

SERFF Tracking Number: MCHX-125734533 State: Arkansas
 Filing Company: John Alden Life Insurance Company State Tracking Number: 39622
 Company Tracking Number: 999.003.001.AR
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.001 Any Size Group
 Expense
 Product Name: 999.BNS.001.XX-JALIC-Association Limited Benefit M
 Project Name/Number: 999.BNS.001.XX-JALIC-Association Limited Benefit Medical Expense-Benefit Summary-Non GI/999.BNS.001.XX-JALIC-
 Association Limited Benefit Medical Expense-Benefit Summary-Non GI

Filing at a Glance

Company: John Alden Life Insurance Company

Product Name: 999.BNS.001.XX-JALIC- Association Limited Benefit M SERFF Tr Num: MCHX-125734533 State: ArkansasLH

TOI: H15G Group Health -

SERFF Status: Closed

State Tr Num: 39622

Hospital/Surgical/Medical Expense

Sub-TOI: H15G.001 Any Size Group

Co Tr Num: 999.003.001.AR

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: SPI McHughConsulting

Disposition Date: 07/15/2008

Date Submitted: 07/15/2008

Disposition Status: Approved-

Closed

Implementation Date Requested: 08/15/2008

Implementation Date:

State Filing Description:

General Information

Project Name: 999.BNS.001.XX-JALIC-Association Limited Benefit
 Medical Expense-Benefit Summary-Non GI

Status of Filing in Domicile: Not Filed

Project Number: 999.BNS.001.XX-JALIC-Association Limited Benefit
 Medical Expense-Benefit Summary-Non GI

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Association

Filing Status Changed: 07/15/2008

State Status Changed: 07/15/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

John Alden Life Insurance Company - NAIC #65080; FEIN #41-0999752

999.003.001.AR - Revised Definition Matrix Page

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6047-AR - Preventive Screening Services Benefit Rider

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

We are submitting the above captioned revised matrix page and benefit rider for your review. These forms are to be used with previously approved certificate form 999.001.XX, as approved by your office on 12/21/2007. To assist with your review we have redlined the differences between the previous version and this one.

The revised matrix page is being filed to give us the ability to cover preventive services as recommended by the United States Preventive Services Task Force in addition to the preventive services that are mandated. The rider will be used as an endorsement to existing plans to allow us to provide the new preventive services.

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. 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)

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

Filing Company Information

John Alden Life Insurance Company CoCode: 65080 State of Domicile: Wisconsin
501 West Michigan Ave. Group Code: 285 Company Type:
Milwaukee, WI 53201-0624 Group Name: State ID Number:
(414) 299-1088 ext. [Phone] FEIN Number: 41-0999752

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Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
John Alden Life Insurance Company	\$50.00	07/15/2008	21419724

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/15/2008	07/15/2008

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Disposition

Disposition Date: 07/15/2008

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	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	999.003.001.AR-Red-Lined Version	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	07.15.08 Submission Letter	Approved-Closed	Yes
Form	Revised Definitions Matrix Pages	Approved-Closed	Yes
Form	PREVENTIVE SCREENING SERVICES BENEFITS RIDER	Approved-Closed	Yes

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Form Schedule

Lead Form Number: 999.003.001.AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	999.003.001.AR	Certificate	Revised Definitions Matrix Pages	Initial		52	999_003_001_AR.PDF
Approved-Closed	6047-AR	Certificate	PREVENTIVE SCREENING SERVICES BENEFITS RIDER	Initial		47	6047-AR.PDF
		Amendmen t, Insert Page, Endorseme nt or Rider					

III. DEFINITIONS

When reading this certificate, terms with a defined meaning will have the first letter of each word capitalized for easy identification. The capitalized terms used in this plan are defined below. Just because a term is defined does not mean it is covered. Please read the certificate carefully.

Access Fee

An Access Fee is the dollar amount that a Covered Person must pay directly to a facility for each Emergency Room visit. [We will waive an Emergency Room Access Fee if the Covered Person is admitted for an Inpatient stay immediately following the Emergency Room visit.] The Access Fee is subtracted from Covered Charges before applying any Deductible[, or] Coinsurance [or other Out-of-Pocket Limit]. An Access Fee will not be reimbursed by Us nor does it count toward satisfying any Deductible[, or] Coinsurance [or other Out-of-Pocket Limit].

An Access Fee only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Access Fees are along with the Covered Charges to which they apply.

Accident or Accidental

Any event that meets all of the following requirements:

1. It causes harm to the physical structure of the body.
2. It results from an external agent or trauma.
3. It is the direct cause of a loss, independent of disease, bodily infirmity or any other cause.
4. It is definite as to time and place.
5. It happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

If an Accident occurs as a result of a Sickness, Covered Charges Incurred for treatment of any Injuries are considered under the applicable Accident benefit and Covered Charges Incurred for treatment of the Sickness are considered under the applicable Sickness benefit.

Ancillary Charge

The difference in cost between a Brand Name Drug and what We will pay for a Generic Drug when a Generic Drug substitute exists but the Brand Name Drug is dispensed. A Covered Person must pay any applicable Ancillary Charge directly to the Participating Pharmacy.

The Ancillary Charge does not count toward satisfying any Copayment, Deductible or Coinsurance under the Outpatient Prescription Drug Benefits section or any other section in this plan.

Behavioral Health

Any condition classified as a mental disorder in the edition of the International Classification of Diseases (ICD) that is published at the time a claim is received by Us. For the purpose of this plan, Behavioral Health does not include Substance Abuse.

[Benefit Waiting Period

The period of consecutive days that must pass after the Effective Date of coverage before a Covered Person is eligible to be covered for a Sickness, an Injury or preventive medicine services under the terms of this plan. Each Covered Person is responsible for payment of all services that are received during the Benefit Waiting Period.

A Benefit Waiting Period only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Benefit Waiting Periods are along with the Covered Charges to which they apply.]

Brand Name Drug

A Prescription Drug for which a pharmaceutical company has received a patent or trade name.

Calendar Year

The period beginning on January 1 of any year and ending on December 31 of the same year.

Cardiac Rehabilitation Program

An Outpatient program that is supervised by a Health Care Practitioner and directed at improving the physiological well-being of a Covered Person with heart disease.

Certificate Holder

The person listed on the Benefit Summary as the Certificate Holder.

Children's Preventive Health Care Services

Physician-delivered or physician-supervised services for eligible Dependents from birth through age eighteen (18), with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards. Periodic preventive care visits includes routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

Coinsurance

Coinsurance is the dollar amount or percentage of Covered Charges that are paid by Us after any Access Fee, Copayment and Deductible are satisfied. Coinsurance applies separately to each Covered Person. You are responsible for paying any Coinsurance balance that is not paid by Us.

[This plan has varying types of Coinsurance that depend on whether the Covered Person's Health Care Practitioner belongs to a particular network or not.] Coinsurance only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Coinsurance percentage or amount is along with the Covered Charges to which they apply.

[One or more of the following Coinsurance amounts may apply to Covered Charges:

1. **[Participating Provider Coinsurance:** The dollar amount or percentage of Covered Charges received from providers in the Participating Provider Network that are paid by Us.]
2. **[Non-Participating Provider Coinsurance:** The dollar amount or percentage of Covered Charges received from Non-Participating Providers that are paid by Us.]]

Complications of Pregnancy

Complications of Pregnancy include the following:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, HELLP syndrome, uterine rupture, amniotic fluid embolism, chorioamnionitis, fatty liver in pregnancy, septic abortion, placenta accrete, gestational hypertension, puerperal sepsis, peripartum cardiomyopathy, cholestasis in pregnancy, thrombocytopenia in pregnancy, placenta previa, placenta abruption, acute cholecystitis and pancreatitis in pregnancy, postpartum hemorrhage, septic pelvic thrombophlebitis, retained placenta, venous air embolus associated with pregnancy, miscarriage, an emergency c-section required because of: a) fetal or maternal distress during labor, or b) severe pre-eclampsia, or c) arrest of descent or dilatation, or d) obstruction of the birth canal by fibroids or ovarian tumors, or e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
2. Non-elective cesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Compounded Medication

A drug product made up of two or more active parts or ingredients which must be specially prepared by a licensed pharmacist pursuant to a Prescription Order. If covered, Compounded Medications will be considered to be Non-Preferred Brand Name Drugs.

Contracted Rate

The amount a [Participating Provider or a] Participating Pharmacy that has a contract with Us or Our Network Manager, as identified for this plan, has agreed to accept as total payment for the [treatment, services, or] supplies or Prescription Drugs provided.

Copayment

A Copayment is the dollar amount that a Covered Person must pay to a provider each time certain visits, services or Prescription Drugs are received. This amount does not count toward satisfying any Access Fee, Deductible[, or] Coinsurance [or Out-of-Pocket Limit]. Covered Charges that require a Copayment are not subject to any Deductible or Coinsurance.

A Copayment only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Copayments are along with the Covered Charges to which they apply.

Cosmetic Services

A surgery, procedure, injection, medication or treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional or psychological distress.

Covered Charge

An expense that We determine meets all of the following requirements:

1. It is Incurred for treatment, services, drugs, medicines or supplies provided by a Health Care Practitioner, facility, Pharmacy or supplier.
2. It is Incurred by a Covered Person while coverage is in force under this plan as the result of:
 - a. A Sickness that first manifests itself on or after the Covered Person's Effective Date; or
 - b. An Injury that is sustained on or after the Covered Person's Effective Date; or
 - c. Preventive medicine services as outlined in the Office Visit Benefits provision in the Medical Benefits section.
3. It is Incurred for treatment, services, drugs, medicines or supplies listed in the Medical Benefits section or Outpatient Prescription Drug Benefits section or Preventive, Restorative and Other Medical Services[, unless the charges are Incurred during a Benefit Waiting Period].
4. It is Incurred for treatment, services, drugs, medicines or supplies which are Medically Necessary.

Covered Dependent

A person who meets the definition of a Dependent and is eligible to receive benefits under this plan.

Covered Person

A person who is eligible to receive benefits under this plan.

Custodial Care

Care, regardless of setting, that can be performed by persons without professional medical training and that is primarily for the purpose of meeting the personal needs of the patient. Custodial Care:

1. Does not contribute substantially to the improvement of a medical condition according to accepted medical standards; or
2. Is provided primarily to assist in the activities of daily living including, but not limited to, help in walking or getting in or out of bed; assistance with bathing, dressing, feeding, homemaking, or preparation of special diets; or supervision of medication which can usually be self-administered and does not entail or require the continuing services of licensed medical personnel; or
3. Is supportive in nature or primarily for the purpose of providing companionship or ensuring safety.

Deductible

The dollar amount of Covered Charges that must be paid by a Covered Person before benefits are payable by Us.

[This plan has varying types of Deductibles. This may depend on whether the Covered Person's Health Care Practitioner belongs to a particular network or not.] A [particular] Deductible only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Deductibles are along with the Covered Charges and the time period to which they apply.

The following Deductibles may apply to Covered Charges:

1. **Common Accident Deductible:** If more than one Covered Person is injured in the same Accident, only one Deductible must be satisfied for the Covered Charges that all Covered Persons Incur as a result of that Accident. The Covered Charges must be Incurred within the first [90 days] after the date the Accident occurs. Covered Charges Incurred more than [90 days] after the date the Accident occurs will be paid subject to all the terms, limits and conditions in this plan without regard to the Common Accident Deductible provision.
2. **[Family Deductible:** The dollar amount that must be satisfied by all Covered Persons on a Family Plan before benefits are payable by Us. When the Family Deductible amount is reached, We will consider the Deductible requirements for all Covered Persons in Your family to be satisfied for the remainder of the time period shown in the Benefit Summary.]
- [3.] **[Individual] [Outpatient] Deductible:** The dollar amount of Covered Charges each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the [Individual] [Outpatient] Deductible have been Incurred and processed by Us, the [Individual] [Outpatient] Deductible for that Covered Person will be satisfied for the remainder of the time period shown in the Benefit Summary.
- [4.] **[Participating Provider Deductible:** The dollar amount of Covered Charges received from providers in the Participating Provider Network that each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the Participating Provider Deductible have been Incurred and processed by Us, the Participating Provider Deductible for that Covered Person will be satisfied for the remainder of the time period shown in the Benefit Summary.]
- [5.] **[Non-Participating Provider Deductible:** The dollar amount of Covered Charges received from Non-Participating Providers that each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the Non-Participating Provider Deductible have been Incurred and processed by Us, the Non-Participating Provider Deductible for that Covered Person will be satisfied for the remainder of the time period shown in the Benefit Summary.]

Dental Injury

Injury resulting from an Accidental blow to the mouth causing trauma to teeth, the mouth, gums or supporting structures of the teeth.

Dependent

A Dependent is:

1. The Certificate Holder's lawful spouse[, including the Certificate Holder's Domestic Partner if recognized under applicable law]; or
2. The Certificate Holder's naturally born child, legally adopted child, a child that is placed for adoption with the Certificate Holder, a stepchild or a child for whom the Certificate Holder is the legal guardian:
 - a. Who is unmarried; and
 - b. Who is age [18] or younger; and

If the child's legal address is different than the Certificate Holder, the child will be considered a Dependent if You submit proof that You are required by a qualified medical child support order to provide medical insurance.

If Your unmarried child is age [19] or older, the child will be considered a Dependent if You give Us proof that:

- a. The child is a full-time student at an accredited educational institution, college or university. A student will be considered full-time if the student meets the standards for full-time status at the school the student is attending. A student will be considered full-time during regular

vacation periods that interrupt, but do not terminate, the continuous full-time course of study;
or

- b. The child is not capable of self-sustaining employment or engaging in the normal and customary activities of a person of the same age because of mental incapacity or physical handicap. The child must also be chiefly dependent on the Certificate Holder for financial support and maintenance. You must give Us notice that the child meets these requirements at the same time that You first enroll for coverage under this plan or after the child reaches the normal age for termination.

A child will no longer be a Dependent on the earliest of the date that he or she:

- a. Is no longer a full-time student; or
- b. Graduates; or
- c. Attains age [24]; or
- d. Marries; or
- e. Is over age [18] and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped.

[If only Dependent children are covered under this plan, the youngest child will be considered the Certificate Holder. All siblings of the Certificate Holder will be considered Covered Dependents if they meet the requirements above.]

Diagnostic Imaging

Procedures and tests including, but not limited to, x-rays, magnetic resonance imaging (MRI) and computerized axial tomography (CT), that are performed to diagnose a condition or determine the nature of a condition.

[Domestic Partner

A person of the same or opposite gender who resides with the Certificate Holder in a long-term relationship of indefinite duration. The partners have an exclusive mutual commitment to be jointly responsible for each others common welfare and share financial obligations. The Domestic Partner must meet all of the following requirements:

1. Be at least [18] years of age.
2. Be competent to enter into a contract.
3. Not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which he or she legally resides.

A Domestic Partner must provide Us with an affidavit attesting that the domestic partnership has existed for a minimum period of [24 months] at the time of enrollment under this plan. Proof that the Domestic Partner relationship continues to exist will be requested by Us periodically.]

Drug List

A list of Prescription Drugs that We designate as eligible for reimbursement. A Drug List is subject to change at any time without notice.

Durable Medical Equipment

Equipment, such as a Hospital bed, wheelchair or crutches, that is customarily used to serve a medical purpose and is designed for and able to withstand repeated use and is intended for use by successive patients.

Effective Date

The date coverage under this plan begins for a Covered Person. The Covered Person's coverage begins at 12:01 a.m. local time at the Certificate Holder's state of residence.

Emergency Room

A place affiliated with and physically connected to a Hospital and used primarily for short term Emergency Treatment.

Emergency Treatment

Treatment, services or supplies for a Sickness or an Injury that develops suddenly and unexpectedly and, if not treated immediately, would:

1. Endanger the Covered Person's life; or
2. Cause serious bodily impairment to the Covered Person.

Experimental or Investigational Services

Treatment, services or supplies which, at the time the charges are Incurred, We determine are:

1. Not proven to be of benefit for diagnosis or treatment of a Sickness or an Injury; or
2. Not generally used or recognized by the medical community as safe, effective and appropriate for diagnosis or treatment of a Sickness or an Injury; or
3. In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or
4. Obsolete or ineffective for the treatment of a Sickness or an Injury; or
5. Medications used for non-FDA approved indications and/or dosage regimens.

For any device, drug, or biological product, final approval must have been received to market it by the Food and Drug Administration (FDA) for the particular Sickness or Injury. However, final approval by the FDA is not sufficient to prove that the treatment, services or supplies are of proven benefit or appropriate or effective for diagnosis or treatment of a Sickness or an Injury. Any approval granted as an interim step in the FDA regulatory process, such as an investigational device exemption or an investigational new drug exemption, is not sufficient.

Only We can make the determination as to whether charges are for Experimental or Investigational Services based on the following criteria:

1. Once final FDA approval has been granted, the usage of a device for the particular Sickness or Injury for which the device was approved will be recognized as appropriate if:
 - a. It is supported by conclusive evidence that exists in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles; and
 - b. The FDA has not determined the medical device to be contraindicated for the particular Sickness or Injury for which the device has been prescribed.
2. Once final FDA approval has been granted, the usage of a drug or biological product will be recognized as appropriate for a particular Sickness or Injury if the FDA has not determined the drug or biological product to be contraindicated for the particular Sickness or Injury for which the drug or biological product has been prescribed and the prescribed usage is recognized as appropriate medical treatment by:
 - a. The American Medical Association Drug Evaluations; or
 - b. The American Hospital Formulary Service Drug Information; or
 - c. The United States Pharmacopeia Drug Information; or
 - d. Conclusive evidence in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles.
3. For any other treatment, services or supplies, conclusive evidence from generally accepted peer-reviewed literature must exist that:
 - a. The treatment, services or supplies have a definite positive effect on health outcomes. Such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale; and
 - b. Over time, the treatment, services or supplies lead to improvement in health outcomes which show that the beneficial effects outweigh any harmful effects; and
 - c. The treatment, services or supplies are at least as effective in improving health outcomes as established technology, or are useable in appropriate clinical contexts in which established technology is not employable.

Family Plan

A plan of insurance covering the Certificate Holder and one or more of the Certificate Holder's Dependents.

Free-Standing Facility

A facility that provides interventional services, on an Outpatient basis, which require hands-on care by a physician and includes the administration of general or regional anesthesia or conscious sedation to patients. This type of facility may also be referred to as an ambulatory surgical center, an interventional diagnostic testing facility, a facility that exclusively performs endoscopic procedures or a dialysis unit. A designated area within a Health Care Practitioner's office or clinic that is used exclusively to provide interventional services and administer anesthesia or conscious sedation is also considered to be a Free-Standing Facility. Room and board and overnight services are not covered. These facilities must meet all of the following requirements:

1. Be licensed by the state in accordance with the laws for the specific services being provided in that facility.
2. Not primarily provide care for Behavioral Health or Substance Abuse or be an Urgent Care Facility.

Generic Drug

A Prescription Drug that:

1. Has the same active ingredients as an equivalent Brand Name Drug or that can be used to treat the same condition as a Brand Name Drug; and
2. Does not carry any drug manufacturer's brand name on the label; and
3. Is not protected by a patent.

It must be listed as a Generic Drug by Our national drug data bank on the date it is purchased and it must be approved by Us. Compounded Medications are not Generic Drugs. Medications that are commercially manufactured together and/or packaged together are not considered to be Generic Drugs, unless the entire combination product is specifically listed as a Generic Drug product by Our national drug data bank on the date it is purchased and it must be approved by Us.

Health Care Practitioner

A person licensed by the state or other geographic area in which the Covered Charges are rendered to treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

Home Health Care

Treatment, services or supplies provided as part of a program for care and treatment in a Covered Person's home.

Home Office

Our office in [Milwaukee, Wisconsin] or other administrative offices as indicated by Us.

Hospice

An organization that provides medical services in an Inpatient, Outpatient or home setting to support and care for persons who are terminally ill.

Hospital

A facility that provides acute care of a Sickness or an Injury on an Inpatient basis. This type of facility must meet all of

the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide acute care.
2. Be staffed by an on duty physician 24 hours per day.
3. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
4. Maintain daily medical records that document all services provided for each patient.
5. Provide immediate access to appropriate in-house laboratory and imaging services.
6. Not primarily provide care for Behavioral Health, Substance Abuse or Inpatient rehabilitation services although these services may be provided in a distinct section of the same physical facility.

Immediate Family Member

An Immediate Family Member is:

1. You or Your spouse [or Domestic Partner]; or
2. The children, brothers, sisters and parents of either You or Your spouse [or Domestic Partner]; or
3. The spouses of the children, brothers and sisters of You and Your spouse [or Domestic Partner]; or
4. Anyone with whom a Covered Person has a relationship based on a legal guardianship.

Incur or Incurred

The date services are provided or supplies are received.

Injury

Accidental bodily damage, independent of all other causes, occurring unexpectedly and unintentionally.

Inpatient

Admitted to a Hospital for a stay of at least [24 hours] for which a charge is Incurred for room and board or observation.

Inpatient Maximum Benefit

The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred for each Sickness or Injury and for any complications related to that Sickness or Injury over the lifetime of each Covered Person. When the Inpatient Maximum Benefit has been paid by Us, no further benefits are payable for that Sickness or Injury or for any complications related to that Sickness or Injury for the remainder of the time period shown in the Benefit Summary. The Benefit Summary will identify how Covered Charges for Inpatient stays are paid, the maximum benefit available and the time period in which Covered Charges must be Incurred. The Inpatient Maximum Benefit does not apply to Covered Charges for services shown under the Surgical Services provision in the Medical Benefits section that are Incurred while Inpatient.

Low Protein Modified Food Product

A food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease.

[Maximum Lifetime Benefit

The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred by each Covered Person under this plan and any other medical plan issued by Us or an affiliated company over the lifetime of that Covered Person. This maximum will apply even if coverage with Us or an affiliate is interrupted or if a Covered Person has been insured under any plan with Us or an affiliate as either a certificate holder, policyholder or as a covered dependent. When the Maximum Lifetime Benefit has been paid by Us, no further benefits are payable for that Covered Person.]

Medical Food

A food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.

Medical Supply Provider

Agencies, facilities or wholesale or retail outlets that make disposable medical products available for use.

Medically Necessary or Medical Necessity

Treatment, services or supplies that are rendered to diagnose or treat a Sickness or an Injury. Medical Necessity does not include care that is prescribed or provided on the recommendation of a Covered Person's Immediate Family Member. We must determine that such care:

1. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis and treatment of the Sickness or Injury; and
2. Is commonly accepted as proper care or treatment of the condition in accordance with United States medical practice and federal government guidelines; and
3. Can reasonably be expected to result in or contribute substantially to the improvement of a condition resulting from a Sickness or an Injury; and
4. Is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of medical care provided.

The fact that a Health Care Practitioner may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make the treatment, service or supply Medically Necessary for the purpose of determining eligibility for coverage under this plan.

Medicare

Any portion of Title XVIII of the United States Social Security Act of 1965, as amended.

Network Manager

An organization or entity, designated by Us, which may administer the [Participating Provider Network and/or the] Participating Pharmacy Network. The Network Manager's name is shown on the insurance coverage identification (ID) card.

Non-Participating Pharmacy

A Pharmacy that is not under contract with Us or Our Network Manager to provide Prescription Drugs to the Covered Person through Our Participating Pharmacy Network.

[Non-Participating Provider

Any Health Care Practitioner, facility or supplier, not identified for this plan by Us or the Network Manager, as participating.]

Non-Preferred Brand Name Drug

A Brand Name Drug that is not listed as preferred in a Drug List.

Occupational Therapy

The treatment of Sickness or Injury, by a Health Care Practitioner who is an occupational therapist, using purposeful activities or assistive devices that focus on all of the following:

1. Developing daily living skills.
2. Strengthening and enhancing function.
3. Coordination of fine motor skills.
4. Muscle and sensory stimulation.

Office Visit

An in-person, face-to-face meeting between a Covered Person and a Health Care Practitioner in the Health Care Practitioner's office. During this meeting, the Health Care Practitioner evaluates and manages the Covered Person's Sickness or Injury or provides preventive medicine services. For the purpose of this plan, an Office Visit does not include services received in a Hospital's Outpatient department, an Emergency Room, a Free-Standing Facility or an Urgent Care Facility.

Other Insurance

Any plan that provides benefits for services that are also covered by this certificate. If coverage is provided on a service basis instead of cash payments, We will determine a reasonable charge for the service and that amount will be considered the amount paid by the Other Insurance plan.

[Out-of-Pocket Limit

The sum of the Covered Charges for which We do not pay benefits because of the Deductible or Coinsurance. When Covered Charges equal to the Out-of-Pocket Limit have been Incurred and processed by Us, the Out-of-Pocket Limit will be satisfied for the remainder of the time period shown in the Benefit Summary. The Out-of-Pocket Limit applies separately to each Covered Person, except as otherwise provided by this plan.

The following do not count toward satisfying any Out-of-Pocket Limit:

1. Access Fees and Copayments.
- [2.] [Amounts not paid by Us due to the difference between the Non-Participating Provider benefit and the benefit that would have been paid had a Participating Provider been used.]
- [3.] Charges Incurred after the maximum amount has been paid for a benefit under this plan.
- [4.] Ancillary Charges and Prescription Drug Copayments.
- [5.] Amounts not paid by Us due to the difference between the Non-Participating Pharmacy benefit and the benefit that would have been paid had a Participating Pharmacy been used.

An Out-of-Pocket Limit only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Out-of-Pocket Limits are along with the Covered Charges and the time period to which they apply.

- [1.] **[Family Out-of-Pocket Limit:** [The total dollar amount of Covered Charges that must be paid by You and Your Covered Dependents before We will consider the Out-of-Pocket Limit for all Covered Persons under the same Family Plan to be satisfied.]
- [2.] **[Participating Provider Out-of-Pocket Limit:** The dollar amount of Covered Charges for services received from providers in the Participating Provider Network that must be paid by each Covered Person before the Participating Provider Out-of-Pocket Limit is satisfied for that Covered Person.]
- [3.] **[Non-Participating Provider Out-of-Pocket Limit:** The dollar amount of Covered Charges for services received from Non-Participating Providers that must be paid by each Covered Person before the Non-Participating Provider Out-of-Pocket Limit is satisfied for that Covered Person.]]

Outpatient

Treatment, services or supplies received at a licensed medical facility, Health Care Practitioner's office or dispensary on other than an Inpatient basis for a stay of less than [24 hours].

Outpatient Calendar Year Maximum Benefit

The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred during each Calendar Year by a Covered Person for all Outpatient treatment, services and supplies combined. When the Outpatient Calendar Year Maximum Benefit has been paid by Us, no further benefits are payable for Outpatient treatment, services or supplies that the Covered Person receives for the remainder of that Calendar Year. The Outpatient Calendar Year Maximum Benefit does not apply to: ambulance services; services received in an Emergency Room; Outpatient surgery for professional services of the surgeon and any Health Care Practitioner assisting the surgeon during the surgical procedure; services involving the administration of anesthesia; or drugs, medicines and supplies that are covered under the Outpatient Prescription Drug Benefits section.

Outpatient Prescription Drug Calendar Year Maximum Benefit

The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred during each Calendar Year by a Covered Person for drugs, medicines and supplies covered under the Outpatient Prescription Drug Benefits section. When the Outpatient Prescription Drug Calendar Year Maximum Benefit has been paid by Us, no further benefits are payable under the Outpatient Prescription Drug Benefits section for drugs, medicines and supplies that the Covered Person receives for the remainder of that Calendar Year.

Participating Pharmacy

A Pharmacy that is under contract with Us or Our Network Manager to provide Prescription Drugs to the Covered Person through Our Participating Pharmacy Network.

Participating Pharmacy Network

A Prescription Drug delivery system established by Us or the Network Manager in which Participating Pharmacies are under contract with Us or Our Network Manager. The list of Participating Pharmacies is subject to change at any time without notice.

[Participating Provider

Any Health Care Practitioner, facility or supplier, identified for this plan by Us or the Network Manager, as participating.]

[Participating Provider Network

The group of Participating Providers who have agreed to accept a Contracted Rate as payment in full for specific treatment, services or supplies. The list of Participating Providers is subject to change at any time without notice.]

Per Condition

Each Sickness or Injury and any complications related to that Sickness or Injury over the lifetime of each Covered Person.

When no charges have been Incurred for any one Sickness or Injury and any complications related to that Sickness or Injury during a period of [24 consecutive months], We will consider any subsequent treatment for that condition to be a new Sickness or Injury when determining the benefits payable under the certificate.

Personal Medical Equipment

Equipment, such as a prosthesis, that is customarily used to serve a medical purpose, is designed for and able to withstand repeated use and is not intended for use by successive patients.

Pharmacy

A licensed establishment where Prescription Drugs are dispensed by a licensed pharmacist in accordance with all applicable state and federal laws.

Physical Therapy

The treatment of a Sickness or an Injury, by a Health Care Practitioner who is a physical therapist, using therapeutic exercise and other services that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living and alleviating pain.

Policy

The group master contract issued by Us to the Policyholder providing benefits for Covered Persons.

Policyholder

The person, organization or entity to which the Policy is issued as shown in the Benefit Summary.

Pre-Existing Condition

A Sickness or an Injury and related complications:

1. For which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or Prescription Drugs were prescribed during the [24-month] period immediately prior to the Covered Person's Effective Date, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or
2. That produced signs or symptoms during the [24-month] period immediately prior to the Covered Person's Effective Date.

The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:

- a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
- b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.

Preferred Brand Name Drug

A Brand Name Drug that is listed as preferred in a Drug List. This list is subject to change at any time without notice.

Prescription Card Service Administrator (PCSA)

An organization or entity that administers the processing of claims under the Outpatient Prescription Drug Benefits section. This organization or entity may be changed at any time without notice.

Prescription Drug

Any medication that:

1. Has been fully approved by the Food and Drug Administration (FDA) for marketing in the United States; and
2. Can be legally dispensed only with the written Prescription Order of a Health Care Practitioner in accordance with applicable state and federal laws; and
3. Contains the legend wording: "Caution: Federal Law Prohibits Dispensing Without Prescription" or "Rx Only" on the manufacturer's label, or similar wording as designated by the FDA.

Prescription Drug Copayment

A Prescription Drug Copayment is the dollar amount of Covered Charges that a Covered Person pays each time a Prescription Order is received that is covered under the Outpatient Prescription Drug Benefits section. The Covered Person must pay any applicable Prescription Drug Copayment directly to the Participating Pharmacy.

A Prescription Drug Copayment only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Prescription Drug Copayments are. A Prescription Drug Copayment does not count toward satisfying any Access Fee, Ancillary Charge, Deductible[, or] Coinsurance [or Out-of-Pocket Limit] under the Outpatient Prescription Drug Benefits section or any other section in this plan.

Prescription Order

The request by a Health Care Practitioner for

1. Each separate Prescription Drug and each authorized refill; or
2. Insulin or insulin derivatives only by prescription; or
3. Any one of the following supplies used in the self-management of diabetes and purchased during the same transaction only by prescription:
 - a. Disposable insulin syringes and needles; or
 - b. Disposable blood/urine/glucose/acetone testing agents or lancets.

Preventive, Restorative and Other Medical Services

For the purpose of this plan, the following services will be considered the same as services for a Sickness:

1. Necessary care and treatment of loss or impairment of speech or hearing including communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology.
2. Anesthesia and Hospital or Free-Standing Facility services performed in connection with Medically Necessary dental procedures if the Health Care Practitioner treating the patient certifies that:
 - a. a child under seven (7) years of age has been determined by two (2) dentists licensed under the Arkansas Dental Practice Act, to require, without delay, Medically Necessary dental treatment for a significantly complex dental condition;
 - b. a person has been diagnosed with a serious mental or physical condition; or

- c. a person has a significant behavioral problem as determined by the Covered Person's Health Care Practitioner licensed under the Arkansas Medical Practices Act. The dental services themselves are not covered. Dental anesthesia benefits are considered under [and accrue to] the Inpatient Hospital Services, Outpatient Medical Services, or Office Visit Benefits provisions relative to the type of service actually rendered.
- 3. Testing for hypothyroidism, phenylketonuria, galactosemia and sickle-cell anemia for a Covered Dependent newborn child.
- 4. Coverage for amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas prescribed under the direction of a physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism when the expense exceeds [\$2,400] per Covered Person per calendar year.
- 5. Colorectal cancer examination and laboratory tests for a Covered Person:
 - a. age fifty (50) years of age or older;
 - b. less than fifty (50) year of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and
 - c. experiencing the following symptoms of colorectal cancer, as determined by a Health Care Practitioner licensed under the Arkansas Medical Practices Act, bleeding from the rectum or blood in the stool; or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.

Colorectal screening shall involve an examination of the entire colon, including the following examinations and/or laboratory tests:

- a. annual fecal occult blood test utilizing take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
- b. double-contrast barium enema every five (5) years; or
- c. colonoscopy every ten (10) years; and
- d. any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health, determined in consultation with appropriate health care organizations.

Screenings for the management or subsequent need for follow-up colonoscopies shall be limited to:

- a. if the initial colonoscopy is normal, follow-up is recommended in ten (10) years;
 - b. for individuals with one (1) or more neoplastic polyps, adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, follow-up is recommended in three (3) years;
 - c. if single tubular adenoma of less than one centimeter (1 cm) is found, follow-up is recommended in five (5) years; and
 - d. for patients with large sessile adenomas greater than three centimeters (> 3 cm), especially if removed in piecemeal fashion, follow-up is recommended in six (6) months or until complete polyp removal is verified by colonoscopy.
6. [Preventive [medicine] services as recommended by the Unites States Preventive Services Task Force.]

[Service Area

The geographic area, as defined by Us, served by Participating Providers. Contact the Network Manager or Us to determine the precise geographic area serviced by Participating Providers. The Service Area is subject to change at any time without notice.]

Sickness

A disease or an illness of a Covered Person. Sickness does not include a family history of a disease or illness or a genetic predisposition for the development of a future disease or illness. For the purpose of this plan, bug bites, stings or

infestations by microorganisms and poisoning by plants, such as poison ivy, are considered to be a Sickness, not an Injury.

Single Plan

A plan of insurance covering only the Certificate Holder.

Skilled Nursing Facility

A facility that provides continuous skilled nursing services on an Inpatient basis for persons recovering from a Sickness or an Injury. The facility may also provide extended care or Custodial Care.

Speech Therapy

The treatment of a Sickness or an Injury, by a Health Care Practitioner who is a speech therapist, using rehabilitative techniques to improve function for voice, speech, language and swallowing disorders.

Substance Abuse

Abuse of, addiction to, or dependence on drugs, chemicals or alcohol as defined in the edition of the International Classification of Diseases (ICD) that is published at the time a claim is received by Us. For the purpose of this plan, Substance Abuse does not include Behavioral Health.

Surgical Services Maximum Benefit

The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges under the Surgical Services provision in the Medical Benefits section that are Incurred by each Covered Person for each Sickness or Injury and for any complications related to that Sickness or Injury. When the Surgical Services Maximum Benefit has been paid by Us, no further benefits are payable for any other surgical procedures performed with regard to that particular Sickness or Injury and for any complications related to that Sickness or Injury over the lifetime of that Covered Person, including any services involving the administration of anesthesia or provided by an assistant surgeon.

Temporomandibular Joint (TMJ) Dysfunction and Craniomandibular Joint (CMJ) Dysfunction

TMJ Dysfunction and CMJ Dysfunction is any joint disorder of the jaw causing any of the following:

1. Clicking and/or difficulties in opening and closing the mouth.
2. Pain or swelling.
3. Complications including arthritis, dislocation and bite problems of the jaw.

Urgent Care

Treatment, services or supplies provided for a Sickness or an Injury that:

1. Develops suddenly and unexpectedly outside of a Health Care Practitioner's normal business hours; and
2. Requires immediate treatment, but is not of sufficient severity to be considered Emergency Treatment.

Urgent Care Facility

A facility that is attached to a Hospital, but separate from the Emergency Room, or a separate facility that provides Urgent Care on an Outpatient basis. A Health Care Practitioner's office is not considered to be an Urgent Care Facility even if services are provided after normal business hours. Room and board and overnight services are not covered. This type of facility must meet all of the following requirements:

1. Be licensed by the state in accordance with the laws for the specific services being provided in that facility.
2. Be staffed by an on duty physician during operating hours.

3. Provide services to stabilize patients who need Emergency Treatment and arrange immediate transportation to an Emergency Room.
4. Provide immediate access to appropriate in-house laboratory and imaging services.

We, Us, Our, Our Company

John Alden Life Insurance Company or its administrator.

You, Your, Yours

The person listed on the Benefit Summary as the Certificate Holder.

PREVENTIVE SCREENING SERVICES BENEFITS RIDER

The policy or certificate to which this Rider is attached is amended as follows.

The Preventive, Restorative and Other Medical Services definition in the Definitions section is amended and restated as follows:

Preventive, Restorative and Other Medical Services

For the purpose of this plan, the following services will be considered the same as services for a Sickness:

1. Necessary care and treatment of loss or impairment of speech or hearing including communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology.
2. Anesthesia and Hospital or Free-Standing Facility services performed in connection with Medically Necessary dental procedures if the Health Care Practitioner treating the patient certifies that:
 - a. a child under seven (7) years of age has been determined by two (2) dentists licensed under the Arkansas Dental Practice Act, to require, without delay, Medically Necessary dental treatment for a significantly complex dental condition;
 - b. a person has been diagnosed with a serious mental or physical condition; or
 - c. a person has a significant behavioral problem as determined by the Covered Person's Health Care Practitioner licensed under the Arkansas Medical Practices Act.The dental services themselves are not covered. Dental anesthesia benefits are considered under [and accrue to] the Inpatient Hospital Services, Outpatient Medical Services, or Office Visit Benefits provisions relative to the type of service actually rendered.
3. Testing for hypothyroidism, phenylketonuria, galactosemia and sickle-cell anemia for a Covered Dependent newborn child.
4. Coverage for amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas prescribed under the direction of a physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism when the expense exceeds [\$2,400] per Covered Person per calendar year.
5. Colorectal cancer examination and laboratory tests for a Covered Person:
 - a. age fifty (50) years of age or older;
 - b. less than fifty (50) year of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and
 - c. experiencing the following symptoms of colorectal cancer, as determined by a Health Care Practitioner licensed under the Arkansas Medical Practices Act, bleeding from the rectum or blood in the stool; or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.

Colorectal screening shall involve an examination of the entire colon, including the following examinations and/or laboratory tests:

- a. annual fecal occult blood test utilizing take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
- b. double-contrast barium enema every five (5) years; or
- c. colonoscopy every ten (10) years; and
- d. any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health, determined in consultation with appropriate health care organizations.

Screenings for the management or subsequent need for follow-up colonoscopies shall be

limited to:

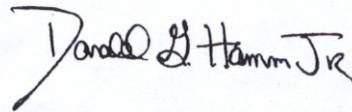
- a. if the initial colonoscopy is normal, follow-up is recommended in ten (10) years;
 - b. for individuals with one (1) or more neoplastic polyps, adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, follow-up is recommended in three (3) years;
 - c. if single tubular adenoma of less than one centimeter (1 cm) is found, follow-up is recommended in five (5) years; and
 - d. for patients with large sessile adenomas greater than three centimeters (> 3 cm), especially if removed in piecemeal fashion, follow-up is recommended in six (6) months or until complete polyp removal is verified by colonoscopy.
6. [Preventive [medicine] services as recommended by the Unites States Preventive Services Task Force.]

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

SERFF Tracking Number: MCHX-125734533 *State:* Arkansas
Filing Company: John Alden Life Insurance Company *State Tracking Number:* 39622
Company Tracking Number: 999.003.001.AR
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.001 Any Size Group
Expense
Product Name: 999.BNS.001.XX-JALIC-Association Limited Benefit M
Project Name/Number: 999.BNS.001.XX-JALIC-Association Limited Benefit Medical Expense-Benefit Summary-Non GI/999.BNS.001.XX-JALIC-
Association Limited Benefit Medical Expense-Benefit Summary-Non GI

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: MCHX-125734533 State: Arkansas
 Filing Company: John Alden Life Insurance Company State Tracking Number: 39622
 Company Tracking Number: 999.003.001.AR
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.001 Any Size Group
 Expense
 Product Name: 999.BNS.001.XX-JALIC-Association Limited Benefit M
 Project Name/Number: 999.BNS.001.XX-JALIC-Association Limited Benefit Medical Expense-Benefit Summary-Non GI/999.BNS.001.XX-JALIC-
 Association Limited Benefit Medical Expense-Benefit Summary-Non GI

Supporting Document Schedules

<p> Satisfied -Name: Certification/Notice Comments: Attachments: AR - READABILITY CERTIFICATION.PDF AR Cert of Compliance with Rule 19.PDF AR Certificate of Compliance #49.PDF </p>	<p> Review Status: Approved-Closed 07/15/2008 </p>
<p> Bypassed -Name: Application Bypass Reason: N/A Comments: </p>	<p> Review Status: Approved-Closed 07/15/2008 </p>
<p> Satisfied -Name: Authorization Letter Comments: Attachment: Authorization Letter.PDF </p>	<p> Review Status: Approved-Closed 07/15/2008 </p>
<p> Satisfied -Name: Forms Listing Comments: Attachment: Forms Listing.PDF </p>	<p> Review Status: Approved-Closed 07/15/2008 </p>
<p> Satisfied -Name: 999.003.001.AR-Red-Lined Version Comments: Attachment: 999_003_001_AR-Red-Lined Version.PDF </p>	<p> Review Status: Approved-Closed 07/15/2008 </p>

SERFF Tracking Number: MCHX-125734533 State: Arkansas
Filing Company: John Alden Life Insurance Company State Tracking Number: 39622
Company Tracking Number: 999.003.001.AR
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.001 Any Size Group
Expense
Product Name: 999.BNS.001.XX-JALIC-Association Limited Benefit M
Project Name/Number: 999.BNS.001.XX-JALIC-Association Limited Benefit Medical Expense-Benefit Summary-Non GI/999.BNS.001.XX-JALIC-
Association Limited Benefit Medical Expense-Benefit Summary-Non GI

Satisfied -Name: Statement of Variability **Review Status:** Approved-Closed 07/15/2008
Comments:
Attachment:
Statement of Variability.PDF

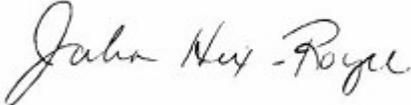
Satisfied -Name: 07.15.08 Submission Letter **Review Status:** Approved-Closed 07/15/2008
Comments:
Attachment:
07_15_08 Submission Letter.PDF

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: John Alden Life 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
999.003.001.AR	52.2
6047-AR	47

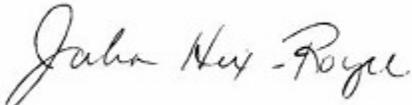
Signed: 
Name: Julia Hix-Royer
Title: Vice President
Date: July 15, 2008

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

Insurer: John Alden Life Insurance Company
999.003.001.AR, 6047-AR

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

July 15, 2008

Date

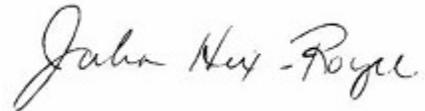
CERTIFICATE OF COMPLIANCE

Insurer: John Alden Life Insurance Company

Form Numbers:

999.003.001.AR, 6047-AR

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

07/15/08

Date



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 be 'Daniel Ziebell', written over a large, stylized oval graphic.

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.

John Alden Life Insurance Company
Form Listing

Form Number	Product
999.003.001.AR	Revised Definitions Matrix Page
6047-AR	Preventive Screening Services Benefit Rider

III. DEFINITIONS

When reading this certificate, terms with a defined meaning will have the first letter of each word capitalized for easy identification. The capitalized terms used in this plan are defined below. Just because a term is defined does not mean it is covered. Please read the certificate carefully.

Access Fee

An Access Fee is the dollar amount that a Covered Person must pay directly to a facility for each Emergency Room visit. [We will waive an Emergency Room Access Fee if the Covered Person is admitted for an Inpatient stay immediately following the Emergency Room visit.] The Access Fee is subtracted from Covered Charges before applying any Deductible[, or] Coinsurance [or other Out-of-Pocket Limit]. An Access Fee will not be reimbursed by Us nor does it count toward satisfying any Deductible[, or] Coinsurance [or other Out-of-Pocket Limit].

An Access Fee only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Access Fees are along with the Covered Charges to which they apply.

Accident or Accidental

Any event that meets all of the following requirements:

1. It causes harm to the physical structure of the body.
2. It results from an external agent or trauma.
3. It is the direct cause of a loss, independent of disease, bodily infirmity or any other cause.
4. It is definite as to time and place.
5. It happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

If an Accident occurs as a result of a Sickness, Covered Charges Incurred for treatment of any Injuries are considered under the applicable Accident benefit and Covered Charges Incurred for treatment of the Sickness are considered under the applicable Sickness benefit.

Ancillary Charge

The difference in cost between a Brand Name Drug and what We will pay for a Generic Drug when a Generic Drug substitute exists but the Brand Name Drug is dispensed. A Covered Person must pay any applicable Ancillary Charge directly to the Participating Pharmacy.

The Ancillary Charge does not count toward satisfying any Copayment, Deductible or Coinsurance under the Outpatient Prescription Drug Benefits section or any other section in this plan.

Behavioral Health

Any condition classified as a mental disorder in the edition of the International Classification of Diseases (ICD) that is published at the time a claim is received by Us. For the purpose of this plan, Behavioral Health does not include Substance Abuse.

[Benefit Waiting Period

The period of consecutive days that must pass after the Effective Date of coverage before a Covered Person is eligible to be covered for a Sickness, an Injury or preventive medicine services under the terms of this plan. Each Covered Person is responsible for payment of all services that are received during the Benefit Waiting Period.

A Benefit Waiting Period only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Benefit Waiting Periods are along with the Covered Charges to which they apply.]

Brand Name Drug

A Prescription Drug for which a pharmaceutical company has received a patent or trade name.

Calendar Year

The period beginning on January 1 of any year and ending on December 31 of the same year.

Cardiac Rehabilitation Program

An Outpatient program that is supervised by a Health Care Practitioner and directed at improving the physiological well-being of a Covered Person with heart disease.

Certificate Holder

The person listed on the Benefit Summary as the Certificate Holder.

Children's Preventive Health Care Services

Physician-delivered or physician-supervised services for eligible Dependents from birth through age eighteen (18), with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards. Periodic preventive care visits includes routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

Coinsurance

Coinsurance is the dollar amount or percentage of Covered Charges that are paid by Us after any Access Fee, Copayment and Deductible are satisfied. Coinsurance applies separately to each Covered Person. You are responsible for paying any Coinsurance balance that is not paid by Us.

[This plan has varying types of Coinsurance that depend on whether the Covered Person's Health Care Practitioner belongs to a particular network or not.] Coinsurance only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Coinsurance percentage or amount is along with the Covered Charges to which they apply.

[One or more of the following Coinsurance amounts may apply to Covered Charges:

1. **[Participating Provider Coinsurance:** The dollar amount or percentage of Covered Charges received from providers in the Participating Provider Network that are paid by Us.]
2. **[Non-Participating Provider Coinsurance:** The dollar amount or percentage of Covered Charges received from Non-Participating Providers that are paid by Us.]]

Complications of Pregnancy

Complications of Pregnancy include the following:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, HELLP syndrome, uterine rupture, amniotic fluid embolism, chorioamnionitis, fatty liver in pregnancy, septic abortion, placenta accrete, gestational hypertension, puerperal sepsis, peripartum cardiomyopathy, cholestasis in pregnancy, thrombocytopenia in pregnancy, placenta previa, placenta abruption, acute cholecystitis and pancreatitis in pregnancy, postpartum hemorrhage, septic pelvic thrombophlebitis, retained placenta, venous air embolus associated with pregnancy, miscarriage, an emergency c-section required because of: a) fetal or maternal distress during labor, or b) severe pre-eclampsia, or c) arrest of descent or dilatation, or d) obstruction of the birth canal by fibroids or ovarian tumors, or e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
2. Non-elective cesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Compounded Medication

A drug product made up of two or more active parts or ingredients which must be specially prepared by a licensed pharmacist pursuant to a Prescription Order. If covered, Compounded Medications will be considered to be Non-Preferred Brand Name Drugs.

Contracted Rate

The amount a [Participating Provider or a] Participating Pharmacy that has a contract with Us or Our Network Manager, as identified for this plan, has agreed to accept as total payment for the [treatment, services, or] supplies or Prescription Drugs provided.

Copayment

A Copayment is the dollar amount that a Covered Person must pay to a provider each time certain visits, services or Prescription Drugs are received. This amount does not count toward satisfying any Access Fee, Deductible[, or] Coinsurance [or Out-of-Pocket Limit]. Covered Charges that require a Copayment are not subject to any Deductible or Coinsurance.

A Copayment only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Copayments are along with the Covered Charges to which they apply.

Cosmetic Services

A surgery, procedure, injection, medication or treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional or psychological distress.

Covered Charge

An expense that We determine meets all of the following requirements:

1. It is Incurred for treatment, services, drugs, medicines or supplies provided by a Health Care Practitioner, facility, Pharmacy or supplier.
2. It is Incurred by a Covered Person while coverage is in force under this plan as the result of:
 - a. A Sickness that first manifests itself on or after the Covered Person's Effective Date; or
 - b. An Injury that is sustained on or after the Covered Person's Effective Date; or
 - c. Preventive medicine services as outlined in the Office Visit Benefits provision in the Medical Benefits section.
3. It is Incurred for treatment, services, drugs, medicines or supplies listed in the Medical Benefits section or Outpatient Prescription Drug Benefits section or Preventive, Restorative and Other Medical Services[, unless the charges are Incurred during a Benefit Waiting Period].
4. It is Incurred for treatment, services, drugs, medicines or supplies which are Medically Necessary.

Covered Dependent

A person who meets the definition of a Dependent and is eligible to receive benefits under this plan.

Covered Person

A person who is eligible to receive benefits under this plan.

Custodial Care

Care, regardless of setting, that can be performed by persons without professional medical training and that is primarily for the purpose of meeting the personal needs of the patient. Custodial Care:

1. Does not contribute substantially to the improvement of a medical condition according to accepted medical standards; or
2. Is provided primarily to assist in the activities of daily living including, but not limited to, help in walking or getting in or out of bed; assistance with bathing, dressing, feeding, homemaking, or preparation of special diets; or supervision of medication which can usually be self-administered and does not entail or require the continuing services of licensed medical personnel; or
3. Is supportive in nature or primarily for the purpose of providing companionship or ensuring safety.

Deductible

The dollar amount of Covered Charges that must be paid by a Covered Person before benefits are payable by Us.

[This plan has varying types of Deductibles. This may depend on whether the Covered Person's Health Care Practitioner belongs to a particular network or not.] A [particular] Deductible only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Deductibles are along with the Covered Charges and the time period to which they apply.

The following Deductibles may apply to Covered Charges:

1. **Common Accident Deductible:** If more than one Covered Person is injured in the same Accident, only one Deductible must be satisfied for the Covered Charges that all Covered Persons Incur as a result of that Accident. The Covered Charges must be Incurred within the first [90 days] after the date the Accident occurs. Covered Charges Incurred more than [90 days] after the date the Accident occurs will be paid subject to all the terms, limits and conditions in this plan without regard to the Common Accident Deductible provision.
2. **[Family Deductible:** The dollar amount that must be satisfied by all Covered Persons on a Family Plan before benefits are payable by Us. When the Family Deductible amount is reached, We will consider the Deductible requirements for all Covered Persons in Your family to be satisfied for the remainder of the time period shown in the Benefit Summary.]
- [3.] **[Individual] [Outpatient] Deductible:** The dollar amount of Covered Charges each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the [Individual] [Outpatient] Deductible have been Incurred and processed by Us, the [Individual] [Outpatient] Deductible for that Covered Person will be satisfied for the remainder of the time period shown in the Benefit Summary.
- [4.] **[Participating Provider Deductible:** The dollar amount of Covered Charges received from providers in the Participating Provider Network that each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the Participating Provider Deductible have been Incurred and processed by Us, the Participating Provider Deductible for that Covered Person will be satisfied for the remainder of the time period shown in the Benefit Summary.]
- [5.] **[Non-Participating Provider Deductible:** The dollar amount of Covered Charges received from Non-Participating Providers that each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the Non-Participating Provider Deductible have been Incurred and processed by Us, the Non-Participating Provider Deductible for that Covered Person will be satisfied for the remainder of the time period shown in the Benefit Summary.]

Dental Injury

Injury resulting from an Accidental blow to the mouth causing trauma to teeth, the mouth, gums or supporting structures of the teeth.

Dependent

A Dependent is:

1. The Certificate Holder's lawful spouse[, including the Certificate Holder's Domestic Partner if recognized under applicable law]; or
2. The Certificate Holder's naturally born child, legally adopted child, a child that is placed for adoption with the Certificate Holder, a stepchild or a child for whom the Certificate Holder is the legal guardian:
 - a. Who is unmarried; and
 - b. Who is age [18] or younger; and

If the child's legal address is different than the Certificate Holder, the child will be considered a Dependent if You submit proof that You are required by a qualified medical child support order to provide medical insurance.

If Your unmarried child is age [19] or older, the child will be considered a Dependent if You give Us proof that:

- a. The child is a full-time student at an accredited educational institution, college or university. A student will be considered full-time if the student meets the standards for full-time status at the school the student is attending. A student will be considered full-time during regular

vacation periods that interrupt, but do not terminate, the continuous full-time course of study;
or

- b. The child is not capable of self-sustaining employment or engaging in the normal and customary activities of a person of the same age because of mental incapacity or physical handicap. The child must also be chiefly dependent on the Certificate Holder for financial support and maintenance. You must give Us notice that the child meets these requirements at the same time that You first enroll for coverage under this plan or after the child reaches the normal age for termination.

A child will no longer be a Dependent on the earliest of the date that he or she:

- a. Is no longer a full-time student; or
- b. Graduates; or
- c. Attains age [24]; or
- d. Marries; or
- e. Is over age [18] and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped.

[If only Dependent children are covered under this plan, the youngest child will be considered the Certificate Holder. All siblings of the Certificate Holder will be considered Covered Dependents if they meet the requirements above.]

Diagnostic Imaging

Procedures and tests including, but not limited to, x-rays, magnetic resonance imaging (MRI) and computerized axial tomography (CT), that are performed to diagnose a condition or determine the nature of a condition.

[Domestic Partner

A person of the same or opposite gender who resides with the Certificate Holder in a long-term relationship of indefinite duration. The partners have an exclusive mutual commitment to be jointly responsible for each others common welfare and share financial obligations. The Domestic Partner must meet all of the following requirements:

1. Be at least [18] years of age.
2. Be competent to enter into a contract.
3. Not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which he or she legally resides.

A Domestic Partner must provide Us with an affidavit attesting that the domestic partnership has existed for a minimum period of [24 months] at the time of enrollment under this plan. Proof that the Domestic Partner relationship continues to exist will be requested by Us periodically.]

Drug List

A list of Prescription Drugs that We designate as eligible for reimbursement. A Drug List is subject to change at any time without notice.

Durable Medical Equipment

Equipment, such as a Hospital bed, wheelchair or crutches, that is customarily used to serve a medical purpose and is designed for and able to withstand repeated use and is intended for use by successive patients.

Effective Date

The date coverage under this plan begins for a Covered Person. The Covered Person's coverage begins at 12:01 a.m. local time at the Certificate Holder's state of residence.

Emergency Room

A place affiliated with and physically connected to a Hospital and used primarily for short term Emergency Treatment.

Emergency Treatment

Treatment, services or supplies for a Sickness or an Injury that develops suddenly and unexpectedly and, if not treated immediately, would:

1. Endanger the Covered Person's life; or
2. Cause serious bodily impairment to the Covered Person.

Experimental or Investigational Services

Treatment, services or supplies which, at the time the charges are Incurred, We determine are:

1. Not proven to be of benefit for diagnosis or treatment of a Sickness or an Injury; or
2. Not generally used or recognized by the medical community as safe, effective and appropriate for diagnosis or treatment of a Sickness or an Injury; or
3. In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or
4. Obsolete or ineffective for the treatment of a Sickness or an Injury; or
5. Medications used for non-FDA approved indications and/or dosage regimens.

For any device, drug, or biological product, final approval must have been received to market it by the Food and Drug Administration (FDA) for the particular Sickness or Injury. However, final approval by the FDA is not sufficient to prove that the treatment, services or supplies are of proven benefit or appropriate or effective for diagnosis or treatment of a Sickness or an Injury. Any approval granted as an interim step in the FDA regulatory process, such as an investigational device exemption or an investigational new drug exemption, is not sufficient.

Only We can make the determination as to whether charges are for Experimental or Investigational Services based on the following criteria:

1. Once final FDA approval has been granted, the usage of a device for the particular Sickness or Injury for which the device was approved will be recognized as appropriate if:
 - a. It is supported by conclusive evidence that exists in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles; and
 - b. The FDA has not determined the medical device to be contraindicated for the particular Sickness or Injury for which the device has been prescribed.
2. Once final FDA approval has been granted, the usage of a drug or biological product will be recognized as appropriate for a particular Sickness or Injury if the FDA has not determined the drug or biological product to be contraindicated for the particular Sickness or Injury for which the drug or biological product has been prescribed and the prescribed usage is recognized as appropriate medical treatment by:
 - a. The American Medical Association Drug Evaluations; or
 - b. The American Hospital Formulary Service Drug Information; or
 - c. The United States Pharmacopeia Drug Information; or
 - d. Conclusive evidence in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles.
3. For any other treatment, services or supplies, conclusive evidence from generally accepted peer-reviewed literature must exist that:
 - a. The treatment, services or supplies have a definite positive effect on health outcomes. Such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale; and
 - b. Over time, the treatment, services or supplies lead to improvement in health outcomes which show that the beneficial effects outweigh any harmful effects; and
 - c. The treatment, services or supplies are at least as effective in improving health outcomes as established technology, or are useable in appropriate clinical contexts in which established technology is not employable.

Family Plan

A plan of insurance covering the Certificate Holder and one or more of the Certificate Holder's Dependents.

Free-Standing Facility

A facility that provides interventional services, on an Outpatient basis, which require hands-on care by a physician and includes the administration of general or regional anesthesia or conscious sedation to patients. This type of facility may also be referred to as an ambulatory surgical center, an interventional diagnostic testing facility, a facility that exclusively performs endoscopic procedures or a dialysis unit. A designated area within a Health Care Practitioner's office or clinic that is used exclusively to provide interventional services and administer anesthesia or conscious sedation is also considered to be a Free-Standing Facility. Room and board and overnight services are not covered. These facilities must meet all of the following requirements:

1. Be licensed by the state in accordance with the laws for the specific services being provided in that facility.
2. Not primarily provide care for Behavioral Health or Substance Abuse or be an Urgent Care Facility.

Generic Drug

A Prescription Drug that:

1. Has the same active ingredients as an equivalent Brand Name Drug or that can be used to treat the same condition as a Brand Name Drug; and
2. Does not carry any drug manufacturer's brand name on the label; and
3. Is not protected by a patent.

It must be listed as a Generic Drug by Our national drug data bank on the date it is purchased and it must be approved by Us. Compounded Medications are not Generic Drugs. Medications that are commercially manufactured together and/or packaged together are not considered to be Generic Drugs, unless the entire combination product is specifically listed as a Generic Drug product by Our national drug data bank on the date it is purchased and it must be approved by Us.

Health Care Practitioner

A person licensed by the state or other geographic area in which the Covered Charges are rendered to treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

Home Health Care

Treatment, services or supplies provided as part of a program for care and treatment in a Covered Person's home.

Home Office

Our office in [Milwaukee, Wisconsin] or other administrative offices as indicated by Us.

Hospice

An organization that provides medical services in an Inpatient, Outpatient or home setting to support and care for persons who are terminally ill.

Hospital

A facility that provides acute care of a Sickness or an Injury on an Inpatient basis. This type of facility must meet all of

the following requirements:

1. Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide acute care.
2. Be staffed by an on duty physician 24 hours per day.
3. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
4. Maintain daily medical records that document all services provided for each patient.
5. Provide immediate access to appropriate in-house laboratory and imaging services.
6. Not primarily provide care for Behavioral Health, Substance Abuse or Inpatient rehabilitation services although these services may be provided in a distinct section of the same physical facility.

Immediate Family Member

An Immediate Family Member is:

1. You or Your spouse [or Domestic Partner]; or
2. The children, brothers, sisters and parents of either You or Your spouse [or Domestic Partner]; or
3. The spouses of the children, brothers and sisters of You and Your spouse [or Domestic Partner]; or
4. Anyone with whom a Covered Person has a relationship based on a legal guardianship.

Incur or Incurred

The date services are provided or supplies are received.

Injury

Accidental bodily damage, independent of all other causes, occurring unexpectedly and unintentionally.

Inpatient

Admitted to a Hospital for a stay of at least [24 hours] for which a charge is Incurred for room and board or observation.

Inpatient Maximum Benefit

The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred for each Sickness or Injury and for any complications related to that Sickness or Injury over the lifetime of each Covered Person. When the Inpatient Maximum Benefit has been paid by Us, no further benefits are payable for that Sickness or Injury or for any complications related to that Sickness or Injury for the remainder of the time period shown in the Benefit Summary. The Benefit Summary will identify how Covered Charges for Inpatient stays are paid, the maximum benefit available and the time period in which Covered Charges must be Incurred. The Inpatient Maximum Benefit does not apply to Covered Charges for services shown under the Surgical Services provision in the Medical Benefits section that are Incurred while Inpatient.

Low Protein Modified Food Product

A food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease.

[Maximum Lifetime Benefit

The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred by each Covered Person under this plan and any other medical plan issued by Us or an affiliated company over the lifetime of that Covered Person. This maximum will apply even if coverage with Us or an affiliate is interrupted or if a Covered Person has been insured under any plan with Us or an affiliate as either a certificate holder, policyholder or as a covered dependent. When the Maximum Lifetime Benefit has been paid by Us, no further benefits are payable for that Covered Person.]

Medical Food

A food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.

Medical Supply Provider

Agencies, facilities or wholesale or retail outlets that make disposable medical products available for use.

Medically Necessary or Medical Necessity

Treatment, services or supplies that are rendered to diagnose or treat a Sickness or an Injury. Medical Necessity does not include care that is prescribed or provided on the recommendation of a Covered Person's Immediate Family Member. We must determine that such care:

1. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis and treatment of the Sickness or Injury; and
2. Is commonly accepted as proper care or treatment of the condition in accordance with United States medical practice and federal government guidelines; and
3. Can reasonably be expected to result in or contribute substantially to the improvement of a condition resulting from a Sickness or an Injury; and
4. Is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of medical care provided.

The fact that a Health Care Practitioner may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make the treatment, service or supply Medically Necessary for the purpose of determining eligibility for coverage under this plan.

Medicare

Any portion of Title XVIII of the United States Social Security Act of 1965, as amended.

Network Manager

An organization or entity, designated by Us, which may administer the [Participating Provider Network and/or the] Participating Pharmacy Network. The Network Manager's name is shown on the insurance coverage identification (ID) card.

Non-Participating Pharmacy

A Pharmacy that is not under contract with Us or Our Network Manager to provide Prescription Drugs to the Covered Person through Our Participating Pharmacy Network.

[Non-Participating Provider

Any Health Care Practitioner, facility or supplier, not identified for this plan by Us or the Network Manager, as participating.]

Non-Preferred Brand Name Drug

A Brand Name Drug that is not listed as preferred in a Drug List.

Occupational Therapy

The treatment of Sickness or Injury, by a Health Care Practitioner who is an occupational therapist, using purposeful activities or assistive devices that focus on all of the following:

1. Developing daily living skills.
2. Strengthening and enhancing function.
3. Coordination of fine motor skills.
4. Muscle and sensory stimulation.

Office Visit

An in-person, face-to-face meeting between a Covered Person and a Health Care Practitioner in the Health Care Practitioner's office. During this meeting, the Health Care Practitioner evaluates and manages the Covered Person's Sickness or Injury or provides preventive medicine services. For the purpose of this plan, an Office Visit does not include services received in a Hospital's Outpatient department, an Emergency Room, a Free-Standing Facility or an Urgent Care Facility.

Other Insurance

Any plan that provides benefits for services that are also covered by this certificate. If coverage is provided on a service basis instead of cash payments, We will determine a reasonable charge for the service and that amount will be considered the amount paid by the Other Insurance plan.

[Out-of-Pocket Limit

The sum of the Covered Charges for which We do not pay benefits because of the Deductible or Coinsurance. When Covered Charges equal to the Out-of-Pocket Limit have been Incurred and processed by Us, the Out-of-Pocket Limit will be satisfied for the remainder of the time period shown in the Benefit Summary. The Out-of-Pocket Limit applies separately to each Covered Person, except as otherwise provided by this plan.

The following do not count toward satisfying any Out-of-Pocket Limit:

1. Access Fees and Copayments.
- [2.] [Amounts not paid by Us due to the difference between the Non-Participating Provider benefit and the benefit that would have been paid had a Participating Provider been used.]
- [3.] Charges Incurred after the maximum amount has been paid for a benefit under this plan.
- [4.] Ancillary Charges and Prescription Drug Copayments.
- [5.] Amounts not paid by Us due to the difference between the Non-Participating Pharmacy benefit and the benefit that would have been paid had a Participating Pharmacy been used.

An Out-of-Pocket Limit only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Out-of-Pocket Limits are along with the Covered Charges and the time period to which they apply.

- [1.] **[Family Out-of-Pocket Limit:** [The total dollar amount of Covered Charges that must be paid by You and Your Covered Dependents before We will consider the Out-of-Pocket Limit for all Covered Persons under the same Family Plan to be satisfied.]
- [2.] **[Participating Provider Out-of-Pocket Limit:** The dollar amount of Covered Charges for services received from providers in the Participating Provider Network that must be paid by each Covered Person before the Participating Provider Out-of-Pocket Limit is satisfied for that Covered Person.]
- [3.] **[Non-Participating Provider Out-of-Pocket Limit:** The dollar amount of Covered Charges for services received from Non-Participating Providers that must be paid by each Covered Person before the Non-Participating Provider Out-of-Pocket Limit is satisfied for that Covered Person.]]

Outpatient

Treatment, services or supplies received at a licensed medical facility, Health Care Practitioner's office or dispensary on other than an Inpatient basis for a stay of less than [24 hours].

Outpatient Calendar Year Maximum Benefit

The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred during each Calendar Year by a Covered Person for all Outpatient treatment, services and supplies combined. When the Outpatient Calendar Year Maximum Benefit has been paid by Us, no further benefits are payable for Outpatient treatment, services or supplies that the Covered Person receives for the remainder of that Calendar Year. The Outpatient Calendar Year Maximum Benefit does not apply to: ambulance services; services received in an Emergency Room; Outpatient surgery for professional services of the surgeon and any Health Care Practitioner assisting the surgeon during the surgical procedure; services involving the administration of anesthesia; or drugs, medicines and supplies that are covered under the Outpatient Prescription Drug Benefits section.

Outpatient Prescription Drug Calendar Year Maximum Benefit

The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred during each Calendar Year by a Covered Person for drugs, medicines and supplies covered under the Outpatient Prescription Drug Benefits section. When the Outpatient Prescription Drug Calendar Year Maximum Benefit has been paid by Us, no further benefits are payable under the Outpatient Prescription Drug Benefits section for drugs, medicines and supplies that the Covered Person receives for the remainder of that Calendar Year.

Participating Pharmacy

A Pharmacy that is under contract with Us or Our Network Manager to provide Prescription Drugs to the Covered Person through Our Participating Pharmacy Network.

Participating Pharmacy Network

A Prescription Drug delivery system established by Us or the Network Manager in which Participating Pharmacies are under contract with Us or Our Network Manager. The list of Participating Pharmacies is subject to change at any time without notice.

[Participating Provider

Any Health Care Practitioner, facility or supplier, identified for this plan by Us or the Network Manager, as participating.]

[Participating Provider Network

The group of Participating Providers who have agreed to accept a Contracted Rate as payment in full for specific treatment, services or supplies. The list of Participating Providers is subject to change at any time without notice.]

Per Condition

Each Sickness or Injury and any complications related to that Sickness or Injury over the lifetime of each Covered Person.

When no charges have been Incurred for any one Sickness or Injury and any complications related to that Sickness or Injury during a period of [24 consecutive months], We will consider any subsequent treatment for that condition to be a new Sickness or Injury when determining the benefits payable under the certificate.

Personal Medical Equipment

Equipment, such as a prosthesis, that is customarily used to serve a medical purpose, is designed for and able to withstand repeated use and is not intended for use by successive patients.

Pharmacy

A licensed establishment where Prescription Drugs are dispensed by a licensed pharmacist in accordance with all applicable state and federal laws.

Physical Therapy

The treatment of a Sickness or an Injury, by a Health Care Practitioner who is a physical therapist, using therapeutic exercise and other services that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living and alleviating pain.

Policy

The group master contract issued by Us to the Policyholder providing benefits for Covered Persons.

Policyholder

The person, organization or entity to which the Policy is issued as shown in the Benefit Summary.

Pre-Existing Condition

A Sickness or an Injury and related complications:

1. For which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or Prescription Drugs were prescribed during the [24-month] period immediately prior to the Covered Person's Effective Date, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or
2. That produced signs or symptoms during the [24-month] period immediately prior to the Covered Person's Effective Date.

The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:

- a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
- b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.

Preferred Brand Name Drug

A Brand Name Drug that is listed as preferred in a Drug List. This list is subject to change at any time without notice.

Prescription Card Service Administrator (PCSA)

An organization or entity that administers the processing of claims under the Outpatient Prescription Drug Benefits section. This organization or entity may be changed at any time without notice.

Prescription Drug

Any medication that:

1. Has been fully approved by the Food and Drug Administration (FDA) for marketing in the United States; and
2. Can be legally dispensed only with the written Prescription Order of a Health Care Practitioner in accordance with applicable state and federal laws; and
3. Contains the legend wording: "Caution: Federal Law Prohibits Dispensing Without Prescription" or "Rx Only" on the manufacturer's label, or similar wording as designated by the FDA.

Prescription Drug Copayment

A Prescription Drug Copayment is the dollar amount of Covered Charges that a Covered Person pays each time a Prescription Order is received that is covered under the Outpatient Prescription Drug Benefits section. The Covered Person must pay any applicable Prescription Drug Copayment directly to the Participating Pharmacy.

A Prescription Drug Copayment only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Prescription Drug Copayments are. A Prescription Drug Copayment does not count toward satisfying any Access Fee, Ancillary Charge, Deductible[, or] Coinsurance [or Out-of-Pocket Limit] under the Outpatient Prescription Drug Benefits section or any other section in this plan.

Prescription Order

The request by a Health Care Practitioner for

1. Each separate Prescription Drug and each authorized refill; or
2. Insulin or insulin derivatives only by prescription; or
3. Any one of the following supplies used in the self-management of diabetes and purchased during the same transaction only by prescription:
 - a. Disposable insulin syringes and needles; or
 - b. Disposable blood/urine/glucose/acetone testing agents or lancets.

Preventive, Restorative and Other Medical Services

For the purpose of this plan, the following services will be considered the same as services for a Sickness:

1. Necessary care and treatment of loss or impairment of speech or hearing including communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology.
2. Anesthesia and Hospital or Free-Standing Facility services performed in connection with Medically Necessary dental procedures if the Health Care Practitioner treating the patient certifies that:
 - a. a child under seven (7) years of age has been determined by two (2) dentists licensed under the Arkansas Dental Practice Act, to require, without delay, Medically Necessary dental treatment for a significantly complex dental condition;
 - b. a person has been diagnosed with a serious mental or physical condition; or

- c. a person has a significant behavioral problem as determined by the Covered Person's Health Care Practitioner licensed under the Arkansas Medical Practices Act. The dental services themselves are not covered. Dental anesthesia benefits are considered under [and accrue to] the Inpatient Hospital Services, Outpatient Medical Services, or Office Visit Benefits provisions relative to the type of service actually rendered.
- 3. Testing for hypothyroidism, phenylketonuria, galactosemia and sickle-cell anemia for a Covered Dependent newborn child.
- 4. Coverage for amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas prescribed under the direction of a physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism when the expense exceeds [\$2,400] per Covered Person per calendar year.
- 5. Colorectal cancer examination and laboratory tests for a Covered Person:
 - a. age fifty (50) years of age or older;
 - b. less than fifty (50) year of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and
 - c. experiencing the following symptoms of colorectal cancer, as determined by a Health Care Practitioner licensed under the Arkansas Medical Practices Act, bleeding from the rectum or blood in the stool; or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.

Colorectal screening shall involve an examination of the entire colon, including the following examinations and/or laboratory tests:

- a. annual fecal occult blood test utilizing take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
- b. double-contrast barium enema every five (5) years; or
- c. colonoscopy every ten (10) years; and
- d. any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health, determined in consultation with appropriate health care organizations.

Screenings for the management or subsequent need for follow-up colonoscopies shall be limited to:

- a. if the initial colonoscopy is normal, follow-up is recommended in ten (10) years;
- b. for individuals with one (1) or more neoplastic polyps, adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, follow-up is recommended in three (3) years;
- c. if single tubular adenoma of less than one centimeter (1 cm) is found, follow-up is recommended in five (5) years; and
- d. for patients with large sessile adenomas greater than three centimeters (> 3 cm), especially if removed in piecemeal fashion, follow-up is recommended in six (6) months or until complete polyp removal is verified by colonoscopy.

- 6. [\[Preventive \[medicine\] services as recommended by the Unites States Preventive Services Task Force.\]](#)

[Service Area

The geographic area, as defined by Us, served by Participating Providers. Contact the Network Manager or Us to determine the precise geographic area serviced by Participating Providers. The Service Area is subject to change at any time without notice.]

Sickness

A disease or an illness of a Covered Person. Sickness does not include a family history of a disease or illness or a genetic predisposition for the development of a future disease or illness. For the purpose of this plan, bug bites, stings or

infestations by microorganisms and poisoning by plants, such as poison ivy, are considered to be a Sickness, not an Injury.

Single Plan

A plan of insurance covering only the Certificate Holder.

Skilled Nursing Facility

A facility that provides continuous skilled nursing services on an Inpatient basis for persons recovering from a Sickness or an Injury. The facility may also provide extended care or Custodial Care.

Speech Therapy

The treatment of a Sickness or an Injury, by a Health Care Practitioner who is a speech therapist, using rehabilitative techniques to improve function for voice, speech, language and swallowing disorders.

Substance Abuse

Abuse of, addiction to, or dependence on drugs, chemicals or alcohol as defined in the edition of the International Classification of Diseases (ICD) that is published at the time a claim is received by Us. For the purpose of this plan, Substance Abuse does not include Behavioral Health.

Surgical Services Maximum Benefit

The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges under the Surgical Services provision in the Medical Benefits section that are Incurred by each Covered Person for each Sickness or Injury and for any complications related to that Sickness or Injury. When the Surgical Services Maximum Benefit has been paid by Us, no further benefits are payable for any other surgical procedures performed with regard to that particular Sickness or Injury and for any complications related to that Sickness or Injury over the lifetime of that Covered Person, including any services involving the administration of anesthesia or provided by an assistant surgeon.

Temporomandibular Joint (TMJ) Dysfunction and Craniomandibular Joint (CMJ) Dysfunction

TMJ Dysfunction and CMJ Dysfunction is any joint disorder of the jaw causing any of the following:

1. Clicking and/or difficulties in opening and closing the mouth.
2. Pain or swelling.
3. Complications including arthritis, dislocation and bite problems of the jaw.

Urgent Care

Treatment, services or supplies provided for a Sickness or an Injury that:

1. Develops suddenly and unexpectedly outside of a Health Care Practitioner's normal business hours; and
2. Requires immediate treatment, but is not of sufficient severity to be considered Emergency Treatment.

Urgent Care Facility

A facility that is attached to a Hospital, but separate from the Emergency Room, or a separate facility that provides Urgent Care on an Outpatient basis. A Health Care Practitioner's office is not considered to be an Urgent Care Facility even if services are provided after normal business hours. Room and board and overnight services are not covered. This type of facility must meet all of the following requirements:

1. Be licensed by the state in accordance with the laws for the specific services being provided in that facility.
2. Be staffed by an on duty physician during operating hours.

3. Provide services to stabilize patients who need Emergency Treatment and arrange immediate transportation to an Emergency Room.
4. Provide immediate access to appropriate in-house laboratory and imaging services.

We, Us, Our, Our Company

John Alden Life Insurance Company or its administrator.

You, Your, Yours

The person listed on the Benefit Summary as the Certificate Holder.

Statement of Variability

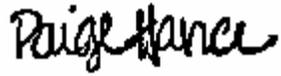
- All numbers (excluding form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.
- Bracketed paragraphs vary to the extent that such paragraphs may be included, omitted or transferred to another page 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.

*Commissioner of Insurance
John Alden Life Insurance Company
Page 2 of 2*

Attached please find any required certifications and/or transmittal forms. 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