PEKIN LIFE INSURANCE COMPANY

2505 COURT STREET PEKIN, ILLINOIS 61558

Policy No: **Name:**

BASIC INDIVIDUAL MAJOR MEDICAL EXPENSE POLICY

Pekin Life Insurance Company will pay the benefits of this policy under its terms, for injury occurring or sickness first manifested while it is in force. This policy is issued based upon the statements in the attached copy of the application and the payment of the first premium in advance of the date of issue. Coverage is not in effect under this policy until 12:01 a.m., Standard Time, on the date of issue shown above, at the place where you reside.

10 DAY RIGHT TO EXAMINE POLICY ... Please read this policy and the attached application carefully. If you are not satisfied with it for any reason, you may return it to us, or to the agent who took your application, together with a request for cancellation within 10 days after you receive it. You will be sent a full refund of any premium paid. Then the policy will be void from the beginning as if no policy had been issued.

RENEWABILITY ... We will renew this policy each time we receive the correct premium before the end of the grace period. We cannot refuse to renew this policy unless : (a) all policies of the same class of this form initially delivered or issued for delivery in this state are not renewed; or (b) you submit to the Company any fraudulent misstatements on your personal application or any fraudulent claim. While this policy is in force, we can't change its benefits without your consent. The term of coverage ends on the first renewal date shown above. Each time this policy is renewed, a new term begins.

In witness whereof, Pekin Life Insurance Company has caused this policy to be signed by its Executive Officers on the date of issue.

Daniel V. Connell
Secretary

Scott A. Martin
President

Renewable As Stated Above
The Company Can Change The Premium Rates By Class
The Premium May Change Because Of An Increase in Age,
Change Of Residence, Or Change In Benefits

GUIDE TO YOUR POLICY

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SECTION 1. BENEFITS

ELIGIBLE EXPENSES

ELIGIBLE EXPENSES are those expenses incurred for the services, supplies and treatments listed below which are received and do not exceed the usual and customary charge. Eligible expenses must be for medically necessary treatments and services given for an injury or sickness. We will not pay for services, supplies or treatments considered to be experimental or investigational as determined by us. Usual and customary charges are the charges usually made for such service, supply or treatment by other providers in the same locality.

All eligible expenses must be incurred while this policy is in force. Eligible expenses incurred must result from an injury occurring or sickness first manifested while this policy is in force.

Benefits for the following eligible expenses are provided as set out below:

(A) First, the deductible amount must be satisfied. We do not pay for any eligible expenses which are used to satisfy the deductible amount.

(B) Then, we will pay the applicable coinsurance percentage, shown on page 3 for eligible expenses incurred which exceed the deductible amount up to the coinsurance amount, shown on page 3. After reaching the coinsurance amount, we will pay the higher coinsurance percentage for eligible expenses incurred. All benefits are subject to the Maximum Calendar Year Limit. The coinsurance amount does not include the deductible amount.

ELIGIBLE EXPENSES:

(A) Average Semi-private hospital room and board and general nursing care expense. We will not pay the private room charge.

(B) Hospital intensive care confinement expense. We will pay up to three times the limit in (A) above for each day of confinement in a special intensive care facility.

(C) Emergency Room Visit. Emergency Room visit is subject to $75 deductible in addition to the Calendar Year Deductible. Emergency Room Deductible is waived if admitted to the hospital.

(D) Accumulated maximum of $5,000 per calendar year applies to the following expenses:

- Nursing facility confinement expense. The covered person must be admitted to a nursing facility within 30 days after a hospital stay of at least 3 days in a row (not counting the day of discharge).
- Home Health Care or nursing service visits. We will pay for up to one visit per day. Such visits must be provided by a home health care agency, a nurse or licensed home health aide/homemaker as a part of a plan of treatment prescribed by the attending doctor. The doctor must certify that without the home health care or nursing visits, the covered person would have required a stay in a hospital or nursing facility. The home health care service must be performed by someone other than a member of the covered person's immediate family. The covered person must be under the care of a doctor.
- Hospice Care Program. We will pay for up to 180 days of such care. Hospice Care services must be provided by a hospital, related institution, home health agency, hospice, or other licensed facility under a hospice care program.

(E) Medical diagnosis, treatment and surgery by a doctor in or out of the hospital. We will not pay expenses incurred for a Standby Physician.

(F) Anesthesiologist's service for a covered surgery.

(G) Miscellaneous services and supplies used while in a hospital, a hospital's outpatient department or a doctor's office.

(H) Professional ambulance service to and from the nearest local hospital providing the necessary care. It must be a local ambulance serving a local hospital.

(I) Durable Medical Equipment. Purchase or rental (whichever costs less) of durable medical equipment for temporary use, not to exceed a six-month period.

(J) Alternative Care or Treatment Plan. Such Plan would be for an alternate method of medical care or treatment not otherwise covered by this policy, and which must be approved by you and us in writing.

(K) Prescription Drugs. We will pay for medically necessary covered drugs. We will pay a maximum of $2500 per calendar year.

(L) WELLNESS BENEFIT. We will pay for expenses incurred for wellness services. We will provide benefits for the expenses of the following.

- Screening mammography to detect the presence of breast cancer in adult women:

  1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography

  2) If a woman is at least forty years of age but under fifty years of age, either of the following:

     a) One screening mammography every two years

     b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year

  2) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

The total benefits for a screening mammography shall not exceed one hundred thirty percent of the Medicare reimbursement rate in this state for screening mammography. This maximum benefit covers both the facility and the professional charges. This benefit also includes expenses incurred for well child care.

We will pay for covered expense for a child from birth through age eight. Any applicable deductible and coinsurance amounts will apply.

We will not pay more than $500 including a required hearing screening, during the period from birth to age one. We will not pay more than $75 for the hearing screening.

We will not pay more than $150 per year for child care for a child age one through age eight.

(M) Cytologic screening for the presence of cervical cancer.

(N) Mental or nervous disorders. We will pay for in or outpatient treatment. Outpatient treatment is limited to $50 maximum allowable charge per visit. We will pay up to a maximum of $5,000 for all such expenses for any covered person during your lifetime. Calendar year maximum for inpatient will be $2,000 and outpatient will be $550.

(O) Alcohol and Substance treatment expenses. We will pay for in or outpatient treatment. Outpatient treatment is limited to $50 maximum allowable charge per visit. We will pay up to a maximum of $5,000 for all such expenses for any covered person during your lifetime. Calendar year maximum for inpatient will be $2,000 and outpatient will be $550.

(P) Human organ or tissue transplants or replacements. This benefit is subject to the AUTHORIZATION BEFORE TREATMENT provision. Any eligible expenses incurred by a donor will be considered as if incurred by the covered person. We will provide benefits up to a maximum amount of $100,000 for each covered person for eligible expenses incurred for only those human organ or tissue transplants or replacements listed below:

(1) bone marrow transplants; (2) heart transplants; (3) liver transplants; (4) kidney transplants; (5) cornea transplants; (6) heart/lung; (7) lung; (8) pancreas

Covered benefits are limited to: Initial testing and diagnosis; immunosuppressant drug therapy, before and after surgery; complications resulting from surgery, organ rejection/failure; and repeat transplants of same organ.

No other organ transplants are covered.

(Q) Outpatient Physical Therapy. We will pay $40 per visit with a maximum of 20 visits per year.

(R) Skeletal Adjustment/Adjunctive Therapy/Vertebral Manipulation?Dislocation-Subluxation Services. We will pay $25 per visit with a maximum of 10 visits per year.

(S) Assistant Surgeon. In the event an assisting surgeon is medically necessary to assist in performance of an operation, the maximum benefit shall not exceed 20% of all eligible charges made by the surgeon performing the operation.

If two or more procedures are performed in the same operative session, the maximum payment shall be limited to:

a. if two or more procedures are performed through the same incision, payment shall be limited to the amount payable for the procedure having the greater payment.

b. payments shall be limited to the amount payable for the procedure having the greater payment plus one-half of the amount that would have otherwise been payable for the procedure having the lesser benefit.

(T) Reconstructive Surgery Following Mastectomies. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for any covered person who is receiving benefits in connection with a mastectomy, who elects breast reconstruction for:

a. Reconstruction of the breast on which the mastectomy has been performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphendemas.

Coverage is subject to any applicable deductibles, co-payments, plan maximums and coinsurance.

AUTHORIZATION BEFORE TREATMENT

In order to receive full benefits for some eligible expenses, we require you to have authorization. We do not require an authorization before treatment in the case of an emergency, but we do require a later authorization.

We require you to have AUTHORIZATION for any eligible expenses incurred due to the treatment of a covered injury or sickness which requires a hospital stay or a surgery. If you do not follow the authorization procedure set out below the expenses will be considered UNAUTHORIZED and the benefits will be reduced. We require you to have AUTHORIZATION prior to the beginning of the donor search and selection for a covered human organ transplant or replacement procedure.

AN AUTHORIZATION DOES NOT GUARANTEE THAT BENEFITS WILL BE PAID. PAYMENT

OF BENEFITS WILL BE DETERMINED BY THE TERMS AND LIMITS OF THE POLICY.

If a Covered Person fails to obtain authorization for treatment, 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. This authorization penalty is in addition to the Plan Deductible and is not applied toward meeting any out-of-pocket limits.

AUTHORIZATION PROCEDURE- Follow these steps to obtain an authorization:

(A) You must tell your doctor he or she must first obtain an authorization for the expenses from us. The authorization must be obtained BEFORE any hospital admission or surgery is done, except in the case of an emergency services.

EMERGENCY SERVICES means those medical and health services provided to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including, but 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:

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

Emergency services include:

- a medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition;
- such further medical examination and treatment that is required by federal law to stabilize an emergency medical condition and is within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

Covered expense for emergency services is subject to all applicable deductible and coinsurance share amounts.

A person with a condition requiring emergency services should seek appropriate care and treatment, which may include the use of the 9-1-1 system and any other telephone access systems utilized to access prehospital emergency services.

(B) We have an authorization SERVICE. Your doctor can call the Service, Monday through Friday during normal business hours. We will provide you with the name and toll-free number of the Service.

(C) The Service may require another doctor's opinion before it can authorize the treatment or surgery. If another doctor's opinion is required, we will give you a list of other doctors from which to choose. The Service may allow you to use a doctor not on its list. Such doctor must:

(1) be a board certified specialist in the field of the proposed treatment or surgery;

(2) not be financially affiliated with the doctor who asks for the authorization; and

(3) not then give the treatment or do the surgery.

If the second doctor agrees with your doctor, then we will consider the treatment or surgery to be authorized. However, if the second doctor does not agree the treatment or surgery is necessary, the Service may require an opinion from a third doctor. The third doctor must also meet the requirements listed above. We will pay the fees of the second and third doctors when they are required by the Service.

(D) Your doctor may begin treatment on the basis of a verbal authorization from the Service. A written authorization will be sent to you, your doctor and to the hospital. The written authorization will confirm the verbal authorization.

(E) If the treatment or surgery is AUTHORIZED, it will be authorized for a period of 30 days from the date of the written authorization. If authorized treatment has not occurred within 30 days, your doctor must call the Service and request an extension; otherwise, expenses incurred will be considered UNAUTHORIZED and benefits will be reduced. The Service may or may not grant the extension. If the Service does not grant the extension, any eligible expenses incurred will be considered UNAUTHORIZED and benefits will be reduced.

(F) If any portion of a hospital confinement exceeds the number of authorized days, you doctor must call the Service at least 24 hours before the original discharge date and request an extension. The Service may or may not grant the extension. If the Service does not grant the extension, any elgible expenses incurred after the original discharge date will be cinsidered UNAUTHORIZED and benefits will be reduced.

UNAUTHORIZED TREATMENT- Hospital admissions and surgeries will be considered UNAUTHORIZED when:

(A) the Authorization SERVICE has not been contacted by you or your doctor, or the AUTHORIZATION procedures have not been followed, as set out above; or

(B) the time period for the AUTHORIZED confinement or surgery has expired; or

(C) the type of treatment, admitting doctor or facility differs from the AUTHORIZED treatment, doctor or facility.

If a treatment or surgery is considered UNAUTHORIZED, the first $500 of the 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. This penalty is in addition to the Plan Deductible and is not applied toward meeting any out-of-pocket limits.

Within 30 days after we deny coverage for this reason, we will notify you of the opportunity to have our coverage denial reviewed by an independent review organization assigned by the superintendent of insurance. The assigned review organization will select a panel to review your request. We will pay the cost of the review. We will provide to the assigned independent review organization a copy of the reocrds we have in our possession that are relevant to your medical condition and the review. At the request of the review organization, we or your physician requesting the therapy must provide any additional information the reviewer needs to complete the review. An expert reviewer is not required to render an opinion if the necessary requested information has not been received.

The review organization will issue a written decision within 7 days after filing a request for an expedited review, or 30 days after filing a request for a non-expedited review. The opinion of a majority of the experts on the panel is binding on us with respect to your request for review. If the opinions are evenly divided, then our decision will be in favor of coverage.

We do not have to provide a second external, independent review if our initial denial of coverage is based upon an external, independent review meeting the requirements of this section.

SECTION 2. DEFINITIONS

THE **DEDUCTIBLE AMOUNT** for each covered person during a calendar year is the greater of:

(A) the Basic Deductible Amount, shown on page 3, or

(B) When the Covered Person's Deductible for a Calendar Year is the Other Coverage Deductible, We will then pay:

100% of the Covered Expense incurred in that Calendar Year in excess of the Other Coverage Deductible, but We will not pay more than we would have padi if other coverage had not been in effect.

Plan Deductible means:

- With respect to an individual coverage plan, the amount of Covered Expense that must be incurred in a Calendar Year by the Covered Person before any major medical benefits (other than preventive benefits as described in the policy) are payable under this policy, and
- With respect to a family coverage plan, the amount of Covered Expense that must be incurred in a Calendar Year by each Covered Person before any major medical benefits are payable under this policy (other than preventive benefits as described in the policy).

OTHER COVERAGE means any plan which provides insurance, reimbursement, or benefits on a service basis, for Hospital, surgical or other medical expenses. This includes:

- individual or group health policies, including Other Coverage with Us; and Blue Cross–Blue Shield plans
- health maintenance organization subscriber contracts
- self–insured group plans
- welfare plans
- medical coverage under home or auto insurance
- service provided or payment received under laws of any national, state, or local government.

THE **MAXIMUM CALENDAR YEAR LIMIT** for this policy is shown on page 3 for each covered person. However, some eligible expenses have specific benefit limits as set out in the BENEFITS Section. The maximum calendar limit will be raised when other coverage pays more than the basic deductible amount. The added amount is figured as follows: Such amount paid by other coverage above the basic deductible amount will be multiplied by 4 and added to the calendar limit.

A **HOSPITAL** is an institution which:

(A) is licensed as a hospital (if licensing is required in your state) or operates under the law as a hospital;

(B) operates primarily for the admission, acute care and treatment of injured or sick persons as inpatients;

(C) has 24–hour–a–day nursing service by or under the supervision of a graduate registered nurse (RN) or a licensed practical nurse (L.P.N.);

(D) has a staff of one or more licensed physicians available at all times;

(E) provides organized facilities for diagnosis and surgery either on its premises or in facilities available to the hospital on a contractual prearranged basis. A HOSPITAL is not a clinic, a rest home, a convalescent or nursing home, or an extended care facility. It is not a home or facility which operates primarily for the care or treatment of the aged, even if it is a section of a hospital. It is not a facility primarily affording custodial, educational or rehabilitative care.

A **NURSING FACILITY** is an institution which:

(A) operates under the law;

(B) operates primarily to provide, in addition to room and board, skilled nursing care under the direction of a doctor;

(C) has 24–hour–a–day nursing service by or under the supervision of a graduate registered nurse (R.N.) or a licensed practical nurse (L.P.N.); and

(D) keeps a daily medical record of each patient.

A **NURSING FACILITY** is not a rest home. It is not a home or facility which operates primarily for the care or treatment of mental diseases or disorders, the aged, drug addicts or alcoholics. It is not a facility which primarily provides custodial or educational care.

SKILLED NURSING CARE means any treatment which is rehabilitative in nature, which is required to restore a covered person to his or her level of health after an injury or sickness and hospitalization, and which is related to the condition which was the cause of the confinement. Skilled Nursing Care is any level of care greater than custodial care.

HOME HEALTH CARE EXPENSES mean reasonable and customary charges made by a home health care agency, for services or supplies furnished to a covered person in the person's home in accordance with the home health care plan.

HOME HEALTH CARE EXPENSES do not include: services or supplies not included in the home health care plan; or services of a person who ordinarily resides in the home of the covered person; or services performed by a member of the covered person's immediate family; or custodial care or transportation services; or charges for any period during which the insured is not under the continuing care of a doctor.

HOME HEALTH CARE AGENCY means a home health agency which has been certified under Title XVIII of the Social Security Act, or certified/licensed in the state in which the home health services are delivered.

HOSPICE CARE PROGRAM means a program for meeting the needs of terminally ill covered persons, by providing support and palliative care to individuals who have no reasonable prospect of cure; and, as estimated by a physician, have a life expectancy of less than 180 days.

DOCTOR means a qualified physician, surgeon or other medical practitioner who is licensed to practice, so long as the service is within the scope of the license.

NURSE means a registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse, so long as the service is within the scope of the license.

AN **INJURY** means accidental bodily injury which occurs while this policy is in force.

A **SICKNESS** of a covered person means a condition, a state of ill health, or an illness, first manifested by a covered person while this policy is in force on a covered person.

COVERED DRUGS means drugs or medicines which are: prescribed by a **DOCTOR; MEDICALLY NECESSARY** for the care and treatment of a covered **INJURY** or **SICKNESS;** legally available only by prescription; and one of the following:

1) Federal legend drug. A drug which must have "Caution: Federal Law prohibits dispensing without a prescription" on it.

2) State Restricted Drug. A drug which, under state law, is available only by prescription.

3) Compounded Medication. Compounded drugs which contain:

a) at least one Federal Legend or State Restricted Drug; or

b) combined drugs which require a prescription for the dosage or amount prescribed; and

c) if liquid, it must contain at least one solid that is weighed or three measured liquids.

A **PRE-EXISTING CONDITION** means:

(A) any expense incurred for treatment of a pre-existing condition during the Covered Person's first 12 months of coverage under this policy will not be considered a covered loss. This pre-existing conditions limitation does not apply to conditions which are fully disclosed to Us in the application for coverage under this policy were present prior to six months preceding the effective date and were not excluded by rider. This policy does not cover any condition that is excluded by name or specific description, even after the 12 monts.

(B) any condition that was diagnosed or treated by a Physician within six (6) months before the person's coverage began. It also means any condition that produced symptoms within six (6) months before the person's coverage began. The symptoms must have been such as to cause an ordinarily prudent person to seek diagnosis or treatment.

We will credit toward satisfaction of this limitation, the period of time a Covered Person had prior Creditable Coverage in effect. This Creditable Coverage must have been continuous and in force within thirty (30) days prior to the effective date of this policy.

MEDICALLY NECESSARY means services and/or treatments which are (a) prescribed by a doctor; (b) considered to be necessary and appropriate for the diagnosis and treatment for the sickness or injury; and (c) commonly accepted as proper care or treatment for the condition by the American medical community.

MEDICALLY NECESSARY does not include care or treatment that, at the time the treatment or services are provided, is considered to be (a) provided only as a convenience to the covered person or provider; or (b) in excess (in scope, duration or intensity) of that level of care which is needed to provide safe, adequate and appropriate diagnosis and treatment. We reserve the right to utilize independent medical consultants to evaluate any claim.

A **COMPLICATION OF PREGNANCY** means

(A) A condition that is distinct from pregnancy, but is adversely affected by pregnancy. Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, and conditions of comparable severity.

(B) It also includes conditions such as emergency non-elective cesarean section, ectopic pregnancy, hyperemesis gravidarum, and spontaneous abortion occurring when a viable birth is not possible.

A **COMPLICATION OF PREGNANCY** is not false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness or similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

TOTALLY DISABLED means an injury or sickness which results in a covered person's complete inability to:

(A) engage in any employment or occupation for which the covered person, if employed, is qualified by reason of education, training, or experience and the covered person is under the care of a doctor; or

(B) perform activities normally performed by persons of the same age and sex in good health.

USUAL AND CUSTOMARY CHARGE means the common charge for the same or comparable service or supply in the geographic area in which the service or supply is furnished. Usual and customary charges are determined based upon: the amount of resources expended to deliver the treatment, the complexity of the treatment rendered, and charging protocols and billing practices generally accepted by the medical community.

MENTAL OR NERVOUS DISORDERS, ALCOHOL OR DRUG ABUSE means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder.

MEDICARE means Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended.

EXPERIMENTAL OR INVESTIGATIONAL means services, supplies or treatments not recognized as conforming to accepted standards of medical practice; and any for which the required approval of a government agency has not been granted at the time the services, supplies and treatments are provided.

WELL-CHILD CARE means pediatric preventive services appropriate to the age of a child from birth through age eight as defined by current Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at a minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, vision and hearing screening, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

POLICY YEARS AND ANNIVERSARIES are figured from the date of issue.

A **CALENDAR YEAR** begins January 1, and ends December 31, each year

SECTION 3. PREMIUMS

PREMIUM PAYMENT — The premium must be paid on or before the date it is due or during the grace period.

GRACE PERIOD — The grace period is the 31 days from the date the premium is due. This policy stays in force during the grace period.

PREMIUM CHANGE — Any covered person's premium may go up on any anniversary date because that person is 1 year older. We may change the premium table for this policy but only on a policy renewal date. A policy renewal date is a date when your premium is due and may be a date other than the anniversary date. Such change shall be made for all policies with this form number in a class as determined by us. No premium change may be made on an individual basis.

LAPSE This policy will go out of force if the premium is not paid by the end of the grace period.

REINSTATEMENT If this policy should lapse, we (the Company or an agent we specifically authorize to accept premiums) may accept your premium without having you apply to reinstate this policy. Your premium payment will then put this policy back in force. If we require you to complete an application to reinstate this policy, we will give you a conditional receipt for your payment. This policy will be reinstated when we approve your application. Your policy will be reinstated if you have not received notice in writing from us that the application is not approved within 45 days from the date of such conditional receipt.

If this policy is reinstated, it will pay for only those injuries which occur after the reinstatement date. It will pay for only those sicknesses that are first manifested more than 10 days after the reinstatement date. All other rights of ours or yours will be the same as they were before this policy lapsed, subject to any rider added to this policy when it was reinstated. If we reinstate this policy, your payment may be used to pay the premium for a period of time for which the premium had not been paid, but not more than 60 days before the reinstatement date.

SECTION 4. RIGHT TO BENEFITS

CONTROL OF POLICY As the Insured, only you are entitled to the policy benefits and to exercise any rights granted under this policy.

SECTION 5. COVERED PERSONS

INSURED COVERAGE As the Insured, you are a covered person under this policy from its date of issue so long as this policy is in force.

FAMILY MEMBER COVERAGE Your family members named on page 3 of this policy are also covered persons from the date of issue, so long as this policy is in force. You may apply to add other family members after the date of issue. You may remove any family member from coverage at any time by instructing us in writing.

NEWBORN CHILD Your newborn child (including a legally placed or adopted child) will be covered by this policy for injury and sickness from the moment of birth or placement for 31 days. This includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, but not routine nursery or well baby care.. However, you must notify us to add the child within 31 days after the child's birth or placement, to continue coverage after the first 31 days. There will be an added premium for your child's coverage. To keep your child insured, you must send us the premium within 31 days after we send you a notice for the added premium.

CONTINUED COVERAGE Should you die, your covered spouse will become the Insured. Should your spouse not be covered, your oldest covered child will become the Insured.

CONVERSION PRIVILEGE If you and your covered spouse are divorced, you may both continue your insurance. Either you or your covered spouse may have a separate policy on a form then being offered by us with benefits similar to those contained in this policy. The request for the new policy must be made within 31 days after you or your covered spouse are removed from this policy. The new policy will be issued without proof of insurability. The premiums charged will be determined based on the same class of insureds

as for this policy. All probationary or waiting periods in the new policy will be considered as being met to the extent coverage was in force under this policy.

Any covered person may have a separate policy issued in his or her name upon request. Should we refuse to renew this policy on any policy renewal date, we will provide benefits for eligible expenses incurred by a covered person due to a continuous loss for a covered sickness or injury which occurred prior to the end of such covered person's coverage under this policy.

However, if such covered person is totally disabled and under a doctor's care when coverage ends due to nonrenewal by us, we will continue to pay benefits for the disabling covered injury or sickness. We will pay such benefits while the covered person remains totally disabled and under the care of a doctor until: (a) the end of the policy year; (b) we have paid benefits to the benefit limit, whichever occurs first.

If we accept a premium for a covered person for a period of time beyond which coverage under this policy has ended, we will continue the coverage for such covered person for such a period of time.

EXCEPTIONS

Except as specifically provided for, no benefits will be provided for or we will not pay benefits:

(A) For transportation, except local, to or from a Hospital, by professional ground ambulance services.

(B) For normal childbirth, normal pregnancy or routine nursery care (except as provided in the Schedule of Benefits), elective cesarean section or voluntarily induced abortion.

(C) For fertility or infertility studies, diagnostic testing, advice, consultation, examination, medication, or for any treatment related to or connected in any way with the restoration or enhancement of fertility or the inability to conceive or conception by artificial means, including, but not limited to, in-vitro fertilization or embryo transfer.

(D) For replacement of artificial limbs and artificial eyes.

(E) For blood or blood plasma which has been replaced.

(F) For donation of any body organ by an insured person.

(G) For services performed by a person who ordinarily resides in the insured person's home or is a close relative of the insured person or by the insured person's employer or partner.

(H) Except as stated in the plan for any cosmetic surgery, unless required to restore a part of the body that has been altered as a result of an accidental bodily injury or illness.

(I) For custodial care.

(J) Applied to a deductible or coinsurance amount under any benefit of the policy.

(K) For services or treatment not prescribed by a doctor or for services or treatment not shown as covered.

(L) Due to an illness arising out of, or in the course of, employment for wages or profit.

(M) For expenses incurred after the insurance terminates

(N) For treatment or services experimental or investigational in nature.

(O) For eye surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring), including, but not limited to radial keratotomy; or for eye refractions, eye glasses or contact lens including fitting any examinations.

(P) For treatment, services or supplies furnished by a department or agency of the United States Government. This exclusion will not apply to a non-service connected illness of a veteran of the United States armed forces who does not have a service-connected illness.

(Q) For services and supplies eligible for payment by a government or charitable program, except as required by law.

(R) For hearing aids, including fitting and examinations.

(S) Which are not necessary to the care or treatment of an illness.

(T) Which would not be made if no insurance existed.

(U) For recreational or educational therapy or vocational rehabilitation.

(V) Except as allowed under covered charges subject to limitations, for speech or occupational therapy and related diagnostic testing if the therapy or testing is in connection with or related in any way to the treatment of a learning disability, speech impediment, or developmental delay even though therapy is recommended due to organic dysfunction, including, but not limited to, congenital deformity or birth trauma.

(W) For which the insured person is not legally obliged to pay.

(X) For treatment or services which are not generally accepted medical practices in the United States for a given illness.

(Y) For treatment of obesity, morbid obesity or for weight reduction purposes.

(Z) For illness that results from participation in any assault, unlawful act, strike, civil disorder or riot.

(AA) For the treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and the implantation of a penile prosthesis.

(BB) For routine physical or premarital examination except as may be covered under the child wellness benefit. Mammograms and pap smears are covered.

(CC) For a private room in excess of the average semi-private room and board rate.

(DD) No benefits will be paid for charges due to a pre-existing condition. This limitation relates only to conditions treated during the six months immediately preceding the effective date of coverage. Benefits will be paid for such charges incurred after the end of the period of twelve (12) consecutive months while insured under the policy. This exclusion does not apply to federally eligible individuals.

(EE) In excess of reasonable and customary charges.

(FF) For services or supplies prohibited by law.

(GG) For sex changes.

(HH) For sterilization and reversal of sterilization.

(II) Resulting from any suicide, attempted suicide or intentionally self-inflicted injury or sickness while sane or insane unless such act is the result of an underlying medical condition.

(JJ) For examination, treatment or surgery of the teeth, gums or direct supporting structure, except for repair of injury to sound natural teeth, (including their replacement) as a result of an accidental bodily injury. Treatment must be given within ninety (90) days of the date of the accident.

(KK) For an illness caused by any act of war, whether or not declared.

(LL) For surrogate pregnancy.

(MM) For surgery of the jaw or for any treatment of temporomandibular joint (TMJ) disorder. Treatment of jaw fractures and removal of tumors of the jaw will not be subject to this exclusion.

(NN) For the treatment of complications arising from or connected in any way with a surgical or medical treatment or procedure that is not a covered expense under the terms of the policy, whether or not the insured person was insured under the policy at the time the non–covered treatment or procedure was performed.

(OO) For foot care due to:

a. treatment of weak, strained or flat feet or instability or imbalance of the foot.

b. treatment of corn, calluses or the free edge of toenails, except when necessitated for peripheral vascular disease or other illnesses of similar medical seriousness.

(PP) For contraceptives, infertility drugs and growth hormones.

PRE-EXISTING CONDITIONS LIMITATION

Any expense incurred for treatment of a pre–existing condition during the Covered Person's first 12 months of coverage under this policy will not be considered a covered loss. This pre–existing conditions limitation does not apply to conditions which are fully disclosed to Us in the application for coverage under this policy were present prior to six months preceding the effective date and were not excluded by rider. This policy does not cover any condition that is excluded by name or specific description, even after the 12 months.

A pre–existing condition means any condition that was diagnosed or treated by a Physcian within six (6) months before the person's coverage began. It also means any condition that produced symptoms within six (6) months before the person's coverage began. The symptoms must have been such as to cause an ordinary prudent person to seek diagnosis or treatment.

We will credit toward satisfaction of this limitation, the period of time a Covered Person had prior Creditable Coverage in effect. This Creditable Coverage must have been continuous and in force within thirty (30) days prior to the effective date of this policy.

If a covered person enters active military service, that person will be covered during that service. We will refund any premium we accepted for that person during such service.

SECTION 7. HOW TO FILE A CLAIM

NOTICE OF CLAIM — You must tell us in writing of a claim for benefits within 60 days after you have had an injury or sickness for which you are presenting a claim, or as soon as is reasonably possible. You may give us the notice, or you can have someone give it for you. The notice should give your name and either your policy number or identification number. The notice should be sent to us at our home office address or to any of our agents.

CLAIM FORMS — When we receive your notice of claim for benefits, we will send you forms to complete. If these forms are not sent to you in 15 days, you will have met the requirements of your proof of claim, if you notify us in writing about the expenses for which you are making a claim for benefits within 90 days after the expenses were incurred.

PROOF OF YOUR CLAIM — You must give us written proof of all expenses you have incurred for which you are claiming benefits. This proof must reach us within 90 days after you have incurred the expense, or, if this is not possible, as soon as is reasonably possible. Your proof must, however, be given to us within 1 year, unless you are not legally competent to act.

TIME OF PAYMENT

Benefits will be paid immediately after We receive written Proof of Loss. All claims and indemnities payable under ther terms of a policy of accident and health insurance shall be paid within 30 days following receipt by Us of Proof of Loss. Failure to pay within such period shall entitle the covered Person to interest at the rate of 9 percent per annum from the 30th day after receipt of Proof of Loss to the date of late payment, providing that interest amounting to less than one dollar need not be paid.

SECTION 8. PAYMENT OF CLAIMS

All benefits are payable to You. Benefits unpaid at Your death will be paid to Your estate. Any premiums owed to Us will be deducted from Your benefit. Up to $1000 may be payable to a relative by blood or marriage if it would have been payable to:

- Your estate
- A person not legally competent to give a release, or
- A minor.

The relative must be judged by Us to entitled to payment. Any payment will be made in good faith. It will satisfy Our responisibility to the exten of that payment.

We reserve the right to pay benefits directly to the Hospital or other provider of medical services.

SECTION 9. GENERAL PROVISIONS

ENTIRE CONTRACT CHANGES

This policy and any attachments are the entire contract. No agent may change it in any way. Only an executive officer of the Company may make a change and the change must appear in writing as a part of this policy.

TIME LIMIT ON CERTAIN DEFENSES

We will not void this policy or deny a claim for loss for any expenses incurred after 2 years from the effective date of coverage because of false statements, except for fraudulent statements. made in the application. A false statement in the application must be proven to be willfully false, that it was fraudulently made and that it materially affects either the acceptance of risk or the hazard assumed.

CANCELLATION BY THE INSURED

The insured may cancel this policy at anytime by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. The earned premium shall be computed by the use of the shortrate table last filed with the state official having supervision of insurance in the state where the insured resided when this policy was issued.

NON–CANCELLATION BY INSURED

The insurer may not cancel this policy. This provision nullifies any other provision, contained in this policy or in any endorsement hereon or in any rider attached hereto, which provides for cancellation of this policy by the insurer or by the insured.

PHYSICAL EXAMINATIONS

We have the right to require that any covered person have a physical examination as often as it may be reasonably necessary to prove a claim. We will pay for any physical examination we require

LEGAL ACTIONS

You must wait for at least 60 days after you have given us due proof of any claim for benefits in writing before you can bring a legal action to recover under this policy. You have 3 years after the date proof of claim for benefits is required to bring a legal action.

ILLEGAL OCCUPATION

We will not be liable for any claim for benefits when a contributing cause was the covered person's committing or attempting to commit a felony or from a covered person's engaging in an illegal occupation

MISSTATEMENT OF AGE If the age of any covered person is misstated, the benefits will be what the premium paid would have bought at the correct age.

COMPLAINTS

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

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

APPEAL PROCESS- If the authorization procedure has been followed, but your doctor disagrees with the outcome of the decision by the SERVICE, you have the right to obtain a review of the decision. Send your written request for an appeal to us and include your name, address, policy number, social security number and any other information, documentation or evidence to support your appeal request. Until such time as AUTHORIZATION may be granted, the surgery or treatment will be considered as UNAUTHORIZED.

NOTICE OF RIGHT TO AN EXTERNAL REVIEW Once you have exhausted our internal review process, you (or your authorized representative) have the right to an external review if:

- we have denied, reduced, or terminated coverage because we have determined that a health care service is not medically necessary; and
- the proposed service, plus any ancillary services and follow-up care, will cost you more than $500 if we do not cover the service. However, the $500 requirement does not apply if your provider certifies that an expedited review is needed.

For an expedited review, your provider must certify that your condition could, in the absence of immediate medical attention, result in any of the following:

- placing your health or, with the respect to a pregnant woman, her health or the health of an unborn child, in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part.

You will not be provided an external review if:

- the superintendent of insurance has determined that your health care service is not covered service under the policy; or
- you have failed to exhaust our internal review process; or
- you were previously provided an external review for the same denial of coverage, and no new clinical information has been submitted to us.

An external review must be requested in writing, except that if you have a condition that requires an expedited review, the review may be requested orally or be electronic means. When an oral or electronic request for review is made, it must be followed up with a written request submitted to us within five days after the initial request is made. An external review request that is not for an expedited review must be accompanied by written certification from your provider rendering the health care service that your proposed service, plus any ancillary services and follow-up care will cost you more than $500 if we do not cover the service.

The review will be conducted by an independent review organization assigned by the superintendent of insurance. We will pay the entire cost of the review. We will provide to the assigned independent review organization copies of records we have in our possession that are relevant to your medical condition and the review.

At the request of the independent review organization, additional information may need to be provided by us, you, or your providers. A decision is not required from the independent review organization if they have not received all requested information. If a review organization cannot make a decision for this reason, both you and us will be notified of the reason.

For a review that is not an expedited review, the independent review organization will issue a written decision not later than 30 days after the filing of the request. For an expedited review, a written decision will be issued not later than 7 days after the filing of the request for review.

We may, at any time, elect to cover a requested service and terminate the review. We will send a notice by mail, or electronic means if requested, if this occurs.

If a service was denied as not covered, you may request a review by the Ohio Department of Insurance. You may contract the Ohio Department of Insurance by writing to:

Ohio Department of Insurance
2100 Stella Court
Columbus, OH 43215-1067
(614) 644-2658

RIGHT TO REVIEW OF A DENIAL OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT FOR TERMINAL CONDITIONS

You (or your authorized representative) also has the right to an external review if we have denied a drug, device, procedure or therapy because we have determined it to be experimental/investigational and you meet all of the following:

- you have a terminal condition that, according to the current diagnosis of your physician, has to high probability of causing death within two years;
- you request a review not later than 60 days after you receive notice from the superintendent of insurance that making a determination requires resolution of a medical issue;
- your physician certifies that you have a terminal condition for which:
  - standard therapies have not been effective in improving your condition; and
  - standard therapies are not medically appropriate for you; and
  - there is no standard therapy that we cover that would be more beneficial than the drug, device, procedure, or other therapy being recommended. Your physician must certify, in writing, that, in his/her opinion, the service is likely to be more beneficial to you than standard therapies, or that you have requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.

You must have exhausted all internal review processes. You must submit a request for review in writing. However, if your physician determines that a therapy would be significantly less effective if not promptly initiated, the review may be requested orally or by electronic means. When an oral or electronic request is made, it must be followed up with a written request not later than five days after the initial request is submitted.