

SERFF Tracking Number: AMRP-125703630 State: Arkansas
Filing Company: World Insurance Company State Tracking Number: 39359
Company Tracking Number: AC4800W
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: AC4800W
Project Name/Number: /Schedule of Benefits for AC4800W

Filing at a Glance

Company: World Insurance Company

Product Name: AC4800W

TOI: H16G Group Health - Major Medical

Sub-TOI: H16G.001A Any Size Group - PPO

Filing Type: Form

SERFF Tr Num: AMRP-125703630 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 39359

Co Tr Num: AC4800W

State Status: Filed-Closed

Co Status:

Reviewer(s): Rosalind Minor

Authors: Norm Von Seggern, Susan Falk, Beverly Shuey

Date Submitted: 06/20/2008

Disposition Date: 06/23/2008

Implementation Date Requested: 07/01/2008

Implementation Date:

State Filing Description:

General Information

Project Name:

Project Number: Schedule of Benefits for AC4800W

Requested Filing Mode:

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: Filed at the same time.

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/23/2008

State Status Changed: 06/23/2008

Corresponding Filing Tracking Number:

Filing Description:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Association, Other

Deemer Date:

Informational filing of an amended Schedule of Benefits for use with AC4800W, et al.

Company and Contact

Filing Contact Information

Norm Von Seggern, Product Analyst 4

norm.von.seggern@americanenterprise.com

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P. O. Box 3160 (402) 496-8289 [Phone]
Omaha, NE 68103-0160 (402) 496-8040[FAX]

Filing Company Information

World Insurance Company CoCode: 70629 State of Domicile: Nebraska
11808 Grant Street Group Code: 3527 Company Type: Life and Health
Omaha, NE 68103-8000 Group Name: American Enterprise State ID Number:
(402) 496-8289 ext. [Phone] FEIN Number: 47-0339860

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Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
World Insurance Company	\$0.00	06/20/2008	

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed-Closed	Rosalind Minor	06/23/2008	06/23/2008

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Disposition

Disposition Date: 06/23/2008

Implementation Date:

Status: Filed-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Filed-Closed	Yes
Supporting Document	Application	Filed-Closed	Yes
Supporting Document	Cover letter	Filed-Closed	Yes
Form	Revised Schedule of Benenefits	Filed-Closed	Yes

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Form Schedule

Lead Form Number: AC4800W

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Filed-Closed	AC4800W	Schedule Pages	Revised Schedule of Initial Benenfits				Schedule of Benefits AC4800W (06-19).pdf

Schedule of Benefits

This Schedule of Benefits provides important information about the benefits you have selected and out-of-pocket expenses for which you are responsible when you Incur Covered Expenses under your Certificate.

SECTION 1. MAXIMUM BENEFITS

A. Maximum Lifetime Benefit

Maximum cumulative amount we will ever pay in benefits for your Covered Expenses: [\$250,000 to \$5,000,000]

[B. Calendar Year Maximum Benefit

Maximum amount we will pay in benefits during a Calendar Year for your Covered Expenses: [\$100,000 to \$5,000,000]

SECTION 2. YOUR OUT-OF-POCKET EXPENSES

Your out-of-pocket expenses are the amounts you must pay each Calendar Year before Covered Expenses are payable by us. Depending on the benefit for which you are making a claim under this Certificate, you are responsible for paying one of (or a combination of) the following amounts before we have an obligation to pay benefits related to the claim.

[A. Deductibles

Individual Deductible (per Calendar Year per Covered Person)

Participating Provider: [\$0 to \$50,000]
Nonparticipating Provider: [\$0 to \$100,000]

Family [Aggregate] Deductible (per Calendar Year)

Participating Provider: Your Participating Provider Family Deductible for a Calendar Year is satisfied when [two/three] family members each satisfy the Participating Provider Individual Deductible during that Calendar Year. At that point, no further Participating Provider Deductibles will apply for the covered family members for the remainder of the Calendar Year.

Nonparticipating Provider: Your Nonparticipating Provider Family Deductible for a Calendar Year is satisfied when [two/three] family members each satisfy the Nonparticipating Provider Individual Deductible during that Calendar Year. At that point, no further Nonparticipating Provider Deductibles will apply for the covered family members for the remainder of the Calendar Year.

[Participating Provider:] [\$3,000 to \$50,000]
[Nonparticipating Provider:] [\$6,000 to \$100,000]

[B. Coinsurance Percentage (per Covered Person per Calendar Year)

After you have satisfied the appropriate Deductible for Covered Expenses that are subject to the Certificate’s Deductible and Coinsurance, you are responsible for paying Coinsurance as described below. After you satisfy your Coinsurance obligation, we will pay 100% of the remainder of Covered Expenses through the end of the Calendar Year (subject to other limitations in the Certificate and this Schedule of Benefits).

Participating Provider: [50%/40%/30%/25%/20%/10%/0%] of the first [\$5,000 to \$50,000] of Covered Expenses.

Nonparticipating Provider: [50%/40%/30%/20%] of the first [\$10,000 to \$100,000] of Covered Expenses.]

[C. Copays and Access Fees

Copays and Access Fees are defined in the Certificate. The dollar amounts for Copays and Access Fees are shown in Section 3 below. Copays and Access Fees do not apply toward satisfying the Deductible, Coinsurance Percentage amount or out-of-pocket limit.]

[D. Your Out-of-Pocket Limit

Subject to other provisions, exclusions and limitations in the Certificate, the out-of-pocket limit is the maximum **Deductible and Coinsurance Percentage amount** a Covered Person will have to pay for Covered Expenses during a Calendar Year.

Participating Provider: [\$0 to \$100,000]

Nonparticipating Provider: [\$0 to \$100,000]]

[*(If product is an HSA, the following statement must be included on Schedule of Benefits)*

PLEASE NOTE: ON EACH JANUARY 1ST, THE DEDUCTIBLE AND THE OUT-OF-POCKET LIMIT ARE INDEXED FOR INFLATION IN \$50 INCREMENTS, BASED ON THE NATIONAL CONSUMER PRICE INDEX. A CHANGE IN THE DEDUCTIBLE AND THE OUT-OF-POCKET COVERED EXPENSE LIMIT MAY AFFECT THE DOLLAR AMOUNTS SHOWN UNDER THE SECTION TITLED “YOUR OUT-OF-POCKET LIMIT.”]

SECTION 3. SPECIFIC BENEFITS

[Inpatient Treatment

Once you have satisfied the applicable Access Fee, Deductible and Coinsurance Percentage, we will pay benefits for Inpatient Covered Expenses up to the applicable Calendar Year maximum (subject to other provisions, exclusions and limitations in your Certificate).

Inpatient Access Fee per Confinement: [\$0 to \$1,000]

Maximum amount we pay in a Calendar Year per Covered Person for Inpatient Treatment: [\$100,000 to \$1,000,000 or N/A]

Outpatient Treatment

Once you have satisfied the applicable Access Fee, Deductible and Coinsurance Percentage, we will pay benefits for Outpatient Covered Expenses up to the applicable Calendar Year maximum (subject to other provisions, exclusions and limitations in your Certificate).

Outpatient Access Fee per visit: [\$0 to \$1,000]

Maximum amount we pay in a Calendar Year per Covered Person for Outpatient Treatment: [\$5,000 to \$50,000 or N/A]

[Emergency Room Benefit

Once you have satisfied the applicable Access Fee, Deductible and Coinsurance Percentage, we will pay benefits for Emergency Room expenses (subject to other provisions, exclusions and limitations in the Certificate).

Emergency Room Access Fee per visit: [\$0 to \$500]

Or

Covered Expenses per Covered Person per Calendar Year: After the Access Fee, [100%] of the next [\$1,000], with the remainder subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Emergency Room Access Fee per visit: [\$0 to \$500]

[Diagnostic X-ray and Laboratory

[Once you have satisfied the applicable Access Fee, Deductible and Coinsurance Percentage, we will pay benefits for Diagnostic X-Rays and Laboratory expenses up to the applicable Calendar Year maximum (subject to other provisions, exclusions and limitations in the Certificate).]

X-Ray and Laboratory Access Fee per service: [\$0 to \$500 or N/A]

Maximum amount we pay in a Calendar Year per Covered Person: [\$100 to \$10,000 or N/A]

Or

Covered Expenses per Covered Person per test/service: [After the Copay, we pay up to [100%] of the per test maximum.**]

X-Ray and Laboratory Copay per test/service: [\$0 to \$500]

Maximum we pay per test/service ("per test maximum"): [\$100 to Unlimited]

Maximum amount we pay in a Calendar Year per Covered Person: [\$100 to \$10,000 or N/A]

**We do not provide benefits for any Outpatient test/service expenses you Incur that exceed the per test maximum amount. In addition, any Outpatient expenses you Incur that exceed the per test maximum do not apply toward satisfying your Deductible.]

[Magnetic Resonance Imaging ("MRI") / Computerized-Tomography Scanning ("CAT") / Positron Emission Tomography ("PET")

[Once you have satisfied the applicable Access Fee, Deductible and Coinsurance Percentage, we will pay benefits for MRI, CAT, and PET expenses up to the applicable Calendar Year Maximum (subject to other provisions, exclusions and limitations in the Certificate).]

MRI / CAT / PET Access Fee per service:	[\$0 or \$250 to \$1,000]
Maximum amount we pay in a Calendar Year per Covered Person:	[\$1,000 to \$25,000 or N/A]
Or	
Covered Expenses per Covered Person per test/service:	[After Copay, we pay up to [100%] of the per test maximum**.]
MRI / CAT / PET Copay per test/service:	[\$0 or \$250 to \$1,000]
Maximum we pay per test/service ("per test maximum"):	[\$100 to Unlimited]
Maximum amount we pay in a Calendar Year per Covered Person:	[\$1,000 to \$25,000 or N/A]

**We do not provide benefits for any Outpatient test/service expenses you Incur that exceed the per test maximum amount. In addition, any Outpatient expenses you Incur that exceed the per test maximum do not apply toward satisfying your Deductible.]

[Transplants

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum lifetime amount we pay for this benefit per Covered Person at a Center of Excellence ("COE"):	[\$1,000,000 or N/A]
Maximum amount we pay per Covered Person per transplant at a COE:	[\$500,000 or N/A]
Maximum transportation and living expenses we pay per covered transplant at a designated COE:	[\$5,000]
For transplants that are not performed at a COE, the maximum lifetime amount we will pay for this benefit per transplant per Covered Person is:	[\$100,000]
Maximum amount we pay per Covered Person per transplant when not performed at a COE:	[\$100,000]

[Acute Rehabilitation

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.]

[Urgent Care Facility

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.]

[Ambulance Service (Local Ground)

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.]

[Ambulance Service (Air)

[Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.]

[Maximum amount we pay in a Calendar Year per covered Illness or Injury:] [\$5,000 to \$25,000 or No Maximum]

Or

[Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.]

[Maximum amount we pay in a Calendar Year per Covered Person per Calendar Year:] [\$5,000 to \$30,000 or No Maximum]

[Emergency Foreign Travel Benefit

Covered Expenses are subject to the Certificate's Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum lifetime amount we pay for all covered Illnesses and/or Injuries under this benefit: [\$100,000]

[Home Health Care

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum number of Home Health Care Visits per Calendar Year: [40 to 100]

[Hospice Treatment and Services

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum we pay for Outpatient Hospice benefits, per day: [\$100 to \$500]

Maximum we pay for Treatment and Room and Board Expenses while an Inpatient in a Hospice Facility, per day: [\$200 to \$1,000]

Maximum lifetime benefit we pay for Inpatient and Outpatient Hospice Treatment (combined): [\$5,000 to \$50,000]

[Outpatient Occupational, Physical and Speech Therapy

[Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.]

[Maximum we pay per visit: [\$50 to \$250]

Maximum we pay for all three types of therapy (combined),
per Covered Person per Calendar Year: [\$2,000 to \$25,000]]

[Skilled Care Facility Benefit

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum number of days we pay per Calendar Year: [60]]

[Spinal Manipulation

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum we pay per day of Treatment (including x-rays): [\$50 to \$100]

Maximum for all Treatments and x-rays under this benefit, per
Covered Person per Calendar Year: [\$500 to \$2,500]]

[Sterilization

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum lifetime benefit we will pay per Covered Person: [\$500]]

[Treatment of Allergies

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum Calendar Year benefit we will pay per Covered
Person: [\$500]]

[Treatment for Sleep Apnea

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum lifetime benefit we will pay per Covered Person: [\$15,000]]

[Treatment for Growth Disorders

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum lifetime benefit we will pay per Covered
Dependent child: [\$15,000]]

OPTIONAL BENEFIT RIDERS

[Accident Expense Benefit

Maximum amount we pay for this benefit, per Covered Person per Calendar Year: [\$500 - \$25,000]]

[Accidental Death Benefit

Maximum amount we pay for this benefit: [\$1,000 - \$100,000]]

[Convalescent Care Benefit (Short Term)

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum Benefit Period (Lifetime Maximum) number of days for which we pay benefit): [30/60/90/180/360 days per Covered Person]

Elimination Period: [20 to 90 days]

Daily Benefit Amount (maximum amount per day we pay for this benefit): [\$0 to \$500 per Covered Person (in \$10 increments)]]

[Critical Illness Benefit

Critical Illness Maximum Lifetime Benefit: [\$10,000/ \$25,000/ \$50,000]

Specified Critical Illness and Specified Surgeries:	Percentage of Critical Illness Maximum Benefit Payable:
Angioplasty	[10%]
Blindness	[100%]
Coronary Artery Bypass Surgery	[25%]
End Stage Renal Failure	[100%]
Heart Attack	[100%]
Life-Threatening Cancer	[100%]
Loss of Limbs	[100%]
Major Organ Transplant Surgery	[100%]
Multiple Sclerosis	[100%]
Permanent Paralysis	[100%]
Stroke	[100%]]

[Decreasing Deductible

First Certificate Year Decrease: [\$100 to \$5,000]

Second Certificate Year Decrease: [\$500 to \$10,000]]

[Maternity Expense Benefit

Routine Pregnancy Benefit Amount: [\$250 to \$500 per Unit]
Number of Units: [1 to 20]

Or

Maternity Waiting Period: [0 to 9 months]
Maternity Benefit Deductible Amount: [\$1,000 to \$25,000]
Maternity Benefit Percentage: [50% to 100%]]

[Office Visit Benefit

[Covered Expenses are subject to the Certificate’s Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.]

Or

[Participating Provider:
Maximum Benefit amount we pay per Covered Person per visit: [\$25/ \$50/ \$75/ \$100/ \$125/ \$150/ \$200/ \$250]

Maximum number of visits for which we will pay per Covered Person per Calendar Year: [1 to 5 or N/A]

Nonparticipating Provider:
Maximum Benefit amount we pay per Covered Person per visit: Maximum Benefit amount is 50% of the Participating Provider Maximum Benefit]

Or

[Participating Provider:
Covered Expenses per Covered Person per Calendar Year: After Copay, [100%] of the next [1/2/3/4/ Unlimited Visits], with the remainder subject to the Certificate’s Participating Provider Calendar Year Deductible and Coinsurance Percentage.

Office Visit Copay: [\$20/\$30/\$40/\$50/\$60]

Number of Office Copays Waived: [0/1/2/3]

Nonparticipating Provider: [Covered Expenses are subject to the Certificate’s Nonparticipating Provider Deductible and Coinsurance Percentage.]]

[Premium Discount for Good Health

[Included/(if not included, item will not be listed)]

[Refund of Premium for Good Health]

Consecutive Calendar Years: Specified Percentage:
First: [5%]
Second: [10%]
Third and after: [15%]]

[Wellness Benefit

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum we pay per Covered Person per Calendar Year: [\$100 to \$2,500 or N/A]

[Preventive Dental Services applied against Wellness Benefit
Maximum: [\$50/\$75/\$100]]

[Waiting Period before this benefit is available: [None/6 months/12 months]]]

Or

[Wellness Benefit

Covered Expenses per Covered Person per Calendar Year: After Copay, [100%] of the Benefit Maximum per Calendar Year.

Wellness Copay per visit: [\$0 to 500]

Benefit Maximum in Year 1: [\$100 to \$2,500 or N/A]

Benefit Maximum in Year 2: [\$100 to \$2,500 or N/A]

Benefit Maximum in Year 3 and after: [\$100 to \$2,500 or N/A]

[Preventive Dental Services applied against Wellness Benefit
Maximum: [\$50/\$75/\$100]]

[Waiting Period before this benefit is available: [None/6 months/12 months]]]

[Term Life Insurance Benefit Amount

Insured: [\$15,000/ \$25,000/ \$50,000]

Covered Dependent: [\$7,500/\$12,500/\$25,000]

Covered Dependent Child - 14 days to 6 months old: [\$250/\$500/\$1,000]

Covered Dependent Child – 6 months to 18 years old: [\$1,000/\$2,000/\$5,000]]

[Outpatient Prescription Drug Benefit

[Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.]

Or

[Prescription Drug Generic Copay: [\$0 to\$25]
You do not have coverage for Brand Name Drugs or Specialty Medications.]

Or

[Prescription Drug Generic Copay: [\$0 to\$25]

Coverage for Specialty Medications is subject to your Certificate's Deductible and Coinsurance Percentage.

You do not have coverage for Brand Name Drugs.]

Or

Prescription Drug Generic Copay (or Prescription Drug Percentage):	The higher of [\$10 to \$20] or [10% to 50%]
Prescription Drug Brand Formulary Copay (or Prescription Drug Percentage):	The higher of [\$20 to \$35] or [10% to 50%]
Prescription Drug Brand Nonformulary Copay (or Prescription Drug Percentage):	The higher of [\$30 to \$50] or [10% to 50%]
Prescription Drug Deductible:	[\$250 to \$1000 or N/A]
Prescription Drug Generic Deductible:	[\$100 to \$300 or N/A]
Prescription Drug Brand Deductible:	[\$200 to \$500 to N/A]
Prescription Drug Brand Maximum:	[\$500 to \$2000 or N/A]

Coverage for Specialty Medications is subject to your Certificate's Deductible and Coinsurance Percentage.]

Or

Prescription Drug Generic Copay:	[\$10 to \$20]
Prescription Drug Brand Formulary Copay:	[\$20 to \$35]
Prescription Drug Brand Nonformulary Copay:	[\$30 to \$50]
Prescription Drug Deductible:	[\$250 to \$1000 or N/A]
Prescription Drug Generic Deductible:	[\$100 to \$300 or N/A]
Prescription Drug Brand Deductible:	[\$200 to \$500 or N/A]
Prescription Drug Brand Maximum:	[\$500 to \$2000 or N/A]

Coverage for Specialty Medications is subject to your Certificate's Deductible and Coinsurance Percentage.]

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Rate Information

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Supporting Document Schedules

Bypassed -Name:	Certification/Notice	Review Status:	
Bypass Reason:	Not applicable -- please refer to cover letter.	Filed-Closed	06/23/2008
Comments:			
Bypassed -Name:	Application	Review Status:	
Bypass Reason:	Not applicable	Filed-Closed	06/23/2008
Comments:			
Satisfied -Name:	Cover letter	Review Status:	
Comments:		Filed-Closed	06/23/2008
Attachment:			
June 19 WIC.pdf			



June 19, 2008

Arkansas Department of Insurance
Compliance - Life and Health
1200 West Third
Little Rock, Arkansas 72201-1904

Attention: Rosalind Minor

Re: Informational Filing
NAIC #70609
Schedule of Benefits (Schedule) for use with AC4800W, et al

Dear Ms. Minor:

Please find enclosed a corrected copy of the Schedule of Benefits that will be used with form AC4800W, et al, which was approved by your Department on March 31, 2008. Please substitute the enclosed Schedule for the previously submitted and approved Schedule. Changes were made to provide clarity and to correct typographical errors.

Thank you for your assistance and please feel free to contact me if you have any questions.

Sincerely,

Norman Von Seggern, FLMI, HIA
Product Analyst 4
Phone: (402) 496-8289
Fax: (402) 496-8040
e-mail: norm.von.seggern@americanenterprise.com