



## 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.

#### **COVERED EXPENSES**

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

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

#### **CUSTODIAL CARE**

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

#### **DENTAL**

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

#### **DEPENDENT**

The spouse and the child or children of the employee, who are not themselves insured as employees under the policy.

#### **DESIGNATED TRANSPLANT FACILITY**

Means a facility which has entered into an agreement through a national organ transplant network to render approved transplant services to our insureds. The designated transplant facility may or may not be located within the insured's geographic area. A list of designated transplant facilities is available from us.

#### **DURABLE MEDICAL EQUIPMENT**

Durable medical equipment is medical equipment:

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

It includes blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, lancets, and lancing devices.

The following items are not considered durable medical equipment, and are not covered under this policy:

1. air purifiers or cleaners, air conditioners, humidifiers, dehumidifiers, vaporizers, or heaters;
2. any equipment which provides comfort or convenience;

3. structure or vehicle alterations, ramps, or elevators;
4. whirlpools, exercise machines of any type, swimming pools, hot tubs;
5. computers or communication devices;
6. heating pads, heat lamps, duplicate equipment; or
7. similar types of items or equipment.

**EFFECTIVE DATE**

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

**ELIGIBLE**

Meets the qualifications to apply for insurance.

**EMERGENCY CARE**

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

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

**EMERGENCY SERVICES**

Means those medical and health services provided to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

**EMPLOYEE**

A person employed by the Policyholder on a permanent full-time basis. He/she must meet the qualifications described in the Policyholder's Policy Schedule. It does not mean temporary, part-time, or seasonal employees.

**ENROLLMENT DATE**

The earlier of the date of enrollment of the individual in the policy, or the first day of the waiting period for enrollment.

**EQUIVALENT GENERIC DRUG**

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

**EXPERIMENTAL/INVESTIGATIONAL**

Means any service, supply, or treatment that is not commonly and customarily recognized by the physician's profession and within the United States as appropriate treatment of the patient's diagnosed illness or injury and determined to be of proven effectiveness by the appropriate National Scientific Organization related to the diagnosed illness or injury.

A medical treatment, procedure, drug or device that is approved through clinical trials will be considered experimental or investigational if reliable evidence shows it is the subject of ongoing phase I, II, or III clinical trials or understudy to determine its safety, efficacy, or its efficacy as compared with the standard means of treatment or diagnosis, and reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis, and approval has not been given by the United States Food and Drug Administration at the time it is furnished.

**EVIDENCE OF INSURABILITY**

Evidence of good health acceptable to us.

**FAMILY COVERAGE**

Means, the insured employee and/or spouse and/or children of the insured employee, who are insured as a family unit under the insured employee's certificate number.

**FAMILY STATUS CHANGE**

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

**FORMER POLICY**

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

**GROUP HEALTH PLAN**

An employee welfare benefit plan that provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise.

**GROUP-TYPE PLAN**

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

**HEALTH INSURANCE COVERAGE**

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

**HOME HEALTH CARE**

Care and treatment of an insured under a plan of care established by his/her physician. The plan must be submitted to us in writing, and be pre approved by us. The plan of care must be reviewed at least every two months by your physician.

It consists of the medically necessary services for:

1. part-time or intermittent home nursing care by or under the supervision of a registered nurse (R.N.).
2. part-time or intermittent home health aide services, which solely consist of caring for the patient, and which are provided under the supervision of a R.N. or medical social worker.
3. physical, respiratory, occupational or speech therapy.
4. nutrition counseling provided by or under the supervision of a registered dietitian.
5. evaluation and development of a home health plan by a R.N., physician extender or medical social worker, when approved or requested by the primary care physician.

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

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

**HOSPICE**

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

1. be certified or licensed as a hospice by the state in which they are operating;

2. operate under the direct supervision of a physician;
3. provide services 24 hours a day, seven days a week; and
4. maintain medical records on each patient.

### **HOSPICE CARE**

Care and treatment provided by a hospice for a terminally ill person and the immediate family members of the person if they are covered under this policy.

### **HOSPITAL**

Means a place which:

1. is legally operated for the inpatient care and treatment of ill or injured persons;
2. 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
4. a free-standing ambulatory surgical facility that arranges for overnight stays within the facility

### **ILLNESS**

Any condition, disease, or sickness which causes loss and affects normal bodily function, other than a condition caused by injury.

It is also means:

1. a pregnancy or complication of pregnancy;
2. a congenital defect or birth abnormality for a child.

### **IMMEDIATE FAMILY**

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

### **INDIVIDUAL COVERAGE**

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

### **INFANT SCREENING TESTS**

Tests performed on a newborn infant to detect phenylketonuria, hypothyroidism, hemoglobinopathies including sickle cell anemia, galactosemia, maple syrup urine disease, homocystinuria, inborn errors of metabolism that result in mental retardation and that are designated by the state department, congenital adrenal hyperplasia, biotinidase deficiency, disorders detected by tandem mass spectrometry or other technologies with the same or greater detection capabilities as tandem mass spectrometry, physiologic hearing impairments, HIV or the antibody or antigen to HIV.

### **INHERITED METABOLIC DISEASE**

A disease caused by inborn errors of amino acids, organic acid, or urea cycle metabolism, and is treatable by the dietary restriction of one or more amino acids.

### **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 FAMILY COVERAGE COINSURANCE SHARE**

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

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

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

### **IN-NETWORK INDIVIDUAL COVERAGE COINSURANCE SHARE**

The amount of covered expense that an insured with individual coverage must pay for services provided by a preferred provider, after we have paid the coinsurance amount.

In-Network individual coinsurance share does not include:

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

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

### **IN-NETWORK INDIVIDUAL COVERAGE DEDUCTIBLE**

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

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

### **IN-NETWORK FAMILY COVERAGE DEDUCTIBLE**

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

### **INPATIENT**

Means a confinement in a hospital that results in the hospital making a room and board charge. An overnight stay in an observation unit of a hospital or licensed ambulatory surgical facility will be considered an inpatient stay for pre-certification purposes.

### **INSURED**

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

**INTENSIVE CARE**

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

1. provides constant nursing care which is not usual in other rooms and wards;
2. has special lifesaving equipment which is immediately available at all times; and
3. has at least one R.N. on duty at all times.

**LATE ENROLLEE**

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

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

**MANIPULATIVE THERAPY**

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

**MAXIMUM BENEFIT**

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

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

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

**MEDICAL FOOD**

A formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation, and formulated to be consumed or administered internally under the direction of a physician.

**MEDICALLY NECESSARY**

Means treatment that:

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

**MEDICARE**

Title XVIII of the Social Security Act as amended.

**MENTAL ILLNESS/NERVOUS DISORDER**

Includes:

1. neuroses, psycho neuroses, psychopathy, psychosis or other emotional disorder;
2. affective disorders (including bipolar disorder and major depression);
3. Tourette's disorder;
4. attention deficit disorder;
5. conduct disorder;
6. adjustment disorder; and

7. serious mental illness, including schizophrenia, paranoid and other psychotic disorders, bipolar disorders (hypomanic, depressive, and mixed), major depressive disorders (single episode or recurrent), schizoaffective disorders (bipolar or depressive), obsessive-compulsive disorders, depression in childhood and adolescence, panic 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, if the nearest Preferred Provider is more than 50 miles from the insured's residence, then a non-preferred provider within 50 miles of the insured's residence will be paid as if the service was provided by a preferred provider.

**OUT OF NETWORK**

Means covered expense provided by a non-preferred provider.

**OUT OF NETWORK FAMILY COVERAGE COINSURANCE SHARE**

The amount of covered expense that insureds with family coverage must pay for services provided by a non-preferred provider, after we have paid the coinsurance amount. Out of Network family coverage coinsurance 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 penalty for noncompliance with plan requirements;
4. any In-Network coinsurance share; or
5. expense an insured would pay as a result of an organ transplant at a non-designated transplant facility.

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

## **OUT OF NETWORK FAMILY COVERAGE DEDUCTIBLE**

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

## **OUT OF NETWORK INDIVIDUAL COVERAGE COINSURANCE SHARE**

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

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

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

## **OUT OF NETWORK INDIVIDUAL COVERAGE DEDUCTIBLE**

The amount of covered expense for services provided by a non-preferred provider that must be incurred in a calendar year by an insured with individual coverage before any covered expense is paid by us. It is equal to the amount specified under the Out of Network Individual coverage deductible amount shown on the Schedule of Benefits.

In-Network deductible amounts will not be used to satisfy the Out of Network deductible amounts.

## **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. We recommend that you verify that the provider you are using or considering is currently a preferred provider.

## **PROOF OF INCAPACITY**

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

## **PROOF OF LOSS**

Consists of:

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

## **QUALIFYING CREDITABLE COVERAGE**

Coverage by an individual under:

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

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

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

## **REGULAR, REASONABLE & CUSTOMARY**

The 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 a R.N. It must maintain daily medical records of each patient. This definition does not include:

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

## **SPOUSE**

Wife 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 1<sup>st</sup> following the date he/she applies; he/she should apply between November 15<sup>th</sup> and December 15<sup>th</sup> of the year prior to the January 1<sup>st</sup> 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:
  1. a reduction in the number of hours of employment;
  2. termination of employment;
  3. termination of employer contributions;
  4. the COBRA continuation provision that they were covered under is exhausted under the other group health plan or health insurance coverage; or
  5. 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 written proof of loss. It must cover the occurrence, type, and extent of loss.



## **PROOF OF LOSS**

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

## **PHYSICAL EXAMINATION AND AUTOPSY**

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

## **LEGAL ACTIONS**

No suit at law or in equity may be brought to recover on this policy:

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

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

### **BENEFIT FOR COVERED EXPENSE PROVIDED BY A PREFERRED PROVIDER**

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

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

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

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

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

When you incur covered expense for emergency services provided in a hospital emergency room, you must pay a \$50 emergency room access fee. This amount must be paid anytime you receive emergency services in a hospital emergency room, and are not directly admitted to the hospital as an inpatient. This amount is in addition to any deductibles and coinsurance share amounts.

After you pay the first \$50 of covered expense, we will pay other covered expense as outlined above in the section titled "Benefit for Covered Expense Provided by a Preferred Provider."

If you are directly admitted to the hospital as an inpatient following an emergency room visit, you will not be required to pay the \$50 emergency room access fee.

## **BENEFIT FOR COVERED EXPENSE PROVIDED BY A NON-PREFERRED PROVIDER**

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

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

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

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

## **USE OF NON-PREFERRED PROVIDERS**

When you use a non-preferred provider:

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

## **BENEFIT FOR EMERGENCY CARE**

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

## EXPENSE COVERED BY THE PLAN

Benefits are payable for covered expense. Covered expenses are charges:  
by a hospital for:

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;
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;
- 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 ;
- Drugs labeled "Caution-limited by federal laws to investigational use", Off-label drugs or Experimental/Investigational drugs but ONLY:
  - as outlined in - EXPENSES COVERED BY THE PLAN, -. Clinical Trials;
  - when the drug is recognized for treatment of the condition in at least 1 standard reference compendium; or
  - 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.
- 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;
- drugs requiring a written prescription, which are purchased using the discount drug card we provide, and submitted electronically to us by the discount drug card company;
- for medical food that is medically necessary, and prescribed by an insured's treating physician for treatment of that insured's inherited metabolic disease;
- insulin, diabetic syringes and needles, and glucagon emergency kits;
- diabetes self-management training and supplies to test and monitor diabetes;
- for anesthesia and hospital charges for dental care, other than treatment for 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 America 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;

- breast prosthesis or reconstructive surgery following a mastectomy, including surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - 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;
  - 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 colorectal cancer examinations and laboratory tests for colorectal cancer for any nonsymptomatic 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.

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

**WELLNESS BENEFIT FOR PREVENTIVE HEALTH CARE**

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

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

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

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

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

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

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 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. unless the following applies:

Coverage for the newborn under this section shall include infant screening tests.

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 expense for covered illnesses 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 addiction 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.

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 all treatment of mental illness/nervous disorders is limited to 50% of all covered expenses in excess of the deductible amount.
  - b. The benefit payable for all treatment of chemical dependency/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, under 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;
  - hearing aids, eyeglasses, frames, contact lenses, dentures;
  - 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 congenital defects and birth abnormalities, including cleft palate or cleft lip;
    - any orthodontic procedure or appliance, except that the policy will provide coverage for treatment of congenital defects and birth abnormalities, including cleft palate or cleft lip, for a child;
  - 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, or treatment of congenital defects and birth abnormalities, including cleft lip or cleft palate repair, or which is the result of an injury. The injury must have occurred while the insured was covered under this policy or the former policy. The treatment must be performed during the first 12 months after the date of injury;
  - services or supplies that are not for the diagnosis or treatment of an existing illness or injury, except as provided under any Wellness Benefit for Preventive Care;
  - eye examinations for the correction of vision or fitting of glasses or contact lenses;
  - immunizations or vaccinations, including Synagis or similar immunization agents, except as provided under any Wellness Benefit for Preventive Care;
  - abortions, except where the mother's life is threatened;
  - normal pregnancy or childbirth, including expense incurred for a well newborn's initial hospital confinement, except as may be provided in this policy under a specific provision titled "Pregnancy Like Any Illness". However, expense that is in excess of the amount incurred for a normal delivery, and that is incurred for a complication of pregnancy, will be considered covered expense;
  - more than one ultrasound examination for a normal pregnancy;
  - amniocentesis, except for the diagnosis or treatment of an existing complication of pregnancy;

- reversal of sterilization procedures;
- nonmedical services and supplies;
- durable medical equipment unless we have 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, 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.
- 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;
- treatment related to the restoration of fertility or promotion of conception including in vitro fertilization;
- fetal treatment;
- any surgical procedure to remove excess tissue caused by weight loss;
- 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;
- sexual transformation;

- breast reduction surgery, except when performed in conjunction with reconstructive surgery following a mastectomy;
- treatment performed outside the United States, except when an emergency;
- removal of breast implants that were implanted solely for cosmetic reasons;
- growth hormone treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to growth hormone deficiency, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the insured's condition;
- self-injected prescription medications, except when pre-approved by us;
- any oral prescription medication that was purchased without using the discount drug card that we provide;
- over the counter medications;
- the difference between the cost of a Brand name drug and an Equivalent Generic drug;
- duplicate prescriptions or prescriptions refilled more frequently than the prescribed dosage indicates;
- fluoride supplements, minerals, Minoxidil for the treatment of alopecia, or vitamins.

### **PRE-CERTIFICATION PROGRAM**

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

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

You can make the phone call, or you can have a relative or your physician make the phone call. However, you are responsible for making sure that someone calls the Pre-certification Hotline.

### **NON-EMERGENCY HOSPITALIZATIONS OR SURGERIES**

The Pre-certification Hotline must be called at least 72 hours before an insured is scheduled for non-emergency surgery outside of the primary care physician's office or admitted to a hospital or skilled nursing facility for an inpatient stay.

### **MEDICAL EMERGENCY**

The Pre-certification Hotline must be called within 2 business days (or as soon as reasonably possible if the insured's condition prevents them from calling within that time frame) following emergency surgery or emergency admission to a hospital or skilled nursing facility.

### **PREGNANCY**

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

### **INFORMATION NEEDED**

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

1. the insured patient's name, date of birth, sex, and the social security number of the insured;
2. the policy number;
3. the proposed (or actual) date and reason for admission or surgery;
4. the name and phone number of the hospital (or skilled nursing facility) and admitting physician;
5. any information regarding any other insurance plans.

### **PRE-CERTIFICATION PROCESS**

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

If your stay exceeds the recommended length of stay, the hospital (skilled nursing facility) or your physician should contact the reviewer, who will again review your case.

## **MEDICAL NECESSITY**

No benefits will be payable for any confinement or surgery that is not approved by the reviewer as being medically necessary. The fact that a physician or another health care provider has prescribed or ordered an admission, surgery, or continued stay, does not necessarily mean the stay is medically necessary. Benefits are only payable if the pre-certification reviewer determines the admission, or continued stay, is medically necessary.

## **RIGHT TO APPEAL**

The physician or insured may, at any time, initiate a request for reevaluation or extension of a reviewer's decision, by calling the Precertification Hotline.

## **FAILURE TO PRECERTIFY**

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

## **DISCONTINUANCE & REPLACEMENT PROVISIONS**

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

## **DEDUCTIBLE CREDIT PROVISION**

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

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

## **COINSURANCE CREDIT PROVISION**

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

## **RECEIVING CREDIT**

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

## **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 we will coordinate our benefits with Medicare in accordance with the "Coordination of Benefits" provisions in the policy.

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 or 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. Upon receipt of a notice of an IRO’s decision to reverse Our adverse decision, We shall immediately approve the coverage that was the subject of the determination, except for those services which may be specifically excluded under the Policy.

An External Grievance decision is binding on Us. You and Your authorized representative may not file a subsequent request for external review involving the same adverse decision for which You have already received an External Grievance decision.

**Reconsideration of Adverse Decision**

If at any time during the External Grievance process You or Your authorized representative submit additional information which may result in Us reconsidering Our adverse decision, We will request that the IRO cease the External Grievance review until Our reconsideration is completed. For a non-urgent service or proposed service We will complete Our reconsideration within 15 days after the information is submitted. For an urgent service or proposed services We will complete Our reconsideration within 72 hours after the information is submitted.

If Our reconsideration continues to be adverse, You may request that the IRO resume the External Grievance review. We will forward the additional submitted information to the IRO within 2 business days after receipt of the information and request that the External Grievance review resumes to completion.

**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/doi](http://www.in.gov/doi).