

SERFF Tracking Number: MCHX-125791748 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 40070  
 Company Tracking Number: 496.001.AR  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: 496.001.XX-TIC-Limited Benefit Certificate of Medi  
 Project Name/Number: 496.001.XX-TIC-Limited Benefit Certificate of Medical Office Visit Insurance-Assoc WS/496.001.XX-TIC-Limited Benefit Certificate of Medical Office Visit Insurance-Assoc WS

## Filing at a Glance

Company: Time Insurance Company

Product Name: 496.001.XX-TIC-Limited Benefit SERFF Tr Num: MCHX-125791748 State: ArkansasLH  
 Certificate of Medi

TOI: H21 Health - Other

SERFF Status: Closed

State Tr Num: 40070

Sub-TOI: H21.000 Health - Other

Co Tr Num: 496.001.AR

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: SPI McHughConsulting

Disposition Date: 09/05/2008

Date Submitted: 08/26/2008

Disposition Status: Approved-Closed

Implementation Date Requested: 09/26/2008

Implementation Date:

State Filing Description:

## General Information

Project Name: 496.001.XX-TIC-Limited Benefit Certificate of Medical Office Visit Insurance-Assoc WS Status of Filing in Domicile: Not Filed

Project Number: 496.001.XX-TIC-Limited Benefit Certificate of Medical Office Visit Insurance-Assoc WS 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: 09/05/2008

State Status Changed: 09/05/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Time Insurance Company

NAIC # 69477 FEIN # 39-0658730

Association Limited Benefit Medical Office Visit Expense Certificate

496.001.AR, et al - Certificate



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

## Company and Contact

### Filing Contact Information

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

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

### Filing Company Information

Time Insurance Company CoCode: 69477 State of Domicile: Wisconsin  
 501 West Michigan Avenue Group Code: 19 Company Type:  
 Milwaukee, WI 53201-0624 Group Name: State ID Number:  
 (414) 299-1140 ext. [Phone] FEIN Number: 39-0658730  
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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 #
Time Insurance Company	\$50.00	08/26/2008	22140924

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 Certificate of Medical Office Visit Insurance-Assoc WS

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/05/2008	09/05/2008

### 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	08/28/2008	08/28/2008	SPI McHughConsulting	09/04/2008	09/04/2008

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Certificate of Medical Office Visit Insurance-Assoc WS

## **Disposition**

Disposition Date: 09/05/2008

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	No
Supporting Document	Application	Approved-Closed	No
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	No
Supporting Document	08.26.08 Submission Letter	Approved-Closed	No
Supporting Document	Authorization Letter	Approved-Closed	No
Supporting Document	Forms Listing	Approved-Closed	No
Supporting Document	Statement of Variability	Approved-Closed	No
Supporting Document	09.04.08 Resubmission Letter	Approved-Closed	No
Form	Limited Benefit Certificate of Medical Office Visit Insurance-I. Medical Benefits	Approved-Closed	No
Form	Limited Benefit Certificate of Medical Office Visit Insurance-II Outpatient Prescription Drug Benefits	Approved-Closed	No
Form	Limited Benefit Certificate of Medical Office Visit Insurance-III. Exclusions	Approved-Closed	No
Form	Limited Benefit Certificate of Medical Office Visit Insurance-IV. Claim Provisions	Approved-Closed	No
Form	Limited Benefit Certificate of Medical Office Visit Insurance-V. Premium Provisions	Approved-Closed	No
Form	Limited Benefit Certificate of Medical Office Visit Insurance-VI. Effective Date and Termination Date	Approved-Closed	No
Form	Limited Benefit Certificate of Medical Office Visit Insurance-VII. Other Provisions	Approved-Closed	No
Form	Limited Benefit Certificate of Medical Office Visit Insurance-VIII. Definitions	Approved-Closed	No
Form (revised)	LIMITED BENEFIT CERTIFICATE OF MEDICAL OFFICE VISIT INSURANCE	Approved-Closed	No
Form	LIMITED BENEFIT CERTIFICATE OF MEDICAL OFFICE VISIT INSURANCE	Withdrawn	No

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<b>Form</b>	Limited Benefit Medical Office Visit Insurance Benefit Summary	Approved-Closed	No
<b>Form</b>	Enrollment Application	Approved-Closed	No
<b>Form</b>	OFFER of OPTIONAL TREATMENT OF ALCOHOL AND OTHER DRUG DEPENDENCY COVERAGE	Approved-Closed	No
<b>Form</b>	OFFER of OPTIONAL MAMMOGRAM SCREENING COVERAGE	Approved-Closed	No
<b>Form</b>	OPTIONAL MUSCULOSKELETAL DISORDERS OF THE FACE, NECK OR HEAD BENEFITS OFFER	Approved-Closed	No
<b>Form</b>	OFFER of OPTIONAL MENTAL ILLNESS COVERAGE	Approved-Closed	No
<b>Form</b>	OPTIONAL HOSPICE BENEFITS OFFER	Approved-Closed	No
<b>Form</b>	Supplemental Notice to Master Group Policy Application	Approved-Closed	No

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 08/28/2008  
Submitted Date 08/28/2008

Respond By Date

Dear Lauren Regnery,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Limited Benefit Certificate of Medical Office Visit Insurance-I. Medical Benefits (Form)
- Limited Benefit Certificate of Medical Office Visit Insurance-II Outpatient Prescription Drug Benefits (Form)
- Limited Benefit Certificate of Medical Office Visit Insurance-III. Exclusions (Form)
- Limited Benefit Certificate of Medical Office Visit Insurance-IV. Claim Provisions (Form)
- Limited Benefit Certificate of Medical Office Visit Insurance-V. Premium Provisions (Form)
- Limited Benefit Certificate of Medical Office Visit Insurance-VI. Effective Date and Termination Date (Form)
- Limited Benefit Certificate of Medical Office Visit Insurance-VII. Other Provisions (Form)
- Limited Benefit Certificate of Medical Office Visit Insurance-VIII. Definitions (Form)

Comment:

These forms did not have attachments for review.

### Objection 2

- LIMITED BENEFIT CERTIFICATE OF MEDICAL OFFICE VISIT INSURANCE (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. ACA 23-86-108(4) and Bulletin 14-81.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

## Response Letter

SERFF Tracking Number: MCHX-125791748 State: Arkansas  
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Project Name/Number: 496.001.XX-TIC-Limited Benefit Certificate of Medical Office Visit Insurance-Assoc WS/496.001.XX-TIC-Limited Benefit Certificate of Medical Office Visit Insurance-Assoc WS

Response Letter Status Submitted to State  
Response Letter Date 09/04/2008  
Submitted Date 09/04/2008

Dear Rosalind Minor,

**Comments:**

Attached is a response to your August 28, 2008 objection letter.

**Response 1**

Comments: Please see the attached response to your August 28, 2008 objection letter.

**Related Objection 1**

Applies To:

- Limited Benefit Certificate of Medical Office Visit Insurance-I. Medical Benefits (Form)
- Limited Benefit Certificate of Medical Office Visit Insurance-II Outpatient Prescription Drug Benefits (Form)
- Limited Benefit Certificate of Medical Office Visit Insurance-III. Exclusions (Form)
- Limited Benefit Certificate of Medical Office Visit Insurance-IV. Claim Provisions (Form)
- Limited Benefit Certificate of Medical Office Visit Insurance-V. Premium Provisions (Form)
- Limited Benefit Certificate of Medical Office Visit Insurance-VI. Effective Date and Termination Date (Form)
- Limited Benefit Certificate of Medical Office Visit Insurance-VII. Other Provisions (Form)
- Limited Benefit Certificate of Medical Office Visit Insurance-VIII. Definitions (Form)

Comment:

These forms did not have attachments for review.

**Related Objection 2**

Applies To:

- LIMITED BENEFIT CERTIFICATE OF MEDICAL OFFICE VISIT INSURANCE (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. ACA 23-86-108(4) and Bulletin 14-81.

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**Changed Items:**

**Supporting Document Schedule Item Changes**

Satisfied -Name: 09.04.08 Resubmission Letter  
 Comment:

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
LIMITED BENEFIT CERTIFICATE OF MEDICAL OFFICE VISIT INSURANCE	496.001.A	R	Certificate	Revised		64	496_001_AR.PDF
<b>Previous Version</b>							
LIMITED BENEFIT CERTIFICATE OF MEDICAL OFFICE VISIT INSURANCE	496.001.A	R	Certificate	Initial		64	496_001_AR.PDF

No Rate/Rule Schedule items changed.

Thank you for your continued assistance with this file

Sincerely,  
 SPI McHughConsulting

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## Form Schedule

Lead Form Number: 496.001.AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	496.002.AR	Certificate	Limited Benefit Certificate of Medical Office Visit Insurance-I. Medical Benefits	Initial		64	
Approved-Closed	496.003.AR	Certificate	Limited Benefit Certificate of Medical Office Visit Insurance-II Outpatient Prescription Drug Benefits	Initial		64	
Approved-Closed	496.004.XX	Certificate	Limited Benefit Certificate of Medical Office Visit Insurance-III. Exclusions	Initial		64	
Approved-Closed	496.005.XX	Certificate	Limited Benefit Certificate of Medical Office Visit Insurance-IV. Claim Provisions	Initial		64	
Approved-Closed	496.006.AR	Certificate	Limited Benefit Certificate of Medical Office Visit Insurance-V. Premium Provisions	Initial		64	
Approved-Closed	496.007.AR	Certificate	Limited Benefit Certificate of Medical Office Visit Insurance-VI.	Initial		64	

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Effective Date and Termination Date

Approved- Closed	496.008.AR	Certificate	Limited Benefit	Initial	64	
			Certificate of Medical Office Visit Insurance-VII. Other Provisions			
Approved- Closed	496.009.AR	Certificate	Limited Benefit	Initial	64	
			Certificate of Medical Office Visit Insurance-VIII. Definitions			
Approved- Closed	496.001.AR	Certificate	LIMITED BENEFIT CERTIFICATE OF MEDICAL OFFICE VISIT INSURANCE	Revised	64	496_001_AR.PDF
						Replaced Form #: Previous Filing #:
Approved- Closed	496.BNS.A	Schedule R	Limited Benefit	Initial	40	496_BNS_AR.PDF
		Pages	Medical Office Visit Insurance Benefit Summary			
Approved- Closed	29700	Application/	Enrollment	Initial	40	29700.PDF
		Enrollment Form	Application			
Approved- Closed	9038-AR	Certificate	OFFER of	Initial	40	9038-AR.PDF
		Amendmen	OPTIONAL			
		t, Insert	TREATMENT OF			
		Page,	ALCOHOL AND			
		Endorseme	OTHER DRUG			
		nt or Rider	DEPENDENCY			
			COVERAGE			
Approved- Closed	9040-AR	Certificate	OFFER of	Initial	40	9040-AR.PDF
		Amendmen	OPTIONAL			
		t, Insert	MAMMOGRAM			
		Page,	SCREENING			
		Endorseme	COVERAGE			
		nt or Rider				
Approved- Closed	9044-AR	Certificate	OPTIONAL	Initial	40	9044-AR.PDF

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Closed	Amendmen MUSCULOSKELETA t, Insert L DISORDERS OF Page, THE FACE, NECK Endorseme OR HEAD nt or Rider BENEFITS OFFER			
Approved- Closed	9046-AR Certificate OFFER of Initial Amendmen OPTIONAL MENTAL t, Insert ILLNESS Page, COVERAGE Endorseme nt or Rider	40	9046-AR.PDF	
Approved- Closed	9048-AR Certificate OPTIONAL Initial Amendmen HOSPICE t, Insert BENEFITS OFFER Page, Endorseme nt or Rider	40	9048-AR.PDF	
Approved- Closed	AR-TMJ Other Supplemental Notice Initial Notice to Master Group Policy Application	100	AR-TMJ Notice.PDF	



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

**LIMITED BENEFIT CERTIFICATE OF MEDICAL OFFICE VISIT INSURANCE  
With Limited Outpatient Prescription Drug Benefits**

This certificate provides limited benefits and maximums. This plan does not provide benefits for mastectomy.

The insurance described in this certificate is effective on the date shown in the Benefit Summary only if You are eligible for the insurance, become insured, and remain insured subject to the terms, limits and conditions of this plan. This certificate is evidence of Your coverage under the Policy of medical insurance issued to a[n] [association/trust].

This certificate describes the benefits and major provisions which affect Covered Persons. The final interpretation of any specific provision is based on the terms of the Policy. [The Policy is issued in the State of [Illinois] and is governed by applicable laws of that State and federal laws, except as otherwise provided by this certificate or the Policy.] The Policy may be examined at Our Home Office or the main office of the Policyholder.

This certificate is issued based on the statements and agreements in the enrollment form and during the enrollment process, any exam that may be required, any other amendments or supplements and payment of the required premium. This certificate and/or the Policy may be changed. If that happens, You will be notified of any such changes.

**RIGHT TO EXAMINE CERTIFICATE FOR 10 DAYS**

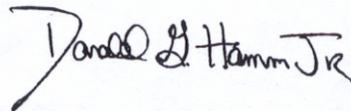
If You are not satisfied, return the certificate to Us or Our agent within [10] days after You have received it. All premiums will be refunded and Your coverage will be void from the Effective Date.

**IMPORTANT NOTICE CONCERNING STATEMENTS  
IN YOUR ENROLLMENT FORM FOR INSURANCE**

Please read the copy of the enrollment form included with this certificate. We issued this coverage in reliance upon the accuracy and completeness of the information provided in the enrollment form and during the enrollment process. [If a material omission or misstatement is made in the enrollment form, We have the right to deny any claim, rescind the coverage and/or modify the terms of the coverage or the premium amount.] Carefully check the enrollment form and, if any information shown in the enrollment form is not correct and complete, write to Us at the address above, within 10 days.



Secretary



President

**This certificate has limited benefits and annual maximums. Read Your certificate carefully to understand any coverage limitations. Read the Benefit Summary for information on what benefits are provided for Covered Charges.**

**GUIDE TO YOUR COVERAGE**

The sections of the certificate appear in the following order:

- I Medical Benefits
- II Outpatient Prescription Drug Benefits
- III Exclusions
- IV Claim Provisions
- V Premium Provisions
- VI Effective Date and Termination Date
- VII Other Provisions
- VIII Definitions

## **[I.] MEDICAL BENEFITS**

We will pay Covered Charges only for the treatment and services Incurred as part of an Office Visit or covered Diagnostic Imaging and laboratory services as listed in this section of the plan as Medical Benefits, including those for Preventive, Restorative and Other Medical Services. How Covered Charges are paid and the maximum benefit for the Covered treatment and services listed in this section are shown in the Benefit Summary. Refer to the Exclusion section of the plan for treatment, services and supplies that are not covered.

After the Covered Person has paid any Copayment[,Deductible,] [Coinsurance] or any other applicable fees, benefits will be paid by Us for Covered Charges for the services listed in this section and according to the terms shown in the Benefit Summary. Benefits paid under this section will be applied to any applicable maximum benefit limitations provided under this plan and in the benefit summary. Benefits are subject to all the terms, limits and conditions in this plan. Any Copayment[, Deductible,] [Coinsurance] or any other applicable fees under this section will not count toward satisfying any Ancillary Charge, Prescription Drug Copayment or any other fees under the Outpatient Prescription Drug Benefits section.

[Unless a Prescription Drug is specifically listed as a Covered Charge in the Medical Benefits section, all Prescription Drugs that are received on an Outpatient basis are considered for benefits under the Outpatient Prescription Drug Benefits section. When the maximum benefit has been paid for any charges covered under the Medical Benefits section, any amount in excess of this maximum benefit is not covered under the Outpatient Prescription Drug Benefits section.]

We pay only for the following Covered Charges:

### **Office Visit Benefits**

Office Visit charges Incurred for services performed during an Office Visit for a Covered Person are payable as shown in the Benefit Summary. [For the purpose of this provision, Office Visits include evaluation and management services as defined in the most recent edition of Current Procedural Terminology [and preventive medicine services].] [An Office Visit will also include [minor] [surgical procedures performed during the Office Visit,] [allergy testing,] [allergy shots,] [immunotherapy injections of inhaled allergens,] [preventive medicine services][and][ diabetic treatment including: routine eye exams, nutritional counseling, diabetic training, routine foot care, and home glucose monitoring training].Office Visit benefits also include Children's Preventive Health Care Services for Covered Dependent children limited to one Office Visit at approximately the following age intervals: 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, ten years, twelve years, fourteen years, sixteen years, and eighteen years.

[Covered Charges will not include [magnetic resonance imaging (MRI),] [computerized axial tomography (CAT scan),] [preventive medicine services,] [chemotherapy,] [allergy testing,] [cardiac rehabilitation programs,] [dialysis,] [occupational therapy,] [physical therapy,] [radiation therapy,] [respiratory therapy,] [infusion of medications] [speech therapy,] [and] [the administration of anesthesia] [or] [any other service not specifically listed as a Covered Charge in the Benefit Summary for this Office Visit provision].]

### **Diagnostic Imaging and Laboratory Services Benefits**

Services that are provided by a Health Care Practitioner for Diagnostic Imaging services and laboratory services[, if a written report with interpretation is produced directly by the Health Care Practitioner], including interpretation thereof, are payable as shown in the Benefit Summary.

Benefits include testing of Covered Dependent newborn children for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia and all other disorders of metabolism for which screening is performed by or for the State of Arkansas.  
496.002.AR

## **[[II.] OUTPATIENT PRESCRIPTION DRUG BENEFITS**

Only the drugs, medicines and supplies listed in this section as Outpatient Prescription Drug Benefits will be considered a Covered Charge. How Covered Charges are paid and the maximum benefit for the covered drugs, medicines and supplies listed in this section are shown in the Benefit Summary. Refer to the Exclusions section of the plan for drugs, medicines and supplies that are not covered.

**THE COVERED PERSON MUST USE THE PARTICIPATING PHARMACY NETWORK TO RECEIVE THE MAXIMUM BENEFITS AVAILABLE.**

[Prior Authorization may be required for certain drugs, medicines and supplies before they are considered for coverage under the Outpatient Prescription Drug Benefits section. Please access the website listed on the back of the identification (ID) card to receive information on which drugs, medicines and supplies require prior authorization and to check prescription drug coverage and pricing or to locate a Participating Pharmacy.]

After the Covered Person has paid any Ancillary Charge, Prescription Drug Copayment or any other applicable fees, benefits will be paid by Us for Covered Charges for the drugs, medicines and supplies listed in this section. Any applicable Prescription Drug Copayment and the time period to which it applies are shown in the Benefit Summary. Benefits paid under this section will be applied to [the Maximum Lifetime Benefit and are also subject to] any [other] applicable maximum benefit provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.

Any Ancillary Charge, Prescription Drug Copayment or any other applicable fees under this section will not count toward satisfying any Copayment or any other fees under the Medical Benefits section.

Unless a Prescription Drug is specifically listed as a Covered Charge in the Medical Benefits section, all Prescription Drugs that are received on an Outpatient basis are considered for benefits under the Outpatient Prescription Drug Benefits section. When the maximum benefit has been paid for any charges covered under the Outpatient Prescription Drug Benefits section, any amount in excess of this maximum benefit is not covered under the Medical Benefits section.

### **Outpatient Prescription Drug Benefits**

This plan provides benefits only for the following Covered Charges for drugs, medicines and supplies that are received on an Outpatient basis:

1. Prescription Drugs that are fully approved by the U.S. Food and Drug Administration (FDA) for marketing in the United States and can be obtained only with a Prescription Order from a Health Care Practitioner, including a prescription drug and the Medically Necessary services associated with the administration of the drug, for cancer treatment even if the off-label use of such prescription drug has not been approved by the FDA for that type of cancer for which the drug has been prescribed, provided:
  - i. The drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one (1) or more such compendia:
    1. The American Hospital Formulary Service drug information;
    2. The United States Pharmacopoeia dispensing information; or
  - ii. The drug has been recognized as safe and effective for treatment of that specific type of cancer in two (2) articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature.
2. .
3. Up to a 30 consecutive day supply for each Prescription Order, unless restricted to a lesser amount by the Prescription Order, the manufacturers' packaging or any limitations in this plan.
4. Up to 3 vials or up to a 30 consecutive day supply of one type of self-injectable insulin for each Prescription Order, whichever is less.
4. Up to 100 disposable insulin syringes and needles, up to 100 disposable blood/urine/glucose/acetone testing agents, or up to 100 lancets, or up to a 30 consecutive day supply for each Prescription Order, whichever is less.
5. Prescription Drugs, in dosages, dosage forms, dosage regimens and durations of treatment that are Medically Necessary for the treatment of a Sickness or an Injury that is covered under this plan, and for FDA approved Prescription Drugs for use as contraceptive drugs or devices including oral contraceptives, contraceptive patches, contraceptive vaginal rings, diaphragms, injectables and implants.
6. Prescription Drugs that are within the quantity, supply, cost-sharing or other limits that We determine are appropriate for a Prescription Drug.
7. Prescription Drugs and Prescription Drug products if all active ingredients are covered under this plan.

### **Manufacturer's Packaging Limits**

Some Prescription Drugs may be subject to additional supply, quantity, duration, gender, age, lifetime, cost sharing or other limits based on the manufacturer's packaging, plan limits or the Prescription Order. Examples of these situations are:

1. If a Prescription Drug is taken on an as-needed basis, only enough medication for a single episode of care may be covered per Prescription Drug Copayment; or
2. If two or more covered Prescription Drug products are packaged and/or manufactured together, the Covered Person may be required to pay a Prescription Drug Copayment for each of the Prescription Drug products contained in the packaging and/or in the combination Prescription Drug product; or
3. If two or more Prescription Drug products are packaged and/or manufactured together and one or more of the active ingredients in the products are not covered under this plan, then the entire packaged and/or manufactured combination product is also not covered under this plan; or
4. If a Compounded Medication contains one or more active ingredients that are not covered under this plan, then the entire Compounded Medication is also not covered under this plan.

Any Prescription Drug which is a metabolite, isomer, extended release or other dosage form, unique salt or other formulation, or other direct or indirect derivative of a Prescription Drug approved by the FDA may be subject to similar terms, limits and conditions of coverage or will not be covered by this plan if the original drug would not be covered.

### **Participating Pharmacy**

The following provisions apply to covered Outpatient drugs, medicines and supplies purchased at a Participating Pharmacy when the identification (ID) card is presented to the Participating Pharmacy:

1. The Covered Person must pay the Participating Pharmacy the difference between the entire amount charged for a covered Prescription Drug and the amount We will pay.
2. When a covered Generic Drug is available and that Generic Drug is received, the Covered Person pays the Prescription Drug Copayment for that Generic Drug as shown in the Benefit Summary.
3. When a Generic Drug is not available and a Brand Name Drug is received, the Covered Person pays the Prescription Drug Copayment for that Brand Name Drug as shown in the Benefit Summary.
4. If a Brand Name Drug is received when a Generic Drug is available, the Covered Person pays the Prescription Drug Copayment for that Brand Name Drug, as shown in the Benefit Summary, plus the difference in the Contracted Rate between the cost of the Brand Name Drug and the Generic Drug. The difference in the Contracted Rate between the two drugs will not be reimbursed by Us nor does it count toward satisfying any Copayment[, Deductible] [or] [Coinsurance] under any section of this plan.
5. When a covered Prescription Drug is available under two or more names, dosages, dosage forms, dosage regimens or manufacturers' packaging or when more than one covered Prescription Drug may be used to treat a covered condition, We will consider benefits only for the most cost effective drug, dosage form or packaging that would be a Covered Charge under the plan and that will produce a professionally adequate result.

The following provisions apply to covered Outpatient drugs, medicines and supplies purchased at a Participating Pharmacy when the identification (ID) card is not presented to the Participating Pharmacy:

1. The Covered Person must pay the entire amount charged for a Prescription Drug to the Participating Pharmacy.
2. To receive reimbursement for Covered Charges, the Covered Person must file a claim with Us. A prescription drug claim form must be completed. This form can be obtained from Us. Send it and any Prescription Drug receipts to the Prescription Card Service Administrator (PCSA) at the address shown on the form for reimbursement of Covered Charges.
3. The Covered Person will be reimbursed at the Contracted Rate that would have been paid to a Participating Pharmacy for the cost of the covered Prescription Drug minus any applicable Ancillary Charge and Prescription Drug Copayment.

### **Non-Participating Pharmacy**

The following provisions apply to covered Outpatient drugs, medicines and supplies purchased at a Non-Participating Pharmacy:

1. The Covered Person must pay the entire amount charged for a Prescription Drug to the Non-Participating Pharmacy.
2. To receive reimbursement for Covered Charges, the Covered Person must file a claim with Us. A prescription drug claim form must be completed. This form can be obtained from Us. Send it and any Prescription Drug receipts to the address shown on the form for reimbursement of Covered Charges.
3. The Covered Person will be reimbursed at the Contracted Rate that would have been paid to a Participating Pharmacy for the cost of the covered Prescription Drug minus any applicable Ancillary Charge and Prescription Drug Copayment.

### **Miscellaneous Provisions**

No benefits are payable for any Prescription Order filled for a Covered Person on or after the date his or her coverage terminates under this plan. Thus, all Covered Persons are required to turn in their identification (ID) card at the time of coverage termination. If You fail to do so and any Covered Person uses the ID card after coverage ends, You are responsible for all Prescription Drugs purchased after the termination date. We will recover from You any amounts paid by Us for drugs purchased after coverage terminates under the plan.

The amount paid by Us under the Outpatient Prescription Drug Benefits section may not reflect the ultimate cost to Us for the Prescription Drug. Any amounts that the Covered Person is responsible for paying are paid on a per prescription or refill basis and will not be adjusted if We receive any retrospective volume drug discounts or Prescription Drug rebates under any portion of the plan. Manufacturer product discounts, also known as rebates, may be sent back to Us and may be related to certain drug purchases under the Plan. These amounts will be retained by Us.

The Covered Person is responsible for any Prescription Drug Copayment that is paid for a Prescription Order that is filled, regardless of whether the Prescription Order is revoked or changed due to adverse reaction or changes in dosage, dosage regimen or Prescription Order. These charges will not be reimbursed by Us.

[Payment by Us for a Prescription Drug under this section does not constitute any assumption of liability for coverage of a Sickness or an Injury under the Medical Benefits section. It also does not constitute any assumption of liability for further coverage of the Prescription Drug under this section.]

496.003.AR

### **[III.] EXCLUSIONS**

We will not pay benefits for any of the following:

1. Charges that:
  - a. Are not specifically listed as a Covered Charge under the Medical Benefits and Outpatient Prescription Drug Benefits provisions.
  - b. Are Incurred before the Covered Person's Effective Date or after the termination date of coverage.
2. [Charges for: a condition that arises out of, or is the result of, any work for wage or profit; a work-related condition that is eligible for benefits under worker's compensation, employers' liability or similar laws even when the Covered Person does not file a claim for benefits. This exclusion will not apply to a Covered Person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage. However, the Covered Person must receive services in accordance with the Medical Benefits section.]
3. Charges for:
  - a. Dental care that is routine.
  - b. A masseur, masseuse or massage therapist; massage therapy; a rolfer.
4. [Charges for:
  - [a.] [Non-medical items, self-care or self-help programs.]
  - [b.] [Aroma therapy.]
  - [c.] [Meditation or relaxation therapy.]
  - [d.] [Naturopathic medicine.]
  - [e.] [Treatment of hyperhidrosis (excessive sweating).]
  - [f.] [Acupuncture; biofeedback; neurotherapy; electrical stimulation.]
  - [g.] [Treatment of spider veins.]
  - [h.] [Family or marriage counseling.]
  - [i.] [Applied behavior therapy treatment for autistic spectrum disorders.]
  - [j.] [Smoking deterrence or cessation.]
  - [k.] [Snoring or sleep disorders, such as obstructive sleep apnea.]
  - [l.] [Change in skin coloring or pigmentation.]
  - [m.] [Stress management.]
  - [n.] [Medical supplies and equipment, except as specifically covered under the Medical Benefits or Outpatient Prescription Drug Benefits provisions.]
5. [Charges for treatment of an Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, exceeded the blood alcohol level otherwise permitted by law or violated legal standards for a person

operating a motor vehicle in the state where the Injury occurred. This exclusion applies whether or not the Covered Person is charged with any violation in connection with the Accident.]

6. [Charges for services ordered, directed or performed by a Health Care Practitioner or supplies purchased from a Medical Supply Provider who is a Covered Person, an Immediate Family Member, employer of a Covered Person or a person who ordinarily resides with a Covered Person. ]

7. Charges for any amount in excess of any maximum benefit for covered services.

8. [Charges that do not meet the definition of a Covered Charge in this plan including, but not limited to, charges that are not Medically Necessary.]

9. [Charges Incurred outside of the United States, including charges for drugs or medicines obtained from pharmacy provider sources outside the United States.]

10. Charges for vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner.

11. Charges for any over-the-counter drugs or medicines whether or not prescribed by a Health Care Practitioner.

12. Charges for drugs or medicines used to treat, impact or influence: athletic performance; body conditioning, strengthening, or energy; social phobias; slowing the normal processes of aging; daytime drowsiness; overactive bladder; dry mouth; excessive salivation; genetic make-up or genetic predisposition; prevention or treatment of hair loss, excessive hair growth or abnormal hair patterns.

13. [Charges for: unit-dose drugs; drugs or medicines used to treat onychomycosis (nail fungus); botulinum toxin and its derivatives.]

14. [Charges for drugs or medicines: prescribed for treatment of a condition that is not specifically listed as a Covered Charge; that are illegal under federal law, such as marijuana, even if they are prescribed for a medical use in a state.]

15. [Charges under the Outpatient Prescription Drug Benefits section for: biological sera; vaccines and other immunizing agents; injectable parenteral administration, except insulin or Imitrex.]

496.004.XX

#### [IV.] CLAIM PROVISIONS

##### **Proof of Loss**

Most providers will file claims directly with Us. You are responsible for filing a claim with Us if the provider does not file it. The following provisions tell You how to file claims with Us.

We must receive written or electronic notice of the services that were received for which the claim is made. Notice must be provided to Us within [60 days] after a covered loss occurs or as soon as reasonably possible. Unless You are declared incompetent by a court of law, proof of loss must be sent to Us within [12 months] of the date of loss.

The proof of loss must include all of the following:

1. Your name and certificate number.
2. The name of the Covered Person who Incurred the claim.
3. The name and address of the provider of the services.
4. An itemized bill from the provider of the services that includes all of the following as appropriate:
  - a. International Classification of Diseases (ICD) diagnosis codes.
  - b. International Classification of Diseases (ICD) procedures.
  - c. Current Procedural Terminology (CPT) codes.
  - d. Healthcare Common Procedure Coding System (HCPCS) level II codes.
  - e. National Drug Codes (NDC).

When We receive written or electronic proof of loss, We may require additional information. You must furnish all items We decide are necessary to determine Our liability in accordance with the Right to Collect Information provision in this section. We will not pay benefits if the required information or authorization for its release is not furnished to Us.

##### **Right to Collect Information**

To determine Our liability, We may request additional information from a Covered Person, Health Care Practitioner, facility, or other individual or entity. A Covered Person must cooperate with Us, and assist Us by obtaining the following information within [30 days] of Our request. Charges will be denied if We are unable to determine Our liability because a Covered Person, Health Care Practitioner, facility, or other individual or entity failed to:

1. Authorize the release of all medical records to Us and other information We requested.
2. Provide Us with information We requested about pending claims, Other Insurance coverage or proof of creditable coverage.
3. Provide Us with information that is accurate and complete.
4. Have any examination completed as requested by Us.

5. Provide reasonable cooperation to any requests made by Us.

Such charges may be considered for benefits upon receipt of the requested information, provided all necessary information is received prior to expiration of the time allowed for submission of claim information as set forth in this Claim Provisions section.

#### **Physical Examination**

We have the right to have a Health Care Practitioner of Our choice examine a Covered Person at any time regarding a claim for benefits. These exams will be paid by Us.

#### **Payment of Benefits**

Benefits will be paid when We receive due written proof of loss, subject to any time period requirements under state law. Benefits for services provided will be paid to the Certificate Holder unless they have been assigned to a provider. However, We pay Participating Pharmacy providers directly for Covered Charges. Any benefits unpaid at Your death will be paid at Our option to Your spouse, [Your Domestic Partner,] Your estate or the providers of the services.

We will pay medical claims when coded according to the latest editions of the Current Procedural Terminology (CPT) manual or International Classification of Diseases (ICD) manual. We will not pay for: charges that are billed separately as professional services when the procedure requires only a technical component; or charges that are billed incorrectly or billed separately but are an integral part of another billed service, as determined by Us; or other claims that are improperly billed; or duplicates of previously received or processed claims.

Any amount We pay in good faith will release Us from further liability for that amount. Payment by Us does not constitute any assumption of liability for further coverage under this plan. Payment by Us for a Prescription Drug under the Outpatient Prescription Drug Benefits section does not constitute any assumption of liability for coverage of a condition under the Medical Benefits section.

#### **[Payment of Outpatient Prescription Drug Benefits**

Present the ID card with the Prescription Order at the Pharmacy each time a Prescription Order is filled at a Participating Pharmacy. Pay the Participating Pharmacy the difference between the charge for the covered Prescription Drug and the amount We will pay. This applies to each covered Prescription Drug that is filled at a Participating Pharmacy. If the ID card is not used to obtain Prescription Drugs at a Participating Pharmacy, the Covered Person must pay the Participating Pharmacy the entire amount charged for the covered Prescription Drug. Complete a prescription drug claim form. Send it and any Prescription Drug receipts to the Prescription Card Service Administrator (PCSA) at the address shown on the form for reimbursement of Covered Charges. A prescription drug claim form can be obtained from Us.

At a Non-Participating Pharmacy, the Covered Person must pay the Pharmacy the entire amount charged for the covered Prescription Drug. Complete a prescription drug claim form. Send it and any Prescription Drug receipts to the address shown on the form for reimbursement of Covered Charges. A prescription drug claim form can be obtained from Us. ]

#### **Overpayment**

If a benefit is paid under this plan and it is later shown that a lesser amount should have been paid, We will be entitled to recover the excess amount from You or the person or entity receiving the incorrect payment. We may offset any overpayment to You or a provider against future benefit payments.

#### **Rights of Administration**

We maintain Our ability to determine Our rights and obligations under this plan including, without limitation, the eligibility for and amount of any benefits payable.

#### **Claims Involving Misrepresentation or Fraud**

Claims will be denied in whole or in part in the event of misrepresentation or fraud by a Covered Person or a Covered Person's representative. If benefits are paid under this plan and it is later shown the claims for these benefits involved misrepresentation or fraud, We will be entitled to a refund from You or the person or entity receiving the payment.

A claim will not be honored if the Covered Person or the provider of the charges will not, or cannot, provide adequate documentation to substantiate that treatment was rendered for the claim submitted. If the Covered Person, or anyone acting on the Covered Person's behalf, knowingly files a fraudulent claim, claims may be denied in whole or in part, coverage may be terminated or rescinded, and the Covered Person may be subject to civil and/or criminal penalties.

#### **Workers' Compensation Not Affected**

Insurance under this plan does not replace or affect any requirements for coverage by workers' compensation insurance. If state law allows, We may participate in a workers' compensation dispute arising from a claim for which We paid benefits.

**Claim Appeal**

You have the right to request a review of all adverse claim decisions. A review must be requested in writing within [180 days] following Your receipt of the notice that the claim was denied or reduced.  
496.005.XX

**[V.] PREMIUM PROVISIONS****Consideration**

This plan is issued based on the statements and agreements in the Covered Person's enrollment form and during the enrollment process, any exam of a Covered Person that is required, any other amendments or supplements to the enrollment form and payment of the required premium. Each renewal premium is payable on the due date subject to the Grace Period provision in this section.

**Premium Payment**

The initial premium must be paid on or before the due date for this coverage to be in force. Subsequent premiums are due as billed by Us. Each renewal premium must be received by Us on its due date subject to the Grace Period provision in this section. Premiums must be received in cash or check at Our office on the date due. [We may agree to accept premium payment in alternative forms, such as credit card [or automatic charge to a bank account].] [We reserve the right to dishonor any such agreement for payment of premium during the grace period if We tried to obtain payment for the amount due using the alternative method but were unsuccessful.]

Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic area, gender, age, payment method and plan design. All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You add or delete Covered Dependents, change the payment method, move to another zip code or otherwise change the coverage. [The mode of payment (monthly, quarterly or other) is subject to change at Our discretion.]

**Grace Period**

There is a grace period of [31 days] for the payment of each premium due after the initial premium. If the full premium due is not received at Our Home Office by the end of the grace period, the coverage will end on the date that the unpaid premium was due and no charges Incurred during the grace period will be considered for benefits. If the premium is received during or by the end of the grace period, coverage will continue without interruption unless You call Our office or give Us written notice to cancel the coverage.

**Reinstatement**

If any premium is not paid within the required time period, coverage for You and any Covered Dependents will lapse. The coverage will be reinstated if all of the following requirements are met:

1. The lapse was not more than [30 days].
2. You submit an enrollment form for reinstatement to Us along with the required premium payment. Submission of premium to Your agent is not submission of premium to Us.
3. We approve Your enrollment form for reinstatement.

The coverage will be reinstated on the date We approve Your enrollment form for reinstatement. If We have not responded to Your enrollment form for reinstatement by the 45th day after We receive the enrollment form, the coverage will be reinstated on that date.

If the coverage is reinstated, loss resulting from an Injury will be covered only if the Injury is sustained on or after the date of reinstatement. Loss due to a Sickness will be covered only if the Sickness begins [more than [10] days] after the date of reinstatement. No benefits will be paid for a Sickness or an Injury and related complications if during the time between the lapse date and the reinstatement date:

1. Medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or Prescription Drugs were prescribed, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or
2. The condition produced signs or symptoms and 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.

This limitation will apply until coverage has been in force for [12 months] after the reinstatement date, unless the condition has been specifically excluded from coverage.

In all other respects, You and Our Company will have the same rights as existed under this plan before the coverage lapsed, subject to any provisions included with or attached to this plan in connection with the reinstatement.

### **Conversion Privilege**

You and Your Covered Dependents have a right to convert to another similar medical plan that We issue in the Covered Person's state of residence if coverage under the group Policy terminates for any reason, other than non-payment of premium, including discontinuance of the group Policy in its entirety. A Covered Person is not eligible for a conversion with Us if the Covered Person:

1. Replaces this certificate with similar coverage within 31 days after discontinuance of the group Policy.
2. Is eligible for coverage under Medicare.
3. Is eligible for coverage under any other group accident and health policy or contract that provides benefits for all of the Covered Person's pre-existing conditions.

To obtain conversion coverage, the Covered Person must submit a written enrollment form and the required premium to Us within 31 days after coverage under this plan terminates. Evidence of insurability will not be required. Coverage will be provided on the limited benefit medical insurance form that We select for providing conversion coverage at that time. **The benefits in the conversion plan do not necessarily equal or match those benefits provided in this group Policy.** The conversion plan may also provide different premium rates.

If written enrollment is not made within 31 days following the termination of insurance under this plan, conversion coverage may not be available.

The conversion coverage will take effect at 12:01 a.m. local time at the covered person's residence on the day after coverage under this plan terminates. Benefits paid under the new plan cannot exceed the [Maximum Lifetime Benefit or any other] applicable maximum benefit that would have otherwise been paid under the terms of this certificate if coverage under this certificate would have remained in force.

### **Continuation of Coverage**

A Covered Dependent may be eligible to continue coverage under this plan after coverage would otherwise terminate due to loss to dependency or change in marital status. The benefits will be the same as those in effect on the date of termination. You must furnish written request for continuation to Us within 10 days after ceasing to be eligible for coverage. The continued coverage will end on the earliest of:

1. full coverage under any other group accident and health policy or contract. This includes being covered for conditions deemed to be pre-existing conditions under that plan;
2. the end of the period for which premiums are paid;
3. the period ending 120 days from the date continuation began;
4. the premium due date following the date the dependent becomes eligible for Medicare;
5. the date coverage under the plan would have otherwise terminated;
6. the date the Life Time Maximum Benefit amount is reached; or
7. the date the Master Group Policy ends.

The individual shall be eligible for conversion after exhaustion of continuation of coverage.  
496.006.AR

## **[VI.] EFFECTIVE DATE AND TERMINATION DATE**

### **Eligibility and Effective Date of Certificate Holder**

A person who is eligible may elect to be covered under this plan by completing the enrollment process and submitting any required premium. You must be a member of the association to be eligible for coverage. [Evidence of insurability must also be provided.] Your coverage will take effect at 12:01 a.m. local time at the Certificate Holder's state of residence on the date We approve coverage under Our coverage criteria.

[If the Certificate Holder moves to a different state after the Effective Date, We will replace this certificate with a similar plan that is issued in the Certificate Holder's new state of residence. Coverage under the new plan will be effective on the date the Certificate Holder becomes a resident of the new state. If the Certificate Holder moves to a state where We do not provide insurance coverage under a plan similar to this certificate, We reserve the right to terminate this coverage for You and any Covered Dependents.]

### **Eligibility and Effective Date of Dependents**

The following information explains how You can obtain coverage for any Dependents that You want to add to Your plan. A Dependent can be added after the Certificate Holder's Effective Date. To be covered under this plan, a person must meet the Dependent definition in this plan and is subject to the additional requirements below:

- a. **Adding a Newborn Child:** A newborn child can be added on the date the child was born. You must call Our office or send Us written notice of the birth of the child and We must receive any required additional premium within 90 days of birth. The Effective Date of coverage will be 12:01 a.m. local time at the Certificate Holder's state of residence on the date the child is born. [If these requirements are not met, Your newborn child will be covered for Sickness or Injury, including the necessary care and treatment of medically diagnosed congenital defects for the first 90 days from birth.]
- b. **Adding an Adopted Child:** A newly adopted child can be added on the date petition for adoption is filed. You must call Our office or send Us written notice of the petition for adoption of the child and We must receive any required additional premium within 60 days of the placement for adoption. The Effective Date of coverage will be 12:01 a.m. local time at the Certificate Holder's state of residence on the date the petition for adoption is filed. [If these requirements are not met, Your newly adopted child will be covered for Sickness or Injury only for the first 60 days from petition for adoption.] A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement.
- c. **Adding Any Other Dependent:** To add any other Dependents, an enrollment form must be completed and sent to Us along with any required premium. [Evidence of insurability must also be provided.] The Effective Date of coverage will be 12:01 a.m. local time at the Certificate Holder's state of residence on the date We approve coverage under Our coverage criteria.

### **Termination Date of Coverage**

The Certificate Holder may cancel this coverage at any time by sending Us written notice or calling Our office. Upon cancellation, We will return the unearned portion of any premium paid, in accordance with the laws in the Certificate Holder's state of residence, minus any claims that were Incurred after the termination date and paid by Us.

This certificate will terminate at 12:01 a.m. local time at the Certificate Holder's state of residence on the earliest of the following dates:

1. The date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Certificate Holder for termination.
2. The date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is requested by the Certificate Holder for termination of a Covered Dependent.
3. The date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
4. The date there is fraud or intentional misrepresentation of material fact made by or with the knowledge of any Covered Person [applying for this coverage or] filing a claim for benefits.]
- 5.] The date all certificates with the same form number as this certificate are non-renewed in the state in which this certificate was issued or the state in which the Certificate Holder presently resides. We will give You 90 days advance notice of the termination of Your coverage.
- 6.] The date We terminate or non-renew health insurance coverage in the individual market in the state in which this certificate was issued or the state in which You presently reside. We will give You 180 days advance notice, as required by state law, of the termination of Your coverage.
- 7.] [On] [T][t]he date the Certificate Holder moves to a state where We do not provide insurance coverage under a plan with the same form number as this certificate[, We reserve the right to terminate this coverage].
- 8.] The date a Covered Dependent no longer meets the Dependent definition in this plan.
- 9.] The date a Covered Person is no longer a member of the association show as Policyholder on Your Benefit Summary.

496.007.AR

## **[VII.] OTHER PROVISIONS**

### **Modification of Coverage**

We may modify the insurance coverage for You and any Covered Dependents. This modification will be consistent with state law and will apply uniformly to all certificates with Your plan of coverage. You will be notified of any change.

No change in the certificate will be valid unless approved by one of Our executive officers and included with this certificate. No agent or other employee of Our Company has authority to waive or change any plan provision or waive any other applicable enrollment or application requirements.

The group master Policy may be changed at any time. We will give the Policyholder [30 days] notice prior to any change.

#### **Clerical Error**

If a clerical error is made by Us, it will not affect the insurance to which a Covered Person is entitled. Delay or failure to report termination of any insurance will not continue the insurance in force beyond the date it would have terminated according to this certificate. The premium charges will be adjusted as required, but not for more than [two years] prior to the date the error was found. If the premium was overpaid, We will refund the difference. If the premium was underpaid, the difference must be paid to Us within [60 days] of Our notifying You of the error.

#### **Conformity with State Statutes**

If this plan, on its Effective Date, is in conflict with any applicable federal laws or laws of the state where it is issued, it is changed to meet the minimum requirements of those laws. In the event that new or applicable state or federal laws are enacted which conflict with current provisions of this plan, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the plan to the contrary.

#### **Enforcement of Plan Provisions**

Failure by Us to enforce or require compliance with any provision within this plan will not waive, modify or render any provision unenforceable at any other time, whether the circumstances are the same or not.

#### **Entire Contract**

This certificate is issued to the Certificate Holder. The entire contract of insurance includes the group master Policy, a Covered Person's enrollment form, the Covered Person's certificate of insurance and any riders and endorsements.

In the absence of fraud, all statements made by applicants, the Policyholder, or Covered Persons are deemed representations and not warranties and no statement made for the purpose of effective insurance shall void the insurance or reduce benefits unless contained in a written instrument signed by the applicant, Policyholder or Covered Person, a copy of which has been furnished to the person or his or her beneficiary.

#### **[Incentives, Rebates and Contributions**

[We may elect to furnish [or participate in programs with other organizations that furnish] [group applicants for coverage] [members of groups applying for coverage][individual applicants for coverage][Covered Persons] [individuals] [that meet common criteria or requirements determined by Us] [not to include health or claims history] with "premium holidays" or programs where premiums, fees, plan benefit limits will be discounted, credited, refunded, waived or otherwise adjusted [or] [where other gifts or items of value may be offered or provided to You at no charge or a discount] [at a time or times] [or] [for a period] determined by Us.]]

#### **Misstatements**

If a Covered Person's material information has been misstated and the premium amount would have been different had the correct information been disclosed, an adjustment in premiums may be made based on the corrected information. In addition to adjusting future premiums, We may require payment of past premiums at the adjusted rate to continue coverage. If the Covered Person's age is misstated and coverage would not have been issued based on the Covered Person's true age, Our sole liability will be to refund all of the premiums paid for that Covered Person's coverage, minus the amount of any benefits paid by Us.

#### **[Rescission of Insurance and/or Denial of Claim**

Within the first two years after the Effective Date of coverage, We have the right to rescind or modify Your certificate of insurance coverage and/or deny a claim for a Covered Person if the enrollment form contains an omission or misrepresentation, whether intended or not, which We determine to be material. We also reserve the right to rescind a

certificate of insurance and/or deny a claim for a fraudulent misstatement or omission at any time during the coverage period. ]

**Legal Action and Forum**

No suit or action at law or in equity may be brought to recover benefits under this plan until the exhaustion of administrative remedies. You agree that You will not file a suit or legal action against Us for any breach of this agreement or denial of benefits without first submitting the dispute through Our claims review process. No suit or action at law or in equity can be brought later than [3 years] from the date the charges were Incurred. Any lawsuits or disputes arising under the terms of the group master Policy must be brought in the United States District Court for the Eastern District of Wisconsin.  
496.008.AR

**[VIII.] 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.

**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 under the Outpatient Prescription Drug Benefits section or any other section in this plan.

**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.

**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 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. ]

### **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 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 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. The Benefit Summary will identify what any applicable Copayments are along with the Covered Charges to which they apply.

### **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 Medical Benefits section.
3. It is Incurred for treatment, services, drugs, medicines or supplies listed in the Medical Office Visits Benefits section, including those for Preventive, Restorative and Other Medical Services, or Outpatient Prescription Drug Benefits section.
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 enrolled and eligible to receive benefits under this plan.

### **Covered Person**

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

### **[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. **[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.]
- [2.] **[Individual 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 Deductible have been Incurred and processed by Us, the Individual Deductible for that Covered Person will be satisfied for the remainder of the time period shown in the Benefit Summary. ]]]

### **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.]

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. ]

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. [Attains age [24]; or]
- c. [Marries; or]
- d. [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.]

### **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.

### **[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 Office**

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

**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.

**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 Allowable Cost (MAC) List**

A list of Prescription Drugs that are considered for reimbursement at a Generic Drug product level [or a Prescription Drug Class level] [based on the Prescription Drug Class Reference Price] that is established by Us. This list is subject to change at any time without notice.]

**[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 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-Preferred Brand Name Drug**

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

**Office Visit**

An in-person, face-to-face meeting between a Covered Person and a [Primary Care Practitioner] [,] [or] [Health Care Practitioner] [or] [Specialist Practitioner] in his or her office[or][,] at a Retail Health Clinic[, or in an Urgent Care Facility]. During this meeting, the [Primary Care Practitioner] [,] [or] [Health Care Practitioner] [or] [Specialist 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 or a free-standing facility.

**[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.]

**[Pharmacy**

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

**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.

#### [Primary Care Practitioner

A Health Care Practitioner who is a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) whose practice predominantly includes pediatrics, internal medicine, family practice, general practice or obstetrics/gynecology. [A [licensed nurse practitioner,] [podiatrist,] chiropractor [and] [dentist] would also qualify as a Primary Care Practitioner if he or she meets the definition of a Health Care Practitioner and the services rendered would be Covered Charges if performed by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is also a Primary Care Practitioner.]

#### [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 Class

Prescription Drugs that are grouped by Us according to a specific category, such as [Therapeutic Class,] Brand Name Drug or Generic Drug designation, diagnosis or cost effectiveness. The actual Prescription Drugs that are included in each category are shown on a Drug List that is broken down by tiers or levels based on the way Covered Charges for the drugs are reimbursed by Us. We may periodically change the placement of a Prescription Drug from one tier or level to another at any time without notice. As a result of these changes, a Covered Person may be required to pay more or less for a Prescription Drug.

The Benefit Summary will identify what any applicable Prescription Drug Copayment[, [and] other Prescription Drug Out-of-Pocket Limits] and any maximum limits are for each tier or level of coverage in each category [along with the [time period] [Plan Year] [Calendar Year] [Benefit Period] that applies to each coverage tier or level].]

#### [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 Ancillary Charge 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

Office Visit and Diagnostic Imaging and Laboratory services, as provided in the Medical Benefits section, for:

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. For purposes of determining benefits under this plan, each admission or outpatient visit will be considered an Office Visit and subject to all plan terms, conditions and maximum benefit limitations for Office Visits as shown on the Benefit Summary.

3. 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.

#### **[Reference Price**

The maximum amount that We will pay for covered Prescription Drugs within a Prescription Drug Class or within similar Prescription Drug Classes as established by Us.]

#### **Retail Health Clinic**

A facility that meets 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 a Health Care Practitioner in accordance with the laws of that state;
3. is attached to or part of a store or retail facility;
4. is separate from a hospital, emergency room, acute medical rehabilitation facility, free-standing facility, skilled nursing facility, subacute rehabilitation facility, or urgent care facility, and any Health Care Practitioner's office located therein, even when services are performed after normal business hours;"
5. provides general medical treatment or services for a Sickness or Injury[, or provides preventive medicine services,] on a non-seasonal basis; and
6. does not provide room and board or overnight services.

#### **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.

**[Specialist Practitioner**

A Health Care Practitioner who is classified as a specialist by the American Boards of Medical Specialties. [A Specialist Practitioner, for purposes of this plan, [is not][and][cannot be] a Primary Care Practitioner. For purposes of benefit determination under this plan, a psychological examiner is considered a Specialist Practitioner for treatment of mental health disorders.]

**[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 Diagnostic Imaging and Laboratory Services.]

**We, Us, Our, Our Company**

Time Insurance Company or its administrator.

**You, Your, Yours**

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

**BENEFIT SUMMARY**  
**LIMITED BENEFIT MEDICAL OFFICE VISIT INSURANCE**

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

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

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

<b>Policyholder, Certificate Holder and Plan Information</b>	
Policyholder:	[ABC Association]
Certificate Holder:	[Name] Effective Date: [XX/XX/XXXX] [Address/City/State/Zip]
Covered Dependents:	[Spouse's Name] Effective Date: [XX/XX/XXXX] [Dependent Child's Name] Effective Date: [XX/XX/XXXX] [Dependent Child's Name] Effective Date: [XX/XX/XXXX]
Certificate Number:	[XXXXXXXX]
Payment Option:	[Monthly]
<b>Medical Office Visit Benefits</b>	
We will pay benefits only for the treatment, services and supplies listed as Covered Charges in the Medical Benefits section of the plan.	
[[Maximum Lifetime Benefit:] [Deductible:] [Coinsurance:]]	[\$[None/1,000,000-unlimited] – All benefit payments apply to the Maximum Lifetime Benefit unless otherwise indicated.] [\$100-1000] [50-100%]
Office Visit Benefits:	<ul style="list-style-type: none"> <li>• Copayments: \$[XX] per Office Visit in a Retail Health Clinic \$[XX] per Office Visit in a [Primary Care][Health Care] Practitioner's office. \$[XX] per Office Visit in a Specialist Practitioner's office.]</li> <li>• [Not] [(S)subject to [Deductible] [or] [Coinsurance]</li> <li>• The maximum benefit is [X] visits per Calendar Year [up to a maximum benefit limit of \$[XXX] [per Office Visit][for all visits combined per Calendar Year][,per Covered Person]].</li> <li>• [An Office Visit during which only services for allergy shots or immunotherapy injections of inhaled allergens are rendered is not subject to the Calendar Year maximum of number of visits[; the maximum benefit limit of \$[XXX] [per Office Visit][for all visits combined per Calendar Year][,per Covered Person] still applies].]</li> <li>• Office Visits for Children's Preventive Health Care Services accrue to but are not subject to the Calendar Year maximum benefit limitation on number of visits[, however the \$[XXX] maximum benefit amount per [Office Visit][Calendar Year] still applies, except as provided below for immunization benefits].</li> <li>• Office Visits during which only services for Dependent child immunizations are rendered is not subject to the Calendar Year maximum of number of visits nor the maximum benefit limit [per Office Visit][for all visits combined per Calendar Year]. The Office Visit Copayment is also waived.</li> <li>• [Surgical procedures performed during an Office Visit benefits are limited to a \$[XXX] maximum benefit for all Covered Charges per Calendar Year[, per Covered Person].]</li> </ul>
Diagnostic Imaging and Laboratory Services Benefits	<ul style="list-style-type: none"> <li>• [Diagnostic Imaging and laboratory services, including interpretation, benefits are limited to a \$[XXX] maximum benefit for all Covered Charges per Calendar Year[, per Covered Person].]</li> <li>• [Not] [(S)subject to [Deductible] [or] [Coinsurance]]</li> </ul>

	<ul style="list-style-type: none"> <li>Covered Charges for testing of Covered Dependent newborn children for disorders of metabolism for which screening is performed by or for the State of Arkansas accrue to but are not subject to the Calendar Year maximum benefit limitation.</li> </ul>
<b>Outpatient Prescription Drug Benefits</b> We will pay benefits only for the drugs, medicines and supplies listed as Covered Charges in the Outpatient Prescription Drug Benefits section of the plan. Use a Participating Pharmacy to receive the maximum benefits available under the plan.	
Outpatient Prescription Drug Copayment:	\$[XX] for each Prescription Order for Generic Drugs. \$[XX] for each Prescription Order for [Preferred] Brand Name Drugs. \$[XX] for each Prescription Order for Non-Preferred Brand Name Drugs.
Outpatient Prescription Drug Calendar Year Maximum Benefit:	Up to \$[XXX] per Calendar Year[, per Covered Person].

**[IMployee<sup>SM</sup>] [- insert product/marketing name(s)]**  
**Enrollment form [for] [limited benefit] [health insurance] [program]**

PLEASE PRINT IN BLACK INK

**PERSON(S) TO BE INSURED**

Attach a separate sheet, signed and dated, if additional space is needed below.

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

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

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

5. Phone Number: (\_\_\_\_) \_\_\_\_\_ 6. E-mail Address: \_\_\_\_\_

[7][a.][Primary Insured Occupation: \_\_\_\_\_]  
 [Company Name: \_\_\_\_\_] [Work Number: (\_\_\_\_) \_\_\_\_\_]  
 [Duties: \_\_\_\_\_]  
 [Is the Primary Insured [self-employed] [or] a [sole proprietor]?.....  Yes  No]  
 [Is the Primary Insured covered by Workers' Compensation?.....  Yes  No]

[7b.] [Spouse [ /Domestic Partner] [ /Civil Union] Occupation: \_\_\_\_\_]  
 [Company Name: \_\_\_\_\_] [Work Number: (\_\_\_\_) \_\_\_\_\_]  
 [Duties: \_\_\_\_\_]  
 [Is the Spouse [ /Domestic Partner] [ /Civil Union] [self-employed]  
 [or] a [sole proprietor]?.....  Yes  No]  
 [Is the Spouse [ /Domestic Partner] [ /Civil Union] covered by  
 Workers' Compensation?.....  Yes  No]

**[REQUESTED EFFECTIVE DATE**

[8.] [Requested effective date \_\_\_\_\_]

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

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

## BILLING

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

[We recommend you pick [a] [an] [Electronic Funds Transfer] [EFT] [/Check-O-Matic] draft date that is the same as your effective date.]

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

[You have [two] options if choosing to pay by credit card [- recurring or 1<sup>st</sup> payment only].]

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

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

[You have four billing methods to choose from:]

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

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

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

→ To begin withdrawals:

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

Bank name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Routing number: \_\_\_\_\_

Account number: \_\_\_\_\_

Jane Doe  
1234 Any Street  
Anytown, US 12345  
DATE \_\_\_\_\_  
PAY TO THE ORDER OF \_\_\_\_\_ \$ \_\_\_\_\_  
DOLLARS  
ANYTOWN BANK  
MEMO  
123456789 0987654321 1234  
Routing Number Account Number  
9 digits

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

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

Accountholder signature: \_\_\_\_\_ Date: \_\_\_\_\_ ]

[ 3.][Credit card] → Choose how often:  Monthly]  Quarterly]  Semi-Annual]  Annual]  
[or  
→  Charge first payment only\*]

[\*You must also select a secondary billing method for subsequent payments.  
Once you choose below, go to that section and complete.]

Choose method:  Payroll deduction]

[Monthly [Electronic Funds Transfer] [EFT] [/Check-O-Matic]]]  Bill me directly]]

Authorization for credit card payments – **please sign below**  
I authorize Time Insurance Company to charge my account for the individual medical policy. I understand there will be no refund of premium after the 10-day free look in the contract.

Card number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Card type:  MasterCard  VISA

Expiration date: \_\_\_\_/\_\_\_\_ [Security code number ([3] digits on back of card): \_\_\_\_ \_\_\_\_ ]

Name as it appears on card: \_\_\_\_\_

Address of cardholder, if different: \_\_\_\_\_

Cardholder signature: \_\_\_\_\_ Date: \_\_\_\_\_ ]

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

If your billing address is different than your home address, please enter it here:

Billing Address: \_\_\_\_\_  
(Street) (City) (State) (ZIP)

Name of person paying, if different: \_\_\_\_\_ ]

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

**[LIFE INSURANCE]**

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

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

**[HEALTH ADVOCATES ALLIANCE MEMBERSHIP APPLICATION]**

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

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

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

\_\_\_\_\_  
Member Signature Date

**[HIPAA ELIGIBILITY]**

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

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

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

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

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

**[EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT]**

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

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

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

Do you agree with this statement? .....  Yes  No]

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

## [AUTHORIZATION]

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

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

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

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

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

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

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

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, [P.O. Box 3050][,] [501 West Michigan, Milwaukee, WI 5320[1][3][]-3050.] Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

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

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

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

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

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

Signature of Primary Proposed Insured

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

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

Guardian's Signature

Premium Amount Sent: \$ \_\_\_\_\_

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

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

City and State signed in

Attention: (Agent)

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

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

\_\_\_\_\_  
Licensed Resident Agent's Signature

\_\_\_\_\_  
Print Agent's Name

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

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

**[ARE YOU AN EXISTING CUSTOMER?**

[Policy # \_\_\_\_\_ ]

[What do you want to do?]

Add Dependent]

Policy/Benefit Change to an existing policy]

[List type of change requested: \_\_\_\_\_ ]

Reinstatement of Coverage]

Internal Replacement]

Conversion (over-age dependent/divorce)]]

**[AGENT/AGENCY INFORMATION**

Agent Name: \_\_\_\_\_

Agent Number: \_\_\_\_\_

Key Agency Contact: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Agency Number: \_\_\_\_\_

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

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

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

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

## **[IMPORTANT NOTICES – LEAVE WITH CUSTOMER**

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

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

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

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

### **[ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES**

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

### **[FRAUD NOTICE**

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

### **[PRIVACY**

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

**LEAVE THIS PAGE WITH THE CUSTOMER - DO NOT FAX**

OFFER of OPTIONAL TREATMENT OF ALCOHOL AND OTHER DRUG  
DEPENDENCY COVERAGE

Group Policyholder:  
Group Policy Number:

The consideration for this Offer is payment of the additional premium required to provide the benefit. The policy or certificate to which this Offer is attached is amended as follows if elected.

Covered Charges are included in the plan for the benefits described below, if elected by the Policyholder in the Benefit Election provision of this Offer.

Treatment of Alcohol and Other Drug Dependency

Coverage shall be provided for necessary care and treatment in an alcohol or drug dependency treatment facility or care and treatment in a hospital. Treatment may include detoxification, administration of a therapeutic regimen for the treatment of alcohol or drug dependent or substance abusing persons, and related services.

For purposes of payment of Covered Charges under this plan, treatment at a hospital or free standing or alcohol or drug treatment facility will be considered an Office Visit, and subject to all benefit limitations thereof as described in the Certificate and Benefit Summary.

Benefit Election

The optional benefits provided by this Offer are effective only to the extent they are elected by the Policyholder as indicated below.

The Policyholder elects the optional coverage under this Offer.

The Policyholder declines the optional coverage under this Offer.

\_\_\_\_\_  
Policyholder's Signature, Title

\_\_\_\_\_  
Date

This Offer applies only to Covered Persons who reside in the State of Arkansas. The optional benefits provided by this Offer are effective only to the extent that the benefit is elected by the Policyholder as indicated in the Benefit Election section above. Nothing contained in this Offer 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 Offer is the Effective Date of the policy or certificate to which it is attached, or the endorsement date if later.



Secretary

## OFFER of OPTIONAL MAMMOGRAM SCREENING COVERAGE

Group Policyholder:  
Group Policy Number:

The consideration for this Offer is payment of the additional premium required to provide the benefit. The policy or certificate to which this Offer is attached is amended as follows if elected.

Covered Charges are included in the plan for the benefits described below, if elected by the Policyholder in the space provided at the end of this Offer.

### Mammogram Screening

Coverage shall be provided for the following mammogram screening of occult breast cancer:

- (1) A baseline mammogram for a woman covered by such policy who is thirty-five (35) to forty (40) years of age;
- (2) A mammogram for a woman covered by such policy who is forty (40) to forty-nine (49) years of age, inclusive every one (1) to two (2) years based on the recommendation of such woman's physician;
- (3) A mammogram each year for a woman covered by such policy who is at least fifty (50) years of age;
- (4) Upon recommendation of a woman's physician, without regard to age, where such woman has had a prior history of breast cancer or where such woman's mother or sister has had a history of breast cancer.

Covered Charges for Mammogram Screening accrue to but are not subject to any Calendar Year maximum benefit amount limitation.

### Benefit Election

The optional benefits provided by this Offer are effective only to the extent they are elected by the Policyholder as indicated below.

The Policyholder elects the optional coverage under this Offer.

The Policyholder declines the optional coverage under this Offer.

\_\_\_\_\_  
Policyholder's Signature, Title

\_\_\_\_\_  
Date

This Offer applies only to Covered Persons who reside in the State of Arkansas. The optional benefits provided by this Offer are effective only to the extent that the benefit is elected by the Policyholder as indicated in the Benefit Election section above. Nothing contained in this Offer 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 Offer is the Effective Date of the policy or certificate to which it is attached, or the endorsement date if later.



Secretary

**OPTIONAL MUSCULOSKELETAL DISORDERS OF THE FACE, NECK OR HEAD  
BENEFITS OFFER**

Group Policyholder: [Health Advocates Alliance]  
Group Policy Number: [6096-001]

The consideration for this Rider is the additional premium shown in Your billing statement. If elected, the Policy or certificate with which this Rider is included is amended as follows.

The certificate is revised to include Covered Charges for the benefits described below, as elected by the Policyholder in the space provided at the end of this Rider. These benefits are applicable to Arkansas residents only, and are subject to all other certificate terms, limits and conditions, except to the extent specifically modified by this Rider.

**MUSCULOSKELETAL DISORDERS OF THE FACE, NECK OR HEAD BENEFITS**

If this Rider is elected by the Policyholder as indicated in the Benefit Election section below, Covered Charges include the Medically Necessary care and treatment, whether they are a result of accident, trauma, congenital defect, developmental defect, or pathology, of the musculoskeletal disorders of the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder, under the same terms and conditions as those Incurred for any other Sickness or Injury, subject to the limitations set forth in the Certificate. For purposes of determining benefits under this plan, each inpatient session or outpatient visit for treatment of musculoskeletal disorders of the face, neck or head will be considered Office Visit, and subject to all maximum benefit limitations thereof as shown on the Benefit Summary.

**Benefit Election**

The optional benefits provided by this Rider are effective only to the extent elected by the Policyholder as hereby indicated.

- The Policyholder hereby elects the optional musculoskeletal disorders of the face, neck or head coverage provided by this Offer.
- The Policyholder hereby declines the optional musculoskeletal disorders of the face, neck or head coverage provided by this Offer.

\_\_\_\_\_  
Policyholder's Signature

\_\_\_\_\_  
Date

This Rider applies only to Covered Persons who reside in the State of Arkansas. The optional benefits provided are effective only to the extent that this Rider is elected by the Policyholder as indicated in the Benefit Election section above. Nothing contained in this Rider will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the certificate other than as stated above.

If elected, the Effective Date of this Rider is the Effective Date of the Policy or certificate with which it is included.



Secretary

## OFFER of OPTIONAL MENTAL ILLNESS COVERAGE

Group Policyholder:  
Group Policy Number:

The consideration for this Offer is payment of the additional premium required to provide the benefit. Benefits to be elected or declined are those required to be offered by Arkansas Insurance Code section 23-86-113, and this rider is deemed to meet the minimum requirement of such law. The policy or certificate to which this Offer is attached is amended as follows if elected.

Covered Charges are included in the plan for the benefits described below, if elected by the Policyholder in the Benefit Election provision of this Offer.

### Mental Illness Coverage

Coverage shall be provided for reasonable and customary charges for partial hospitalization and confinement as an inpatient in a hospital, psychiatric hospital, or outpatient psychiatric center licensed by the Department of Health or a community mental health center certified by the Division of Mental Health Services of the Department of Human Services and outpatient services furnished by a hospital, psychiatric hospital or an outpatient psychiatric center licensed by the Department of Health.

All Covered Charges are subject to 80% Coinsurance. Coinsurance is the dollar amount or percentage of Covered Charges that are paid by Us after any plan 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 and any amount in excess of the allowed reasonable and customary charge for services.

### Benefit Election

The optional benefits provided by this Offer are effective only to the extent they are elected by the Policyholder as indicated below.

The Policyholder elects the optional coverage under this Offer.

The Policyholder declines the optional coverage under this Offer.

\_\_\_\_\_  
Policyholder's Signature, Title

\_\_\_\_\_  
Date

This Offer applies only to Covered Persons who reside in the State of Arkansas. The optional benefits provided by this Offer are effective only to the extent that the benefit is elected by the Policyholder as indicated in the Benefit Election section above. Nothing contained in this Offer 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 Offer is the Effective Date of the policy or certificate to which it is attached, or the endorsement date if later.



Secretary

## OPTIONAL HOSPICE BENEFITS OFFER

Group Policyholder: [Health Advocates Alliance]  
Group Policy Number: [6096-001]

The consideration for this Rider is the additional premium shown in Your billing statement. If elected, the Policy or certificate with which this Rider is included is amended as follows.

The certificate is revised to include Covered Charges for the benefits described below, as elected by the Policyholder in the space provided at the end of this Rider. These benefits are applicable to Arkansas residents only, and are subject to all other certificate terms, limits and conditions, except to the extent specifically modified by this Rider.

### HOSPICE BENEFITS

If this Rider is elected by the Policyholder as indicated in the Benefit Election section below, Covered Charges include the Medically Necessary treatment and prognosis of a terminally ill Covered Person under the same terms and conditions as those Incurred for any other Sickness or Injury, subject to the limitations set forth in this Rider.

The maximum benefit for Covered Charges is the rate of reimbursement as are provided for hospice care under Medicare, the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as in effect January 1, 1999.

### Benefit Election

The optional benefits provided by this Rider are effective only to the extent elected by the Policyholder as hereby indicated.

The Policyholder hereby elects the optional hospice coverage under this Offer.

The Policyholder hereby declines the optional hospice coverage under by this Offer.

\_\_\_\_\_  
Policyholder's Signature

\_\_\_\_\_  
Date

This Rider applies only to Covered Persons who reside in the State of Arkansas. The optional benefits provided are effective only to the extent that this Rider is elected by the Policyholder as indicated in the Benefit Election section above. Nothing contained in this Rider will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the certificate other than as stated above.

If elected, the Effective Date of this Rider is the Effective Date of the Policy or certificate with which it is included.



Secretary

## Supplemental Notice to Master Group Policy Application

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

*SERFF Tracking Number:* MCHX-125791748                      *State:* Arkansas  
*Filing Company:* Time Insurance Company                      *State Tracking Number:* 40070  
*Company Tracking Number:* 496.001.AR  
*TOI:* H21 Health - Other                      *Sub-TOI:* H21.000 Health - Other  
*Product Name:* 496.001.XX-TIC-Limited Benefit Certificate of Medi  
*Project Name/Number:* 496.001.XX-TIC-Limited Benefit Certificate of Medical Office Visit Insurance-Assoc WS/496.001.XX-TIC-Limited Benefit  
Certificate of Medical Office Visit Insurance-Assoc WS

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: MCHX-125791748 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 40070  
 Company Tracking Number: 496.001.AR  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: 496.001.XX-TIC-Limited Benefit Certificate of Medi  
 Project Name/Number: 496.001.XX-TIC-Limited Benefit Certificate of Medical Office Visit Insurance-Assoc WS/496.001.XX-TIC-Limited Benefit Certificate of Medical Office Visit Insurance-Assoc WS

## Supporting Document Schedules

<b>Satisfied -Name:</b> Certification/Notice	<b>Review Status:</b> Approved-Closed	09/05/2008
<b>Comments:</b>		
<b>Attachments:</b>		
AR - READABILITY CERTIFICATION.PDF		
Certification of Compliance Rule 19.PDF		
Certification #49.PDF		
<b>Bypassed -Name:</b> Application	<b>Review Status:</b> Approved-Closed	09/05/2008
<b>Bypass Reason:</b> N/A		
<b>Comments:</b>		
<b>Bypassed -Name:</b> Health - Actuarial Justification	<b>Review Status:</b> Approved-Closed	09/05/2008
<b>Bypass Reason:</b> N/A		
<b>Comments:</b>		
<b>Bypassed -Name:</b> Outline of Coverage	<b>Review Status:</b> Approved-Closed	09/05/2008
<b>Bypass Reason:</b> N/A		
<b>Comments:</b>		
<b>Satisfied -Name:</b> 08.26.08 Submission Letter	<b>Review Status:</b> Approved-Closed	09/05/2008
<b>Comments:</b>		
<b>Attachment:</b>		
08_26_08 Submission Letter.PDF		
<b>Satisfied -Name:</b> Authorization Letter	<b>Review Status:</b> Approved-Closed	09/05/2008

*SERFF Tracking Number:* MCHX-125791748                      *State:* Arkansas  
*Filing Company:* Time Insurance Company                      *State Tracking Number:* 40070  
*Company Tracking Number:* 496.001.AR  
*TOI:* H21 Health - Other                      *Sub-TOI:* H21.000 Health - Other  
*Product Name:* 496.001.XX-TIC-Limited Benefit Certificate of Medi  
*Project Name/Number:* 496.001.XX-TIC-Limited Benefit Certificate of Medical Office Visit Insurance-Assoc WS/496.001.XX-TIC-Limited Benefit  
Certificate of Medical Office Visit Insurance-Assoc WS

**Comments:**

**Attachment:**

Authorization Letter.PDF

SERFF Tracking Number: MCHX-125791748 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 40070  
 Company Tracking Number: 496.001.AR  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: 496.001.XX-TIC-Limited Benefit Certificate of Medi  
 Project Name/Number: 496.001.XX-TIC-Limited Benefit Certificate of Medical Office Visit Insurance-Assoc WS/496.001.XX-TIC-Limited Benefit Certificate of Medical Office Visit Insurance-Assoc WS

**Satisfied -Name:** Forms Listing **Review Status:** Approved-Closed 09/05/2008  
**Comments:**  
**Attachment:**  
 Forms Listing.PDF

**Satisfied -Name:** Statement of Variability **Review Status:** Approved-Closed 09/05/2008  
**Comments:**  
**Attachment:**  
 Statement of Variability.PDF

**Satisfied -Name:** 09.04.08 Resubmission Letter **Review Status:** Approved-Closed 09/05/2008  
**Comments:**  
**Attachment:**  
 09\_04\_08 Resubmission Letter.PDF

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

**COMPANY NAME:** Time Insurance Company

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

<b>Form Number</b>	<b>Score</b>
496.001.AR	64
496.002.AR	64
496.003.AR	64
496.004.XX	64
496.005.XX	64
496.006.AR	64
496.007.AR	64
496.008.AR	64
496.009.AR	64
496.BNS.AR	40
29700	40
9038-AR	40
9040-AR	40
9044-AR	40
9046-AR	40
9048-AR	40

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

<b>Form Number</b>	<b>Score</b>
AR-TMJ Notice	100

Signed:   
Name: Julia Hix-Royer  
Title: Vice President

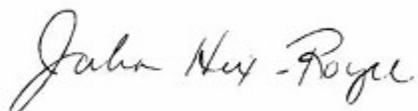
Date: August 26, 2008

## Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Time Insurance Company

Form Number(s): 496.001.AR, 496.002.AR, 496.003.AR, 496.004.XX, 496.005.XX, 496.006.AR,  
496.007.AR, 496.008.AR, 496.009.AR, 496.BNS.AR,  
9044-AR, 9048-AR, 9040-AR, 9046-AR, 9038-AR, 29700,  
AR-TMJ Notice

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

\_\_\_\_\_  
August 26, 2008

Date

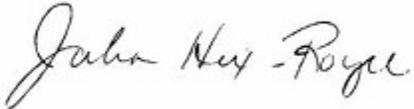
**CERTIFICATE OF COMPLIANCE**

Insurer: Time Insurance Company

Form Numbers:

496.001.AR, 496.002.AR, 496.003.AR, 496.004.XX, 496.005.XX, 496.006.AR, 496.007.AR,  
496.008.AR, 496.009.AR, 496.BNS.AR,  
9044-AR, 9048-AR, 9040-AR, 9046-AR, 9038-AR, 29700,  
AR-TMJ Notice

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



\_\_\_\_\_  
Signature of Company Officer

Julia Hix-Royer  
\_\_\_\_\_  
Name

Vice President  
\_\_\_\_\_  
Title

08/26/08  
\_\_\_\_\_  
Date



listing of all submitted forms that are included within each certificate form is enclosed along with the required certifications.

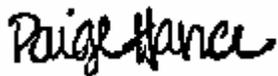
Please note that the Certificate is numbered using a matrix format, where each section of the document has a unique form number. For example, the Certificate face page is numbered 496.001.AR, while the Exclusions section of the same document is numbered 496.004.XX. The Company employs this form numbered style for administrative and tracking purposes. The Certificate will always be issued in their entirety with all sections and form numbers included.

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.

These forms are 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 Policyholder's request. Variable data will never exclude or limit provisions required by applicable law.

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

Sincerely,

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

Paige Hance, Consultant  
McHugh Consulting Resources, Inc.



**ASSURANT**  
Health

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

[www.assurant.com](http://www.assurant.com)

January 8, 2008

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

Dear Sir or Madam,

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

Best Regards,

A handwritten signature in black ink, appearing to read "Daniel Ziebell". The signature is written over a large, faint, circular watermark or stamp.

Daniel Ziebell, MHP  
Director, Product Compliance  
[daniel.ziebell@assurant.com](mailto:daniel.ziebell@assurant.com)  
T 414.299.6045  
F 414.299.6168

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

Limited Benefit Certificate of Medical Office Visit Insurance  
With Limited Outpatient Prescription Drug Benefits

Forms Listing

<b><u>Form Number</u></b>	<b><u>Form Description</u></b>
496.001.AR	Certificate of Coverage (includes the following matrix insert sections)
496.002.AR	Matrix Insert Section: Medical Benefits
496.003.AR	Matrix Insert Section: Outpatient Prescription Drug Benefits
496.004.XX	Matrix Insert Section: Exclusions
496.005.XX	Matrix Insert Section: Claim Provisions
496.006.AR	Matrix Insert Section: Premium Provisions
496.007.AR	Matrix Insert Section: Effective Date and Termination Date
496.008.AR	Matrix Insert Section: Other Provisions
496.009.AR	Matrix Insert Section: Definitions
496.BNS.AR	Benefit Summary – Limited Benefit Medical Office Visit Insurance
9044-AR	Optional Musculoskeletal Disorders of the Face, Neck or Head Benefits Rider
9048-AR	Optional Hospice Benefits Offer
9040-AR	Offer of Optional Mammography Screening Coverage
9046-AR	Optional Offer of Mental Illness Coverage
9038-AR	Offer of Optional Treatment of Alcohol and Other Drug Dependency Coverage
AR-TMJ Notice 29700	Supplemental Notice to Master Group Policy Application Application

### **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.
- 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.
- 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.
- Items which customarily vary according to the policyholder's or certificateholder's specific plan of insurance.

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.

.....

# McHugh Consulting Resources, Inc.

September 4, 2008

**Submitted via SERFF**

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

**RE: RESUBMISSION**  
**SERFF Tracking # MCHX-125791748**  
**Time Insurance Company**  
NAIC # 69477 FEIN # 39-0658730

**Association Limited Benefit Medical Office Visit Expense Certificate**  
496.001.AR, et al – Certificate

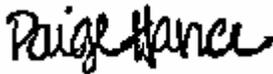
Dear Ms. Minor:

Thank you for your objection letter dated August 28, 2008 regarding the above referenced filing. Time Insurance Company has reviewed your letter and offers the following in response in the order presented:

1. Per your conversation with Lauren Regnery on August 28, 2008, this is a matrix filing and the complete Certificate is attached under form number 496.001.AR.
2. We have attached the revised certificate form with the amended Dependent definition.

We trust that this information will be sufficient for you to complete your review. If, however, you have questions or need additional information, please feel free to contact our office.

Sincerely,



Paige Hance, Consultant  
McHugh Consulting Resources, Inc.

SERFF Tracking Number: MCHX-125791748 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 40070  
 Company Tracking Number: 496.001.AR  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: 496.001.XX-TIC-Limited Benefit Certificate of Medi  
 Project Name/Number: 496.001.XX-TIC-Limited Benefit Certificate of Medical Office Visit Insurance-Assoc WS/496.001.XX-TIC-Limited Benefit  
 Certificate of Medical Office Visit Insurance-Assoc WS

## Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	LIMITED BENEFIT CERTIFICATE OF MEDICAL OFFICE VISIT INSURANCE	08/26/2008	496_001_AR.PD F

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

**LIMITED BENEFIT CERTIFICATE OF MEDICAL OFFICE VISIT INSURANCE  
With Limited Outpatient Prescription Drug Benefits**

This certificate provides limited benefits and maximums. This plan does not provide benefits for mastectomy.

The insurance described in this certificate is effective on the date shown in the Benefit Summary only if You are eligible for the insurance, become insured, and remain insured subject to the terms, limits and conditions of this plan. This certificate is evidence of Your coverage under the Policy of medical insurance issued to a[n] [association/trust].

This certificate describes the benefits and major provisions which affect Covered Persons. The final interpretation of any specific provision is based on the terms of the Policy. [The Policy is issued in the State of [Illinois] and is governed by applicable laws of that State and federal laws, except as otherwise provided by this certificate or the Policy.] The Policy may be examined at Our Home Office or the main office of the Policyholder.

This certificate is issued based on the statements and agreements in the enrollment form and during the enrollment process, any exam that may be required, any other amendments or supplements and payment of the required premium. This certificate and/or the Policy may be changed. If that happens, You will be notified of any such changes.

**RIGHT TO EXAMINE CERTIFICATE FOR 10 DAYS**

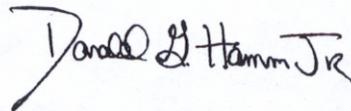
If You are not satisfied, return the certificate to Us or Our agent within [10] days after You have received it. All premiums will be refunded and Your coverage will be void from the Effective Date.

**IMPORTANT NOTICE CONCERNING STATEMENTS  
IN YOUR ENROLLMENT FORM FOR INSURANCE**

Please read the copy of the enrollment form included with this certificate. We issued this coverage in reliance upon the accuracy and completeness of the information provided in the enrollment form and during the enrollment process. [If a material omission or misstatement is made in the enrollment form, We have the right to deny any claim, rescind the coverage and/or modify the terms of the coverage or the premium amount.] Carefully check the enrollment form and, if any information shown in the enrollment form is not correct and complete, write to Us at the address above, within 10 days.



Secretary



President

**This certificate has limited benefits and annual maximums. Read Your certificate carefully to understand any coverage limitations. Read the Benefit Summary for information on what benefits are provided for Covered Charges.**

**GUIDE TO YOUR COVERAGE**

The sections of the certificate appear in the following order:

- I Medical Benefits
- II Outpatient Prescription Drug Benefits
- III Exclusions
- IV Claim Provisions
- V Premium Provisions
- VI Effective Date and Termination Date
- VII Other Provisions
- VIII Definitions

## **[I.] MEDICAL BENEFITS**

We will pay Covered Charges only for the treatment and services Incurred as part of an Office Visit or covered Diagnostic Imaging and laboratory services as listed in this section of the plan as Medical Benefits, including those for Preventive, Restorative and Other Medical Services. How Covered Charges are paid and the maximum benefit for the Covered treatment and services listed in this section are shown in the Benefit Summary. Refer to the Exclusion section of the plan for treatment, services and supplies that are not covered.

After the Covered Person has paid any Copayment[,Deductible,] [Coinsurance] or any other applicable fees, benefits will be paid by Us for Covered Charges for the services listed in this section and according to the terms shown in the Benefit Summary. Benefits paid under this section will be applied to any applicable maximum benefit limitations provided under this plan and in the benefit summary. Benefits are subject to all the terms, limits and conditions in this plan. Any Copayment[, Deductible,] [Coinsurance] or any other applicable fees under this section will not count toward satisfying any Ancillary Charge, Prescription Drug Copayment or any other fees under the Outpatient Prescription Drug Benefits section.

[Unless a Prescription Drug is specifically listed as a Covered Charge in the Medical Benefits section, all Prescription Drugs that are received on an Outpatient basis are considered for benefits under the Outpatient Prescription Drug Benefits section. When the maximum benefit has been paid for any charges covered under the Medical Benefits section, any amount in excess of this maximum benefit is not covered under the Outpatient Prescription Drug Benefits section.]

We pay only for the following Covered Charges:

### **Office Visit Benefits**

Office Visit charges Incurred for services performed during an Office Visit for a Covered Person are payable as shown in the Benefit Summary. [For the purpose of this provision, Office Visits include evaluation and management services as defined in the most recent edition of Current Procedural Terminology [and preventive medicine services].] [An Office Visit will also include [minor] [surgical procedures performed during the Office Visit,] [allergy testing,] [allergy shots,] [immunotherapy injections of inhaled allergens,] [preventive medicine services][and][ diabetic treatment including: routine eye exams, nutritional counseling, diabetic training, routine foot care, and home glucose monitoring training].Office Visit benefits also include Children's Preventive Health Care Services for Covered Dependent children limited to one Office Visit at approximately the following age intervals: 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, ten years, twelve years, fourteen years, sixteen years, and eighteen years.

[Covered Charges will not include [magnetic resonance imaging (MRI),] [computerized axial tomography (CAT scan),] [preventive medicine services,] [chemotherapy,] [allergy testing,] [cardiac rehabilitation programs,] [dialysis,] [occupational therapy,] [physical therapy,] [radiation therapy,] [respiratory therapy,] [infusion of medications] [speech therapy,] [and] [the administration of anesthesia] [or] [any other service not specifically listed as a Covered Charge in the Benefit Summary for this Office Visit provision].]

### **Diagnostic Imaging and Laboratory Services Benefits**

Services that are provided by a Health Care Practitioner for Diagnostic Imaging services and laboratory services[, if a written report with interpretation is produced directly by the Health Care Practitioner], including interpretation thereof, are payable as shown in the Benefit Summary.

Benefits include testing of Covered Dependent newborn children for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia and all other disorders of metabolism for which screening is performed by or for the State of Arkansas.  
496.002.AR

## **[[II.] OUTPATIENT PRESCRIPTION DRUG BENEFITS**

Only the drugs, medicines and supplies listed in this section as Outpatient Prescription Drug Benefits will be considered a Covered Charge. How Covered Charges are paid and the maximum benefit for the covered drugs, medicines and supplies listed in this section are shown in the Benefit Summary. Refer to the Exclusions section of the plan for drugs, medicines and supplies that are not covered.

**THE COVERED PERSON MUST USE THE PARTICIPATING PHARMACY NETWORK TO RECEIVE THE MAXIMUM BENEFITS AVAILABLE.**

[Prior Authorization may be required for certain drugs, medicines and supplies before they are considered for coverage under the Outpatient Prescription Drug Benefits section. Please access the website listed on the back of the identification (ID) card to receive information on which drugs, medicines and supplies require prior authorization and to check prescription drug coverage and pricing or to locate a Participating Pharmacy.]

After the Covered Person has paid any Ancillary Charge, Prescription Drug Copayment or any other applicable fees, benefits will be paid by Us for Covered Charges for the drugs, medicines and supplies listed in this section. Any applicable Prescription Drug Copayment and the time period to which it applies are shown in the Benefit Summary. Benefits paid under this section will be applied to [the Maximum Lifetime Benefit and are also subject to] any [other] applicable maximum benefit provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.

Any Ancillary Charge, Prescription Drug Copayment or any other applicable fees under this section will not count toward satisfying any Copayment or any other fees under the Medical Benefits section.

Unless a Prescription Drug is specifically listed as a Covered Charge in the Medical Benefits section, all Prescription Drugs that are received on an Outpatient basis are considered for benefits under the Outpatient Prescription Drug Benefits section. When the maximum benefit has been paid for any charges covered under the Outpatient Prescription Drug Benefits section, any amount in excess of this maximum benefit is not covered under the Medical Benefits section.

### **Outpatient Prescription Drug Benefits**

This plan provides benefits only for the following Covered Charges for drugs, medicines and supplies that are received on an Outpatient basis:

1. Prescription Drugs that are fully approved by the U.S. Food and Drug Administration (FDA) for marketing in the United States and can be obtained only with a Prescription Order from a Health Care Practitioner, including a prescription drug and the Medically Necessary services associated with the administration of the drug, for cancer treatment even if the off-label use of such prescription drug has not been approved by the FDA for that type of cancer for which the drug has been prescribed, provided:
  - i. The drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one (1) or more such compendia:
    1. The American Hospital Formulary Service drug information;
    2. The United States Pharmacopoeia dispensing information; or
  - ii. The drug has been recognized as safe and effective for treatment of that specific type of cancer in two (2) articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature.
2. .
3. Up to a 30 consecutive day supply for each Prescription Order, unless restricted to a lesser amount by the Prescription Order, the manufacturers' packaging or any limitations in this plan.
4. Up to 3 vials or up to a 30 consecutive day supply of one type of self-injectable insulin for each Prescription Order, whichever is less.
4. Up to 100 disposable insulin syringes and needles, up to 100 disposable blood/urine/glucose/acetone testing agents, or up to 100 lancets, or up to a 30 consecutive day supply for each Prescription Order, whichever is less.
5. Prescription Drugs, in dosages, dosage forms, dosage regimens and durations of treatment that are Medically Necessary for the treatment of a Sickness or an Injury that is covered under this plan, and for FDA approved Prescription Drugs for use as contraceptive drugs or devices including oral contraceptives, contraceptive patches, contraceptive vaginal rings, diaphragms, injectables and implants.
6. Prescription Drugs that are within the quantity, supply, cost-sharing or other limits that We determine are appropriate for a Prescription Drug.
7. Prescription Drugs and Prescription Drug products if all active ingredients are covered under this plan.

### **Manufacturer's Packaging Limits**

Some Prescription Drugs may be subject to additional supply, quantity, duration, gender, age, lifetime, cost sharing or other limits based on the manufacturer's packaging, plan limits or the Prescription Order. Examples of these situations are:

1. If a Prescription Drug is taken on an as-needed basis, only enough medication for a single episode of care may be covered per Prescription Drug Copayment; or
2. If two or more covered Prescription Drug products are packaged and/or manufactured together, the Covered Person may be required to pay a Prescription Drug Copayment for each of the Prescription Drug products contained in the packaging and/or in the combination Prescription Drug product; or
3. If two or more Prescription Drug products are packaged and/or manufactured together and one or more of the active ingredients in the products are not covered under this plan, then the entire packaged and/or manufactured combination product is also not covered under this plan; or
4. If a Compounded Medication contains one or more active ingredients that are not covered under this plan, then the entire Compounded Medication is also not covered under this plan.

Any Prescription Drug which is a metabolite, isomer, extended release or other dosage form, unique salt or other formulation, or other direct or indirect derivative of a Prescription Drug approved by the FDA may be subject to similar terms, limits and conditions of coverage or will not be covered by this plan if the original drug would not be covered.

### **Participating Pharmacy**

The following provisions apply to covered Outpatient drugs, medicines and supplies purchased at a Participating Pharmacy when the identification (ID) card is presented to the Participating Pharmacy:

1. The Covered Person must pay the Participating Pharmacy the difference between the entire amount charged for a covered Prescription Drug and the amount We will pay.
2. When a covered Generic Drug is available and that Generic Drug is received, the Covered Person pays the Prescription Drug Copayment for that Generic Drug as shown in the Benefit Summary.
3. When a Generic Drug is not available and a Brand Name Drug is received, the Covered Person pays the Prescription Drug Copayment for that Brand Name Drug as shown in the Benefit Summary.
4. If a Brand Name Drug is received when a Generic Drug is available, the Covered Person pays the Prescription Drug Copayment for that Brand Name Drug, as shown in the Benefit Summary, plus the difference in the Contracted Rate between the cost of the Brand Name Drug and the Generic Drug. The difference in the Contracted Rate between the two drugs will not be reimbursed by Us nor does it count toward satisfying any Copayment[, Deductible] [or] [Coinsurance] under any section of this plan.
5. When a covered Prescription Drug is available under two or more names, dosages, dosage forms, dosage regimens or manufacturers' packaging or when more than one covered Prescription Drug may be used to treat a covered condition, We will consider benefits only for the most cost effective drug, dosage form or packaging that would be a Covered Charge under the plan and that will produce a professionally adequate result.

The following provisions apply to covered Outpatient drugs, medicines and supplies purchased at a Participating Pharmacy when the identification (ID) card is not presented to the Participating Pharmacy:

1. The Covered Person must pay the entire amount charged for a Prescription Drug to the Participating Pharmacy.
2. To receive reimbursement for Covered Charges, the Covered Person must file a claim with Us. A prescription drug claim form must be completed. This form can be obtained from Us. Send it and any Prescription Drug receipts to the Prescription Card Service Administrator (PCSA) at the address shown on the form for reimbursement of Covered Charges.
3. The Covered Person will be reimbursed at the Contracted Rate that would have been paid to a Participating Pharmacy for the cost of the covered Prescription Drug minus any applicable Ancillary Charge and Prescription Drug Copayment.

### **Non-Participating Pharmacy**

The following provisions apply to covered Outpatient drugs, medicines and supplies purchased at a Non-Participating Pharmacy:

1. The Covered Person must pay the entire amount charged for a Prescription Drug to the Non-Participating Pharmacy.
2. To receive reimbursement for Covered Charges, the Covered Person must file a claim with Us. A prescription drug claim form must be completed. This form can be obtained from Us. Send it and any Prescription Drug receipts to the address shown on the form for reimbursement of Covered Charges.
3. The Covered Person will be reimbursed at the Contracted Rate that would have been paid to a Participating Pharmacy for the cost of the covered Prescription Drug minus any applicable Ancillary Charge and Prescription Drug Copayment.

### **Miscellaneous Provisions**

No benefits are payable for any Prescription Order filled for a Covered Person on or after the date his or her coverage terminates under this plan. Thus, all Covered Persons are required to turn in their identification (ID) card at the time of coverage termination. If You fail to do so and any Covered Person uses the ID card after coverage ends, You are responsible for all Prescription Drugs purchased after the termination date. We will recover from You any amounts paid by Us for drugs purchased after coverage terminates under the plan.

The amount paid by Us under the Outpatient Prescription Drug Benefits section may not reflect the ultimate cost to Us for the Prescription Drug. Any amounts that the Covered Person is responsible for paying are paid on a per prescription or refill basis and will not be adjusted if We receive any retrospective volume drug discounts or Prescription Drug rebates under any portion of the plan. Manufacturer product discounts, also known as rebates, may be sent back to Us and may be related to certain drug purchases under the Plan. These amounts will be retained by Us.

The Covered Person is responsible for any Prescription Drug Copayment that is paid for a Prescription Order that is filled, regardless of whether the Prescription Order is revoked or changed due to adverse reaction or changes in dosage, dosage regimen or Prescription Order. These charges will not be reimbursed by Us.

[Payment by Us for a Prescription Drug under this section does not constitute any assumption of liability for coverage of a Sickness or an Injury under the Medical Benefits section. It also does not constitute any assumption of liability for further coverage of the Prescription Drug under this section.]

496.003.AR

### **[III.] EXCLUSIONS**

We will not pay benefits for any of the following:

1. Charges that:
  - a. Are not specifically listed as a Covered Charge under the Medical Benefits and Outpatient Prescription Drug Benefits provisions.
  - b. Are Incurred before the Covered Person's Effective Date or after the termination date of coverage.
2. [Charges for: a condition that arises out of, or is the result of, any work for wage or profit; a work-related condition that is eligible for benefits under worker's compensation, employers' liability or similar laws even when the Covered Person does not file a claim for benefits. This exclusion will not apply to a Covered Person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage. However, the Covered Person must receive services in accordance with the Medical Benefits section.]
3. Charges for:
  - a. Dental care that is routine.
  - b. A masseur, masseuse or massage therapist; massage therapy; a rolfer.
4. [Charges for:
  - [a.] [Non-medical items, self-care or self-help programs.]
  - [b.] [Aroma therapy.]
  - [c.] [Meditation or relaxation therapy.]
  - [d.] [Naturopathic medicine.]
  - [e.] [Treatment of hyperhidrosis (excessive sweating).]
  - [f.] [Acupuncture; biofeedback; neurotherapy; electrical stimulation.]
  - [g.] [Treatment of spider veins.]
  - [h.] [Family or marriage counseling.]
  - [i.] [Applied behavior therapy treatment for autistic spectrum disorders.]
  - [j.] [Smoking deterrence or cessation.]
  - [k.] [Snoring or sleep disorders, such as obstructive sleep apnea.]
  - [l.] [Change in skin coloring or pigmentation.]
  - [m.] [Stress management.]
  - [n.] [Medical supplies and equipment, except as specifically covered under the Medical Benefits or Outpatient Prescription Drug Benefits provisions.]
5. [Charges for treatment of an Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, exceeded the blood alcohol level otherwise permitted by law or violated legal standards for a person

operating a motor vehicle in the state where the Injury occurred. This exclusion applies whether or not the Covered Person is charged with any violation in connection with the Accident.]

6. [Charges for services ordered, directed or performed by a Health Care Practitioner or supplies purchased from a Medical Supply Provider who is a Covered Person, an Immediate Family Member, employer of a Covered Person or a person who ordinarily resides with a Covered Person. ]

7. Charges for any amount in excess of any maximum benefit for covered services.

8. [Charges that do not meet the definition of a Covered Charge in this plan including, but not limited to, charges that are not Medically Necessary.]

9. [Charges Incurred outside of the United States, including charges for drugs or medicines obtained from pharmacy provider sources outside the United States.]

10. Charges for vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner.

11. Charges for any over-the-counter drugs or medicines whether or not prescribed by a Health Care Practitioner.

12. Charges for drugs or medicines used to treat, impact or influence: athletic performance; body conditioning, strengthening, or energy; social phobias; slowing the normal processes of aging; daytime drowsiness; overactive bladder; dry mouth; excessive salivation; genetic make-up or genetic predisposition; prevention or treatment of hair loss, excessive hair growth or abnormal hair patterns.

13. [Charges for: unit-dose drugs; drugs or medicines used to treat onychomycosis (nail fungus); botulinum toxin and its derivatives.]

14. [Charges for drugs or medicines: prescribed for treatment of a condition that is not specifically listed as a Covered Charge; that are illegal under federal law, such as marijuana, even if they are prescribed for a medical use in a state.]

15. [Charges under the Outpatient Prescription Drug Benefits section for: biological sera; vaccines and other immunizing agents; injectable parenteral administration, except insulin or Imitrex.]

496.004.XX

#### [IV.] CLAIM PROVISIONS

##### **Proof of Loss**

Most providers will file claims directly with Us. You are responsible for filing a claim with Us if the provider does not file it. The following provisions tell You how to file claims with Us.

We must receive written or electronic notice of the services that were received for which the claim is made. Notice must be provided to Us within [60 days] after a covered loss occurs or as soon as reasonably possible. Unless You are declared incompetent by a court of law, proof of loss must be sent to Us within [12 months] of the date of loss.

The proof of loss must include all of the following:

1. Your name and certificate number.
2. The name of the Covered Person who Incurred the claim.
3. The name and address of the provider of the services.
4. An itemized bill from the provider of the services that includes all of the following as appropriate:
  - a. International Classification of Diseases (ICD) diagnosis codes.
  - b. International Classification of Diseases (ICD) procedures.
  - c. Current Procedural Terminology (CPT) codes.
  - d. Healthcare Common Procedure Coding System (HCPCS) level II codes.
  - e. National Drug Codes (NDC).

When We receive written or electronic proof of loss, We may require additional information. You must furnish all items We decide are necessary to determine Our liability in accordance with the Right to Collect Information provision in this section. We will not pay benefits if the required information or authorization for its release is not furnished to Us.

##### **Right to Collect Information**

To determine Our liability, We may request additional information from a Covered Person, Health Care Practitioner, facility, or other individual or entity. A Covered Person must cooperate with Us, and assist Us by obtaining the following information within [30 days] of Our request. Charges will be denied if We are unable to determine Our liability because a Covered Person, Health Care Practitioner, facility, or other individual or entity failed to:

1. Authorize the release of all medical records to Us and other information We requested.
2. Provide Us with information We requested about pending claims, Other Insurance coverage or proof of creditable coverage.
3. Provide Us with information that is accurate and complete.
4. Have any examination completed as requested by Us.

5. Provide reasonable cooperation to any requests made by Us.

Such charges may be considered for benefits upon receipt of the requested information, provided all necessary information is received prior to expiration of the time allowed for submission of claim information as set forth in this Claim Provisions section.

#### **Physical Examination**

We have the right to have a Health Care Practitioner of Our choice examine a Covered Person at any time regarding a claim for benefits. These exams will be paid by Us.

#### **Payment of Benefits**

Benefits will be paid when We receive due written proof of loss, subject to any time period requirements under state law. Benefits for services provided will be paid to the Certificate Holder unless they have been assigned to a provider. However, We pay Participating Pharmacy providers directly for Covered Charges. Any benefits unpaid at Your death will be paid at Our option to Your spouse, [Your Domestic Partner,] Your estate or the providers of the services.

We will pay medical claims when coded according to the latest editions of the Current Procedural Terminology (CPT) manual or International Classification of Diseases (ICD) manual. We will not pay for: charges that are billed separately as professional services when the procedure requires only a technical component; or charges that are billed incorrectly or billed separately but are an integral part of another billed service, as determined by Us; or other claims that are improperly billed; or duplicates of previously received or processed claims.

Any amount We pay in good faith will release Us from further liability for that amount. Payment by Us does not constitute any assumption of liability for further coverage under this plan. Payment by Us for a Prescription Drug under the Outpatient Prescription Drug Benefits section does not constitute any assumption of liability for coverage of a condition under the Medical Benefits section.

#### **[Payment of Outpatient Prescription Drug Benefits**

Present the ID card with the Prescription Order at the Pharmacy each time a Prescription Order is filled at a Participating Pharmacy. Pay the Participating Pharmacy the difference between the charge for the covered Prescription Drug and the amount We will pay. This applies to each covered Prescription Drug that is filled at a Participating Pharmacy. If the ID card is not used to obtain Prescription Drugs at a Participating Pharmacy, the Covered Person must pay the Participating Pharmacy the entire amount charged for the covered Prescription Drug. Complete a prescription drug claim form. Send it and any Prescription Drug receipts to the Prescription Card Service Administrator (PCSA) at the address shown on the form for reimbursement of Covered Charges. A prescription drug claim form can be obtained from Us.

At a Non-Participating Pharmacy, the Covered Person must pay the Pharmacy the entire amount charged for the covered Prescription Drug. Complete a prescription drug claim form. Send it and any Prescription Drug receipts to the address shown on the form for reimbursement of Covered Charges. A prescription drug claim form can be obtained from Us. ]

#### **Overpayment**

If a benefit is paid under this plan and it is later shown that a lesser amount should have been paid, We will be entitled to recover the excess amount from You or the person or entity receiving the incorrect payment. We may offset any overpayment to You or a provider against future benefit payments.

#### **Rights of Administration**

We maintain Our ability to determine Our rights and obligations under this plan including, without limitation, the eligibility for and amount of any benefits payable.

#### **Claims Involving Misrepresentation or Fraud**

Claims will be denied in whole or in part in the event of misrepresentation or fraud by a Covered Person or a Covered Person's representative. If benefits are paid under this plan and it is later shown the claims for these benefits involved misrepresentation or fraud, We will be entitled to a refund from You or the person or entity receiving the payment.

A claim will not be honored if the Covered Person or the provider of the charges will not, or cannot, provide adequate documentation to substantiate that treatment was rendered for the claim submitted. If the Covered Person, or anyone acting on the Covered Person's behalf, knowingly files a fraudulent claim, claims may be denied in whole or in part, coverage may be terminated or rescinded, and the Covered Person may be subject to civil and/or criminal penalties.

#### **Workers' Compensation Not Affected**

Insurance under this plan does not replace or affect any requirements for coverage by workers' compensation insurance. If state law allows, We may participate in a workers' compensation dispute arising from a claim for which We paid benefits.

**Claim Appeal**

You have the right to request a review of all adverse claim decisions. A review must be requested in writing within [180 days] following Your receipt of the notice that the claim was denied or reduced.  
496.005.XX

**[V.] PREMIUM PROVISIONS****Consideration**

This plan is issued based on the statements and agreements in the Covered Person's enrollment form and during the enrollment process, any exam of a Covered Person that is required, any other amendments or supplements to the enrollment form and payment of the required premium. Each renewal premium is payable on the due date subject to the Grace Period provision in this section.

**Premium Payment**

The initial premium must be paid on or before the due date for this coverage to be in force. Subsequent premiums are due as billed by Us. Each renewal premium must be received by Us on its due date subject to the Grace Period provision in this section. Premiums must be received in cash or check at Our office on the date due. [We may agree to accept premium payment in alternative forms, such as credit card [or automatic charge to a bank account].] [We reserve the right to dishonor any such agreement for payment of premium during the grace period if We tried to obtain payment for the amount due using the alternative method but were unsuccessful.]

Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic area, gender, age, payment method and plan design. All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You add or delete Covered Dependents, change the payment method, move to another zip code or otherwise change the coverage. [The mode of payment (monthly, quarterly or other) is subject to change at Our discretion.]

**Grace Period**

There is a grace period of [31 days] for the payment of each premium due after the initial premium. If the full premium due is not received at Our Home Office by the end of the grace period, the coverage will end on the date that the unpaid premium was due and no charges Incurred during the grace period will be considered for benefits. If the premium is received during or by the end of the grace period, coverage will continue without interruption unless You call Our office or give Us written notice to cancel the coverage.

**Reinstatement**

If any premium is not paid within the required time period, coverage for You and any Covered Dependents will lapse. The coverage will be reinstated if all of the following requirements are met:

1. The lapse was not more than [30 days].
2. You submit an enrollment form for reinstatement to Us along with the required premium payment. Submission of premium to Your agent is not submission of premium to Us.
3. We approve Your enrollment form for reinstatement.

The coverage will be reinstated on the date We approve Your enrollment form for reinstatement. If We have not responded to Your enrollment form for reinstatement by the 45th day after We receive the enrollment form, the coverage will be reinstated on that date.

If the coverage is reinstated, loss resulting from an Injury will be covered only if the Injury is sustained on or after the date of reinstatement. Loss due to a Sickness will be covered only if the Sickness begins [more than [10] days] after the date of reinstatement. No benefits will be paid for a Sickness or an Injury and related complications if during the time between the lapse date and the reinstatement date:

1. Medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or Prescription Drugs were prescribed, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or
2. The condition produced signs or symptoms and 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.

This limitation will apply until coverage has been in force for [12 months] after the reinstatement date, unless the condition has been specifically excluded from coverage.

In all other respects, You and Our Company will have the same rights as existed under this plan before the coverage lapsed, subject to any provisions included with or attached to this plan in connection with the reinstatement.

### **Conversion Privilege**

You and Your Covered Dependents have a right to convert to another similar medical plan that We issue in the Covered Person's state of residence if coverage under the group Policy terminates for any reason, other than non-payment of premium, including discontinuance of the group Policy in its entirety. A Covered Person is not eligible for a conversion with Us if the Covered Person:

1. Replaces this certificate with similar coverage within 31 days after discontinuance of the group Policy.
2. Is eligible for coverage under Medicare.
3. Is eligible for coverage under any other group accident and health policy or contract that provides benefits for all of the Covered Person's pre-existing conditions.

To obtain conversion coverage, the Covered Person must submit a written enrollment form and the required premium to Us within 31 days after coverage under this plan terminates. Evidence of insurability will not be required. Coverage will be provided on the limited benefit medical insurance form that We select for providing conversion coverage at that time. **The benefits in the conversion plan do not necessarily equal or match those benefits provided in this group Policy.** The conversion plan may also provide different premium rates.

If written enrollment is not made within 31 days following the termination of insurance under this plan, conversion coverage may not be available.

The conversion coverage will take effect at 12:01 a.m. local time at the covered person's residence on the day after coverage under this plan terminates. Benefits paid under the new plan cannot exceed the [Maximum Lifetime Benefit or any other] applicable maximum benefit that would have otherwise been paid under the terms of this certificate if coverage under this certificate would have remained in force.

### **Continuation of Coverage**

A Covered Dependent may be eligible to continue coverage under this plan after coverage would otherwise terminate due to loss to dependency or change in marital status. The benefits will be the same as those in effect on the date of termination. You must furnish written request for continuation to Us within 10 days after ceasing to be eligible for coverage. The continued coverage will end on the earliest of:

1. full coverage under any other group accident and health policy or contract. This includes being covered for conditions deemed to be pre-existing conditions under that plan;
2. the end of the period for which premiums are paid;
3. the period ending 120 days from the date continuation began;
4. the premium due date following the date the dependent becomes eligible for Medicare;
5. the date coverage under the plan would have otherwise terminated;
6. the date the Life Time Maximum Benefit amount is reached; or
7. the date the Master Group Policy ends.

The individual shall be eligible for conversion after exhaustion of continuation of coverage.  
496.006.AR

## **[VI.] EFFECTIVE DATE AND TERMINATION DATE**

### **Eligibility and Effective Date of Certificate Holder**

A person who is eligible may elect to be covered under this plan by completing the enrollment process and submitting any required premium. You must be a member of the association to be eligible for coverage. [Evidence of insurability must also be provided.] Your coverage will take effect at 12:01 a.m. local time at the Certificate Holder's state of residence on the date We approve coverage under Our coverage criteria.

[If the Certificate Holder moves to a different state after the Effective Date, We will replace this certificate with a similar plan that is issued in the Certificate Holder's new state of residence. Coverage under the new plan will be effective on the date the Certificate Holder becomes a resident of the new state. If the Certificate Holder moves to a state where We do not provide insurance coverage under a plan similar to this certificate, We reserve the right to terminate this coverage for You and any Covered Dependents.]

### **Eligibility and Effective Date of Dependents**

The following information explains how You can obtain coverage for any Dependents that You want to add to Your plan. A Dependent can be added after the Certificate Holder's Effective Date. To be covered under this plan, a person must meet the Dependent definition in this plan and is subject to the additional requirements below:

- a. **Adding a Newborn Child:** A newborn child can be added on the date the child was born. You must call Our office or send Us written notice of the birth of the child and We must receive any required additional premium within 90 days of birth. The Effective Date of coverage will be 12:01 a.m. local time at the Certificate Holder's state of residence on the date the child is born. [If these requirements are not met, Your newborn child will be covered for Sickness or Injury, including the necessary care and treatment of medically diagnosed congenital defects for the first 90 days from birth.]
- b. **Adding an Adopted Child:** A newly adopted child can be added on the date petition for adoption is filed. You must call Our office or send Us written notice of the petition for adoption of the child and We must receive any required additional premium within 60 days of the placement for adoption. The Effective Date of coverage will be 12:01 a.m. local time at the Certificate Holder's state of residence on the date the petition for adoption is filed. [If these requirements are not met, Your newly adopted child will be covered for Sickness or Injury only for the first 60 days from petition for adoption.] A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement.
- c. **Adding Any Other Dependent:** To add any other Dependents, an enrollment form must be completed and sent to Us along with any required premium. [Evidence of insurability must also be provided.] The Effective Date of coverage will be 12:01 a.m. local time at the Certificate Holder's state of residence on the date We approve coverage under Our coverage criteria.

### **Termination Date of Coverage**

The Certificate Holder may cancel this coverage at any time by sending Us written notice or calling Our office. Upon cancellation, We will return the unearned portion of any premium paid, in accordance with the laws in the Certificate Holder's state of residence, minus any claims that were Incurred after the termination date and paid by Us.

This certificate will terminate at 12:01 a.m. local time at the Certificate Holder's state of residence on the earliest of the following dates:

1. The date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Certificate Holder for termination.
2. The date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is requested by the Certificate Holder for termination of a Covered Dependent.
3. The date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
4. The date there is fraud or intentional misrepresentation of material fact made by or with the knowledge of any Covered Person [applying for this coverage or] filing a claim for benefits.]
- 5.] The date all certificates with the same form number as this certificate are non-renewed in the state in which this certificate was issued or the state in which the Certificate Holder presently resides. We will give You 90 days advance notice of the termination of Your coverage.
- 6.] The date We terminate or non-renew health insurance coverage in the individual market in the state in which this certificate was issued or the state in which You presently reside. We will give You 180 days advance notice, as required by state law, of the termination of Your coverage.
- 7.] [On] [T][t]he date the Certificate Holder moves to a state where We do not provide insurance coverage under a plan with the same form number as this certificate[, We reserve the right to terminate this coverage].
- 8.] The date a Covered Dependent no longer meets the Dependent definition in this plan.
- 9.] The date a Covered Person is no longer a member of the association show as Policyholder on Your Benefit Summary.

496.007.AR

## **[VII.] OTHER PROVISIONS**

### **Modification of Coverage**

We may modify the insurance coverage for You and any Covered Dependents. This modification will be consistent with state law and will apply uniformly to all certificates with Your plan of coverage. You will be notified of any change.

No change in the certificate will be valid unless approved by one of Our executive officers and included with this certificate. No agent or other employee of Our Company has authority to waive or change any plan provision or waive any other applicable enrollment or application requirements.

The group master Policy may be changed at any time. We will give the Policyholder [30 days] notice prior to any change.

#### **Clerical Error**

If a clerical error is made by Us, it will not affect the insurance to which a Covered Person is entitled. Delay or failure to report termination of any insurance will not continue the insurance in force beyond the date it would have terminated according to this certificate. The premium charges will be adjusted as required, but not for more than [two years] prior to the date the error was found. If the premium was overpaid, We will refund the difference. If the premium was underpaid, the difference must be paid to Us within [60 days] of Our notifying You of the error.

#### **Conformity with State Statutes**

If this plan, on its Effective Date, is in conflict with any applicable federal laws or laws of the state where it is issued, it is changed to meet the minimum requirements of those laws. In the event that new or applicable state or federal laws are enacted which conflict with current provisions of this plan, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the plan to the contrary.

#### **Enforcement of Plan Provisions**

Failure by Us to enforce or require compliance with any provision within this plan will not waive, modify or render any provision unenforceable at any other time, whether the circumstances are the same or not.

#### **Entire Contract**

This certificate is issued to the Certificate Holder. The entire contract of insurance includes the group master Policy, a Covered Person's enrollment form, the Covered Person's certificate of insurance and any riders and endorsements.

In the absence of fraud, all statements made by applicants, the Policyholder, or Covered Persons are deemed representations and not warranties and no statement made for the purpose of effective insurance shall void the insurance or reduce benefits unless contained in a written instrument signed by the applicant, Policyholder or Covered Person, a copy of which has been furnished to the person or his or her beneficiary.

#### **[Incentives, Rebates and Contributions**

[We may elect to furnish [or participate in programs with other organizations that furnish] [group applicants for coverage] [members of groups applying for coverage][individual applicants for coverage][Covered Persons] [individuals] [that meet common criteria or requirements determined by Us] [not to include health or claims history] with "premium holidays" or programs where premiums, fees, plan benefit limits will be discounted, credited, refunded, waived or otherwise adjusted [or] [where other gifts or items of value may be offered or provided to You at no charge or a discount] [at a time or times] [or] [for a period] determined by Us.]]

#### **Misstatements**

If a Covered Person's material information has been misstated and the premium amount would have been different had the correct information been disclosed, an adjustment in premiums may be made based on the corrected information. In addition to adjusting future premiums, We may require payment of past premiums at the adjusted rate to continue coverage. If the Covered Person's age is misstated and coverage would not have been issued based on the Covered Person's true age, Our sole liability will be to refund all of the premiums paid for that Covered Person's coverage, minus the amount of any benefits paid by Us.

#### **[Rescission of Insurance and/or Denial of Claim**

Within the first two years after the Effective Date of coverage, We have the right to rescind or modify Your certificate of insurance coverage and/or deny a claim for a Covered Person if the enrollment form contains an omission or misrepresentation, whether intended or not, which We determine to be material. We also reserve the right to rescind a

certificate of insurance and/or deny a claim for a fraudulent misstatement or omission at any time during the coverage period. ]

**Legal Action and Forum**

No suit or action at law or in equity may be brought to recover benefits under this plan until the exhaustion of administrative remedies. You agree that You will not file a suit or legal action against Us for any breach of this agreement or denial of benefits without first submitting the dispute through Our claims review process. No suit or action at law or in equity can be brought later than [3 years] from the date the charges were Incurred. Any lawsuits or disputes arising under the terms of the group master Policy must be brought in the United States District Court for the Eastern District of Wisconsin.  
496.008.AR

**[VIII.] 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.

**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 under the Outpatient Prescription Drug Benefits section or any other section in this plan.

**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.

**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 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. ]

### **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 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 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. The Benefit Summary will identify what any applicable Copayments are along with the Covered Charges to which they apply.

### **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 Medical Benefits section.
3. It is Incurred for treatment, services, drugs, medicines or supplies listed in the Medical Office Visits Benefits section, including those for Preventive, Restorative and Other Medical Services, or Outpatient Prescription Drug Benefits section.
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 enrolled and eligible to receive benefits under this plan.

### **Covered Person**

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

### **[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. **[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.]
- [2.] **[Individual 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 Deductible have been Incurred and processed by Us, the Individual Deductible for that Covered Person will be satisfied for the remainder of the time period shown in the Benefit Summary. ]]]

### **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.]

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 within [31 days] 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. [Attains age [24]; or]
- c. [Marries; or]
- d. [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.]

### **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.

### **[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 Office**

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

#### **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.

#### **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 Allowable Cost (MAC) List**

A list of Prescription Drugs that are considered for reimbursement at a Generic Drug product level [or a Prescription Drug Class level] [based on the Prescription Drug Class Reference Price] that is established by Us. This list is subject to change at any time without notice.]

#### **[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 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-Preferred Brand Name Drug**

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

**Office Visit**

An in-person, face-to-face meeting between a Covered Person and a [Primary Care Practitioner] [,] [or] [Health Care Practitioner] [or] [Specialist Practitioner] in his or her office[or][,] at a Retail Health Clinic[, or in an Urgent Care Facility]. During this meeting, the [Primary Care Practitioner] [,] [or] [Health Care Practitioner] [or] [Specialist 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 or a free-standing facility.

**[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.]

**[Pharmacy**

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

**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.

**[Primary Care Practitioner**

A Health Care Practitioner who is a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) whose practice predominantly includes pediatrics, internal medicine, family practice, general practice or obstetrics/gynecology. [A [licensed nurse practitioner,] [podiatrist,] chiropractor [and] [dentist] would also qualify as a Primary Care Practitioner if he or she meets the definition of a Health Care Practitioner and the services rendered would be Covered Charges if performed by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is also a Primary Care Practitioner.]

**[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 Class**

Prescription Drugs that are grouped by Us according to a specific category, such as [Therapeutic Class,] Brand Name Drug or Generic Drug designation, diagnosis or cost effectiveness. The actual Prescription Drugs that are included in each category are shown on a Drug List that is broken down by tiers or levels based on the way Covered Charges for the drugs are reimbursed by Us. We may periodically change the placement of a Prescription Drug from one tier or level to another at any time without notice. As a result of these changes, a Covered Person may be required to pay more or less for a Prescription Drug.

The Benefit Summary will identify what any applicable Prescription Drug Copayment[, [and] other Prescription Drug Out-of-Pocket Limits] and any maximum limits are for each tier or level of coverage in each category [along with the [time period] [Plan Year] [Calendar Year] [Benefit Period] that applies to each coverage tier or level].]

**[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 Ancillary Charge 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**

Office Visit and Diagnostic Imaging and Laboratory services, as provided in the Medical Benefits section, for:

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. For purposes of determining benefits under this plan, each admission or outpatient visit will be considered an Office Visit and subject to all plan terms, conditions and maximum benefit limitations for Office Visits as shown on the Benefit Summary.
3. 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.

#### **[Reference Price**

The maximum amount that We will pay for covered Prescription Drugs within a Prescription Drug Class or within similar Prescription Drug Classes as established by Us.]

#### **Retail Health Clinic**

A facility that meets 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 a Health Care Practitioner in accordance with the laws of that state;
3. is attached to or part of a store or retail facility;
4. is separate from a hospital, emergency room, acute medical rehabilitation facility, free-standing facility, skilled nursing facility, subacute rehabilitation facility, or urgent care facility, and any Health Care Practitioner's office located therein, even when services are performed after normal business hours;"
5. provides general medical treatment or services for a Sickness or Injury[, or provides preventive medicine services,] on a non-seasonal basis; and

6. does not provide room and board or overnight services.

**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.

**[Specialist Practitioner**

A Health Care Practitioner who is classified as a specialist by the American Boards of Medical Specialties. [A Specialist Practitioner, for purposes of this plan, [is not][and][cannot be] a Primary Care Practitioner. For purposes of benefit determination under this plan, a psychological examiner is considered a Specialist Practitioner for treatment of mental health disorders.]

**[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 Diagnostic Imaging and Laboratory Services.]

**We, Us, Our, Our Company**

Time Insurance Company or its administrator.

**You, Your, Yours**

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