

SERFF Tracking Number: ICCI-125759352 State: Arkansas  
Filing Company: Standard Security Life Insurance Company of New York State Tracking Number: 39832  
Company Tracking Number: SSL MMC SB 0708  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO  
Product Name: SSL 0205 (0708) revised schedule pages  
Project Name/Number: SSL 0708 revised schedule pages/SSL MMC SB 0708

## Filing at a Glance

Company: Standard Security Life Insurance Company of New York

Product Name: SSL 0205 (0708) revised schedule pages SERFF Tr Num: ICCI-125759352 State: ArkansasLH

TOI: H16G Group Health - Major Medical SERFF Status: Closed State Tr Num: 39832  
Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: SSL MMC SB 0708 State Status: Approved-Closed  
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor  
Author: Brenda Dawson Disposition Date: 08/18/2008  
Date Submitted: 08/04/2008 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: SSL 0708 revised schedule pages

Project Number: SSL MMC SB 0708

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/18/2008

State Status Changed: 08/18/2008

Corresponding Filing Tracking Number:

Filing Description:

See attached cover letter and Schedule of Benefits.

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small

Group Market Type: Trust

Deemer Date:

## Company and Contact

### Filing Contact Information

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

Brenda Dawson, Authorized Representative    Brendadawson@inscompliance.com  
519 Colman Center Drive    (815) 316-6714 [Phone]  
Rockford, IL 61108    (815) 316-6720[FAX]

**Filing Company Information**

Standard Security Life Insurance Company of New York    CoCode: 69078    State of Domicile: New York  
485 Madison Avenue, 14th Floor    Group Code:    Company Type:  
New York, NY 10022    Group Name:    State ID Number:  
(212) 355-4141 ext. [Phone]    FEIN Number: 13-5679267  
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## Filing Fees

Fee Required? Yes  
Fee Amount: \$60.00  
Retaliatory? No  
Fee Explanation: \$20 per form  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Security Life Insurance Company of New York	\$60.00	08/04/2008	21758741

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/18/2008	08/18/2008

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	08/16/2008	08/16/2008	Brenda Dawson	08/18/2008	08/18/2008

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## **Disposition**

Disposition Date: 08/18/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Filing Fee schedule	Approved-Closed	Yes
<b>Supporting Document</b>	SSL Authorization Letter	Approved-Closed	Yes
<b>Supporting Document</b>	Cover letter	Approved-Closed	Yes
<b>Supporting Document</b>	Cover letter 8/18/08	Approved-Closed	Yes
<b>Form</b>	Schedule of Benefits	Approved-Closed	Yes
<b>Form</b>	Schedule of Benefits	Approved-Closed	Yes
<b>Form</b>	Schedule of Benefits	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 08/16/2008  
Submitted Date 08/16/2008

Respond By Date

Dear Brenda Dawson,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Schedule of Benefits (Form)
- Schedule of Benefits (Form)
- Schedule of Benefits (Form)

Comment:

Our Bulletin 9-85 states that there can be no more than a 25% differential in payments between a PPO and Non-PPO. In reviewing the schedules, it appears that some benefits are more than the 25% differential.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 08/18/2008  
Submitted Date 08/18/2008

Dear Rosalind Minor,

**Comments:**

### Response 1

SERFF Tracking Number: ICCI-125759352 State: Arkansas  
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Comments: See attached letter

### Related Objection 1

Applies To:

- Schedule of Benefits (Form)
- Schedule of Benefits (Form)
- Schedule of Benefits (Form)

Comment:

Our Bulletin 9-85 states that there can be no more than a 25% differential in payments between a PPO and Non-PPO. In reviewing the schedules, it appears that some benefits are more than the 25% differential.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: Cover letter 8/18/08

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,  
Brenda Dawson

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## Form Schedule

Lead Form Number: SSL MMC DD SB 0708

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SSL MMC DD SB 0708 AR	Schedule Pages	Schedule of Benefits	Initial		50	AR SSL MMC DD SB 0708 AR w specialty drug 7-29-08.pdf
Approved-Closed	SSL MMC PPO SB 0708 AR	Schedule Pages	Schedule of Benefits	Initial		50	AR SSL MMC PPO SB 0708 AR w specialty drugs 7-29-08.pdf
Approved-Closed	SSL MMC SD SB 0708 AR	Schedule Pages	Schedule of Benefits	Initial		50	AR SSL MMC SD 0708 AR w HSA lang 7-29-08.pdf

## SCHEDULE OF BENEFITS

### Arkansas

Lifetime Maximum Benefit for all Covered Charges combined	\$[1,000,000-5,000,000]
[Lifetime Maximum Benefit for In-Network Specified Covered Organ Transplants in a Centers of Excellence]	\$[1,000,000-5,000,000]
Lifetime Maximum Benefit for In-Network Specified Covered Organ Transplants	\$[200,000-400,000]
Lifetime Maximum Benefit for Out-of-Network Specified Covered Organ Transplants	\$[100,000-200,000]
[Lifetime Maximum Benefit for Mental, Nervous and Chemical Dependency Disorders combined]	\$[10,000-20,000]
Lifetime Maximum Benefit for Hospice Care	[0-6 months of Covered Charges]

### MEDICAL DEDUCTIBLE[\*], PER CALENDAR YEAR

**[Deductible amount per person per calendar day**

For each calendar day in which You incur Covered Charges, You are responsible for an amount up to Your Daily Deductible Selection. The Daily Deductible amount applies per calendar day, regardless of the number of providers rendering services in that calendar day. Once your Daily Deductible amount has been satisfied for the calendar day, any remaining balance is paid by the Plan at 100%.]

**[When Dependents are not covered by the plan]  
[In-Network]  
\$[250-1000]**

**[When Dependents are covered by the plan\*]  
[Out-of-Network]  
\$[500-2000]**

[The In-Network and Out-of-Network Daily Deductibles accumulate separately and distinctly.]

**[Deductible Maximum:** When two (2) individual Insured Persons in a family satisfy their In-Network or Out-of-Network Daily Deductibles, the In-Network or Out-of- Network Daily Deductibles for any remaining Insured Person in the family are deemed satisfied for the remainder of the Calendar Day.]

**[Additional Deductibles:**

Failure to Pre-Certify Inpatient Care	\$[500-1,000]
Failure to Pre-Certify specified Prescription Medications	[no coverage for the specified medication]

[Notwithstanding anything to the contrary found in the Certificate, the additional Deductible for failure to pre certify do not accumulate toward the Calendar Year Deductible amounts or Out-Of-Pocket Maximum amounts.]

[\*Primary Insured and covered Dependents share one common Deductible amount for the Calendar Year.]

### OUT-OF-POCKET MAXIMUM, PER CALENDAR YEAR

**[When Dependents are [not] covered  
by the plan]  
[In-Network/Out-of-Network]  
\$[4,000/8,000]**

	<b>[In-Network]</b>	<b>[Out-of-Network]</b>
[Maximum Amount of Covered Charges applied toward Daily Deductible in a Calendar Year for each insured person]	\$[4,000 or \$6,000 or \$8,000]	\$[8,000 or \$12,000 or \$16,000]

[The In-Network and Out-of-Network Calendar Year Out-of-Pocket maximums are accumulated separately. However, when the Out-of-Network Calendar Year Out-of-Pocket Maximum is satisfied, the In-Network Out-of-Pocket Maximum will be deemed satisfied for the remainder of that Calendar Year. Covered Charges applicable to the Daily Deductible will accumulate towards the plan's Calendar Year Out-of-Pocket Maximum. ]

[Maximum Out-of-Pocket Amount per Calendar Year per Insured Family:

Once any [two-three (2-3)] Insured Persons in an Insured family (an Insured Person and his or her Insured Dependents) have satisfied their individual Maximum Out-of-Pocket Amounts per Calendar Year, all other Insured Persons in the Insured family will be deemed to have satisfied this requirement for the remainder of the Calendar Year.]

[The following Covered Charges do not accumulate toward the Maximum Out-of-Pocket Amount Per Calendar Year: (1) Expenses incurred for the Outpatient treatment of Mental, Nervous or Chemical Dependency Disorders, (2) Pre-Certification Deductibles (3) Copays.]

**[DAILY COPAYS]**

Physician office Visit [or Free Standing Urgent Care Center Facility Visit] [at In-Network providers only.]	\$[None-50]
[Diagnostic x-ray, labs and tests at In-Network providers only ( <i>applies for each provider</i> )]	\$[None-50]]

**COINSURANCE AND BENEFIT LIMITATIONS**

All Benefit Limits are per Insured Person per Calendar Year.

	<b>[In-Network Benefit] [After your selected Deductible has been satisfied]</b>	<b>[Out-Of-Network Benefit] [After your selected Deductible has been satisfied]</b>
<b>MEDICAL SERVICES AND SUPPLIES</b>		
Physician Office Visit or Free Standing Urgent Care Center Visit	[After Copay, then 100%] [70-100% after Deductible]	[ 50%-100% after Deductible]
Outpatient Diagnostic Lab [not performed by LabOne]	[After Copay, then 100%] [70-100% after Deductible]	[50-100% after Deductible]

Outpatient Diagnostic X-ray and tests [not performed by LabOne]	[70-100% after Deductible]	[50-100% after Deductible]
[Outpatient Diagnostic Lab, X-ray and tests performed by LabOne]	[100%]	[100%]
Physical, Speech, or Occupational Therapy	[70-100% after Deductible]	[50-100% after Deductible]
Durable Medical Equipment	[70-100% after Deductible]	[50-100% after Deductible]
Non-Surgical Back Treatment	[70-100% after Deductible]	[50-100% after Deductible]
Outpatient Registered Nurse Services	[70-100% after Deductible]	[50-100% after Deductible]
Home Health Care	[70-100% after Deductible]	[50-100% after Deductible]
Hospice Care	[100%]	[100%]
Cytological & Mammography Screening Services	[100%]	[100%]

**OUTPATIENT SURGICAL SERVICES (Outpatient surgery and related services when rendered at a outpatient facility)**

Outpatient Hospital or Ambulatory Surgical Center Facility Services	[100%, 70% after Deductible]	[50-100% after Deductible]
Surgery, Assistant Surgeon, and Anesthesiology Services	[100%, 70% after Deductible]	[50-100% after Deductible]

**FACILITY CHARGES (Inpatient surgical or other services when rendered at a inpatient facility)**

Hospital Inpatient Facility Confinement	[100%, 70% after Deductible]	[50-100% after Deductible]
Skilled Nursing Facility Services	[100%, 70% after Deductible]	[50-100% after Deductible]
Physician services, including consultations and diagnostic testing	[100%, 70% after Deductible]	[50-100% after Deductible]

**EMERGENCY CARE**

Emergency Room	[100%, 70% after Deductible]	[100%, 70% after Deductible]
Ambulance Services – Ground, Air, and Water	[100%, 70% after Deductible]	[100%, 70% after Deductible]

**MENTAL, NERVOUS AND CHEMICAL DEPENDENCY DISORDERS**

Mental and Nervous Inpatient Care	[100%, 70% after Deductible]	[50-100% after Deductible]
[Mental, Nervous and Chemical Dependency Outpatient Care]	[50-100% after Deductible]	[50-100% after Deductible]

**HOSPITAL ROOM/DAILY RATE SCHEDULE (All applicable Deductibles and coinsurance will apply)**

Private or Semi-Private Room	[Up to the Most Common Semi-Private Room Rate]	[Up to the Most Common Semi-Private Room Rate]
If the Hospital does not provide semi-private rooms, the Hospital benefit will be paid at 90% of the Hospital's lowest priced private room rate. In the event a private room is Medically Necessary due to a contagious disease, We will consider the cost of the private room as a Covered Charge.		
Intensive Care Unit	[Up to the Most Common ICU Rate]	[Up to 3 times the Most Common Semi-Private Room Rate]
Observation Room or Intermediate Care Unit	[Up to 2 times the Most Common Semi-Private Room Rate]	[Up to 2 times the Most Common Semi-Private Room Rate]

**BENEFIT LIMITS**

All Benefit Limits are per Insured Person per Calendar Year

[Calendar Year Maximum Benefit for all Covered Charges combined][, including organ transplants provided in a Centers of Excellence]	\$[100,000][1,000,000-5,000,000]
Physical, Speech, or Occupational Therapy	[30-60 treatments per Calendar Year for any one type of therapy and up to 60-90 treatments per Calendar Year for any combination of these therapies]
Non-Surgical Back Treatment	[Limited to \$500-1,000 maximum benefit per Calendar Year]
Home Health Care	[A maximum 60-90 visits per Calendar Year]
Hospice Care	[Limited to 0-6 months of Covered Charges.]
Low Protein Modified Food Products	Not to exceed \$2,400 per child
Skilled Nursing Facility Services	[Limited to \$100-200 daily and a maximum of 60-90 days per Calendar Year ]
Mental and Nervous Inpatient Care	[A maximum 10-20 days per Calendar Year up to \$2,500-5,000 per Calendar Year]

[Mental and Nervous Outpatient Care]	[Daily maximum of \$50-100 not to exceed 25-50 visits per Calendar Year up to \$1,250-2,000 per Calendar Year]
[Mental, Nervous & Chemical Dependency Outpatient Care]	[Daily maximum of \$50 not to exceed 25 visits per Calendar Year up to \$1,250 per Calendar Year Maximum for Mental and Nervous Outpatient Care and Chemical Dependency Outpatient Care combined]
[Chemical Dependency Outpatient Care ]	[Daily maximum of \$50-100 not to exceed 25-50 visits per Calendar Year up to \$1,250 per Calendar Year]
Organ Transplant Transportation Expense	[An allowance up to \$5,000-10,000 is available for transportation expenses per Transplant performed in a Center of Excellence]
Oral Surgery	\$ [5,000-10,000] per Calendar Year]

**OPTIONAL BENEFITS**

**[Optional Wellness Benefit Rider** [YES/NO]  
 [\$35 Copay, then 100% up to \$250-1,000]

**[Optional 24-Hour Occupation Coverage Rider** [YES/NO]

**[Optional Prescription Medication Benefit Rider** [YES/NO]

**[OPTION 1 – Rx Discount:** No prescription drug card benefit.  
 Specialty Drugs included – discount only]

[ or ]

**[OPTION 2**

	<b>Your Share of the Cost</b>	
	<b>Deductible</b>	<b>Copay</b>
Per <b>Generic</b> Prescription Order or Refill	None	\$15-25
Per <b>Formulary Brand Name</b> Prescription Order or Refill	\$250 per	\$45-60
Per <b>Non-formulary Brand Name</b> Prescription Order or Refill	Calendar Year*	\$60-90
Specialty Drugs	None	\$90-120

**[\* When three (3) individual Insured Persons in a family satisfy their Outpatient Prescription Medication Calendar Year Deductible, the remaining Outpatient Prescription Deductibles for any Insured Person in the family are deemed satisfied for the remainder of the Calendar Year.]**

[ or ]

**[OPTION 3**

	<b>Your Share of the Cost</b>
Per <b>Generic</b> Prescription Order or Refill	\$10-25 Copay
Per <b>Formulary Brand Name</b> Prescription Order or Refill	\$25-50 Copay
Per <b>Non-formulary Brand Name</b> Prescription Order or Refill	\$40-60 Copay
Specialty Drugs	\$50-100 Copay]]

**[Optional Life and Accidental Death and Dismemberment Benefit Rider** [YES/NO]]

Life Insurance Amount	[\$10,000-\$100,000]
Accidental Death and Dismemberment Insurance	[The Principal Sum is equal to one times the Life Insurance Amount]
[Ages 65-69	65% of selected amount
Ages 70-74	40% of selected amount
Ages 75-79	25% of selected amount
Ages 80-84	15% of selected amount
Ages 85+	10% of selected amount]

**[Optional Dependent Life Insurance]**

Spouse Life Insurance Amount	[\$2,000-4,000]
Children	
Age 14 days, but less than 6 months	[\$100-500]
age 6 months, but less than 19 years	[\$1,000-2,000]
age 19 years, but less than 25 years (if a student attending school on a full-time basis)]	[\$1,000-2,000]

**[Optional Supplemental Accident Coverage]** [YES/NO]]

[100% up to a \$500-\$5,000 maximum benefit then copay, Deductible and coinsurance]

**[Optional Pregnancy Benefit]** [YES/NO]

[Optional for groups of 5-14 (fewer where mandated), mandatory for 15+	[In-Network Subject to Deductibles and coinsurance	Out-of-Network Subject to Deductibles and Coinsurance]
In-Vitro Fertilization lifetime maximum benefit - \$15,000]		

**[Optional Weekly Disability Benefit]** [YES/NO]]

[Benefits begin: Day 1 due to an accident Day 8 due to a sickness Up to 26 weeks per disability.]	[Up to a maximum benefit of \$[100-500] per week]]
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<b>[Optional Dental Benefit Rider</b>	<b>[YES/NO]]</b>		
	Plan 1	Plan 2	
Lifetime Deductible	[\$25-50]	[\$25-50]	
Calendar Year Deductible	[\$50-100 for Basic and Major, \$50-100 for Orthodontia (Maximum of three per family)]	[\$50-100 for Basic and Major (Maximum of three per family)]	
Calendar Year Maximum	[\$1,500-2,000 for Preventive, Basic and Major \$1,000-2,000 for orthodontia]	[\$1,500-2,000 for Preventive, Basic and Major]	
Lifetime Maximum	[\$1,000-2,000 for orthodontia]	[\$1,000-2,000 for orthodontia]	
Waiting Periods			
Preventive and Basic	[None]	[None]	
Major and Orthodontic(if included)	[0-12 months]	[0-12 months]	
<b>Covered Procedures</b>			
Preventive Services (Type 1)	[Plan pays 100%]	[Plan pays 90%]	
Basic Services(Type 2)	[Plan pays 80%]	[Plan pays 60%]	
Major Service (Type 3)	[Plan pays 50%]	[Plan pays 50%]	
Orthodontia (Type 4) (for children under age 19)	[Plan pays 50%]	[No coverage]	
<b>[Optional Vision Benefit Rider</b>	<b>[YES/NO]]</b>		
	<b>[In-Network Benefit]</b>	<b>[Out-Of-Network Benefit]</b>	<b>[Benefit Frequency]</b>
[Vision Exam	[\$10 or 20 copay]	[Up to \$35.00]	[12-24 Months]
Contact Lenses			[12-24 Months]
Conventional	[\$115.00 Allowance + 15% discount of the balance over \$115.00]	[Up to \$100.00]	
Disposable	[\$115.00 Allowance + 100% of the balance over	[Up to \$100.00]	

	\$115.00]		
Medically Necessary	[\$250.00 Allowance + 100% of the balance over \$250.00]	[Up to \$200.00]	
Glasses Frames	[\$100.00 Allowance + 20% discount of the balance over \$100.00]	[Up to \$45.00]	[12-24 Months]
Glasses Lenses			[12-24 Months]
Single vision	[\$25.00 copay]	[Up to \$25.00]	
Bifocal	[\$25.00 copay]	[Up to \$40.00]	
Trifocal	[\$25.00 copay]	[Up to \$55.00]	
Lenticular	[\$25.00 copay]	[Up to \$55.00]	
In-Network Lens Options (Additional Copays)			
Basic Progressives*	[\$45.00]	[N/A]	
Basic Polycarbonate	[\$35.00]	[N/A]	
Ultra violet	[\$12.00]	[N/A]	
Basic Anti-Reflective	[\$45.00]	[N/A]	
Tint (Solid & Gradient)	[\$12.00]	[N//A]	
Basic Scratch-Resistance	[\$15.00]	[N/A]	
Other Add-Ons & Service	[20% discount]	[N/A]	
[*add-on to bifocal]]			

# SCHEDULE OF BENEFITS

## Arkansas

Lifetime Maximum Benefit for all Covered Charges combined	\$[1,000,000-5,000,000]
[Lifetime Maximum Benefit for In-Network Specified Covered Organ Transplants in a Centers of Excellence]	\$[1,000,000-5,000,000]
Lifetime Maximum Benefit for In-Network Specified Covered Organ Transplants	\$[200,000-400,000]
Lifetime Maximum Benefit for Out-of-Network Specified Covered Organ Transplants	\$[100,000-200,000]
[Lifetime Maximum Benefit for Mental, Nervous and Chemical Dependency Disorders combined]	\$[10,000-20,000]
Lifetime Maximum Benefit for Hospice Care	[0-6 months of Covered Charges]

### MEDICAL DEDUCTIBLE, PER CALENDAR YEAR

<b>[Deductible:</b>	[IN-NETWORK]	[OUT-OF-NETWORK ]
	\$[500-10,000]	\$[1,000-30,000]

[The In-Network and Out-of-Network Deductibles are accumulated separately. However, when the Out-of-Network Deductible is met for the Calendar Year, the In-Network Deductible will be deemed satisfied for the remainder of that Calendar Year.]

**[Deductible Maximum:** When three (3) individual Insured Persons in a family satisfy their In-Network or Out-of-Network Calendar Year Deductibles, the In-Network or Out-of-Network Deductibles for any remaining Insured Person in the family are deemed satisfied for the remainder of the Calendar Year.] [Employee and Dependents share one common Deductible amount for the Calendar Year.]

**[Additional Deductibles:**

Failure to Pre-Certify Inpatient Care	\$[0-500]
Failure to Pre-Certify specified Prescription Medications	[no coverage for the specified medication]

[Notwithstanding anything to the contrary found in the Certificate, the additional Deductible for failure to pre certify does not accumulate toward the Calendar Year Deductible amounts or Out-Of-Pocket Maximum amounts.]

### OUT-OF-POCKET MAXIMUM, PER CALENDAR YEAR

In-Network	Out-of-Network
\$[1,000-5,000]	\$[2,000-15,000]

OR

### [OUT-OF-POCKET MAXIMUM AMOUNT PER CALENDAR YEAR FOR EACH INSURED PERSON]

	[In Network]	[Out-Of-Network]
[Medical Services & Supplies & [Outpatient Surgical Services]]	\$[1,500-8,000]	\$[4,500-15,000]
[Inpatient Facility Confinement] [&] [Inpatient and Outpatient] [Surgical Services]	\$[4,000-8,000]	\$[10,000-24,000]

[The In-Network and Out-of-Network Calendar Year Out-of-Pocket Maximums are accumulated separately [.] except when the Out-of-Network Calendar Year Out-of-Pocket Maximum is satisfied, the In-Network Out-of-Pocket Maximum will be deemed satisfied for the remainder of that Calendar Year.][In addition, Out-of-Pocket Calendar year Maximum Amounts for Medical Services & Supplies and Inpatient & Outpatient Surgical Services accumulate separately.] [The following Covered Charges do not accumulate toward the Maximum Out-of-Pocket Amount Per Calendar Year: (1) Expenses incurred for the Outpatient treatment of Mental, Nervous or Chemical Dependency Disorders; (2) Pre-Certification Deductibles; (3) [Outpatient] Copays; (4) Any Deductible amounts[;][.] [(5) In patient Out-of-Network Coinsurance]]

[Maximum Out-of-Pocket Amount per Calendar Year per insured family: Once any [two-three (2-3)] Insured Persons in an Insured family (an [Insured Person][Employee] and his or her Insured Dependents) have satisfied their individual Maximum Out-of-Pocket Amounts per Calendar Year, all other Insured Persons in the insured family will be deemed to have satisfied this requirement for the remainder of the Calendar Year]

**[COPAYS][& COINSURANCE AND BENEFIT LIMITATIONS PER INSURED PERSON]**

Physician office visit charge for examination and evaluation at In-Network providers only.		[None-\$50]
[Outpatient Diagnostic Lab, x-ray and test Copay per provider (In Network only)]		[None- \$50]
Emergency Room Copay <i>(waived if the Insured Person is admitted)[for the visit is determined to be Medically Necessary Emergency Care]</i>		[\$100-200]
Emergency Ambulance Services – Ground, Air, and Water		[\$100-200]]
	<b>[In-Network]</b>	<b>[Out-of-Network]</b>
[Inpatient Facility Confinement]	\$[200-500]	\$[200-1,000]
[Outpatient Surgery]	\$[200-500]	\$[200-1,000]

**[COINSURANCE AND BENEFIT LIMITATIONS]**

All Benefit Limits are per Insured Person per Calendar Year]

	<b>[In-Network Benefit]</b> [After satisfaction of Your In-Network Calendar Year Deductible]	<b>[Out-Of-Network Benefit]</b> [After satisfaction of Your Out-of-Network Calendar Year Deductible]
<b>MEDICAL SERVICES AND SUPPLIES</b>		
Physician Office Visit or Free Standing Urgent Care Center Visit	[After \$20-50 Copay, then 100%][after] [100%, 90%, 80%, 70% after Deductible]	[After \$50-70 Copay, then 100%] [after] [70%, 60%, 50% after Deductible]

Outpatient Diagnostic Lab, X-ray and tests [not performed by LabOne]	<p>[\$40 Copay, then 100% For Outpatient MRIs, CT scans and nuclear imaging testing, after \$200 Copay, then 100%] [After [\$20-50] Copay, then 100% after][up to \$150 per visit, then] [100%, 90%, 80%, 70% after Deductible]</p>	<p>[After \$70 Copay, then 70% For Outpatient MRIs, CT scans and nuclear imaging testing, after \$400 Copay, then 70%] [[After \$50-70 Copay,] [70%, 60%, 50% after Deductible]</p>
[Outpatient Diagnostic Lab, X-ray and tests performed by LabOne]	[100%]	[N/A]
Physical, Speech, or Occupational Therapy	<p>[After \$20-50 Copay, then 100%] [after] [100%, 90%, 80%, 70% after Deductible]</p>	<p>[[After \$50-70 Copay, then] [70%, 60%, 50% after Deductible]</p>
Durable Medical Equipment	<p>[After \$20-50 Copay, then 100%] [after] [100%, 90%, 80%, 70% after Deductible]</p>	<p>[[After \$50-70 Copay, then] [70%, 60%, 50% after Deductible]</p>
Non-Surgical Back Treatment	<p>[After \$20-50 Copay, then 100%] [after] [100%, 90%, 80%, 70% after Deductible]</p>	<p>[[After \$50-70 Copay, then] [70%, 60%, 50% after Deductible]</p>
Outpatient Registered Nurse Services	<p>[After \$20-50 Copay, then 100%] [after] [100%, 90%, 80%, 70% after Deductible]</p>	<p>[[After \$50-70 Copay, then] [70%, 60%, 50% after Deductible]</p>
Home Health Care	<p>[After \$20-50 Copay, then 100%] [after] [100%, 90%, 80%, 70% after Deductible]</p>	<p>[[After \$50-70 Copay, then] [70%, 60%, 50% after Deductible]</p>
Hospice Care	[100%]	[100%]
[Cervical] Cytological & Mammography Screening Services	[100%]	[100%]

**OUTPATIENT SURGICAL SERVICES (Outpatient surgery and related services when rendered at a outpatient facility)**

Outpatient Hospital or Ambulatory Surgical Center Facility Services	[After \$200-500 Copay, then 100%] [100%, 90%, 80%, 70%][after Deductible]	[After \$200-1,000 Copay, then] [70%, 60%, 50%] [after Deductible]
Surgery, Assistant Surgery, and Anesthesiology Services	[After \$200-500 Copay then 100%] [100%, 90%, 80%, 70%][after Deductible]	[After \$200-1,000 Copay, then] [70%, 60%, 50%] [after Deductible]

**FACILITY CHARGES (Inpatient surgical or other services when rendered at a inpatient facility)**

Hospital Inpatient Facility Confinement	[After \$200-500 Copay then 100%] [100%, 90%, 80%, 70%][after Deductible]	[After \$200-1,000 Copay, then] [70%, 60%, 50%] [after Deductible]
Skilled Nursing Facility Services	[After \$200-500 Copay then 100%] [100%, 90%, 80%, 70%][after Deductible]	[After \$200-1,000 Copay, then] [70%, 60%, 50%] [after Deductible]
Physician services, including consultations and diagnostic testing	[After \$200-500 Copay then 100%] [100%, 90%, 80%, 70%][after Deductible]	[After \$200-1,000 Copay, then] [70%, 60%, 50%] [after Deductible]

**EMERGENCY CARE**

Emergency Room	[After \$200-500 Copay, then 100%,] [90%, 80%, 70%] [after Deductible]	[After \$200-1,000 Copay, then 100%] [90%, 80%, 70%, 50%][after Deductible]
Ambulance Services – Ground, Air, and Water	[After \$200-500 Copay, then 100%,] [90%, 80%, 70%] [after Deductible]	[After \$200-1,000 Copay, then 100%] [90%, 80%, 70%] [after Deductible]

**MENTAL, NERVOUS AND CHEMICAL DEPENDENCY DISORDERS**

Mental and Nervous Inpatient Care	[After \$200-500 Copay, then 100%,] [100%, 90%, 80%, 70%] [after Deductible]	[[After \$200-1,000 Copay, then 70%, 60%, 50%] [after Deductible]
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[Mental, Nervous and Chemical Dependency Outpatient Care]	[After \$20-50 Copay, then] [50% after Deductible]	[[After \$50-70 Copay, then] [50% after Deductible]
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**HOSPITAL ROOM/DAILY RATE SCHEDULE (All applicable Deductibles and coinsurance will apply)**

Private or Semi-Private Room	[Up to the Most Common Semi-Private Room Rate]	[Up to the Most Common Semi-Private Room Rate]
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If the Hospital does not provide semi-Private rooms, the Hospital benefit will be paid at 90% of the Hospital's lowest priced Private room rate. In the event a private room is Medically Necessary due to a contagious disease, We will consider the cost of the private room as a Covered Charge.

Intensive Care Unit	[Up to the Most Common ICU Rate]	[Up to 3 times the Most Common Semi-Private Room Rate]
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Observation Room or Intermediate Care Unit	[Up to 2 times the Most Common Semi-Private Room Rate]	[Up to 2 times the Most Common Semi-Private Room Rate]
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**BENEFIT LIMITS**

All Benefit Limits are per Insured Person per Calendar Year

[Calendar Year Maximum Benefit for all Covered Charges combined][, including organ transplants covered in a Centers of Excellence]	[\$100,000][1,000,000-5,000,000]
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Physical, Speech, or Occupational Therapy	[30-60 treatments per Calendar Year for any one type of therapy and up to 60-90 treatments per Calendar Year for any combination of these therapies]
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Non-Surgical Back Treatment	[Limited to \$500-1,000 maximum benefit per Calendar Year]
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Home Health Care	[A maximum 60-90 visits per Calendar Year]
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Hospice Care	[Limited to 0-6 months of Covered Charges.]
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Low Protein Modified Food Products	Not to exceed \$2,400 per child
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Skilled Nursing Facility Services	[Limited to \$100-200 daily and a maximum of 60 days per Calendar Year ]
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Mental and Nervous Inpatient Care	[A maximum 10-20 days per Calendar Year up to \$2,500-5,000 per Calendar Year]
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[Mental and Nervous Outpatient Care]	[Daily maximum of \$50 not to exceed 25 visits per Calendar Year up to \$1,250 per Calendar Year]
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[Mental, Nervous & Chemical Dependency Outpatient Care]	[Daily maximum of \$50 not to exceed 25 visits per Calendar Year up to \$1,250 per Calendar Year Maximum for Mental and Nervous Outpatient Care and Chemical Dependency Outpatient Care combined]
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**[Optional Life and Accidental Death and Dismemberment Benefit Rider]** [YES/NO]

Life Insurance Amount \$[10,000-100,000]  
Accidental Death and Dismemberment Insurance The Principal Sum is equal to one times the Life Insurance Amount]

Ages 65-69 65% of selected amount  
Ages 70-74 40% of selected amount  
Ages 75-79 25% of selected amount  
Ages 80-84 15% of selected amount  
Ages 85+ 10% of selected amount]

**[Optional Dependent Life Insurance]**

Spouse Life Insurance Amount [\$2,000-5,000]

Children

Age 14 days, but less than 6 months age 6 months, but less than 19 years age 19 years, but less than 25 years (if a student attending school on a full-time basis)]  
[\$ 100-500]  
[\$1,000-2,000]  
[\$1,000-2,000]

**[Optional Supplemental Accident Coverage]** [YES/NO]

[100% up to a \$500-\$5,000 maximum benefit amount as specified on your Validation of Coverage Face Page]

**[Optional Pregnancy Benefit]** [YES/NO]

[Optional for groups of 5-14 (fewer where mandated), mandatory for 15+]	[In-Network Subject to Deductibles and coinsurance]	[Out-of-Network Subject to Deductibles and Coinsurance]
In-Vitro Fertilization lifetime maximum benefit - \$15,000]		

**[Optional Weekly Disability Benefit]** [YES/NO]

[Benefits begin:  
Day 1 due to an accident [Up to a maximum benefit of \$[100-500] per week]]  
Day 8 due to a sickness  
Up to 26 weeks per disability.]

<b>[[Optional Dental Benefit Rider</b>	[YES/NO]]	
	Plan 1	Plan 2
Lifetime Deductible	[\$25-50]	[\$25-50]
Calendar Year Deductible	[\$50-100 for Basic and Major, \$50-100 for Orthodontia (Maximum of three per family)]	[\$50-100 for Basic and Major (Maximum of three per family)]
Calendar Year Maximum	[\$1,500-2,000 for Preventive, Basic and Major, \$1,000-2,000 for orthodontia]	[\$1,500-2,000 for Preventive, Basic and Major]
Lifetime Maximum	[\$1,000-2,000 for orthodontia]	
Waiting Periods		
Preventive and Basic	[None]	[None]
Major and Orthodontic(if included)	[12-24 months]	[12-24 months]
Covered Procedures		
Preventive Services (Type 1)	[Plan pays 100%]	[Plan pays 90%]
Basic Services (Type 2)	[Plan pays 80%]	[Plan pays 60%]
Major Service (Type 3)	[Plan pays 50%]	[Plan pays 50%]
Orthodontia (Type 4) (for children under age 19)	[Plan pays 50%]	[Not Covered]]

<b>[[Optional Vision Benefit Rider</b>	[YES/NO]]		
	<b>[In-Network Benefit]</b>	<b>[Out-Of-Network Benefit]</b>	<b>[Benefit Frequency]</b>
[Vision Exam	[\$10.00 copay]	[Up to \$35.00]	[12-24 Months]
Contact Lenses			[12-24 Months]
Conventional	[\$115.00 Allowance + 15% discount of the balance over \$115.00]	[Up to 100.00]	
Disposable	[\$115.00 Allowance + 100%	[Up to 100.00]	

	of the balance over \$115.00]		
Medically Necessary	[\$250.00 Allowance + 100% of the balance over \$250.00]	[Up to 200.00]	
Glasses Frames	[\$100.00 Allowance + 20% discount of the balance over \$100.00]	[Up to \$45.00]	[12-24 Months]
Glasses Lenses			[12-24 Months]
Single vision	[\$25.00 copay]	[Up to \$25.00]	
Bifocal	[\$25.00 copay]	[Up to \$40.00]	
Trifocal	[\$25.00 copay]	[Up to \$55.00]	
Lenticular	[\$25.00 copay]	[Up to \$55.00]	
In-Network Lens Options – Additional Copays			
Basic Progressives*	[\$45.00]	[N/A]	
Basic Polycarbonate	[\$35.00]	[N/A]	
Ultra violet	[\$12.00]	[N/A]	
Basic Anti-Reflective	[\$45.00]	[N/A]	
Tint (Solid & Gradient)	[\$12.00]	[N//A]	
Basic Scratch-Resistance	[\$15.00]	[N/A]	
Other Add-Ons & Service *add-on to bifocal]	[20% discount[	[N/A]]	

## SCHEDULE OF BENEFITS

### Arkansas

Lifetime Maximum Benefit for all Covered Charges combined	\$[1,000,000-5,000,000]
[Lifetime Maximum Benefit for In-Network Specified Covered Organ Transplants in a Centers of Excellence]	\$[1,000,000-5,000,000]
Lifetime Maximum Benefit for In-Network Specified Covered Organ Transplants	\$[200,000-400,000]
Lifetime Maximum Benefit for Out-of-Network Specified Covered Organ Transplants	\$[100,000-200,000]
[Lifetime Maximum Benefit for Mental, Nervous and Chemical Dependency Disorders combined]	\$[10,000-20,000]
Lifetime Maximum Benefit for Hospice Care	[0-6 months of Covered Charges]

### MEDICAL DEDUCTIBLE[\*] PER CALENDAR YEAR

	[IN-NETWORK]	[OUT-OF-NETWORK]
<b>[Deductible when Dependents are not covered by the Plan:]</b>	[\$1,150-5,000 In-Network Providers]	[\$3,300-15,000 Out-of-Network Providers]
<b>[Deductible when Dependents are covered by the Plan:]</b>	[\$2,300-10,000 In-Network Providers]	[\$6,600-30,000 Out-of-Network Providers]

[However, when the Out-of-Network Deductible is met for the Calendar Year, the In-Network Deductible will be deemed satisfied for the remainder of that Calendar Year.]

<b>[Deductible:</b>	<b>[When Dependents are not covered by the plan]</b> \$[1,000, 1,700; 2,600; 3,500; 5,000, 10,000]	<b>[When Dependents are covered by the plan*]</b> \$[2,500; 3,350; 5,150; 7,500; 10,000]
<b>[Additional Deductibles:</b>		
Failure to Pre-Certify Inpatient Care		\$[0-500]
Failure to Pre-Certify specified Prescription Medications		[no coverage for the specified medication]

[Notwithstanding anything to the contrary found in the Certificate, additional Deductibles for failure to pre certify do not accumulate toward the Calendar Year Deductible amounts or Out-Of-Pocket Maximum amounts.]

[In-Network and Out-of-Network services accumulate in the aggregate to satisfy the Deductible amount for the Calendar Year.]

[Notwithstanding anything to the contrary found in the Certificate, the Calendar Year Deductible accumulates toward the Out of Pocket Maximum]

[\*Primary Insured and covered Dependents share one common Deductible amount for the Calendar Year. HSA Plan Deductibles and Out-of-Pocket Maximum will be adjusted annually based on changes mandated by the Federal Government.]

**[OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR\*]**

<b>[When Dependents are not covered by the Plan:]</b>	[IN-NETWORK 100% COINSURANCE PLAN \$0 Or 80% COINSURANCE PLAN \$1,500]	[OUT-OF-NETWORK 70% COINSURANCE PLAN \$1,500 Or 50% COINSURANCE PLAN \$3,000]
	[100% COINSURANCE PLAN \$0 Or 80% COINSURANCE PLAN \$3,000]	[70% COINSURANCE PLAN \$3,000 Or 50% COINSURANCE PLAN \$6,000]
<b>[When Dependents are covered by the Plan:]</b>		

\*Out-of-Pocket amount does not include the In Network or Out-of-Network Deductible amounts. However, when the Out-of-Network Out-of-Pocket is met for the Calendar Year, the In-Network Out-of-Pocket will be deemed satisfied for the remainder of that Calendar Year.

**[OUT-OF-POCKET MAXIMUM, PER CALENDAR YEAR]**

<b>[When Dependents are not covered by the plan]</b>	<b>[When Dependents are covered by the plan]</b>
[\$2,500; 3,350; 5,000;7,500; 15,000]	[\$5,000; 6,150; 10,000;15,000]

**[OPTIONAL] [COPAYS]**

Physician office Visit or Free Standing Urgent Care Center Facility Visit at In-Network providers only.	[\$None-50]
[Outpatient] Diagnostic x-ray, labs and tests at In-Network providers only ( <i>applies for each provider</i> )	[\$None-50]

## COINSURANCE AND BENEFIT LIMITATIONS

All Benefit Limits are per Insured Person per Calendar Year.

	In-Network Benefit	Out-Of-Network Benefit
<b>MEDICAL SERVICES AND SUPPLIES</b>		
Physician Office Visit or Free Standing Urgent Care Center Visit	[After Copay, then 100%] [100%- 70% after Deductible]	[70%-50% after Deductible]
Outpatient Diagnostic Lab [tests][not performed by LabOne]	[After Copay, then 100%] [100%-70% after Deductible]	[70%-50% after Deductible]
Outpatient Diagnostic X-ray and tests [not performed by LabOne]	[100%-70% after Deductible]	[70%-50% after Deductible]
[Outpatient Diagnostic Lab, X-ray and tests performed by LabOne]	[100%]	[100%]
Physical, Speech, or Occupational Therapy	[100%-70% after Deductible]	[70%-50% after Deductible]
Durable Medical Equipment	[100%-70% after Deductible]	[70%-50% after Deductible]
Non-Surgical Back Treatment	[100%-70% after Deductible]	[70%-50% after Deductible]
Outpatient Registered Nurse Services	[100%-70% after Deductible]	[70%-50% after Deductible]
Home Health Care	[100%-70% after Deductible]	[70%-50% after Deductible]
Hospice Care	[100%]	[100%]
Cytological & Mammography Screening Services	[100%]	[100%]
<b>OUTPATIENT SURGICAL SERVICES (Outpatient surgery and related services when rendered at a outpatient facility)</b>		
Outpatient Hospital or Ambulatory Surgical Center Facility Services	[100%-70% after Deductible]	[70%-50% after Deductible]
Surgery, Assistant Surgeon, and Anesthesiology Services	[100%-70% after Deductible]	[70%-50% after Deductible]
<b>FACILITY CHARGES (Inpatient surgical or other services when rendered at a inpatient facility)</b>		
Hospital Inpatient Facility Confinement	[100%-70% after Deductible]	[70%-50% after Deductible]
Skilled Nursing Facility Services	[100%-70% after Deductible]	[70%-50% after Deductible]
Physician services, including consultations and diagnostic testing	[100%, 70% after Deductible]	[70%-50% after Deductible]

**EMERGENCY CARE**

Emergency Room	[100%-70% after Deductible]	[100%-70% after Deductible]
Ambulance Services – Ground, Air, and Water	[100%-70% after Deductible]	[100%-70% after Deductible]

**MENTAL, NERVOUS AND CHEMICAL DEPENDENCY DISORDERS**

Mental and Nervous Inpatient Care	[100%-70% after Deductible]	[70%-50% after Deductible]
[Mental, Nervous and Chemical Dependency Outpatient Care]	[50% after Deductible]	[50% after Deductible]

**HOSPITAL ROOM/DAILY RATE SCHEDULE (All applicable Deductibles and coinsurance will apply)**

Private or Semi-Private Room	[Up to the Most Common Semi-Private Room Rate]	[Up to the Most Common Semi-Private Room Rate]
If the Hospital does not provide semi-private rooms, the Hospital benefit will be paid at 90% of the Hospital's lowest priced private room rate. In the event a private room is Medically Necessary due to a contagious disease, We will consider the cost of the private room as a Covered Charge.		
Intensive Care Unit	[Up to the Most Common ICU Rate]	[Up to 3 times the Most Common Semi-Private Room Rate]
Observation Room or Intermediate Care Unit	[Up to 2 times the Most Common Semi-Private Room Rate]	[Up to 2 times the Most Common Semi-Private Room Rate]

**BENEFIT LIMITS**

All Benefit Limits are per Insured Person per Calendar Year

[Calendar Year Maximum Benefit for all Covered Charges combined][, including organ transplants provided in a Centers of Excellence]	[\$100,000][1,000,000-5,000,000]
Physical, Speech, or Occupational Therapy	[30-60 treatments per Calendar Year for any one type of therapy and up to 60-90 treatments per Calendar Year for any combination of these therapies]
Non-Surgical Back Treatment	[Limited to \$1,000-2,000 maximum benefit per Calendar Year]
Home Health Care	[A maximum 60-90 visits per Calendar Year]
Hospice Care	[Limited to 0-6 months of Covered Charges.]
Low Protein Modified Food Products	Not to exceed \$2,400 per child
Skilled Nursing Facility Services	[Limited to \$100-200 daily and a maximum of 60-90 days per Calendar Year ]
Mental and Nervous Inpatient Care	[A maximum 10-20 days per Calendar Year up to \$2,500-5,000 per Calendar Year]

[Mental and Nervous Outpatient Care]	[Daily maximum of \$50-100 not to exceed 25-50 visits per Calendar Year up to \$1,250-2,000 per Calendar Year]
[Mental, Nervous & Chemical Dependency Outpatient Care]	[Daily maximum of \$50 not to exceed 25 visits per Calendar Year up to \$1,250 per Calendar Year Maximum for Mental and Nervous Outpatient Care and Chemical Dependency Outpatient Care combined]
[Chemical Dependency Outpatient Care]	[Daily maximum of \$50-100 not to exceed 25-50 visits per Calendar Year up to \$1,250 per Calendar Year]
Organ Transplant Transportation Expense	[An allowance up to \$5,000-10,000 is available for transportation expenses per Transplant performed in a Center of Excellence]
Oral Surgery	[\$5,000-10,000] per Calendar Year]

**OPTIONAL BENEFITS**

[Optional Wellness Benefit Rider [YES/NO]

[\$0-50 Copay, then 100% up to \$250-1,000]

[Optional 24-Hour Occupation Coverage Rider [YES/NO]

[Optional Prescription Medication Benefit Rider [YES/NO]

[OPTION 1 – Rx Discount: No prescription drug card benefit. Specialty Drugs included – discount only]

[or]

**[OPTION 2**

	<b>Your Share of the Cost</b>	
	<b>Deductible</b>	<b>Copay</b>
Per <b>Generic</b> Prescription Order or Refill	None	\$15
Per <b>Formulary Brand Name</b> Prescription Order or Refill	\$250 per	\$45
Per <b>Non-formulary Brand Name</b> Prescription Order or Refill	Calendar Year*	\$60
Specialty Drugs	None	\$90]

[\*When three (3) individual Insured Persons in a family satisfy their Outpatient Prescription Medication Calendar Year Deductible, the remaining Outpatient Prescription Deductibles for any Insured Person in the family are deemed satisfied for the remainder of the Calendar Year.]

[ or]

**[OPTION 3**

	<b>Your Share of the Cost</b>
Per <b>Generic</b> Prescription Order or Refill	\$10-50 Copay
Per <b>Formulary Brand Name</b> Prescription Order or Refill	\$25-50 Copay
Per <b>Non-formulary Brand Name</b> Prescription Order or Refill	\$40-100 Copay

Specialty Drugs

\$50-200 Copay]

[ or ]

**[OPTION 4**

[Outpatient Prescription Medications, including oral contraceptives are covered by the plan subject to the same deductibles, coinsurance, out-of-pocket, and plan maximums as any other covered medical services. As such, and notwithstanding anything to the contrary found in this certificate, copayments by the insured under this option, accumulate to satisfy the plan's Calendar Year Deductible and Out-of-Pocket maximum amounts.

Specialty Drugs included]

**[Optional Life and Accidental Death and Dismemberment Benefit Rider [YES/NO]]**

Life Insurance Amount [\$10,000-\$100,000]  
Accidental Death and Dismemberment Insurance [The Principal Sum is equal to one times the Life Insurance Amount]

Ages 65-69 65% of selected amount  
Ages 70-74 40% of selected amount  
Ages 75-79 25% of selected amount  
Ages 80-84 15% of selected amount  
Ages 85+ 10% of selected amount]

**[Optional Dependent Life Insurance]**

Spouse Life Insurance Amount [\$2,000-4,000]

Children

Age 14 days, but less than 6 months [\$100-500]  
age 6 months, but less than 19 years [\$1,000-2,000]  
age 19 years, but less than 25 years [\$1,000-2,000]  
(if a student attending school on a full-time basis)]

**[Optional Supplemental Accident Coverage] [YES/NO]**

[100% up to a \$500-\$5,000 maximum benefit then copay, Deductible and coinsurance]

**[Optional Pregnancy Benefit] [YES/NO]**

[Optional for groups of 5-14 (fewer where mandated), mandatory for 15+ [In-Network Subject to Deductibles and coinsurance Out-of-Network Subject to Deductibles and Coinsurance]  
In-Vitro Fertilization lifetime maximum benefit - \$15,000]

**[Optional Weekly Disability Benefit]**

[Benefits begin:  
Day 1 due to an accident  
Day 8 due to a sickness  
Up to 26 weeks per disability.]

[YES/NO]  
[Up to a maximum benefit of \$[100-500] per  
week]]

<b>[Optional Dental Benefit Rider</b>	[YES/NO]		
	Plan 1		Plan 2
Lifetime Deductible	[\$25-50]		[\$25-50]
Calendar Year Deductible	[\$50-100 for Basic and Major, \$50-100 for Orthodontia (Maximum of three per family)]		[\$50-100 for Basic and Major (Maximum of three per family)]
Calendar Year Maximum	[\$1,500-2,000 for Preventive, Basic and Major \$1,000-2,000 for orthodontia]		[\$1,500-2,000 for Preventive, Basic and Major]
Lifetime Maximum	[\$1,000-2,000 for orthodontia]		[\$1,000-2,000 for orthodontia]
Waiting Periods			
Preventive and Basic	[None]		[None]
Major and Orthodontic(if included)	[12-24 months]		[12-24 months]
Covered Procedures			
Preventive Services (Type 1)	[Plan pays 100%]		[Plan pays 90%]
Basic Services(Type 2)	[Plan pays 80%]		[Plan pays 60%]
Major Service (Type 3)	[Plan pays 50%]		[Plan pays 70%]
Orthodontia (Type 4) (for children under age 19)	[Plan pays 50%]		[No coverage]]
<b>[Optional Vision Benefit Rider</b>	[YES/NO]]		
	<b>[In-Network Benefit]</b>	<b>[Out-Of-Network Benefit]</b>	<b>[Benefit Frequency]</b>
[Vision Exam	[\$10 or 20 copay]	[Up to \$35.00]	[12-24 Months]
Contact Lenses			[12-24 Months]
Conventional	[\$115.00 Allowance + 15% discount of the balance over	[Up to \$100.00]	

		\$115.00]		
Disposable		[\$115.00 Allowance + 100% of the balance over \$115.00]	[Up to \$100.00]	
Medically Necessary		[\$250.00 Allowance + 100% of the balance over \$250.00]	[Up to \$200.00]	
Glasses Frames		[\$100.00 Allowance + 20% discount of the balance over \$100.00]	[Up to \$45.00]	[12-24 Months]
Glasses Lenses				[12-24 Months]
Single vision		[\$25.00 copay]	[Up to \$25.00]	
Bifocal		[\$25.00 copay]	[Up to \$40.00]	
Trifocal		[\$25.00 copay]	[Up to \$55.00]	
Lenticular		[\$25.00 copay]	[Up to \$55.00]	
In-Network Lens Options (Additional Copays)				
Basic Progressives*		[\$45.00]	[N/A]	
Basic Polycarbonate		[\$35.00]	[N/A]	
Ultra violet		[\$12.00]	[N/A]	
Basic Anti-Reflective		[\$45.00]	[N/A]	
Tint (Solid & Gradient)		[\$12.00]	[N//A]	
Basic Scratch-Resistance		[\$15.00]	[N/A]	
Other Add-Ons & Service		[20% discount]	[N/A]]	
[*add-on to bifocal]				



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 Filing Company: Standard Security Life Insurance Company of New York State Tracking Number: 39832  
 Company Tracking Number: SSL MMC SB 0708  
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO  
 Product Name: SSL 0205 (0708) revised schedule pages  
 Project Name/Number: SSL 0708 revised schedule pages/SSL MMC SB 0708

## Supporting Document Schedules

<b>Satisfied -Name:</b> Certification/Notice	<b>Review Status:</b> Approved-Closed	08/18/2008
<b>Comments:</b>		
<b>Attachment:</b> Cert of Comp with Rule 19 SSL MMC SB 0708.pdf		
<b>Bypassed -Name:</b> Application	<b>Review Status:</b> Approved-Closed	08/18/2008
<b>Bypass Reason:</b> This is a schedule of benefits filing only.		
<b>Comments:</b>		
<b>Satisfied -Name:</b> Filing Fee schedule	<b>Review Status:</b> Approved-Closed	08/18/2008
<b>Comments:</b>		
<b>Attachment:</b> AR_Fee_Schedule SSL MMC SB 0708.pdf		
<b>Satisfied -Name:</b> SSL Authorization Letter	<b>Review Status:</b> Approved-Closed	08/18/2008
<b>Comments:</b>		
<b>Attachment:</b> ICC Authorization letter SSL 2008.pdf		
<b>Satisfied -Name:</b> Cover letter	<b>Review Status:</b> Approved-Closed	08/18/2008
<b>Comments:</b>		
<b>Attachment:</b> AR SSL MMC SB 0708.pdf		
<b>Satisfied -Name:</b> Cover letter 8/18/08	<b>Review Status:</b> Approved-Closed	08/18/2008





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

Insurer: Standard Security Life Insurance Company of New York

Form Number(s):     SSL MMC SS SB 0708 AR  
                          SSL MMC PPO SB 0708 AR  
                          SSL MMC DD SB 0708 AR

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.



Signature of Company Officer

Rachel Lipari

Name

President

Title

August 4, 2008

Date



ARKANSAS INSURANCE DEPARTMENT

1200 West Third Street
Little Rock Arkansas 72201-1904
501-371-2600

Mike Pickens
Insurance Commissioner

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: Standard Security Life Insurance Company
Company NAIC Code: 69078
Company Contact Person & Telephone #: Brenda Dawson, Insurance Compliance Consultants, Inc., (815) 316-6714
Form Number(s): SSL MMC SB 0708

\*\*\*\*\*
\* INSURANCE DEPARTMENT USE ONLY \*
\* ANALYST: AMOUNT: ROUTE SLIP: \*

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing \* x \$50 = \*\*Retaliatory

Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer. \* x \$50 = \*\*Retaliatory

Life and/or Disability Policy, Contract or Annuity Forms: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form. \*3 x \$20 = \$60 \*\*Retaliatory

Policy and contract forms, all lines, filing corrections in previously filed policy and contract forms. \* x \$20 = \*\*Retaliatory

Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer. \* x \$25 = \*\*Retaliatory

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to \* x \$400 =

amend an Insurer's Certificate of Authority.

Filing to amend Certificate of Authority.

\*\*\* \_\_\_\_\_ x \$100 = \_\_\_\_\_

\*THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE AND REGULATION 57.

\*\*THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.

\*\*\*THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. 23-61-401.



January 1, 2008

Mr. Brian Camling  
President  
Insurance Compliance Consultants, Inc.  
519 Colman Center Dr.  
Rockford, IL 61108

Dear Mr. Camling:

Please accept this letter as written confirmation that Insurance Compliance Consultants, Inc., has authority to file the attached form(s) or a state specific variation of it, and to act on behalf of Standard Security Life Insurance Company of New York regarding such filings, in all jurisdictions where this form(s) or a state specific variation of it is being filed. Standard Security may withdraw this authorization at any time, by giving notice to Insurance Compliance Consultants.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Kettig". The signature is fluid and cursive, with a long, sweeping tail.

David Kettig



INSURANCE  
COMPLIANCE  
CONSULTANTS, INC.

519 Colman Center Drive  
Rockford, Illinois 61108

Phone: (815) 316-6714  
FAX: (815) 316-6720

August 4, 2008

Honorable Julie Benafield Bowman  
Insurance Commissioner  
State of Arkansas  
Arkansas Department of Insurance  
1200 W. Third St.  
Little Rock, AR 72201-1904

RE: STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK - NAIC# 69078  
FEIN# 13-5679267  
Schedule of Benefits – SSL MMC DD SB 0708 AR  
Schedule of Benefits – SSL MMC PPO SB 0708 AR  
Schedule of Benefits – SSL MMC SD SB 0708 AR

Dear Commissioner Benafield Bowman:

Enclosed for review and approval for use in your state are the above referenced Schedules of Benefits. These Schedules of Benefits are new and are not intended to replace any Schedules of Benefit previously approved by your Department. These Schedules of Benefits are intended to be used with Group Major Medical Expense Policy form SSL MMC 0205 previously approved by your Department on June 30, 2005.

Insurance Compliance Consultants, Inc., is making this filing on behalf of Standard Security Life Insurance Company of New York. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc., at the address shown above.

These Schedules of Benefits reflect additional deductibles and various coinsurance amounts.

We certify that to the best of our knowledge and belief, that this form does not violate any laws or regulations of your state and does not contain any previously disapproved provisions.

These documents were prepared on a personal computer and will ultimately be printed from another data processing system that may cause some print style and/or page spacing changes. However, there will not be any changes to the non-variable text of the forms or to the general print size.

Your prompt review of this submission will be greatly appreciated. If I can provide any additional information, please contact me at (815)316-6714, fax me at (815)316-6720, or e-mail me at [Brendadawson@inscompliance.com](mailto:Brendadawson@inscompliance.com) . Thank you.

Sincerely,

Brenda Dawson, FLMI, AIRC, ACS  
Authorized Representative  
Insurance Compliance Consultants, Inc.



INSURANCE  
COMPLIANCE  
CONSULTANTS, INC.

519 Colman Center Drive  
Rockford, Illinois 61108

Phone: (815) 316-6714  
FAX: (815) 316-6720

August 18, 2008

Rosalind Minor  
State of Arkansas  
Arkansas Department of Insurance  
1200 W. Third St.  
Little Rock, AR 72201-1904

RE: STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK - NAIC# 69078  
FEIN# 13-5679267  
Schedule of Benefits – SSL MMC DD SB 0708 AR  
Schedule of Benefits – SSL MMC PPO SB 0708 AR  
Schedule of Benefits – SSL MMC SD SB 0708 AR  
Your letter dated August 16, 2008  
State Tracking # 39832  
SERFF Tracking # ICCI-125759352

Dear Ms. Minor:

Thank you for your letter of the above referenced date. This letter will serve as certification that the benefits payable between a PPO and a Non-PPO will not be more than a 25% differential.

Your continued review for approval is greatly appreciated. If I can provide any additional information, please contact me at (815)316-6714, fax me at (815)316-6720, or e-mail me at [Brendadawson@inscompliance.com](mailto:Brendadawson@inscompliance.com) . Thank you.

Sincerely,

Brenda Dawson, FLMI, AIRC, ACS  
Authorized Representative  
Insurance Compliance Consultants, Inc.