

SERFF Tracking Number: MCHX-125711822 State: Arkansas
 Filing Company: Time Insurance Company State Tracking Number: 39430
 Company Tracking Number: 499.BNS.001.AR
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.001 Any Size Group
 Expense
 Product Name: 499.BNS.001.XX-TIC Association Limited Benefit Med
 Project Name/Number: 499.BNS.001.XX-TIC Association Limited Benefit Medical Expense-Benefit Summary-Non GI/499.BNS.001.XX-TIC Association
 Limited Benefit Medical Expense-Benefit Summary-Non GI

Filing at a Glance

Company: Time Insurance Company
 Product Name: 499.BNS.001.XX-TIC
 Association Limited Benefit Med
 TOI: H15G Group Health -
 Hospital/Surgical/Medical Expense
 Sub-TOI: H15G.001 Any Size Group
 Filing Type: Form

SERFF Tr Num: MCHX-125711822 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 39430

Co Tr Num: 499.BNS.001.AR

State Status: Approved-Closed

Co Status:

Reviewer(s): Rosalind Minor

Author: SPI McHughConsulting

Disposition Date: 07/02/2008

Date Submitted: 06/26/2008

Disposition Status: Approved-Closed

Implementation Date Requested: 07/26/2008

Implementation Date:

State Filing Description:

General Information

Project Name: 499.BNS.001.XX-TIC Association Limited Benefit
 Medical Expense-Benefit Summary-Non GI
 Project Number: 499.BNS.001.XX-TIC Association Limited Benefit
 Medical Expense-Benefit Summary-Non GI
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 07/02/2008
 State Status Changed: 07/02/2008
 Corresponding Filing Tracking Number:
 Filing Description:
 Time Insurance Company
 NAIC # 69477 FEIN # 39-0658730

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Association

Deemer Date:

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Association Limited Benefit Medical Expense - Benefit Summary

499.BNS.001.AR, et al -Benefit Summary/Schedule Page

McHugh Consulting Resources, Inc. has been retained to file the attached forms on behalf of Time Insurance Company. We have provided an authorization letter for your files.

We are submitting the above captioned form for your review. The form is a new alternative benefit summary form that allows for use of Calendar Year maximums up to the Lifetime Maximum Amount, and is to be used with previously approved certificate form 499.001.XX, as approved by your office on 12/19/2007. Since this benefit summary is substantially similar to the previously approved benefit summary, to assist with your review we have redlined the differences between the previous version and this one.

This Limited Benefit Medical Expense program will be marketed through agent/broker solicitation, subject to individual underwriting. Coverage will be offered to members of an association with situs in Illinois. This program is being concurrently filed in the association situs state of Illinois. This program provides Limited Benefit Medical Expense coverage. It provides medical and outpatient prescription drug benefits due to accident and sickness.

Also enclosed, please find an additional term life rider providing supplemental benefits payable upon death of the insured. This rider is submitted for review on a general use basis, and may be used with any individually underwritten forms offered to an out of state association or trust, including those herewith submitted.

Please be advised that we are submitting application form number, Form 29800 for your review and approval. This application is new and does not replace any form previously approved by your Department.

Assurant Health is comprised of Time Insurance Company and John Alden Life Insurance Company. Identical forms have been submitted for each Company. The only differences are to the form numbers and Company names. Since Time and John Alden are sister companies and because the forms are identical, we respectfully request that the same analyst review both filings.

This form is subject only to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. The actual wording of each provision will remain the same. Otherwise

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variable data is bracketed. Amounts may vary or provisions may be modified to fit a specific Insured's request. Variable data will never exclude or limit provisions required by applicable law.

Attached please find any required certifications and/or transmittal forms and filing fees. Please do not hesitate to contact the undersigned at (215) 230-7960 if there are any questions I can answer regarding this filing.

Company and Contact

Filing Contact Information

(This filing was made by a third party - McHughConsulting)

Lauren Evans, Compliance Assistant mcr@mchughconsulting.com
 McHugh Consulting Resources, Inc. (215) 230-7960 [Phone]
 Doylestown, PA 18901 (215) 230-7961[FAX]

Filing Company Information

Time Insurance Company	CoCode: 69477	State of Domicile: Wisconsin
501 West Michigan Avenue	Group Code: 19	Company Type:
Milwaukee, WI 53201-0624	Group Name:	State ID Number:
(414) 299-1140 ext. [Phone]	FEIN Number: 39-0658730	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Time Insurance Company	\$50.00	06/26/2008	21106264

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/02/2008	07/02/2008

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Disposition

Disposition Date: 07/02/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Red-Lined Benefit Summary	Approved-Closed	Yes
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Supporting Document	Forms Listing	Approved-Closed	Yes
Supporting Document	06.25.08 Submission Letter	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	LIMITED BENEFIT MEDICAL INSURANCE BENEFIT SUMMARY	Approved-Closed	Yes
Form	LIFE INSURANCE BENEFITS RIDER	Approved-Closed	Yes
Form	Enrollment Application	Approved-Closed	Yes
Form	Notice	Approved-Closed	Yes

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Form Schedule

Lead Form Number: 499.BNS.001.AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	499.BNS.001.AR	Schedule Pages	LIMITED BENEFIT MEDICAL INSURANCE BENEFIT SUMMARY	Initial		58	499_BNS_001_AR.PDF
Approved-Closed	4797	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	LIFE INSURANCE BENEFITS RIDER	Initial		40	4797.PDF
Approved-Closed	29800	Application/ Enrollment Form	Enrollment Application	Initial		40	29800.PDF
Approved-Closed	AR-TMJ Notice	Other	Notice	Initial		100	AR-TMJ Notice.PDF

LIMITED BENEFIT MEDICAL INSURANCE BENEFIT SUMMARY

Date of this Benefit Summary: [XX/XX/XXXX]

THIS BENEFIT SUMMARY CONTAINS LIMITED INFORMATION ABOUT YOUR PLAN. IN ADDITION, THE PLAN HAS LIMITED BENEFITS AND ANNUAL MAXIMUMS. PLEASE READ YOUR CERTIFICATE CAREFULLY TO UNDERSTAND ANY COVERAGE LIMITATIONS. REVIEW THIS BENEFIT SUMMARY FOR INFORMATION ON WHAT BENEFITS ARE PROVIDED FOR COVERED CHARGES.

Benefits will be paid for Covered Charges Incurred while coverage is in force. Payment of benefits is subject to all the terms, limits and conditions in the plan. The benefits shown in this Benefit Summary apply to each Covered Person unless otherwise indicated below.

Policyholder, Certificate Holder and Plan Information		
Policyholder:	[Name]	
Certificate Holder:	[Name] [Address/City/State/Zip]	Effective Date: [XX/XX/XXXX]
Covered Dependents:	[Spouse's Name]	Effective Date: [XX/XX/XXXX]
	[Dependent Child's Name]	Effective Date: [XX/XX/XXXX]
	[Dependent Child's Name]	Effective Date: [XX/XX/XXXX]
Certificate Number:	[XXXXXXXX]	
Payment Option:	[Monthly/Quarterly/Semi-Annually/Annually]	
Medical Benefits		
We will pay benefits only for the treatment, services and supplies listed as Covered Charges in the Medical Benefits section of the plan. [Use a Participating Provider to receive the maximum benefits available under the plan.]		
[[Maximum Lifetime Benefit:]]	[\$[50,000-unlimited] – All benefit payments apply to the Maximum Lifetime Benefit unless otherwise indicated.]	
[Outpatient Calendar Year Maximum Benefit:	Up to \$[XXX] maximum benefit for Covered Charges Incurred for all Outpatient services combined during a Calendar Year. Covered Charges for ambulance services, services received in an Emergency Room, Outpatient services shown under the Surgical Services provision and drugs covered under the Outpatient Prescription Drug Benefits section do not apply towards the Outpatient Calendar Year Maximum Benefit.]	
[Inpatient Maximum Benefit:	Up to \$[XXX,XXX] maximum benefit for Covered Charges Incurred while Inpatient [per Calendar Year][Per Condition][and billed by the Hospital where the services are received] [over the lifetime of each Covered Person]. See the Inpatient Hospital Services provision below for the maximum benefit per day for Covered Charges that are Incurred while Inpatient, depending on whether the Covered Person is being treated for a Sickness or an Injury. Covered Charges for services shown under the Surgical Services provision that are Incurred while Inpatient do not apply towards the Inpatient Maximum Benefit.]	
[Surgical Services Maximum Benefit:	Up to \$[XX,XXX] maximum benefit for Covered Charges shown in the Surgical Schedule that are Incurred while Inpatient or Outpatient for professional surgical services of a surgeon [Per Condition] [over the lifetime of each Covered Person][per Calendar Year]. Covered Charges for an assistant surgeon and anesthesia services do not apply towards the Surgical Services Maximum Benefit. However, when the Surgical Services Maximum Benefit has been paid by Us, no further benefits are payable for an Assistant Surgeon's Benefit or Anesthesia Benefit for that condition either.]	
Deductible:	[Participating Provider Benefit:] The Deductible applies to all Covered Charges [from a Participating Provider] unless otherwise indicated. • [Individual] [Participating Provider]	[Non-Participating Provider Benefit:] The Deductible applies to all Covered Charges from a Non-Participating Provider unless otherwise indicated. • Non-Participating Provider

	<p>Deductible: \$[XXX] per Calendar Year.</p> <ul style="list-style-type: none"> • [Family Deductible: \$[XXX] per Calendar Year.] • Common Accident Deductible: \$[XXX] for all Covered Persons injured in the same Accident. 	<p>Deductible: \$[XXX] per Calendar Year.</p> <ul style="list-style-type: none"> • [Family Deductible: \$[XXX] per Calendar Year.] • Common Accident Deductible: \$[XXX] for all Covered Persons injured in the same Accident.
Coinsurance:	<ul style="list-style-type: none"> • [XX]% of Covered Charges [from a Participating Provider] after the Deductible is satisfied - The Coinsurance applies to all Covered Charges [from a Participating Provider] unless otherwise indicated. 	<ul style="list-style-type: none"> • [XX]% of Covered Charges from a Non-Participating Provider after the Deductible is satisfied - The Coinsurance applies to all Covered Charges from a Non-Participating Provider unless otherwise indicated.
Inpatient Hospital Services:	<p>The following applies to Covered Charges received in a Hospital while Inpatient (this does not include services covered in the Surgical Services provision):</p> <ul style="list-style-type: none"> • Up to \$[XXX] maximum benefit per day for room and board, nursing services and all other Covered Charges that are Incurred while Inpatient for treatment of a Sickness [and billed by the Hospital where the services are received]. • Up to \$[X,XXX] maximum benefit per day for room and board, nursing services and all other Covered Charges that are Incurred while Inpatient for treatment of an Injury[and billed by the Hospital where the services are received]. • If treated for both a Sickness and an Injury during an Inpatient stay, all Covered Charges Incurred for the entire Inpatient stay[that are billed by the Hospital where the services are received] will be considered under only the Injury benefit above. • No Deductible applies. • Coinsurance applies. • Benefit payments apply towards the Inpatient Maximum Benefit. 	<p>The following applies to Covered Charges received in a Hospital while Inpatient (this does not include services covered in the Surgical Services provision):</p> <ul style="list-style-type: none"> • Up to \$[XXX] maximum benefit per day for room and board, nursing services and all other Covered Charges that are Incurred while Inpatient for treatment of a Sickness[and billed by the Hospital where the services are received]. • Up to \$[X,XXX] maximum benefit per day for room and board, nursing services and all other Covered Charges that are Incurred while Inpatient for treatment of an Injury[and billed by the Hospital where the services are received]. • If treated for both a Sickness and an Injury during an Inpatient stay, all Covered Charges Incurred for the entire Inpatient stay[that are billed by the Hospital where the services are received] will be considered under only the Injury benefit above. • No Deductible applies. • Coinsurance applies. <p>Benefit payments apply towards the Inpatient Maximum Benefit.</p>
Outpatient Medical Services:	<p>The following applies to Covered Charges received in an Emergency Room (this does not include services covered in the Surgical Services provision):</p> <ul style="list-style-type: none"> • \$[XXX] Access Fee [(waived if admitted for an Inpatient stay immediately following the Emergency Room visit)]. • The maximum benefit is [X] visits per Calendar Year up to a maximum limit of \$[XXX] per visit. This maximum limit does not apply to services shown in the Surgical Services provision below. • [No Deductible or Coinsurance applies.] • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit. <p>The following applies to Covered Charges received in a Hospital's Outpatient department, a Free-Standing Facility or an</p>	<p>The following applies to Covered Charges received in an Emergency Room (this does not include services covered in the Surgical Services provision):</p> <ul style="list-style-type: none"> • \$[XXX] Access Fee [(waived if admitted for an Inpatient stay immediately following the Emergency Room visit)]. • The maximum benefit is [X] visits per Calendar Year up to a maximum limit of \$[XXX] per visit. This maximum limit does not apply to services shown in the Surgical Services provision below. • [No Deductible or Coinsurance applies.] • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit. <p>The following applies to Covered Charges received in a Hospital's Outpatient department, a Free-Standing Facility or an</p>

	<p>Urgent Care Facility (this does not include services covered in the Surgical Services provision):</p> <ul style="list-style-type: none"> • [Deductible and Coinsurance apply.] • Benefit payments apply towards the Outpatient Calendar Year Maximum Benefit. <p>The following applies to Covered Charges received in a Health Care Practitioner's office (this does not include services covered in the Office Visit Benefits or Surgical Services provision):</p> <ul style="list-style-type: none"> • [Deductible and Coinsurance apply.] • Benefit payments apply towards the Outpatient Calendar Year Maximum Benefit. 	<p>Urgent Care Facility (this does not include services covered in the Surgical Services provision):</p> <ul style="list-style-type: none"> • [Deductible and Coinsurance apply.] • Benefit payments apply towards the Outpatient Calendar Year Maximum Benefit. <p>The following applies to Covered Charges received in a Health Care Practitioner's office (this does not include services covered in the Office Visit Benefits or Surgical Services provision):</p> <ul style="list-style-type: none"> • [Deductible and Coinsurance apply.] • Benefit payments apply towards the Outpatient Calendar Year Maximum Benefit.
Office Visit Benefits:	<ul style="list-style-type: none"> • Copayments: \$[XX] per Office Visit in a Health Care Practitioner's office. • The maximum benefit is [X] visits per Calendar Year [up to a maximum limit of \$[XXX] [per Office Visit][for all visits combined per Calendar Year]]. The maximum does not apply to child immunizations. • [An Office Visit during which only services for allergy shots or immunotherapy injections of inhaled allergens are rendered is not subject to the Calendar Year maximum of number of visits[; the maximum benefit limit of \$[XXX] [per Office Visit][for all visits combined per Calendar Year][,per Covered Person] still applies].] • No Deductible or Coinsurance applies. • Copayments do not apply to child immunizations. • [Benefit Waiting Period: [XX] days from Covered Person's Effective Date. The Benefit Waiting Period does not apply to child immunizations.] <p>Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit.</p>	<ul style="list-style-type: none"> • Copayments: \$[XX] per Office Visit in a Health Care Practitioner's office. • The maximum benefit is [X] visits per Calendar Year [up to a maximum limit of \$[XXX] [per Office Visit] [for all visits combined per Calendar Year]]. The maximum does not apply to child immunizations. • [An Office Visit during which only services for allergy shots or immunotherapy injections of inhaled allergens are rendered is not subject to the Calendar Year maximum of number of visits[; the maximum benefit limit of \$[XXX] [per Office Visit][for all visits combined per Calendar Year][,per Covered Person] still applies].] • No Deductible or Coinsurance applies. • Copayments do not apply to child immunizations. • [Benefit Waiting Period: [XX] days from Covered Person's Effective Date. The Benefit Waiting Period does not apply to child immunizations.] <p>Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit.</p>
Professional Ground or Air Ambulance Services:	<ul style="list-style-type: none"> • Up to \$[XXX] maximum benefit per trip by ground ambulance to the nearest Hospital per Sickness or Injury. • Up to \$[X,XXX] maximum benefit per trip by air ambulance to the nearest Hospital per Sickness or Injury. • The maximum benefit is [X] trips per Calendar Year for ground and air ambulance combined. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit. 	<ul style="list-style-type: none"> • Paid under the Participating Provider Benefit.

Surgical Services:	<ul style="list-style-type: none"> • Surgeon's Benefit: Up to [[XXX] % multiplied by] the dollar amount shown in the Surgical Schedule below for the surgical procedure that is being performed. • Assistant Surgeon's Benefit: Up to [XX]% of the Surgeon's Benefit for all assistant surgeons combined who are involved in the related surgical procedure. • Anesthesia Benefit: Up to [XX]% of the Surgeon's Benefit for all services involved in the administration of anesthesia during the related surgical procedure. • Two or more surgical procedures performed during the same operative session are considered one operation and the Surgeon's Benefit will be considered based on the most expensive procedure shown in the Surgical Schedule. • If a surgical procedure is performed that is not shown in the Surgical Schedule, the Surgeon's Benefit will be considered up to [\$(XXX) multiplied by] the total non-facility unit value assigned by Medicare for the procedure on the date the service is Incurred. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit or the Inpatient Maximum Benefit. • [Benefit payments apply towards the Surgical Services Maximum Benefit, except for the Assistant Surgeon's Benefit and Anesthesia Benefit. However, when the Surgical Services Maximum Benefit has been paid by Us for a condition, no further benefits are payable for an Assistant Surgeon's Benefit or Anesthesia Benefit for that condition either.] 	<ul style="list-style-type: none"> • Surgeon's Benefit: Up to [[XXX] % multiplied by] the dollar amount shown in the Surgical Schedule below for the surgical procedure that is being performed. • Assistant Surgeon's Benefit: Up to [XX]% of the Surgeon's Benefit for all assistant surgeons combined who are involved in the related surgical procedure. • Anesthesia Benefit: Up to [XX]% of the Surgeon's Benefit for all services involved in the administration of anesthesia during the related surgical procedure. • Two or more surgical procedures performed during the same operative session are considered one operation and the Surgeon's Benefit will be considered based on the most expensive procedure shown in the Surgical Schedule. • If a surgical procedure is performed that is not shown in the Surgical Schedule, the Surgeon's Benefit will be considered up to [\$(XXX) multiplied by] the total non-facility unit value assigned by Medicare for the procedure on the date the service is Incurred. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit or the Inpatient Maximum Benefit. • [Benefit payments apply towards the Surgical Services Maximum Benefit, except for the Assistant Surgeon's Benefit and Anesthesia Benefit. However, when the Surgical Services Maximum Benefit has been paid by Us for a condition, no further benefits are payable for an Assistant Surgeon's Benefit or Anesthesia Benefit for that condition either.]]
Children's Preventive Health Care Services:	<ul style="list-style-type: none"> • Copayments: \$[XX] per Office Visit in a Health Care Practitioner's office. • No Deductible or Coinsurance applies. • Copayments do not apply to child immunizations. • [Benefit Waiting Period: [XX] days from Covered Person's Effective Date. The Benefit Waiting Period does not apply to child immunizations.] • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit. 	<ul style="list-style-type: none"> • Copayments: \$[XX] per Office Visit in a Health Care Practitioner's office. • No Deductible or Coinsurance applies. • Copayments do not apply to child immunizations. • [Benefit Waiting Period: [XX] days from Covered Person's Effective Date. The Benefit Waiting Period does not apply to child immunizations.] • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit.
<p>[Surgical Schedule</p> <p>We will pay Covered Charges for the following surgical procedures up to the benefit amounts shown in the Surgical Services provision above. [Use a Participating Provider to receive the maximum benefits available under the plan.]</p>		

CARDIOVASCULAR SYSTEM

Insertion of electrode leads and pulse generator	[\$5,000]
Upgrade of implanted pacemaker system, including conversion of a single chamber system to a dual chamber system	[\$2,250]
Valvotomy, mitral valve; closed heart.....	[\$7,000]
Valvuloplasty, mitral valve, with cardiopulmonary bypass.....	[\$10,000]
Valvotomy, pulmonary valve, closed heart; transventricular	[\$7,500]
Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch	[\$9,000]
Ligation, division, and stripping, short or long saphenous vein.....	[\$1,500]
Ligation, division, and stripping, of short and long saphenous vein, bilateral	[\$2,250]

DIGESTIVE SYSTEM

Biopsy of salivary gland, needle.....	[\$225]
Biopsy of salivary gland, incisional	[\$300]
Tonsillectomy, with or without adenoidectomy, under 12 years of age.....	[\$752]
Tonsillectomy, with or without adenoidectomy, 12 and over years of age.....	[\$1,000]
Excision, local; ulcer or benign tumor of stomach.....	[\$3,000]
Gastrectomy, total.....	[\$5,000]
Colectomy, total, with proctectomy; with Ileostomy.....	[\$5,500]
Incision and drainage of appendicular abscess, open	[\$1,500]
Appendectomy	[\$2,000]
Proctectomy; complete, combined abdominoperineal, with colostomy.....	[\$5,000]
Colonoscopy, diagnostic.....	[\$1,000]
Colonoscopy with biopsy	[\$1,500]
Colonoscopy with removal of tumor, polyp or other lesions	[\$2,000]
Incision of rectal fistula, superficial	[\$500]
Fissurectomy, with or without sphincterotomy	[\$1,000]
Hemorrhoidectomy, external, complete.....	[\$1,000]
Hemorrhoidectomy, internal and external, complete.....	[\$1,500]
Cholecystectomy (removal of gall bladder).....	[\$2,500]
Cholecystectomy with exploration of common duct	[\$3,500]
Pancreatectomy, total	[\$7,000]
Exploratory laparotomy; exploratory celiotomy	[\$2,000]
Repair inguinal hernia; sliding; any age	[\$1,750]
Repair initial femoral hernia	[\$1,750]

EAR

Tympanostomy	[\$150]
Stapes mobilization.....	[\$3,500]
Fenestration of semicircular canal	[\$4,000]

EYE

Removal of foreign body, conjunctival, superficial	[\$53]
Removal of foreign body, corneal, with or without slit lamp	[\$100]
Excision or transposition of pterygium; without graft.....	[\$1,250]
Cataract removal, intra capsular, extracapsular, with insertion of intraocular lens	[\$4,000]
Repair of retinal detachment; scleral buckling, with or without implant	[\$5,000]
Muscle operation involving one or more muscles in one or both eyes	[\$3,000]

GYNECOLOGY

Incision and drainage of Bartholin's gland abscess	[\$253]
Excision of Bartholin's gland or cyst	[\$1,000]
Anterior colporrhaphy, repair of cystocele, with or without repair of urethrocele	[\$1,750]
Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	[\$1,750]
Combined anteroposterior colporrhaphy	[\$2,500]
Cautery of cervix; electro or thermal	[\$153]
Dilation and curettage, diagnostic and/or therapeutic (non-obstetrical).....	[\$752]
Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)	[\$3,000]
Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	[\$2,750]
Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)	[\$5,000]

Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)	\$[2,250]
Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	\$[2,250]
MUSCULOSKELETAL SYSTEM	
Muscle biopsy, superficial.....	\$[253]
Muscle biopsy, deep.....	\$[500]
Arthrocentesis, large joint	\$[153]
Removal of implant; superficial, (e.g., buried wire, pin or rod) (separate procedure).....	\$[752]
Closed treatment of mandibular fracture with interdental fixation	\$[1,500]
Arthrodesis, including laminectomy and/or diskectomy	\$[6,000]
Closed treatment of clavicular fracture; without manipulation.....	\$[752]
Open treatment of clavicular fracture, with or without internal or external fixation	\$[2,000]
Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation.....	\$[1,500]
Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(s)	\$[2,500]
Closed treatment of shoulder dislocation, with manipulation; without anesthesia.....	\$[253]
Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia	\$[253]
Open treatment of acute shoulder dislocation.....	\$[2,750]
Arthrotomy, elbow, including exploration, drainage, or removal of foreign body.....	\$[2,500]
Treatment of closed elbow dislocation; without anesthesia.....	\$[253]
Treatment of closed elbow dislocation; requiring anesthesia	\$[1,250]
Open treatment of acute or chronic elbow dislocation	\$[2,750]
Closed treatment of ulnar shaft fracture; without manipulation.....	\$[1,000]
Open treatment of ulnar shaft fracture.....	\$[2,000]
Closed treatment of radial and ulnar shaft fractures.....	\$[1,250]
Open treatment; fixation of radius or ulna.....	\$[2,500]
Open treatment; fixation of radius AND ulna.....	\$[3,000]
Closed treatment of distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation	\$[752]
Open treatment of distal radial fracture or epiphyseal separation, with internal fixation	\$[2,000]
Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each	\$[752]
Excision of lesion of tendon sheath or joint capsule (e.g., cyst, mucous cyst, or ganglion), hand or finger	\$[500]
Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each.....	\$[373]
Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each.....	\$[1,000]
Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure.....	\$[752]
Arthrotomy, hip, including exploration or removal of loose or foreign body	\$[3,500]
Closed treatment of femoral fracture, proximal end, neck; without manipulation	\$[2,250]
Closed treatment of femoral fracture, proximal end, neck; with manipulation	\$[3,000]
Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement.....	\$[4,000]
Arthrotomy, knee, with exploration, drainage, or removal of foreign body.....	\$[2,500]
Amputation, thigh, through femur, any level	\$[3,000]
Amputation, thigh, through femur, any level; open, circular (guillotine)	\$[2,500]
Closed reduction of fracture of tibia, shaft.....	\$[1,250]
Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation	\$[1,500]
Open treatment of fracture of tibia, shaft.....	\$[2,500]
Closed treatment of proximal fibula or shaft fracture; without manipulation.....	\$[752]
Open treatment of proximal fibula or shaft fracture, with or without internal or external fixation.....	\$[1,500]
Closed treatment of distal fibular fracture (lateral malleolus); without manipulation.....	\$[752]
Open treatment of distal fibular fracture (lateral malleolus).....	\$[2,000]
Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation	\$[1,250]
Closed treatment of bimalleolar ankle fracture, (including Potts); with manipulation.....	\$[1,750]
Open treatment of bimalleolar ankle fracture, with or without internal or external fixation.....	\$[2,500]
Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (e.g., cyst or ganglion); toes, wrist, forearm, foot, ankle.....	\$[752]
Closed treatment of fracture great toe	\$[253]
Open treatment of fracture great toe	\$[752]
Closed treatment of fracture of toes, other than great toes, without manipulation, each	\$[253]
Open treatment of fracture of toes, other than great toes, without manipulation, each	\$[625]
Amputation, toe; interphalangeal joint.....	\$[500]

NERVOUS SYSTEM

Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural.....	\$[4,500]
Burr holes , intracerebral.....	\$[5,000]
Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural.....	\$[7,500]
Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural.....	\$[5,000]
Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma.....	\$[6,500]
Spinal puncture, lumbar, diagnostic.....	\$[100]
Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa).....	\$[500]
Injection procedure for diskography.....	\$[500]
Laminectomy with decompression of spinal cord and discectomy, cervical.....	\$[6,000]
Laminotomy and/or excision of herniated intervertebral disk, single interspace.....	\$[4,500]
Sympathectomy, cervical.....	\$[3,000]
Sympathectomy, lumbar.....	\$[2,750]

RESPIRATORY SYSTEM

Excision of nasal polyp(s), simple.....	\$[352]
Excision of nasal polyp(s), extensive requiring hospitalization.....	\$[1,000]
Submucous resection, classic, nasal septum.....	\$[1,500]
Laryngectomy; total, without radical neck dissection.....	\$[5,000]
Laryngectomy; total, with radical neck dissection.....	\$[7,000]
Bronchoscopy, diagnostic without biopsy.....	\$[752]
Bronchoscopy with bronchial or endobronchial biopsy.....	\$[1,000]
Bronchoscopy with removal of foreign body.....	\$[1,250]
Bronchoscopy with excision of tumor.....	\$[1,250]
Thoracotomy, exploratory, including biopsy.....	\$[2,500]
Lobectomy, total, subtotal, or segmentation, single lobe.....	\$[5,000]
Bilobectomy.....	\$[6,000]
Pulmonary resection with concomitant thoracoplasty.....	\$[7,500]

Skin Lesions, Cysts and Mastectomy

Incision and drainage of abscess; simple or single.....	\$[100]
Incision and drainage of pilonidal cyst.....	\$[100]
Biopsy of skin, subcutaneous tissue and/or mucous membrane, single lesion.....	\$[153]
Biopsy of each additional lesion in addition to primary procedure.....	\$[50]
Excision, benign lesions including margins, except skin tag, 2cm or less.....	\$[200]
Excision, benign lesions including margins, except skin tag, over 2 cm.....	\$[300]
Excision of pilonidal cyst or sinus, simple.....	\$[500]
Excision of pilonidal cyst or sinus, extensive.....	\$[1,000]
Excision of pilonidal cyst or sinus, complicated.....	\$[1,500]
Destruction of benign or premalignant lesions; one lesion.....	\$[153]
Destruction of benign or premalignant lesions, second thru 14 lesions, each.....	\$[50]
Wart destruction, up to 14.....	\$[175]
Wart destruction 15 or more.....	\$[275]
Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion, open, male or female, one or more lesions.....	\$[752]
Mastectomy, simple, complete.....	\$[1,500]
Radical mastectomy, including breast, pectoral muscles and axillary lymph nodes.....	\$[3,500]

THYROID

Excision of cyst or adenoma of thyroid.....	\$[2,000]
Partial thyroidectomy unilateral.....	\$[3,000]
Thyroidectomy, total or complete.....	\$[3,500]
Total or subtotal for malignancy with limited neck dissection.....	\$[4,000]
Total or subtotal for malignancy with radical neck dissection.....	\$[5,000]
Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid.....	\$[4,000]

URINARY

Nephrectomy.....	\$[3,500]
Kidney lithotripsy.....	\$[2,500]
Excision or fulguration of Skene's glands.....	\$[352]

Outpatient Prescription Drug Benefits			
We will pay benefits only for the drugs, medicines and supplies listed as Covered Charges in the Outpatient Prescription Drug Benefits section of the plan. Use a Participating Pharmacy to receive the maximum benefits available under the plan.			
[[Benefit Waiting Period]	[[XX] days from Covered Person's Effective Date.]		
Outpatient Prescription Drug Copayment:	\$[XX] for each Prescription Order for Generic Drugs. \$[XX] for each Prescription Order for Preferred Brand Name Drugs. \$[XX] for each Prescription Order for Non-Preferred Brand Name Drugs.		
Outpatient Prescription Drug Calendar Year Maximum Benefit:	Up to \$[XXX] per Calendar Year.		
Outpatient Prescription Drug Benefit:	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>[Participating Pharmacy Benefit:]</p> <ul style="list-style-type: none"> • [XXX%] after satisfaction of the Outpatient Prescription Drug Copayment up to the Outpatient Prescription Drug Calendar Year Maximum Benefit. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit. </td> <td style="width: 50%; vertical-align: top;"> <p>[Non-Participating Pharmacy Benefit:]</p> <ul style="list-style-type: none"> • Contracted Rate after satisfaction of the Outpatient Prescription Drug Copayment up to the Outpatient Prescription Drug Calendar Year Maximum Benefit. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit.]] </td> </tr> </table>	<p>[Participating Pharmacy Benefit:]</p> <ul style="list-style-type: none"> • [XXX%] after satisfaction of the Outpatient Prescription Drug Copayment up to the Outpatient Prescription Drug Calendar Year Maximum Benefit. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit. 	<p>[Non-Participating Pharmacy Benefit:]</p> <ul style="list-style-type: none"> • Contracted Rate after satisfaction of the Outpatient Prescription Drug Copayment up to the Outpatient Prescription Drug Calendar Year Maximum Benefit. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit.]]
<p>[Participating Pharmacy Benefit:]</p> <ul style="list-style-type: none"> • [XXX%] after satisfaction of the Outpatient Prescription Drug Copayment up to the Outpatient Prescription Drug Calendar Year Maximum Benefit. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit. 	<p>[Non-Participating Pharmacy Benefit:]</p> <ul style="list-style-type: none"> • Contracted Rate after satisfaction of the Outpatient Prescription Drug Copayment up to the Outpatient Prescription Drug Calendar Year Maximum Benefit. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit.]] 		

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

LIFE INSURANCE BENEFITS RIDER

[The consideration for this Rider is the additional premium shown in the Benefit Summary.] The policy or certificate to which this Rider is attached is amended as follows.

[The life insurance benefit[s] listed in this rider [is] [are] optional.] We will pay benefits for the [optional] life insurance benefit[s] that [is] [are] covered under this rider up to the maximum amount shown herein. However, benefits are subject to all the other applicable terms, limits and conditions in this plan.

This rider provides coverage only for the following life insurance benefit[s] that [is] [are] purchased by You [and any Covered Dependents]:

[Life Insurance]	
[Certificate Holder]	\$[5,000-500,000]
[Covered Dependent Spouse]	[\$[2,000-250,000]]
[Covered Dependent Child(ren)]	[\$[1,000-250,000]]
[This Amount of Life Insurance will be subject to the Age Reduction Percentages listed below:]	
[Age Reduction Percentages:]	
<u>[Reduction Age:]</u>	<u>[Reduction Percentage:]</u>
[[55]	Reduces to [70]% of the amount in force immediately prior to age [55]]
[[65]	Reduces to [60]% of the amount in force immediately prior to age [65]]
[[70]	Reduces to [60]% of the amount in force immediately prior to age [70]]

[Accelerated Benefit]
Up to [10-80%] of the Life Insurance Benefit]

[Accidental Death & Dismemberment Insurance:]	
[The Accidental Death Benefit will be] [[an amount equal to] [and in addition to]] the amount of Life Insurance [(including any applicable adjustment or reduction)] in effect on the date of loss.]	
[Certificate Holder]	\$[5,000-500,000]]
[Dependent Covered Spouse]	[\$[2,000-250,000]]
[Dependent Covered Child(ren)]	[\$[1,000-250,000]]

[Term Life Insurance]
[We will pay the term life insurance benefit to the Beneficiary if We receive proof of the Covered Person's death.] [We reserve the right to have an autopsy done where it is not prohibited by law before benefits are considered.]

[At age 65, the term life insurance coverage [terminates] [is reduced to [65%] of the original amount of term life insurance coverage that the Covered Person had on the Effective Date].] [On the date [term life

insurance coverage] [any of the [optional] coverage[s] listed in this section] end[s] for the Certificate Holder, that coverage will also end for any Covered Dependents.]]

[Payment will be made to the designated Beneficiary.] If there is no surviving Beneficiary, payment will be made to the Covered Person's estate. The Beneficiary designation should be kept up-to-date so that benefits will be paid as the Covered Person wants them to be paid. The Beneficiary may be changed by sending Us written notice. No change is effective until We receive written notice. If the Covered Person would like a payment option other than lump sum, please contact Us.]

[Once an amount equal to the term life insurance benefit has been paid for a Covered Person, no other benefits are available for that Covered Person under this provision.]]

[Accelerated Benefit

We will pay an accelerated benefit for a Covered Person who has a terminal illness if all of the following requirements are met:

1. A claim for the accelerated benefit is sent to Us.
2. The Covered Person has a condition which will cause his or her life expectancy to be [12 months] or less.
3. We receive proof and a certification from a Health Care Practitioner that objectively documents the presence of a terminal illness and provides a prognosis that the Covered Person has [12 months] or less to live. The Health Care Practitioner cannot be a Covered Person, an Immediate Family Member[, employer of a Covered Person] or a person who ordinarily resides with a Covered Person.]

Payment of the accelerated benefit will be subject to any irrevocable Beneficiary designation or prior assignment of the term life insurance benefit under this plan. We will make only one accelerated benefit payment during each Covered Person's lifetime. [We reserve the right to obtain a second opinion from a Health Care Practitioner at Our expense before benefits are considered.]

Following payment of the accelerated benefit, the maximum amount for the term life insurance coverage will be reduced by an amount equal to the amount that is paid for the accelerated benefit. A new Benefit Summary will be sent to You reflecting the new benefit amount for the term life insurance coverage. Premium payments must be continued for the full amount of the term life insurance coverage that the Covered Person had prior to receiving the accelerated benefit payment.

Receipt of an accelerated benefit may be a taxable event. You may want to consult a tax advisor about any potential income tax consequences.]

[Accidental Death Benefit

We will pay an Accidental death benefit to the Beneficiary if all of the following requirements are met:

1. We receive proof of the Covered Person's death.
2. The proof shows that death resulted directly from bodily Injury caused solely as a result of an Accident and independent of disease, physical condition, bodily infirmity or any other cause.
3. Death occurred within the first [180 days] after the Accident.

The maximum accidental death benefit amount is in addition to the term life insurance coverage amount. [We reserve the right to have an autopsy done where it is not prohibited by law before benefits are considered.]]

[Termination of Coverage

The Certificate Holder's life insurance coverage terminates on the earliest of the date as determined in accordance with the termination date of this plan or the date of renewal occurring on or after his or her [65th] birthday. Dependent life insurance coverage terminates on the earliest of the date as determined in accordance with the termination date of this plan, or the date the Certificate Holder's life insurance

coverage ceases, or, if a Covered Dependent spouse [or Domestic Partner], the date of renewal occurring on or after his or her [65th] birthday or the date on which the Certificate Holder and Covered Dependent spouse [or Domestic Partner] become legally divorced.]

[General Provisions

With the exception of the Extension of Benefits provision and the provisions stated below, this coverage is subject to applicable provisions in this plan, including the Eligibility and Effective Date of Certificate Holder, Eligibility and Effective Date of Dependents, termination date of this plan and Misstatements provisions. Nothing will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations in this plan, other than as stated in this Life Insurance Benefits section.

For purposes of this Life Insurance Benefits section only, the Assignment, Incontestability and Entire Plan provisions below are added.]

[Beneficiary

Is the person or entity to whom a life insurance benefit is payable in the event of a Covered Person's death. The Beneficiary is named by the [Covered Person][Certificate/Policy Holder]. [The Primary Insured is the Beneficiary of any Spouse [/Domestic Partner][/Civil Union] or Child9ren0 Life Insurance.]]

[Assignment

A Covered Person's right to benefits under this Life Insurance Benefits section is assignable. A signed copy of the assignment must be sent to Our Home Office in a form acceptable to Us. The assignment is subject to any payment made or other action taken before We receive the assignment. We are not responsible for the validity or effect of any assignment of life insurance benefits.]

[Incontestability

In the absence of fraud, all statements made on the enrollment form will be deemed representations and not warranties. Except for nonpayment of premium, no statement made in any enrollment form shall be used to void coverage after coverage has been in force for 2 years. In the event of the Covered Person's death or incapacity, no statement made in any enrollment form shall be used to void the coverage unless a copy of the enrollment form is furnished to the Covered Person's beneficiary or personal representative. This provision does not preclude defenses based upon provisions relating to eligibility.]

[Entire Plan

The entire agreement is made up of the [group master] Policy, a Covered Person's enrollment form[, the certificate of insurance] and any riders and endorsements. A copy of the enrollment form shall be included when the [Policy/certificate] is issued. All statements made by the [group master] Policyholder are considered to be representations, not warranties. This means that the statements are considered to have been made in good faith. No statement will void this rider unless it is contained in a written enrollment form and a copy is furnished to the person making such statement.]

[For purposes of this Life Insurance Benefits rider only, the Reinstatement provision is revised as follows:

Death occurring between the date the coverage lapses and coverage is reinstated will not be covered.]]

[We will not pay term life insurance benefits for death caused by any of the following:

- [1.] [War or any act of war[, whether declared or undeclared.]
- [2.] [Participation in the military service of any country or international organization[, including non-military units supporting such forces.]
- [3.] [[Suicide,] attempted suicide or self-inflicted Sickness or Injury[, while sane or insane,] [even if the Covered Person did not intend to cause the harm which resulted in death from the action which led to the self-inflicted Sickness or Injury].] [Attempted suicide or self-inflicted Injury, during the first two years coverage is in force.]
- [4.] [Taking part in a riot or insurrection, or an act of riot or insurrection.]
- [5.] [Participating in, voluntarily attempting to commit or commission of a felony, whether or not charged, or engaging in an illegal occupation or activity at the time of an Accident.]

- [6.] [Voluntary use of any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.]
- [7.] Riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.
- [8.] [Intoxication that includes, but is not limited to, operating a motor vehicle while intoxicated. Intoxication and intoxicated mean that the Covered Person's blood alcohol level at the time of the incident exceeded the blood alcohol level otherwise permitted by law or violates legal standards [for a person operating a motor vehicle] in the state where death occurs.]]

[We will not pay benefits under the Accidental Death Benefit provision for death caused directly from any of the following:

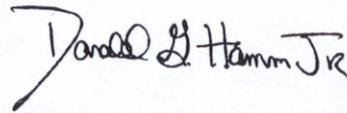
- [1.] [War or any act of war, whether declared or undeclared.]
- [2.] [Participation in the military service of any country or international organization[, including non-military units supporting such forces.]
- [3.] [[Suicide,] attempted suicide or self-inflicted Sickness or Injury[, while sane or insane,] [even if the Covered Person did not intend to cause the harm which resulted in death from the action which led to the self-inflicted Sickness or Injury].]
- [4.] [Taking part in a riot or insurrection, or an act of riot or insurrection.]
- [5.] [Participating in, voluntarily attempting to commit or commission of a felony, whether or not charged, or engaging in an illegal occupation or activity at the time of an Accident.]
- [6.] [Voluntary use of any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.]
- [7.] [Injury while riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.]
- [8.] [Injury while acting as pilot, student pilot, crew member, flight instructor, or examiner on any aircraft.]
- [9.] [Voluntarily taking, absorbing, or inhaling any gas, poison or drugs.]
- [10.] [Disease, other than bacterial infection, occurring through an Accidental injury, or medical or surgical treatment of disease or infirmity.]]]

Nothing contained in this Rider will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the policy or certificate other than as stated above.

The Effective Date of this Rider is the Effective Date of the policy or certificate to which it is attached, or the endorsement date if later.



Secretary



President

[IMployeeSM] [- insert product/marketing name(s)]
Enrollment form [for] [limited benefit] [health insurance] [program]

PLEASE PRINT IN BLACK INK

PERSON(S) TO BE INSURED

Attach a separate sheet, signed and dated, if additional space is needed below. Label additional dependents starting with the letter "E" and after.

[Only complete the [spouse] [/domestic partner] [/civil union] and dependent information if it applies.]

	Last	Name First	MI	Sex	Birthdate (MM/DD/YY)	State of Birth	Social Security Number
1. Primary							
2. Spouse [/Domestic Partner] [/Civil Union]							
3. Dependents (list relationship below)	Last	Name First	MI	Sex	Birthdate (MM/DD/YY)	Full-time student?	Social Security Number
[A.]							
[B.]							
[C.]							
[D.]							

[Examples of types of coverage are individual medical insurance, group insurance, and supplemental coverage for specific conditions, like cancer.]

4. Resident Address: _____
 (NO P.O. BOXES) (Street) (City) (State) (ZIP)

5. Phone Number: (____) _____ 6. E-mail Address: _____

[7a.] [Are any of the proposed insureds covered by, or has application been made for any type of medical insurance?..... Yes No] [If "Yes," complete the section below.]

Proposed Insured's Name	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date (MM/DD/YY)	Termination Date (MM/DD/YY)	Is this coverage being replaced by proposed coverage?

[7b.] [Primary Insured Occupation: _____]

[Company Name: _____] [Work Number: (____) _____]

[Duties: _____]

[Is the Primary Insured [self-employed] [or] a [sole proprietor]?..... Yes No]

[Is the Primary Insured covered by Workers' Compensation?..... Yes No]

[7c.] [Spouse [/Domestic Partner] [/Civil Union] Occupation: _____]

[Company Name: _____] [Work Number: (____) _____]

[Duties: _____]

[Is the Spouse [/Domestic Partner] [/Civil Union] [self-employed]

[or] a [sole proprietor]?..... Yes No]

[Is the Spouse [/Domestic Partner] [/Civil Union] covered by

Workers' Compensation?..... Yes No]

[REQUESTED EFFECTIVE DATE

[8.] [Requested effective date _____]

[Your effective date is based on the date [you sign] [we receive] your enrollment form.] [If [you sign] [we receive] it on the [1st] through the [15th] of the month, your effective date will be the [1st] of the [following] month. If [you sign] [we receive] the enrollment form on the [16th] through the [31st] of the month, your effective date is the [15th] of the [following] month.] [Check with your agent for more details.]

[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO [414-299-6020]]

[HEALTH STATEMENT

[To determine if you're eligible for this individual medical plan, you need to answer a few medical questions for you and anyone else applying for coverage.]

[Attach a separate sheet if additional information is needed. Date and sign any additional sheets.]

[Note: The plan cannot be issued to any person who answers YES to any of the following questions.]

[Enter dependent information in same order as page 1.]

[Primary]	[Spouse]	[Domestic Partner/ Civil Union]	[A]	[B]	[C]	[D]
-----------	----------	------------------------------------	-----	-----	-----	-----

[9.] [Are you, your spouse, or any person to be insured now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?]

Yes	<input type="checkbox"/>					
No	<input type="checkbox"/>					

[10.] [Have you, your spouse, or any person to be insured seen a health care professional for any reason other than preventive care in the past 30 days?]

Yes	<input type="checkbox"/>					
No	<input type="checkbox"/>					

[11.] [For any of the following conditions within the last 5 years, have you or any person to be insured received any abnormal test results or medical or surgical treatment, or consulted a health care professional, or taken medication for:

Yes	<input type="checkbox"/>					
No	<input type="checkbox"/>					

- [Heart disorder][, excluding] [Mitral Valve Prolapse (MVP)] [or] [surgically corrected or closed] [Atrial Septal Defect (ASD)][/][Ventricular Septal Defect (VSD)]
- [Stroke]
- [Crohn's Disease] [or] [Ulcerative Colitis]
- [Liver disorders][, excluding fully recovered Hepatitis A]
- [Kidney disorders][, excluding kidney stones]
- [Emphysema] [or] [Chronic Obstructive Pulmonary Disease (COPD)]
- [Diabetes][, excluding Gestational Diabetes]
- [Basal Cell Carcinoma with recommended surgery that has not been completed]
- [Cancer] [or] [Tumor]
- [Alcoholism][,] [Alcohol or Chemical Dependency][,] [or] [Drug or Alcohol Abuse]
- [Acquired Immune Deficiency Syndrome (AIDS)] [or] [tested positive for Human Immunodeficiency Virus (HIV)]
- [Multiple Sclerosis (MS)]
- [Tuberculosis (TB)]
- [Any condition that resulted in Bariatric Surgery]

FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO 414-299-6020

BILLING

[You have [four] choices for billing. It's important to note we'll request funds as soon as we issue your policy.]

[You have four billing methods to choose from:]

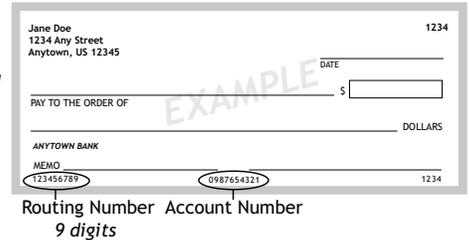
[1.][Monthly payroll deduction [(list bill)]]

→ Assigned [list bill] number, if known: _____
[Note to agent: this option requires the employer have a List Bill agreement on file.]

[2.][Monthly [Electronic Funds Transfer] [EFT][/Check-O-Matic]

→ To begin withdrawals:
Select a desired withdrawal date [1-28]: _____
[Your first [two months'] premium may not be deducted on the same day each month as your requested withdrawal date.]

Bank name: _____
City: _____ State: _____
Routing number: _____
Account number: _____



→ To add this policy to an existing [Electronic Funds Transfer] [EFT] [/Check-O-Matic] Existing [Electronic Funds Transfer] [EFT] [/Check-O-Matic] number _____
Associated policy number: _____]

[The accountholder's signature is needed here if requesting [Electronic Funds Transfer] [EFT] [/Check-O-Matic]]

Authorization for [Electronic Funds Transfer] [EFT] [/Check-O-Matic] – **please sign below**
I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Accountholder signature: _____ Date: _____]

[You have [two] options if choosing to pay by credit card [– recurring or 1st payment only].]

[3.][Credit card] → Choose how often: Monthly] Quarterly] Semi-Annual] Annual]
[or
→ Charge first payment only*]
[*You must also select a secondary billing method for subsequent payments. Once you choose below, go to that section and complete.]
Choose method: Payroll deduction]
 [Monthly [Electronic Funds Transfer] [EFT] [/Check-O-Matic]]] Bill me directly]]

[The cardholder's signature is needed here if requesting to pay by credit card.]

Authorization for credit card payments – **please sign below**
I authorize Time Insurance Company to charge my account for the individual medical policy. I understand there will be no refund of premium after the 10-day free look in the contract.
Card number: _____ - _____ - _____ - _____
Card type: MasterCard VISA
Expiration date: ____/____ [Security code number ([3] digits on back of card): ____ ____ ____]
Name as it appears on card: _____
Address of cardholder, if different: _____
Cardholder signature: _____ Date: _____]

[4.][Bill me directly: → Choose how often: Monthly] Quarterly] Semi-Annual] Annual]]

[Please complete this if your billing address is different than your home address.]

If your billing address is different than your home address, please enter it here:
Billing Address: _____
(Street) (City) (State) (ZIP)
Name of person paying, if different: _____]

[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO [414-299-6020]]

[LIFE INSURANCE]

[Complete this section to designate a beneficiary for life insurance.]

Beneficiary for Primary Insured: _____
(Full Name) (Relationship)
Contingent Beneficiary: _____]
(Full Name) (Relationship)

[HEALTH ADVOCATES ALLIANCE MEMBERSHIP APPLICATION]

[Membership in Health Advocates Alliance (HAA) is required to apply for individual medical coverage. [Enrollment starts at the low cost of [\$X.XX] per month.] Your signature is needed here to complete HAA enrollment.]

Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for [the] [health] insurance [coverage] [program]. Membership privileges include the opportunity to participate in all [programs] [benefits] offered or sponsored by the Association. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure [(Form JI-1033)].

I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association; if participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored [programs] [or] [benefits].

Member Signature Date

[HIPAA ELIGIBILITY]

[Complete this section to help us determine if you're eligible for a HIPAA plan with no pre-existing condition limitation.]

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing exclusion. In order for Time Insurance Company to determine whether you or anyone applying for coverage is entitled to such a plan, please review the following and indicate whether ALL of the below statements are true at the time you or anyone to be insured applies for individual coverage:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days.
- Your most recent coverage was under a group plan, a governmental plan or a church plan.
- You are not covered under another group health plan.
- Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud.
- You are not currently eligible for Medicare or Medicaid.
- You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible.

No, I or anyone to be insured do not meet any of the above requirements.

Yes, I or anyone to be insured meet all of the above requirements.]

[EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT]

[By checking "yes" here, you agree that the insurance you're applying for will not be paid for by an employer.]

You understand and agree that you are applying for individual [limited benefit] health insurance for you (and your family). [You further understand that this application for health insurance [will] [may] [be] [fully] [medically] [underwritten][,] [and] [is subject to eligibility requirements] [and that coverage is not guaranteed].] You are personally paying the entire premium for this health insurance coverage. Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

[[If my employer has [50] or fewer full-time employees,] I agree that I will not use funds from a Health Reimbursement Arrangement [(HRA)] [or a Cafeteria Plan] to pay the premium for my individual coverage.]

Do you agree with this statement? Yes No]

[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO [414-299-6020]]

[Signatures are needed in this section. It's important to note you are applying for limited benefit health insurance. Coverage comes with a 10-day free look.]

[AUTHORIZATION]

[My [enrollment form][,] [recorded Authorizations][,] [recorded personal health history] [and any amendments] shall be the basis for the contract. [I agree that I must call Time Insurance Company and complete [the] [Authorization] [and] [personal health history] portion of the enrollment process within [10] [day[s]] of commencement of the enrollment process.]

[I understand the insurance coverage is subject to underwriting.] [The insurance[, if approved by Time Insurance Company,] will be in force only when issued by Time Insurance Company.] [The effective date is assigned by Time Insurance Company.] [The first full premium must be paid.] [A change in the [eligibility] [health] of the proposed insured(s) after the completion of the enrollment form and before the delivery of the contract may affect my eligibility for insurance with the company.] [I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker.] [If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.]

[I agree that a photocopy of this authorization shall be valid for [two] [year[s]] from the date signed.]

[[In order to determine my (our) eligibility for insurance,] I hereby authorize any health care provider or medically related facility, pharmacy[, pharmacy benefit manager] or pharmacy related facility, [MIB, Inc.,] [("MIB")] [formerly known as the Medical Information Bureau][,] consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information [including information regarding [employment,] [other insurance coverage,] [personal information,] [medical or pharmacy care, advice, treatment, or medication use]] as may be requested to Time Insurance Company [(or any consumer-reporting agency authorized by Time Insurance Company)], its legal representative or any medical records retrieval service Time Insurance Company may engage[,] [.] [including, but not limited to, [EMSI,]] [Examination Management Services, Inc.][.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to any medical records company engaged by Time Insurance Company, including but not limited to [EMSI] and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children[.] [or for Time Insurance Company's underwriting or risk rating determinations.] If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, [P.O. Box 3050][,] [501 West Michigan, Milwaukee, WI 53201][3][3][3050].] Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: denial of my application, declination of enrollment, or, if insured, when I am no longer an insured of Time Insurance Company.]

[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO [414-299-6020]]

[I acknowledge receiving the notification regarding [MIB, Inc.] [(“MIB”)] [and] [the Abbreviated Notice of Insurance Information Practices] [and] [the Outline of Coverage for Health Insurance] [,] [if required].]

[I acknowledge that I have read the completed enrollment form.] [I attest that all statements and answers on this enrollment form are complete, true and correct.] [I understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the [enrollment form][,] [recorded] [Authorizations][,] [recorded] [personal health history] [and/or any amendments] may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.]

[I understand that the coverage offered provides LIMITED BENEFITS and has specific benefit limitations.]

Signature of Primary Proposed Insured

Signature of Spouse[/Domestic Partner] [/Civil Union] or Other (if proposed to be insured)

Signature(s) of Other Dependent(s) 18 or Over (if proposed to be insured)

Guardian's Signature

Premium Amount Sent: \$ _____

[One-time Processing Fee Sent*: _____]
*Not applicable in all states

Date and Time signed (including a.m./p.m.)

City and State signed in

Attention: (Agent)

I have reviewed this enrollment form to ensure that all required items have been completed.

To the best of my knowledge, there
 IS IS NOT
a replacement of medical insurance involved in this transaction.

Licensed Resident Agent's Signature

Print Agent's Name

_____ Initial here if you witnessed the signing of this form by the proposed insured.

[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO 414-299-6020]

[ARE YOU AN EXISTING CUSTOMER?

[Policy # _____]

[What do you want to do?]

Add Dependent]

Policy/Benefit Change to an existing policy]

[List type of change requested: _____]

Reinstatement of Coverage]

Internal Replacement]

Conversion (over-age dependent/divorce)]]

[AGENT/AGENCY INFORMATION

Agent Name: _____

Agent Number: _____

Key Agency Contact: _____

Fax Number: _____

Phone Number: _____

E-mail Address: _____

Agency Name: _____

Agency Number: _____

[Policy should be mailed to:] Agent] Agency] Policyholder]]

[You don't need to do anything here. Your agent will complete this section.]

[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO [414-299-6020]]

[These additional notices provide you with more information on [your personal medical information,] your rights [, and] fraud and privacy. Keep this sheet for your records.]

[IMPORTANT NOTICES – LEAVE WITH CUSTOMER

[NOTIFICATION REGARDING [MIB, Inc.] [(“MIB”)] [formerly known as the Medical Information Bureau]

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to [MIB], a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another [MIB] Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, [MIB], upon request, will supply such company with the information in its file.

Upon receipt of a request from you, [MIB] will arrange disclosure of any information it may have in your file. Please contact [MIB] at [866 692-6901] [(TTY 866 346-3642)]. If you question the accuracy of information in [MIB’s] file, you may contact [MIB] and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of [MIB’s] information office is [Post Office Box 105, Essex Station, Boston, Massachusetts 02112].

Time Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.]

[ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, [Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.]

[FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.]

[PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.]]

LEAVE THIS PAGE WITH THE CUSTOMER - DO NOT FAX

Supplemental Notice to Master Group Policy Application

NOTICE: The following OPTIONAL MUSCULOSKELETAL DISORDERS OF THE FACE, NECK OR HEAD BENEFITS RIDER is hereby attached to and made part of your existing Master Group Policy Application. You may accept or reject the optional coverage for Arkansas resident members covered under the Master Group Policy, however REJECTION OF THIS OPTIONAL RIDER MEANS THAT COVERED BENEFITS PROVIDED TO CERTIFICATE HOLDERS WILL NOT INCLUDE TEMPOROMANDIBULAR JOINT DISORDER OR CRANIOMANDIBULAR JOINT DISORDER.

SERFF Tracking Number: MCHX-125711822 *State:* Arkansas
Filing Company: Time Insurance Company *State Tracking Number:* 39430
Company Tracking Number: 499.BNS.001.AR
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.001 Any Size Group
Expense
Product Name: 499.BNS.001.XX-TIC Association Limited Benefit Med
Project Name/Number: 499.BNS.001.XX-TIC Association Limited Benefit Medical Expense-Benefit Summary-Non GI/499.BNS.001.XX-TIC Association
Limited Benefit Medical Expense-Benefit Summary-Non GI

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: MCHX-125711822 State: Arkansas
 Filing Company: Time Insurance Company State Tracking Number: 39430
 Company Tracking Number: 499.BNS.001.AR
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.001 Any Size Group
 Expense
 Product Name: 499.BNS.001.XX-TIC Association Limited Benefit Med
 Project Name/Number: 499.BNS.001.XX-TIC Association Limited Benefit Medical Expense-Benefit Summary-Non GI/499.BNS.001.XX-TIC Association
 Limited Benefit Medical Expense-Benefit Summary-Non GI

Supporting Document Schedules

Satisfied -Name: Red-Lined Benefit Summary **Review Status:** Approved-Closed 07/02/2008
Comments:
Attachment:
 Red-Lined Benefit Summary.PDF

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 07/02/2008
Comments:
Attachments:
 AR Cert of Compliance with Rule 19.PDF
 AR Certificate of Compliance #49.PDF
 AR - READABILITY CERTIFICATION.PDF

Bypassed -Name: Application **Review Status:** Approved-Closed 07/02/2008
Bypass Reason: N/A
Comments:

Satisfied -Name: Authorization Letter **Review Status:** Approved-Closed 07/02/2008
Comments:
Attachment:
 Authorization Letter.PDF

Satisfied -Name: Forms Listing **Review Status:** Approved-Closed 07/02/2008
Comments:
Attachment:
 Forms Listing.PDF

SERFF Tracking Number: MCHX-125711822 State: Arkansas
Filing Company: Time Insurance Company State Tracking Number: 39430
Company Tracking Number: 499.BNS.001.AR
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.001 Any Size Group
Expense
Product Name: 499.BNS.001.XX-TIC Association Limited Benefit Med
Project Name/Number: 499.BNS.001.XX-TIC Association Limited Benefit Medical Expense-Benefit Summary-Non GI/499.BNS.001.XX-TIC Association
Limited Benefit Medical Expense-Benefit Summary-Non GI

Satisfied -Name: 06.25.08 Submission Letter **Review Status:** Approved-Closed 07/02/2008
Comments:
Attachment:
06_25_08 Submission Letter.PDF

Satisfied -Name: Statement of Variability **Review Status:** Approved-Closed 07/02/2008
Comments:
Attachment:
Statement of Variability.PDF

LIMITED BENEFIT MEDICAL INSURANCE BENEFIT SUMMARY

Date of this Benefit Summary: [XX/XX/XXXX]

THIS BENEFIT SUMMARY CONTAINS LIMITED INFORMATION ABOUT YOUR PLAN. IN ADDITION, THE PLAN HAS LIMITED BENEFITS AND ANNUAL MAXIMUMS. PLEASE READ YOUR CERTIFICATE CAREFULLY TO UNDERSTAND ANY COVERAGE LIMITATIONS. REVIEW THIS BENEFIT SUMMARY FOR INFORMATION ON WHAT BENEFITS ARE PROVIDED FOR COVERED CHARGES.

Benefits will be paid for Covered Charges Incurred while coverage is in force. Payment of benefits is subject to all the terms, limits and conditions in the plan. The benefits shown in this Benefit Summary apply to each Covered Person unless otherwise indicated below.

Policyholder, Certificate Holder and Plan Information		
Policyholder:	[Name]	
Certificate Holder:	[Name] [Address/City/State/Zip]	Effective Date: [XX/XX/XXXX]
Covered Dependents:	[Spouse's Name] [Dependent Child's Name] [Dependent Child's Name]	Effective Date: [XX/XX/XXXX] Effective Date: [XX/XX/XXXX] Effective Date: [XX/XX/XXXX]
Certificate Number:	[XXXXXXXX]	
Payment Option:	[Monthly/Quarterly/Semi-Annually/Annually]	
Medical Benefits		
We will pay benefits only for the treatment, services and supplies listed as Covered Charges in the Medical Benefits section of the plan. [Use a Participating Provider to receive the maximum benefits available under the plan.]		
[[Maximum Lifetime Benefit:]	[\$[50,000-unlimited] – All benefit payments apply to the Maximum Lifetime Benefit unless otherwise indicated.]	
[Outpatient Calendar Year Maximum Benefit:	Up to \$[XXX] maximum benefit for Covered Charges Incurred for all Outpatient services combined during a Calendar Year. Covered Charges for ambulance services, services received in an Emergency Room, Outpatient services shown under the Surgical Services provision and drugs covered under the Outpatient Prescription Drug Benefits section do not apply towards the Outpatient Calendar Year Maximum Benefit.]	
[Inpatient Maximum Benefit:	Up to \$[XXX,XXX] maximum benefit for Covered Charges Incurred while Inpatient [per Calendar Year][Per Condition][and billed by the Hospital where the services are received] [over the lifetime of each Covered Person]. See the Inpatient Hospital Services provision below for the maximum benefit per day for Covered Charges that are Incurred while Inpatient, depending on whether the Covered Person is being treated for a Sickness or an Injury. Covered Charges for services shown under the Surgical Services provision that are Incurred while Inpatient do not apply towards the Inpatient Maximum Benefit.]	
[Surgical Services Maximum Benefit:	Up to \$[XX,XXX] maximum benefit for Covered Charges shown in the Surgical Schedule that are Incurred while Inpatient or Outpatient for professional surgical services of a surgeon [Per Condition] [over the lifetime of each Covered Person][per Calendar Year]. Covered Charges for an assistant surgeon and anesthesia services do not apply towards the Surgical Services Maximum Benefit. However, when the Surgical Services Maximum Benefit has been paid by Us, no further benefits are payable for an Assistant Surgeon's Benefit or Anesthesia Benefit for that condition either.]	
Deductible:	[Participating Provider Benefit:] The Deductible applies to all Covered Charges [from a Participating Provider] unless otherwise indicated. • [Individual] [Participating Provider]	[Non-Participating Provider Benefit:] The Deductible applies to all Covered Charges from a Non-Participating Provider unless otherwise indicated. • Non-Participating Provider

	<p>Deductible: \$[XXX] per Calendar Year.</p> <ul style="list-style-type: none"> • [Family Deductible: \$[XXX] per Calendar Year.] • Common Accident Deductible: \$[XXX] for all Covered Persons injured in the same Accident. 	<p>Deductible: \$[XXX] per Calendar Year.</p> <ul style="list-style-type: none"> • [Family Deductible: \$[XXX] per Calendar Year.] • Common Accident Deductible: \$[XXX] for all Covered Persons injured in the same Accident.
Coinsurance:	<ul style="list-style-type: none"> • [XX]% of Covered Charges [from a Participating Provider] after the Deductible is satisfied - The Coinsurance applies to all Covered Charges [from a Participating Provider] unless otherwise indicated. 	<ul style="list-style-type: none"> • [XX]% of Covered Charges from a Non-Participating Provider after the Deductible is satisfied - The Coinsurance applies to all Covered Charges from a Non-Participating Provider unless otherwise indicated.
Inpatient Hospital Services:	<p>The following applies to Covered Charges received in a Hospital while Inpatient (this does not include services covered in the Surgical Services provision):</p> <ul style="list-style-type: none"> • Up to \$[XXX] maximum benefit per day for room and board, nursing services and all other Covered Charges that are Incurred while Inpatient for treatment of a Sickness [and billed by the Hospital where the services are received]. • Up to \$[X,XXX] maximum benefit per day for room and board, nursing services and all other Covered Charges that are Incurred while Inpatient for treatment of an Injury[and billed by the Hospital where the services are received]. • If treated for both a Sickness and an Injury during an Inpatient stay, all Covered Charges Incurred for the entire Inpatient stay[that are billed by the Hospital where the services are received] will be considered under only the Injury benefit above. • No Deductible applies. • Coinsurance applies. • Benefit payments apply towards the Inpatient Maximum Benefit. 	<p>The following applies to Covered Charges received in a Hospital while Inpatient (this does not include services covered in the Surgical Services provision):</p> <ul style="list-style-type: none"> • Up to \$[XXX] maximum benefit per day for room and board, nursing services and all other Covered Charges that are Incurred while Inpatient for treatment of a Sickness[and billed by the Hospital where the services are received]. • Up to \$[X,XXX] maximum benefit per day for room and board, nursing services and all other Covered Charges that are Incurred while Inpatient for treatment of an Injury[and billed by the Hospital where the services are received]. • If treated for both a Sickness and an Injury during an Inpatient stay, all Covered Charges Incurred for the entire Inpatient stay[that are billed by the Hospital where the services are received] will be considered under only the Injury benefit above. • No Deductible applies. • Coinsurance applies. <p>Benefit payments apply towards the Inpatient Maximum Benefit.</p>
Outpatient Medical Services:	<p>The following applies to Covered Charges received in an Emergency Room (this does not include services covered in the Surgical Services provision):</p> <ul style="list-style-type: none"> • \$[XXX] Access Fee [(waived if admitted for an Inpatient stay immediately following the Emergency Room visit)]. • The maximum benefit is [X] visits per Calendar Year up to a maximum limit of \$[XXX] per visit. This maximum limit does not apply to services shown in the Surgical Services provision below. • [No Deductible or Coinsurance applies.] • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit. <p>The following applies to Covered Charges received in a Hospital's Outpatient department, a Free-Standing Facility or an</p>	<p>The following applies to Covered Charges received in an Emergency Room (this does not include services covered in the Surgical Services provision):</p> <ul style="list-style-type: none"> • \$[XXX] Access Fee [(waived if admitted for an Inpatient stay immediately following the Emergency Room visit)]. • The maximum benefit is [X] visits per Calendar Year up to a maximum limit of \$[XXX] per visit. This maximum limit does not apply to services shown in the Surgical Services provision below. • [No Deductible or Coinsurance applies.] • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit. <p>The following applies to Covered Charges received in a Hospital's Outpatient department, a Free-Standing Facility or an</p>

	<p>Urgent Care Facility (this does not include services covered in the Surgical Services provision):</p> <ul style="list-style-type: none"> • [Deductible and Coinsurance apply.] • Benefit payments apply towards the Outpatient Calendar Year Maximum Benefit. <p>The following applies to Covered Charges received in a Health Care Practitioner's office (this does not include services covered in the Office Visit Benefits or Surgical Services provision):</p> <ul style="list-style-type: none"> • [Deductible and Coinsurance apply.] • Benefit payments apply towards the Outpatient Calendar Year Maximum Benefit. 	<p>Urgent Care Facility (this does not include services covered in the Surgical Services provision):</p> <ul style="list-style-type: none"> • [Deductible and Coinsurance apply.] • Benefit payments apply towards the Outpatient Calendar Year Maximum Benefit. <p>The following applies to Covered Charges received in a Health Care Practitioner's office (this does not include services covered in the Office Visit Benefits or Surgical Services provision):</p> <ul style="list-style-type: none"> • [Deductible and Coinsurance apply.] • Benefit payments apply towards the Outpatient Calendar Year Maximum Benefit.
Office Visit Benefits:	<ul style="list-style-type: none"> • Copayments: \$[XX] per Office Visit in a Health Care Practitioner's office. • The maximum benefit is [X] visits per Calendar Year [up to a maximum limit of \$[XXX] [per Office Visit][for all visits combined per Calendar Year]]. The maximum does not apply to child immunizations. • <u>[An Office Visit during which only services for allergy shots or immunotherapy injections of inhaled allergens are rendered is not subject to the Calendar Year maximum of number of visits]; the maximum benefit limit of \$[XXX] [per Office Visit][for all visits combined per Calendar Year].per Covered Person] still applies].</u> • No Deductible or Coinsurance applies. • Copayments do not apply to child immunizations. • [Benefit Waiting Period: [XX] days from Covered Person's Effective Date. The Benefit Waiting Period does not apply to child immunizations.] <p>Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit.</p>	<ul style="list-style-type: none"> • Copayments: \$[XX] per Office Visit in a Health Care Practitioner's office. • The maximum benefit is [X] visits per Calendar Year [up to a maximum limit of \$[XXX] [per Office Visit] [for all visits combined per Calendar Year]]. The maximum does not apply to child immunizations. • <u>[An Office Visit during which only services for allergy shots or immunotherapy injections of inhaled allergens are rendered is not subject to the Calendar Year maximum of number of visits]; the maximum benefit limit of \$[XXX] [per Office Visit][for all visits combined per Calendar Year].per Covered Person] still applies].</u> • No Deductible or Coinsurance applies. • Copayments do not apply to child immunizations. • [Benefit Waiting Period: [XX] days from Covered Person's Effective Date. The Benefit Waiting Period does not apply to child immunizations.] <p>Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit.</p>
Professional Ground or Air Ambulance Services:	<ul style="list-style-type: none"> • Up to \$[XXX] maximum benefit per trip by ground ambulance to the nearest Hospital per Sickness or Injury. • Up to \$[X,XXX] maximum benefit per trip by air ambulance to the nearest Hospital per Sickness or Injury. • The maximum benefit is [X] trips per Calendar Year for ground and air ambulance combined. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit. 	<ul style="list-style-type: none"> • Paid under the Participating Provider Benefit.

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Surgical Services:	<ul style="list-style-type: none"> • Surgeon's Benefit: Up to [[XXX] % multiplied by] the dollar amount shown in the Surgical Schedule below for the surgical procedure that is being performed. • Assistant Surgeon's Benefit: Up to [XX]% of the Surgeon's Benefit for all assistant surgeons combined who are involved in the related surgical procedure. • Anesthesia Benefit: Up to [XX]% of the Surgeon's Benefit for all services involved in the administration of anesthesia during the related surgical procedure. • Two or more surgical procedures performed during the same operative session are considered one operation and the Surgeon's Benefit will be considered based on the most expensive procedure shown in the Surgical Schedule. • If a surgical procedure is performed that is not shown in the Surgical Schedule, the Surgeon's Benefit will be considered up to [\$[XXX] multiplied by] the total non-facility unit value assigned by Medicare for the procedure on the date the service is Incurred. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit or the Inpatient Maximum Benefit. • [Benefit payments apply towards the Surgical Services Maximum Benefit, except for the Assistant Surgeon's Benefit and Anesthesia Benefit. However, when the Surgical Services Maximum Benefit has been paid by Us for a condition, no further benefits are payable for an Assistant Surgeon's Benefit or Anesthesia Benefit for that condition either.] 	<ul style="list-style-type: none"> • Surgeon's Benefit: Up to [[XXX] % multiplied by] the dollar amount shown in the Surgical Schedule below for the surgical procedure that is being performed. • Assistant Surgeon's Benefit: Up to [XX]% of the Surgeon's Benefit for all assistant surgeons combined who are involved in the related surgical procedure. • Anesthesia Benefit: Up to [XX]% of the Surgeon's Benefit for all services involved in the administration of anesthesia during the related surgical procedure. • Two or more surgical procedures performed during the same operative session are considered one operation and the Surgeon's Benefit will be considered based on the most expensive procedure shown in the Surgical Schedule. • If a surgical procedure is performed that is not shown in the Surgical Schedule, the Surgeon's Benefit will be considered up to [\$[XXX] multiplied by] the total non-facility unit value assigned by Medicare for the procedure on the date the service is Incurred. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit or the Inpatient Maximum Benefit. • [Benefit payments apply towards the Surgical Services Maximum Benefit, except for the Assistant Surgeon's Benefit and Anesthesia Benefit. However, when the Surgical Services Maximum Benefit has been paid by Us for a condition, no further benefits are payable for an Assistant Surgeon's Benefit or Anesthesia Benefit for that condition either.]]
Children's Preventive Health Care Services:	<ul style="list-style-type: none"> • Copayments: \$[XX] per Office Visit in a Health Care Practitioner's office. • No Deductible or Coinsurance applies. • Copayments do not apply to child immunizations. • [Benefit Waiting Period: [XX] days from Covered Person's Effective Date. The Benefit Waiting Period does not apply to child immunizations.] • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit. 	<ul style="list-style-type: none"> • Copayments: \$[XX] per Office Visit in a Health Care Practitioner's office. • No Deductible or Coinsurance applies. • Copayments do not apply to child immunizations. • [Benefit Waiting Period: [XX] days from Covered Person's Effective Date. The Benefit Waiting Period does not apply to child immunizations.] • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit.
<p>[Surgical Schedule</p> <p>We will pay Covered Charges for the following surgical procedures up to the benefit amounts shown in the Surgical Services provision above. [Use a Participating Provider to receive the maximum benefits available under the plan.]</p>		

CARDIOVASCULAR SYSTEM

Insertion of electrode leads and pulse generator	\$[5,000]
Upgrade of implanted pacemaker system, including conversion of a single chamber system to a dual chamber system.....	\$[2,250]
Valvotomy, mitral valve; closed heart.....	\$[7,000]
Valvuloplasty, mitral valve, with cardiopulmonary bypass.....	\$[10,000]
Valvotomy, pulmonary valve, closed heart; transventricular	\$[7,500]
Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch	\$[9,000]
Ligation, division, and stripping, short or long saphenous vein.....	\$[1,500]
Ligation, division, and stripping, of short and long saphenous vein, bilateral	\$[2,250]

DIGESTIVE SYSTEM

Biopsy of salivary gland, needle.....	\$[225]
Biopsy of salivary gland, incisional	\$[300]
Tonsillectomy, with or without adenoidectomy, under 12 years of age.....	\$[752]
Tonsillectomy, with or without adenoidectomy, 12 and over years of age.....	\$[1,000]
Excision, local; ulcer or benign tumor of stomach.....	\$[3,000]
Gastrectomy, total.....	\$[5,000]
Colectomy, total, with proctectomy; with ileostomy.....	\$[5,500]
Incision and drainage of appendicular abscess, open	\$[1,500]
Appendectomy.....	\$[2,000]
Proctectomy; complete, combined abdominoperineal, with colostomy.....	\$[5,000]
Colonoscopy, diagnostic.....	\$[1,000]
Colonoscopy with biopsy	\$[1,500]
Colonoscopy with removal of tumor, polyp or other lesions	\$[2,000]
Incision of rectal fistula, superficial	\$[500]
Fissurectomy, with or without sphincterotomy	\$[1,000]
Hemorrhoidectomy, external, complete.....	\$[1,000]
Hemorrhoidectomy, internal and external, complete.....	\$[1,500]
Cholecystectomy (removal of gall bladder).....	\$[2,500]
Cholecystectomy with exploration of common duct	\$[3,500]
Pancreatectomy, total	\$[7,000]
Exploratory laparotomy; exploratory celiotomy	\$[2,000]
Repair inguinal hernia; sliding; any age	\$[1,750]
Repair initial femoral hernia	\$[1,750]

EAR

Tympanostomy	\$[150]
Stapes mobilization	\$[3,500]
Fenestration of semicircular canal	\$[4,000]

EYE

Removal of foreign body, conjunctival, superficial	\$[53]
Removal of foreign body, corneal, with or without slit lamp	\$[100]
Excision or transposition of pterygium; without graft.....	\$[1,250]
Cataract removal, intra capsular, extracapsular, with insertion of intraocular lens	\$[4,000]
Repair of retinal detachment; scleral buckling, with or without implant	\$[5,000]
Muscle operation involving one or more muscles in one or both eyes	\$[3,000]

GYNECOLOGY

Incision and drainage of Bartholin's gland abscess	\$[253]
Excision of Bartholin's gland or cyst	\$[1,000]
Anterior colporrhaphy, repair of cystocele, with or without repair of urethrocele	\$[1,750]
Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	\$[1,750]
Combined anteroposterior colporrhaphy.....	\$[2,500]
Cautery of cervix; electro or thermal	\$[153]
Dilation and curettage, diagnostic and/or therapeutic (non-obstetrical).....	\$[752]
Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)	\$[3,000]
Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s).....	\$[2,750]
Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)	\$[5,000]

Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)	\$[2,250]
Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	\$[2,250]
MUSCULOSKELETAL SYSTEM	
Muscle biopsy, superficial.....	\$[253]
Muscle biopsy, deep.....	\$[500]
Arthrocentesis, large joint	\$[153]
Removal of implant; superficial, (e.g., buried wire, pin or rod) (separate procedure).....	\$[752]
Closed treatment of mandibular fracture with interdental fixation	\$[1,500]
Arthrodesis, including laminectomy and/or discectomy	\$[6,000]
Closed treatment of clavicular fracture; without manipulation	\$[752]
Open treatment of clavicular fracture, with or without internal or external fixation	\$[2,000]
Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation.....	\$[1,500]
Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(s)	\$[2,500]
Closed treatment of shoulder dislocation, with manipulation; without anesthesia.....	\$[253]
Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia	\$[253]
Open treatment of acute shoulder dislocation.....	\$[2,750]
Arthrotomy, elbow, including exploration, drainage, or removal of foreign body.....	\$[2,500]
Treatment of closed elbow dislocation; without anesthesia.....	\$[253]
Treatment of closed elbow dislocation; requiring anesthesia	\$[1,250]
Open treatment of acute or chronic elbow dislocation	\$[2,750]
Closed treatment of ulnar shaft fracture; without manipulation.....	\$[1,000]
Open treatment of ulnar shaft fracture.....	\$[2,000]
Closed treatment of radial and ulnar shaft fractures.....	\$[1,250]
Open treatment; fixation of radius or ulna.....	\$[2,500]
Open treatment; fixation of radius AND ulna.....	\$[3,000]
Closed treatment of distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation	\$[752]
Open treatment of distal radial fracture or epiphyseal separation, with internal fixation	\$[2,000]
Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each	\$[752]
Excision of lesion of tendon sheath or joint capsule (e.g., cyst, mucous cyst, or ganglion), hand or finger.....	\$[500]
Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each.....	\$[373]
Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each.....	\$[1,000]
Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	\$[752]
Arthrotomy, hip, including exploration or removal of loose or foreign body	\$[3,500]
Closed treatment of femoral fracture, proximal end, neck; without manipulation	\$[2,250]
Closed treatment of femoral fracture, proximal end, neck; with manipulation	\$[3,000]
Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement.....	\$[4,000]
Arthrotomy, knee, with exploration, drainage, or removal of foreign body.....	\$[2,500]
Amputation, thigh, through femur, any level	\$[3,000]
Amputation, thigh, through femur, any level; open, circular (guillotine)	\$[2,500]
Closed reduction of fracture of tibia, shaft.....	\$[1,250]
Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation.....	\$[1,500]
Open treatment of fracture of tibia, shaft.....	\$[2,500]
Closed treatment of proximal fibula or shaft fracture; without manipulation	\$[752]
Open treatment of proximal fibula or shaft fracture, with or without internal or external fixation	\$[1,500]
Closed treatment of distal fibular fracture (lateral malleolus); without manipulation	\$[752]
Open treatment of distal fibular fracture (lateral malleolus).....	\$[2,000]
Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation	\$[1,250]
Closed treatment of bimalleolar ankle fracture, (including Potts); with manipulation	\$[1,750]
Open treatment of bimalleolar ankle fracture, with or without internal or external fixation.....	\$[2,500]
Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (e.g., cyst or ganglion); toes, wrist, forearm, foot, ankle.....	\$[752]
Closed treatment of fracture great toe	\$[253]
Open treatment of fracture great toe	\$[752]
Closed treatment of fracture of toes, other than great toes, without manipulation, each	\$[253]
Open treatment of fracture of toes, other than great toes, without manipulation, each	\$[625]
Amputation, toe; interphalangeal joint.....	\$[500]

NERVOUS SYSTEM

Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural.....	\$[4,500]
Burr holes , intracerebral.....	\$[5,000]
Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural	\$[7,500]
Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural	\$[5,000]
Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	\$[6,500]
Spinal puncture, lumbar, diagnostic.....	\$[100]
Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa).....	\$[500]
Injection procedure for diskography	\$[500]
Laminectomy with decompression of spinal cord and diskectomy, cervical	\$[6,000]
Laminotomy and/or excision of herniated intervertebral disk, single interspace	\$[4,500]
Sympathectomy, cervical	\$[3,000]
Sympathectomy, lumbar	\$[2,750]

RESPIRATORY SYSTEM

Excision of nasal polyp(s), simple	\$[352]
Excision of nasal polyp(s), extensive requiring hospitalization.....	\$[1,000]
Submucous resection, classic, nasal septum.....	\$[1,500]
Laryngectomy; total, without radical neck dissection	\$[5,000]
Laryngectomy; total, with radical neck dissection.....	\$[7,000]
Bronchoscopy, diagnostic without biopsy	\$[752]
Bronchoscopy with bronchial or endobronchial biopsy	\$[1,000]
Bronchoscopy with removal of foreign body	\$[1,250]
Bronchoscopy with excision of tumor.....	\$[1,250]
Thoracotomy, exploratory, including biopsy.....	\$[2,500]
Lobectomy, total, subtotal, or segmentation, single lobe	\$[5,000]
Bilobectomy	\$[6,000]
Pulmonary resection with concomitant thoracoplasty.....	\$[7,500]

Skin Lesions, Cysts and Mastectomy

Incision and drainage of abscess; simple or single.....	\$[100]
Incision and drainage of pilonidal cyst.....	\$[100]
Biopsy of skin, subcutaneous tissue and/or mucous membrane, single lesion.....	\$[153]
Biopsy of each additional lesion in addition to primary procedure.....	\$[50]
Excision, benign lesions including margins, except skin tag, 2cm or less.....	\$[200]
Excision, benign lesions including margins, except skin tag, over 2 cm.....	\$[300]
Excision of pilonidal cyst or sinus, simple	\$[500]
Excision of pilonidal cyst or sinus, extensive	\$[1,000]
Excision of pilonidal cyst or sinus, complicated.....	\$[1,500]
Destruction of benign or premalignant lesions; one lesion	\$[153]
Destruction of benign or premalignant lesions, second thru 14 lesions, each.....	\$[50]
Wart destruction, up to 14	\$[175]
Wart destruction 15 or more	\$[275]
Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion, open, male or female, one or more lesions.....	\$[752]
Mastectomy, simple, complete	\$[1,500]
Radical mastectomy, including breast, pectoral muscles and axillary lymph nodes	\$[3,500]

THYROID

Excision of cyst or adenoma of thyroid.....	\$[2,000]
Partial thyroidectomy unilateral.....	\$[3,000]
Thyroidectomy, total or complete	\$[3,500]
Total or subtotal for malignancy with limited neck dissection	\$[4,000]
Total or subtotal for malignancy with radical neck dissection.....	\$[5,000]
Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid	\$[4,000]

URINARY

Nephrectomy	\$[3,500]
Kidney lithotripsy	\$[2,500]
Excision or fulguration of Skene's glands	\$[352]

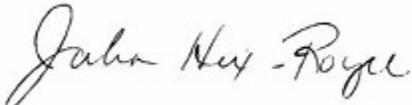
Outpatient Prescription Drug Benefits			
We will pay benefits only for the drugs, medicines and supplies listed as Covered Charges in the Outpatient Prescription Drug Benefits section of the plan. Use a Participating Pharmacy to receive the maximum benefits available under the plan.			
[[Benefit Waiting Period]	[[XX] days from Covered Person's Effective Date.]		
Outpatient Prescription Drug Copayment:	\$[XX] for each Prescription Order for Generic Drugs. \$[XX] for each Prescription Order for Preferred Brand Name Drugs. \$[XX] for each Prescription Order for Non-Preferred Brand Name Drugs.		
Outpatient Prescription Drug Calendar Year Maximum Benefit:	Up to \$[XXX] per Calendar Year.		
Outpatient Prescription Drug Benefit:	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>[Participating Pharmacy Benefit:]</p> <ul style="list-style-type: none"> • [XXX%] after satisfaction of the Outpatient Prescription Drug Copayment up to the Outpatient Prescription Drug Calendar Year Maximum Benefit. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit. </td> <td style="width: 50%; vertical-align: top;"> <p>[Non-Participating Pharmacy Benefit:]</p> <ul style="list-style-type: none"> • Contracted Rate after satisfaction of the Outpatient Prescription Drug Copayment up to the Outpatient Prescription Drug Calendar Year Maximum Benefit. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit.]] </td> </tr> </table>	<p>[Participating Pharmacy Benefit:]</p> <ul style="list-style-type: none"> • [XXX%] after satisfaction of the Outpatient Prescription Drug Copayment up to the Outpatient Prescription Drug Calendar Year Maximum Benefit. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit. 	<p>[Non-Participating Pharmacy Benefit:]</p> <ul style="list-style-type: none"> • Contracted Rate after satisfaction of the Outpatient Prescription Drug Copayment up to the Outpatient Prescription Drug Calendar Year Maximum Benefit. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit.]]
<p>[Participating Pharmacy Benefit:]</p> <ul style="list-style-type: none"> • [XXX%] after satisfaction of the Outpatient Prescription Drug Copayment up to the Outpatient Prescription Drug Calendar Year Maximum Benefit. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit. 	<p>[Non-Participating Pharmacy Benefit:]</p> <ul style="list-style-type: none"> • Contracted Rate after satisfaction of the Outpatient Prescription Drug Copayment up to the Outpatient Prescription Drug Calendar Year Maximum Benefit. • No Deductible or Coinsurance applies. • Benefit payments do not apply towards the Outpatient Calendar Year Maximum Benefit.]] 		

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: Time Insurance Company
499.BNS.001.AR, 4797, 29800, AR-TMJ Notice

Form Number(s):

I hereby certify that to the best of my knowledge and belief, the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Julia Hix-Royer

Name

Vice President

Title

June 25, 2008

Date

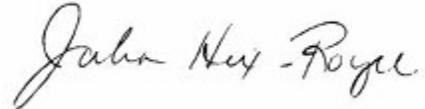
CERTIFICATE OF COMPLIANCE

Insurer: Time Insurance Company

Form Numbers:

499.BNS.001.AR, 4797, 29800, AR-TMJ Notice

I hereby certify that the filing above meets all applicable Arkansas requirements including Regulation 49 (Life and Health Guaranty Fund Notice) and Ark. Code Ann. 23-79-138 and Bulletin 11-88 (Consumer Information Notice).



Signature of Company Officer

Julia Hix-Royer

Name

Vice President

Title

June 25, 2008

Date

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Time Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
499.BNS.001.AR	58
4797	40
29800	40
AR-TMJ Notice	100

Signed: _____

Name: Julia Hix-Royer

Title: Vice President

Date: June 25, 2008



ASSURANT
Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

www.assurant.com

January 8, 2008

Re: John Alden Life Insurance Company - NAIC 65080-285; FEIN 41-999752
Time Insurance Company-NAIC 69477; FEIN 39-0658730

Dear Sir or Madam,

This letter acts as authorization for McHugh Consulting Resources and its representative analysts to file any or all policy forms as referenced on the attached form listing on behalf of the above referenced companies and to serve as the primary contact on behalf of the company regarding such filings while under review. Please contact McHugh Consulting Resources with questions or comments regarding the enclosed filing.

Best Regards,

A handwritten signature in black ink, appearing to read "Daniel Ziebell", with a large, stylized flourish extending to the right.

Daniel Ziebell, MHP
Director, Product Compliance
daniel.ziebell@assurant.com
T 414.299.6045
F 414.299.6168

Assurant Health markets products underwritten by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.

Limited Benefit Medical Insurance

Forms Listing

<u>Form Number</u>	<u>Form Description</u>
499.BNS.001.AR	Benefit Summary – Limited Benefit Medical Insurance
29800	Enrollment Application
4797	Life Insurance Benefits Rider
AR-TMJ Notice	Supplemental Notice to Master Group Policy Application

Also enclosed, please find an additional term life rider providing supplemental benefits payable upon death of the insured. This rider is submitted for review on a general use basis, and may be used with any individually underwritten forms offered to an out of state association or trust, including those herewith submitted.

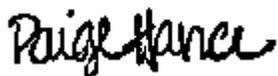
Please be advised that we are submitting application form number, Form 29800 for your review and approval. This application is new and does not replace any form previously approved by your Department.

Assurant Health is comprised of Time Insurance Company and John Alden Life Insurance Company. Identical forms have been submitted for each Company. The only differences are to the form numbers and Company names. Since Time and John Alden are sister companies and because the forms are identical, we respectfully request that the same analyst review both filings.

This form is subject only to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. The actual wording of each provision will remain the same. Otherwise variable data is bracketed. Amounts may vary or provisions may be modified to fit a specific Insured's request. Variable data will never exclude or limit provisions required by applicable law.

Attached please find any required certifications and/or transmittal forms and filing fees. Please do not hesitate to contact the undersigned at (215) 230-7960 if there are any questions I can answer regarding this filing.

Sincerely,

A handwritten signature in black ink that reads "Paige Hance". The signature is written in a cursive, slightly slanted style.

Paige Hance, Consultant

Statement of Variability

- All numbers (excluding form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.
- Bracketed paragraphs vary to the extent that such paragraphs may be included, omitted or transferred to another page to suit the needs of a particular policyholder or certificateholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.
- Bracketed definitions may vary to the extent that such definition may be included, omitted or transferred to another page to suit the needs of a particular policyholder or certificateholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.
- Benefit levels and other items which customarily vary according to the policyholder's or certificateholder's specific plan of insurance may vary according to the company's marketing design and benefit selections of the applicant.

We also reserve the right to amend the attached to fix any minor typographical errors we may have neglected to find prior to submitting for approval and amend the language to clarify the intent within the confines of the law.