
 - c. he/she is an insured dependent of a retiree who died after a Ch. 11 bankruptcy proceeding.
6. An insured can continue his/her insurance for his/her lifetime, if:
- a. 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
 - b. he/she is a retiree who retired before the Ch. 11 bankruptcy proceeding; or
 - c. 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: an insured child no longer meets the policy's definition of an insured dependent child.
 - a. a divorce or legal separation;
 - b. 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.

INSURED'S 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:

1. the date the maximum continuation period has been exhausted;
2. the date the employer ceases to maintain any group health plan for any employee;
3. the date the insured is covered by another group health plan which does not include a preexisting condition clause or which would have the preexisting condition limitation period reduced by qualifying COBRA continuation coverage;
4. the date the insured becomes covered by Medicare;
5. the date any premium that is due is not paid within the time allowed.

An insured's continuation will terminate anytime this policy is terminated.

RIGHTS FOLLOWING COBRA CONTINUATION

An insured may be able to convert his/her insurance to an individual conversion policy, if his/her continuation is ending because his/her insurance has continued for the maximum period allowed by this provision. Conversion rights are outlined under the provision "Conversion Privilege - Changing to an Individual Health Policy."

CONVERSION PRIVILEGE - CHANGING TO AN INDIVIDUAL HEALTH POLICY

The insured or insured dependent may convert his/her medical benefits to an individual health policy without evidence of insurability. The Policyholder must notify him/her of this conversion privilege. The individual health policy will provide benefits for hospital room and board, miscellaneous hospital expenses, and surgical and in-hospital expenses. The benefit will be at least equal to any minimum requirements for conversion policies in the state of delivery. The policy will be on a form currently being issued by us as a group health conversion policy.

To convert benefits, an insured or insured dependent must:

1. have been continuously covered for medical benefits under this policy, or the former policy, for three months immediately prior to termination of coverage under this policy; and
2. have had his/her coverage under this policy terminated for any reason other than:
 - a. termination of this entire policy because a new entity is going to insure this group; or
 - b. failure to pay any premiums due; and
3. not be eligible for Medicare; and
4. not be eligible for any other health insurance, which together with the conversion policy, would result in overinsurance; and
5. submit a written application and pay the first premium. The application and premium must be submitted to our Home Office at 2505 Court, Pekin, IL 61558, within 31 days after termination under this policy; or within 15 days after the insured has been given written notice of the existence of the conversion privilege, but in no event later than 60 days after his/her termination.

The individual health policy that is issued will become effective immediately upon termination under this policy.

The premium for the conversion policy will be determined by the rate tables being used by us when application is made.

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 as if he/she was not on leave.

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

TERMINATION OF HEALTH INSURANCE

Health insurance benefits will end on the earliest of the following dates:

1. the date that any portion of the health premium that is due is not paid;
2. the premium due date following the date the employee no longer qualifies under this or another policy continuation provision;
3. the date this policy terminates;
4. the premium due date following the date the employee gives notice of an intent not to return to work.

If coverage is terminated for any reason other than nonpayment of premium, or the termination of the entire policy, then the employee may be able to continue his/her health insurance 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 any life, accidental death and dismemberment, disability, health, and dental benefits 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.

COMPLAINTS

It is our policy to treat each claim submission fairly. If, however, you are not satisfied with our handling of a claim, you may want us to reconsider a decision or may have additional information that could change our decision. You can appeal a claim decision by writing to:

LIFE & HEALTH CLAIM COMMITTEE
PEKIN LIFE INSURANCE COMPANY
2505 COURT STREET
PEKIN, IL 61558

You can also write to the State Insurance Department. The addresses are:

ILLINOIS DEPARTMENT OF INSURANCE
CONSUMER DIVISION
122 S. MICHIGAN AVE, 19TH FLOOR
CHICAGO, IL 60603

Or

ILLINOIS DEPARTMENT OF INSURANCE
CONSUMER DIVISION
320 WEST WASHINGTON STREET
SPRINGFIELD, IL 62767