Beyond the expected®
PEKIN®
INSURANCE

CERTIFICATE OF INSURANCE

The following states the name of the insured employee, whether dependent coverage is provided, the employee's original effective date, the date of the most recent change, and the types of insurance in effect for the insured.

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.

NOTICE: Precertification or preauthorization does not guarantee coverage for or the payment of the service or procedure reviewed.

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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.

AUTISM SPECTRUM DISORDERS

Autism spectrum disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder and autism spectrum disorders not otherwise specified

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. adopted child:
        1. that has been placed for the purpose of adoption, or
        2. for which an entry of an order granting the adoptive parent custody of the child for purposes of adoption has occurred;
    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 one of the following:
    a. under 26 years of age; or
    b. An unmarried Child who is totally and permanently disabled, physically or mentally. The child must have become disabled before he/she became 26 years of age.

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.

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.

COPAY

The specified dollar amount that you are required to pay towards a covered expense. Copay amounts for different services are shown on the Schedule of Benefits.

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 the RX 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

The spouse and 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. is mainly engaged in providing medical and diagnostic services;
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

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 means:

1. a pregnancy or complication of pregnancy;
2. a congenital defect or birth abnormality for a child who was continuously insured from birth under this policy.

IMMEDIATE FAMILY

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

IN VITRO FERTILIZATION

Means any attempt at laboratory-produced conception, including but not 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.

INJURY

Bodily injury caused by an accident.

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 COINSURANCE SHARE

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

1. any copay 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 amount the insured had to pay unde the prescription drug card benefit;
4. any penalty for noncompliance with plan requirements;
5. any out of network coinsurance share; or
6. 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 DEDUCTIBLE

The amount of covered expense for services provided by a preferred provider that must be incurred in a calendar year by an insured before any covered expense is paid by us. It is equal to the lessor of:

1. the amount specified under the In-Network Individual Deductible amount shown on the Schedule of Benefits.
2. the amount needed to satisfy the In-Network Family Deductible amount shown on the Schedule of Benefits.

The amount of covered expense that is incurred during the last three months of a calendar year and applied to that year's In-Network deductible for an insured, will be used to reduce the In-Network Individual Deductible for that insured for the following calendar year.

Copay, Out of Network Deductible, and prescription deductible and copay amounts will not be used to satisfy the In-Network deductible amount.

IN-NETWORK FAMILY DEDUCTIBLE

The maximum amount of deductible an insured family must pay in a calendar year for services provided by preferred providers. This amount is shown on the Schedule of Benefits. The In-Network Family Deductible may be satisfied by combining all amounts applied to In-Network Individual Deductibles for the insured employee and the insured employee's dependents for the calendar year. However, only covered expense that is incurred in a calendar year and applied to that same calendar year's In-Network Individual Deductible can be used to satisfy the In-Network Family Deductible.

IN-NETWORK INDIVIDUAL DEDUCTIBLE

The maximum amount of major medical deductible that an individual insured must pay in a calendar year for services provided by preferred providers.

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.

It does not mean an employee who is employed by a small employer that offers multiple health insurance plans and who elects a different plan during an open enrollment period.

MAIL ORDER PRESCRIPTION COPAY AMOUNT

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

MAINTENANCE MEDICATION

Means a medication designated by RX Company as being a maintenance medication, and listed on the RX Company's maintenance medication list.

MANIPULATIVE THERAPY

Treatment consisting primarily of manipulation, heat, ultrasound, diathermy or similar types of treatment, regardless of the medical degree of the person providing the 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. panic disorder;
5. attention deficit disorder;
6. conduct disorder;
7. adjustment disorder; and

8. similar conditions or illnesses.

A pervasive developmental disorder will be considered an illness, but not a mental illness/nervous disorder.

MINOR

A person who is under the legal age of competence.

MORBID OBESITY

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

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

NEWBORN CHILD

A dependent child born to the employee while he/she is insured under 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, it does not mean a provider within 50 miles of the insured's residence if the nearest Preferred Provider is more than 50 miles from the insured's residence.

OUT OF NETWORK

Means covered expense provided by a non-preferred provider.

OUT OF NETWORK COINSURANCE SHARE

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

1. any copay or 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 amount the insured had to pay under the prescription drug card benefit;
4. any penalty for noncompliance with plan requirements;
5. any In-Network coinsurance share; or
6. expense an insured would pay as a result of an organ transplant at a non-designated transplant facility.

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

OUT OF NETWORK DEDUCTIBLE

The amount of covered expense for services provided by a non-preferred provider that must be incurred in a calendar year by an insured before any covered expense is paid by us. It is equal to the lessor of:

1. the amount specified under the Out of Network Individual deductible amount shown on the Schedule of Benefits.

2. the amount needed to satisfy the Out of Network Family Deductible amount shown on the Schedule of Benefits.

The amount of covered expense that is incurred during the last three months of a calendar year and applied to that year's Out of Network deductible for an insured, will be used to reduce the Out of Network Individual Deductible for that insured for the following calendar year.

Copay, In-Network deductible, and prescription deductible and copay amounts will not be used to satisfy the Out of Network amount.

OUT OF NETWORK FAMILY DEDUCTIBLE

The maximum amount of deductible an insured family 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 Deductible may be satisfied by combining all amounts applied to Out of Network Individual Deductibles for the insured employee and the insured employee's dependents for the calendar year. Ho wever, only covered expense that is incurred in a calendar year and applied to that same calendar year's Out of Network Individual Deductible can be used to satisfy the Out of Network Family Deductible.

OUT OF NETWORK INDIVIDUAL DEDUCTIBLE

The maximum amount of major medical deductible that an individual insured must pay in a calendar year for services provided by non-preferred providers.

PERVASIVE DEVELOPMENTAL DISORDER

Means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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.

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. Periodically, we will provide a Preferred Provider directory for your reference. We make every effort to ensure the accuracy of the directory; however, there will be providers who are added or deleted following the date you receive the directory. We recommend that you verify that the provider you are using or considering is currently a preferred provider.

PRESCRIPTION COPAY

The amount the insured must pay after the prescription deductible has been met for each prescription order for the lesser of a 34 day supply or 100 unit doses, obtained at a retail pharmacy. It is shown on the Policyholder's Schedule of Benefits and the insured's Certificate of Insurance.

PRESCRIPTION DEDUCTIBLE

The amount of covered prescription expense that must be incurred by each insured in a calendar year, before any benefit is payable under the prescription drug card program. It is shown on the Policyholder's Schedule of Benefits and the insured's Certificate of Insurance. Any expense applied to the prescription deductible cannot be used to satisfy any other deductible amount. Any expense applied to any other deductible amount cannot be used to satisfy the prescription deductible.

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 lessor 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 an 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 or husband.

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
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 is covered from the moment of birth. The newborn child is covered without premium charge for the first 31 days after birth. In order for coverage to extend beyond the first 31 days after birth, you must apply for coverage for the newborn and pay any premium due within 31 days after the newborn's birth.

Coverage for a newborn shall consist of coverage of injury or illness, including but not limited to benefits for inpatient or outpatient expense arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate.

A well newborn's initial hospital confinement will only be considered covered expense if we are paying benefits for the mother's pregnancy under the benefit titled "Pregnancy Like Any Illness."

4. ADOPTED CHILDREN

An adopted child is covered from the earliest of:

a. the date of placement for the purpose of adoption; or
b. the date of the entry of an order granting the adoptive parent custody of the child for purposes of an adoption.

The adopted child is covered without premium charge for the first 31 days after the earliest of the above dates. In order for coverage to extend beyond the first 31 days after the earliest of the above dates, you must apply for coverage for the adopted child and pay any premium due within 31 days after the earliest of the above dates.

Any pre-existing condition limitation will not apply to an adopted child enrolled under this provision.

5. 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.

6. 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.

7. 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 INSUREDS

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 Dependent's insurance has a retroactive effect to the Effective Date under the policy; or
   e) The date of the employee's death.
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 mental retardation or mental or physical disability 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. Proof of incapacity and dependency must be furnished to us within 120 days of the date the child no longer meets the definition of a dependent as defined in this policy. During the first two years following the child's attainment of the limiting age, we may request proof of incapacity at reasonable intervals. After two years following the child's attainment of the limiting age, we will not require proof of incapacity more often than once a year.
   c. the date that any portion of the premium that is due is not paid

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 within 15 days after we receive notice of a claim, a claim may be filed without using them. Such claims must contain wr itten 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.

PAYMENT OF CLAIMS

All benefits payable under the policy will be paid within 30 days for an electronic claim, or 45 days for a paper claim, once we receive all information required to determine liability under the terms of the policy. If we do not pay the claim within that time limit, we will pay interest on the claim to the assignee (or insured if unassigned) in the amount required by IC 27-8-5.7.

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 $5,000.00 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. 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 other services provided by a Preferred Provider, covered expense equal to the In-Network deductible must be incurred in a calendar year. We will then pay benefits for covered expense provided by a preferred provider that are in excess of the 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"). If the amount of covered expense you pay for In-Network coinsurance share during a calendar year equals the In-Network Maximum Coinsurance Share, we will then pay the covered expense for these services at 100% for the remainder of the calendar year.

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 Maximum 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 $100 emergency room copay amount. 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 $100 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 $100 emergency room copay amount.

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 Out of Network deductible must be incurred in a calendar year. We will then pay benefits for covered expense provided by a non-preferred provider that are in excess of the 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"). If the amount of covered expense you pay for Out of Network Coinsurance Share during a calendar year equals the Out of Network Maximum Coinsurance Share, we will then pay covered expense for these services at 100% for the remainder of the calendar year.

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 Maximum Coinsurance Share.

USE OF NON-PREFERRED PROVIDERS

When you use a non-preferred provider:

1. the amount of payment may be 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 PROVIDED BY A NON-PREFERRED PROVIDER

Emergency care provided by a non-preferred provider will be paid as if the services were provided by a preferred provider.

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, except that insulin and syringes are only covered under the prescription drug card benefit;
   - 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;
   - laboratory tests;
   - Non-experimental, Medically Necessary bariatric surgical procedure when performed to treat Morbid Obesity when
     - Morbid Obesity has persisted for at least five (5) years; and
     - for which nonsurgical Treatment that is supervised by a Physician has been unsuccessful for at least six (6) consecutive months; and
     - the Insured is over the age of 21, unless the Insured is under 21 and two (2) authorized Physicians determine that the surgery is necessary to:
       - Save the life of the Insured; or
       - Restore the Insured's ability to maintain a major life activity

     Each Physician must document in the Insured's medical record the reason for the Physician's determination. Requires Pre-Approval by Us;
   - diagnosis and Treatment of Autism Spectrum Disorder(s) that is prescribed by the Insured's treating physician in accordance with a treatment plan;
   - outpatient physical therapy/manipulative 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;
   - anesthesia (general) and Hospital or ambulatory surgical facility services related to covered Dental services if:
     - an Insured Dependent Child is age 19 or under; or
     - an Insured with a physical or mental impairment that substantially limits one or more of the major life activities and who has a record of or regarded as having such impairment; has a chronic disability; or
     - based on a determination by a licensed dentist and the Insured's treating Physician, the Insured has one or more medical conditions that would create significant or undue medical risk in the course of delivery of any necessary Dental Treatment or surgery if not rendered in a Hospital or ambulatory surgical facility;
   - artificial eyes and larynx;
   - the purchase, repair or replacement of artificial limbs and orthotic custom fabricated braces or supports designed as a component of the artificial limb;
   - 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 preauthorized 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;
- diabetes self-management training and supplies used to test and monitor diabetes;
- breast prosthesis or reconstructive surgery following a mastectomy, including surgery and reconstruction of the other breast to produce a symmetrical appearance;
- the laboratory work for an annual cervical smear or pap smear for female insureds;
- a prostate-specific antigen test, for male insureds age 50 and over, or male insureds under age 50 who are at high risk for prostate cancer;
- for anesthesia and hospital charges for dental care, other than treatment of temporomandibular joint disorder, if the mental or physical condition of the insured requires dental treatment to be rendered in a hospital or ambulatory outpatient surgical center. An insured who has a physical or mental impairment that substantially limits one or more of the major life activities of the individual will be eligible for this benefit. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the utilization standards that will be used for determining whether performing dental procedures necessary to treat the insured's condition under general anesthesia constitutes appropriate treatment;
- a baseline mammogram for women age 35 to 39 years of age;
- an annual mammogram for women 40 years of age or older, or less than 40 years of age and a woman at risk;
- any additional mammography views that are required for proper evaluation;
- for colorectal cancer examinations and laboratory tests for colorectal cancer for any non-symptomatic insured who is at least 50 years of age, or less than 50 years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society; the examinations and laboratory tests shall be in accordance with the current American Cancer Society guidelines;

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. for medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of a newborn's birth defect known as cleft lip and cleft palate.
9. for treatment of a pervasive developmental disorder that is prescribed by the insured's treating physician in accordance with a treatment plan. All copays, deductibles, and maximum dollar limits apply to this treatment. Other exclusions or limitations do not apply to this treatment.

Clinical Trials

Covered Expense includes routine patient costs incurred by a qualified individual who participates in an approved clinical trial. A qualified individual who wishes to participate in an approved clinical trial must use an In-Network Provider if an In-Network Provider is participating in the trial and the In-Network Provider accepts the qualified individual as a participant in the trial. However, if the

approved clinical trial is either conducted outside the state in which the qualified individual resides by an Out-of-Network Provider or there is no In-Network provider conducting the approved clinical trial and accepting the qualified individual in the individual's state of residence, then routine patient costs will be covered as if provided by an In-Network provider.

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

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV Clinical Trial that is (1) conducted in relation to the prevention, detection, or Treatment of cancer or other life-threatening disease or condition and (2) is one of the following:

- Federally funded trials

  The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - The National Institutes of Health.
  - The Centers for Disease Control and Prevention.
  - The Agency for Health Care Research and Quality.
  - The Centers for Medicare & Medicaid Services.
  - A bona fide Clinical Trial Cooperative group or center of any of the entities described in clauses 1) through 4) above or the Department of Defense or the Department of Veterans Affairs.
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - Any of the following in clauses a. - c. below if the following conditions are met: The study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
    - The Department of Veterans Affairs
    - The Department of Defense
    - The Department of Energy; or.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- The study or investigation is a drug trial that is exempt from the investigational new drug application requirements.

Life-threatening condition

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

Qualified Individual

An Insured who meets the following conditions:

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

Routine Patient Costs

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

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

Clinical Trial participation requires Pre-Approval by Us.

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 aquisition

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.

PRESCRIPTION DRUG CARD BENEFIT

The prescription drug card benefit provides benefit for expense incurred for drugs which require a written prescription, and which are dispensed by a licensed pharmacist. The program also provides benefit for expense for insulin, syringes for administration of insulin, test strips for glucose monitors, and glucagon emergency kits, when prescribed by a physician and dispensed by a licensed pharmacist.

This prescription drug card benefit is administered by the prescription drug card company, hereafter referred to as the RX Company.

AMOUNT OF BENEFIT

Before any benefits are paid by us, allowable covered expense for prescription drugs equal to the prescription deductible must be incurred in a calendar year. After the prescription deductible has been met, the insured must then pay a prescription copay amount each time he places a prescription order. The amount of copay he/she must pay will vary by the type of medication purchased, and the place of purchase.

ALLOWABLE COVERED PRESCRIPTION EXPENSE

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

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

1. non-injectable legend drugs;
2. insulin on prescription;
3. disposable insulin needles/syringes;
4. glucagon emergency kits;
5. Tretinoin, all dosage forms (Retin-A), for individuals through the age of 25 years;
6. compounded medication if at least one ingredient is a legend drug;
7. any other drug which, under the applicable state laws, may only be dispensed upon the written prescription of a physician or other lawful prescriber;
8. Contraceptives. amino acid-based elemental formulas and medical food, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula or food is Medically Necessary Treatment of PKU, eosinophilic disorders, inherited metabolic diseases or short-bowel syndrome ;
9. Drugs labeled "Caution-limited by federal laws to investigational use", Off-label drugs or Experimental/Investigational drugs but ONLY:
    a. as outlined in - EXPENSES COVERED BY THE PLAN, -. Clinical Trials;
    b. when the drug is recognized for treatment of the condition in at least 1 standard reference compendium; or
10. the drug is recommended for the particular type of cancer it is being used for and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

Any expense considered under this provision will not be considered under any other provision of this policy.

PRESCRIPTIONS PURCHASED AT A RETAIL PHARMACY - LESSOR OF 34 DAY SUPPLY OR 100 UNIT DOSES

You may purchase a prescription drug order at a retail pharmacy, as long as the order does not exceed the lesser of a 34 day supply or 100 unit doses. You must first pay the prescription deductible amount. Once you have paid the prescription deductible amount, you must then pay the applicable prescription copay amount. We will then pay 100% of the amount in excess of the prescription deductible and the prescription copay amount for the prescription drug order. The prescription deductible and prescription copay amounts are shown on the Schedule of Benefits. The "generic prescription copay amount" must be paid anytime you purchase a generic medication. The "preferred brand prescription copay amount" must be paid anytime you purchase a brand medication listed on the preferred brand medication list and for which an equivalent generic drug is not available. The "brand prescription copay amount" must be paid anytime you purchase a brand medication that is not on the "preferred brand medication list" and for which an equivalent generic drug is not available.

We will not allow more than the price we have negotiated with the RX Company for a prescription, less any applicable prescription deductible and copay amount. We will not pay the difference in charge between a brand drug and a generic drug, if the generic drug has been designated an equivalent generic drug.

PRESCRIPTIONS PURCHASED FROM THE MAIL SERVICE PROGRAM

A 90 day supply of a maintenance medication can be obtained from the mail service program. Once you have satisfied the prescription deductible, you must pay the applicable mail order prescription copay amount. We will then pay 100% of the amount in excess of the mail order prescription copay amount for the prescription drug order. The prescription deductible and the mail order prescription copay amounts are shown on the Schedule of Benefits. The "generic mail order prescription copay amount" must be paid anytime you purchase a mail order supply of a generic maintenance medication. The "preferred brand mail order prescription copay amount" must be paid anytime you purchase a brand maintenance medication listed on the preferred brand medication list for which an equivalent generic drug is not available. The "brand prescription mail order copay amount" must be paid anytime you purchase a brand maintenance medication this is not on the "preferred brand medication list" and for which an equivalent generic drug is not available.

We will not pay more than the price we have negotiated with the RX Company for a prescription, less any applicable prescription deductible and copay amount. We will not pay the difference in charge between a brand drug and a generic drug, if the generic drug has been designated an equivalent generic drug.

HOW TO FILE A CLAIM

To file a claim at a retail pharmacy, an insured person should present his/her prescription drug card to a participating pharmacy. The pharmacist will use the card to file the claim with the RX Company.

If an insured does not have his/her prescription drug card at the time he/she wants to purchase a prescription at a retail pharmacy, he/she can file a paper claim with the RX Company. He/she can also file a paper claim with the RX Company for drugs purchased at a nonparticipating pharmacy. It is the insured's responsibility to see that the paper claim is completed with the necessary information, and filed with the RX Company. The RX Company will directly reimburse the insured for any benefit payable.

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

Nonparticipating pharmacy means a pharmacy licensed to dispense prescription drugs which is not a participating pharmacy. It is not a pharmacy in a physician's office, hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution.

To file a claim under the Mail Service Program, an insured must mail the original prescription and the necessary forms to the RX Company Mail Service Program. The necessary forms and instruction brochures can be obtained from the RX Company Mail Service Provider.

PRESCRIPTION DRUG CARD EXCLUSIONS

A prescription drug order does not include and no benefit will be payable for the following, regardless of the reason for which prescribed:

1. the amount of expense for a medication that is in excess of the amount agreed upon between the RX Company and us.
2. the difference between the cost of a Brand Name drug and an Equivalent Generic drug, if the generic drug has been designated an Equivalent Generic drug by the RX Company.
3. for duplicate prescriptions or prescriptions refilled more frequently than the prescribed dosage indicates (a prescription purchased at retail pharmacy cannot be refilled until the patient has used 75% of the medication as prescribed; a prescription purchased at mail order cannot be refilled until the patient has used 60% of the medication as prescribed)
4. any prescription drug that is not intended to be self-administered.
5. medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a Hospital, rest home, sanitarium, Skilled Nursing Facility, convalescent care facility, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

6. drugs dispensed by a physician.
7. fluoride supplements.
8. hematinics.
9. immunization agents, biological sera, blood or blood plasma.
10. injectable drugs, except insulin.
11. minerals.
12. Minoxidil (Rogaine) for the treatment of alopecia.
13. Nicorette (or any other drug containing nicotine or other smoking deterrent medications).
14. anorexiants (any drugs used for purposes of weight control).
15. non-legend drugs other than insulin.
16. Tretinoin, all dosage forms (Retin-A), for individuals 26 years of age or older.
17. Vitamins, singly or in combination, except for legend prenatal vitamins.
18. therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed under allowable covered prescription expense.
19. charges for the administration or injection of any drug.
20. prescriptions which an eligible person is entitled to receive without charge under any Worker's Compensation law.
21. drugs labeled "Caution-limited by federal laws to investigational use", or experimental/investigational drugs, even though a charge is made to the individual.
22. for prescriptions refilled in excess of the number ordered by the physician.
23. for prescriptions refilled after one year from the physician's original order.
24. for prescriptions to replace lost or damaged prescriptions.
25. for prescriptions for the treatment of infertility or in vitro fertilization.

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.

After you pay the Copay amount, we will pay 100% of the reasonable and customary charge for expense incurred for preventive 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; and
6. tuberculosis skin test;
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.

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

HOSPITAL BENEFITS FOR DENTAL SURGERY

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

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 in patient in a hospital.

The expense will be subject to all major medical 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.

If a newborn child needs treatment for an illness or injury, benefits will be available for that care only if the newborn child is insured as a dependent under this policy. To insure your newborn as a dependent under this policy, you must apply for coverage for the newborn and pay any premium due within 31 days after the newborn's birth.

MENTAL HEALTH PARITY BENEFIT

If this policy contains this benefit it will be shown on the Schedule of Benefits. This benefit will replace items 1.a. and 1.b. under the following section titled "Limitations to Health Benefits Provided by this Policy".

Covered expense incurred for the treatment of mental illness/nervous disorders will be paid the same as other covered expenses for covered illness under this policy.

Treatment of substance abuse and chemical dependency when the services are required in the treatment of mental illness/nervous disorders will be paid the same as other covered expense for covered illnesses under the policy.

Treatment of chemical dependency/substance abuse including alcoholism and drug addicition when the treatment is not required for the treatment of mental illness/nervous disorder will be 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, other than the Prescription Drug Card Benefit.

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/Substance Abuse
   a. The benefit payable for the treatment of mental illness/nervous disorders is limited to 50% of the covered expenses in excess of the deductible amount.
   b. The benefit payable for the treatment of chemical dependency/substance abuse including alcoholism and drug addiction is limited to 50% of the covered expenses in excess of the deductible amount.

2. 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 9 months of coverage under this policy will not be considered a covered expense. We begin counting the 9 month period from the enrollment date. The 9 month period will be reduced by the number of days of qualifying 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 activities.
2. This insurance does not pay any benefit for expense for:
   - services that aren't medically necessary;
   - services for which no benefit is defined or described in 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;
- eye examinations for the correction of vision or fitting of glasses or contact lenses;
- hearing aids, eyeglasses, frames, contact lenses, denture;
- 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 breast reconstruction following a mastectomy, cleft lip or cleft palate repair, or which is the result of 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;
- 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;
- 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;
- any oral medication intended to be self-administered except as may be provided under the Prescription Drug Card Benefit;
- durable medical equipment unless we have preauthorized 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, copay, 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 infertility, the restoration of fertility, or the promotion of conception including in vitro fertilization;
- 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;
- 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;
- 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;
- fetal 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;
- any medical treatment not listed in the SECTION "EXPENSES COVERED BY THE PLAN", weight reduction program, membership dues, or clinic fees for the treatment of obesity or morbid obesity, except that surgical treatment of morbid obesity will be covered only if:
  - the morbid obesity condition has persisted for at least 5 years; and
  - for which nonsurgical treatment that is supervised by a physician has been unsuccessful for at least 18 consecutive months;
- any surgical procedure to remove excess tissue caused by weight loss;
- any dental treatment, dental surgery, or extractions, except that the policy will provide coverage 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;
  - treatment of cleft palate or cleft lip for a child who has been continuously insured from birth under this policy;
- any orthodontic procedure or appliance, except that the policy will provide coverage for treatment of cleft palate or cleft lip for a child who has been continuously insured from birth under this policy.

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.

INTEGRATION OF BENEFITS WITH MEDICARE

If an insured is eligible for Medicare and incurs covered expenses for which benefits are payable under this policy, then we will determine if the policy is primary or secondary to coverage provided by Medicare. Primary means that benefits payable under this policy will be determined and paid without regard to Medicare. Secondary means that the total benefit under the policy will first be calculated without taking Medicare into consideration. Once the total benefit has been determined, then Medicare's benefit will be subtracted from the total benefit to arrive at the amount payable.

This policy will always be primary if the insured:

1. is an employee age 65 or older who has current employment status with a Participating Employer that employs at least 20 individuals, or the spouse age 65 or older of an employee who has current employment status with a Participating Employer that employs at least 20 individuals; or
2. is under age 65 and entitled to Medicare due to Social Security Disability, and is covered due to the insured's or a family member of the insured's current employment status with a Participating Employer that employs at least 100 individuals; or
3. is entitled to benefits under Medicare because of end state renal disease (kidney disease) during the "coordination period" prescribed by Medicare regulations (currently the first 30 months).

This policy will be Secondary and Medicare will be the Primary Payer if the insured:

1. is over 65 and has current employment status with a Participating Employer that employs fewer than 20 individuals, or the spouse age 65 or older of an employee who has current employment status with a Participating Employer that employs fewer than 20 individuals; or
2. is under age 65 and entitled to Medicare due to Social Security Disability, and is covered due to the insured's or a family member of the insured's current employment status with a Participating Employer that employs fewer than 100 individuals; or
3. has been entitled to benefits under Medicare because of end stage renal disease (kidney disease) for longer than the "coordination period" prescribed by Medicare regulations (currently 30 months).
4. is over 65 and does not have current employment status or is not the dependent of an individual with current employment status.

When Medicare is the Primary Payer, if an insured does not enroll for coverage under Part A and Part B of Medicare or does not make due claim for Medicare benefits, we will calculate benefits as if the insured were enrolled in both parts of Medicare and full claim for benefits had been made.

We will decide whether this policy is primary or secondary based on the status of the insured on the date the covered expense is incurred.

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.

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 a widow or widower of a retiree who died before the 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:
   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 employee may convert his/her medical benefits to an individual health policy without evidence of insurability. The benefits of the conversion policy will meet the 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 health insurance benefits, an insured employee must:

1. have been continuously covered for health insurance for at least 90 days; and
2. have lost coverage due to:
    a. termination of employment;
    b. reduction of hours; or
    c. marriage dissolution.

The insured employee must apply for a conversion policy with us within 30 days after he/she loses coverage under this policy.

FAMILY AND MEDICAL LEAVE ACT (FLMA) 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.

GRIEVANCE AND APPEALS

A **"Grievance"** means any dissatisfaction expressed to Us by You or Your authorized representative in reference to an adverse decision regarding:

- a determination that a service or proposed service is not appropriate or Medically Necessary;
- a determination that a service or proposed service is Experimental or Investigational;

- the availability of participating providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between You and Us or the Policyholder and Us;
- Our decision to rescind coverage.

Grievance Procedures

If You have received an adverse decision by Us, You may file a Grievance. We will review Your Grievance in accordance with the following procedures. If You need assistance or require further information You may call 1-800-371-9622 and speak to a qualified representative who is knowledgeable about Our Grievance and Appeal procedures.

You must file a Grievance within 180 days after You receive notice of Our adverse decision. You may file Your Grievance by calling [1-800-371-9622] or by mailing a written Grievance to:

MAIL: Pekin Insurance
Health Claim Appeals
2505 Court Street
Pekin, Illinois 61558-0001
FAX: (309)346-8265
EMAIL: HealthClaimAppeal@pekininsurance.com

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

We will provide You or Your authorized representative with any new or additional evidence or rationale and any other information and documents obtained during the Grievance process; without regard to whether such information was considered in the initial determination. No deference will be given to the initial adverse decision. Such new or additional evidence or rationale and information will be provided to You or Your authorized representative sufficiently in advance of the date a final decision is made in order to give You a chance to respond. The Grievance process will be conducted by individuals associated with Us and/or by external advisors but who were not involved in making the initial adverse decision.

Expedited Grievances

If Your Grievance relates to an urgent service or proposed service, including, but not limited to, procedures or Treatments ordered by a health care provider, for which the denial could significantly increase the risk to the Insured's health, then You may be entitled to a Grievance review on an expedited basis. Before authorization of benefits for an ongoing course of Treatment is terminated or reduced, We will provide You with notice and an opportunity to appeal. For the ongoing course of Treatment, coverage will continue during the Grievance process.

Upon receipt of an urgent service or proposed service Grievance, We will notify the party filing the Grievance, as soon as possible, but no more than 24 hours after submission of the Grievance, if additional information is needed. Additional information must be submitted within 24 hours of the request. We shall render a determination within 24 hours after receiving the requested information.

Other Grievances

Upon receipt of a non-urgent service or proposed service Grievance, an acknowledgement of receipt will be sent within 5 business days. We shall render a determination of the grievance as expeditiously as possible, but no more than 20 business days after We have received all information necessary.

If additional information is needed, We will notify You in writing of a 10 business day extension. This notice of extension will be sent to You before the end of the 20 day period. The extension may occur when information is needed and requested from either You or Your health care provider. In the event of an extension, We will resolve the grievance within 30 business days from the date we received the Grievance. If the requested information is not received, We will make a determination based on the information within Our possession.

Once We have made a determination regarding the Grievance, We will notify You in writing within 5 business days.

Appeals

An **"Appeal"** is a formal request by You or Your authorized representative for reconsideration of a decision not resolved to Your satisfaction under the Grievance level.

If You are not satisfied with the determination of Your Grievance, You or Your authorized representative may Appeal Our decision by notifying Us at the above listed phone number or address. We will acknowledge receipt of Your Appeal within 5 business days. A decision on Appeal will be made within 45 business days after the Appeal is filed. We will notify You in writing within 5 business days following the Appeal decision. If You are appealing a Grievance decision for a service or proposed service that was not found to be appropriate or Medically Necessary, or a service or proposed service which was determined to be Experimental or Investigational, You may have the right to an independent physician review.

Expedited Appeals

There may be situations where the normal Appeal process may not apply. An expedited Appeal can be implemented for urgent situations such that Your health may be in serious jeopardy, or in the opinion of Your physician, You may experience pain that cannot be adequately controlled while You wait for a decision on the Appeal. Expedited Appeals will be resolved within 48 hours after receipt of the Appeal. The Appeal must include adequate information for Us to make a determination upon review.

Notice of Grievance and Appeal Determination

We will notify the party filing the Grievance or Appeal, and any applicable health care provider, orally and/or by written notice.

The written notice will include:

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

If Our decision is to continue to uphold Our denial or partial denial, or You do not receive a timely decision, You may be able to request an external review by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the External Grievance section below.

External Grievance

An **"External Grievance"** is Your right to request an external review of an Appeal decision that is not acceptable to You. An External Grievance is conducted by an Independent Review Organization (IRO).You may be eligible to request an External Grievance if Your continued Grievance is regarding:

- an adverse determination of appropriateness; or
- an adverse determination of Medical Necessity; or
- a determination that a service or proposed service is Experimental of Investigational; or
- Our decision to rescind coverage.

You or Your authorized representative must make a request for an External Grievance within 4 months of receiving Our decision on Appeal. After receiving Your request for an External Grievance, we will promptly forward the Grievance, along with all relevant information to an approved IRO. The IRO will make a determination to uphold or reverse our decision within 15 business days of the filed request. The IRO will notify You and Us of its determination within 72 hours for services or proposed services which are non-urgent.

Expedited External Grievance

There may be situations where the normal External Grievance process may not apply. An expedited External Grievance can be implemented for urgent situations in which Your health may be in serious jeopardy, or in the opinion of Your physician, You may experience pain that cannot be adequately controlled while You wait for a decision. For an expedited External Grievance, an IRO will render a decision within 3 business days and will notify You and Us of its determination within 24 hours.

NOTICE TO POLICYHOLDERS

It is Our policy to treat each claim submission fairly. Pekin Life insurance Company values you as a customer.

Questions regarding your policy or coverage should be directed to:

PEKIN LIFE INSURANCE COMPANY
2505 Court Street
Pekin, Illinois 61558
800-371-9622

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.