

TRUSTMARK INSURANCE COMPANY (MUTUAL)

400 Field Drive
Lake Forest, Illinois 60045
(Herein We, Us and Our)

MAJOR MEDICAL EXPENSE COVERAGE

This is Your Certificate of Insurance (Certificate) while You are Insured. It explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a contract between the Policyholder and Us.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in this Certificate. Benefit payment is governed by all the terms, conditions and limitations of the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

A copy of the Policy is kept at Our home office. You may inspect it during regular business hours.

This Certificate was issued on the basis that the information on Your application is correct and complete. **If any information on the application is not correct or complete, write to Us within ten (10) days of receipt of this Certificate. An error or omission may result in loss of coverage as of its effective date.**

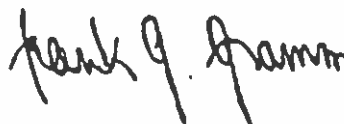
Right to Examine: If You are not satisfied with this Certificate, return it to Our home office or to Your agent within ten (10) days after the date You received it. The Certificate will then be canceled and any Premium paid will be refunded.

NOTICE: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible for you to comply with both plans at the same time. Read all of the rules very carefully, including the coordination of benefit section, and compare them with the rules of any other plan that covers you or your family.

Please Read this Certificate Carefully



J. Grover Thomas Jr.
President & Chief Executive Officer



Frank G. Gramm
Corporate Secretary & General Counsel

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**NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE
OHIO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of Ohio who purchase life insurance, annuities or disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is **NOT** provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Ohio Life and Health Insurance Guaranty Association
1840 Mackenzie Drive
Columbus, Ohio 43220
Department of Insurance State of Ohio
2100 Stella Court
Columbus, Ohio 43266-0566

The state law that provides for this safety-net is called the Ohio Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association

COVERAGE

Generally, individuals will be protected by the Ohio Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);

- the insurer was not authorized to do business in this state;
- their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is; not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Association is obligated to pay out: The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$100,000 in cash surrender values, \$100,000 in health insurance benefits. \$100,000 in present value of annuities, or \$300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for the unallocated annuities that fund governmental retirement plans under **401(k), 403(b), or 457 of the Internal Revenue Code, the limit is \$100,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the Association be liable to spend more than \$300,000 in the aggregate per individual; for covered unallocated annuities that fund other plans, a special limit of \$1,000,000 applies to each contractholder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

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DEFINITIONS

Approved Transplant Services: Services and supplies which are related to a transplant procedure, approved in writing by Us, and include but are not limited to:

- Pre-transplant evaluation for the Medical Necessity of the transplant;
- Hospital charges;
- Physician charges; and
- Tissue typing and ancillary services.

Brand Name: A Prescription Drug manufactured, marketed and sold under a trademark name.

Complications of Pregnancy: A condition which: (a) is not part of a normal pregnancy; and (b) whose diagnosis is distinct from pregnancy but is adversely affected by or caused by pregnancy.

Complications of Pregnancy include: (1) nonelective caesarean section or ectopic pregnancy which is terminated; (2) spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible; (3) acute nephritis; (4) nephrosis; (5) cardiac decompensation; (6) missed abortion; (7) hyperemesis gravidarum; (8) eclampsia; (9) puerperal infection; (10) RH factor problems; (11) severe loss of blood requiring transfusions; and (12) similar medical and surgical conditions of comparable severity.

Complications of Pregnancy does not include: (1) false labor; (2) occasional spotting; (3) Physician prescribed rest during pregnancy; (4) morning sickness; (5) preeclampsia; and (6) similar conditions associated with the management of a difficult pregnancy but which are not a separate complication of pregnancy.

Compound Medication: A randomly prepared dosage form containing:

- At least one Federal Legend or State Restricted Drug; or
- Combined ingredients which require a prescription for the specific dosage or amount prescribed; and
- If a liquid, includes either: at least one solid that is weighed; or three measured liquids.

Copayment: The portion of the Covered Drug expense a Covered Person must pay for each prescription or authorized refill after the Drug Deductible has been met. The Copayment is shown on the Schedule. This amount does not apply toward the satisfaction of the Out-of-Pocket maximum.

Covered Person: A person listed on the Schedule as insured under this Certificate.

Deductible: The amount of Covered Charges a Covered Person must pay before We pay any benefits. The Deductible applies separately to each Covered Person each Year. This amount does not apply toward the satisfaction of the Out-of-Pocket Limit.

Dependent: A person who is:

- (1) Your legally married spouse.
- (2) Your unmarried natural or legally adopted children who are dependent upon You for support and maintenance and are under the age of 19.
- (3) Your step children who reside with You and are under the age of 19.
- (4) Your unmarried natural, step or legally adopted children age 19 to age 24, but only if they are:
 - (a) Full-time students at an accredited educational institution; and
 - (b) Dependent upon You for support and maintenance.

A child age 19 to age 24 ceases to be a Dependent on the last day of the month in which the child fails to qualify as a full-time student, except for regularly scheduled vacation periods.

- (5) Your unmarried child for whom a court has issued a medical support order which decrees that You must provide medical coverage.

Designated Facility: A facility which has an agreement with Us to render Approved Transplant Services. The facility may be outside a Covered Person's geographic area.

Drug Deductible: The amount of Covered Drug expense a Covered Person must pay before We pay any benefits. The Drug Deductible applies separately to each Covered Person each Year. The Drug Deductible is shown on the Schedule.

Emergency: An Injury or sudden onset of a medical condition, which manifests itself by acute symptoms, which is sufficiently severe that without immediate medical care the person could reasonably expect: (a) his life or health would be in serious jeopardy; (b) his bodily functions would be seriously impaired; or © a body organ or part would be seriously damaged. This would include childbirth.

Emergency Room Access Fee: A per visit amount that must be paid by the Covered Person for services rendered in the emergency room when the person is not Hospital confined. If the Covered Person is admitted as an inpatient directly from the emergency room then this fee will be waived. The Emergency Room Access Fee is in addition to the Deductible and is shown on the Schedule. This amount does not apply toward the satisfaction of the Out-of-Pocket Maximum. Any amounts incurred above the Emergency Room Access Fee are subject to Deductible and Insured Percent.

Experimental/Investigational: A drug, device or medical treatment or procedure is considered experimental or investigational if:

- It has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law;
- Reliable evidence shows it is the subject of ongoing Phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment of diagnosis; or
- Reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility or other facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical treatment or procedure.

Family Member: You, Your spouse, or the parent, child, brother or sister of You or Your spouse.

Federal Legend Drug: Any drug or medicine which must bear the legend: "Caution: Federal Law prohibits dispensing without a prescription."

Free Standing Surgical Center: A facility licensed as a free standing or ambulatory surgical center; which is operated solely for the purpose of providing outpatient surgical care.

Generic: A Prescription Drug manufactured, marketed and sold under a generic name which is medically equivalent to a Brand Name as determined by the federal Food and Drug Administration.

Home Health Care: Treatment, services or supplies furnished in a Covered Person's home by a licensed or certified home health agency pursuant to a written plan prescribed by a Physician as Medically Necessary.

Hospice Care: A program of palliative and supportive care provided by a licensed or certified hospice. Hospice Care is available to a Covered Person and his immediate family upon a Physician's diagnosis of terminal illness.

Hospital: An institution licensed, accredited or certified by the State which: (a) is accredited by the Joint Commission on Accreditation of Hospitals; (b) provides 24-hour nursing service by registered nurses (RN); (c) mainly provides diagnostic and therapeutic care under the supervision of Physicians on an inpatient basis; and (d) maintains permanent surgical facilities.

A place, special ward, floor or other accommodation used for: custodial or educational care; rest; the aged; a nursing home; or an institution mainly rendering extended care or intermediate care will not be considered a Hospital.

Injury: Accidental bodily injury independent of disease, bodily infirmity or other cause.

Insured Percent: The portion of Covered Charges that We will pay after the Deductible has been met.

Maintenance Drugs: Prescription Drugs taken on a regular, routine or long term basis for care and treatment of chronic conditions only. The following are examples of chronic conditions for which maintenance drugs are taken: high blood pressure, arthritis, heart conditions and diabetes.

Manipulative Treatment: The diagnosis, analysis and adjustment of spinal subluxation; and manipulative therapy and related treatment of the musculoskeletal structure for other than fractures and dislocation of the extremities.

Medically Necessary/Medical Necessity: A service, supply or drug that is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to a confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A service, supply or drug shall not be considered as Medically Necessary if it:

- Is Experimental, Investigational or furnished in connection with medical research;
- Is provided solely for the convenience of the patient, the patient's family, Physician, Hospital or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
- Could have been omitted without adversely affecting the person's condition or the quality of medical care;
- Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration; or
- Involves a service, supply or drug not considered reasonable and necessary by the Health Care Financing Administration Medicare coverage issues manual.

We retain the right to determine whether a service, supply or drug is Medically Necessary.

Medicare: Title XVIII of the Social Security Act of 1995, as amended. A person is considered to be eligible for Medicare on and after the date the person is first eligible for any Medicare coverage.

Mental Illness: Any condition or disease, regardless of its cause, listed in the most recent edition of the Diagnostic and Statistical Manual of Disorders of the American Psychiatric Association as a mental illness.

Non-Designated Facility: A facility which is not a Designated Facility.

Non-Participating Pharmacy: A licensed pharmacy which is not a Participating Pharmacy.

Other Medical Expense Coverage: Any hospital or medical expense incurred policy or certificate, hospital or medical service plan and health maintenance organization subscriber contract, whether insured or uninsured, and regardless of where issued; or medical payments made pursuant to any national, state, or other governmental law of any country.

Participating Pharmacy: A licensed pharmacy which has contracted to participate in the prescription drug program.

Physician: A licensed medical doctor; surgeon; osteopath; podiatrist; dentist; optometrist; or chiropractor, psychologist, or mechanotherapist acting within the scope of such license, who is not a Family Member.

Pre-existing Condition: During the 12 months prior to the Effective Date: (a) a Sickness or Injury for which medical care, treatment, diagnosis or advice was received or recommended; or (b) the existence of symptoms which would cause an ordinarily prudent person to seek medical care, treatment, diagnosis or advice.

A Sickness or Injury fully disclosed on the application will not be considered a Pre-Existing Condition.

Prescription Drug(s): Drugs and medicines which are:

- Prescribed in writing by a Physician;
- Legally available only by prescription; and
- Are one of the following:
 - Federal Legend Drug;
 - State Restricted Drug; or
 - Compounded Medication.

Routine Physical Examination: A visit to a Physician's office which is not prompted by Sickness or Injury.

Sickness: Illness; disease; complication of pregnancy; and congenital defect, birth abnormality or prematurity of a covered newborn child.

Skilled Nursing Home: A licensed facility which: (a) operates within the scope of its license; (b) provides room and board accommodations at the patient's expense; © keeps a daily medical record of each patient; (d) routinely provides skilled nursing care under the direction of a Physician; and (e) provides skilled nursing care by, or under the supervision of, a registered nurse.

Skilled Nursing Home does not include: a rest home; a home for the aged; a place mainly for treating drug addiction, alcoholism or mental illness; or custodial or educational care facility.

State Restricted Drug: Any drug or medicine which is legally available only by prescription under applicable State law.

Usual and Customary Charge: The lesser of: (a) the actual charge; (b) the fee most often charged by the provider for the same service or supply; or © the fee most often charged in the same area by providers with similar training and experience for a comparable service or supply. "Area" means a metropolitan area, a county or a greater area if needed to find a cross-section of providers of a comparable service or supply.

Year: The calendar period beginning each January 1 and ending the following December 31. The first Year shall begin on the Effective Date.

You or Your: The Insured named on the Schedule.

All male terms will include the female, unless stated otherwise.

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CONDITIONS OF INSURANCE

ELIGIBILITY

- **INSURED** - You are eligible for coverage when You complete a valid application, provide evidence of insurability, pay the Total Initial Premium, and meet Our underwriting standards.
- **DEPENDENT** - A Dependent is eligible for coverage on the later of:
 - The date You become eligible for insurance; or
 - The date You acquire the Dependent.

A Dependent is deemed to be acquired as follows:

- **Spouse:** On the date of the marriage.
- **Natural Child:** On the date of birth.
- **Adopted Child:** On the date the child is placed in Your custody or the date You are legally or financially responsible for the child, if earlier.
- **Step Child:** On the date the Insured marries the step child's natural parent.

If an eligible person does not meet Our underwriting standards, We may:

- Refuse to insure that person;
- Insure that person but exclude a specific disease or physical condition from coverage; or
- Make a surcharge for that person's coverage.

EFFECTIVE DATE

- **INSURED** - Coverage will start at 12:00 a.m. standard time at Your residence, on the Effective Date shown on the Schedule.
- **DEPENDENT**
- **Newborn:** Coverage for a newborn is effective from the moment of birth. For coverage to continue:
 1. We must receive written notice of the newborn within 45 days of the birth or before the end of the period for which Premium has been paid if later, and
 2. You must pay any additional Premium within 31 days of receiving a notice of the amount due.

If notification of a newborn is received late, insurance will be effective only if an application for coverage is accepted by Us and Premium is paid.

- **Other Than A Newborn:** You must complete and sign an application which includes Your Dependents. If accepted by Us, an Effective Date will be assigned as follows:
 - The date Your insurance is effective for Dependents eligible on that date and for whom coverage is applied for;
 - For Dependents eligible on or first acquired after Your Effective Date; coverage will be effective on the date We assign.

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TERMINATION DATE

- **INSURED**

Coverage will terminate at 12:00 a.m. standard time at Your home on the earliest of:

- The date coverage is terminated by Us for all certificate holders in Your state.
- The date the Policy terminates.
- The date We receive Your written request to have Your insurance terminated.
- The end of the period for which Premium is paid, subject to the Grace Period.
- The date of Your death.
- The date We refuse to renew Your coverage because of fraud or intentional misrepresentation of a material fact under the terms of coverage.

At least 30 days prior written notice will be given to You if We terminate Your coverage for any reason, except for nonpayment of premium.

- **DEPENDENT**

Dependent coverage will terminate at 12:00 a.m. standard time at Your home at the earliest of:

- The premium due date following the date a Dependent ceases to be a Dependent as defined.
- The end of the period for which Premium for Dependent coverage is paid.
- The date Your coverage terminates, subject to any Continuation Of Coverage.
- The date We receive Your written request to terminate Dependent coverage.

CONTINUATION FOR DEPENDENTS

If You die or become eligible for Medicare and voluntarily terminate Your coverage, Your Dependents whose coverage was in effect on the date of Your death, or the date You became eligible for Medicare, may continue coverage under this Certificate. We should be notified of this election within 31 days of Your date of death, or within 31 days of Your Medicare eligibility. Benefits will be paid to the Dependent or a legal guardian, if the Dependent is a minor.

CONTINUATION FOR INCAPACITATED CHILDREN

Dependent children, insured herein, that reach the limiting age and are incapable of self-sustaining employment due to mental retardation or physical handicap may continue to be covered regardless of age. The Dependent must be chiefly dependent on You for support and maintenance.

You must claim handicap status within 31 days of such child attaining the limiting age. We will require proof of handicap as often as necessary, but not more than once a year.

Coverage for a handicapped child will end on the earliest of:

- The date the Dependent marries;
- The date the Dependent obtains self-sustaining employment;
- The date the Dependent ceases to be handicapped;
- The date the Dependent ceases to be chiefly dependent upon You for support and maintenance;
- Sixty (60) days after a written request for proof of disability, if proof is not provided within such 60 days;
- The date You refuse to allow Us to examine the Dependent; or
- The date coverage would otherwise terminate.

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CONVERSION

If coverage ends due to divorce, annulment, dissolution of marriage, legal separation or attainment of the limiting age, the Dependent may elect to convert to individual coverage.

Notice of this election must be received by us within 31 days of the event. No evidence of insurability will be required. Premium for the conversion policy must be paid within 31 days after the election is made. Premium will be based on our rates in effect at the time of conversion.

Benefits under the Conversion policy will not be greater than those provided under this Certificate.

Conversion is not available if:

- The Dependent has been covered by this Certificate for less than 3 months;
- The Dependent is eligible for Medicare; or
- The Dependent is eligible for Other Medical Expense Coverage.

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EXTENSION OF BENEFITS

If a Covered Person is Hospital confined on the date the Policy terminates or coverage is terminated for all Certificate holders in Your state, We will extend that Covered Person's benefits.

Extension applies only during Hospital confinement. Benefits will be paid as if coverage had remained in effect.

Extension of Benefits will end at the earliest of:

- The date Hospital confinement ends;
- Three (3) months from the date coverage otherwise ended; or
- The date You become eligible for Other Medical Expense Coverage.

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BENEFIT PROVISIONS

Benefits are only payable for incurred Covered Charges which are Medically Necessary and provided by or under the direction of a Physician. After the Deductible, We will pay the Insured Percent for Covered Charges, Transplant Benefits, and Wellness Benefits subject to:

1. The Usual and Customary Charge as established by Us;
2. Definitions, limitations, exclusions, benefit maximums and other provisions of the Certificate; and
3. The Cost Containment Procedures.

A Covered Charge is considered incurred on the date the service is rendered or the supply is furnished.

DEDUCTIBLE

The Deductible applies separately to each Covered Person each Year. A separate Deductible must be met for a covered newborn child. The Individual Deductible is shown on the Schedule.

FAMILY MAXIMUM: All Covered Persons under this Certificate need only satisfy a set number of Deductibles each Year. Once that happens, any remaining Deductible amounts are considered satisfied for that Year. The Family Maximum Deductible is shown on the Schedule.

COMMON ACCIDENT: If two or more Covered Persons are injured in the same accident, only one Deductible will be applied to the Covered Charges for that accident in the Year the accident occurs.

INSURED PERCENT AND OUT-OF-POCKET MAXIMUMS

The Insured Percent is the portion of Covered Charges that We will pay after the Deductible has been met. The Insured Percent may vary for certain Covered Charges. The Insured Percents are shown on the Schedule.

The Individual Out-of-Pocket Maximum is the amount of Covered Charges that You must pay each Year for each Covered Person. Once the Individual Out-of-Pocket Maximum has been paid, Covered Charges are payable at 100 percent for that Covered Person for the remainder of the Year. The Individual Out-of-Pocket Maximum is shown on the Schedule.

The Family Out-of-Pocket Maximum is the total amount of Covered Charges that You must pay each Year for all Covered Persons. Once the Family Out-of-Pocket Maximum has been paid, Covered Charges are payable at 100 percent for all Covered Persons for the remainder of the Year. The Family Out-of-Pocket Maximum is shown on the Schedule.

Out-of-Pocket amounts paid for the following will not apply toward the Out-of-Pocket Maximum:

1. Any applicable Deductible(s);
2. Covered Charges incurred for the treatment of Mental Illness;
3. The portion of a Covered Charge in excess of the Usual and Customary Charge;
4. Any expense which is not a Covered Charge;
5. Any benefit reduction or penalty for failure to use the Cost Containment Procedures;
6. The Emergency Room Access Fee; or
7. Any amount paid by You for Prescription Drug Card and Mail Order Prescription Drug Benefit.

MAXIMUM BENEFIT AMOUNTS

LIFETIME MAXIMUM: The Lifetime Maximum is the maximum amount of benefits We will pay on behalf of any Covered Person over the lifetime of that person for all Covered Charges. This includes any amounts paid under any conversion policy issued as a result of this Certificate. At no time, will total benefits available exceed the Lifetime Maximum shown on the Schedule.

SEPARATE COVERED CHARGE MAXIMUMS: Covered Charges for treatment of a certain Sickness or Injury are subject to Separate Benefit Maximums. These maximums are shown on the Schedule. Benefits paid pursuant to a Separate Benefit Maximum are included in the Lifetime Maximum.

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COVERED CHARGES

- Inpatient Hospital charges for:
 1. Room, board and general nursing care for each day of confinement, up to the most common semi-private (two bed) room rate at the Hospital where confined. If a Hospital has only private rooms, benefits will not exceed the most common semi-private room rate in the area.
 2. Confinement in an intensive care or coronary care unit.
 3. Other Medically Necessary services and supplies furnished by a Hospital for inpatient medical care.
- Physician charges for:
 1. Home, office and inpatient visits.
 2. Surgery.
 3. Dental treatment or surgery for Injury, except chewing injuries, to sound natural permanent teeth, within 6 months of the accident.
 4. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

- Outpatient medical care charges furnished at:
 1. A Free Standing Surgical Center; or
 2. The outpatient department of a Hospital.
- Charges for:
 1. Anesthetics and its administration;
 2. Professional local ambulance service to or from the nearest Hospital with available facilities to treat the Covered Person.
 3. X-rays, except dental x-rays, and laboratory tests for diagnosis or treatment.
 4. X-ray and radioactive isotope therapy.
 5. Dental x-rays necessary for the removal of a cyst or tumor.
- Manipulative Treatment, heat treatments and ultrasound, subject to the Separate Benefit Maximum shown in the Schedule.
- Supply and Equipment charges for:
 1. Blood and blood plasma.
 2. Oxygen and rental equipment for its administration.
 3. Original purchase of standard artificial limbs or eyes. Subsequent purchase only as needed due to: (a) growth of a child; or (b) progression of a Sickness or Injury.
 4. Original purchase of casts, splints, non-dental braces or crutches and surgical dressings.
 5. Rental of a wheelchair or hospital style bed or other durable medical equipment with the minimum features necessary for the circumstances. We may, at Our option, purchase such equipment. If purchased, the Covered Charge is limited to the purchase price and the cost of installation reduced by any amount paid for rental.
 6. Heart pacemaker.
 7. Intraocular lens implant or the first contact lenses or glasses following cataract surgery.
- Physical or speech therapy provided by a licensed therapist acting within the scope of that license who is not a Family Member.
- Private duty nursing care by a registered nurse (RN) or licensed practical nurse (LPN) who is not a Family Member, subject to the Separate Benefit Maximum shown on the Schedule.
- Inpatient and outpatient prescription drugs, insulin and supplies for insulin administration.
- Inpatient and outpatient treatment of chemical abuse or dependency, subject to the Separate Benefit Maximum shown on the Schedule.
- Inpatient, outpatient and intermediate primary care for alcoholism when performed in an office, a hospital, a community mental health facility or in an accredited alcoholism treatment facility.
- Inpatient and outpatient treatment of Mental Illness, subject to the Separate Benefit Maximum shown on the Schedule.
- Reconstructive surgery:
 1. Related to or following surgery for Injury, trauma, infection or other disease; or
 2. For the correction of birth abnormalities or congenital defects of a newborn child.
 3. Following mastectomy as follows:
 - 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. Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

- Home Health Care within 14 days following confinement in a Hospital or Skilled Nursing Facility for which benefits are payable. The attending Physician must certify prior to the first visit, that:
 1. Confinement would otherwise be required; and
 2. A Family Member cannot provide the necessary care without undue hardship.
- Home Health Care benefits are subject to the Separate Benefit Maximum shown on the Schedule, and are limited to:
 1. Physician home visits.
 2. Nursing care by or under the supervision of a registered nurse (RN).
 3. Home health aide services of a medical or therapeutic nature.
 4. Physical or speech therapy.
 5. Nutrition counseling by a registered dietitian.
 6. Medical services, prescription drugs and supplies which would be covered if Confined.

Up to 4 hours of treatment or services in any 24-hour period will be considered as one Home Health Care visit. This includes time spent evaluating the need for or developing the home care plan.

No Home Health Care benefits are payable for: medical care not included in the written home care plan; services provided by a Family Member; homemaker services; services to aid in the normal activities of daily living; or services not listed above as a benefit.

- Skilled Nursing Home charges for room, board and skilled nursing care, subject to the Separate Benefit Maximum shown on the Schedule, when such confinement:
 1. Begins within 14 days following a Hospital confinement; and
 2. Continues treatment of the Sickness or Injury which caused the Hospital confinement.
- Inpatient and outpatient Hospice Care prescribed by a Physician, subject to the Separate Benefit Maximum shown on the Schedule. Hospice Care charges will not be considered under any other Covered Charge benefit.

ITCOHCM10001

TRANSPLANT BENEFITS

Benefits are payable only for Approved Transplant Services.

Transplant Benefits are subject to Pre-Treatment Certification.

No Transplant Benefits will be paid without prior authorization. You should contact Us when a transplant has been decided, but before the donor selection process begins, to establish available benefits.

Prior authorization means You must:

1. **Notify Us of the procedure to be performed;**
2. **Have the Physician submit a complete medical history, including current diagnosis, transplant protocol and informed consent; and**
3. **Have the Physician certify that the procedure is Medically Necessary and that alternative procedures, services or courses of treatment would not be effective.**

Expenses must be incurred during the transplant benefit period. The transplant benefit period begins 5 days before the date the transplant is performed and ends 12 months thereafter. During the transplant benefit period, if a second admission is required, and a retransplant occurs, a new transplant benefit period starts 5 days before the date the retransplant is performed and ends 12 months thereafter.

TRANSPLANTS

Transplants are limited to the following, subject to all Benefit Maximums shown on the Schedule:

A) Organ transplants

Benefits are payable only for human to human organ Transplants.

1. Cornea;
2. Heart;
3. Liver;
4. Kidney; and
5. Lung;

B) High Dose Chemotherapy (HDC);

C) Stem Cell Infusion (SCI);

D) Autologous Bone Marrow Transplant (ABMT(1)); and

E) Allogenic Bone Marrow Transplant (ABMT(2)).

Donor Expenses

Unless covered by Other Medical Expense Coverage, Approved Transplant Services are payable for an organ donor. Benefits payable for the donor will be charged to the recipient's claim and subject to the Lifetime Maximum shown on the Schedule.

Designated Facilities for Approved Transplant Services

A person who is authorized for a transplant procedure will be referred to a Designated Transplant Facility. If the person is denied the procedure by the Designated Transplant Facility, he will be referred to a second such facility for evaluation. If the person is denied the procedure at the second Designated Transplant Facility, no benefits will be paid for any services or supplies related to that procedure. This applies regardless of whether the procedure is performed at a third Designated Transplant Facility or at a Non-Designated Transplant Facility.

In addition to Approved Transplant Services, benefits will be paid, up to \$10,000 per procedure, subject to the Lifetime Maximum shown on the Schedule, for:

1. Reasonable and necessary travel, by the covered person and family member(s) accompanying him, to a Designated Transplant Facility over 50 miles away from the Covered Person's residence;
2. Reasonable and necessary lodging and meal expenses for family member(s) accompanying the covered person to the Designated Transplant Facility; and
3. Air ambulance or other emergency transportation to, but not from, a Designated Transplant Facility, when necessary and approved.

ITCXXCM10500

WELLNESS BENEFIT

For the benefit maximums and listing of the services covered under this benefit, see the Separate Benefit Maximum shown on the Schedule.

ITCOHCM11001

PRESCRIPTION DRUG CARD AND MAIL ORDER PRESCRIPTION DRUG BENEFIT

COVERED DRUGS

Drugs which will be considered Covered Drugs are:

- Prescription Drugs and authorized refills.
- Disposable blood/urine/glucose/acetone testing agents (Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes-Tape).
- Disposable insulin needles and syringes.

BENEFITS

Payment for any Covered Drug is subject to payment of any applicable Drug Deductible and Copayment, as shown on the Schedule, which does not apply toward the Deductible, as defined in the Definitions section. Payment is also subject to definitions, limitations, exclusions and maximum benefits and other provisions of this Certificate.

If the Covered Person elects to purchase a Brand Name or if the Physician has specified "dispense as written" (DAW), benefits will be payable for the Brand Name, as shown on the Schedule.

A) PRESCRIPTION DRUGS

Benefits are payable only for Covered Drugs purchased on an outpatient basis. A maximum 34 day supply will be covered for each Covered Drug.

Participating Pharmacy: When purchasing a Covered Drug from a Participating Pharmacy:

- Present Your identification card to the pharmacist at the time of purchase.
- If the Drug Deductible has not been met, the Covered Person must pay for the entire cost of the Covered Drug.
- If the Drug Deductible has been met, the Covered Person must pay the Copayment for the Covered Drug.
- If Your identification card is not presented at the time of purchase, the Covered Person must pay for the entire cost of the Covered Drug. A claim form must then be submitted to Us. You will be reimbursed at the negotiated rate that would have been paid to a Participating Pharmacy for the cost of the Covered Drug minus any applicable Drug Deductible and Copayment.

Non-Participating Pharmacy: When purchasing a Covered Drug from a Non-Participating Pharmacy:

- The Covered Person will have to pay the Non-Participating Pharmacy for the entire cost of the Covered Drug and then submit a claim form to Us for reimbursement. You will be reimbursed at the negotiated rate that would have been paid to a Participating Pharmacy for the cost of the Covered Drug minus any applicable Drug Deductible and Copayment.

B) MAIL ORDER PRESCRIPTION DRUGS

Only covered Maintenance Drugs may be purchased through the mail service option.

- A maximum [90 day] supply will be covered for each covered Maintenance Drug.

When purchasing a Covered Drug from a mail order service other than the one We contract with:

The Covered Person will have to pay the other mail order service for the entire cost of the Covered Drug and then submit a claim form to Us for reimbursement. You will be reimbursed at the negotiated rate that would have been paid to Our mail order service for the cost of the Covered Drug minus any applicable Drug Deductible and Mail Order Copayment.

PRESCRIPTION DRUG CARD EXCLUSIONS

- No Prescription Drug Card and Mail Order Drug benefits are payable for:
- Refills in excess of the number specified by the Physician; or any drug or medicine dispensed more than one year after the date on the prescription;
- Covered Drugs administered while confined in a Hospital or while an inpatient in a hospice, rest home, nursing home or other institution;
- Any over-the-counter drugs or medicines, except as specifically stated.
- Any drug for which there is no charge;
- Any drug labeled "Caution: Limited by Federal Law to Investigational Use" or Experimental drugs;
- Any type of equipment or device used to render drugs effective, except as specifically stated.
- Tretinoin, all dosage forms (e.g. Retin-A), except for the treatment of Acne Vulgaris;
- Charges for the administration or injection of any drug;
- Vitamins, cosmetics and dietary supplements;
- Immunization agents, biological sera, blood/blood plasma or oxygen, including its administration;
- Contraceptives, contraceptive materials or devices or infertility drugs; and
- Hypodermic syringes and/or needles, injectables or any prescription directing administration or injection, other than insulin.

PRESCRIPTION DRUG CARD LIMITATIONS

No Prescription Drug Card and Mail Order Prescription Drug benefits are payable for the following Prescription Drugs. Benefits for these Prescription Drugs are payable as Covered Charges:

- Didanosine (Videx);
- Growth Hormones;
- Levonorgestrel (Norplant);
- Minoxidil (Rogaine) for the treatment of alopecia;
- Zidovudine (Retrovir);
- Azidothymidine (AZT); and
- Viagra.

Other Prescription Drugs may only be payable as Covered Charges under this Certificate. You will be notified of this requirement: by the Participating Pharmacy at the time of purchase; or by Us when a claim is made for Prescription Drugs purchased at a Non-Participating Pharmacy.

ITCXXPD11500

COST CONTAINMENT PROCEDURES

REQUIRED OUTPATIENT SURGERY

Certain surgical procedures must be performed on an outpatient basis. If such surgery is performed on an inpatient basis, benefits will be reduced. This reduction is shown on the Schedule.

Benefit reduction will be waived if:

- Your Physician provides evidence, satisfactory to Us, that confinement is Medically Necessary; or
- Appropriate outpatient facilities, as determined by Us, are not available within 50 miles of the Covered Person's residence.

Surgical procedures which must be performed on an outpatient basis are:

- Adenoidectomy
- Arthroscopy and cartilage removal
- Breast biopsy
- Carpal tunnel
- Cataract removal
- Cystometrogram
- Dilatation and Curettage (D&C)
- Endoscopic procedures, including but not limited to:
 - Colonoscopy
 - Cystoscopy
 - E.R.C.P.
 - Esophagoscopy
 - Gastroscopy
 - Laparoscopy
- Examination under anesthesia
- Excisions:
 - Exostosis excision
 - Ganglion excision
 - Hammertoe excision
 - Neuroma or Morton's neuroma excision
- Eye muscle surgery
- Hemorrhoidectomy
- Hernia:
 - Inguinal hernia
 - Umbilical hernia repair
- Hydrocelectomy
- Palmer fasciectomy
- Pilonidal sinus
- Simple fistulectomy
- Tonsillectomy
- Tympanostomy with insertion of ventilatory tube

Other surgical procedures may be required to be performed on an outpatient basis. You will be notified of such additional requirement as part of the Pre-Treatment Certification process.

PRE-TREATMENT CERTIFICATION

Pre-treatment Certification (Certification) requires You, Your representative or Your Physician to notify our review agency of all Hospital admissions, including inpatient surgery.

Certification is a review process to determine the Medical Necessity of a Hospital admission or proposed surgery. A determination as to the necessary length of a Hospital stay is also made. You or Your Physician may, at any time prior to discharge, request a reevaluation or extension of the number of Hospital days certified.

If Certification is not completed, benefits will be reduced. The reduction is shown on the Schedule.

Certification will be valid for 60 days for the requesting Physician and the named Hospital. A change in Physician or Hospital will require a new Certification.

How to Certify: To certify a Hospital admission or surgery, call the telephone number on Your identification card. Be prepared to give the following information:

- Insured's name, social security number and Certificate Number.
- Patient's name and date of birth.
- Hospital name and address.
- Physician's name and telephone number.
- The diagnosis (what is wrong).
- The treatment (what will be done and when).

It is Your responsibility to ensure that proper Certification is made. We recommend that You follow-up with the attending Physician to ensure that all medical information is provided.

If We do not agree with the Medical Necessity of any treatment, we will pay 100% of the Usual and Customary charge for a second opinion, subject to the annual deductible. If the second opinion does not confirm the Medical Necessity of the treatment, no benefits will be payable for any expense related to the Hospital confinement, including surgical expenses.

When to Call: For routine elective admission or surgery, You must call at least 2 business days before You are admitted to the Hospital.

Emergency admission: An Emergency admission must be called in within 48 hours of the admission or the next business day if a weekend or holiday is involved.

Transplants: a transplant procedure must be called in before the transplant benefit period begins.

If it is not reasonably possible to make the Certification call within the times provided, payment will not be reduced if the call is made as soon as is reasonably possible.

Certification does not guarantee that proposed Hospital admissions or surgeries are covered under the Certificate. Please read the coverage provisions carefully.

ITCXXCO40000

EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for any expenses arising from:

- Treatment, services or supplies which are not listed as Covered Charges.
- Treatment, services or supplies which are incurred when coverage is not in effect.
- Charges in excess of the Usual and Customary Charge.

- Treatment, services or supplies which:
 - Are not Medically Necessary or recognized by Us as effective;
 - Are not prescribed by a Physician as necessary to treat a Sickness or Injury;
 - We determine to be Experimental or Investigational in nature;
 - Are received without charge or legal obligation to pay;
 - Would not routinely be paid in the absence of insurance;
 - Are received outside of the 50 United States and the District of Columbia, except as specifically stated; or
 - Are received while incarcerated by legal authorities of any state or country for any reason, when such items result from an action or omission for which the governmental entity operating the correctional facility, or the governmental entity with which the law enforcement officer is affiliated, is liable.
- Routine physical examinations; x-ray; laboratory tests; and immunizations not related to diagnosis or treatment of a Sickness or Injury, except as specifically stated.
- Dental treatment or surgery, except as specifically stated.
- Temporomandibular joint dysfunction syndrome (TMJ); except for surgery to the temporomandibular joint.
- Cosmetic surgery or procedures and related care or complications arising therefrom; except for specifically stated reconstructive surgery.
- Routine eye or hearing examinations; radial keratotomy or other surgery to correct errors of refraction; eyeglasses or contact lenses, except as specifically stated; any type of external appliances used to improve visual acuity and their fittings; and vision therapy.
- Routine hearing examinations, hearing aids or fitting thereof.
- Treatment, services or supplies for which the Covered Person receives, or is eligible to receive, Workers' Compensation, Occupational Disease Act or similar benefits.
- Normal pregnancy or childbirth.
- Nursery or well baby care or circumcision for a Dependent child following birth.
- Artificial insemination; in vitro fertilization; fertility testing or treatment; and contraceptives.
- Sterilization procedures or procedures to reverse sterilization.
- Treatment, services or supplies to change gender and related care or complications arising therefrom.
- Custodial care or rest.
- Military or naval service of any country.
- War or act of war, declared or undeclared.
- Suicide, attempted suicide, or intentionally self-inflicted Injury, while sane or insane
- A Covered Person engaging in civil disturbance or an illegal occupation.
- A Covered Person's commission of, or attempt to commit, a felony or act which would be considered a felony if prosecuted.
- A Covered Person's use of alcohol, or intoxicating or hallucinogenic drugs or medicine, unless taken on the advice of, and in accordance with the direction of, a Physician.

- Over-the-counter drugs or medicine, even if prescribed by a Physician.

ITCOHEX20001

PRE-EXISTING CONDITION LIMITATION

Expenses that result from care or treatment of a Pre-existing Condition will not be considered as Covered Charges for the 12 months following the Covered Person's Effective Date of coverage.

ITCXEX20500

TRAVEL OUTSIDE OF THE UNITED STATES

No benefits are payable for any medical care, treatment, services or supplies received outside of the United States, except for Emergency treatment. Benefits are limited to Injury or Sickness which first occurs during the initial 180 days of travel. No benefits are payable for any Injury or Sickness that occurs during travel for the 180 day period following the Effective Date of coverage for a Covered Person.

Hospital confinement for Emergency treatment is limited to 30 days per trip for each Covered Person.

Pre-Treatment Certification of Hospital admission is not required when so confined outside of the United States.

The term "United States" means the 50 states and the District of Columbia. It does not include territories or possessions such as Puerto Rico or Guam.

ITCXEX21000

PREMIUM PROVISIONS

PAYMENT OF PREMIUM

All premium, charges or fees (hereinafter "Premium") must be paid to Us at Our home office. All Premium is payable in advance.

We reserve the right to change the method of Premium payment selected with proper notice to You.

DUE DATE

The first Premium is due on the Effective Date of coverage. Subsequent Premium is due on the premium payment date shown on the Schedule. Failure to pay Premium when due shall result in termination of coverage on such due date subject to the Grace Period.

RETURNED OR DISHONORED PAYMENT

If a payment for any Premium is dishonored for insufficient funds, a reasonable service charge may be debited to You. A dishonored payment shall be considered a failure to pay Premium. A rejected debit to Your bank account or credit card shall be considered a failure to pay Premium.

If Your selected method of payment is dishonored as described, You will need to submit Premium in a method acceptable to Us prior to the end of the grace period.

GRACE PERIOD

If written notice of termination has not been received from You, a Grace Period of 31 days will be allowed for each Premium payment after the first Premium. If any Premium is unpaid at the end of the Grace Period, coverage shall automatically terminate on the last day for which Premium has been paid.

REINSTATEMENT

If coverage ends for failure to pay Premium, You may request a reinstatement. Such request must be in writing and submitted within 90 days from the date coverage ended and is subject to Our approval. If approved by Us, reinstated coverage will become effective on the date We assign. Credit will be given for waiting periods satisfied prior to the date coverage ended.

PREMIUM ADJUSTMENT

Premium rates may be adjusted from time to time as determined necessary by Us. No rate adjustment will take effect until:

- The end of any rate guarantee period; and
- At least 31 days prior written notice is given to You.

The rate guarantee and notice period shall not apply to any rate adjustment due to:

- Your request for a change in benefits or coverage;
- A change in any Premium tax law;
- A change in Federal or State law or regulation which affects the benefits or provisions of the Certificate;
- A misstatement of age, sex, or residence of any Covered Person; or
- A change in the residence of any Covered Person.

When coverage ends for a Covered Person, any resulting change in Premium will be made on the next premium Due Date.

ITCXXPP40001

CLAIMS PAYMENT PROVISIONS

NOTICE OF CLAIM

We must receive written notice of claim within 30 days after a covered loss starts or as soon thereafter as reasonably possible. Notice should include Your name and Certificate Number.

CLAIM FORMS

When We receive the notice of claim, We will send You forms for filing a Proof of Loss. If these forms are not sent to You within 15 days, You will meet the Proof of Loss requirement by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

PROOF OF LOSS

Written Proof of Loss must be completed and returned to Us within 90 days or as soon thereafter as reasonably possible. Except for absence of legal capacity, no claim for benefits will be accepted after one year from the date treatment was completed.

FORGIVENESS OF OUT-OF-POCKET MAXIMUMS AND/OR DEDUCTIBLE

If any provider intentionally does not collect (forgives) any Covered Charge amount, benefits payable will be recalculated as follows:

- The amount accepted by the provider as payment in full will be considered the actual fee (i.e. the reported charge less any forgiven amount).
- The adjusted charge will be reduced by the applicable Deductible.
- The corresponding Insured Percent will be applied to the result.

Any resulting overpayment will be billed to You without prejudicing any other right or remedy available to Us at law or in equity.

PAYMENT OF CLAIMS

Benefits will be paid to You, unless assigned to the provider. In the case of a Dependent child in the legal custody of a person other than You, payment may be made directly to the custodian, at Our discretion or as required by law. Any unpaid Premium that is due may be deducted from a claim. Payment of benefits will discharge Us from all liability to You and Your beneficiary.

PAYMENT ERROR

Any benefit paid in error may be recovered from the person receiving the incorrect payment or from You. At Our option, We may offset the overpayment against future benefit payments. The acceptance of Premium or paying other benefits shall not constitute a waiver of Our rights under this section. Recovery or offset shall be in addition to any other remedies available to Us at law or in equity.

FRAUDULENT CLAIM SUBMISSION

If any Covered Person knowingly submits or participates in the submission of a claim for benefits which contains false or misleading information that would have the effect of increasing the benefit payable, We shall have the right to rescind that Covered Person's coverage to the date the fraud was perpetrated. Such rescission is without prejudice to any other right or remedy available to Us at law or in equity.

APPEAL OF DENIED CLAIMS

If a claim for benefits is wholly or partially denied, You will be sent a written notice of the decision. This notice will:

- Give the specific reason(s) for the denial;
- Make specific reference to the provisions on which the denial is based; and
- Provide an explanation of the review procedure.

On any denied claim, You or Your representative may appeal to Us for a full and fair review. You may:

- Request a review in writing within 60 days of receipt of a claim denial; and
- Submit issues and comments in writing.

We will make a decision no more than 60 days after receipt of the request, except in special circumstances, but in no case more than 120 days after the request for review is received. The written decision will include specific references to the provision(s) on which the decision is based.

PHYSICAL EXAMINATIONS

We have the right, at Our expense, to have a Covered Person examined as often as reasonably necessary while a claim on that Covered Person is pending.

ITCXXCP40000

GENERAL PROVISIONS

STATEMENTS IN THE APPLICATION

All statements made in Your application, in the absence of fraud, are considered to be representations and not warranties. No statement made by You shall be used to contest coverage or reduce benefits unless: (a) the statement is contained in an application; and (b) a copy of the statement is furnished to You.

After a Covered Person's coverage has been in effect for 2 years, during the lifetime of that person, only fraudulent misstatements in the application may be used to void coverage or deny any claim.

Any increase in coverage or reinstatement of coverage, as requested by application from You, shall begin a new two-year contestable period for the amount of the increase or reinstated coverage from the effective date of such coverage.

MISSTATEMENT OF AGE

If the age of a Covered Person is misstated such that coverage is provided for which the person is not otherwise eligible at the correct age, the misapplied coverage shall be rescinded and any applicable Premium refunded.

If the age of a Covered Person is misstated such that the person is eligible for coverage at the correct age, premium will be adjusted. Any additional Premium due must be paid within 31 days of receiving a notice of the amount due.

CLERICAL ERROR

If a clerical error is made so that an otherwise eligible person's coverage does not become effective, coverage may be in effect if: (a) the person makes a written request for coverage on a form We approve; and (b) any premium not paid because of the error is paid in full from the effective date of coverage. Company reserves the right to limit retroactive coverage to two months preceding the date the error was reported.

If a clerical error is made so that the coverage is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any Premium refund will be reduced by any payment made for claims. If claims paid exceed the Premium refund, the Insured shall reimburse Company for the overpayment.

LEGAL ACTIONS

No legal action may be brought against Us within 60 days after written Proof of Loss has been sent to Us. No such action may be brought more than 3 years from the time written Proof of Loss is required to be given.

ITCXXGP40001

COORDINATION OF BENEFITS

"Coordination of Benefits" is the procedure used to pay health care expenses when a person is covered by more than one plan. Trustmark Insurance Company (Mutual) follows rules established by Ohio law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family are covered by another group plan in addition to this one, we will follow Ohio coordination of benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the bill to the secondary plan.

Trustmark Insurance Company (Mutual) pays for health care only when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

DEFINITIONS

Allowable Expense: A necessary, reasonable and customary item of expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.

Plan: Any plan, including this one, that provides benefits or services for medical expenses on a group basis. "Plan" includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid), and no fault insurance (when allowed by law). "Plan" shall be treated separately for that part of a plan which reserves the right to coordinate with benefits or services of other plans and that part which does not.

Primary Plan: The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.

Year: The Calendar Year, or any part of it, during which a person claiming benefits is covered under this Plan.

BENEFIT COORDINATION

Benefits will be adjusted so that the total payment under all Plans is no more than 100 percent of the Covered Person's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of coordination.

If a Covered Person's benefits paid under this Plan are reduced due to coordination, each benefit will be reduced proportionately. The amount of the reduction will be applied as a benefit credit to pay any portion of the Covered Person's Allowable Expense not covered by any Plan. This credit applies only to charges incurred during the same Year as the credit.

Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

THE ORDER OF BENEFIT DETERMINATION

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.
2. When a person is covered by a Plan without a coordination provision, the Plan without the provision will be the Primary Plan.
3. When a person is covered by more than one Plan with a coordination provision, the order of benefit payment is as follows:
 - **Non-dependent/Dependent.** A Plan which covers a person other than as a Dependent will pay before a Plan which covers that person as a Dependent.
 - **Dependent Child/Parents Not Separated or Divorced.** For a Dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan which has covered the Dependent child for the longer period will pay first.

If the other Plan uses gender to determine which Plan pays first, We will also use that basis.
 - **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:
 - A. The Plan of the parent who has responsibility for providing insurance as determined by a court order;
 - B. The Plan of the parent with custody of the child;
 - C. The Plan of the spouse of the parent with custody; and
 - D. The Plan of the parent without custody of the child.
 - **Dependent Child/Joint Custody.** If the joint custody court decree does not specifically state which parent is responsible for the child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.
4. When an order of payment is not established by the above, the Plan which has covered the person for the longer period of time will pay first.

RIGHT TO EXCHANGE INFORMATION

We may release to, or obtain from, any other insurance company, organization or person information necessary for coordination. This will not require the consent of, or notice to You or any claimant. You are required to give Us information necessary for coordination.

RIGHT TO MAKE PAYMENTS TO ANOTHER PLAN

Coordination may result in payments made by another Plan which should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

RIGHT TO RECEIVE PAYMENTS

Coordination may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

ITCXCB40000

COORDINATION DISPUTES

If you believe that we have not paid a claim properly, You should first attempt to resolve the problem by contacting us. If you are still not satisfied, You may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686-1526.

ITCOHCB4000

LIMITED RIGHT OF REIMBURSEMENT

If a Covered Person incurs medical expenses for Covered Charges that occurred due to the negligence of a third party, We will not provide any benefits unless and until the Covered Person, or his legal representative, agrees in writing:

1. To reimburse Us from any and all damages collected whether by action at law, settlement or otherwise, all benefits paid for the same medical expenses; and
2. To assign to Us, the right to recover from that third party, or its insurer, to the extent of the benefits paid under this Plan.

ITCXLR40000

NOTICE

If you have any questions with regards to medical benefit payment(s), please follow this procedure:

Contact our Service Representative at 1-800-366-6663 or send written inquiry to Trustmark Insurance Company (Mutual), P.O. Box 7900, Lake Forest, IL 60045. A thorough review of your claim will be conducted within the Individual Health Benefit Claims Department.