CLASSIC CHOICE

Your group policy will contain provisions and terms not included in this sales brochure. If any discrepancies between the group policy and this brochure exist, the group policy will control.

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Pekin Life Insurance Company

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Where quality and service count!

Classic Choice

Highlights of Your Plan	Share of Costs Classic Choice In Network	Classic Choice Out of Network
Calendar Year Deductibles	$500, $1,000, $1,500, $2,500, $3,000, $5,000 Three-Deductible family maximum	$1,000, $2,000, $3,000, $5,000, $6,000, $10,000 Three-Deductible family maximum
Annual Coinsurance Share Maximum Choices 90/60 Plan	$1,000 plus Deductible per individual $3,000 plus Deductible per family	$4,000 plus Deductible per individual $12,000 plus Deductible per family
80/50 Plan	$2,000 plus Deductible per individual $6,000 plus Deductible per family	$5,000 plus Deductible per individual $15,000 plus Deductible per family
70/50 Plan	$3,000 plus Deductible per individual $9,000 plus Deductible per family	$5,000 plus Deductible per individual $15,000 plus Deductible per family
Out of Network Hospital Confinement Copay Penalty	N/A	$250, then subject to Deductible and Coinsurance
Office Visits	Choice of $30 or $40 Copay per insured per visit for office visit charge at Preferred Physicians	Subject to Out of Network Deductible and Out of Network Coinsurance Share Maximum
Hospital Services **Inpatient Care**	Subject to In Network Deductible and In Network Coinsurance Share Maximum	Subject to $250 Copay, Out of Network Deductible, and Out of Network Coinsurance
Hospital Services **Outpatient Surgery** **Outpatient Non-Surgical Care**	Subject to In Network Deductible and In Network Coinsurance Share Maximum	Subject to Out of Network Deductible and Out of Network Coinsurance Share Maximum
Other Medical Services **Home Health Care** **Skilled Nursing Facility** **Durable Medical Equipment** **Hospice**	Subject to In Network Deductible and In Network Coinsurance Share Maximum	Subject to Out of Network Deductible and Out of Network Coinsurance Share Maximum
Diagnostic X-ray and Lab in Preferred Physician's Office	Waive In Network Deductible, then subject to In Network Coinsurance Share Maximum	Subject to Out of Network Deductible and Out of Network Coinsurance Share Maximum
Emergency Room	$50 Access Fee, then subject to In Network Deductible and In Network Coinsurance Share Maximum	
Prescription Drug Benefit		
Retail Pharmacy (Up to 34-day supply)		
Generic Drugs Copay	$10 or 10% of the cost of the drug, whichever is greater	
Preferred Brand Copay	$25 or 25% of the cost of the drug, whichever is greater	
Brand Copay	$40 or 40% of the cost of the drug, whichever is greater	
Mail Order Pharmacy (Up to a 90-day supply for maintenance medications)		
Mail Order Generic Drugs Copay	$30 Mail Order Copay	
Mail Order Preferred Brand Copay	$75 Mail Order Copay	
Mail Order Brand Copay	$120 Mail Order Copay	

Classic Choice Plan Provisions

Deductible

Each employer may elect one of the following calendar year In Network deductible amounts: $500, $1,000, $1,500, $2,500, $3,000, or $5,000 (15+ groups only).

The Out of Network deductible amounts are two times the In Network Deductible amounts.

There is a per confinement copay of $250 for each admittance as an inpatient to a non-preferred provider hospital.

Covered expenses incurred during the last three months of the calendar year and applied toward that calendar year's deductible may also be applied toward the following year's deductible.*

Family Deductible

The Family Deductible may be satisfied by combining all amounts applied to the individual deductibles for the insured employee and his/her insured dependents for the calendar year. The Family Deductible is three times the Individual In Network or Out of Network Deductible.

Coinsurance Share

There is an In Network Coinsurance Share and an Out of Network Coinsurance Share. The coinsurance share is the amount of covered expenses that an insured must pay after the deductible has been satisfied.

It does not include any copay amounts (including drug card copay amounts) or any amounts paid at 50% under any limitations.

Preferred Physician Office Visit Copay

There is a choice of a $30 or $40 copay amount for each office visit charge by a Preferred Physician, provided the office visit charge is for a covered expense. The copay applies to each office visit charge by a preferred physician, and it does not apply to charges other than the office visit charge itself.

If, during an office visit, a preferred physician performs and bills for x-ray or laboratory tests, we will waive the In Network deductible amount and pay the covered expense for those x-ray and laboratory tests at the In Network Coinsurance percentage.

*Does not apply when Shared Deductible option is selected.

Non-Preferred Provider Charges

All charges by non-preferred providers are reduced to the 60th percentile of reasonable and customary before consideration.

Emergency Room Access Fee

There is a $50 emergency room access fee for expenses incurred for emergency services provided in a hospital emergency room. This amount is in addition to any deductibles and coinsurance share amounts. The insured does not have to pay the emergency room access fee if directly admitted to the hospital as an inpatient following an emergency room visit.

Maximum Benefit Amount

The Maximum Benefit Amount is $5,000,000.

Choice of PPO Network

We are better able to reduce the costs of health care through various PPO networks of physicians, hospitals, and other providers. The benefits and premiums for this plan are based on the assumption that insureds will use these preferred hospitals, participating physicians, and other providers who are members of the PPO Network selected by the group.

Shared Deductible

The employer can select a higher deductible amount and offer the employees a lower deductible with the employer assuming the risk for the difference.

- Employer selects a high deductible amount ($1,500 and higher).
- Employer chooses the deductible amount and/or coinsurance each employee must meet within that self-funded deductible.
- Employer will access his fund when an employee actually incurs expenses beyond their share of the high deductible or if the Wellness Benefit was selected.
- Employer reduces his health benefits expense without assuming significant risk while keeping superior benefits for the employees.
- We do the administration - including writing checks to providers on the employer's checking account.

We offer administrative claim services for those employers who want to self-fund a portion of the deductible provided to their employees. This option is available to groups of 5 or more insured employees, with deductibles of $1,500 or

higher under the insured portion of the plan. There is a monthly per employee fee for processing the self-funded claims.

The following choices must be made by the employer:

- The deductible and coinsurance options for the plan and the underlying deductible and/or coinsurance share for the employees with Individual Coverage and for employees with Family Coverage.
- Whether or not the employer wishes to add a Wellness Benefit which would be self-funded under the plan by the employer.
- Pekin Life Insurance Company will process the claims under the self-funded portion of the plan. The employer will have these claims paid directly by us through the employer's checking account.

The employer must decide if he/she is funding any portion of the out of network expenses under the plan, or if he/she wants the employee to assume all out of network expenses. Once the maximum self-funded benefits have been paid, Pekin Life Insurance Company will pay any additional benefits according to the terms of the insured portion of the plan.

Pre-Certification and Utilization Review

Pre-Admission Certification

The Pre-Certification Hotline must be called when an insured is going to be admitted as an inpatient to a hospital or skilled nursing facility or when an insured is going to have surgery performed outside of their primary care physician's office.

The Pre-Certification Hotline must be called at least 72 hours before an insured is scheduled for non-emergency surgery performed outside of the primary care physician's office or admitted to a hospital or skilled nursing facility for an inpatient stay. The Pre-Certification Hotline must be called within two business days following emergency surgery or emergency admission to a hospital or skilled nursing facility. The Pre-Certification Hotline must also be called two months before the expected date of delivery for a pregnancy and called again on the day of delivery.

Continued Stay Review

The reviewer will assign a length of stay to the proposed admission (upon completion of the pre-admission certification). 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.

If insureds fail to have their admission or surgery pre-certified, then the first $500 of covered expense incurred as a result of the surgery or admission will not be covered.

Covered Expenses

Covered expenses are subject to deductibles; coinsurance; copay, if applicable; the exclusions and limitations; and the maximum benefit selected.

Hospital and Other Facility Charges

- Semi-private room and board.
- Intensive care.
- Hospital services and supplies which are to be used while in the hospital.
- Emergency services in a hospital emergency room.
- Outpatient medical care and treatment.
- X-rays, 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 reasonable & customary fees for home chemotherapy.
- Laboratory tests.
- Outpatient surgery performed in a licensed ambulatory surgical facility.

Physician Charges

- Physician office visits or 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 reasonable & customary amount for the first surgical procedure, 50% of reasonable & customary amount for the second surgical procedure, and 25% of reasonable & customary for each additional surgical procedure.
- 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.

Skilled Nursing Facility Care

Up to 30 days of care in a licensed skilled nursing facility are covered if:

a. Entry to the skilled nursing facility occurs within 24 hours after discharge from a hospital; and
b. the care is certified as medically necessary by the attending physician, and is recertified every seven days; and
c. the care is continued treatment of the same illness or injury that the insured has been hospitalized for prior to entry to the skilled nursing facility.

However, charges in excess of the maximum daily rate established for a licensed skilled nursing facility by the Department of Health and Social Services will not be considered covered expense.

Hospice Care

(Subject to prior approval by our case management nurse.)

Home Health Care

(Subject to prior approval by our case management nurse.) 40 visits in any 12-month period.

Miscellaneous

- Blood, blood plasma, and its administration.
- Casts, splints, trusses, braces, and crutches.
- Durable medical equipment, when we have preauthorized the purchase or rental.
- The initial purchase of artificial limbs, eyes, and larynx.
- Local ground ambulance transportation to the nearest preferred provider hospital able to provide the care, not to exceed $1,000 in a calendar year.
- Air ambulance transportation to the nearest preferred provider hospital able to provide the care, not to exceed $10,000 in a calendar year.
- Ostomy supplies.
- Surgical dressings for two months following surgery.
- The purchase of one pair of the following while insured under this policy:
  - One pair of orthopedic shoes.
  - One support stocking for each leg.
  - One article of similar apparel-type item.
- The installation and purchase of one insulin infusion pump per calendar year, and for other equipment and supplies used for the treatment of diabetes, including diabetic self-management education programs.
- Blood lead tests for children under six years of age.
- Second surgical opinion by a preferred physician.
- Breast prosthesis or reconstructive surgery following a mastectomy, including surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Two mammograms for women age 45 to 49 years of age, when separated by at least two years.
- An annual mammogram for women 50 years of age or older.
- For diagnostic procedures and medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders if all of the following apply:
  a. The condition is caused by congenital, developmental, or acquired deformity, disease, or injury.
  b. Under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.
  c, The purpose of the procedure or device is to control or eliminate infection, pain, or disease.
  d. The procedure or device is not for cosmetic or elective orthodontic care, periodontic care, or general dental care.

  However, we will not pay more than $1,250 in a calendar year for diagnostic procedures and medically necessary nonsurgical treatment for the correction of temporomandibular disorders.
- For hospital or ambulatory surgery center charges and anesthetics provided in conjunction with dental care that is provided to an insured in a hospital or ambulatory surgery center, if any of the following apply:
  a. The insured is a child under the age of five.
  b. The insured has a chronic disability that meets all of the conditions under s.230.04(9r)(a)2.a., b., and c.
  c. The insured has a medical condition that requires hospitalization or general anesthesia for dental care.
- For covered expense for necessary and appropriate immunizations provided by a preferred provider for an insured dependent child under six years of age. Benefit will be paid at 100% and will not be subject to any deductible or coinsurance. Necessary and appropriate immunizations means the administration of vaccine that meets the standards approved by the U.S. public health service for such biological products against all of the following: diphtheria, pertussis, tetanus, polio, measles, mumps, rubella, hemophilus influenza B, hepatitis B, and varicella.
- Anesthesia and its administration.
- Allergens dispensed by a physician.
- Medications requiring a written prescription that are self-injected, except that insulin and syringes are only covered under the prescription drug card benefit.

Transplant Benefit

- We will pay 100% of approved transplant services if they are performed at a designated transplant facility. (Contact Pekin Life Insurance Company for a list of designated transplant facilities.) This would include transportation for the insured member to and from the designated transplant facility, as well as lodging for one member of that person's immediate family. The maximum amount we will pay for food and lodging for the accompanying family member is $10,000, with a daily maximum benefit amount of $200. The organ procurement and acquisition costs are also covered in full when performed at a designated transplant facility.
- If a non-designated transplant facility is used, we will pay 90% of the covered expense in excess of the deductible. Once the insured has paid 10% of $100,000 of covered expense, then we will pay 100% of the covered expense for the rest of the calendar year during which the organ transplant occurred. There is no coverage for transportation or for organ procurement and acquisition.

Prescription Drug Card Benefits

A Prescription Drug Card is included as part of this policy. The insured pays a copay or a percentage of the cost of the covered medication. The insured's portion of the cost varies by the type of medication purchased and the place of purchase. The copay and percentage amounts are shown on page one of this brochure.

Our drug card benefit has utilization controls in place to make certain an insured is taking the most appropriate, cost-effective medication.

- The step therapy program requires insureds to try and fail less expensive, therapeutically equivalent medications before we will cover a more expensive medication.
- Our quantity limit programs will only cover dosage amounts of a medication that meet the manufacturer's recommendations. If one pill a day will suffice, we will not cover two pills of a lesser dose a day. We will also only allow the lesser of a 34-day supply or 100-unit doses of a medication purchased at a retail pharmacy, and a 90-day supply of a medication purchased from the mail order pharmacy.
- The drug card only covers the cost of a generic drug if available. If an insured purchases a brand drug when a generic equivalent is available, the insured will be required to pay the generic copay amount plus the difference in cost between the brand and generic drugs.

Injectable medications, other than insulin, are excluded under the drug card benefit. These items are covered under the major medical. If an insured needs an injectable medication other than insulin, he or she will need to contact our case management nurse for referral to a cost-effective vendor and for preapproval of the medication.

A detailed list of covered and excluded prescriptions is available upon request.

Contraceptive Benefit

This benefit provides coverage for injections for contraceptive purposes, including Depo-Provera® and Norplant®, and for contraceptive devices which require a written prescription before dispensing. The prescription drug card will cover oral contraceptives, regardless of intended use.

Mental Health Parity Benefit

This benefit is available only to groups with 50 or more employees.

The inclusion of mental parity changes the Mental Illness/Nervous Disorders and Chemical Dependency Coverage. The limitations for Mental Illness/Nervous Disorders are removed with mental parity. The limits will still apply to Chemical Dependency.

Limitations

When an insured receives treatment for the following limited benefits, the plan's regular coinsurance percentages, coinsurance share amounts, and copay amounts may not apply.

Mental Illness/Nervous Disorders & Chemical Dependency

The maximum benefit per calendar year for inpatient treatment is $7,000, minus any applicable deductible or coinsurance.

The maximum benefit for outpatient treatment is $2,000, minus any applicable copays.

The maximum benefit for transitional treatment is $3,000, minus any applicable deductible or coinsurance.

The maximum benefit per calendar year for all forms of treatment is $7,000.

Sterilization

We pay 50% after a 12-month waiting period and after the deductible has been satisfied.

Physical Therapy

The maximum benefit that will be paid for outpatient physical therapy is limited to $1,000 for each insured in a calendar year.

Occupational Therapy

The maximum benefit that will be paid for outpatient occupational therapy is $1,000 for each insured in a calendar year.

Speech Therapy

The maximum benefit that will be paid for outpatient speech therapy is $1,000 for each insured in a calendar year.

Kidney Disease

We will not pay for more than $30,000 of covered expense in a calendar year for kidney disease treatment.

Pre-Existing Condition Limitation

- If an insured is not a late enrollee, an expense incurred for treatment of a pre-existing condition during the insured's first 12 months of coverage will not be considered a covered expense.
- The 12-month period will be reduced by the amount of time the insured was covered by qualifying creditable coverage the insured had as of the enrollment date.
- Pre-existing 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.
- Pregnancy is not considered a pre-existing condition.

Exclusions

This policy does not cover and no benefits are payable for charges for, or related to:

- An act of war.
- Service in the armed forces.
- Complications arising from excluded treatment, except for complications of pregnancy.
- Commission of a felony or illegal activities.
- Services that are not medically necessary.
- Services for which no benefit is defined or described in the 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.
- Norplant®, or any items that can be used for contraceptive purposes, except as provided under the "Contraceptive Benefit."
- 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 workers 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 workers compensation-type coverage has denied a claim, but the insured is still pursuing coverage with the workers 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 workers compensation-type coverage.
- Eye examinations for the correction of vision or fitting of glasses or contact lenses except as provided under any Wellness Benefit for Preventive Health Care.
- Hearing aids, eyeglasses, frames, contact lenses, denture.
- Any dental treatment, dental surgery, or extractions; except for:
    - The treatment of injuries to whole natural teeth. The injury must have occurred while the insured was covered under this policy or the former policy. The treatment must be performed during the first 12 months after the date of injury.
    - Treatment for temporomandibular joint disorder, as specifically outlined under the section titled "Expense Covered by the Plan."
    - For hospital or ambulatory surgery center charges and anesthetics provided in conjunction with dental care that is provided to an insured in a hospital or ambulatory surgery center, as specifically outlined under the section titled "Expense Covered by the Plan."
- Any service or supply not recommended or approved by a licensed medical practitioner.
- Any treatment or surgery that results in the improvement of appearance, except for that which is

the result of an injury. The injury must have occurred while the insured was covered under this policy or the former policy. The treatment must be performed during the first 12 months after the date of injury.

- Services or supplies that are not for the diagnosis or treatment of an existing illness or injury, except as provided under any Wellness Benefit for Preventive Health Care.
- Immunizations or vaccinations, including Synagis or similar immunization agents, except as provided under any Wellness Benefit for Preventive Health Care.
- Abortions, except where the mother's life is threatened.
- Normal pregnancy or childbirth, including expense for a well newborn's initial hospital confinement, except as may be provided in this policy under a specific provision titled "Pregnancy Like Any Illness." However, expense that is in excess of the amount incurred for a normal delivery and that is incurred for a complication of pregnancy will be considered covered expense.
- Any orthodontic procedure or appliance.
- More than one ultrasound examination for a normal pregnancy.
- Amniocentesis, except for the diagnosis or treatment of an existing complication of pregnancy.
- Reversal of sterilization procedures.
- Nonmedical services and supplies.
- Any oral medication intended to be self-administered except as may be provided under the Prescription Drug Card Benefit.
- Durable medical equipment, unless we have preauthorized the purchase or rental of the equipment.
- Any service or supply that the insured is not legally required to pay for, including any forgiveness of deductible, copay, or coinsurance by a provider.
- Any surgery for the correction of a refractive error.
- Treatment received in the emergency room of a hospital, except when emergency services are being rendered.
- The replacement of a piece of durable medical equipment or a prosthesis.
- Custodial care.
- Services furnished by the insureds or a member of their or their spouse's immediate family, or by a person who regularly lives in their home.
- Hospital charges for the first weekend in the hospital if the insured is admitted to a hospital on a Friday, Saturday, or Sunday, except when the admission is for emergency services, or when surgery is performed the next morning.
- Treatment related to infertility or the restoration of fertility, or the promotion of conception including in vitro fertilization.
- Nutritional supplements.
- Animal to human organ transplants.
- Replacement of human organs by artificial or mechanical devices.
- Treatment of nicotine, caffeine, gambling, computer, or similar addictions.
- Any medical treatment, surgical procedure, weight reduction program, membership dues, or clinic fees for the treatment of obesity, including morbid obesity; any surgical procedure to remove excess tissue caused by weight loss.
- Services provided by a midwife, except where specifically licensed by the state to practice midwifery.
- A sterilization procedure performed during the insured patient's first 12 months of coverage under this policy or the former policy.
- By a registered nurse (RN) for private duty professional nursing services.
- Sclerotherapy for varicose veins.
- For devices used specifically as safety items or to affect performance, primarily in sports-related activities.
- Medical or surgical treatment of upper or lower jaw alignment conditions or malformations including orthognathic surgery, except for:
  - Direct treatment of acute traumatic injury or cancer; or
  - as provided specifically for the treatment of Temporomandibular Joint Disorder.
- Wigs or hair prosthesis.
- Routine foot care related to corns, calluses, flat feet, fallen arches, weak feet, or chronic foot strain, except that routine foot care for patients with diabetes will be covered; shoe inserts, casting for orthotics, and orthotics.
- Physical conditioning programs such as athletic training, body-building exercises, fitness and flexibility programs.
- Surrogate parenting.
- The services of a massage therapist, athletic trainer, or masseuse; acupuncture or acupressure treatment.
- Fetal treatment.
- Sexual transformation.
- Breast reduction surgery, except when performed in conjunction with reconstructive surgery following a mastectomy.
- Treatment performed outside the United States, except when an emergency.
- Removal of breast implants that were implanted solely for cosmetic reasons.
- Growth hormone treatment, except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to growth hormone deficiency, growth retardation secondary to chronic renal failure before or during dialysis, or for patient 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.

Optional Health Coverage

The employer may choose from the following optional coverages for the group policy. If selected, they will be included in the group proposal.

Wellness Benefit for Preventive Health Care

This optional benefit is available if the employer selects it. After the insured pays the copay amount toward the Preferred Physician's charge for a preventive health care exam, we will pay 100% of the reasonable and customary charges in excess of the copay amount for preventive health care. Preventive health care means a history and general physical examination, routine immunizations, and the following tests when ordered by a Preferred Physician in conjunction with the preventive health care exam and provided by a Preferred Provider:

- Mammogram.
- Pap smear.
- Blood screening tests such as screening tests for cholesterol level, diabetes, sexually transmitted disease, PSA test, and liver function.
- Chest x-rays, electrocardiograms, and stress tests.
- Screening tests for colon cancer.
- Tuberculosis skin test.
- Routine vision exam.

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.

Pregnancy Like Any Illness

Expenses of a normal pregnancy are paid the same as any other sickness, if this option is selected. Groups with two to four employees require a minimum of two family-type coverages to have the pregnancy benefit. This optional benefit may only be added at the time of issue or upon the next renewal date after a request to add is made. This benefit may be deleted on the next renewal date after such a request is made. Once deleted, maternity cannot be re-added later.

The expense incurred during a well newborn's initial confinement is covered only if we pay benefits for the pregnancy under this Optional Benefit. If a newborn child needs treatment for an illness or injury, benefits will be available for that newborn only if the newborn child is insured as a dependent under the policy.

For a covered pregnancy, hospital services for inpatient care for the mother and dependent child will be covered for a minimum of 48 hours following a vaginal delivery, or a minimum of 96 hours following a cesarean section (unless a post-discharge office visit to the physician or an in-home nurse visit is provided in the first 48 hours after discharge, or an earlier discharge is consented to by the mother and the attending physician).

Employee Life and AD & D Insurance

Group Life Insurance and Accidental Death and Dismemberment protection are optional coverages. The life insurance amount for an insured employee reduces 35% at age 65 and an additional 35% at age 70.

Choose from a flat amount of $15,000 or more, or a multiple of salary, not to exceed $50,000 or two and one-half times salary for groups with 2 to 14 employees. The life amount selected by the employer will be indicated on the group quote proposal. Groups with 15 or more employees may choose a life maximum amount based on the volume of the group. Check with the underwriter.

Dependent Life Insurance

Dependent Life Insurance is optional to the group. The amount of life insurance on each dependent varies by group size. For groups with 2 to 14 employees, the employer may select $5,000 on the spouse, $2,500 on children 6 months of age and older, and $250 on children age 14 days to 6 months. Groups with 15 or more employees may select any life amount for dependents, as long as it is equal to or less than the employee life amount and is a minimum of $2,000. The amount for children 14 days to 6 months is 10% of the amount for children 6 months and over. The amount selected by the employer will be indicated on the group proposal.

Weekly Benefit or Loss of Income Rider

If selected by the employer and indicated on the group quote proposal, this optional coverage replaces a portion of the employee's income lost due to an injury or illness. The waiting period and the amount of weekly benefit should be coordinated with any employer-sponsored sick time. The disability must begin while the employee is insured. Payment will begin after the waiting period and will never exceed more than 70% of the employee's salary. Benefits will be paid for a period no longer than the benefit period selected by the employer.

For employers with less than 15 employees, the waiting period is zero days for accident, seven days for sickness, and benefits will be paid for 26 weeks. For employers with 15 or more employees, the following options are available:

Waiting Period for Accident	(0, 7, 14, or 30 days)
Waiting Period for Sickness	(7, 14, or 30 days)
Benefit Period	(13 or 26 weeks)

Benefit changes due to a change in salary will occur only on January 1 of each year and will be based on the salary as of that date. No coverage is provided for any period of partial disability.

Administrative Guidelines

Employee Eligibility

All active full-time employees working at least 30 hours each week are eligible for coverage.

Employees beginning work on a full-time basis after the policy is effective become eligible following the completion of a waiting period chosen by the employer.

Dependent Eligibility

Dependents are eligible when the employee is eligible. Eligible dependents include the employee's spouse and unmarried children to age 19, or to age 25 if a full-time student in classroom attendance, or a child dependent on the insured for full maintenance and support due to mental retardation or physical handicap.

Participation Requirement

Number of Eligible Employees	2	3	4	5	6	7	8	9	10+
Minimum Participation Required	2	3	3	4	5	6	6	7	75%

At least 75% of all eligible employees not covered by other health insurance must participate in the health insurance plan. A minimum of 50% of all eligible employees must participate in the health insurance plan, and a group must never have less than two employees insured under the policy.

Contribution Requirement

The employer must contribute a minimum of 50% toward the employee-only premium, or 25% of the employee and dependent premium.

Underwriting

All applicants are to complete all sections of the application. Also, it is necessary to include a Certificate of Creditable Coverage, if the applicant has had any other health insurance coverage in force in the 12 months before the application date.

- **Adding a new employee**
  If an employee or his dependents apply on or before the date they are eligible, they will become insured on the date they are eligible. If an employee or his dependents apply within 30 days after the date they are eligible, they will become insured on the premium due date following the date they apply.
- **Late enrollees**
  The application for a late enrollee in Wisconsin will be postponed for 18 months from the date it is signed.

  If the employee is continuously employed by the employer during the 18-month period, those eligible and listed on the application will become insured on the premium due date following the end of the 18-month postponement period.

Coordination of Benefits

If a person has medical or dental coverage under another group plan, we will coordinate our benefits with those of that plan.

Renewability

This plan may be nonrenewed or terminated for the following reasons:

- Fraud or misrepresentation.
- Noncompliance with the policy's minimum participation requirements.
- Noncompliance with the policy's employer contribution requirements.
- Noncompliance with plan provisions.
- Repeated misuse of the Preferred Provider Network provisions.
- The group is not actively engaged in any business.

Premium Changes

Premiums may change if there is a need for new rates after the policy has been in force for 12 months, or sooner than 12 months if the group has taken on substantial health risks since initially written. Also, if not all health information was disclosed at the time of issue, we may go back to the original issue date and charge the appropriate premium. We will give the group at least 30 days notice of any rate change, except rate changes due to changes in coverage.

For those groups issued with 2 to 14 employees, employers need to be aware that the employee rates are "banded" in 5-year age bands. Whenever an employee has a birthday that moves him into a new age band, then the premium for that employee unit will change that month, regardless of when the policy was written.

Coverage Continuation

Continued coverage may be available after termination in accordance with the appropriate state regulations.

COBRA continuation of health insurance is also offered to groups required to comply with that law.

Deductible Credit

This provision applies when we replace another group-type contract. We will subtract the amount of the deductible the employee or dependent satisfied under the former group-type policy from our deductible. Proof acceptable to us must be submitted to show the amount of the deductible satisfied with the prior carrier.

Right of Reimbursement

If an insured receives benefits from us and a third party, we have the right to recover our benefits.

Termination of Employee/ Dependent Coverage

The insurance will end on the earliest of the following dates:

- The date any premium due is not paid; or
- the premium due date following the date the employee or the dependent no longer meets the definition of an employee or dependent; or
- the date the group policy terminates.

The employer may choose to leave employees on the plan for a fixed period of time if an employee is laid off, granted a leave of absence, or is totally disabled. The period of time is chosen by the employer when the policy is issued.

Disclosure of Information

Information concerning the Group policy is available upon request by a small employer. Contact us at the Group Department, 2505 Court Street, Pekin, Illinois 61558. Some of the information available upon your request is information concerning:

- The provisions of the policy concerning our right to change premium rates and the factors that may affect changes in premium rates.
- The provisions of the policy relating to renewability of coverage.
- The provisions of the policy relating to any pre-existing condition exclusion.
- The benefits and premiums available under all health insurance coverage for which the employer is qualified.

Requesting a Proposal

A proposal can be requested by submitting a "Request for Group Proposal, Form LG213," to the Pekin Life Insurance Company's Home Office. These forms can be obtained from the Home Office.

Pekin Life Insurance Company's plan provides agents the ability to rate small groups of 2 through 14 employees by using our Intranet Rating System.

Enrolling a Group

Contact your Pekin Life Insurance Company Group Underwriter immediately when a quote has been accepted. They will see that an enrollment kit is sent to you the same day. Please request the enrollment kit from the Home Office to avoid enrolling a group on the wrong application. All applications must be submitted at the time of enrollment.

Premiums shown in the proposal have been computed using the data that was furnished to us. We reserve the right to adjust the premiums if the enrollment information differs from the information that was used to compute the premiums. The health of those enrolling may also affect the premiums.

Before coverage can start, we must approve the group. The first month's premium, the master application, and an enrollment form completed by each employee must be received by us prior to the desired effective date before we can approve the group.