ILLINOIS
LIFE AND HEALTH INSURANCE GUARANTY
ASSOCIATION LAW

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty 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 policy obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) 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, as noted below.

Illinois Life and
Health Insurance Guaranty Association
Disclaimer

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.** Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life & Health Insurance
Guaranty Association
8420 West Bryn Mawr Avenue
Chicago Illinois 60631
(773) 714-8050

Illinois Department of Insurance
320 West Washington Street
4th Floor
Springfield Illinois 62767
(217) 782-4515

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association "Law" 215 ILCS 5/531.01, et seq. The following contains a brief summary of this Law's coverages, exclusions and limits. This summary does not cover all the provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

(Please turn to the other side.)

a) Coverage:

The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:

1) life insurance, health insurance, and annuity contracts;
2) life, health or annuity certificates under direct group policies or contracts;
3) unallocated annuity contracts; and
4) contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.

b) Exclusions from Coverage:

1) The Guaranty Association does not provide coverage for:

a) any policy or portion of a policy for which the individual has assumed the risk;
b) any policy of reinsurance (unless an assumption certificate was issued);
c) interest rate guarantees which exceed certain statutory limitations;
d) certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
e) any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
f) any stop loss insurance.

2) In addition, persons are not protected by the Guaranty Association if:

a) the Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
b) their policy was issued by an organization which is not a member of the Association.

c) Limits on Amount of Coverage:

1) The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Association's liability is limited to the lesser of either:

a) The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or
b) With respect to any one life, regardless of the number of policies, contracts, or certificates:
i) in the case of life insurance, $300,000 in death benefits but not more than $100,000 in net cash surrender or withdrawal values;
ii) in the case of health insurance, $300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
iii) with respect to annuities, $100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and $100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is $5,000,000 in benefits per contract holder, regardless of the number of contracts.

2) However, in no event is the Guaranty Association liable for more than $300,000 with respect to any one individual.

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.

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Please Read this Certificate Carefully

J. Grover Thomas Jr.
President & Chief Executive Officer

Frank G. Gramm
Corporate Secretary & General Counsel

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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.

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.

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. 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.

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 (c) a body organ or part would be seriously damaged. This would include childbirth.

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.

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.

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.

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.
- 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.

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.

Physician: A licensed medical doctor; surgeon; osteopath; podiatrist; dentist; optometrist; or chiropractor, 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.

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; (c) 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.

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 (c) 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 terms, 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 and pay the Initial Premium.

- 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.

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 You become eligible for Medicare.

  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.
  - The date the Dependent becomes eligible for Medicare.

CONTINUATION FOR DEPENDENTS

If You die or become eligible for Medicare, 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 or physical handicap may continue to be covered regardless of age. The Dependent must be chiefly dependent on You for support and maintenance.

A Dependent who has reached the limiting age is considered "chiefly dependent on You for support and maintenance" if he is Dependent On Other Care Providers for lifetime care and supervision.

Dependent On Other Care Providers: An insured Dependent who requires a community integrated living arrangement, supervised apartment or other residential services licensed or certified by the Department of Mental Health and Developmental Disabilities, the Department of Public Health or the Department of Public Aid.

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 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 60 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;
- Twelve (12) 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, Preventive Benefits, and Routine Physical Examinations 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; or
5. Any benefit reduction or penalty for failure to use the Cost Containment Procedures.

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 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.

- 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.

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TRANSPLANT BENEFITS

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.

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PREVENTIVE BENEFITS

1. For female Covered Persons, screening by low dose mammography for the presence of occult breast cancer at the following intervals:

    - One baseline mammogram between ages 35 and 39;
    - One mammogram every 2 years between ages 40 and 49, or more frequently if recommended by a Physician; and

- An annual mammogram at age 50 and older.

2. One Papanicolaou (PAP) smear test per Year and associated office visit.

ROUTINE PHYSICAL EXAMINATION

For each Covered Person, one annual routine physical examination subject to the Separate Benefit Maximum shown on the Schedule.

ITCXXCM11000

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 or in connection with:

- 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.
- 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.
- Injury sustained while traveling in any type of aircraft, except as a fare-paying passenger in a scheduled or chartered flight operated by a commercial airline.
- 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.
- Covered Person's use of 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.

ITCXXEX20000

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.

ITCXXEX20500

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.

ITCXXEX21000

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.

A pro rata adjustment of Premium will be made if coverage ends due to Medicare eligibility.

ITCXXPP40000

CLAIM 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.

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.

ITCXXGP40000

COORDINATION OF BENEFITS

DEFINITIONS

Allowable Expense: An 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.

Coordination of Benefits: Taking other Plans into account when We pay benefits.

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.

ITCXXCB40000

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.

ITCXXLR40000