

SERFF Tracking Number: HUMA-125880356 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 40731
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Annual Max Plan
Project Name/Number: /

Filing at a Glance

Company: Humana Insurance Company

Product Name: Annual Max Plan

TOI: H16G Group Health - Major Medical

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

Filing Type: Form

SERFF Tr Num: HUMA-125880356 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 40731

Co Tr Num:

State Status: Approved-Closed

Co Status:

Reviewer(s): Rosalind Minor

Author: Latunia Riley

Disposition Date: 01/08/2009

Date Submitted: 10/31/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

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: 01/08/2009

State Status Changed: 01/08/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

New Filing

Company and Contact

Filing Contact Information

Latunia Riley, Contract Analyst

lriley2@humana.com

2 Riverwood Place

(262) 951-2617 [Phone]

Waukesha, WI 53188

SERFF Tracking Number: HUMA-125880356

State: Arkansas

Filing Company: Humana Insurance Company

State Tracking Number: 40731

Company Tracking Number:

TOI: H16G Group Health - Major Medical

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

Product Name: Annual Max Plan

Project Name/Number: /

Filing Company Information

Humana Insurance Company
1100 Employers Boulevard
Green Bay, WI 54344
(800) 558-4444 ext. [Phone]

CoCode: 73288
Group Code: 119
Group Name:
FEIN Number: 39-1263473

State of Domicile: Wisconsin
Company Type: Life & Health
State ID Number:

SERFF Tracking Number: HUMA-125880356 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 40731
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Annual Max Plan
Project Name/Number: /

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Insurance Company	\$50.00	10/31/2008	23634331

SERFF Tracking Number: HUMA-125880356

State: Arkansas

Filing Company: Humana Insurance Company

State Tracking Number: 40731

Company Tracking Number:

TOI: H16G Group Health - Major Medical

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

Product Name: Annual Max Plan

Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Rosalind Minor	01/08/2009	01/08/2009

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	12/30/2008	12/30/2008	Latunia Riley	01/05/2009	01/05/2009
Pending Industry Response	Rosalind Minor	11/03/2008	11/03/2008	Latunia Riley	11/04/2008	11/04/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Response Letter	Supporting Document	Latunia Riley	12/30/2008	12/30/2008
Musculoskeletal Disorders Option	Supporting Document	Latunia Riley	12/30/2008	12/30/2008
Arkansas	Form	Latunia Riley	12/30/2008	12/30/2008
Arkansas	Form	Latunia Riley	12/30/2008	12/30/2008
Arkansas	Form	Latunia Riley	11/05/2008	11/05/2008

SERFF Tracking Number: HUMA-125880356

State: Arkansas

Filing Company: Humana Insurance Company

State Tracking Number: 40731

Company Tracking Number:

TOI: H16G Group Health - Major Medical

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

Product Name: Annual Max Plan

Project Name/Number: /

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Your amendment submitted on 11/5/08	Note To Filer	Rosalind Minor	11/06/2008	
Policyholder Enrollment Form	Note To Filer	Rosalind Minor	11/04/2008	

SERFF Tracking Number: HUMA-125880356 *State:* Arkansas
Filing Company: Humana Insurance Company *State Tracking Number:* 40731
Company Tracking Number:
TOI: H16G Group Health - Major Medical *Sub-TOI:* H16G.001A Any Size Group - PPO
Product Name: Annual Max Plan
Project Name/Number: /

Disposition

Disposition Date: 01/08/2009

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: HUMA-125880356

State: Arkansas

Filing Company: Humana Insurance Company

State Tracking Number: 40731

Company Tracking Number:

TOI: H16G Group Health - Major Medical

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

Product Name: Annual Max Plan

Project Name/Number: /

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	By-Laws	Approved-Closed	Yes
Supporting Document	PBA Brochure	Approved-Closed	Yes
Supporting Document	Statements of Variability	Approved-Closed	Yes
Supporting Document	Association Checklist	Approved-Closed	Yes
Supporting Document	Policy Variables	Approved-Closed	Yes
Supporting Document	Matrix Filing Listing	Approved-Closed	Yes
Supporting Document	NAIC Transmittal Document	Approved-Closed	Yes
Supporting Document (revised)	Response Letter	Approved-Closed	Yes
Supporting Document	Response Letter	Replaced	Yes
Supporting Document	Musculoskeletal Disorders Option	Approved-Closed	Yes
Supporting Document	Group Application	Approved-Closed	Yes
Form	Certificate Cover	Approved-Closed	Yes
Form	Table of Contents	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	How We Pay Benefits	Approved-Closed	Yes
Form	Utilization Management	Approved-Closed	Yes
Form	Your Certificate Benefits	Approved-Closed	Yes
Form	Claims Payment	Approved-Closed	Yes
Form	Coordination of Benefits	Approved-Closed	Yes
Form	Pre-Existing Condition	Approved-Closed	Yes
Form	Limitations and Exclusions	Approved-Closed	Yes
Form	Termination Rights	Approved-Closed	Yes
Form	Transferring Coverage	Approved-Closed	Yes
Form	Premium Payment	Approved-Closed	Yes
Form	Changes to the Certificate	Approved-Closed	Yes
Form	General Provisions	Approved-Closed	Yes
Form	Recovery Rights	Approved-Closed	Yes
Form	Definitions	Approved-Closed	Yes

SERFF Tracking Number: HUMA-125880356 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 40731
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: Annual Max Plan
 Project Name/Number: /

Form	Office Copayment Rider	Approved-Closed	Yes
Form	Supplemental Accident Rider	Approved-Closed	Yes
Form	Term Life Rider	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form (revised)	Arkansas	Approved-Closed	Yes
Form	Arkansas	Replaced	Yes
Form	Arkansas	Replaced	Yes
Form	Arkansas	Replaced	Yes
Form	Optional Mammography Rider	Approved-Closed	Yes
Form	Optional Alcohol and Dependency Rider	Approved-Closed	Yes
Form	Optional Hospice Rider	Approved-Closed	Yes
Form	Optional Musculoskeletal Disorders Rider	Approved-Closed	Yes
Form	Mental Illness Rider	Approved-Closed	Yes
Form	Back Cover	Approved-Closed	Yes
Form	HumanaOne PPO Annual	Approved-Closed	Yes

SERFF Tracking Number: HUMA-125880356 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 40731
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Annual Max Plan
Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 12/30/2008

Submitted Date 12/30/2008

Respond By Date

Dear Latunia Riley,

This will acknowledge receipt of the captioned filing.

Objection 1

- Musculoskeletal Disorders Option (Supporting Document)

Comment: To be in compliance with the TMJ law, the application/enrollment form must follow the law as outlined below:

As outlined under ACA 23-79-150(c)(1), it is stated that...."The policyholder shall accept or reject the optional coverage in writing on the application....". This form does not appear to be an application and/or enrollment form.

Also, as outlined under ACA 23-79-150(c)(2), it is stated that...."The application shall specifically and conspicuously inform the policyholder that rejection of the option means that covered benefits provide to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder....".

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State

Response Letter Date 01/05/2009

Submitted Date 01/05/2009

Dear Rosalind Minor,

Comments:

Response 1

Comments: Dear Ms Minor,

SERFF Tracking Number: HUMA-125880356 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 40731
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Annual Max Plan
Project Name/Number: /

I attached the group application that we respectfully ask to be filed for informational purposes. The group application list the optional TMJ mandate following ACA 23-79-150 (c) (2).

Thank you for your time and all the helpful information you have provided me in completing this filing.

Latunia Riley

Related Objection 1

Applies To:

- Musculoskeletal Disorders Option (Supporting Document)

Comment:

To be in compliance with the TMJ law, the application/enrollment form must follow the law as outlined below:

As outlined under ACA 23-79-150(c)(1), it is stated that...."The policyholder shall accept or reject the optional coverage in writing on the application....". This form does not appear to be an application and/or enrollment form.

Also, as outlined under ACA 23-79-150(c)(2), it is stated that...."The application shall specifically and conspicuously inform the policyholder that rejection of the option means that covered benefits provide to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder....".

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Group Application

Comment: Please note that this application is for informational purposes only.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Latunia Riley

SERFF Tracking Number: HUMA-125880356 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 40731
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Annual Max Plan
Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 11/03/2008
Submitted Date 11/03/2008
Respond By Date
Dear Latunia Riley,

This will acknowledge receipt of the captioned filing.

Objection 1

- HumanaOne PPO Annual (Form)

Comment: Since you have TMJ as an optional rider, under ACA 23-79-150(c)(1) - The policyholder shall accept or reject the optional coverage in writing on the application.

Also, under ACA 23-79-150(c)(2), the application shall specifically and conspicuously inform the policyholder that rejection of the option means that covered benefits provided to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder.

Objection 2

- Schedule of Benefits (Form)

Comment: With respect to benefits payable a PPO and Non-PPO, it is requested that you provide written certification that benefits payable will comply with our Bulletin 9-85 that there will be no more than a 25% differential in the benefits paid a PPO and Non-PPO.

Please feel free to contact me if you have questions.

Sincerely,
Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 11/04/2008
Submitted Date 11/04/2008

Dear Rosalind Minor,

SERFF Tracking Number: HUMA-125880356 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 40731
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Annual Max Plan
Project Name/Number: /

Comments:

Response 1

Comments: Dear Ms Minor:

Attached is a copy of my response letter addressing your objections that was sent to my attention on 11/3/08.

Thank you,

Latunia Riley

Related Objection 1

Applies To:

- HumanaOne PPO Annual (Form)

Comment:

Since you have TMJ as an optional rider, under ACA 23-79-150(c)(1) - The policyholder shall accept or reject the optional coverage in writing on the application.

Also, under ACA 23-79-150(c)(2), the application shall specifically and conspicuously inform the policyholder that rejection of the option means that covered benefits provided to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder.

Related Objection 2

Applies To:

- Schedule of Benefits (Form)

Comment:

With respect to benefits payable a PPO and Non-PPO, it is requested that you provide written certification that benefits payable will comply with our Bulletin 9-85 that there will be no more than a 25% differential in the benefits paid a PPO and Non-PPO.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Response Letter

Comment:

No Form Schedule items changed.

SERFF Tracking Number: HUMA-125880356

State: Arkansas

Filing Company: Humana Insurance Company

State Tracking Number: 40731

Company Tracking Number:

TOI: H16G Group Health - Major Medical

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

Product Name: Annual Max Plan

Project Name/Number: /

No Rate/Rule Schedule items changed.

Sincerely,
Latunia Riley

SERFF Tracking Number: HUMA-125880356 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 40731
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Annual Max Plan
Project Name/Number: /

Amendment Letter

Amendment Date:

Submitted Date: 12/30/2008

Comments:

Revised Response Letter that includes policyholder TMJ election form

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Response Letter

Comment:

AR AMP Response Letter.pdf

SERFF Tracking Number: HUMA-125880356 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 40731
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Annual Max Plan
Project Name/Number: /

Amendment Letter

Amendment Date:

Submitted Date: 12/30/2008

Comments:

Hello Rosalind,

Attached is a copy of the policyholder election form for TMJ. We are filing this form for informational purposes only to show what will be sent to the policyholder.

Thank you!

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Musculoskeletal Disorders Option

Comment: This form is filed for informational purposes only

Optional AMP Benefit Election-Musculoskeletal Disorders filed for informational purposes only..pdf

SERFF Tracking Number: HUMA-125880356

State: Arkansas

Filing Company: Humana Insurance Company

State Tracking Number: 40731

Company Tracking Number:

TOI: H16G Group Health - Major Medical

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

Product Name: Annual Max Plan

Project Name/Number: /

Amendment Letter

Amendment Date:

Submitted Date: 12/30/2008

Comments:

Revised Children's preventive healthcare services.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
AR-71012-01 LBP 1/2008	Policy/Contract/Fraternal Certificate:	Arkansas	Initial					AR LBP Certificate Resident Rider.pdf
	Amendment, Insert Page, Endorsement or Rider							

SERFF Tracking Number: HUMA-125880356 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 40731
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: Annual Max Plan
 Project Name/Number: /

Amendment Letter

Amendment Date:
 Submitted Date: 12/30/2008

Comments:
 Revised rider with corrected Children preventive health services.

Changed Items:
Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
AR-71012-01 LBP 1/2008	Policy/Contract/Fraternal Certificate:	Arkansas	Initial					AR LBP Certificate Resident Rider.pdf
	Amendment, Insert Page, Endorsement or Rider							

SERFF Tracking Number: HUMA-125880356 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 40731
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: Annual Max Plan
 Project Name/Number: /

Amendment Letter

Amendment Date:
 Submitted Date: 11/05/2008

Comments:

Dear Ms Minor:

I have included a revised copy of the state specific rider in addition to the response letter that was sent to your attention on 11/4/08.

Thank You,

Latunia Riley

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
AR-71012-01 LBP 1/2008	Policy/Contract/Certificate:	Arkansas	Initial					AR LBP Certificate Resident Rider.pdf
	Amendment, Insert Page, Endorsement or Rider							

SERFF Tracking Number: HUMA-125880356 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 40731
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Annual Max Plan
Project Name/Number: /

Note To Filer

Created By:

Rosalind Minor on 11/06/2008 08:52 AM

Subject:

Your amendment submitted on 11/5/08

Comments:

In my Note to Filer on 11/4/08, I requested a copy of the approved enrollment form for the policyholder. If a form has not yet been submitted for approval, please do so. The form must contain the language as outlined under ACA 23-79-150 (c)(1)& (2).

Thank you so much for your cooperation in this matter.

SERFF Tracking Number: HUMA-125880356 *State:* Arkansas
Filing Company: Humana Insurance Company *State Tracking Number:* 40731
Company Tracking Number:
TOI: H16G Group Health - Major Medical *Sub-TOI:* H16G.001A Any Size Group - PPO
Product Name: Annual Max Plan
Project Name/Number: /

Note To Filer

Created By:

Rosalind Minor on 11/04/2008 08:43 AM

Subject:

Policyholder Enrollment Form

Comments:

Before this filing is approved, please provide our Department with a copy of the approved enrollment form for the policyholder.

We appreciate your cooperation in this matter.

SERFF Tracking Number: HUMA-125880356 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 40731
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: Annual Max Plan
 Project Name/Number: /

Form Schedule

Lead Form Number: GN-71012-01 1/2008

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GN-71012-01 1/2008	Policy/Cont ract/Fraternal	Certificate Cover	Initial			GN Certificate Cover.pdf
Approved-Closed	GN-71012-01 TAB 1/2008	Policy/Cont ract/Fraternal	Table of Contents	Initial			GN Table of Contents.pdf
Approved-Closed	GN-71012-01 SCH 1/2008	Policy/Cont ract/Fraternal	Schedule of Benefits	Initial			GN Schedule of Benefits.pdf
Approved-Closed	GN-71012-01 PAY 1/2008	Policy/Cont ract/Fraternal	How We Pay Benefits	Initial			GN How We Pay Benefits.pdf

SERFF Tracking Number: HUMA-125880356 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 40731
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: Annual Max Plan
 Project Name/Number: /

t, Insert
 Page,
 Endorseme
 nt or Rider

Approved- GN-71012- Policy/Cont Utilization Initial GN Utilization
 Closed 01 UM ract/Fratern Management Management.
 1/2008 al pdf

Certificate:
 Amendmen
 t, Insert
 Page,
 Endorseme
 nt or Rider

Approved- GN-71012- Policy/Cont Your Certificate Initial GN Your
 Closed 01 BEN ract/Fratern Benefits Certificate
 1/2008 al Benefits.pdf

Certificate:
 Amendmen
 t, Insert
 Page,
 Endorseme
 nt or Rider

Approved- GN-71012- Policy/Cont Claims Payment Initial GN Claims
 Closed 01 CLM ract/Fratern Payment.pdf
 1/2008 al

Certificate:
 Amendmen
 t, Insert
 Page,
 Endorseme
 nt or Rider

Approved- GN-71012- Policy/Cont Cloordination of Initial GN
 Closed 01 COB ract/Fratern Benefits Coordination
 1/2008 al of
 Certificate: Benefits.pdf

Amendmen
 t, Insert
 Page,

SERFF Tracking Number: HUMA-125880356 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 40731
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: Annual Max Plan
 Project Name/Number: /

Approved- Closed	GN-71012- 01 PREM 1/2008	Policy/Cont Premium Payment ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	GN Premium Payment .pdf
Approved- Closed	GN-71012- 01 CHG 1/2008	Policy/Cont Changes to the ract/Fratern Certificate al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	GN Changes to the Certificate.pdf
Approved- Closed	GN-71012- 01 GP 1/2008	Policy/Cont Gneral Provisions ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	GN General Provisions.pdf
Approved- Closed	GN-71012- 01 RR 1/2008	Policy/Cont Recovery Rights ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	GN Recovery Rights.pdf
Approved- Closed	GN-71012- 01 DEF	Policy/Cont Defintions ract/Fratern	Initial	GN Definitions.pdf

<i>SERFF Tracking Number:</i>	<i>HUMA-125880356</i>	<i>State:</i>	<i>Arkansas</i>	
<i>Filing Company:</i>	<i>Humana Insurance Company</i>	<i>State Tracking Number:</i>	<i>40731</i>	
<i>Company Tracking Number:</i>				
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001A Any Size Group - PPO</i>	
<i>Product Name:</i>	<i>Annual Max Plan</i>			
<i>Project Name/Number:</i>	<i>/</i>			
	1/2008	al		
		Certificate:		
		Amendmen		
		t, Insert		
		Page,		
		Endorseme		
		nt or Rider		
Approved- Closed	GN-71012- 01 COPAY 1/2008	Policy/Cont Office Copayment ract/Fratern Rider al	Initial	GN Office Visit Copayment Rider.pdf
		Certificate:		
		Amendmen		
		t, Insert		
		Page,		
		Endorseme		
		nt or Rider		
Approved- Closed	GN-71012- 01 SAB 1/2008	Policy/Cont Supplemental ract/Fratern Accident Rider al	Initial	GN Supplemental Accident Rider.pdf
		Certificate:		
		Amendmen		
		t, Insert		
		Page,		
		Endorseme		
		nt or Rider		
Approved- Closed	GN-71012- 01 TLR 1/2008	Policy/Cont Term Life Rider ract/Fratern al	Initial	GN Term Life Insurance Rider.pdf
		Certificate:		
		Amendmen		
		t, Insert		
		Page,		
		Endorseme		
		nt or Rider		
Approved- Closed	GN-71012- 01 AMNED 1/2008	Policy/Cont Amendment ract/Fratern al	Initial	GN Amendment.p df
		Certificate:		

SERFF Tracking Number: HUMA-125880356 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 40731
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: Annual Max Plan
 Project Name/Number: /

Page,
 Endorseme
 nt or Rider

Approved- Closed	AR-71012- 01 MD LBP 1/2008	Policy/Cont Optional rct/Fratern Musculoskeletal al Disorders Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	AR MD Rider Optional Rider.pdf
Approved- Closed	AR-71012- 01 MI LBP 1/2008	Policy/Cont Mental Illness Rider rct/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	AR Mental Illness Rider.pdf
Approved- Closed	GN-BACK COVER	Policy/Cont Back Cover rct/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	GN Back Cover.pdf
Approved- Closed	AR-71005 10/2008	Application/HumanaOne PPO Enrollment Annual Form	Initial	AR-71005- 1008.pdf

CERTIFICATE OF INSURANCE

[*Policyholder*: [ABC Association]]
[*Primary Insured*: [John Doe]]
[*Certificate number*: [12345]]
[*Effective date*: [January 1, 2008 as of 12:01 a.m.]]
[Initial] premium amount: [\$ Monthly/Quarterly/Semi-annually/Annually]]

Humana Insurance Company has issued a group *policy* to an association to insure *covered persons* who are named in the Schedule of Benefits. In accordance with the terms of the *policy* issued, we certify that a *covered person* is insured for the benefits described in this *certificate*. State mandated benefits, if applicable, are incorporated through a rider attached to this *certificate*. We reserve the full and exclusive right to interpret the terms of the *policy* and this *certificate* to determine the benefits payable hereunder.

The benefits of this *certificate* providing your coverage are governed primarily by the laws of a state other than the state in which you reside. In fact, the benefits of this *certificate* are governed by the laws of the District of Columbia. Please read this *certificate* carefully.

[This *certificate* is issued in consideration of the *primary insured's* enrollment form, a copy of which is attached and made a part of this *certificate*, and such *primary insured's* payment of premiums as provided under this *certificate*. [Please check your *certificate* for errors. An incorrect or incomplete enrollment form may cause your *certificate* to be voided and claims to be reduced or denied].]

This *certificate* and the insurance it provides become effective 12:01 a.m. (*your time*) of the *effective date* stated above. This *certificate* and the insurance it provides terminate at 12:00 Midnight (*your time*) of the date of termination. The provisions stated above and on the following pages are part of this *certificate*.

[1700]

Renewability

This *certificate* remains in effect at the option of the *primary insured* except as provided in the "Termination Rights" section of this *certificate*.

[1701]

Right to Return Certificate

You have the right to return this *certificate* within [10 calendar days] of its initial delivery. If *you* choose to return this *certificate* within the [10 day] period, *we* will refund any premium that *you* have paid. If *you* return this *certificate* within the [10 day] period, it will be void and *we* will have no liability under any of the terms or provisions of this *certificate*. There will be no coverage for any claims incurred.

[1702]

[Signature of Officer]
[Typed Name of Officer]
[Title of Officer]

TABLE OF CONTENTS

[Schedule of Benefits] [A summary of <i>deductibles, copayments, out-of-pocket limits</i> , waiting periods, <i>calendar year certificate</i> maximums and benefit maximums]	[xx]
[How We Pay Benefits] [An explanation of how <i>we</i> determine coverage under this <i>certificate</i>]	[xx]
[Utilization Management] [A description of the <i>services</i> which require notification and <i>our</i> review process]	[xx]
[Your Certificate Benefits] [An explanation of <i>covered expenses</i>]	[xx]
[Claims Payment] [An explanation of how claims are submitted and paid]	[xx]
[Coordination of Benefits] [An explanation of how benefits are determined for a <i>covered person</i> who is covered by more than 1 health plan]	[xx]
[Pre-Existing Condition Limitation] [The time period that conditions are excluded from payment under this <i>certificate</i>]	[xx]
[Limitations and Exclusions] [<i>Services</i> that are not covered, partially covered or covered only under certain conditions]	[xx]
[Termination Rights] [Why and when coverage may end]	[xx]
[Transferring Coverage] [How a <i>covered person</i> may continue coverage or obtain a new <i>certificate</i>]	[xx]
[Premium Payment] [Explanation of premium obligations]	[xx]
[Changes to the Certificate] [How <i>you</i> may make changes to <i>your</i> coverage]	[xx]
[General Provisions] [General information about how <i>we</i> administer this <i>certificate</i>]	[xx]
[Recovery Rights] [<i>Our</i> policy regarding duplication of benefits]	[xx]
[Definitions] [Definitions of words and phrases that appear in italics through this <i>certificate</i>]	[xx]
[Office Visit Copayment Rider]	[xx]
[Supplemental Accident Rider]	[xx]

TABLE OF CONTENTS

[Term Life Insurance Rider]
[1703]

[xx]

SCHEDULE OF BENEFITS

Your certificate refers to various dollar and percentage amounts, as well as other benefit information that may be specific to the *covered person(s)*. This "Schedule of Benefits" summarizes benefit information and the date these benefits take effect. *You* selected some of these benefits when *you* applied for this plan. As *your* needs change over the time *you* own this *certificate*, *you* may change some of these benefits without replacing or purchasing an entirely new plan. Some of the provisions of this *certificate* require automatic changes to *your certificate*. For example, when a *dependent* no longer qualifies for coverage under this *certificate* due to age or school status, that *dependent's* coverage under this *certificate* will be terminated. When changes are made to benefits, they may be reflected in this section.

Please read *your* entire *certificate* to fully understand all terms, conditions, limitations and exclusions that apply.

[1704]

Date these benefits take effect: [xx/xx/xxxx]

[1705]

Certificate Effective Date: [xx/xx]xxxx

Primary insured: [name]

[*Certificate number:*] [#]

Covered Person(s):	Name:	Amendment/Exclusion Rider:
[Primary insured]	[name]	[none] [form #]
[Dependent]	[name]	[none] [form #]

[1706]

Medical Deductible Information

Individual medical deductible per covered person per calendar year for all *services* except [*prescription* drugs] or as otherwise provided [(any expenses *you* incur as *copayments* or *coinsurance* do not apply to the *calendar year deductible*)]

Network Provider: [\$XXX]

Non-Network Provider: [\$XXX]/[X] [times the individual medical *deductible* amount for *network provider*

[1707]

Family medical deductible per calendar year for all *services* except [*prescription* drugs] or as otherwise provided [(any expenses *you* incur as *copayments* or *coinsurance* do not apply to the *calendar year deductible*)]

Network Provider: [X] [times the individual medical *deductible* amount for *network providers*]/[\$XXXX]

Non-Network Provider: [X] [times the individual medical *deductible* amount for *non-network providers*]/[X] [times the family medical *deductible* amount for *network provider*]/[\$XXXX]

[1708]

SCHEDULE OF BENEFITS

Prescription drug deductible per covered person per calendar year [(copayments do not apply to the calendar year deductible.) This is in addition to the covered person's individual medical deductible). [Level 1 drugs are exempt from the prescription drug deductible.]

Network Pharmacy: [\$xxx]

[Non-Network Pharmacy: [\$xxx]]

[1709]

Coinsurance and Out-of-Pocket Limit Information

Coinsurance Shared Expenses Breakdown

Network Provider: You pay [XX%], we pay [XX%] of certain covered expenses

Non-Network Provider: You pay [XX%], we pay [XX%] of certain covered expenses

When the amount of combined covered expenses paid by you and/or all your covered dependents satisfy the separate network and/or non-network provider deductible and out-of-pocket limits as shown below, we will pay [100%] of covered expenses for the remainder of the calendar year, unless specifically indicated, subject to any [calendar year maximums,] [benefit maximums,][and] [the] [lifetime maximum of this certificate]

[1710]

Individual out-of-pocket limit per calendar year (any expenses a covered person incurs [as copayments or deductibles,] [or] [utilization management penalties,] [or prescription drugs] do not apply toward the calendar year out-of-pocket limit)

Network Provider: [\$XXXX] per covered person per calendar year

Non-Network Provider: [\$XXXX] per covered person per calendar year

[1711]

Family out-of-pocket limit per calendar year (any expenses a covered person incurs [as copayments or deductibles,] [or] [utilization management penalties,] [or prescription drugs] do not apply toward the calendar year out-of-pocket limit)

Network Provider: [X] [times the individual out-of-pocket limit amount for network providers per covered family per calendar year/[\$XXXX] per covered family per calendar year

Non-Network Provider: [X] [times the individual out-of-pocket limit amount for non-network providers per covered family per calendar year/ [\$XXXX} per covered family per calendar year

[1712]

Some coinsurance percentages and limits relating to non-network providers will revert to those of the network providers when we determine access to network providers is inadequate. See the "How We Pay Benefits" section for the circumstances causing this reversion to apply.

[1713]

SCHEDULE OF BENEFITS

Waiting Periods

[XX] [days for all *sicknesses* and includes *services* provided for non-emergency] [and *emergency care*]

[XX] [days] [for] [non-emergency] [removal] [of] [tonsils] [and]/[or] [adenoids]

[XX] [days] [for] [non-emergency] [surgical treatment] [for] [hernia,] [bunions,] [varicose veins,] [or] [hemorrhoids]

[1714]

Calendar Year Certificate Maximums

- The maximum benefit this *certificate* will pay in a *calendar year* is the **All Covered Expenses Certificate Maximum**. When *covered expenses* are paid for *services* rendered in a *calendar year* and the amount reaches the **All Covered Expenses Certificate Maximum**, no additional benefits are payable for *services* rendered in that *calendar year*.
- During the *calendar year*, covered *outpatient services* will be applied and reduce the **Outpatient Services Certificate Maximum**. When covered *outpatient services* are paid for *services* rendered in a *calendar year* and the amount reaches the **Outpatient Services Certificate Maximum**, no additional *outpatient services* benefits are payable for these *services* rendered in that *calendar year*.
- In addition, certain *outpatient services*, [Ambulance,] [Durable Medical Equipment,] [Skilled Nursing Facility,] [Home Health,] [Physical Medicine,] [Prescription Drugs,] [Preventive Care,] [and] [Transplant Services], have a *calendar year Benefit Maximum*. When *covered expense* benefits are paid for *services* rendered in a *calendar year* and the amount reaches the **Benefit Maximum**, no additional benefits are payable for these *services* rendered in that *calendar year*
- *Covered expenses* applied to the **Benefit Maximum** for certain *services*, as outlined above, the **Outpatient Services Certificate Maximum** will also apply to and reduce the **All Covered Expenses Certificate Maximum** for *services* rendered in a *calendar year*

Outpatient Services Certificate Maximum

[\$XXXXXX] per *covered person* per *calendar year*

[1715]

All Covered Expenses Certificate Maximum

[\$XXXXXX} per *covered person* per *calendar year*

[1715.1]

Lifetime Certificate Maximum

[\$XXXXXXX] per *covered person*

[1716]

SCHEDULE OF BENEFITS

Medical Covered Expenses and Benefit Maximums

Ambulance

- [Benefit maximum [\$XXXX] per covered person per calendar year]

Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

Non-Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

[1717]

Durable Medical Equipment

- [Benefit maximum [\$XXXX] per covered person per calendar year]

Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

Non-Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

[1718]

Emergency Services

Network Provider: [copay [\$XX] per visit (waived if admitted as inpatient)], [deductible] [and] [\$XX][XX%] coinsurance/[You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

Non-Network Provider: [copay [XX] per visit (waived if admitted as inpatient)], [deductible] and [\$XX][XX%] coinsurance/[You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

[1719]

Healthcare Treatment Facility Services

- [*Skilled nursing facility* is limited to [XX days] per covered person per calendar year]

Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

Non-Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expense [after deductible]

[1720]

Healthcare Practitioner Services

- *Services* for an assistant surgeon are limited to [20%] of the *covered expense* for the surgeon performing the *surgery*
- *Services* for certified surgical assistant are limited to [10%] of the *covered expense* if billed through the surgeon, unless otherwise allowed by state law

SCHEDULE OF BENEFITS

- *Surgery*, including necessary postoperative care. Benefits will be reduced for secondary or multiple surgical procedures performed in the same operative session
 - [50%] of the *maximum allowable fee* for the secondary procedure; and
 - [25%] of the *maximum allowable fee* for the third and subsequent procedures

Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

Non-Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

[1721]

Home Health

- [Benefit maximum of [XX] visits per covered person per calendar year]

Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

Non-Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

1722]

Hospice

Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

Non-Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

[1723]

Mastectomy

Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

Non-Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

[1724]

Newborn Services (Sick Baby)

Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

Non-Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

[1725]

SCHEDULE OF BENEFITS

Physical Medicine

- [Benefit maximum limited to [XX visits] per *covered person* per *calendar year*.] [This benefit maximum does not apply to *Habilitative services*.]

Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

Non-Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

[1726]

Pregnancy Services (Complications of Pregnancy)

Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

Non-Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

[1727]

Prescription Drugs

- [Benefit maximum of [\$XXXX] per *covered person* per *calendar year*.] [Covered *prescription drugs* will accumulate toward and reduce the all *covered expenses certificate* maximum.]
- *Prescription drugs* received from a *network* or *non-network pharmacy* for up to a [XX-day] supply of a drug, medicine, or medication received from a retail *pharmacy* [or a *specialty pharmacy*]. [Some retail *pharmacies* [and *specialty pharmacies*] participate in *our* program which allows a *covered person* to receive a [XX-day] supply of a *prescription* or refill.] The cost is [X] times the applicable [copayment] [coinsurance] as outlined below, after the drug *deductible* is met. [*Self-administered injectable drugs* [and *specialty drugs*] are limited to a [XX-day] supply from a retail *pharmacy* [or *specialty pharmacy*], unless otherwise determined by *us*.]
- [Prescription *drugs* received from a *network* or *non-network pharmacy* for up to a [XX-day] supply of a drug, medicine or medication received from a *mail order pharmacy*. The cost is [X] times the applicable [copayment] [coinsurance] as outlined below, after the drug *deductible* is met.]
- [If the dispensing *pharmacy's* charge is less than the [copayment,] [coinsurance,] the *covered person* will be responsible for the lesser amount]
- [When a *non-network pharmacy* is used or when a *covered person* does not present his/her *ID card* to the *network pharmacy* at the time of purchase, the *covered person* will also be responsible for [XX%] of the actual charge made by the dispensing *pharmacy*, after the applicable [copayment] [coinsurance]]

SCHEDULE OF BENEFITS

[Network Pharmacy:

- Level 1 drugs copayment [\$XX] [XX%] per prescription, [\$XX] [XX%] coinsurance
- Level 2 drugs copayment [\$XX] [XX%] per prescription, [\$XX] [XX%] coinsurance
- Level 3 drugs copayment [\$XX] [XX%] per prescription, [\$XX] [XX%] coinsurance
- Level 4 drugs.....[\$XX] [XX%] per prescription , [[\$XX] [XX%] coinsurance]

[Non-Network Pharmacy:

- Level 1 drugs [copayment] [\$XX] [XX%] per prescription, plus [\$XX][XX%] coinsurance
- Level 2 drugs [copayment] [\$XX] [XX%] per prescription, plus [\$XX][XX%] coinsurance
- Level 3 drugs [copayment] [\$XX] [XX%] per prescription, plus [\$XX][XX%] coinsurance
- Level 4 drugs.....[\$XX] [XX%] per prescription , plus [\$XX][XX%] coinsurance]

[Network Pharmacy: You pay [XX%] coinsurance per prescription to the dispensing pharmacy [after deductible]

[Non-network Pharmacy: You pay [XX%] coinsurance, pay [XX%] of covered expenses [after deductible]

[1728]

Preventive Care

- [Benefit maximum for preventive care is limited to [\$XXX] of covered expenses per covered person per calendar year, subject to applicable coinsurance.] [This benefit maximum does not apply to the HPV immunization, Colorectal Cancer Screening, Routine Mammogram, Routine Cervical Cytologic Screening and Prostate Cancer Screening.]
- [Waiting period for preventive care benefits is [XX days][month[s]][X year[s].] [This waiting period does not apply to Colorectal Cancer Screening, Routine Mammogram, Routine Cervical Cytologic Screening and Prostate Cancer Screening.]

Routine Services to Include: [Exams,] [Immunizations,] [and] [PSA Tests]

Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

Non-Network Provider: Not covered

Routine [Laboratory,] [Pathology] [and] [Radiology] Tests (Other than Routine [Mammograms,] [Pap Smears] [and] [PSA Tests])

Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

Non-Network Provider: Not covered

SCHEDULE OF BENEFITS

Colorectal Cancer Screening and Prostate Cancer Screening

Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

Non-Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

Routine Mammogram and Routine Cervical Cytologic Screening

Network Provider: We pay 100% of covered expenses

Non-Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

[1729]

Transplant Services (Organ)

- Benefit maximum for *covered organ transplant services* received from a non-participating transplant provider is limited to [\$35,000] [per calendar year] [for each *covered organ transplant*]
- [*Covered expense* for all direct, non-medical costs for the *covered person* receiving the *covered organ transplant* and his/her *family member(s)* is limited to [the lesser of:] a combined maximum of [\$10,000] per *covered organ transplant*] [or] the *outpatient services certificate* maximum]]
- Direct transportation and temporary lodging costs for the *covered person* when the *hospital* performing the *covered organ transplant* is more than [100] miles away from the *covered person's* residence
 - If the servicing *hospital* is a participating transplant facility we will pay [100%] of reasonable transportation charges
 - If the servicing *hospital* is not a participating transplant facility we will pay [70%] of reasonable transportation charges
 - Transportation *covered expenses* will be limited to [2] round trips per *covered organ transplant* and [the lesser of:] a combined maximum [or] [the *outpatient services certificate* maximum]
- If temporary lodging is requested, *you* must gain *our* prior approval. Coverage will be limited to [\$75] per day per *covered organ transplant* and [the lesser of:] a combined maximum [or] [the *outpatient services certificate* maximum].
- *Family member* travel benefits are limited to [1] member of the *covered person's* immediate family or [2] members if the patient is under [18] years of age

Participating Transplant Provider: *You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]*

Non-Participating Transplant Provider: *You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]*

[1730]

SCHEDULE OF BENEFITS

For All Other Services (Other Than For Medically Necessary Cervical Cytologic Screening)

Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

Non-Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

[1731]

Medically Necessary Cervical Cytologic Screening

Network Provider: We pay 100% of covered expenses

Non-Network Provider: You pay [XX%] coinsurance, we pay [XX%] of covered expenses [after deductible]

[1732]

Riders

Refer to riders attached to this *certificate* for additional coverage and/or limitations

[1733]

[Office Visit Copayment Rider

- [Benefit maximum for office visits[X] visits per *covered person* per *calendar year*]

Network Provider: [For the first [X]] office visits,] you pay a [\$XX] copayment for primary care network provider office visits and [\$XX] copayment for specialty care network provider office visits. [Thereafter, you pay [XX%] coinsurance, we pay [XX%] of covered expenses after deductible.] [Services for outpatient x-ray and laboratory will be paid at [XX%] limited to the first [\$XXX] per calendar year.]

The medical deductible and coinsurance does not apply to the [first [X]] office visits [or the first [\$XXX] of covered expenses for outpatient x-ray and laboratory] [per calendar year].

[1734]

[Exclusion Riders]

HOW WE PAY BENEFITS

General benefit payments

We will pay benefits for *covered expenses* as stated on the “Schedule of Benefits” and “Your Certificate Benefits” sections and according to any riders, amendments or endorsements which are part of *your certificate*. All benefits we pay will be subject to the *maximum allowable fee* and all conditions, limitations and maximums of this *certificate*.

Upon a *covered person* receiving a *service*, we will determine if such *service* qualifies as a *covered expense*. Any *service* that qualifies as a *covered expense* must not be excluded by the terms of this *certificate*, excluded by rider or limited by a *pre-existing condition* or waiting period. [After determining that the *service* is a *covered expense*, we will pay benefits as follows:]

- [We will determine the total amount of eligible *covered expenses incurred* related to a particular *service*.]
- [We will then review the eligible *covered expenses incurred* against any, plan benefit or *calendar year* maximums which may apply to a particular *service*.]
- [If you are required to pay a *copayment*, we will subtract the amount of *your copayment* from the eligible *covered expense incurred* amount.]
- [If you have not met *your deductible*, we will subtract any amounts you are required to pay as part of *your deductible*.]
- [We will then review *your out-of-pocket limit*. If you have not yet incurred enough *coinsurance* expenses to equal the amount of the *out-of-pocket limit* we will subtract any *coinsurance* amounts you must pay from the eligible *covered expenses incurred*.]
- [Finally, we will make payment for the remaining eligible *covered expenses incurred* to you or *your servicing provider*.]

[1735]

What is a deductible?

The *deductible* is the amount shown on the “Schedule of Benefits” which the *covered person* must incur in *covered expenses* before we pay benefits at 100%, [less] [including] any [copayment(s)] [or] [coinsurance]. This amount will be applied on a *calendar year* basis, and will vary for *services* obtained by *network* and *non-network provider*.

[1736]

How do you know when you no longer have to pay toward your deductible?

For services provided by a network provider – When the total amount of eligible *covered expenses* you have incurred reaches the *network provider deductible* amount as shown on the “Schedule of Benefits.

[1737]

HOW WE PAY BENEFITS

For services provided by a non-network provider –When the total amount of *covered expenses* you have incurred reaches the non-network *deductible* amount shown on the “Schedule of Benefits”.

[1738]

Family deductible – Each *calendar year*, once you have fulfilled the [number] [amount] [of [individual] [family] *deductible[s]*, as [described above] [shown on the “Schedule of Benefits”], you will not have to pay any further [individual] *deductible[s]* for the rest of that same *calendar year*.

[1739]

Common accident – If [2] or more *covered persons* are injured in the same accident, you will incur *deductible* expenses equal to [1] individual *deductible*. This is limited only to *covered expenses* related to the accident.

[1740]

What is coinsurance?

Coinsurance is the amount of *covered expenses* the *covered person* must pay toward the total *expenses incurred* for *services*. This amount is shown on the “Schedule of Benefits”.

Coinsurance will vary depending upon whether the *service* was provided by a *network* or *non-network provider*. Charges you pay as *coinsurance* do not apply to any responsibility you have for [*copayments*] [or] [*deductibles*].

[1741]

What is the out-of-pocket limit?

This is the amount of [*copayments,*] [*deductible*] [and] *coinsurance* the *covered person* [and/or family] must pay before we pay benefits at 100%, [less any] [*copayments,*] [*deductible*] [or] [other *certificate* limits]. This amount is shown on the “Schedule of Benefits”. The *prescription* drug benefit does not have an *out-of-pocket limit*.

[1742]

How do you know when you have reached your out-of-pocket limit?

After the *deductible* has been met in each *calendar year* for a *covered expense*, the *out-of-pocket limit* will be reached in the following manner [:]

[1743]

For services provided by a network provider – When your total amount of *covered expenses* incurred reaches the *network provider out-of-pocket limit* as shown on the “Schedule of Benefits.

[1744]

For services provided by a non-network provider – When the total amount of *covered expenses* you have incurred reaches the *non-network out-of-pocket limit* as shown on the “Schedule of Benefits”.

[1745]

HOW WE PAY BENEFITS

Family out-of-pocket limit – Each *calendar year*, once *your* family has fulfilled the family *out-of-pocket limit* amount, as shown on the “Schedule of Benefits”, neither *you* nor *your* covered *dependents* will have any additional out-of-pocket responsibility for *covered expenses* for the rest of that same *calendar year*. The maximum amount any 1 *covered person* in *your* family can contribute toward the family *out-of-pocket limit* in a *calendar year* is the amount applied toward the individual *out-of-pocket limit*.

[1746]

What is a copayment?

This is the amount shown on the “Schedule of Benefits” which the *covered person* must pay directly to the *healthcare practitioner* each time a covered *service* is received.

Copayments, if any, do not apply toward the *deductible*, [*coinsurance*] [or] *out-of-pocket limit*].

[1747]

What are waiting periods?

The waiting period is the time period during which *we* will not pay for certain *services*. This time period begins on the *covered person's effective date* and lasts for the time shown on the “Schedule of Benefits”.

[The [30-day] waiting period for *sickness* will be waived if other major medical insurance with reasonably similar benefits was in effect up to a date no more than [63 days] before the *effective date* of this *certificate*.]

[1748]

What are benefit maximums?

The amount *we* pay for some *services* is limited to a benefit maximum. *We* will not make benefit payments in excess of the benefit maximum for the *covered expenses* and time periods shown on the “Schedule of Benefits”.

[1749]

What are calendar year certificate maximums?

The *calendar year certificate* maximums shown on the “Schedule of Benefits” are the maximum amounts *we* will pay in a *calendar year* for *covered services* rendered to a *covered person* during a *calendar year*. When these maximums are reached, no additional benefits are payable for *covered services* rendered in that *calendar year*.

[1750]

Why are benefits paid differently for different providers?

Generally, if a *covered person* uses a *network provider*, the *covered person* will incur lower *coinsurance* costs. When a *covered person* uses a *network provider* he/she must only pay the *copayment*, *deductible* and/or *coinsurance* and is not responsible for any other portion of a *covered expense*.

HOW WE PAY BENEFITS

If a *covered person* uses a *non-network provider*, the *covered person* will incur higher *coinsurance* costs. Additionally, *non-network providers* may balance bill *you* or the *covered person* for charges in excess of the *maximum allowable fee*. These additional charges will not apply toward the *coinsurance*, the *out-of-pocket limit* or the *deductible*.

[1751]

What is the lifetime maximum benefit?

The lifetime maximum benefit shown on the “Schedule of Benefits” is the maximum amount *we* will pay for *covered expenses* incurred by a *covered person* while this *certificate* is in effect.

[1752]

What happens if there is no network provider near you?

If *you* live in an area where *we* determine there are not enough *network providers* in *our* provider network, *we* will pay benefits for all *covered expenses* at the *network provider* level subject to the *maximum allowable fee*. This does not include [preventive care] [and] [prescription drug services,] [or any benefits in the Office Visit Copayment Rider].

We will determine network adequacy based on the standards required by *your* state.

[1753]

UTILIZATION MANAGEMENT

We require notification before and during certain *services*. We will not pay for *services* if:

- We are not notified in advance; and
- The *services* are not *medically necessary*.

[1754]

Preauthorization

A *covered person* or the *covered person's healthcare practitioner* is required to notify us, and obtain our approval through the *preauthorization* process for certain *services* specified below.

[1755]

Types of services

Preauthorization is required for [transplant *services* (organ),] [*durable medical equipment*,] [or] [*services* from a] [*home health care provider*,] [*skilled nursing facility*] [or] [*hospice facility*,] [and] [certain *prescription drugs*].

[1756]

Process and timing

The *covered person* must telephone or write us:

- [At least [7 days] prior to the initial evaluation for transplant *services* (organ); and]
- [At least [48 hours] before receiving *durable medical equipment*, or *services* from a *home health care provider*, *skilled nursing facility* or a *hospice facility*.]

If *preauthorization* is necessary for a proposed treatment plan, we will:

- Advise if the *services* within the proposed treatment plan are a *covered expense*; and
- Advise if we will continue to review the *covered person's confinement* or *services* throughout the course of the *covered person's* treatment of *sickness* or *bodily injury*.

[1757]

Impact on benefit payment

If *preauthorization* is not received from us, no benefits will be payable for these *services*.

[1758]

Preservice notice

A *covered person* is required to notify us prior to receiving certain *services*. However, we will not make a coverage determination until we receive the claim and all related information.

[1759]

UTILIZATION MANAGEMENT

Types of services

Preservice notification is required for *inpatient services*, *non-emergency care* outpatient surgeries in a *hospital* or *healthcare treatment facility*, [or *diagnostic services* including, but not limited to:] [Magnetic Resonance Imaging (MRI),] [Computerized Axial Tomography (CAT Scan)], [or] [Positron Emission Tomography (PET Scan).]

[1760]

Process and timing

The *covered person* or the *covered person's healthcare practitioner* must telephone or write us:

- [At least [7 days] prior to the date of *service* for scheduled *inpatient services* or *non-emergency care* outpatient surgery;]
- [At least [48 hours] prior to the date of *service* for *diagnostic services* including, but not limited to: [Magnetic Resonance Imaging (MRI),] [Computerized Axial Tomography (CAT Scan),] [or] [Positron Emission Tomography (PET Scan);] [or]
- [At least [48 hours] after the date of *service* for any *emergency care* for which the *covered person* is admitted for inpatient care in a *hospital* or *healthcare treatment facility*.]

We will advise you if *preservice review* and/or *preauthorization* of the treatment plan is required by us after the *covered person's healthcare practitioner* has provided us with the *covered person's* diagnosis and treatment plan.

If *preservice review* is necessary for a proposed treatment plan, we will:

- Advise if the *services* within the proposed treatment plan are *medically necessary*; and
- Advise if we will continue to review the *covered person's confinement* or *services* throughout the course of the *covered person's* treatment of *sickness* or *bodily injury*.

If *expenses incurred* under a proposed treatment plan are determined at any time either partially or totally not to be a *covered expense*, we will only pay for *services* that are determined by us to be *covered expenses*.

[1761]

Impact on benefit payment

If we do not receive the required *preservice notification*, the *covered person* will be required to pay [\$500] of *covered expense* before we begin to pay *covered expenses*. [Further, the [\$500] *expense incurred* by the *covered person* for the *service* will not be applied toward the *deductible* or *coinsurance out-of-pocket limit*.]

[1762]

UTILIZATION MANAGEMENT

Time of review

When *preservice review* or *preauthorization* is required, *we* will review all the necessary information within [2 working days] of receiving such information and will notify the *covered person's healthcare practitioner* within [24 hours] of making the initial determination. In the case of an adverse determination, written notification will be given within [24 hours] or the next working day.
[1763]

Reconsideration rights

The *healthcare practitioner* rendering the *service* can request reconsideration of an adverse determination on the *covered person's* behalf. The reconsideration will occur within [1 working day] of the receipt of such request. If this process does not resolve the difference of opinion, the adverse determination may be appealed.
[1764]

Concurrent review

We will conduct a concurrent review when a *covered person* has received *preauthorization* or a *preservice review*, and during the course of their treatment plan, it is determined that additional *services* or an extended stay may be necessary.

Once *we* receive the request for the additional *services* or extended stay, *we* will evaluate the *services* within the proposed treatment plan and determine if they are *medically necessary*. *We* will notify the *healthcare practitioner* rendering the additional *services* within [1 working day] of making the determination.

In the case of an adverse determination, notification will be given within [24 hours] of making the adverse determination. If notification was verbal, it will be followed by written notification within [1 working day].
[1765]

Reconsideration rights

The *healthcare practitioner* rendering the *service* can request reconsideration of an adverse determination on the *covered person's* behalf. The reconsideration will occur within [1 working day] of the receipt of such request. If this process does not resolve the difference of opinion, the adverse determination may be appealed.
[1766]

Retrospective review

If the required *preservice review* was not received prior to receiving healthcare *services*, a retrospective review may be conducted after such *services* are provided to a *covered person*.

UTILIZATION MANAGEMENT

Within [30 working days] of receiving all the necessary information, *we* will make a determination as to whether the *services* were *medically necessary* and are *covered expenses*. *We* will provide written notice of *our* determination to the *covered person*.

[1767]

Right to make substitution for covered expenses

We reserve the right to consider for payment *expenses incurred* for *services* which are substitutions for the *covered expenses* of this *certificate*. The expenses are considered at *our* option and must:

- Be *medically necessary*;
- Have *your* knowledge and agreement in receiving the *service*;
- Be prescribed and approved by the *covered person's healthcare practitioner*; and
- Offer a medical therapeutic value at least equal to the covered *service* that would otherwise be performed or given.

We may disallow, discontinue or substitute *service* at any time at *our* sole option by sending a reasonable advance written notice to *you* or the *covered person* and the *covered person's healthcare practitioner*.

[1768]

YOUR CERTIFICATE BENEFITS

We will only pay benefits on *covered expenses* as explained in the “How We Pay Benefits” section. Benefits for the *services* explained below are limited to the benefit and *calendar year certificate* maximums shown on the “Schedule of Benefits”.

[1769]

Ambulance

- Local [ground] [or] [air] professional ambulance service from the scene of a medical emergency to the local *hospital*; and
- Transportation to the nearest *hospital*, equipped to provide treatment, if the *bodily injury* or *sickness* requires special treatment not available in a local *hospital*.

[1770]

Dental benefits

- Treatment for a *dental injury* to a *sound natural tooth*. Treatment must begin within [90 days] from the date of the *dental injury* and be completed within [12 months]. We will limit *covered expenses* to the least expensive *service* that we determine will produce professionally adequate results;
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;
- Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Reduction of fractures and dislocation of the jaw;
- External incision and drainage of cellulites;
- Incision of accessory sinuses, salivary glands or ducts; and
- Frenectomy (the cutting of the tissue in the midline of the tongue).

[1771]

Durable medical equipment

You must obtain *preauthorization* for the rental of any equipment to be consider *covered expenses*.

- Non-motorized wheelchair;
- Hospital bed;
- Ventilator;
- Hospital type equipment;
- Oxygen and rental of equipment for its administration;
- Initial prosthetic devices or supplies, including, but not limited to, limbs and eyes. The prosthetic devices for a lost limb or eye must be necessary to restore their minimal basic function. Replacement of prosthetic devices is a *covered expense* when the replacement is due to pathological changes. Repair of the prosthetic device is a *covered expense* if not covered by the manufacturer;
- Casts, splints (other than dental), trusses, braces (other than orthodontic), and crutches;
- The following special supplies up to a [30 day] supply, when prescribed by the *healthcare practitioner*:
 - Surgical Dressings;
 - Catheters;

YOUR CERTIFICATE BENEFITS

- Colostomy bags, rings and belts;
- Flotation pads; and
- Initial contact lenses or eyeglasses following cataract surgery;
- Diabetic equipment associated with diabetic *services* outlined in the “Other Covered Expenses” provision; and
- Other *durable medical equipment*.

Costs for these services will be limited to the lesser of the rental cost or the purchase price, as determined by *us*. If *we* determine the lesser cost is the purchase option, any amount paid as rent for such durable medical equipment shall be credited toward the purchase price.

[1772]

Emergency care

- A *hospital* for the emergency room and ancillary services; and
- An emergency room *healthcare practitioner* for *outpatient services*.

If *emergency care* is obtained through a *non-network provider*, *we* will pay benefits at the network level until the *covered person* can be safely transported to a *network provider*.

[1773]

Healthcare treatment facility services

- Daily room and board up to the semi-private room rate for each day of *confinement*;
- *Confinement* in a critical care unit;
- Operating room;
- Ancillary services;
- Blood and blood plasma which is not replaced by donation;
- Administration of blood and blood products including blood extracts or derivatives;
- *Healthcare treatment facility* charges;
- Regularly scheduled treatment such as dialysis, chemotherapy, inhalation therapy or radiation therapy in a *healthcare treatment facility* as ordered by the *covered person*'s attending *healthcare practitioner*; and
- *Outpatient services* in a *hospital* or *free standing surgical facility* when the *covered person* is in *observation status*, however, the *covered expense* will be limited to the average semi-private room rate.

[1774]

Healthcare treatment facility drug services

Drugs and medicines that are provided or administered to the *covered person* while confined in a *hospital* or *skilled nursing facility*, from a *healthcare practitioner* during an office visit or from a *home health care provider*.

[1775]

YOUR CERTIFICATE BENEFITS

Healthcare practitioner services

- Physician visits;
- Diagnostic x-ray and laboratory tests;
- Anesthesia;
- Surgery, including necessary postoperative care; and
- Allergy injections, testing and treatment.

[1776]

Home health care

You must obtain *preauthorization* from *us* in order for any benefits in this section to be considered *covered expenses*.

- *Services* provided by a *home health care provider*, at the *covered person's* home, under a *home health care plan*.

[1777]

Hospice care

You must obtain *preauthorization* from *us* in order for any benefits in this provision to be considered *covered expenses*.

- Once *preauthorization* is obtained we will provide benefits for expenses incurred for *services* under a *hospice care program* furnished in a *hospice facility* or in the *covered person's* home by a *hospice care agency*;
- Room and board in a *hospice facility*, when it is for management of acute pain or for an acute phase of chronic symptom management;
- Other *services*;
- Part-time nursing care provided by or supervised by a Registered Nurse (R.N.) for up to [8 hours] per day;
- Part-time home health aide services for up to [8 hours] in any 1 day; and
- Medical supplies, drugs and medicines prescribed by a *healthcare practitioner*.

For this benefit only, immediate family is considered to be the *covered person's* parent, spouse and children or step-children.

[1778]

Mastectomy services

- Reconstructive surgery of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to achieve symmetrical appearance; and
- Prostheses and physical complications from all stages of mastectomy, including lymphedemas.

[1779]

YOUR CERTIFICATE BENEFITS

Newborn services

Sick baby *covered expenses* for a covered *dependent* newborn child includes the following:

- *Bodily injury* or *sickness*;
- Care and treatment for premature birth; and
- Medically diagnosed birth defects and abnormalities.

[1780]

Physical medicine

Outpatient services by a *healthcare practitioner* for the following:

- Services to restore speech or swallowing impairment and cognitive therapy pertaining to head injury or stroke to attain a previous level of function; and
- Other therapy services for rehabilitation of the loss to attain a previous level of function including, but not limited to, [occupational therapy,] [and] [physical therapy,] [and] [cognitive therapy,] [and] [audiology therapy,] [and] [speech therapy,] [and] [pulmonary therapy,] [and] [cardiac rehabilitation,] [and] [cardiac rehabilitation].

[1781]

Pregnancy services

We will pay for *expenses incurred* for *services* related to *complications of pregnancy* at the point the complication occurs, for any female *covered person*.

[1782]

Prescription drug benefit

Any *expenses incurred* under this benefit apply toward meeting the [prescription drug deductible but do not apply toward the] *covered person's deductible* or *out-of-pocket limits*.

Benefits may be subject to *dispensing limits* and *prior authorization* requirements, if any.

- [Drugs, medicines or medications that under federal or state law may be dispensed only by *prescription* from a *healthcare practitioner* [that are necessary for the treatment of menopause];]
- [Limited to a maximum of a [30-day] supply based upon the FDA approved dosage regardless of manufacturer packaging, per *prescription* or refill at a retail *pharmacy*;]
- [Limited to a maximum of a [90 day] supply based on the FDA approved dosage, regardless of manufacturing packaging, per *prescription* or refill received from a [mail order pharmacy]. *Self-administered injectable drugs* are limited to a maximum of a [30-day supply] per *prescription* or refill received from a *mail order pharmacy*;]
- [Drugs, medicines or medications that are included on the *drug list*;]
- [Insulin and *diabetic supplies*;]
- [Hypodermic needles or syringes when prescribed by a *healthcare practitioner* for use with insulin or *self-administered injectable drugs*. Hypodermic needles and syringes used in conjunction with covered drugs may be available at no cost to the *covered person*;]
- [*Specialty drugs*] and *self-administered injectable drugs* approved by us;]
- [Drugs for hormone replacement necessary for the treatment of menopause;]

YOUR CERTIFICATE BENEFITS

- [Formulas necessary for the treatment of phenylketonuria (PKU) or other inherited diseases;]
[and]
- [Spacers and/or peak flow meters for the treatment of asthma.]
[1783]

Preventive care

We only provide benefits for *services* as recommended by the United States Preventive Services Task Force.

- A routine exam or annual physical exam performed by a *healthcare practitioner*;
- Routine radiology, laboratory and pathology tests;
- Routine immunizations for *covered persons* (TB tine and allergy desensitization injections are not considered routine immunizations) for:
 - HPV for the prevention of cervical cancer (e.g. Gardasil vaccine);
 - Prevention of Shingles (e.g. Zostavax vaccine);
 - Prevention of Meningitis (e.g. Meningococcal vaccine); and
 - Other routine immunizations for *covered persons* under age [18];
- Routine mammogram – a baseline mammogram for a female *covered person* and an annual mammogram for a female *covered person*;
- Annual routine cervical cytologic screen for a female *covered person*;
- Colorectal cancer screening in accordance with the published American Cancer Society guidelines; and
- Prostate cancer screening for a male *covered person* in accordance with the published American Cancer Society guidelines.

[1784]

Skilled nursing facility

You must obtain *preauthorization* from *us* in order for any benefits in this provision to be considered *covered expenses*. Once *preauthorization* is obtained we will provide benefits for *expenses incurred* for:

- Daily room and board and general nursing *services* for each day of *confinement* in a *skilled nursing facility*, provided the *covered person* is under the regular care of a *healthcare practitioner* who has reviewed and approved the *confinement*.

[1785]

Transplant services

If a *covered person* requires an organ transplant, all related transplant *services* must be *preauthorized* in advance by *us*.

- *Hospital and healthcare practitioner services*; and
- Organ acquisition and donor costs, if they are not covered by another party.

We will pay benefits if the pre-transplant *services*, the *covered organ transplant* and post-discharge *services* are approved by *us*.

YOUR CERTIFICATE BENEFITS

The following are considered *covered organ transplants*:

- [Heart;]
- [Lung(s);]
- [Heart-lung;]
- [Liver;]
- [Kidney;]
- [*Bone marrow*;]
- [Pancreas;]
- [Simultaneous pancreas/kidney;]
- [Intestine;]
- [Pancreas following kidney;] [and]
- [Any organ not listed above, if required by state or federal law.]

[Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular *certificate* benefits and are subject to other applicable provisions of this *certificate*.]

[1786]

Transportation and lodging

Direct transportation and temporary lodging costs for the *covered person* when the *hospital* performing the *covered organ transplant* is more than [100] miles away from the *covered person's* residence.

- If the servicing *hospital* is a participating transplant facility *we* will pay [100%] of reasonable transportation charges.
- If the servicing *hospital* is not a participating transplant facility *we* will pay [70%] of reasonable transportation charges.
- Transportation *covered expenses* will be limited to [2] round trips per *covered organ transplant* and a combined maximum*.

*If temporary lodging is requested, the *covered person* must gain *our* prior approval. Lodging will be limited to [\$75] per day per *covered organ transplant* and a combined maximum.

[1787]

Family members travel benefits

We will provide transportation and lodging expenses for family members provided they meet the same standards as the *covered person* as described above. Family member benefits are limited to [1] member of the *covered person's* immediate family (2 members if the patient is under [18] years of age).

[1788]

Provider selection

The *covered person* may select any provider he/she wishes to perform the transplant *services*. However, if the *covered person* selects a participating transplant provider, he/she will avoid having the benefit payment reduced for going outside the transplant network.

YOUR CERTIFICATE BENEFITS

Please remember that all *network providers* do not necessarily qualify as participating transplant providers. If the *covered person(s)* are unsure as to whether a provider qualifies as a participating transplant provider please contact *us* for information.

[1789]

Other covered expenses

We will pay for *expenses incurred* for:

- Removal of tonsils and/or adenoids after the waiting period shown on the “Schedule of Benefits”, unless the condition required *emergency care*;
- Surgical treatment for hernia, bunions, varicose veins or hemorrhoids after the waiting period shown on the “Schedule of Benefits”, unless the condition required *emergency care*. A strangulated or incarcerated hernia is not subject to this waiting period;
- Outpatient self-management training and education, including medical nutritional therapy, prescribed by a *healthcare practitioner*, for the treatment of:
 - Insulin-dependent diabetes;
 - Insulin-using diabetes;
 - Gestational diabetes; and
 - Non-insulin using diabetes;
- Equipment, prescribed by a *healthcare practitioner*, for the treatment of diabetes;
- *Habilitative services* for a child under the age of 21 with a *congenital or genetic birth defect*. No coverage is provided for such *services* that are provided through early intervention or a school system;
- Cervical cytologic screening for a female *covered person* upon certification by a *healthcare practitioner* that the test is *medically necessary*; and
- Reconstructive surgery resulting from:
 - [A *bodily injury* or *sickness* when functional impairment is present; or]
 - [Congenital disease or anomaly of a covered *dependent* child which resulted in a functional defect.]

[The presence of a psychological condition will not entitle a *covered person* to coverage for cosmetic surgery, plastic or reconstructive, unless it is for the conditions or surgery described above.]

[1790]

CLAIMS PAYMENT

Notifying us of your claim

Generally, any *services* the *covered person* receives will be billed to *us* by the provider.

If the *covered person* receives a *service* which will not be billed to *us* by the provider, the *covered person* must send *us* a letter with his/her name, the *service* received and the *certificate* number. He/she should mail the letter to *our* address shown on the *ID card*.

We must receive a letter from the *covered person* or the provider informing *us* of the claim within [30 days] from the date the *service* was received.

[1791]

Completing the claim form

We do not use a standard claim form in processing benefits. Therefore, once *we* receive the letter informing *us* of the claim, *we* will notify the *covered person* of any additional information *we* need to process the claim.

[1792]

Submitting the claim information

The *covered person* must complete and submit all claim information *we* need to pay the claim within the time required by state law or provider contract. Examples of some of the information *we* may need includes:

- Authorizations for the release of medical information including the names of all providers from whom the *covered person* received *services*;
- Medical information and/or records from any provider;
- Information about other insurance coverage; and
- Any information *we* need to administer the terms of this *certificate*.

This list is not comprehensive, and only provides a few examples of the information *we* may request.

If the *covered person* doesn't provide *us* with the necessary information, *we* will deny any current or future claims related to that information until it is provided.

In limited circumstances where it is necessary to administer the terms of the *certificate*, *we* have the right to have the *covered person* examined or autopsied, unless prohibited by law. These procedures will be conducted as often as *we* deem reasonably necessary to determine benefits, at *our* expense.

[1793]

Payment of claim to whom benefits are payable

Once *we* receive all the necessary information, *we* will determine if benefits are available, and if they are, *we* will pay amounts due under this *certificate* in the timeframe required by state law or by provider contract. If *you* receive services from a *network provider*, *we* will pay the provider directly for all *covered expenses*. *You* will not have to submit a claim for payment.

CLAIMS PAYMENT

All benefit payments for *services* rendered by a *non-network provider* are due and owing solely to the *covered person*. Assignment of benefits is prohibited, however, *you* may request that *we* direct a payment of selected medical benefits to the *healthcare practitioner* on whose charge the claim is based. If *we* consent to this request, *we* will pay the *healthcare practitioner* directly. Such payments will not constitute the assignment of any legal obligation to the *non-network provider*. If *we* decline this request, *we* will pay *you* directly, and *you* are then responsible for all payments to the *non-network provider(s)*.

If any *covered person* to whom benefits are payable is a minor or, in *our* opinion, not able to give a valid receipt for any payment due him/her, such payment will be made to his/her parent or legal guardian. However, if no request for payment has been made by the parent or legal guardian, *we* may, at *our* option, make payment to the person or institution appearing to have assumed his/her custody and support.

If the *covered person* is deceased, payment will be made, at *our* option, to any 1 of the following:

- *You* in the case of a covered *dependent*;
- *Your* spouse;
- A provider; or
- *Your* estate.

Any payment made by *us* in good faith will fully discharge *us* of any liability to the extent of such payment.

[1794]

Reasons we may deny a claim

Below is a list of some of the most common reasons why *we* may deny a claim. Please note that this list is not comprehensive. Claim payment may be limited or denied in accordance with any of the provisions contained in this *certificate*.

[1795]

Not a covered benefit: The *service* is not a *covered expense* under this *certificate*.

[1796]

Eligibility: The *covered person* is no longer eligible as described in the “Changes to the Certificate” or “Termination Rights” sections of this *certificate*.

[1797]

Certificate compliance: The *covered person* has not acted in accordance with this *certificate*'s requirements.

[1798]

Fraud: *You* or the *covered person* commit fraud against *us*, or make an intentional misrepresentation by not telling *us* the correct facts or withholding information which is necessary for *us* to administer this *certificate*.

Health insurance fraud is a crime. Any person(s) who willingly and knowingly engages in an activity intended to defraud *us* by filing a claim or form that contains a false or deceptive statement is committing insurance fraud.

CLAIMS PAYMENT

If *you* or the *covered person* commits fraud against *us*, as determined by *us*, coverage ends automatically, without notice, as of the date fraud is committed. Such termination will be made on a retroactive basis. *We* will also provide information to the proper authorities and support any criminal charges which may be brought. Further, *we* reserve the right to seek any civil remedies which may be available to *us*.

[1799]

What if you made a mistake: If *you* or the *covered person* provided *us* with information in error, and after *we* investigate the matter *we* also determine it was an error, *we* will not end coverage. However, *we* will adjust the premium or the claim payment based on this new information.

[1800]

What if we made a mistake: If the *covered person* provided *us* with the correct information and *we* made an error in processing, the *covered person* will be eligible for coverage and claims payment for *covered expenses*. However, *we* will adjust his/her premium or claim payment based on the correct information.

[1801]

Duplicating provisions: If any charge is described as covered under 2 or more benefit provisions, *we* will pay only under the provision allowing the greater benefit. This may require *us* to make a recalculation based upon both the amounts already paid and the amounts due to be paid. *We* have no obligation to pay for benefits other than those this *certificate* provides.

[1802]

Workers' Compensation/24-hour coverage: This *certificate* is not in lieu of any Workers' Compensation or occupational disease insurance.

[1803]

Non-duplication of Medicare benefits: *We* will not duplicate benefits for expenses that are or could have been paid by Medicare as the primary payer.

If the *covered person* is enrolled in Medicare, *we* will coordinate with Medicare being the primary payer. Before filing a claim with *us*, a claim must first be filed with Medicare. Then send *us* a copy of the itemized bill and a copy of the Explanation of Medicare Benefits.

If the *covered person* is eligible for Medicare benefits but not enrolled, benefits under this *certificate* will be coordinated as if Medicare has been in effect and primary. In all cases, coordination of benefits with Medicare will conform with Federal Statutes and Regulations. Medicare means Title XVIII, Parts A and B, of the Social Security Act, as enacted or amended.

[1804]

Other coverage with us: Coverage effective at any 1 time under a like certificate with *us* is limited to 1 certificate elected by *you*. *We* will return all premium paid for all other certificates.

[1806]

CLAIMS PAYMENT

How to challenge our claim decision (appeal rights)

If a *covered person* disagrees with *our* decision on payment of a particular claim, the *covered person* can request a second review of the claim, also known as an appeal. To request this review, the *covered person* must send *us* a letter requesting a second claim review within [60 days] from the time he/she received notice of *our* claim payment decision. The *covered person* may also send any documents or information which are relevant to *our* decision of how to pay the claim.

Once *we* receive the request, *we* will make a second review of the claim and provide notice of *our* decision, following any processes or timeframes required by state law.

[1807]

Rights you have after a second claim review and denial

You cannot bring any legal action against *us* prior to [60 days] but more than [2 years] after the date all necessary claims payment information has been received. The *covered person* also must have completed a second claim review, and utilized any external appeals procedure available under state law.

[1808]

What happens if a claim is incorrectly paid

If a claim was paid in error to *you* or a provider, *we* have the right to recover *our* payments. *We* may correct this payment error by an adjustment to any amount applied to the *deductible* or *out-of-pocket limit*. Errors may include such actions as:

- Claims paid which are not actually covered under this *certificate*;
- Claims paid where such payment is greater than the amount allowed under this
- *certificate*; or
- Claims paid based on fraud or an intentional misrepresentation.

We may seek recovery of *our* payments made in error from any person(s) to, for, or with respect to whom such payments were made, or any insurance companies or organizations which provide other coverage for the *covered expenses*. *We* alone shall determine from whom *we* shall seek recovery.

For information on our process, see the “Recovery Rights” section.

[1809]

COORDINATION OF BENEFITS

This “Coordination of Benefits” provision applies when a person has health care coverage under more than 1 *plan*. *Plan* is defined below.

If the *covered person* is covered by more than 1 health benefit *plan*, all claims should be filed with each *plan*.

[1810]

Definitions

Plan means, for the purpose of coordination of benefits, one which covers hospital or medical expenses and provides benefits or *services* through:

- Group or blanket insurance coverage;
- Hospital service prepayment plan on a group basis, medical service prepayment plan on a group basis, group practice or other prepayment coverage on a group basis;
- Any coverage under labor-management plans, employer plans, trustee plans, union welfare plans, employee benefit organization plans;
- Any coverage under governmental programs or any coverage mandated by state statute or sponsored or provided by an educational institution, if such coverage is not otherwise excluded from the calculation of benefits under this certificate; and
- Individual insurance.

Employers’ *plans* under the same trust policy are considered separate *plans*.

The term *plan* is construed separately with respect to each policy, contract, or other arrangement for benefits or *services* and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or *services* of other *plans* into consideration in determining its benefits and that portion which does not.

This “Coordination of Benefits” provision does not apply to Blanket Student Accident Insurance provided by or through an educational institution. The term *plan* does not apply to medical coverage in a group, group-type, or individual motor vehicle “no-fault” and traditional “fault” type coverage.

[1811]

Allowable expense means a health care *service* or expense, including *deductible*, *coinsurance* or a *copayment*, that is covered in full or in part by any of the *plans* covering the person.

When a *plan* provides benefits in the form of *services* rather than cash payments the reasonable cash value of each *service* rendered will be considered as both an *allowable expense* and a benefit paid.

[1812]

Claim determination period means a *calendar year*, except that if in any *calendar year* the person is not covered under this certificate for the full *calendar year*, the *claim determination period* for that year will be that portion during which he/she was covered under this certificate.

[1813]

COORDINATION OF BENEFITS

Effect on benefits

We will apply these provisions when the *covered person* incurs *allowable expense* during a *claim determination period* for which benefits are payable under any other *plan(s)*. The provisions will apply only when the sum of the *covered expense* under this certificate and any other *plan(s)* would, in the absence of this “Coordination of Benefits” provision or any similar provisions in the other *plan(s)*, exceed the *allowable expense*.

Benefits provided under this certificate during a *claim determination period* for *allowable expenses* incurred by the *covered person* will be determined as follows:

- If benefits under this certificate are to be paid after benefits are paid under any other *plan*, the benefits under this certificate will be reduced so that the sum of the benefits so reduced plus the benefits payable under all other *plans* will not exceed the total of the *allowable expense*.
- If the benefits under this certificate are to be paid before benefits are paid under any other *plan*, benefits under this certificate will be paid without regard to other *plan(s)*.

Covered expense under any other *plan* includes the benefits that would have been payable had the claim been made.

Reimbursement will not exceed 100% of the total *allowable expense* incurred under this certificate and any other *plans* included under this provision.

A *plan* not containing a coordination of benefits provision that is consistent with state regulations is always primary except for supplementary coverage, which will be secondary.

[1814]

Order of benefits determination

For the purpose of the “Effect on Benefits” provision above, the rules establishing the order of benefit determination are:

- The benefits of a *plan* which covers the person on whose expenses the claim is based other than as a *dependent* are determined before the benefits of a *plan* which covers such person as a *dependent*.
- The benefits of a *plan* which covers the person on whose expenses claim is based as a *dependent* are determined according to which parent’s birthdate occurs first in a *calendar year*, excluding year of birth. If the birthdates of both parents are the same, the *plan* which has covered the parent for the longer period of time will be determined first, except if a claim is made for a *dependent* child:
 - When parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a *plan* which covers the child as a *dependent* of a parent with custody of the child are determined before the benefits of a *plan* which covers the child as a *dependent* of the parent without custody;

COORDINATION OF BENEFITS

- When parents are divorced and the parent with custody of the child has remarried, the benefits of a *plan* which covers the child as a *dependent* of the parent with custody are determined before the benefits of a *plan* which covers that child as a *dependent* of the step-parent, and the benefits of a *plan* which covers that child as a *dependent* of the step-parent are determined before the benefits of a *plan* which covers that child as a *dependent* of the parent without custody;
 - Notwithstanding the 2 preceding rules, if there is a court decree which would otherwise establish financial responsibility for the medical or other health care expenses with respect to a child, and that parent has actual knowledge of those terms, the benefits of a *plan* which covers the child as a *dependent* of the parent with such financial responsibility are determined before the benefits of any other *plan* which covers the child as a *dependent* child. If the parent with financial responsibility has no coverage for the child's health care expenses, but the parent's spouse does, the spouse's *plan* will be primary;
 - If the specific terms of the court decree state that parents shall share joint custody, without stating that 1 parent is responsible for health care expenses of the *dependent* child, the order of benefits will be determined according to which parent's birthdate occurs first in a *calendar year*, as described above.
- When the first 2 rules do not establish an order of benefit determination, the benefits of a *plan* which covers the person on whose expense claim is based as a laid-off or retired employee or as the *dependent* of such person are determined after the benefits of a *plan* which covers such person through present employment.
 - When the above stated rules do not establish an order of benefit determination, the benefits of a *plan* which has covered the person on whose expense claim is based for the longer period of time are determined before the benefits of a *plan* which has covered such person the shorter period of time.
 - If *plans* cannot agree on the order of benefits within 30 calendar days after the *plans* have received all of the information needed to process the claim, the *plans* shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no *plan* shall be required to pay more than it would have paid had it been primary.

When these provisions reduce the total amount of benefits otherwise payable under this certificate during any *claim determination period*, each benefit that would be payable in the absence of this provision is reduced proportionately and such reduced amounts are charged against any applicable benefit limit of this certificate.

[1815]

Right to necessary information

We may require certain information in order to apply and coordinate these provisions with other *plans*. To obtain the needed information, *we*, without the *covered person's* consent, will release or obtain from any insurance company, organization or person information needed to implement this provision. The *covered person* agrees to furnish any information *we* need to apply these provisions.

[1816]

COORDINATION OF BENEFITS

Non-duplication of Medicare benefits

We will not duplicate benefits for expenses that are paid by Medicare as the primary payer.

If the *covered person* is enrolled in Medicare, the benefits available under this certificate will be coordinated with Medicare, with Medicare as the primary payer. Before filing a claim with *us*, the *covered person* or the provider must first file a claim with Medicare. After filing the claim with Medicare, the *covered person* or the provider must send a copy of the itemized bill and a copy of the Explanation of Medicare Benefits to *us*.

If the *covered person* is eligible for Medicare benefits but not enrolled, benefits under this certificate will be coordinated to the extent benefits otherwise would have been payable under Medicare.

In all cases, coordination of benefits with Medicare will conform with Federal Statutes and Regulations.

Medicare means Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.
[1817]

Facility of payment

Payments made under any other *plan* which according to these provisions should have been made by *us*, will be adjusted by *us*. To do this, *we* reserve the sole right to pay the organization(s) which made such payments the amount(s) *we* determine to be warranted. Any amount(s) so paid are regarded as benefits paid under this certificate. *We* will be fully discharged from liability under this certificate to the extent of any payment so made.

[1818]

Right of recovery

We reserve the right to recover benefit payments made for allowable expenses under this certificate in the amount by which the payments exceed the maximum amount *we* are required to pay under these provisions. This right of recovery applies to *us* against:

- Any person(s) to, for or with respect to whom such payments were made; or
- Any other insurance companies or organizations which according to these provisions owe benefits for the same allowable expense under any other *plan*.

We alone shall determine against whom this “Right of recovery” will be exercised.

[1819]

PRE-EXISTING CONDITION LIMITATION

What is a pre-existing condition?

A *pre-existing condition* exists if a *covered person* had a *sickness* or *bodily injury* that:

- Was diagnosed or treated by a *healthcare practitioner* within [5 years] prior to their *effective date*; or
- Produced signs or symptoms within [5 years] prior to their *effective date*.

A diagnosis is not required for a condition to be pre-existing. Genetic information, in itself, is not considered a *pre-existing condition*.

[1820]

Pre-existing condition limit

[We will not pay benefits for *services* rendered for *pre-existing conditions* [unless those conditions were fully disclosed on the enrollment form for this *certificate* and benefits relating to those conditions are not specifically excluded].]

[Any condition not disclosed on the enrollment form may result in rescission or modification of benefits. Rescission means that coverage is void from the *effective date*.]

[The pre-existing condition limitation will not apply if a *dependent* is added to coverage within [31 days] of birth, placement or adoption.]

[1821]

Duration of pre-existing condition limitation

The *pre-existing condition* limit will not exceed [12 months] from the *effective date* of the *covered person*.

[1822]

LIMITATIONS AND EXCLUSIONS

Below is a list of limitations and exclusions on *certificate* benefits. While the limits are listed by section, please review the entire document, as there may be multiple limitations applying to a particular *service*. These limitations and exclusions apply even if a *healthcare practitioner* has performed or prescribed a medically appropriate *service*. This does not prevent your *healthcare practitioner* or *pharmacist* from providing or performing the *service*, however, the *service* will not be a *covered expense*.

[1823]

- [Services that are not *covered expenses*;]
- [Services incurred before the *effective date* or after the termination date;]
- [Services not *medically necessary* for diagnosis and treatment of a *bodily injury* or *sickness*;]
- [Any *service* which is *experimental, investigational* or for *research purposes*;]
- [Charges in excess of the *maximum allowable fee* for the *service*;]
- [*Pre-existing conditions* to the extent specified in this *certificate*;]
- [Services exceeding the amount of benefits available for a particular *service*;]
- [Services for any condition excluded by rider under this *certificate*;][or]
- [Services provided when the *certificate* is past premium due date, and payment is not received.]

[1824]

Causation exclusions

- [Caused by or related to war or any act of war, whether declared or not;]
- [Caused by any act of armed conflict, or any conflict involving armed forces of any authority;][or]
- [Loss due to commission or attempt to commit a civil or criminal battery or felony.]

[1825]

Prescription drug limitations and exclusions

- [Contraceptives including oral and transdermal, whether medication or device;]
- [Growth hormones (medications, drugs or hormones to stimulate growth)[, unless there is a laboratory confirmed diagnosis of growth hormone deficiency;]
- [Nutritional products;]
- [Fluoride supplements;]
- [Minerals;]
- [Herbs and vitamins, [and pediatric mult-vitamins with fluoride;]
- [Dietary supplements (except for formulas or low protein modified foods necessary for the treatment of phenylketonuria or certain other heritable diseases of amino and organic acids);]
- [*Legend drugs* which are not deemed necessary by *us*;]
- [More than 2 refills for the same drug or therapeutic equivalent medication prescribed by 1 or more *healthcare practitioners* and dispensed by 1 or more retail *pharmacies*;]
- [Any drug prescribed for a *sickness* or *bodily injury* not covered under this *certificate*;]
- [Any drug prescribed for intended use other than for:
 - [Indications approved by the FDA; or]
 - [Off-label indications recognized through peer-reviewed medical literature;]]
- [Any drug, medicine or medication labeled “Caution-limited by federal law to investigational use” or any experimental or investigational drug, medicine or medication, even though a charge is made to the *covered person*;]

LIMITATIONS AND EXCLUSIONS

- [Allergen extracts;]
- [The administration of covered medication(s);]
- [Therapeutic devices or appliances, including, but not limited to:
 - [Hypodermic needles and syringes except needles and syringes for use with insulin, and *self-administered injectable drugs* whose coverage is approved by us;]
 - [Support garments;]
 - [Test reagents;]
 - [Mechanical pumps for delivery of medication;] [and]
 - [Other non-medical substances;]
- [Anabolic steroids;]
- [Anorectic or any drug used for the purpose of weight control;]
- [Abortifacients (drugs used to induce abortions);]
- [Any drug used for cosmetic purposes, including but not limited to:
 - [Tretinoin, e.g. Retin A, except if the *covered person* is under the age of [45] or is diagnosed as having adult acne;]
 - [Dermatologicals or hair growth stimulants;] [or]
 - [Pigmenting or de-pigmenting agents, e.g. Solaquin;]]
- [Notwithstanding any other provision of this *certificate*, we may decline coverage or, if applicable, exclude from the *drug list* any and all *prescriptions* [, including new indications for an existing *prescription*,] until the conclusion of a review period not to exceed [6-12 months] following FDA approval for the use and release of the *prescriptions* [, including new indications for an existing *prescription* [, into the market];]
- [Any drug or medicine that is:
 - [Lawfully obtainable without a *prescription* (over the counter drugs), except insulin; or]
 - [Available in prescription strength without a *prescription*;]]
- [Compounded drugs in any dosage form except when prescribed for pediatric use for children up to [19 years] of age;]
- [Progesterone crystals or powder in any compounded dosage form;]
- [*Infertility services* including medications;]
- [Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra;]
- [Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given or dispensed by the *healthcare practitioner*;]
- [Drug delivery implants, e.g. Norplant;]
- [Treatment for Onychomycosis (nail fungus);]
- [*Prescriptions* that are to be taken by or administered to the *covered person*, in whole or in part, while he/she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
 - [*Hospital*;]
 - [*Skilled nursing facility*;] [or]
 - [*Hospice facility*;]]
- [Injectable drugs, including but not limited to:
 - [Immunizing agents;]
 - [Biological sera;]
 - [Blood;]
 - [Blood plasma;][or]
 - [*Self-administered injectable drugs* for which coverage is not approved by us;]]
- [*Prescription* refills:
 - [In excess of the number specified by the *healthcare practitioner*; or]
 - [Dispensed more than [1 year] from the date of the original order;]]

LIMITATIONS AND EXCLUSIONS

- [Any portion of a *prescription* or refill that exceeds a [90-day] supply received from a [*mail order pharmacy* or a] retail *pharmacy* that participates in *our* program which allows a *covered person* to receive a [90-day] supply of a *prescription* or refill;]
- [Any portion of a *prescription* or refill that exceeds a [30-day] supply received from a retail *pharmacy* that does not participate in *our* program which allows a *covered person* to receive a [90-day] supply of a *prescription* or refill;]
- [Any portion of a [*specialty drug* or] *self-administered injectable drug* received from a [retail *pharmacy*] [or a *mail order pharmacy*] [or a *specialty pharmacy*] that exceeds a [30-day] supply, unless otherwise determined by *us*;]
- [Any drug for which *prior authorization* is required, as determined by *us*, and not obtained;]
- [Any drug for which a charge is customarily not made;]
- [Any portion of a *prescription* or refill that:
 - [Exceeds our drug specific dispensing limit[, e.g. IMITREX];]
 - [Is dispensed to a *covered person* whose age is outside the drug specific age limits defined by *us*;] [or]
 - [Exceeds the duration-specific dispensing limit;]
- [Any drug, medicine or medication received by the *covered person*:
 - [Before becoming covered under this benefit; or]
 - [After the date the *covered person's* coverage under this benefit has ended;]]
- [Any costs related to the mailing, sending or delivery of *prescription* drugs;]
- [Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than the *covered person*;]
- [Any *prescription* or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;]
- [Any *service*, supply or therapy to eliminate or reduce a dependency on or addiction to tobacco and tobacco products, including but not limited to, nicotine withdrawal therapies, programs, *services* or medications;]
- [Any drug or biological that has received designation as an *orphan drug* unless approved by *us*;]
- [Any drug for the treatment of *mental health*;]
- [More than 1 *prescription* or refill within a [23-day] period for the same drug or therapeutic equivalent medication prescribed by 1 or more *healthcare practitioners* and dispensed by 1 or more *pharmacies*, unless received from a [*mail order pharmacy*] [or] [a] [*specialty pharmacy*] [or] [a] [retail *pharmacy* that participates in *our* program which allows a *covered person* to receive a [90-day] supply of a *prescription* or refill]. For drugs received from a [*mail order pharmacy*] [or] [a] [*specialty pharmacy*] [or] [a] [retail *pharmacy* that participates in *our* program which allows a *covered person* to receive a [90-day] supply of a *prescription* or refill], more than 1 *prescription* or refill within a 20-day period for a 1-30-day supply; or a [60-90 day] period for a [61-120-day] supply.] [More than 1 *prescription* or refill for the same drug or therapeutic equivalent medication prescribed by 1 or more *healthcare practitioners* and dispensed by 1 or more *pharmacies* until the *covered person* has used, or should have used, at least 75% of the previous *prescription* or refill, unless the drug or therapeutic equivalent medication is purchased through a [*mail order pharmacy*] [or] [a] [*specialty pharmacy*] [or] [a] [retail *pharmacy* that participates in *our* program which allows a *covered person* to receive a [90-day] supply of a *prescription* or refill], in which case the *covered person* has used, or should have used 66% of the previous *prescription*.] [(Based on the dosage schedule prescribed by the *healthcare practitioner*);] [or]
- [Any *copayments* or *coinsurance* the *covered person* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*;] [or]

LIMITATIONS AND EXCLUSIONS

- [Prescription drugs except drugs for hormone replacement and drugs, medicines or medications that are provided to, or administered to, a *covered person*:
 - [While confined as a bed patient in a *hospital* or *skilled nursing facility*];
 - [By a *healthcare practitioner* during an office visit;] [or]
 - [By a *home health care agency*.]]

[1826]

Durable medical equipment limitations

The following are not considered *covered expenses*:

- [Repair or maintenance of the durable medical equipment; or]
- [Duplicate or similar rentals of durable medical equipment, as determined by *us*.]

[1827]

Healthcare practitioner and healthcare treatment facility limitations

- *Services*:
 - [Not authorized, furnished or prescribed by a *healthcare practitioner* or *health care treatment facility*];
 - [For which no charge is made, or for which the *covered person* would not be required to pay if he/she did not have this insurance, unless charges are received from and reimbursable to the United States government or any of its agencies as required by law;]
 - [Furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law;]
 - [Furnished while a *covered person* is confined in a *hospital* or institution owned or operated by the United States government or any of its agencies for any service-connected *sickness* or *bodily injury*];
 - [Charges receive from a *healthcare practitioner* over the rate *we* would pay for the least costly provider;]
 - [Which are not rendered or not substantiated in the medical records;]
 - [Provided by a *family member* or person who resides with the *covered person*;]
 - [Provided by a chiropractor, including but not limited to exams, x-rays, laboratory, spinal manipulations and spinal adjustment modalities;]
 - [That are performed in association with a *service* that is not covered under this *certificate*;]
 - [Billed above or inconsistent with a standard billing method appropriate to the *service* provided and in accordance with *our* claim payment guidelines;] [or]
 - [Performed prior to the *effective date* or after the termination date;]
- [Any charges, including *healthcare practitioner* charges, which are incurred if a *covered person* is admitted to a *hospital* on a Friday or Saturday unless:
 - [The *hospital* admission is due to *emergency care*; or]
 - [Treatment or surgery is performed on that same day;] [or]
- [Hospital *inpatient services* when the *covered person* is in *observation status*.]

[1828]

LIMITATIONS AND EXCLUSIONS

Home health exclusions

- [Charges for mileage or travel time to and from the *covered person's* home;]
- [Wage or shift differentials for *home health care providers*;]
- [Charges for supervision of *home health care providers*;] [or]
- [Charges for services of a home health aide.]

[1829]

Hospice limitations

These *expenses incurred* will not be considered *covered expenses* unless:

- [A *healthcare practitioner* certifies that the *covered person* is terminally ill with a life expectancy of 6 months or less; and]
- [These *services* are in lieu of a confinement in a *hospital* or *skilled nursing facility*.]

[1830]

Hospice exclusions

- [Private duty nursing when confined in a *hospice facility*;]
- [*Services* relating to a confinement not required for acute pain control or other treatment for an acute phase of chronic symptom management;]
- [Funeral arrangements;]
- [Financial or legal counseling, including estate planning or drafting of a will;]
- [Homemaker or caretaker services, including:
 - [Sitter or companion services;]
 - [Housecleaning;] [and]
 - [Household maintenance;]]
- [*Services* of a social worker other than a licensed clinical social worker;]
- [*Services* by volunteers or persons who do not regularly charge for their *services*;]
- [*Services* by a licensed pastoral counselor to a member of his/her congregation. These are *services* in the course of the duties to which he/she is called as a pastor or minister;]
- [Bereavement counseling services;]
- Counseling for the *hospice patient* and the immediate family by a licensed clinical social worker or pastoral counselor;
- Medical social services for the *covered person* or immediate family including:
 - Assessment of social, emotional and medical needs and the home and family situation;
 - and
 - Identification of the community resources available;]
- Psychological and dietary counseling; [or]
- Physical therapy.

[1831]

Mental health exclusions

- [*Services* provided by a *hospital*, *healthcare practitioner* or *health care treatment facility* for acute inpatient care, outpatient care and office therapy or for *partial hospitalization* programs or *services* rendered in a *residential treatment center* [or halfway house];] and
- [*Prescription* drugs for the treatment of *mental health*.]

[1832]

LIMITATIONS AND EXCLUSIONS

Preventive care exclusions

- [Eye examination for the purpose of prescribing corrective lenses;]
- [Hearing aids;]
- [Dental examinations;]
- [An employment physical or an exam for the purpose of obtaining insurance;] [or]
- [Immunizations other than those specified in this *certificate*.]

[1833]

Service exclusions and limitations

- [Cosmetic surgery or any complication therefrom, unless specifically described in the “Your Certificate Benefits” section;]
- [*Custodial care* and maintenance care;]
- [*Infertility services*;]
- [Pregnancy and well baby care expenses;]
- [Elective medical or surgical procedures;]
- [Sterilization, including tubal ligation and vasectomy, and reversal of sterilization;]
- [Abortion;]
- [Gender reassignment or sexual dysfunction;]
- [Eye refractive disorders, eyeglass frames and lenses or contact lenses, radial keratotomy, laser or lasik and any other surgery to correct myopia, hyperopia or stigmatic error, vision therapy, or orthoptic treatment (eye exercises), unless otherwise specifically described in this *certificate*;]
- [Routine hearing or eye exams;]
- [Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including, but not limited to, excision of partially or completely unerupted impacted teeth, any oral or periodontal surgery and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and any dental *services* related to a *bodily injury* or *sickness* unless otherwise indicated in this *certificate*;]
- [The treatment of *mental health* unless shown in a rider, if any attached to this *certificate*;]
- [Therapy and testing for treatment of allergies not approved by the American Academy of Allergy and Immunology or the Department of Health and Human Services or any of its offices or agencies;]
- [Any treatment for the purpose of reducing obesity, or any use of obesity reduction procedures to treat *sickness* or *bodily injury* caused by, complicated by or exacerbated by obesity including but not limited to surgical procedures;]
- [Treatment of nicotine habit or addiction, including but not limited to, nicotine patches, hypnosis, smoking cessation classes or tapes;]
- [Light treatment for Seasonal Affective Disorder (S.A.D.);]
- [Educational or vocational therapy, *services*, and schools including but not limited to videos and books;]
- [Foot care *services* including but not limited to:
 - [Treatment of weak, strained, flat, unstable or unbalanced feet;]
 - [Treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;]
 - [Tarsalgia, metatarsalgia or bunion treatment, except surgery which involves exposure of bones, tendons or ligaments;]
 - [Treatment of toenails, except removal of nail matrix;] [and]

LIMITATIONS AND EXCLUSIONS

- [Arch supports, heel wedges, lifts, the fitting or provision of foot orthotics or orthopedic shoes, except as an integral part of a brace;]
- [Hearing aids, hair prosthesis, hair transplants or implants and wigs;]
- [Sleep therapy or *services* rendered in a premenstrual syndrome clinic or holistic medicine clinic;]
- [Alternative medicine;]
- [Marital counseling;]
- [Transplant *services* except as specified in this *certificate*;]
- [Routine immunizations unless otherwise specified in this *certificate*;]
- [Immunizations including those required for foreign travel for *covered persons* of any age unless otherwise described in this *certificate*;]
- [Treatment for any jaw joint problem including but not limited to temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull;]
- [Genetic testing, counseling or *services*;]
- [Treatment as a result of attempted suicide or intentionally self-inflicted injury whether sane or insane;]
- [Charges for which there is automobile or any other insurance providing medical payments;]
- [Routine physical examination for occupation, employment, school, travel, the purchase of insurance or premarital tests/examinations;]
- [*Services* received in an emergency room unless required because of *emergency care*;]
- [*Services* received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment[, lack of discipline or other antisocial actions];] [or]
- [*Services* or supplies provided in connection with a *sickness* or *bodily injury* arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation. This exclusion does not apply to *services* or supplies received by a *covered person* qualifying as a sole proprietor, officer or partner under the laws of that state, and such benefits are not covered under any workers' compensation plan, provided he/she is not covered under a workers' compensation plan and he/she is not engaged in the following professions or activities: actors, actresses, air craft operations, air traffic controllers, services related to the sale of alcoholic beverages, asbestos and toxic chemical workers, armed forces, atomic energy, circus or carnival workers, commercial fisherman, dock workers, drivers (racing or testing), entertainers, explosive workers, farming including bailing and drivers, firefighters, fireworks, half-way house workers, heavy construction, home building or remodeling, horse trainers, iron workers, jockeys, law enforcement, loggers, models, migrant workers, mining, musicians, oil or natural gas workers including offshore operations, pilots, private investigators, professional drivers, rodeo participants, roofers, quarry workers, salvage operations, sawmill workers, steel workers, ski instructors, steeplejacks, truckers, tunnel workers or window cleaners (working over 3 stories).]

[1834]

LIMITATIONS AND EXCLUSIONS

Service enhancements exclusions

- [Private duty nursing;]
- [Services rendered by a standby *healthcare practitioner* or assistant surgeon, unless *medically necessary*;]
- [Communications or travel time;]
- [Lodging accommodations or transportation except as described in this *certificate*;] [or]
- [Charges for services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a *healthcare practitioner*) including but not limited to:
 - [Common household items such as air conditions, air purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or exercise equipment;]
 - [Scooters or motorized transportation equipment, escalators, elevators, ramps, modifications or additions to living/working quarters or transportation vehicles;]
 - [Personal hygiene equipment such as bath/shower chairs, or bed side commodes;]
 - [Personal comfort items such as cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools or spas;]
 - [Professional medical equipment such as blood pressure kits, breast pumps, PUVA lights and stethoscopes;]
 - [Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs and all related material and products for these programs;]
 - [Personal computers and related equipment or other similar items or equipment;] [or]
 - [Communication devices except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.]

[1835]

Transplant exclusions

- [Transplants which are *experimental, investigational or for research purposes*;]
- [There is insufficient data or experience to determine whether the procedure is clinically acceptable;]
- [*We* are not contacted for *preauthorization*;]
- [*We* do not approve coverage for the *covered organ transplant* based on *our* established criteria;]
- [The expense relates to the transplantation of any non-human organ or tissue unless otherwise stated in this *certificate*;]
- [A denied transplant is performed. This includes the pre-transplant evaluation, the transplant procedure, follow up care, immunosuppressive drugs and complications of such transplant;] [or]
- [Expenses related to the storage of cord blood and stem cells unless the storage is an integral part of the *covered organ transplant* of *bone marrow* approved by *us*.]

[1836]

TERMINATION RIGHTS

Reasons we will terminate your certificate

This *certificate* is renewable at the option of the *primary insured*, except for the conditions stated below. We will terminate *your certificate* [on the occurrence of the following events] [on the last day of the month in which the following events occur]:

- The date the *policy* terminates;
- You have not paid premium by the end of the payment period;
- You cease active membership in the [ABC Corporation] association;
- You or a *covered person* commit fraud or make an intentional misrepresentation of a material fact, as determined by us;
- You or a *covered person* permit someone else to use *our ID card*;
- You or a *covered person* fail to comply with the *certificate* provisions, as determined by us;
- [You enter full-time military, naval or air service;]
- [You move outside of the service area, as determined by us;]
- You request termination of the *certificate* in writing, or the date such request is received by us, whichever is later;
- We have a right or defense to take such action by law; or
- We cease to offer a type of *certificate* or cease to do business in the individual medical insurance market, as allowed by state law.

[1837]

Reasons we will terminate a covered person

We will terminate coverage for a *covered person* [on the earliest of the following] [on the last day of the month in which the following events occur]:

- [When the *covered person* no longer qualifies as a *dependent* or meets eligibility criteria;]
- The date the *covered person* is no longer a resident of the service area, as determined by us;
- The *covered person* enters full time military, naval, or air service;
- The *covered person* commits fraud or makes an intentional misrepresentation of a material fact, as determined by us; or
- The date this *certificate* terminates.

[1838]

Your duty to notify us

You are responsible to notify us of any of the events stated above, which would result in termination of this *certificate* or a *covered person*.

If you fail to provide timely notification of these events, the termination date and the period for which premium refund (if any) would be calculated will be determined based on when we should have received the notification, as determined by us.

[1839]

TERMINATION RIGHTS

Limitation on termination

After the *covered person* is insured without interruption for 2 years *we* cannot end coverage except for the reasons described in the sections above.

Every time *you* change coverage, either with or without an enrollment form, the 2 year review timeframe starts over, with regard to the new information and benefits.
[1840]

TRANSFERRING COVERAGE

If a *covered person's* benefits under this *certificate* terminate, they may be eligible to convert to a new certificate. Benefits under the new certificate may differ from the benefits under this *certificate*. The following rules apply to such a change in coverage.

[1841]

Are you eligible for a new certificate

A *covered person* may be eligible to receive a new certificate if they have had coverage in effect for [90 days] and 1 of the following events occurs:

- Coverage for a *dependent* child under this *certificate* would terminate due to the child ceasing to meet the definition of *dependent* under this certificate; or
- Coverage under this *certificate* would terminate for the spouse or any covered *dependent* child of the *primary insured* due to dissolution of marriage, annulment or divorce.

If 1 of the above events occurs, the *covered person* must submit a written request for the new certificate and pay the required premium within [31 days] of the date coverage under this *certificate* terminated.

A certificate applied for under 1 of the events described above does not require medical underwriting.

If *you* do not meet the above criteria, *you* can request an enrollment form and apply for a new certificate. *Your* enrollment form will be subject to medical underwriting.

A separate certificate may be issued to each former *covered person*, or a single family certificate may be issued to all former *covered persons* together. However, if coverage ended due to dissolution of marriage, annulment or divorce, only those *covered persons* who cease to be dependent on the *primary insured* are eligible for coverage under the new certificate.

We may refuse to issue a certificate if *we* determine that the *covered person(s)* have other insurance which *we* determine would result in duplicate benefits, or if the previous coverage was terminated due to fraud, intentional misrepresentation or non-payment of premium.

[1842]

Conditions for receiving your new certificate

The new certificate will be effective on the day after coverage under this *certificate* ends. The premium for the new certificate will be the premium charged by *us* as of the effective date based upon the new certificate form, classification of risk, age, benefit amounts selected and other criteria *we* use to determine premium. The premium may change.

The new certificate is not a continuation of the *covered person's* terminated coverage. The certificate benefits may differ from those provided under the prior coverage. All accumulators, including *deductible*, *coinsurance*, *out-of-pocket limit*, *pre-existing condition* exclusion, waiting periods, or benefit and *calendar year* maximums, satisfied under the prior *certificate* will carryover and be applied toward the same of the new certificate.

[1843]

TRANSFERRING COVERAGE

Continuation of coverage for surviving dependents

If this *certificate* has been in effect for at least [90 days] and the *primary insured* dies while dependent coverage is in-force, the surviving *dependents* that are covered under this *certificate* on the date of death may be eligible to continue coverage under this *certificate*.

The surviving spouse or legal guardian of the covered *dependent* child(ren) must notify *us* in writing within [31 days] of the *primary insured's* death. Premium must continue to be paid in order for coverage to continue. The premium may change and will be based upon the classification of risk and age of those continuing coverage.

The surviving *dependent* spouse will become the primary insured if covered under this *certificate* on the date of death. In the case of child-only coverage, the surviving *dependent's* parent or legal guardian will become the primary insured of the continued *certificate*.

All conditions, limitations and maximums of this certificate will continue to apply.

[1844]

PREMIUM PAYMENT

Your duty to pay premium

You must pay the required premium to *us* as it becomes due. If *you* don't pay *your* premium on time, *we* will terminate coverage.

The first premium is due on the date specified by *us*. Subsequent premiums are due on the first day of each premium period. Premium period means [monthly,] [quarterly,] [semi-annually,] [or] [annually] [as selected by *you*]. All premiums are payable to *us* at *our* address.

[1845]

Grace period

You have [31 days] from the premium due date to remit the required funds. If premium is not paid *we* will terminate the insurance as of the last day of the premium period for which premium was paid.

[1846]

Changes to your premium

We will not change the initial premium shown on the cover of this *certificate* for the first [12] consecutive months except for the following:

- Family members are added or deleted;
- Coverage is increased or decreased;
- The *covered person* moves to a different zip code or county; or
- Premium payment method is changed.

The premium change will be effective on the date of such change.

After the first [12] consecutive months, premium may change on any premium due date for any of the reasons stated above or the following:

- A new rate table applies;
- Any *covered person's* age increases; or
- Any *covered person's* rating classification changes.

We will provide written notice at least [31 days] prior to the effective date of any premium change.

[1847]

Return of premium/rescission

In no event, except for the reason described in the "Right to Return Certificate" provision on the cover of this *certificate* or rescission of coverage, will premium be returned.

[If we receive *your* written request to terminate this *certificate*, we will return the unearned portion of any premium received for the periods of coverage after the termination date. Earned premium will be computed by the use of the short-rate table last filed with the Department of Insurance in the state in which *you* resided when this *certificate* was issued.]

PREMIUM PAYMENT

[Further, any refunds required by the state will be prorated to the termination date from the date of the last premium payment.]

[1848]

CHANGES TO THE CERTIFICATE

Your rights to make changes to the certificate

You have several rights to make changes to *your certificate*.
[1849]

Changes in benefits

You may call or write *us* to request additional, increased or decreased benefits.

If the additional benefits *you* request are available, as determined and approved by *us*, the benefit will become effective on the date *we* approve the change.

[1850]

Change in state of residence

If *you* move out of *your* current state of residence *you* may be eligible for new benefits under *your* new state of residence.

At least [14 days] prior to *your* move to a new state, call or write *us* informing *us* of *your* new address and phone number. Once *we* receive this information, *we* will inform *you* of any changes to *your* plan on such topics as new networks, benefits, and premium. Such change will be retroactive and effective as of the date of *your* move.

[1851]

Changes to covered persons

You may request a change to the persons covered under *your certificate* due to certain changes in *your* family.

[1852]

Deletions

If *you* wish to remove a *covered person* from *your certificate*, simply call or write *us* at the address on *your ID card*.

[1853]

Adding dependents

- If a child is born to *you* or any *covered person*, *you* adopt a child, or a child is placed with *you* for the purpose of adoption *we* must be notified of the event in writing and receive any required premium within [31 days] of the event to avoid medical underwriting. If *we* do not receive notice and premium for the first [31 days] and forward, the child will not be a *covered person* under this *certificate*.
- A dependent not falling under the previous paragraph must apply to be added as a *covered person* and be accepted by *us*. If accepted the *covered person* will be covered on the date *we* specify. *Pre-existing condition limitations will apply.*

[1854]

CHANGES TO THE CERTIFICATE

Effective date of dependent changes

- Coverage for a newborn or adopted child will be effective on the date of the birth, placement, or adoption, provided *you* complete an enrollment form and remit the premium within [31 days] of the child's date of birth or adoption.
- If *we* receive the enrollment form and any required premium more than [31 days] after the newborn's date of birth or the child's adoption or placement for adoption, such child will be subject to medical underwriting. If accepted and premium is received, the newborn or adopted child will be covered on the date *we* specify. Pre-existing condition limitations will apply.
- Changes for other *dependents* will be effective upon completion of underwriting, acceptance by *us*, and receipt of premium. Pre-existing condition limitations will apply.

Coverage for a newborn is outlined in the "Newborn Services" provision in the "Your Certificate Benefits" section. No benefits are payable for routine well baby care including *hospital* nursery charges at birth.

[1855]

Child-only coverage

The parent or legal guardian in whose name the *certificate* is issued is considered the *primary insured*. In the case of child-only coverage, as a parent or legal guardian, *you* have contracted on behalf of *your dependent* for the benefits described in this *certificate*. It is *your* responsibility to assure *your dependent's* compliance with any and all terms and conditions outlined in this *certificate*.

To add a dependent child to a child-only certificate, follow the procedures listed above.

[1856]

Our rights to make changes to the certificate

We have the right to make certain changes to *your certificate*.

[1857]

Changes we will make without notice to you

Changes to this *certificate* can be made by *us* at anytime without prior consent of, or notice to *you*, when the changes are:

- Required by state or federal law;
- Required by filing of forms with the Insurance Department of the state; and
- For an increase in benefits without any increase in premium.

[1858]

Changes where we will notify you

We can also make changes to *your certificate* on the premium due date or upon separate notice, provided *we* send *you* a written explanation of the change [31 days] prior to its effect. All such changes will be made in accordance with state law. *Your* continued payment of premium will stand as proof of *your* agreement to the change.

[1859]

CHANGES TO THE CERTIFICATE

How do you know these are our changes

No modification or amendment to the *policy* or this *certificate* will be valid unless approved by the President, Secretary or a Vice-President of *our* company. No agent has authority to modify the *policy* or this *certificate*, waive any of the *policy* or *certificate* provisions, extend the time for premium payment, or bind *us* by making any promise or representation.

[1860]

GENERAL PROVISIONS

Assignment of benefits

Assignment of benefits may be made only with *our* consent. An assignment is not binding until *we* receive and acknowledge in writing the original or copy of the assignment before payment of the benefit. *We* do not guarantee the legal validity or effect of such assignment.

[1861]

Conformity with state statutes

Any provisions which are in conflict with the laws of the state in which this *certificate* is issued are amended to conform to the minimum requirements of those laws.

[1862]

Cost of legal representation

The costs of *our* legal representation in matters related to *our* rights under this *certificate* shall be borne solely by *us*. The costs of legal representation incurred by or on behalf of a *covered person* shall be borne solely by *you* or the *covered person*, unless *we* were given timely notice of the claim and an opportunity to protect *our* own interests and *we* failed or declined to do so.

[1863]

Discount program

From time to time, *we* may offer or provide access to discount programs to *you*. In addition, *we* may arrange for third party service providers such as pharmacies optometrists, dentists and alternative medicine providers to provide discounts on goods and services to *you*. Some of these third party service providers may make payments to *us* when *covered persons* take advantage of these discount programs. These payments offset the cost to *us* of making these programs available and may help reduce the cost of *your* plan administration. Although *we* have arranged for third parties to offer discounts on these goods and services, these discount programs are not *covered services* under this *certificate*. The third party service providers are solely responsible to *you* for the provision of any such goods and/or services. *We* are not responsible for any such goods and/or services, nor are *we* liable if vendors refuse to honor such discounts. Furthermore *we* are not liable to *covered persons* for the negligent provision of such goods and/or services, by third party service providers. Discount programs may not be available to persons who “opt out” of marketing communications and where otherwise restricted by law.

[1864]

Entire Contract

The rules governing *our* agreement to provide *you* with health insurance in exchange for *your* premium payment is based upon several written documents: the *policy*, this *certificate*, riders, amendments, endorsements and the enrollment form.

[1865]

GENERAL PROVISIONS

Reinstatement

If this *certificate* is terminated due to lack of premium payment, *you* may request reinstatement. *We* will reinstate *your certificate* provided:

- A new enrollment form is submitted by *you*;
- Coverage has not been terminated for more than [6 months]; and
- *We* approve the reinstatement.

If *your* request for reinstatement is approved, coverage will be reinstated on the date *we* approve the reinstatement.

No benefit will be paid for any condition that occurs during the time between the termination date and the reinstatement date if:

- A *covered person* received medical treatment, diagnosis, consultation, *service* or took *prescription* drugs;
- The condition produced symptoms or was capable of being diagnosed; or
- The condition is not disclosed on the application for reinstatement.

This limitation will be for [12 months] from the reinstatement date, unless the condition has been specifically excluded from coverage. Further, all accumulators from this *certificate* will be applied to the reinstated coverage.

[1866]

Our relationship with providers

We and health care providers [- both *network* and *non-network providers* -] are at all times acting independently. *We* do not make any medical decisions, nor prescribe treatment options, regardless of any coverage determinations *we* make under this *certificate*.

[1867]

RECOVERY RIGHTS

Your obligation to assist in the recovery process

As explained in the “Claims Payment” section, *we* have the right to collect *our* payments made in error.

The *covered person* is obligated to cooperate and assist *us* and *our* agents in order to protect *our* recovery rights by:

- Obtaining *our* consent before releasing any party from liability for payment of medical expenses;
- Providing *us* with a copy of any legal notices arising from the *covered person*'s injury and its treatment;
- Taking all action to assist *our* enforcement of recovery rights and doing nothing after loss to prejudice *our* recovery rights; and
- Refraining from designating all (or any disproportionate part) of any recovery as exclusively for “pain and suffering”.

If the *covered person* fails to cooperate, *we* shall collect any payments made by *us* from *you*.
[1868]

Our right of subrogation

The *covered person* agrees to transfer to *us* any rights they have to recover any expenses paid under this *certificate*. *We* will be subrogated to these recovery rights from any funds paid or payable.

We may enforce *our* subrogation rights by asserting a claim to any coverages to which the *covered person* may be entitled.

If *we* are precluded from exercising *our* right of subrogation, *we* may exercise *our* right of reimbursement.
[1869]

Right of reimbursement

If *we* pay benefits and later any *covered person* recovers from the responsible party, *we* have the right to recover from *you* or the *covered person* the amount *we* paid.

The *covered person* shall notify *us*, in writing, within [31 days] of any settlement, compromise or judgment. If the *covered person* waives, or impairs *our* right to reimbursement, *we* will suspend payment of past or future *services* until all outstanding lien(s) are resolved.

If any *covered person* recovers payment from and releases any legally responsible party for future medical expenses relating to a *sickness* or *bodily injury*, *we* shall have a continuing right to seek reimbursement from *you* or that *covered person*. This right, however, shall apply only to the extent allowed by law.

RECOVERY RIGHTS

This reimbursement obligation exists in full, regardless of whether settlement, compromise, or judgment designates the recovery as including or excluding medical expenses.

[1870]

Assignment of recovery rights

If the *covered person's* claim against the other insurer is denied or partially paid, *we* will process such claim according to the terms and conditions of this *certificate*. If payment is made by *us* on the *covered person's* behalf, *you* and the *covered person* agree that any right the *covered person* has against the other insurer for medical expenses *we* pay will be assigned to *us*.

If benefits are paid under this *certificate* and *you* or the *covered person* recovers under any automobile, homeowners, premises, or similar coverage, *we* have the right to recover from *you* or the *covered person* an amount equal to the amount *we* paid.

[1871]

Workers' Compensation

If benefits are paid by *us* and *we* determine that the benefits were for treatment of a *bodily injury* or *sickness* that arose from, or was sustained in the course of, any occupation or employment for compensation, profit, or gain, *we* have the right to recover as described below. *We* will exercise *our* right to recover against *you* or the *covered person*.

The recovery rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that *bodily injury* or *sickness* was sustained in the course of or resulted from the *covered person's* employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by the *covered person* or the Workers' Compensation carrier; or
- Medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You and the *covered person* hereby agree that, in consideration for the coverage provided by this *certificate*, *we* will be notified of any Workers' Compensation claim the *covered person* makes, and that *you* or the *covered person* agree to reimburse *us* as described above.

[1872]

DEFINITIONS

The following are definitions of terms as they are used in this *certificate*. Defined terms are printed in italic type wherever found in this *certificate*.

[1873]

A

Acute inpatient services means care given in a *hospital* or *healthcare treatment facility* which:

- Maintains permanent full-time facilities for room and board of resident patients;
- Provides emergency, diagnostic and therapeutic services with a capability to provide life-saving medical and psychiatric interventions;
- Has *healthcare practitioner services* and skilled nursing *services* available 24 hours a day;
- Provides direct daily involvement of the *healthcare practitioner* or licensed Ph.D psychologist; and
- Is licensed and legally operated in the jurisdiction where located.

Acute inpatient services are utilized when there is an immediate risk to engage in actions which would result in death or harm to self or others or there is a deteriorating condition in which an alternative treatment setting is not appropriate.

[1874]

Alternative medicine means an approach to medical diagnosis, treatment or therapy that has been developed or is practiced not using the scientific methods generally accepted in the United States of America. For the purpose of this definition, *alternative medicine* includes but is not limited to acupressure, acupuncture, aromatherapy, syurveda, biofeedback, faith healing, guided mental imagery, herbal medicine, holistic medicine, homeopathy, hypnosis, macrobotics, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsue and yoga.

[1875]

B

Bodily injury means damage resulting from sudden, violent, external physical trauma which could not be avoided or predicted in advance. Bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered a *sickness* and not a *bodily injury*.

[1876]

Bone marrow means the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppressive chemotherapy. Such cells may be derived from *bone marrow*, circulating blood, or a combination of *bone marrow* and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving a *covered organ transplant* of *bone marrow*, the term *bone marrow* includes the harvesting, the transplanatation, and the chemotherapy components.

[1877]

DEFINITIONS

C

Calendar year means the period of time beginning on any January 1st and ending on December 31st of the same year. The first *calendar year* begins for a *covered person* on the date benefits under this *certificate* first become effective for that *covered person* and ends on the following December 31st.

[1878]

Certificate means this document, together with any amendments, riders, or endorsements, which describe the agreement between *you* and *us*.

[1879]

Coinsurance means the portion of *covered expenses* a *covered person* must pay in addition to any *copayments* and *deductible*. This amount is shown on the "Schedule of Benefits".

[1880]

Complications of pregnancy means conditions with diagnoses which are distinct from pregnancy, but are adversely affected by pregnancy or caused by pregnancy, such as:

- [Acute nephritis;]
- [Nephrosis;]
- [Cardiac decompensation;]
- [Hyperemesis gravidarum;]
- [Puerperal infection;]
- [Pre-eclampsia (toxemia);]
- [Eclampsia;]
- [Abruptio placenta;]
- [Placenta previa;]
- [Missed or threatened abortion;]
- [Ectopic pregnancy;]
- [Endometritis;]
- [Hydaiform mole;]
- [Chorionic carcinoma;]
- [Pre-term labor;]
- [Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible;] [or]
- [Gestational diabetes.]

Complications of pregnancy does not mean:

- [False Labor;]
- [Occasional spotting;]
- [Rest prescribed during the period of pregnancy;]
- [Conditions associated with the management of a difficult pregnancy, but which do not constitute a distinct *complication of pregnancy*;] [or]
- [Cesarean section.]

[1881]

DEFINITIONS

Confinement means the status of being a resident patient in a *hospital* or *healthcare treatment facility* receiving *inpatient services*. *Confinement* does not mean detainment in *observation status*.

Successive *confinements* are considered to be 1 *confinement* if:

- Due to the same *bodily injury* or *sickness*; and
 - Separated by fewer than [30] consecutive days when the *covered person* is not confined.
- [1882]

Congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect and includes:

- Autism or an autism spectrum disorder; and
 - Cerebral palsy.
- [1883]

Copayment means a specified dollar amount shown on the “Schedule of Benefits”, to be paid by *you* or a *covered person* to a provider toward *covered expenses* of certain benefits specified in this *certificate*.

[1884]

Cosmetic surgery means surgery performed to reshape normal structures of the body in order to improve a *covered person’s* appearance or self-esteem.

[1885]

Covered expense means a *medically necessary* expense, based on the *maximum allowable fee* for *services* incurred by a *covered person*.

[1886]

Covered organ transplant means pre-transplant, transplant inclusive of any chemotherapy and associated services, post-discharge *services* and treatment of complications after transplantation. Transplantation of multiple organs, when performed simultaneously, is considered 1 organ transplant.

[1887]

Covered person means anyone eligible to receive benefits under this *certificate*. Please refer to the “Schedule of Benefits” for a complete list of *covered persons*.

[1888]

Custodial care means *services* given to a *covered person* if:

- The *covered person* needs *services* that include, but are not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self-administered, getting in and out of bed and maintaining continence; or
- The *services* are required to primarily maintain and not likely to improve the *covered person’s* condition.

Services may still be considered *custodial care* by *us* even if:

- The *covered person* is under the care of a *healthcare practitioner*;

DEFINITIONS

- The *services* are prescribed by a *healthcare practitioner* to support or maintain the *covered person's* condition;
 - Services are being provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);
 - Services involve the use of skills which can be taught to a layperson; or
 - The *covered person* does not require the technical skills of a licensed nurse at all times.
- [1889]

D

Deductible means the amount of *covered expense* that a *covered person* must incur in a *calendar year* and is responsible to pay before *we* pay certain benefits.

[1890]

Dental injury means an injury to a *sound natural tooth* caused by a sudden and external force that could not be predicted in advance and could not be avoided. It does not include biting or chewing injuries.

[1891]

Dependent means *your* legally recognized spouse; *your* unmarried natural child; step-child, or legally adopted child whose age is less than the limiting age; an unmarried child whose age is less than the limiting age and for whom *you* have received a court or administrative order to provide coverage; or *your* adult child who meets the following conditions:

- Is beyond the limiting age of a child;
- Is unmarried;
- Is either mentally retarded or permanently physically handicapped; and
- Incapable of self-sustaining employment.

Each child, other than the child who qualifies because of a court or administrative order, must meet all of the qualifications of a *dependent* as determined by *us*.

Dependent does not mean a:

- Grandchild unless such child is born to a *dependent* covered under this *certificate*;
- Great grandchild;
- Foster child; or
- Child who has not yet attained full legal age but who has been declared by a court to be emancipated.

The limiting age for each child to be considered a *dependent* under this *certificate* is:

- The child's [19th] birthday; or
- The child's [25th] birthday, if such child is a full-time student for the entire period since the later of the *effective date* or the child's [19th] birthday, and for which *you* furnish satisfactory proof to *us*, upon *our* request, that the child is a full-time student.

A child is a full-time student when that child maintains full-time status at an accredited secondary school, college or university, as defined by that school, with no more than 4 months between school terms. In no event will coverage continue beyond the limiting age.

[1892]

DEFINITIONS

Diabetic supplies means:

- Test strips for blood glucose monitors;
- Visual reading and urine test strips;
- Lancets and lancet devices;
- Insulin and insulin analogs;
- Injection aids;
- Syringes;
- Prescriptive and nonprescription oral agents for controlling blood sugar levels;
- Glucagon emergency kits; and
- Alcohol swabs.

[1893]

Dispensing limit means the monthly drug dosage limit and/or the number of months the drug usage is usually needed to treat a particular condition as determined by *us*.

[1894]

Drug list means a list of *prescription* drugs, medicines, medications and supplies specified by *us*. This list identifies drugs as level 1, level 2, level 3 or level 4 and indicates applicable *dispensing limits* and/or any *prior authorization* requirements. This list is subject to change without notice. [Drugs may move between levels[[and] [may be subject to specific time constraints].] [There may be times when a level contains no drugs at all] [or] [a drug may be subject to multiple levels].]

[1895]

Durable medical equipment means equipment that must meet the following conditions:

- Be able to withstand repeated use;
- Be primarily and customarily used to serve a medical purpose;
- Not be generally useful to a person except to treat a *bodily injury* or *sickness*;
- Be *medically necessary* and necessitated by the *covered person's bodily injury* or *sickness*;
- Be provided in the most cost effective manner, either rental, repair or purchase, at *our* discretion, and as required by the *covered person's* condition; and
- Be prescribed by a *healthcare practitioner* as appropriate for use in the home.

[1896]

E

Effective date means the first date all the terms and provisions of this *certificate* apply. It is the date that appears on the cover of this *certificate* or on the date of any amendment, rider or endorsement.

[1897]

Emergency care means any *service* provided for a *bodily injury* or *sickness* manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of that individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

DEFINITIONS

- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency care does not mean any *service* for the convenience of the *covered person* or the provider of treatment or *services*.

[1898]

Expense incurred means the *maximum allowable fee* charged for *services* which are *medically necessary* to treat the condition. The date a *service* is rendered is the *expense incurred* date.

[1899]

Experimental, investigational or for research purposes means a drug, biological product, device, treatment or procedure that meets any 1 of the following criteria, as determined by *us*:

- [Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and which lacks such final FDA approval for the use or proposed use, unless:
 - [Found to be accepted for that use in the most recently published edition of the United States Pharmacopoeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information;]
 - [Identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of *service*;] [or]
 - [Is mandated by state law;]
- [Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA, but has not received a PMA or 510K approval;]
- [Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of *service*;]
- [Is the subject of a National Cancer Institute (NCI) Phase I trial, or any trial not recognized by NCI regardless of the Phase;] [or]
- [Is identified as not covered by the Centers for Medicare and Medicaid Services Coverage Issues Manual, except as required by state or federal law.]

[1990]

F

Family member means the *covered person* or the *covered person's* spouse, or the *covered person* or their spouse's child, brother, sister or parent.

[1901]

Free-standing surgical facility means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient *surgery*. It does not provide *services* or accommodations for patients to stay overnight.

[1902]

DEFINITIONS

H

Habilitative services means services, including occupational therapy, physical therapy, and speech therapy for the treatment of a child with a *congenital or genetic birth defect* to enhance the child's ability to function.

[1903]

Healthcare treatment facility means only a facility, institution or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license. *Healthcare treatment facility* does not include a *residential treatment center* [or a halfway house].

[1904]

Healthcare practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a *bodily injury* or *sickness*, and who provides *services* within the scope of that license. A *healthcare practitioner's services* are not covered if the practitioner resides in the *covered person's* home or is a *family member*.

[1905]

Home health care plan means a plan of health care established with a *home health care provider*.

The *home health care plan* must consist of:

- Care by or under the supervision of a Registered Nurse (R.N.);
- Physical, speech, occupational and respiratory therapy; or
- Medical appliances and equipment, if *expenses incurred* for such supplies would have been *covered expenses* during a *confinement*.

A *healthcare practitioner* must:

- Review and approve the *home health care plan*;
- Certify and verify that the *home health care plan* is required in lieu of *confinement* or a continued *confinement*; and
- Not be related to the *home health care provider* by ownership or contract.

[1906]

Home health care provider means an agency licensed by the proper authority as a home health agency, or Medicare approved as a home health agency and provides 24-hour-a-day, 7-day-a-week service supervised by a *healthcare practitioner*.

[1907]

Home health care visit means home health care *services* provided by any 1 *healthcare practitioner* for [4] consecutive hours or any portion thereof.

[1908]

Hospice care agency means an agency which:

- Has the primary purpose of providing hospice *services* to *hospice patients*;
- Is licensed and operated according to the laws of the state in which it is located; and
- Meets the following requirements:

DEFINITIONS

- Has obtained any required certificate of need;
- Provides 24-hour-a-day, 7-day-a-week service, supervised by a *healthcare practitioner*;
- Has a full-time administrator;
- Keeps written records of services provided to each patient; and
- Has a coordinator who:
 - Is a Registered Nurse (R.N.);
 - Has 4 years of full-time clinical experience, of which at least 2 were involved in caring for terminally ill patients; and
- Has a licensed social service coordinator.

[1909]

Hospice care program means a written plan of hospice care which:

- Is established and reviewed by:
 - The *healthcare practitioner* attending to the person; and
 - The *hospice care agency*; and
- Provides:
 - Palliative care and supportive care to *hospice patients*;
 - Supportive care to the families of *hospice patients*;
 - An assessment of the *hospice patient's* medical and social needs; and
 - A description of the care to meet those needs.

[1910]

Hospice facility means a licensed facility or part of a facility which:

- Principally provides hospice care;
- Keeps medical records of each patient;
- Has an ongoing quality assurance program;
- Has a *healthcare practitioner* on call at all times;
- Provides 24-hour-a-day skilled nursing *services* under the direction of a Registered Nurse (R.N.); and
- Has a full-time administrator.

[1911]

Hospice patient means a terminally ill person who has 6 months or less to live, as certified by a *healthcare practitioner*.

[1912]

Hospital means an institution which:

- Maintains permanent full-time facilities for bed care of resident patients;
- Has a *healthcare practitioner* in regular attendance;
- Provides continuous 24-hour-a-day nursing services;
- Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
- Is legally operated in the jurisdiction where located; and
- Has surgical facilities on its premises or has a contractual agreement for surgical *services* with an institution having a valid license to provide such surgical *services*.

DEFINITIONS

Hospital does not include a place or institution which is primarily for the treatment for *mental health*. Hospital does not include an institution which is principally a rest home, group home, nursing home, convalescent home or home for the aged or a *residential treatment center*.
[1913]

I

Identification card/ID card means cards each *covered person* receives which contain *our* address and telephone number.
[1914]

Infertility services means any treatment or artificial means, supplies, medications or *services* given to achieve pregnancy or to achieve or maintain ovulation. This includes, but is not limited to:

- [Artificial insemination;]
 - [In vitro fertilization;]
 - [GIFT;]
 - [ZIFT;]
 - [Tubal ovum transfer;]
 - [Embryo freezing or transfer;]
 - [Sperm storage or banking;]
 - [Ovum storage or banking;]
 - [Embryo or zygote banking;] [and]
 - [Any assisted reproductive techniques or cloning methods.]
- [1915]

Inpatient services are *services* rendered to a *covered person* during their *confinement*.
[1916]

Insurer means Humana Insurance Company.
[1917]

L

Legend drug means any medicinal substance the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend : “Caution: federal law prohibits dispensing without *prescription*”.
[1918]

Level 1 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by us as level 1 drugs.
[1919]

Level 2 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by us as level 2 drugs.
[1920]

Level 3 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by us as level 3 drugs.
[1921]

DEFINITIONS

Level 4 drugs means a category of *prescription* drugs, medicines or medications within the *drug list* that are designated by us as level 4 drugs.

[1922]

M

Mail-order pharmacy means a *pharmacy* that provides covered *mail order pharmacy services*, as defined by us, and delivers covered *prescriptions* or refills through the mail to *covered persons*.

[1923]

Maintenance care means any services or activity which seeks to prevent diseases, prolong life, or promote health of a *covered person* who has reached the maximum level of improvement, or whose condition is resolved or stable.

[1924]

Maximum allowable fee means the lesser of:

- [The fee charged by the provider for the *service*];
- [The fee that has been negotiated with the provider whether directly or through 1 or more intermediaries or shared savings contracts for the *services*];
- [The fee established by us by comparing rates from 1 or more regional or national databases or schedules for the same or similar *services* from a geographic area determined by us;]
- [The fee based on rates negotiated by us or other payors with 1 or more *network providers* in a geographic area determined by us for the same or similar *services*];
- [The fee equal to the provider's costs for providing the same or similar *services* as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare and Medicaid Services (CMS) annually;] [or]
- [The fee based on a percentage determined by us of the fee Medicare allows for the same or similar *services* provided in the same geographic area.]

[The bill you receive for *services* from *non-network providers* may be significantly higher than the *maximum allowable fee*. In addition to your out-of-pocket *deductible*, *copayments*, *coinsurance* or *out-of-pocket limit*, you are responsible for the difference between the *maximum allowable fee* and the amount the provider bills you for the *services*. Any amount you pay to the provider in excess of the *maximum allowable fee* will not apply to your *out-of-pocket limit* or *deductible*.]

[1925]

Maximum allowable benefit means the specified maximum amount of benefit payable by us per *prescription* or refill for a covered *prescription* drug. The amount paid by us may not be the actual cost to us, depending on any retrospective utilization pricing adjustments that may apply.

[1926]

Medically necessary means the required extent of a health care *service*, treatment or product that a *healthcare practitioner* would provide to his/her patient for the purpose of diagnosing, palliating, or treating a *sickness* or *bodily injury* or its symptoms. The fact that a *healthcare practitioner* may prescribe, authorize or direct a *service* does not of itself make it *medically necessary* or covered under this *certificate*. Such health care *service*, treatment or product must be:

DEFINITIONS

- [In accordance with nationally recognized standards of medical practice and generally accepted as safe, widely used and effective for the proposed use;]
- [Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting and duration;]
- [Not primarily for the convenience of the patient or *healthcare practitioner*;]
- [Clearly substantiated by the medical records and documentation concerning the patient's condition;]
- [Performed in the most cost effective setting required by the patient's condition;] [and]
- [Supported by the preponderance of nationally recognized peer review medical literature, if any, published in the English language as of the date of *service*.]

[1927]

Mental disorder means mental, nervous or emotional diseases or disorders of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders. This is true regardless of the original cause of the disorder.

[1928]

Mental health means *mental disorders*, alcohol or chemical dependency.

[1929]

Morbid obesity (clinically severe obesity) means a body mass index (BMI) of [35-40] kilograms per meter squared (kg/m²) or greater as of the date of *service*.

[1930]

N

Network pharmacy means a *pharmacy* that has signed a direct agreement with *us* or has been designated by *us* to provide:

- Covered *pharmacy services*;
- [Covered *specialty pharmacy services*;] [or]
- Covered *mail order pharmacy services*,

as defined by *us*, to *covered persons*, including covered *prescriptions* or refills delivered through the mail.

[1931]

Network provider means a *hospital*, *healthcare treatment facility*, *healthcare practitioner* or other provider who is designated as such and has signed an agreement with *us*, or who has been designated by *us* to provide *services* to *covered persons*.

[1932]

Non-network pharmacy means a *pharmacy* that has not signed a direct agreement with *us* or has not been designated by *us* to provide:

- Covered *pharmacy services*;
- [Covered *specialty pharmacy services*;] [or]
- Covered *mail order pharmacy services*;

as defined by *us*, to *covered persons*, including covered *prescriptions* or refills delivered through the mail.

[1933]

DEFINITIONS

Non-network provider means a *hospital, healthcare treatment facility, healthcare practitioner,* or other provider who has not signed an agreement with *us* or who has not been designated by *us* to provide services to *covered persons*.

[1934]

O

Observation status means a stay in a *hospital or healthcare treatment facility* for less than 24 hours if the *covered person*:

- Has not been admitted as a resident inpatient;
- Is physically detained in an emergency room, treatment room, observation room or other such area; or
- Is being observed to determine whether a *confinement* will be required.

[1935]

Orphan drug means a drug or biological used for the diagnosis, treatment or prevention of rare diseases or conditions which:

- Affects less than 200,000 persons in the United States; or
- Affects more than 200,000 persons in the United States, however, there is no reasonable expectation that the cost of developing the drug and making it available in the United States will be recovered from the sale of that drug in the United States.

[1936]

Out-of-pocket limit means the portion of coinsurance a *covered person* pays for certain *services* before *we* begin payment at 100%, [less] [including] [*deductibles,*] [and] [*copayments*]. See the “Schedule of Benefits” for the specific amounts.

[1937]

Outpatient services means the *services* that are rendered to a *covered person* while they are not *confined* as a registered inpatient. *Outpatient services* include, but are not limited to, *services* provided in:

- *A health care practitioner’s office;*
- *A hospital outpatient setting;*
- *A free-standing surgical facility;*
- *A licensed birthing center;*
- *An independent laboratory or clinic;*
- [*Ambulance services.*] [;] [or]
- [*Prescription drugs.*]

[*Outpatient services* does not include *prescription drugs* received on an outpatient basis.]

[1938]

P

Palliative care means care given to a *covered person* to relieve, ease or alleviate, but not to cure, a *bodily injury* or *sickness*.

[1939]

DEFINITIONS

Partial hospitalization means *services* provided in an outpatient program.

- For a comprehensive and intensive interdisciplinary psychiatric treatment for a minimum of [3 hours] a day, [5 days] per week; and
- That provides for social, psychological and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range.

[1940]

Pharmacist means a person who is licensed to prepare, compound and dispense medication and who is practicing within the scope of his/her license.

[1941]

Pharmacy means a licensed establishment where *prescription* medications are dispensed by a *pharmacist*.

[1942]

Policy means the document describing the benefits *we* provide as agreed to by *us and the policyholder*.

[1943]

Policyholder means the legal entity identified as the *policyholder* on the face page of the *policy* and this *certificate* and to whom the *policy* is issued.

[1944]

Preadmission testing means laboratory tests or x-ray examinations done as an *outpatient service* within 7 days before *confinement* or outpatient surgery. The tests must be accepted by the *health care treatment facility* in place of like tests done during *confinement*. The tests must be for the same *bodily injury* or *sickness* causing the *confinement*.

[1945]

Preauthorization means the prior approval given by *us*. *Preauthorization* review will determine if the proposed *service* is a *covered expense*.

[1946]

Pre-existing condition means any disease, illness, *sickness*, malady or condition which was diagnosed or treated by a provider or produced symptoms during the specified time period prior to the *covered person's effective date*.

The time period for *pre-existing conditions* affects the benefits under this *certificate* and is described in the "Pre-existing Condition Limitation" section.

[1947]

Prescription means a direct order for the preparation and use of a drug, medicine or medication. The *prescription* must be given by a *healthcare practitioner* to a *pharmacist* for *your* benefit and used for the treatment of a *sickness* or *bodily injury* which is covered under this *certificate*. The drug, medicine or medication must be obtainable only by *prescription*. The *prescription* may be given to the *pharmacist* verbally[, electronically] or in writing by the *healthcare practitioner*.

DEFINITIONS

The *prescription* must include:

- The name of the *covered person*;
- The type and quantity of the drug, medicine or medication prescribed and the directions for its use;
- The date the *prescription* was prescribed; and
- The name and address of the prescribing *healthcare practitioner*.

[1948]

Preservice notification means notification to *us* by *you*, the *covered person* or the *covered person's healthcare practitioner* of a proposed *service*.

[1949]

Preservice review means a review by *us*, at *our* option, of a proposed *service* or *confinement* to determine:

- If it is *medically necessary*;
- If the use of an alternative level of care is appropriate, such as:
 - *Skilled nursing facilities*;
 - Home health care *services*;
 - Inpatient or outpatient *hospice care programs*;
 - *Partial hospitalization*;
 - Intensive outpatient programs; or
 - Any other alternative level of care.

[1950]

Primary insured means the person to whom this *certificate* is issued and whose name is shown on the "Schedule of Benefits".

[1951]

Prior authorization means the required prior approval from *us* for the coverage of *prescription* drugs, medicines or medication, including the dosage, quantity and duration, as appropriate for the *covered person's* diagnosis, age and sex. Certain *prescription* drugs, medicines or medications may require *prior authorization*.

[1952]

R

Residential treatment center means an institution which:

- Is licensed as a 24-hour residential, intensive, inpatient facility, although NOT licensed as a *hospital*;
- Provides a multidisciplinary treatment plan in a controlled environment, with periodic supervision of a licensed *healthcare practitioner* or Ph.D. psychologist; and
- Provides programs such as social, psychological and rehabilitative training, age appropriate for the special needs of the age group of patients, with a focus on reintegration back into the community.

Residential treatment is utilized to provide structure, support and reinforcement of the treatment required to reverse the course of behavioral deterioration.

[1953]

DEFINITIONS

S

Self-administered injectable drugs means an FDA approved medication which a person may administer to himself/herself by means of intramuscular, intravenous or subcutaneous injection excluding insulin, [epinephrine, sumatriptan and glucagons] and intended for use by the *covered person*.

[1954]

Services means procedures, *surgeries*, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices or technologies.

[1955]

Sickness means disturbance in function or structure of the *covered person's* body which causes physical signs or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of the *covered person's* body.

[1956]

Skilled nursing facility means only an institution licensed as a *skilled nursing facility* and lawfully operated in the jurisdiction where located. It must maintain and provide:

- Permanent and full-time bed care facilities for resident patients;
- *A healthcare practitioner's services* at all times;
- 24-hour-a-day skilled nursing services under the full-time supervision of a *healthcare practitioner* or Registered Nurse (R.N.);
- A daily record for each patient;
- Continuous skilled nursing care for sick or injured persons during their convalescence; and
- A utilization review plan in effect.

A *skilled nursing facility* is not, except by incident, a rest home, a home for the care of the aged or engaged in the care and treatment of chemical or alcohol dependence.

[1957]

Sound natural tooth means a tooth that:

- Is organic and formed by the natural development of the body (not manufactured, capped, crowned or bonded);
- Has not been extensively restored;
- Has not become extensively decayed or involved in periodontal disease; and
- Is not more susceptible to injury than a whole natural tooth (for example a tooth that has been previously broken, chipped, filled, cracked or fractured).

[1958]

Specialty drug means a drug, medicine or medication used as a specialized therapy developed for chronic, complex *sickness* or *bodily injuries*. *Specialty drugs* may:

- Require nursing services or special programs to support patient compliance;
- Require disease-specific treatment programs;

DEFINITIONS

- Have limited distribution requirements; or
- Have special handling, storage or shipping requirements.

[1959]

Specialty pharmacy means a *pharmacy* that provides covered *specialty pharmacy services*, as defined by *us*, to *covered persons*.

[1960]

Surgery means *services* categorized as surgery in the Current Procedural Terminology (CPT) Manuals published by the American Medical Association. The term *surgery* includes, but is not limited to:

- Excision or incision of the skin or mucosal tissues or insertion for exploratory purposes into a natural body opening;
- Insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes; and
- Treatment of fractures.

[1961]

W

We, us or **our** means or otherwise refers to the insurer as shown on the cover of this *certificate*.

[1962]

Y

Your/your means the *primary insured*.

[1963]

OFFICE VISIT COPAYMENT RIDER

HUMANA INSURANCE COMPANY

[*Policyholder*: [ABC Association]]

[*Primary Insured*: [John Doe]]

[*Certificate Number*: [12345]]

[*Effective Date*: [January 1, 2008]]

This rider is attached to and made a part of *your certificate*. Except as modified below, all *certificate* terms, conditions, exclusions and limitations apply.

Office Visit Copayment Benefit

For this benefit the *covered person* must utilize a *network provider*. The *copayment* amount is based on whether the *covered person* sees a primary care or specialty care *network provider*.

Refer to the “Schedule of Benefits” for the copayment

For this benefit *network provider* office visit includes only the following *services*:

- Taking a history;
- Performing an examination;
- Making a diagnosis or medical decision; and
- Administering allergy shots.

Primary care network providers include the following:

- Family Practitioners;
- Internists;
- Pediatricians;
- Gynecologists;
- General Practitioners;
- Nurse Practitioners;
- Physician Assistants; and
- Registered Nurses (R.N.).

Specialty care network providers include all other *healthcare practitioners* not listed as primary care *network providers*.

[Supplemental Outpatient X-Ray and Laboratory Services Benefit

We will pay *covered expenses* the *covered person* incurs in a *calendar year* for x-ray and laboratory *services* rendered during a *network provider* office visit. *Covered expenses* in excess of the amount listed on the “Schedule of Benefits” will be subject to the normal *certificate* provisions.

OFFICE VISIT COPAYMENT RIDER

[*Covered expenses* under this benefit do not include charges incurred for Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT) Scan, Pulmonary Function Studies, Cardiac Catherization, Elektrocardiogram (EKG), Electrocardiogram (ECG), Electroencephalogram (EEG).]

This rider does not apply to Preventive Care. Refer to the “Schedule of Benefits” for the Preventive Care benefits.

All covered services under this rider are subject to the *calendar year certificate* maximums shown on the “Schedule of Benefits”.

[1964]

[Signature of Officer]
[Typed Name of Officer]
[Title of Officer]

SUPPLEMENTAL ACCIDENT RIDER

HUMANA INSURANCE COMPANY

[*Policyholder*: [ABC Corporation]]

[*Primary Insured*: [John Doe]]

[*Certificate Number*: [12345]]

[*Effective Date*: [January 1, 2008]]

This rider is attached to and made a part of *your certificate*. Except as modified below, all *certificate* terms, conditions, exclusions and limitations apply.

Supplemental Accident Benefit

We will pay up to the first [\$500/\$1,000] of *covered expenses* for [each] [any one] *bodily injury* sustained by a *covered person* at 100% [subject to any applicable *copayment*].

[Coverage provided under this rider is limited to [one] *bodily injury* per *covered person* per [calendar year].]

The benefit amount is not subject to the [*deductible*] [or] [*coinsurance*] of the *certificate* when:

- *Services* are provided for a *bodily injury*;
- The *bodily injury* happened and loss occurred while the *covered person* is insured under this rider; and
- Treatment is provided within [90] days of the *bodily injury*.

This benefit is for *bodily injuries* only and is not payable for loss due to a *sickness*.

[*Covered expenses* under this rider do not include *prescription* drugs.]

After the benefit amount under this rider is exhausted, *covered expenses* for *bodily injuries* will be covered under the *certificate* subject to all *certificate* provisions.

[1965]

[Signature of Officer]
[Typed Name of Officer]
[Title of Officer]

TERM LIFE INSURANCE RIDER

HUMANA INSURANCE COMPANY

[*Policyholder*: [ABC Association]]
[*Primary insured*: [John Doe]]
[*Spouse applicant*: [Jane Doe]]
[*Certificate number*: [12345]]
[*Effective date*: [January 1, 2008]]
[*Initial*] premium amount: [\$25.00]

This rider is attached to and made a part of *your certificate*. Except as modified below, all *certificate* terms, conditions, exclusions and limitations apply.

Term Life Insurance Coverage

Subject to the terms and provisions within this rider and the *certificate*, the benefit amount will be made payable to the *beneficiary* named by *you*. Payment is made when *we* receive satisfactory proof to *us* that a *covered person's* death occurred while coverage was in effect and to whom the *benefit amount* should be made. Payment is made in 1 lump sum. This Term Life Insurance Rider has no cash surrender value, loan value or dividends.

Benefit Amount

The *benefit amount* is [\$20,000] for each *covered person*.

Beneficiary

You may name any *beneficiary* *you* choose. *You* may also change a named *beneficiary* at any time by notifying *us* in writing. If an *irrevocable beneficiary* is listed as the *beneficiary* a request must be made to *us* in writing to change the *irrevocable beneficiary*.

The *beneficiary* change will be effective on the date *you* sign the form. If *we* make a payment before receiving the *beneficiary* change form, *we* are released from further liability.

If a payment is to be made to 2 or more *beneficiaries*, but *you* have not specified the portions payable to each, the *benefit amount* payment will be shared equally. If *you* have not named a *beneficiary*, or *we* cannot determine who is the appropriate *beneficiary* or the *beneficiary* named is not alive at the time of the *covered persons'* death, payment will be made at *our* option, to any 1 or more of the following:

- *Your* spouse;
- *Your* children;
- *Your* parents;
- *Your* brothers or sisters; or

TERM LIFE INSURANCE RIDER

- *Your* estate.

If *we* conclude that there is uncertainty regarding who is a *beneficiary*, at *our* discretion, *we* will rely upon an affidavit to determine benefit payment. Payment pursuant to the affidavit will release *us* from further liability.

Any amount payable to a minor will be paid to the minor's legal guardian.

Notice of Death

No *benefit amount* will be made unless *we* receive written proof of death satisfactory to *us*. In order to receive benefits, written notice of death must be furnished to *us* within 12 months after the date of death. If a death claim is filed later than 12 months after the date of death, *we* must have proof that it was not possible for the death claim to be filed within 12 months of the date of death.

Claims of Creditors

All payments under this *certificate* are exempt from the claims of creditors to the extent permitted by law. Payments may not be assigned or withdrawn without *our* consent before becoming payable.

Limited Benefit for Suicide

In the event of death by suicide, whether sane or insane, within the [first year] of the *covered person's effective date* under this *certificate*, the *benefit amount* will be limited to the premium paid for such Term Life Insurance coverage.

The following certificate sections are modified:

Definitions

The following are added to the "Definitions" section:

Beneficiary means a person named by the *primary insured* to receive the *benefit amount*.

Benefit amount means the proceeds payable upon the death of the *covered person*.

Irrevocable beneficiary means a *beneficiary* that has been created through an irrevocable trust or other method legally recognized by a court of law and which cannot be changed without agreement of the *beneficiary* or trust.

Termination of Coverage

The following are added to the "Termination Rights" section:

- *We* may terminate this rider at anytime by providing written notice to the *primary insured* not later than 31 days prior to the desired termination date;

TERM LIFE INSURANCE RIDER

- Coverage terminates on the *certificate* anniversary date of the *covered person's* 65th birthdate;
or
- Coverage terminates on the date the *policy* or this *certificate* terminates, whichever is earlier.

Pre-Existing Condition Limitation

The definition of “*pre-existing condition*” and the “Pre-Existing Condition Limitation” section of the *certificate* do not apply to this Term Life Insurance Rider.
[1966]

[Signature of Officer]
[Typed Name of Officer]
[Title of officer]

AMENDMENT

HUMANA INSURANCE COMPANY

[*Policyholder:* [ABC Association]]

Certificate number: [12345] *Primary insured:* [John Doe]

This amendment should be attached to and made a part of *your certificate*.

I hereby agree to the following change(s);

[Example: Effective January 1, 2008, the deductible is \$1,000]

I hereby acknowledge that I have read and understand the above statements.

Date: [_____] *Primary Insured's* signature: _____/s/_____

Date: [_____] Spouse's signature: _____/s/_____
[1967]

[Signature of Officer]
[Typed Name of Officer]
[Title of Officer]

ARKANSAS RIDER

HUMANA INSURANCE COMPANY

Policyholder: [ABC Association]

Primary Insured: [John Doe]

Policy Number: [12345]

Effective Date: [January 1, 2008]

This rider is attached to and made part of the *certificate* to which it is attached. Except as modified below, all *certificate* terms, conditions, exclusions and limitations apply. Notwithstanding any other provisions of the *certificate*, expenses covered under this rider are not covered under any other provisions of the *certificate*.

The provisions in this rider are available to and are applicable to residents of the state of Arkansas. *Certificates* issued to residents of the state of Arkansas are amended by adding the following:

Children's Preventive Health Care Services

We will provide coverage for *expenses incurred* for age-appropriate *children's preventive healthcare services* for a *covered dependent* child from birth to age 19 at the following intervals:

- Birth;
- 2 weeks;
- 2 months;
- 4 months;
- 6 months;
- 9 months;
- 12 months;
- 15 months;
- 18 months;
- 2 years;
- 3 years;
- 4 years;
- 5 years;
- 6 years;
- 8 years;
- 10 years;
- 12 years;
- 14 years;
- 16 years; and
- 18 years.

Services for *children's preventive healthcare services* are to be rendered during a periodic review and are only covered to the extent that such *services* are provided during the course of 1 visit by or under the supervision of a *healthcare practitioner services* for:

ARKANSAS RIDER

- Routine physical examinations including history, development assessment and anticipatory guidance; and
- Laboratory services in connection with routine physical examinations.

Covered expenses are subject to all *certificates* requirements including but not limited to any *copayment, deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

Appropriate immunizations are subject to all *certificate* requirements including but not limited to *certificate* maximums and are exempt from *deductible, coinsurance out-of-pocket limits* and benefit maximums.

Insert paragraph for Coinsurance Option Plan 75/55 **[Contraceptive Drugs and Devices**

Coverage is available for *expenses incurred* for the use of the contraceptive method. The FDA approved uses of contraceptive methods are:

- Implant systems;
- Devices;
- Oral; and
- Injectable medications.

Coverage will also be provided for consultations, exams, procedures and *services* provided on an outpatient basis that are related to the use of the contraceptive method.

Coverage will not be provided for abortion, abortifacient or any FDA approved emergency contraception.

Benefits for contraceptives are payable under this *certificate* the same as any other *Prescription drugs*. *Covered expenses* are subject to all *certificates* requirements including but not limited to any *copayment, deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.]

Definitions

The following has been added to the **Definitions** section:

Children's preventive healthcare services means *healthcare practitioner*-delivered or *healthcare practitioner* supervised *services* for eligible from birth through 18 years of age, with period preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory test, in keeping with prevailing medical standards for the purposes of the section.

Low protein modified food product means a food product that is specifically formulated to have less than 1 gram of protein per serving and intended to be used under the direction of a *healthcare practitioner* for the dietary treatment of an inherited metabolic disease.

Medical food means 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

ARKANSAS RIDER

to be consumed or administered enterally under the direction of a *healthcare practitioner*.

Dental Anesthesia

Coverage will be provided for *outpatient hospital* care and general anesthesia for dental procedures if it is certified that general anesthesia is required to safely perform the procedures and the *covered person* is:

- A *covered dependent* child under 7 years of age who is determined by 2 licensed dentist to require necessary dental treatment for a significantly complex dental condition;
- A *covered person* diagnosed with a serious mental or physical condition; or
- A *covered person* with significant behavior problems as determined by the *covered person's healthcare practitioner*.

Preauthorization is required to be considered *covered expenses*.

No coverage is provided for the treatment of temporomandibular joint (TMJ) disorders.

Covered expenses are subject to all *certificate* requirements including but not limited to any *deductible*, *coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

Dependents

The **Adding Dependents** provision in the **Changes to the Certificate** section is amended as follows:

- 1) The first paragraph is replaced with the following:
 - If a child is born to *you* or any *covered person*, *we* must be notified of the event in writing and receive any required premium within 90 of the event to avoid medical underwriting. If *we* do not receive notice and premium for the first 90 and forward, the child will not be a *covered person* under this *certificate*.
- 2) The second paragraph has been added:
 - If a child or newborn is adopted by *you* or any *covered person* or a child is placed with *you* for the purpose of adoption, *we* must be notified of the event in writing and receive any required premium within 60 days of the petition for adoption. Coverage shall terminate upon the dismissal or denial of a petition of adoption.

Inherited Metabolic Disorders

Coverage will be provided for phenylketonuria (PKU), galactosemia, organic acidemias and disorders of amino acid metabolism if:

- Medical food or low protein modified food are prescribed as for therapeutic treatment;
- Products are administered under the direction of a *healthcare practitioner*; and
- Cost of the medical food products for the *covered dependent* exceeds \$2,400 per year per *covered dependent*.

ARKANSAS RIDER

Benefits for *prescription* drug formulas are payable under this *certificate* the same as any other *Prescription drug*. *Covered expenses* are subject to all *certificate* requirements including but not limited to any *deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

Mastectomy Services

The **Mastectomy services** section has been revised by adding the following to the **Your Certificate Benefits** provision:

- Confinement in a licensed *healthcare facility* not less than 48 hours for inpatient care following a mastectomy or lymph node dissection until the completion of the appropriate period of stay for such inpatient care as determined by the attending *healthcare practitioner* in consultation with the patient.

Speech or Hearing Impairment

Coverage will be provided for *medically necessary* care and treatment of loss or impairment of speech or hearing by a licensed speech pathologist or audiologist

Coverage will not be provided for hearing instruments or devices.

Covered expenses are subject to all *certificate* requirements including but not limited to any *deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

[Signature of Officer]
[Typed Name of Officer]
[Title of Officer]

OPTIONAL MAMMOGRAPHY RIDER

HUMANA INSURANCE COMPANY

Policyholder: [ABC Association]

Primary insured: [John Doe]

Policy Number: [12345]

Effective Date: [January 1, 2008]

This rider is attached to and made part of the *certificate* to which it is attached. Except as modified below, all *certificate* terms, conditions, exclusions and limitations apply. Notwithstanding any other provisions of the *certificate*, expenses covered under this rider are not covered under any other provisions of the *certificate*.

The provisions in this rider are available to and are applicable to residents of the state of Arkansas. *Certificates* issued to residents of the state of Arkansas are amended by adding the following:

Mammography

Coverage is available for routine mammograms as follows:

- A single mammogram for a female *covered person* between the ages of 35 to 40;
- One mammogram every 2 years for a female *covered person* between the ages of 40 to 50;
- Annually for a female *covered person* who is at least 50 years of age; and
- A mammogram upon recommendation of the female *covered person's* Physician, without regard to age, when the female *covered person* has had a prior history of breast cancer.

Benefits for mammograms are payable under this *certificate*, subject to a benefit maximum of \$50.00 per screening which includes professional and technical *services*.

For mammography screening performed on an *outpatient hospital* basis where the professional *services* are billed separately from technical *services*, the claim for the professional *services* are payable under this *certificate*, subject to a benefit maximum of 40% of the total fee.

Covered expenses are subject to all *certificate* requirements including but not limited to any *coinsurance out-of-pocket limits* and *certificate* maximums and are exempt from the *deductible* requirement and the preventive care waiting period.

[SIGNATURE]
Michael B. McCallister
President

OPTIONAL ALCOHOL AND DEPENDENCY RIDER

HUMANA INSURANCE COMPANY

Policyholder: [ABC Association]

Primary insured: [John Doe]

Policy Number: [12345]

Effective Date: [January 1, 2008]

This rider is attached to and made part of the *certificate* to which it is attached. Except as modified below, all *certificate* terms, conditions, exclusions and limitations apply. Notwithstanding any other provisions of the *certificate*, expenses covered under this rider are not covered under any other provisions of the *certificate*.

The provisions in this rider are available to and are applicable to residents of the state of Arkansas. *Certificates* issued to residents of the state of Arkansas are amended by adding the following:

Alcohol and Drug Dependency

Coverage will be provided for *covered expenses* incurred for *medically necessary inpatient services* for alcohol or chemical dependency treatment.

Covered expenses include treatment of:

- Detoxification.

Covered expenses include charges for *services* rendered in a:

- *Hospital* or an attached or freestanding unit of a *hospital*;
- *Psychiatric hospital* or an attached or freestanding unit of a *psychiatric hospital*; or
- Alcoholism treatment facility provided these facilities are approved licensed or credited to provide by the department of health.

No coverage will be provided for *services* rendered in a:

- Halfway house; or
- Recovery farms.

Benefits for alcohol and drug dependency are payable under this *certificate* the same as any other *sickness*. *Covered expenses* are subject to all *certificates* requirements including but not limited to any *copayment*, *deductible*, *coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

OPTIONAL ALCOHOL AND DEPENDENCY RIDER

[SIGNATURE]
Michael B. McCallister
President

OPTIONAL HOSPICE RIDER

HUMANA INSURANCE COMPANY

Policyholder: [ABC Association]

Primary insured: [John Doe]

Policy Number: [12345]

Effective Date: [January 1, 2008]

This rider is attached to and made part of the *certificate* to which it is attached. Except as modified below, all *certificate* terms, conditions, exclusions and limitations apply. Notwithstanding any other provisions of the *certificate*, expenses covered under this rider are not covered under any other provisions of the *certificate*.

The provisions in this rider are available to and are applicable to residents of the state of Arkansas. *Certificates* issued to residents of the state of Arkansas are amended by adding the following:

Hospice

We will provide coverage for *expenses incurred* for hospice *services* for a *covered person* who is terminally ill as certified by a *healthcare practitioner*. *Preauthorization* from us is required in order for any benefits to be considered *covered expenses*.

Benefits are payable for hospice *services* following Medicare Part A benefit level for hospice care. *Covered expenses* are subject to all *certificate* requirements including but not limited to any *deductible*, *coinsurance out-of-pocket limits* and *certificate* maximums.

[SIGNATURE]
Michael B. McCallister
President

OPTIONAL MUSCULOSKELETAL DISORDERS RIDER

HUMANA INSURANCE COMPANY

Policyholder: [ABC Association]

Primary insured: [John Doe]

Policy Number: [12345]

Effective Date: [January 1, 2008]

This rider is attached to and made part of the *certificate* to which it is attached. Except as modified below, all *certificate* terms, conditions, exclusions and limitations apply. Notwithstanding any other provisions of the *certificate*, expenses covered under this rider are not covered under any other provisions of the *certificate*.

The provisions in this rider are available to and are applicable to residents of the state of Arkansas. *Certificates* issued to residents of the state of Arkansas are amended by adding the following:

Musculoskeletal Disorders

Coverage will be provided for *medically necessary* diagnosis and treatment of Musculoskeletal Disorders diagnostic procedures and surgical and non-surgical treatment of Musculoskeletal Disorders, including Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder.

Benefits for the Musculoskeletal Disorders are payable under this *certificate* the same as any other *sickness*. *Covered expenses* are subject to all *certificate* requirements including but not limited to any *copayment, deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

[SIGNATURE]
Michael B. McCallister
President

OPTIONAL MENTAL ILLNESS RIDER

HUMANA INSURANCE COMPANY

Policyholder: [ABC Association]

Primary insured: [John Doe]

Policy Number: [12345]

Effective Date: [January 1, 2008]

This rider is attached to and made part of the *certificate* to which it is attached. Except as modified below, all *certificate* terms, conditions, exclusions and limitations apply. Notwithstanding any other provisions of the *certificate*, expenses covered under this rider are not covered under any other provisions of the *certificate*.

The provisions in this rider are available to and are applicable to residents of the state of Arkansas. *Certificates* issued to residents of the state of Arkansas are amended by adding the following:

Mental Illness

Coverage will be provided for *covered expenses* incurred for *medically necessary* diagnosis and *mental health* treatment of *mental illnesses* and the *mental health* treatment of a *covered person* with *development disorders*. Preadmission screening and *preauthorization* is required to be considered *covered expenses*.

Mental illnesses and developmental disorders mean those illnesses and disorders listed in the International Classification of Diseases Manual and the Diagnostic and Statistical Manual of Mental Disorders.

Benefits for *mental illnesses* and *developmental disorders* are payable under this *certificate* the same as any other *sickness*. *Covered expenses* are subject to all *certificates* requirements including but not limited to any *copayment*, *deductible*, *coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

[SIGNATURE]
Michael B. McCallister
President

HUMANA.
Guidance when you need it most
[1969]

INSURED BY
HUMANA INSURANCE COMPANY

HumanaOne PPO Annual Max Plan Enrollment Form



Please print clearly in ink. Complete all questions. Fill in all fields or indicate "not applicable."

If you have not had continuous health coverage within the past 63 days, you must choose an effective date that is 30-45 days past the date of the enrollment form.

Date of form: ___/___/___ Requested Effective Date: ___/___/___

[Arkansas]

This form is for:

- New Business (First time enrollee)
- Reinstatement (Reapplication)
- Change/modification to Existing Policy or Plan

Reason for change _____

Change/Modification to Existing Policy or Plan # _____

Health & Dental Coverage Options

Health Coverage

Please complete this section when selecting a health plan.

Deductible Amount:

[\$1,000]

[\$2,000]

[\$3,000]

PPO Plan 50/30

(Please select each of the following for the PPO Plan 50/30)

Please Note: Some options may not be available with all deductibles, or annual maximums.

1. Calendar Year Annual Maximum:

[\$100,000] [\$250,000]

2. Calendar Year Annual Outpatient Maximum:

[\$5,000]
 [\$10,000] (Available only with [\$250,000] annual maximum)

3. Supplemental Accident Benefit:

[\$500] [\$1,000]

PPO Plan 75/55

(Please select each of the following for the PPO Plan 75/55)

Please Note: Some options may not be available with all deductibles, or annual maximums.

1. Calendar Year Annual Maximum:

[\$100,000] [\$250,000]

2. Calendar Year Annual Outpatient Maximum:

[\$5,000]
 [\$10,000] (Available only with [\$250,000] annual maximum)

3. Supplemental Accident Benefit:

[\$500] [\$1,000]

Dental Coverage

Please note: You may purchase dental coverage if health coverage is chosen. If dental is selected, it will be approved if the health coverage is approved. If you are changing or modifying an existing/approved policy or plan, dental is only available at your anniversary.

Important information about the Health Insurance Plan you are about to apply for

I have reviewed the plan information and understand the HumanaOne PPO Annual Max plan has calendar year policy limits for all covered services, for outpatient services, and for pharmacy services (where applicable). Expenses applied to the outpatient and pharmacy calendar year limits will also be applied to the all covered services calendar year limit. I understand any costs incurred for services above the calendar year limits are entirely my responsibility. I understand Humana has other plans available that do not have calendar year limits.

Life Coverage Options

Please complete this section if choosing the term life rider or the term life plan for insured and/or spouse.

Please include an additional page if you need to list multiple beneficiaries. Each additional page must be signed and dated.

Primary Insured:

[\$0-20,000] Term Life Rider (can only be purchased with a health plan)

Primary beneficiary name _____

Relationship _____ Benefit % _____

Contingent beneficiary name _____

Relationship _____ Benefit % _____

Term Life Plan (Minimum selection is [\$0-25,000] and [\$0-1,000] increments)

Term life insurance amount: \$ _____

Term length: [10] years [15] years [20] years

Primary beneficiary name _____

Relationship _____ Benefit % _____

Contingent beneficiary name _____

Relationship _____ Benefit % _____

Spouse:

[\$0-20,000] Term Life Rider (can only be purchased with a health plan)

Primary beneficiary name _____

Relationship _____ Benefit % _____

Contingent beneficiary name _____

Relationship _____ Benefit % _____

Term Life Plan (Minimum selection is [\$0-25,000] and [\$0-1,000] increments)

Term life insurance amount: \$ _____

Term length: [10] years [15] years [20] years

Primary beneficiary name _____

Relationship _____ Benefit % _____

Contingent beneficiary name _____

Relationship _____ Benefit % _____

Primary Insured Information

If child-only coverage is requested, the youngest child is the Primary Insured. Questions must be filled out by custodial parent or legal guardian.

First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
Home address (not PO Box)			City	State	Zip code	
Social Security #		Country or State of birth		Email		
Type of business or industry	Occupation		Home phone # ()		Daytime phone # ()	
Mailing address (if different from home address)			City	State	Zip code	
Certificateholder name if different than Primary Insured (applicable for child-only enrollment form)						

Parent or Guardian Information

Please complete this section if Primary Insured is under [0-18] years of age.

First name	MI	Last name	Email			
Home address (not PO Box)			City	State	Zip code	
Home phone # ()		Daytime phone # ()		Relationship to child(ren)		

Family Information

Please complete only if your spouse and/or dependent children are enrolling for coverage. Attach an additional family information sheet if necessary.

Spouse First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
Country or State of birth		Spouse's type of business or industry		Spouse's occupation		
Social Security #			Email			
Dependent 1 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
Full-time student (if [0-18] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						
Dependent 2 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
Full-time student (if [0-18] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						
Dependent 3 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
Full-time student (if [0-18] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						
Dependent 4 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
Full-time student (if [0-18] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

Existing Coverage

IMPORTANT: DO NOT cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

• Existing Health Coverage

If you are enrolling for health coverage, please provide the status of current coverage, including Humana, for each person enrolling.

If additional space is needed, please attach additional pages. Each additional page must be signed and dated.

No Yes Do you or anyone enrolling for coverage have any health insurance coverage currently in force?]

[• If yes, please supply the following for all persons enrolling on the plan:

Name(s) of covered persons

Insurance Carrier Name

Effective Date

__ / __ / ____

• Existing Dental Coverage

[1. No Yes Does anyone enrolling for coverage currently have or had any dental coverage within the last [1-24] months?]

[• If yes, please supply the following for all persons enrolling for coverage on the plan:

Name(s) _____ Effective Date ___/___/_____

Insurance Carrier Name _____ Termination Date ___/___/_____

Name(s) _____ Effective Date ___/___/_____

Insurance Carrier Name _____ Termination Date ___/___/_____]

[2. No Yes Will the insurance coverage enrolled for be used to replace existing dental coverage?]

• Existing Life Coverage

Primary Insured:

[1. No Yes Do you have any life insurance and/or annuity coverage currently in force?]

[2. No Yes Will the insurance coverage enrolled for be used to replace any existing life and/or annuity coverage?]

[• If yes, please supply the following information:

Company name _____ Amount \$ _____ Plan # _____]

Spouse:

[1. No Yes Do you have any life insurance and/or annuity coverage currently in force?]

[2. No Yes Will the insurance coverage enrolled for be used to replace any existing life and/or annuity coverage?]

[• If yes, please supply the following information:

Company name _____ Amount \$ _____ Plan # _____]

Eligibility & Health Status

Please answer for all individuals enrolling for coverage.

For this insurance to be issued, the following eligibility and health questions must be answered fully and truthfully. All requested health information including routine physical exams and information related to spouse and dependents enrolling for coverage must be provided. If any of the answers are "yes", please provide complete details. Failure to disclose any eligibility or health information may result in your plan being modified or terminated, back to your original effective date.

[1. No Yes Is anyone enrolling for coverage a citizen of a country other than the United States?]

[• If yes: Name(s): _____]

Has anyone enrolling for coverage:

[2. No Yes Experienced weight gain or loss of more than [0-100] pounds in the past [1-24] months?]

[3. Within the past [1-24] months, has the primary insured or spouse enrolling for coverage used any tobacco product?]

[Primary Insured: No Yes]

[Spouse: No Yes]

[4. No Yes Does anyone enrolling for coverage plan to participate in any dangerous or extreme sport activities?]

[5. No Yes Is the primary insured, spouse or any of their dependents pregnant or an expectant mother or father?]

Within the past [1-5] years, has anyone enrolling for coverage:

[6. No Yes Been denied for health or life insurance or had their health coverage ridered, rated or rescinded?]

[7. No Yes Been diagnosed with or received treatment for AIDS, or tested positive for AIDS or HIV?]

[8. No Yes Had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any alcohol abuse, dependency or problem, or had any alcohol related arrests?]

[9. No Yes Used any illegal or taken prescription drugs not prescribed by their health care provider or had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any drug abuse, dependency or problem; or had any drug related arrests?]

[10. No Yes Had any testing or procedure performed that has been abnormal or the results of which are pending or unknown?]

[11. No Yes Had or been advised to have inpatient or outpatient surgery, that is complete or has not been completed?]

[12. No Yes Consulted, been advised or recommended to have follow-up testing or treatment by a health care provider or specialist that has not been completed?]

Eligibility & Health Status continued

[13. **Within the past [1-5] years**, has anyone enrolling for coverage had signs of, been prescribed medication or received injections for, or been diagnosed with or treated for:

[A. <input type="checkbox"/> No <input type="checkbox"/> Yes Chest pain or Heart Attack]	[M. <input type="checkbox"/> No <input type="checkbox"/> Yes Behavioral, Emotional, Mental or Nervous Disorder]
[B. <input type="checkbox"/> No <input type="checkbox"/> Yes High Blood Pressure or Hypertension]	[N. <input type="checkbox"/> No <input type="checkbox"/> Yes Eating Disorder]
[C. <input type="checkbox"/> No <input type="checkbox"/> Yes High Cholesterol or Triglycerides]	[O. <input type="checkbox"/> No <input type="checkbox"/> Yes Developmental Disorder or Delay]
[D. <input type="checkbox"/> No <input type="checkbox"/> Yes Cancer or Tumor of any kind]	[P. <input type="checkbox"/> No <input type="checkbox"/> Yes Human Papilloma Virus or Sexually Transmitted Disease]
[E. <input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes or High Blood Sugar]	[Q. <input type="checkbox"/> No <input type="checkbox"/> Yes Infertility]
[F. <input type="checkbox"/> No <input type="checkbox"/> Yes Stroke]	[R. <input type="checkbox"/> No <input type="checkbox"/> Yes Cyst, Growth, Lump or Polyp]
[G. <input type="checkbox"/> No <input type="checkbox"/> Yes Paralysis]	[S. <input type="checkbox"/> No <input type="checkbox"/> Yes Hernia]
[H. <input type="checkbox"/> No <input type="checkbox"/> Yes Epilepsy or Seizure]	[T. <input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis]
[I. <input type="checkbox"/> No <input type="checkbox"/> Yes Migraines or frequent or severe headaches]	[U. <input type="checkbox"/> No <input type="checkbox"/> Yes Implants, Pins, Plates, Rods Screws or Prosthesis]
[J. <input type="checkbox"/> No <input type="checkbox"/> Yes Hepatitis]	[V. <input type="checkbox"/> No <input type="checkbox"/> Yes Connective Tissue or Autoimmune Disorder]
[K. <input type="checkbox"/> No <input type="checkbox"/> Yes Sleep Apnea]	[W. <input type="checkbox"/> No <input type="checkbox"/> Yes Birth Defect]
[L. <input type="checkbox"/> No <input type="checkbox"/> Yes Anxiety or Depression]]

[14. **Within the past [1-5] years**, has anyone enrolling for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

[A. <input type="checkbox"/> No <input type="checkbox"/> Yes Gallbladder, Liver or Pancreas]	[G. <input type="checkbox"/> No <input type="checkbox"/> Yes Breasts]
[B. <input type="checkbox"/> No <input type="checkbox"/> Yes Colon, Esophagus or Stomach]	[H. <input type="checkbox"/> No <input type="checkbox"/> Yes Menstrual Cycle]
[C. <input type="checkbox"/> No <input type="checkbox"/> Yes Bladder or Kidneys]	[I. <input type="checkbox"/> No <input type="checkbox"/> Yes Cervix, Ovaries, Uterus or Vagina]
[D. <input type="checkbox"/> No <input type="checkbox"/> Yes Back, Disc, Neck or Spine]	[J. <input type="checkbox"/> No <input type="checkbox"/> Yes Penis, Prostate or Testicles]
[E. <input type="checkbox"/> No <input type="checkbox"/> Yes Lungs]	[K. <input type="checkbox"/> No <input type="checkbox"/> Yes Skin]
[F. <input type="checkbox"/> No <input type="checkbox"/> Yes Eyes, Ears, Nose, Throat or Sinuses]]

[15. **Within the past [1-5] years**, has anyone enrolling for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

[A. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood Vessels, Heart or Circulatory System]	[E. <input type="checkbox"/> No <input type="checkbox"/> Yes Urinary System]
[B. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood, Gland, Pituitary, Thyroid or Lymph System]	[F. <input type="checkbox"/> No <input type="checkbox"/> Yes Musculoskeletal System]
[C. <input type="checkbox"/> No <input type="checkbox"/> Yes Brain or Nervous System]	[G. <input type="checkbox"/> No <input type="checkbox"/> Yes Respiratory System]
[D. <input type="checkbox"/> No <input type="checkbox"/> Yes Digestive System]	[H. <input type="checkbox"/> No <input type="checkbox"/> Yes Reproductive System]]

[16. No Yes Has anyone enrolling for coverage seen a health care provider or specialist for any reason (including routine visits) or symptom not previously disclosed above?]

[17. No Yes Within the past [1-24] months, has anyone enrolling for coverage been advised to take or taken any prescription medications or injections?]

Additional Eligibility or Health Status Question Information

To be completed if anyone enrolling for coverage answered "Yes" to any question(s) in the Eligibility & Health Status section. Please provide details such as; specific condition, dates of treatment, results or advice given, medication (dosage and frequency), treatment plan, recovery date, physician name and address. Attach an additional health information sheet if necessary. Additional information sheets must be signed and dated by the primary insured or legal representative and/or spouse (if enrolling).

[Question #	Letter	Person treated	Condition
Details:]
[Question #	Letter	Person treated	Condition
Details:]
[Question #	Letter	Person treated	Condition
Details:]

Payment Authorization & Billing Information

If you are paying for the plan, you must complete 1 & 2 below. If someone other than yourself will be paying for the plan, please fill out the separate alternate payor information page. Agent/Producer, Employer payments are not accepted.

Quoted Premium Payment Amount: \$ _____

Association Dues: [\$1-8] Monthly (non-refundable)

1. Initial Premium Payment Options

Initial premium payment must total one month's premium for each product selected. Please choose your preference for payment of first month's premium. Please complete credit card or one-time bank withdrawal below.

Credit Card Payment

Initial payment for each product enrolled for will be drafted separately against your account.

Visa Mastercard

Card # _____

Expiration date _____ / _____

Cardholder's name _____

I authorize Humana to draw initial premium payment from my VISA / Mastercard account.

One-time Automatic Bank Withdrawal

Please print.

Account holder's name _____

Bank name _____

Routing # _____

Account # _____

I authorize Humana to draw initial premium payment from the account above.

2. Subsequent Premium Payment Options

Please indicate billing preference. If choosing automatic bank withdrawal, please complete the section to the right.

Direct Bill, if selected a fee of \$ [_____] will apply.

Monthly billing

Quarterly billing

Semi-Annual billing

Automatic Bank Withdrawal

Monthly billing

Quarterly billing

Semi-Annual billing

Account holder's name _____

Bank name _____

Routing # _____

Account # _____

I authorize Humana to draw premium payment from the account above until this authorization is revoked by me.

Agent / Producer Information

This section to be completed by Agent or Producer.

1. Agent/Agency of Record (for commissions and correspondence)

Name (print) _____

Humana Agent # _____

Commission split: No Yes

If yes, percentage _____ (Total should equal 100%)

1. Writing Agent / Producer:

Name (print) _____

Humana Agent # _____

Commission split: No Yes

If yes, percentage _____ (Total should equal 100%)

2. Agent/Agency of Record (for split-commissions)

Name (print) _____

Humana Agent # _____

Percentage of sales: No Yes

If yes, percentage _____ (Total should equal 100%)

2. Writing Agent / Producer (for split-commissions)

Name (print) _____

Humana Agent # _____

Percentage of sales: No Yes

If yes, percentage _____ (Total should equal 100%)

Agent replacement question:

[Will this plan replace or change any existing life insurance policy(s) and/or annuity(s)? No Yes]

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary insured submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the insuring entity, or one of its subsidiaries. These provisions are available to me and the primary insured in the benefit summary document or other plan literature.

Writing Agent's Name _____ Date ____/____/____

Agreement and Signature

True and Complete Acknowledgment:

I understand, agree and represent:

- I have read this document or it has been read to me.
- The answers are true and complete.
- I have received and reviewed any state or federal required disclosures.
- Neither I nor my company sales representative has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements.
- This plan enrolled for is not an employer-sponsored group health plan and it does not comply with state or federal small employer laws. I certify that I do not qualify for or have willingly waived a group health plan or receive favorable tax treatment under federal or state law that will be used to pay insurance premiums.
- If this enrollment form for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate. Acceptance of premium and fees does not guarantee coverage.
- To automatic withdrawal from my specified bank account or credit card for premium payment and administrative fees if selected under the payment authorization and payment options section.
- Any misrepresentation on this enrollment form may be used by Humana during the first [0-2] plan years to void the contract or modify the terms of coverage. This may result in loss of coverage, modification of coverage and/or claim denial.
- By signing below, I agree to terminate existing coverage if approved.
- As a parent or legal guardian of a dependent [0-18] years or older enrolling for coverage, I attest by my signature below, that I have gathered the necessary health information from my dependent in order to fully and truthfully complete this enrollment form.

This document, together with any supplements, will form part of and be the basis for any certificate issued.

Any person who submits an enrollment form containing a false, incomplete or deceptive statement may be guilty of insurance fraud. If you decide not to sign this agreement, we will decline to enroll you in a medical plan or to give you medical benefits.

Primary Insured or Legal Guardian Signature _____ Date __/__/____

Relationship of Legal Guardian _____

Spouse Signature _____ Date __/__/____
(if covered dependent)

New Association Enrollment: The Association, Peoples' Benefit Alliance, is a membership organization that provides educational information and discounts on goods and services to its members. Membership in the Association is required in order to be eligible for health insurance coverage. The Association benefits information will be sent under separate cover. By signing below, you are requesting enrollment in the Association.

Primary Insured or Legal Guardian Signature _____ Date __/__/____

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana".

**[Medical] and [Life] [products] insured by [Humana Insurance Company]
[Dental] [products] insured by [HumanaDental Insurance Company]**



Alternate Payor Information

If someone other than the primary insured will be paying for the plan, please complete the following information and 1 & 2 below.

Who will be paying for this plan(s)?

First name	MI	Last name	Home phone # ()	Daytime phone # ()
Home address (not PO Box)		City	State	Zip code

Quoted Premium Payment Amount: \$ _____

Association Dues: [\$1-8] Monthly (non-refundable)

1. Initial Premium Payment Options

Initial premium payment must total one month's premium for each product selected. Please choose your preference for payment of first month's premium. Please complete credit card or one-time bank withdrawal below.

Credit Card Payment

Initial payment for each product enrolled for will be drafted separately against your account.

Visa Mastercard

Card # _____

Expiration date /

Cardholder's name _____

I authorize Humana to draw initial premium payment from my VISA / Mastercard account.

One-time Automatic Bank Withdrawal

Please print.

Account holder's name _____

Bank name _____

Routing # _____

Account # _____

I authorize Humana to draw initial premium payment from the account above.

2. Subsequent Premium Payment Options

Please indicate billing preference. If choosing automatic bank withdrawal, please complete the section to the right.

Direct Bill, if selected a fee of \$ [] will apply.

Monthly billing

Quarterly billing

Semi-Annual billing

Automatic Bank Withdrawal

Monthly billing

Quarterly billing

Semi-Annual billing

Account holder's name _____

Bank name _____

Routing # _____

Account # _____

I authorize Humana to draw premium payment from the account above until this authorization is revoked by me.

Alternate Payor Signature _____ Date ____/____/____

SERFF Tracking Number: HUMA-125880356

State: Arkansas

Filing Company: Humana Insurance Company

State Tracking Number: 40731

Company Tracking Number:

TOI: H16G Group Health - Major Medical

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

Product Name: Annual Max Plan

Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: HUMA-125880356

State: Arkansas

Filing Company: Humana Insurance Company

State Tracking Number: 40731

Company Tracking Number:

TOI: H16G Group Health - Major Medical

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

Product Name: Annual Max Plan

Project Name/Number: /

Supporting Document Schedules

Satisfied -Name: Certification/Notice	Review Status: Approved-Closed	01/08/2009
Comments:		
Attachment: AR Certificate of Readability.pdf		

Bypassed -Name: Application	Review Status: Approved-Closed	01/08/2009
Bypass Reason: New application is submitted and included in this filing.		
Comments:		

Satisfied -Name: Cover Letter	Review Status: Approved-Closed	01/08/2009
Comments:		
Attachment: Signed Cover Letter.pdf		

Satisfied -Name: By-Laws	Review Status: Approved-Closed	01/08/2009
Comments:		
Attachment: PBA.Bylaws.pdf		

Satisfied -Name: PBA Brochure	Review Status: Approved-Closed	01/08/2009
Comments:		
Attachment: Peoples Benefit Alliance brochure.pdf		

Satisfied -Name: Statements of Variability	Review Status: Approved-Closed	01/08/2009
Comments:		

SERFF Tracking Number: HUMA-125880356

State: Arkansas

Filing Company: Humana Insurance Company

State Tracking Number: 40731

Company Tracking Number:

TOI: H16G Group Health - Major Medical

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

Product Name: Annual Max Plan

Project Name/Number: /

Attachments:

Statement of Variability _12-7-07_. Contract.pdf

Statement of Variability.Enrollment Form.pdf

SERFF Tracking Number: HUMA-125880356 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 40731
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Annual Max Plan
Project Name/Number: /

Satisfied -Name: Association Checklist **Review Status:** Approved-Closed 01/08/2009
Comments:
Attachment:
Arkansas Association Check List-Issued by Roslind Minor 10-30.pdf

Satisfied -Name: Policy Variables **Review Status:** Approved-Closed 01/08/2009
Comments:
Attachment:
Policy Variables.pdf

Satisfied -Name: Matrix Filing Listing **Review Status:** Approved-Closed 01/08/2009
Comments:
Attachment:
Matrix Filing Listing.pdf

Satisfied -Name: NAIC Transmittal Document **Review Status:** Approved-Closed 01/08/2009
Comments:
Attachment:
Signed Transmittal Document.pdf

Satisfied -Name: Response Letter **Review Status:** Approved-Closed 01/08/2009
Comments:
Attachment:
AR AMP Response Letter.pdf

Satisfied -Name: Musculoskeletal Disorders Option **Review Status:** Approved-Closed 01/08/2009
Comments:

SERFF Tracking Number: HUMA-125880356 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 40731
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Annual Max Plan
Project Name/Number: /

This form is filed for informational purposes only

Attachment:

Optional AMP Benefit Election-Musculoskeletal Disorders filed for informations purposes only..pdf

SERFF Tracking Number: HUMA-125880356 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 40731
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Annual Max Plan
Project Name/Number: /

Satisfied -Name: Group Application **Review Status:** Approved-Closed 01/08/2009

Comments:

Please note that this application is for informational purposes only.

Attachment:

AR Group Application.pdf

CERTIFICATION

RE: Form: GN-71012-01 1/2008

I hereby certify, to the best of my knowledge and belief, that the enclosed form(s) comply(ies) with the requirements of Arkansas Insurance Code 23-80-206.

Form Number(s)

GN-71012-01 1/2008

Flesch Test Reading Ease Score

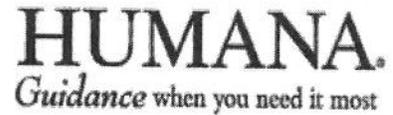
40.7

Signed by:



Steve DeRaleau
Vice President

Date: October 30, 2008



October 30, 2008

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

**RE: GROUP HEALTH INSURANCE FORMS FILING
 HUMANA INSURANCE COMPANY
 POLICY SERIES: GN-71012-01 1/2008, et al. (Forms List Attached)
 NAIC #73288
 FEIN #39-1263473**

Dear Sir/Madam:

We respectfully submit for your approval the enclosed forms. This is a new filing; the enclosed forms do not replace or supersede any like forms previously filed. The master policy form will be issued to an Association located in the District of Columbia. The certificate will be offered in the individual market. The application forms are being filed for general use with all approved policy series.

The individual insurance market has a wide variety of consumer needs and we are expanding our product portfolio to address the uninsured population. The product being filed is targeted towards uninsured individuals and families who are looking for insurance that is reasonably priced for their budget (as these individuals typically have less discretionary income) as well as individuals and families with insurance coverage who are considering dropping their coverage due to increasing premiums or other financial reasons.

The policy form contains a number of benefit options. Our goal is to deliver a policy that is customized to reflect any applicable state mandates and the benefit options that are selected by the proposed policyholder, thereby removing any ambiguity or confusion as to who is covered, what is covered and how it is covered. Consequently, the enclosed forms are being presented in a variable format. In an attempt to be as responsive as we possibly can to the needs of our policyholders, we are providing through this policy various benefit options.

All variable language is indicated by brackets. Generally, any provision which is in brackets may be included, modified or removed in accordance with the plan options offered and the election made by the proposed policyholder in applying. Enclosed is a Statement of Variability for Contract Forms which further describes how the language can be varied along with a list of the Variable Options.

The enclosed forms are submitted utilizing a matrix filing concept wherein you will find that throughout the policy form, we have numbered definitions, paragraphs and provisions. These definitions, paragraphs and provisions may be included in the policy issued depending on the coverage(s) actually selected. Utilization of the matrix format will facilitate production of a variety of plan designs. It will allow us to

customize contracts in order to accommodate the requests of proposed policyholder desiring insurance for themselves and their dependents.

While all benefits required to meet the statutory requirements of your state will be included in every policy, the remainder of the benefit package will be at the choosing of the proposed policyholder based on the plan options we decide to offer. Each individual policy will contain only those provisions applicable to that particular policy. The enclosed Matrix filing document contains the entire library of all possible components. Future filings will consist of only the matrix elements that are new or modified.

To the best of our knowledge, we believe the enclosed forms satisfy the minimum requirements of applicable Arkansas statutes and regulations. The mandated benefits that exceed the base product benefit design are incorporated via rider AR-71012-01 LBP 1/2008.

These forms are submitted in final-print format and are subject only to minor modification in paper size and stock, ink, border, company logo and adaptation to computer printing. The enrollment forms may be offered in a printed, online, or digitized audio recorded format. Enclosed is a Statement of Variability for Enrollment Forms which outlines how the enrollment forms may be varied.

Enclosed are the required:

- NAIC Transmittal Document;
- Readability Certification;
- PBA By-Laws;
- PBA brochure; and
- Association Questionnaire.

If you have questions regarding this filing, please contact me by phone at 1-800-289-0260, extension 2617, by fax at 920-632-0029 or by e-mail at lriley2@humana.com.

Sincerely,
HUMANA INSURANCE COMPANY



Latunia Riley
Contract Analyst

Enclosures

BY-LAWS
OF
"PEOPLES BENEFIT ALLIANCE"

ARTICLE I
PURPOSES

The purpose or purposes of "Peoples Benefit Alliance" ("association") shall be:

To enhance the quality of life for members by offering or providing educational information; to provide access to goods, services and discount benefits by using the buying power of all members. To exercise all the powers conferred upon corporations formed under the Missouri Not-For-Profit Corporation Act.

ARTICLE II
OFFICES

The Association shall have and continuously maintain in this state a registered office and a registered agent, and the registered office of the association shall be identical with that of its registered agent. The Association may have other offices within or without the State of Missouri as the Board of Directors may from time to time determine.

ARTICLE III
MEMBERS

Section 1. Classes of Members. The Association shall have two (2) classes of members. The designation of such classes and qualifications of the members of such classes shall be as follows:

1. Individual membership: The individual is entitled to participate in all benefit programs offered by the Association.

2. Family membership: The member and his spouse are entitled to participate in all benefit programs offered by the Association.

Section 2. Voting Rights. Each member of classes 1 and 2 shall be entitled to one vote on each matter submitted to a vote of the members by the Board of Directors. Voting may be in person or by proxy; provided that no proxy may be used for voting purposes unless the original of the proxy is filed with the Secretary of the Association at least seven (7) days before the meeting at which it is to be used.

Section 3. Termination of Membership. Any member who shall be in default in the payment of dues for the period fixed in Article XI of the By-Laws is automatically ineligible for

membership and loses all privileges and rights of the Association, subject to the discretion of the Board of Directors to extend such time period for the payment of dues.

Section 4. Resignation. Any member may resign by filing a written resignation with the Secretary, but such resignation shall not entitle such member to any refund of dues and the member shall immediately lose all privileges and rights of the Association.

Section 5. Reinstatement. Upon written reapplication a former member may be reinstated to membership in the Association.

Section 6. Transfer of Membership. Membership in the Association is not transferable or assignable.

ARTICLE IV MEETINGS OF MEMBERS

Section 1. Annual Meeting. An annual meeting of the members of the Association shall be held for the purpose of electing Directors and the transaction of any other business as may come before the meeting. The date of the annual meeting shall be determined by the Board of Directors.

Section 2. Special Meeting. Special meetings of the members, for any purpose or purposes, unless otherwise prescribed by law, may be called by the President and shall be called by the Secretary at the direction of a majority of the Board of Directors, or at the request in writing of members representing at least one hundred (100) votes entitled to be cast at such meeting.

Section 3. Place of Meeting. The Board of Directors may designate any place, within or without the State of Missouri as the place of meeting for any annual meeting. The President or the Board of Directors may designate any place within or without the State of Missouri as the place of the meeting for any special meeting. If no designation is made, the place of meeting shall be the registered office of the Association.

Section 4. Notice of Meetings. Written or printed notice stating the place, day and hour of any regular or special meeting of the Association members shall be delivered, either personally, by mail or through the internet, to each member, not less than seven (7) or more than forty (40) days before the date of such meeting, by or at the direction of the President, or Secretary, or the Board of

Directors or person calling the meeting. In the case of special meetings, the purpose for which the meeting is called shall be stated in the notice. If mailed, the notice of meeting shall be deemed delivered when deposited in the United States mail addressed to the member at this address as it appears on the records of the Association, with postage thereon paid. Notice of meetings may be included in any publication that is distributed to the member.

Section 5. Quorum. There shall be no minimum number of members necessary to be present at any regular meeting or special meeting, in order to constitute a quorum. Those members present shall therefore constitute a quorum.

Section 6. Manner of Acting. The act of a majority of the members present at any regular or special meeting shall constitute the act of the members:

Section 7. Informal Action by Members. Upon approval by the directors, any action required to be taken at a meeting of the members of the Association or any other action which may be taken at a meeting, may be taken without a meeting if consents in writing, setting forth the action so taken, shall be signed by a majority of the members with respect to the subject matter thereof.

Section 8. Parliamentary Procedures. Parliamentary Procedure for all meetings of members, directors, and committees shall be conducted in accordance with the latest revised edition of Robert's Rules of Order, unless otherwise inconsistent with these By-Laws.

Section 9. Voting. At all meetings of the members, each member of records shall be entitled to one (1) vote. A vote may be cast either orally or in writing in person or by proxy. A "member of record" is a person who is a member in good standing of the Association as of the close of business on a date, selected by the Board of Directors, not less than forty (40) days nor more than fifty (50) days before the date of the meeting (the "record date"). When a quorum is present at any meeting, the vote of the holders of a majority of members present shall decide any questions brought before such meeting, unless the questions are ones upon which, by express provision of law or of the Association's Articles of Incorporation, a different vote is required, in which case such express provision shall govern and control the decision of such question.

Section 10. Matters Reserved to Membership Vote. The following matters shall be authorized only upon a vote "thereon" by the members at a meeting called to consider such matter:

1. An amendment to the Association's Articles of Incorporation;
2. The election of the Board of Directors; and

3. Any other matter which the Board of Directors, in their sole discretion, by resolution shall commit to a vote of the members.

ARTICLE V BOARD OF DIRECTORS

Section 1. General Powers. The affairs of the Association shall be managed by its Board of Directors.

Section 2. Number, Tenure and Qualifications. The number of directors shall be no fewer than three (3) and no more than twenty-five (25) and may be changed from time to time by resolution of the Board of Directors. The Board of Directors shall appoint a committee to nominate successor directors. The directors shall be elected at an annual meeting of the members, except as provided in Section 8 of this Article, and each director elected shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. Directors shall be residents of the United States of America and be members of the association.

Section 3. Regular Meetings. A regular annual meeting of the Board of Directors shall be held each year immediately after the annual meeting of the members of the Association for the purpose of electing officers and for the transaction of such other business as may come before the meeting. The regular annual meeting of directors shall be held without other notice than these By-Laws. The Board of Directors may provide by resolution the time and place, within or without the State of Missouri for the holding of additional regular meetings of the Board of Directors.

Section 4. Special Meetings. Special meetings of the Board of Directors may be called by or at the request of the President or any two (2) directors. All special meetings shall be held at the registered office of the Association unless otherwise agreed upon by a majority of the Board of Directors in attendance at the meeting.

Section 5. Notice. Notice of any special meeting of the Board of Directors and the business to be transacted shall be given at least five (5) days previously thereto by written notice delivered personally, by mail or through the internet to each director at his address shown on the records of the Association. If notice be given by mail, such notice shall be deemed to be delivered when deposited in the United States mail addressed to the director. Any director may waive notice

transaction of any business because the meeting is not lawfully called or convened. The purpose of any special meeting of the Board of Directors shall be specified in the notice of such meeting.

Section 6. Quorum. A majority of the Board of Directors shall constitute a quorum for the transaction of business at any meeting of the Board of Directors provided that if less than a majority of the directors are present at said meeting, a majority of the directors present may adjourn the meeting from time to time without further notice.

Section 7. Manner of Acting. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, except where otherwise provided by law or these By-Laws.

Section 8. Vacancies. Vacancies created by the death, resignation, or removal of a director may be filled by a majority vote of the directors then in office though less than a quorum, and each director so chosen shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. A director may be removed at any time, with or without cause, by a vote of a majority of the remaining directors. If there are not directors in office, then an election of directors may be held in the manner provided by law. Newly created directorships shall be filled by election at an annual meeting or special meeting called for that purpose.

Section 9. Compensation. Directors as such shall not receive any stated salaries for their services, but by resolution of the Board of Directors, a fixed sum and expenses of attendance, if any, may be allowed for attendance at each meeting of the Board of Directors. Nothing herein contained shall be construed to preclude any director from serving the Association in any other capacity and receiving compensation therefor upon approval by the Board.

Section 10. Telephonic Participation in Meeting. The members of the Board of Directors, or of any committee designated by the Board of Directors, may participate in a meeting of the Board of Directors or committee by means of conference telephone or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in a meeting in this manner shall constitute presence in person at the meeting.

Section 11. Action by Written Consent. Any action which is required to be or may be taken at a meeting of the directors, or of any committee of the directors, may be taken without a meeting if consents in writing, setting forth the action so taken are signed by all of the members of the Board of Directors or of the committee as the case may be. The consents shall have the same force and effect as a unanimous vote at a meeting duly held. The Secretary shall file the consents with the minutes of the meetings of the Board of Directors or of the committee as the case may be.

ARTICLE VI
OFFICERS

Section 1. Officers. The Officers of the Association shall be a President, one or more Vice Presidents (the number thereof to be determined by the Board of Directors), a Treasurer, a Secretary or combination thereof, and such other officers as may be elected in accordance with the provisions of this article. The Board of Directors may elect or appoint other officers, including one or more Assistant Secretaries and one or more Assistant Treasurers, as it shall deem desirable, such officers to have the authority and perform the duties prescribed, from time to time, by the Board of Directors. Any two or more offices may be held by the same person, except the offices of President and Secretary.

Section 2. Election and Term of Office. The Officers of the Association shall be elected annually by the Board of Directors at the regular annual meeting of the Board of Directors. If the election of Officers shall not be held at such meeting, such election shall be held as soon thereafter as convenient. Vacancies may be filled or new officers created and filled at any meeting of the Board of Directors. Each Officer shall hold office until his successor shall have been duly elected and shall have qualified.

Section 3. Removal. Any Officer or Agent elected or appointed by the Board of Directors may be removed by the Board of Directors whenever in its judgment the best interests of the Association would be served thereby.

Section 4. Vacancies. A vacancy in any office because of death, resignation, removal, disqualification or otherwise, may be filled by the Board of Directors for the unexpired portion of the term.

Section 5. President. The President of the Association shall be the principal executive officer of the Association. He shall supervise and conduct the affairs of the Association in such manner as will best accomplish the purposes set forth in the Articles of Incorporation of the Association. He shall preside at all meetings of the Association members and the Board of Directors. He shall countersign all checks together with the Treasurer.

Section 6. Vice President. In the absence of the President, or in the event of his inability or refusal to act, the Vice President shall perform the duties of the President, and when so acting, shall have all the powers of and be subject to all the restrictions upon the President. The Vice President shall perform such other duties as from time to time may be assigned to him by the President or by the Board of Directors.

Section 7. Treasurer. The Treasurer or Assistant Treasurer shall have charge and custody of and be responsible for all funds and securities of the Association; receive and give receipts for monies received by the Association from any source whatsoever, and deposit all such monies in the name of the Association in such banks, trust companies or other depositories as shall be selected in accordance with the provisions of Article VIII of these By-Laws.

Section 8. Secretary. The Secretary or Assistant Secretary of the Association shall keep the minutes of the meetings of the members and of the Board of Directors in one or more books provided for that purpose; see that all notices are duly given in accordance with the provisions of these By-Laws or as required by law; be custodian of the corporate records of the Association; see that the seal of the Association, if any, is affixed to all documents, the execution of which on behalf of the Association under its seal, if any, is duly authorized in accordance with the provisions of these By-Laws; keep a register of the post office address of each member which shall be furnished to the Secretary or Assistant Secretary by such member; and in general perform all duties incident to the office of Secretary and such other duties as from time to time may be assigned to the Secretary or Assistant Secretary by the President or by the Board of Directors.

ARTICLE VII COMMITTEES

Section 1. Committees of Directors. The Board of Directors, by resolution adopted by the majority of the directors in office, may designate one or more committees, each of which shall consist of two (2) or more directors, which committees, to the extent provided in said resolution, shall have and exercise the authority of the Board of Directors in the management of the Association; but the designation of such committees and the delegation thereto of authority shall not operate to relieve the Board of Directors, or any individual director, of any responsibility imposed upon it or him by law. The President shall be an ex-officio member of all committees of directors.

Section 2. Other Committees: Other committees not having and exercising the authority of the Board of Directors in the management of the Association may be designated by a resolution adopted by a majority of the directors present at a meeting at which a quorum is present. Except as otherwise provided in such resolution, members of each such committee shall be members of the Association, and the President of the Association shall appoint the members thereof. Any member thereof may be removed by the person or persons authorized to appoint such member whenever in their judgment the best interests of the Association will be served by such removal. One member of each committee shall be a director.

Section 3 Vacancies. Vacancies in the membership of any committee may be filled by appointments made in the same manner as provided in the case of original appointments.

Section 4. Quorum. Unless provided in the resolution of the Board of Directors designating a committee, a majority of the whole committee shall constitute a quorum and the act of a majority of the members present at a meeting at which a quorum is present shall be the act of the committee.

Section 5. Rules. Each committee may adopt rules for its own government not inconsistent with these By-Laws or with rules adopted by the Board of Directors.

ARTICLE VIII

CONTRACTS, CHECKS, DEPOSITS, AND FUNDS

Section 1. Contracts. The Board of Directors may authorize the officers or agents of the Association to enter into contracts or to execute and deliver documents in the name of and on behalf of the Association. Such authority shall be confined to specific instances. Such contracts may be for any purpose deemed by the Board of Directors to be appropriate, including the contracting with a third party for any or all administrative and other services and functions necessary for the Association to achieve its purpose.

Section 2. Checks, Drafts, Etc. All checks, drafts, or other orders for payment of money, notes or other evidences of indebtedness issued in the name of the Association shall be signed by such officer or officers, agent or agents of the Association and in such manner as shall from time to time be determined by the resolution of the Board of Directors. In the absence of such determination by the Board of Directors, such instruments shall be signed by the Treasurer or an Assistant Treasurer and countersigned by the President or Vice President of the Association.

Section 3. Deposits. All funds coming into possession of the Association shall be deposited from time to time to the credit of the Association in such banks, trust companies, or other depositories as the Board of Directors may select.

Section 4. Gifts. The Board of Directors may accept on behalf of the Association any contributions, gifts, bequests, or device for the general purpose or for any special purpose of the Association.

Section 5. Loans. The Association may, upon authorization of the Board of Directors, from time to time accept or negotiate loans of financial assistance to be repaid at such time as the Association is reasonably able to repay.

ARTICLE IX
CERTIFICATES OF MEMBERSHIP

Section 1. Certificates of Membership. The Board of Directors may provide for the issuance of certificates evidencing membership in the Association which shall be in such form as may be determined by the Board. Such certificates shall be signed by the President or Vice President and shall be sealed with the seal of the Association, if any. The name and address of each member and the date of issuance of the certificate shall be entered on the records of the Association. If any certificate shall become lost, mutilated or destroyed, a new certificate may be issued therefor upon such terms and conditions as the Board of Directors may determine.

Section 2. Issuance of Certificates. When a member has applied for and is eligible for membership and has paid any initiation fee and dues that may then be required, a certificate of membership shall be issued and delivered to him by the Secretary, if the Board of Directors shall have provided for the issuance of certificates of membership under the provisions of Section 1 of this article.

ARTICLE X
BOOKS AND RECORDS

The Association shall keep correct and complete books and records of accounts and shall also keep minutes of the proceedings of its members, Board of Directors and committees having any of the authority of the Board of Directors, and shall keep at the registered or principal office a record giving the names and addresses of the members entitled to vote. All books and records of the Association may be inspected by any member, or his agent or attorney for any purpose at any reasonable time.

ARTICLE XI
DUES AND INITIATION FEE

Section 1. Annual Dues. The Board of Directors may determine from time to time the amount of annual dues payable to the Association by members of each class.

Section 2. Payment of Dues. Dues shall be payable in advance.

Section 3. Default and Termination of Membership. When any member of any class shall be in default in the payment of dues for a period of one month from the beginning of the period from which such dues became payable, such member shall be automatically dropped from membership unless the Board of Directors, in its discretion, extends the time for payment of dues.

Section 4. Initiation Fee. Each member may be required to pay, in addition to applicable dues, the amount of any initiation fee designated by the Board of Directors as a prerequisite to membership. The Board of Directors may provide that the initiation fee is waived for members who are part of a group where the sponsor pays a stated initiation fee on behalf of all group members.

ARTICLE XII
FISCAL YEAR

The fiscal year of the Association shall begin the first day of January and end on the last day of December in each year.

ARTICLE XIII
SEAL

The Board of Directors may provide a corporate seal which shall be in the form of a circle and shall have inscribed thereon the name of the corporation and the words "Corporate Seal".

ARTICLE XIV
WAIVER OF NOTICE

Whenever any notice is required to be given under the provisions of the General Not-For-Profit Corporation Law of Missouri under the provisions of the Articles of Incorporation or the By-Laws of the Association, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

ARTICLE XV
AMENDMENT OF BY-LAWS

These By-Laws may be altered, amended or repealed and new By-Laws may be adopted by a two-thirds (2/3) majority of the directors present at any regular meeting or any special meeting, provided that at least seven (7) days' written notice is given of intention to alter, amend or repeal or to adopt new By-Laws at such meeting.

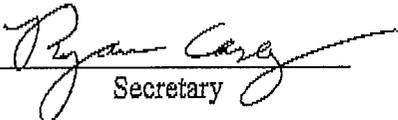
ARTICLE XVI INDEMNIFICATION

The Association shall provide for indemnification by the Association of any and all of its directors of officers or former directors or officers against expenses actually and necessarily incurred by them in connection with the defense of any action, suit, or proceeding, in which they or any of them are made parties, or a party, by reason of having been directors or officers of the Association, except in relation to matters as to which such director or officer or former director or officer shall be adjudged in such action, suit, or proceeding to be liable for gross negligence or misconduct in the performance of duty and to such matters as shall be settled by agreement predicated on the existence of such liability for gross negligence or misconduct.

ARTICLE XVII DISSOLUTION

The Association shall use its funds only to accomplish the objectives and purposes specified in these By-Laws, and no part of said funds shall inure, or be distributed, to the members of the Association. On dissolution of the Association any funds remaining shall be distributed to one or more regularly organized and qualified charitable, educational, scientific, or philanthropic organizations to be selected by the Board of Directors.

Execute on this 15th day of February, 2008.


Secretary

FIRST AMENDMENT TO THE BY-LAWS DISPUTE RESOLUTION PROCEDURES

As used in these By-Laws and Dispute Resolution Procedures, the term "Dispute" shall mean any action, complaint, claim or controversy of any kind, whether in contract or in tort, statutory or common law, legal or equitable or otherwise, now existing or hereafter occurring, between the Association or any officer, director, agent, employee, representative, heir, assign, beneficiary, successor, or affiliate of the Association on the one hand, and any member or prospective member of the Association, or any agent, representative, heir, assign, beneficiary, or successor of such member or prospective member on the other hand, which in any way arises out of or pertains to, directly or indirectly, (i) the Association (ii) the rights, privileges or benefits of membership in the Association, (iii) governance of the Association, or (iv) any other matter involving the Association membership enrollment process, dues, assessments, any representation, modification, extension, interpretation, violation, renewal, termination of this Association or Association membership, as well as the content of any documents related to (i), (ii), (iii), (iv) including, without limitation, advertising brochures, membership materials, member benefit descriptions, applications, correspondence and similar documents, or any past, present or future incidents, omissions, acts, errors, claims, benefits, claims for benefits, practices or occurrences causing any alleged injury or damage to any party whereby the other parties or their agents, employees or representatives may be liable, in whole or in part.

1. Mediation of Disputes. Any and all Disputes arising out of or relating to the Association shall be submitted to the Judicial Arbitration and Mediation Services, Inc. ("JAMS"), or its successor, for mediation, and if the matter is not resolved through mediation, then it shall be submitted to JAMS, or its successor, for final and binding arbitration pursuant to the arbitration procedures provided herein.

2. Mediation Procedures. Either party may commence mediation by providing to JAMS and the other party a written request for mediation, setting forth the subject of the dispute and the relief requested. The parties will cooperate with JAMS and with one another in selecting a mediator from JAMS panel of neutrals, and in scheduling the mediation proceedings. The parties will participate in the mediation in good faith, and they will share equally in its costs. All offers, promises, conduct and statements, whether oral or written, made in the course of the mediation by any of the parties, their agents, employees, experts and attorneys, and by the mediator or any JAMS employees, are confidential, privileged and inadmissible for any purpose, including impeachment, in any arbitration involving the parties, provided that evidence that is otherwise admissible or discoverable shall not be rendered inadmissible or non-discoverable as a result of its use in the mediation.

3. Deadline for Resolution of Disputes by Mediation. In the event the parties do not amicably resolve the Dispute at mediation or within forty five (45) days following the date of the mediation, then either party may initiate arbitration in accordance with these By-Laws with respect to the dispute that was submitted to mediation. The mediation may continue after the commencement of arbitration if the parties so desire. Unless otherwise agreed by the parties, the mediator shall be disqualified from serving as arbitrator in the case.

4. **Mandatory and Binding Arbitration of Disputes.** Any Dispute arising out of or relating to the Association, directly or indirectly, including the determination of the scope or applicability of these Dispute Resolution Procedures that is not amicably resolved by the parties under the Mediation provisions above shall be decided by mandatory and binding arbitration conducted in the state in which the Dispute arose. Mandatory and binding arbitration is intended to be the exclusive means by which Disputes not resolved by mediation are finally resolved. In no event shall any member or other applicable party file a lawsuit or cause legal proceedings to be commenced as a result of any Dispute that is connected to or in any way involves the Association. No Disputes shall be decided in Federal or state courts or before a judge or jury, and the courts shall bar and dismiss any such attempted litigation. Any member or other applicable party who initiates or attempts to initiate any legal action in contravention of these Dispute Resolution Procedures shall be barred by the court from proceeding in such action, and shall pay the attorneys' fees and court costs incurred by the responding parties in defending against such legal action.

5. **Commencement of Arbitration.** In accordance with Section 3 above, arbitration shall be commenced by filing a written demand for arbitration served upon all affected parties.

6. **Selection of Arbitrator.** The arbitration shall be decided before one arbitrator, who must be a member of the panel of neutrals maintained by Judicial Arbitrations and Mediation Services, Inc. ("JAMS"), or its successor. The arbitration shall be administered by JAMS, or its successor, pursuant to its Comprehensive Arbitration Rules and Procedures. The arbitrator shall be chosen by the parties from the roster of neutrals maintained by JAMS, and in the event the parties are unable to mutually agree to the selection of the arbitrator, then the arbitrator will be selected in accordance with the JAMS Comprehensive Arbitration Rules and Procedures from the JAMS roster of neutrals. In the event that JAMS is not available in the state in which the Dispute arose, the arbitrator shall be selected by the American Arbitration Association from its list of neutrals who are retired judges.

7. **Additional Rules.** In addition to administration of the arbitration under the JAMS Comprehensive Arbitration Rules and Procedures, the arbitrator shall apply the substantive law of the state in which the dispute arose, including laws governing limitations of actions.

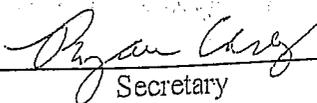
8. **Arbitration Hearing and Award.** The arbitrator shall schedule the hearing as soon as reasonably possible and upon conclusion of the hearing shall make a determination in the context of an "Award" specifying the recovery, if any, and reasons for such determination.

9. **Enforcement of Award.** The arbitration Award may be enforced by any Court of competent jurisdiction, and the party seeking enforcement shall be entitled to an award of all costs, fees and expenses, including attorneys' fees, to be paid by the party against whom enforcement is ordered.

10. **Allocation of Fees and Costs.** The arbitrator may, in the Award, allocate all or part of the costs of the arbitration, including the fees of the arbitrator and the reasonable attorneys' fees of the prevailing party.

11. **Severability.** Should any provision of these Dispute Resolution Procedures be held or otherwise determined unlawful, invalid or unenforceable, such defect shall not affect the legality, validity or enforceability of the remaining parts of these Dispute Resolution Procedures, and all such remaining parts hereof shall be valid and enforceable and have full force and effect as if the illegal, invalid or unenforceable part had not been included. It is agreed that any claim that any provision of these Dispute Resolution Procedures is somehow unlawful, invalid, unconscionable, or unenforceable shall be submitted to binding arbitration for resolution, and in any such arbitration proceeding such claim or challenge shall be urged and addressed specifically and separately.

Amendment adopted and approved this 4th day of September, 2006.


Secretary



www.peoplesbenefitalliance.com
Username: **pbamember**

Dear New Member,

Welcome to the Peoples Benefit Alliance (PBA)!

Please review this Member Guide and the enclosed Member Identification Card, which list important phone and I.D. numbers exclusively for you as a member of the Association.

Through your membership in PBA, you will enjoy numerous health, travel, consumer, and business-related discounts and services. All of your discounts are explained in detail in this guide. You can also find information about your PBA discounts and services online at www.peoplesbenefitalliance.com; please use **pbamember** as your username.

While we believe you will be extremely pleased with your overall Association membership, we cannot, however, warrant or guarantee the performance of any discount or service.

You can count on PBA to continuously and aggressively seek out new discounts to add further value to your membership in the Association. As always, we invite and encourage your suggestions on ways PBA can be increasingly beneficial to you.

If you have any questions about your discounts, call 1-866-838-8437.

Again, a most cordial welcome to PBA.

Sincerely,

PBA Member Services

Table of Contents

HEALTH SERVICES

GlobalFit Fitness Program	3
GymAmerica.com.....	4
Vitamin Discount.....	4
Gateway Medicaid.....	5

TRAVEL SERVICES

Car Rental Discounts	6
Association Travel Club	6

CONSUMER SERVICES

Carperks Buying Network	7
Floral Discounts.....	8
Child ID Card Services.....	9
Moving Service Discount.....	9
HopTheShops.com.....	10

BUSINESS SERVICES

Customized Web Services	11
Crisp Publications.....	11
Office Depot Supplies and Equipment.....	12
Hewlett-Packard Computer & Digital Equipment	12
Discount Long Distance Phone Service	13
High Speed Dial-Up Internet Access Services.....	13
Springer Collection Agency Services	14
TravelCell Global Cell & Satellite Phone Rental.....	14
UPS Express Delivery Services	14
DHL Express Overnight Delivery Services	15
Discover First Data Merchant Services.....	15

HEALTH SERVICES

GlobalFit Fitness Program

To help improve member health and well-being, your association has arranged for you and your family to take advantage of the GlobalFit Fitness Program. With the GlobalFit Fitness Program, you can take advantage of:

- Guaranteed Lowest Rates—Up to 60 percent savings on monthly dues
- Month-to-Month Memberships—No long-term contracts
- Access to over 1,500 top fitness clubs nationwide, now including select Bally Total Fitness, Gold's Gym, and Ladies Workout Express locations
- Additional discounts for family members
- Membership transfer and freeze options available at selected clubs
- 110 percent lowest price guarantee

GlobalFit makes it easier to gain the benefits of regular exercise:

- Reach and maintain a healthy body weight
- Strengthen your heart, lungs, bones, and muscles
- Lower your risk of many serious conditions, including heart disease, high blood pressure, diabetes, stroke, and depression
- Look better, feel better, and sleep better

It's Easy to Register!

1. Go online to **www.globalfit.com**.
2. Click on "Login/Register" and select "Quick Registration."
3. From the alphabetical listing, select the letter "N." On next screen, select Group Name "NAC."
4. Follow the easy registration steps.

Once you've registered, you'll be able to log on to the GlobalFit Website using your chosen password and user ID. To find a club near you or for more information, contact GlobalFit at **www.globalfit.com** or call GlobalFit toll-free at **1-800-294-1500**.

These special rates are available only through GlobalFit and are not offered through the fitness clubs or available to the general public. This offer is made possible only through your association membership. Participation is for new fitness memberships only—memberships are not available to clubs in which you are a current member. Participation for past members may not be available at all clubs; please visit www.globalfit.com or call 1-800-294-1500 for more information.

GymAmerica.com

As a member, you and your family receive special pricing at GymAmerica.com*, the all-in-one interactive toolkit for the personalized diet and exercise program made to fit just one person: you. GymAmerica.com features Genesant's state-of-the-art nutritionist and personal trainer software, honored by Forbes magazine with its "Best of the Web" award.

GymAmerica.com features:

- Personalized meal plans tailored to your needs and goals
- Interactive program that uses your entered results to keep your diet on track
- Smart weekly grocery shopping lists
- Convenient at-a-glance calorie, fat, carb, and protein totals
- Customized workouts to match your fitness level
- Access-Anywhere online workout calendar and log

Use the Web's best interactive exercise and diet program to get your body in shape! Association members receive the promotional discount price—three months for the price of two—of only \$19.98. Visit www.gymamerica.com/NAC and sign up today!

*GymAmerica.com is a proprietary Web property of Genesant Technologies, Inc.

Vitamin Discount

HealthFitLabs is an online/mail order company that sells only the highest-quality natural vitamins, nutritional supplements, and bath and personal care products.

Visit the website, HealthFitLabs.com, to browse several different product search options including categories such as Healthy Lifestyle, Vitamins & Minerals, Bath & Personal Care, and Healthy Pets.

You can also search by health condition. For instance, they have supplements for Eye Health Support, Blood Sugar Support, Mood Support and more. Or shop by brand name; there are 1,900 products available on their website. Most vitamins are available to ship within 24 hours.

Visit www.HealthFitLabs.com and enter **NAC** as the coupon code at checkout to receive an additional 15% off your order. The online prices are already reduced 5-35%!

You can also save up to 30% off catalog prices! Call **1-888-757-2454** to place your order and start saving today! Just mention **NAC** as your coupon code.

Gateway Medicaid

In an emergency, getting vital health information to medical personnel quickly could be critical. Your Gateway Medicaid keeps your personal medical profile handy at all times. Carry it with you at work, on vacation, or just walking in your neighborhood. You'll feel more secure knowing emergency medical personnel will have access to data needed to administer appropriate care.

When you send in your completed Gateway Medicaid data form, it is photographed on microfilm and laminated in a durable plastic card. It is easy to read with a standard magnifying glass routinely carried by medical professionals. Only the Gateway Medicaid data form will be copied onto microfilm. Separate paper(s) or other forms cannot be accepted; be sure all information appears on the Gateway Medicaid data form.

As a member, you may order one free medical card per account each year. It's important to update your card annually to ensure your data is current. You will receive a reminder and renewal form every 12 months. If you need to update your card more often, you may do so for only \$5 each. You may also order cards for your spouse, children and other family members for only \$5 each. Similar cards cost \$8-\$20 from other sources. To order extra cards, request and complete an additional Gateway Medicaid Data Form for each individual.

For more information and to print the Gateway Medicaid data form, please visit www.egroupmanager.com/medicaid/. If you do not have access to the Internet, please call **1-800-992-8044** to have a member service representative send you a Personal Medical Profile form to complete.

TRAVEL SERVICES

Car Rental Discounts

Take advantage of affordable auto rental rates from Alamo®, Avis®, Hertz®, and National®.

Using this Service is Easy!

1. Call any participating car rental company to arrange for a car rental. 24-hour advance reservations are required. Have your credit card number available for payment when you place your reservation.
2. Give the representative the Member ID number listed below.
3. You will be quoted a special member discount rate. Rates are based on the type of car you want and the area where you rent. Discounts apply to weekly, daily, promotional, and holiday rates, as well as some weekend rates.
4. Show your Association Member ID card when you pick up your car.

Toll-Free Reservations

Alamo: 1-800-327-9633 / Member ID#: BY222606

Avis: 1-800-331-1212 / Member ID#: AWD A/B 254701

Hertz: 1-800-654-2200 / Member ID#: CDP-ID 85134

National: 1-800-227-7368 / Member Recap #: 6100610

Note: Some blackout dates and restrictions may apply.

Association Travel Club

Gulliver's Travel, an American Express Travel Services Representative, is the official agency for the Association Travel Club. Gulliver's offers competitive pricing and great service on the purchase of air travel, tours, and cruises.

- **Cruises:** Special group departures and discounts on cruises.
- **Tours:** Special group departures and promotional sales on tours.
- **Air Travel:** Group discounts and personalized low airfare assistance.

For personalized travel planning, call Gulliver's Travel at **1-800-796-7766** and ask for Beverly Noah or send an e-mail to **bev@gullivers.com**.

CONSUMER SERVICES

Carperks Buying Network

Many people dislike shopping for automobiles because they dread the anticipated hassle and the possibility of overpaying for a car. This program allows members to benefit from a National Corporate Pricing Program that solves these issues. *Carperks* is currently offered as a “free perk” to employees of Coca-Cola, Verizon Wireless, American Airlines, Office Depot, and several hundred other companies—and now, to you.

The *Carperks* dealer network has agreed to sell automobiles for a price better than their best Internet price, resulting in a price hundreds of dollars lower than the sales price of the retail sales department.

Enjoy Car Buying Made Easy!

1. Log onto www.carperks.net to register with the program. Use PIN number **NAC11269**.
2. Select the make and model of the automobile you would like to purchase or lease.
3. You will receive, by e-mail, a personalized certificate that specifies the name, address, and phone number of your local participating dealer, and a specific contact name at the dealership. The contact person is well-trained in the *Carperks* program and has pledged to uphold the *Carperks* commitment to you.
4. You print out the certificate, call the named contact person at the dealership, and make arrangements to meet with him or her. After the exact vehicle you want is identified, the National Corporate price is quoted and you may accept or reject the deal with no obligation.

NO RUNAROUND – NO HASSLE – NO PROBLEM!

Floral Discounts

Welcome to “My Online Florist” member discounts. Your association membership lets you send flowers anywhere in North America from our Website or by phone. As an association member, you will receive a 40 to 60 percent discount from most retail flower shop prices. Try it and see!

Just log on to: www.nacassociation.myonlineflorist.com to place an order! Your Association Member Number is **38801**.

You may also take advantage of these important discounts:

Convenience—Call our toll-free number, **1-888-321-ROSE (7673)**, and mention Association Member Number **38801** to receive your association discount. You can call 24 hours a day, seven days a week, and request delivery anywhere in North America!

Quality Guarantee—We guarantee every floral product and provide a customer satisfaction department available to track an order from placement through delivery. All of our arrangements are guaranteed to last at least seven days.

Service—Enjoy personalized attention from My Online Florist’s experienced, friendly Floral Coordinators who can assist you in selecting the perfect gift and assure you that your order will be delivered promptly. We ship UPS and FedEx next-day delivery on most orders.

Diversity—Choose from a wide variety of products including fresh flowers, plants, specialty baskets, gifts, and candies.

Whether you want to send a floral gift in your own neighborhood or anywhere in North America, we can deliver your sentiments beautifully... easily... and expertly!

Child ID Card Services

You can't be with your children all the time—especially when they go to school—but you *can* provide additional protection for those times when they're not with you. By registering your children with UBR Child ID Card Services, authorities will be able to provide faster, more complete help to your child should he/she be missing or abducted.

For each child you register, you'll receive two wallet-sized cards showing the child's photo and vital statistics, including identifying marks and special medical needs. The card also provides instructions for parents on how to quickly notify authorities if an abduction occurs.

Best of all, registration of your first two children is FREE as part of your association membership. Registration of additional children is available for a nominal fee.

How to Register

The Child ID Card Services registration application is available for download at www.egroupmanager.com/childid. If you do not have Internet access, call member services at **1-800-992-8044** (8:30 a.m. to 4:30 p.m. Central Standard Time) for a Child ID Card registration application.

Moving Service Discount

The Association has a special agreement with Cord northAmerican, an agent for North American Van Lines, that applies to relocation services for all Association members. This agreement provides a substantial discount for our members. Cord northAmerican was selected to provide this relocation discount to members because of their ability to offer reduced costs while still providing the highest level of service and customer satisfaction.

Through North American Van Lines, the Association has access to the certified Home-To-Home Handling program and a single contact source. This means that throughout your moving process, you will have just one contact person.

The Home-to-Home Process includes professional packing, loading, and transportation by North American's top drivers, as well as unloading and unpacking. Each relocation can be itemized to help with your needs, wants, and/or budget. Cord northAmerican is proud to present relocation discounts, features, and discounts designed for Association members.

Other services that are available: Office Moving, Record Retention, Logistics, Warehousing, Distribution, and International Services. Estimates/Quotes are free of charge. Please mention code "NAC" to receive your savings.

Cord northAmerican Van Lines, Cindy Ruppel, Representative
(800) 873-2673, ext. 155, by e-mail at cindyrup@cordmoving.com and on the Internet at www.cordmoving.com

HopTheShops.com

Through a special arrangement with eGroupManager, you will receive preferred customer access to HopTheShops.com, a premium online shopping mall.

HopTheShops.com includes more than 150 stores. Find high-quality items at low prices for the best deals in America. Each vendor in the mall has been scrutinized carefully. HopTheShops.com offers the best value on quality items coupled with excellent customer service. Here's a list of categories:

- Sporting Goods
- Health & Beauty Products
- Automobiles
- Office Equipment & Services
- Learning Tools/Education
- Music & Entertainment
- Home & Garden
- Pet Supplies
- Savings & Coupons
- Cards & Gifts
- Computers & Electronics
- Wine & Cigars
- Travel
- Books
- Art
- Toys
- Fashion
- Food

Whether you are looking for a laptop or a new car, you can comparison shop and actually view the items before you purchase them. All of the vendors offer secure sites, prompt delivery service, and full customer satisfaction guarantees.

Preferred Member Program

By signing up with HopTheShops.com, you will receive access to special features that are for members only. HopTheShops.com will provide you with a "Members Only" newsletter, as well as special offers and discounts from their vendors (beyond the discounts already offered). Let them find the best deals for you!

Why Are Prices Lower On The Internet?

Internet merchants do not have the costs of maintaining a brick and mortar storefront. They also sell in large volume. This large volume, coupled with the lower overhead, results in savings on the goods and services that they offer to their customers.

How To Access HopTheShops.com

1. At any computer connected to the Internet, go to www.hoptheshops.com.
2. If you have previously registered at eGroupManager, enter your e-mail address and password in the "Cyber Mall Log-in" section.
3. If this is your first visit, click on "Register" in the "Become a Mall Member" section. Please fill in all of the information fields to open your account. You may also use this same e-mail address and password to access your association discounts and information at www.egroupmanager.com.
4. If you have questions, contact HopTheShops.com by e-mail at: prefcust@ubrnetmall.com, by phone at: **(636) 530-1967** or **1-800-992-8044**. You can also contact them by mail at HopTheShops.com, 16476 Wild Horse Creek Road, Chesterfield, MO 63017.

BUSINESS SERVICES

Customized Web Services

eGroupManager provides the advantage of Website development and maintenance. eGroupManager boasts an experienced staff of programmers and graphic designers ready to work for you. All of the latest programming capabilities—including HTML, ASP.NET, Flash, XML, and database connectivity—are available to you as an association member. Our designs are crisp and clean, blended with creativity, and custom-built to your Website specifications. We can also host your Website with our own AxisConnect Web hosting service.

With an Internet Website by eGroupManager, your company can enjoy growth potential that is virtually limitless! Members receive a **20 percent discount** on the following services:

- Custom Web Design
- Evaluation and Re-Design of Current Sites
- Website Hosting
- Consulting on Viability of Internet Projects
- Internet Marketing

How to Use This Service:

1. For more details call **1-866-793-1972** (or 1-636-530-1967 in the St. Louis area) and ask for a Web development sales representative.
2. Mention that you are an Association member to receive your 20 percent discount.
3. Visit www.egmwebservices.com to learn more about eGroupManager.

Crisp Publications

Association members can enhance their current knowledge, sharpen their minds and stay on the cutting edge of both business and personal issues. Through a special arrangement with Crisp Publications, Association members can take advantage of books and video/book programs on topics such as self-development, customer service, management training, and communication, to name a few. Association members will receive a **40 percent discount** off the cost of a publication or tape.

To find out more or to request a free catalog, call **1-800-442-7477**. When placing an order, identify yourself as an association member to receive your 40 percent discount.

Office Depot Supplies and Furniture

Sign up for the Office Depot program and qualify for discounts off the list price on over 16,000 items. Members report they save an average of **30 percent** when compared to their previous office supplies provider. Buy online from the discounted member Website, by phone or fax, or in the retail stores. There is FREE SHIPPING for members.

You'll also get **40 percent** discounts on in-store high-speed and self-service digital B/W and color copying services (including transparencies, reports/newsletters, brochures/flyers, presentations, and photographs) plus document binding services (finishing and laminating)—everything you need for meetings and conferences!

Online offerings include: custom stamps (date stamps, rubber and self inking, signature style, corporate seals, and embossers/notary seals) and custom printing (business cards, letterhead, envelopes, memo pads, announcements, carbonless forms, custom labels).

To get your Office Depot account and password, complete the registration form at www.business-edge.net. Once you have signed up, you can shop in the stores, order by fax or order online at: <http://bsd.officedepot.com>.

Hewlett-Packard Computer and Digital Equipment

Hewlett-Packard, a worldwide leader in computers and other digital hardware, has the right solution for your business or home office. As a member, you receive discounts on HP notebooks, laptops, desktops, servers, printers, digital cameras, handhelds, point-of-sale (scanners, cash registers, etc.), and more.

Discount levels vary based on product—generally from **3 to 10 percent** off. Monthly promotions are available such as free shipping on discounted printing supplies, rebates, and other value-added member benefits.

To order, call HP at **1-888-860-9572** and mention code **BAE1** for your discount, or visit www.hp.com/go/BusinessAdvantEdge.

Long Distance Phone Services

*Lowest Long Distance Rates Available: As Low as 3.9¢ per Minute State to State—
Anytime, Anywhere—up to 50% Savings over AT&T, Sprint & MCI*

PowerNet Global (PNG) is one of the fastest growing long distance carriers in America today. PNG offers the perfect advantage for residential and business customers who need to maintain that competitive edge. With the highest quality 100% digital fiber optic network, PNG has positioned itself as the nation's leading provider of long distance and data services. PNG is proud to be part of the continuing success of your association.

- Flat Rate 24 hours a day, 7 days a week
- No Monthly Minimum
- One-Minute Increment Billing for Residential
- Six-Second Increment Billing for Business
- Great In-State Rates, No Term Plan

Note: Rate shown above is current rate at time of printing. The rate at time of application is subject to change.

To sign up now or to speak to one of our friendly customer support specialists, please call toll-free at **1-888-917-7333**.

High Speed Dial-Up Internet Access Services

In addition to PowerNet Global's great long distance phone service, you can now take advantage of PNG's Unlimited High Speed Dial-Up Service for only \$1 for the first month, then **\$12.95** per month thereafter. PowerNet Global offers fast and reliable connections, valuable add-ons, and technical support that delivers a robust Internet service at a very reasonable price.

- \$12.95 per month
- Free Technical Support
- Speed Booster (increases download speed up to **5x faster** than standard dial-up)
- Pop-up Blocker
- 5 E-mail Addresses
- 10 MB of WebSpace
- One Bill for Long Distance and Internet

To sign up now or to speak with one of our friendly customer support specialists, please call toll-free at **1-888-917-7333**.

Springer Collection Agency Services

Make sure the check is in the mail! For those rare occasions when you need to take charge of your past due collections, call Springer Collection Services. As a member, you'll save **20 percent** on fees for consumer and/or commercial collections. You pay only when your receivables are collected. Contact Steve Heinz at Springer at **1-800-553-8988** and mention Business AdvantEdge.

TravelCell Global Cell & Satellite Phone Rentals

Stay safe and in touch when you travel abroad by carrying a global phone rented from TravelCell. Cell phone rental fees are cut in **half** for members and start at \$15 per week. A fully charged battery, rapid travel charger, leather case, and belt clip are included with phone, plus a postage-paid return envelope. Per-minute rates vary by country.

Satellite phones operate in the most remote regions in the world and are the perfect solution for cruises, safaris, and adventure travel and can be rented for \$129.99 for the first week; extra weeks at \$49.99 each.

Additional services include: a personal toll free number for calls from the USA that will ring on your TravelCell anywhere you travel, unlimited Blackberry Service, student rates, and long-term, extended stay rates. To rent, call: **1-877-CELL-PHONE (235-5746)** and reference **VC119**.

UPS Express Delivery Services

Member benefits include:

- \$1.50 off UPS Next Day Air Letters;
- 10 percent off UPS Next Day Air Paks/Packages and UPS Second Day AM Air Letters/Packages;
- 25c off UPS Second Day Air Letters;
- 20 percent off UPS Worldwide Express Letters/Documents/Packages.

For discounts, you must apply for a UPS account number. There is no obligation to ship and no cost for account set-up. Register online at www.business-edge.net or by calling Business AdvantEdge at **1-888-734-3343**.

DHL Express Overnight Delivery Services

UniShippers offers members who ship frequently the ability to set up a comprehensive shipping logistics program that includes substantial savings up to **50 percent** on most classes of service including reliable, guaranteed air express overnight delivery, ground shipping, plus courier, freight, and convention services. All billing and customer service will be provided directly by UniShippers.

You must sign up for this service; register at www.business-edge.net or call Business AdvantEdge at **1-888-734-3343**.

Discover First Data Merchant Services

Accept credit cards and take your business to the next level! First Data and Discover Network can help you grow your business and speed up cash flow.

The normal application, monthly minimum and batch fees are waived for members. Requirements for acceptance may include: a minimum of three years in business, three years of financial statements, signed personal guarantee, and three months of previous processing statements (if applicable).

Program includes these major credit cards: VISA®, MasterCard®, American Express®, Discover®, Diners Club® and JCB®. First Data supports both PIN-based and signature debit transactions (PIN-based debit is the fastest growing payment option). Also, reduce your risk when accepting checks with TeleCheck.

You'll get FREE online statements and reporting and there is a \$15.00 chargeback fee, a \$4.75 monthly statement fee and \$15.00 imprinter charge. Rates are dependent on processing volume, type of business and average sales amount.

To get started, call **1-800-425-0919** and mention Business AdvantEdge or fax in your completed enrollment form found online at www.peoplesbenefitalliance.com.

You'll find information about your
PBA discounts and services online at
www.peoplesbenefitalliance.com

Please use **pbamember** as your username.

If you have any questions about your discounts, call 1-866-838-8437.

Statement of Variability for Contract Forms

- All bracketed numbers are variable. Numbers within a section or provision are determined by the laws of the governing jurisdiction and will be varied only within the confines of the law.
- Bracketed paragraphs vary to the extent that such paragraphs may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.
- Bracketed sections vary to the extent that such sections may be included, omitted or transferred to another page to suit the needs of a particular policyholder 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 product.
- 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 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.
- Product information, including items which customarily vary according to the policyholder's specific plan of insurance, is bracketed.

We also reserve the right to amend the attached form(s) to fix any minor clerical errors that may have unintentionally gone unnoticed prior to submitting for approval, and to amend the language to clarify the intent, all within the confines of the law.

Statement of Variability for Enrollment Forms

Bracketed Sections

1. Bracketed sections will refer to an entire portion of the form such as logos, product offerings, payment information, or agreements.
2. Bracketed sections are identified by green brackets.

NOTE: Some exceptions will apply due to state requirements or rulings regarding bracketing.

3. Non-bracketed logos, text, or numbers within the section remains constant and will not be subject to changes without being refiled.
4. Bracketed sections vary to the extent that such sections may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to any statutory or regulatory requirements.
 - For example: We have filed the Dental section of an application but the applicant did not select Dental then that section will not appear.
5. Bracketed variables such as logos, text, or numbers are subject to change as outlined within the various sections of this document.

Bracketed Numbers

1. With the exception of form numbers and matrix numbers, if allowed by the state, all bracketed numbers are variable.
 - Form numbers are located in the lower left-hand corner of the form and are not subject to change without refilling.
 - Reorder numbers (Group forms) and Revision numbers (Individual forms) are located in the lower right-hand corner of the form and are considered variable and included within this statement.
2. Bracketed numbers within a section are determined by the laws of the governing jurisdiction and will be varied only within the confines of the law.
3. Bracketed numbers will include the minimum and maximum ranges.
4. If the state determines ranges are not acceptable, only a single number will be shown on the form and that number will not be bracketed.

Bracketed Questions

1. Text within the bracketed question will not change (Refers to language only. See # 3 for formatting and placement changes).
2. Any bracketed variables within that question are subject to change.
3. Bracketed questions vary only to the extent that such questions may be included, omitted or transferred within the form subject to any statutory or regulatory requirements.

Instructions or Help Text

1. Bracketed instructional text varies to the extent that such text may be included, omitted or transferred to another page to meet the needs of applicants completing the application.
2. Humana reserves the right to make minor instructional or help text revisions, even if it is not bracketed, as needed to clarify instructions for completion of the application and amend the language to clarify the intent within the confines of the law.

Product Information

1. Product information may vary to the extent such information may be included, omitted, or transferred to another page subject to any statutory or regulatory requirements
2. Additional fields within an existing product offering section can be added to an application without refiling for the purpose of offering new insurance products or benefits subject to
 - prior approval of certificate or policy forms for the new products or benefits; and,
 - any statutory or regulatory requirements

Legal Entities

1. New product or benefit plan designs or offerings that create a new or modify an existing legal entity will require filing.
2. Legal entities will be bracketed when multiple entities are listed as insuring or administering entities. The applicable entity(s) will be shown based upon the applicant's/groups selection.
3. If there is only one legal entity listed as insuring or administering then it will not be bracketed

Demographic Information

Demographic information will not be bracketed but will fall under administrative changes which can be amended without refiling.

Administrative Changes and Clerical Errors

Humana reserves the right to amend the attached form(s) for any minor administrative changes or to fix clerical errors that may have unintentionally gone unnoticed prior to submitting for approval and to amend the language to clarify the intent within the confines of the law.

Forms are submitted in filing version format and are subject only to minor modification in paper size, stock, ink, border, and adaptation to computer printing. The application may be offered in a printed, on line, or digitized audio recorded format.

We have received your filing regarding the above named association/ discretionary group. To determine if this organization is a qualified group under our statutes, please provide the answers to the following questions:

1. Name and address of the group.

**Peoples Benefit Alliance
16476 Wild Horse Creek Road
Chesterfield, MO 63017**

2. Is this group incorporated? If so, give state of incorporation.
Yes, Missouri

3. Is there a current office in Arkansas?

Detailed information of this kind is not supplied to Humana Insurance Company by the association.

4. Does the Arkansas part of the organization have any officers, committees, or chapters? If so, give details.

Detailed information of this kind is not supplied to Humana Insurance Company by the association.

5. Are annual dues charged? If so, specify amount.

Detailed information of this kind is not supplied to Humana Insurance Company by the association.

6. What are the specific activities of the organization?

Detailed information of this kind is not supplied to Humana Insurance Company by the association.

7. What benefits are provided to the members in addition to insurance?
PLEASE ATTACH BROCHURES ON THE BENEFITS.

Brochure is attached and included in Arkansas filing in SERFF that can be located in the “Supporting Document section”.

8. What qualifies an individual for membership?

An individual or family that has the desire to benefit from the common purpose of receiving information, education, services and products of a greater value to a member that would be available on an independent basis must apply for membership by completing the association membership application.

9. How are members recruited? If by mailing list, advise the source of this list.

Detailed information of this kind is not supplied to Humana Insurance Company by the association.

10. Attach a copy of the organization by-laws.

Information attached and included in filing through SERFF, information can be located in the “supporting documents”.

11. Also, enclose a list of dues paying members residing in Arkansas with full addresses. If the organization considers this privileged information, we will treat it as such and once it has served our purpose, it will be destroyed.

Detailed information of this kind is not supplied to Humana Insurance Company by the association.

12. Please attach a copy of the organization’s most recent financial statement.

Detailed information of this kind is not supplied to Humana Insurance Company by the association.

13. Does the organization receive any compensation of any kind from the insurer issuing contracts to its members?

Detailed information of this kind is not supplied to Humana Insurance Company by the association.

Approval of the organization as a qualified group for insurance purposes will be determined upon receipt of your reply.

Variable Options

Individual deductible [for network providers]: \$0 to \$25,000

Individual deductible for non-network providers: 1, 2, 3 or 4 times the individual deductible for network providers or \$0 to \$25,000

Family deductible [for network providers]: 1, 2, 3 or 4 times the individual deductible amount for network providers or \$0 to \$40,000

Family deductible for non-network providers: 1, 2, 3 or 4 times the individual deductible amount for non-network providers or \$0 to \$40,000

Prescription drug deductible for network providers : \$0 to \$2000

Prescription drug deductible for non- network providers : \$0 to \$2000

Percentage applied to covered expenses in determining coinsurance:

For preventive care:

Routine exam or annual physical exam, routine immunizations, routine mammogram, routine pap smear and PSA test when services are rendered by a network provider: 0% to 100%

Routine laboratory, pathology and radiology tests (other than routine mammogram, routine pap smear and PSA tests) when services are rendered by a network provider: 0% to 100%

For ambulance services [when services are rendered by a [network provider] [non-network provider]]: 0% to 100%

For transplant services (organ) [when services are rendered by a [participating transplant provider] [non-participating transplant provider]]: 0% to 100%

For prescription drugs [when received from a [network pharmacy] [non-network pharmacy]: 0% to 100%

For all other services [when services are rendered by a [network provider] [non-network provider]]: 0% to 100%

Coinsurance out-of-pocket limits:

For transplant services (organ), when services are rendered by a non-participating transplant provider: \$0 to \$60,000

For all other services when services are rendered by a network provider:
\$0 to \$40,000 per covered person [and family] per calendar year
\$0 to \$60,000 per family per calendar year

For all other services when services are rendered by a non-network provider:
\$0 to \$100,000 per covered person [and family] per calendar year
\$0 to \$180,000 per family per calendar year

Annual maximum benefit:

For outpatient services: \$2,000 to unlimited

For all other services: \$50,000 to unlimited

Lifetime maximum benefit: \$500,000 to unlimited

Emergency room copayment: \$0 to \$500

Waiting periods for:

- ◇ **Any sickness** - 0 to 180 days
- ◇ **Non-emergency removal of tonsils and/or adenoids** - 0 to 365 days
- ◇ **Non-emergency surgical treatment for hernia, bunions, varicose veins or hemorrhoids** - 0 to 365 days
- ◇ **Preventive care** - 0 to 11 months or 1 to 3 years

Benefit maximums for:

- ◇ **Ambulance** - \$100 to \$30,000
- ◇ **Durable Medical Equipment** - \$200 to \$10,000
- ◇ **Physical medicine** - 10 to 365
- ◇ **Skilled nursing facility** - 20 to 365
- ◇ **Home health care** - 20 to unlimited
- ◇ **Preventive care: routine exam or annual physical exam, routine immunizations, [routine mammogram], [routine pap smear] [and] [PSA test]** - \$150 to \$10,000
- ◇ **Prescription Drugs** - \$1,000 - \$10,000

Prescription drug copayment:

Level 1 drugs: \$5 to \$250 or 5% to 30%

Level 2 drugs: \$5 to \$250 or 5% to 30%

Level 3 drugs: \$5 to \$250 or 5% to 30%

Level 4 drugs: \$5 to \$250 or 5% to 30%

Supply limits for prescription drugs: 30 days, 45 days, 60 days, 90 days, 120 days, 270 days, 365 days, or 1 to 12 months

Office visit copayment rider:

Benefit maximum for office visits: 0 to 20

**Copayment when services are rendered by a [primary care network provider]
[specialty care network provider]:** \$0 to \$2000

**Coinsurance when services are rendered by a network provider for outpatient x-ray
and laboratory services:** 50% to 100%

**Coinsurance limit for services rendered by a network provider for outpatient x-ray
and laboratory services:** \$50 to \$1000

Coinsurance when services are rendered by a non-network provider: 0% to 100%

Supplemental accident rider:

Benefit maximum for each bodily injury: \$100 to \$5000

MATRIX FILING LISTING

Group Medical Policy Series GN-71012-01 1/2008, et al

<u>Matrix Element</u>	<u>Title</u>	<u>Form Type</u>
1700	Introduction	Matrix Insert
1701	Renewability	Matrix Insert
1702	Right to Return Policy	Matrix Insert
1703	Table of Contents	Matrix Insert
1704	Schedule of Benefits	Matrix Insert
1705	Schedule of Benefits	Matrix Insert
1706	Schedule of Benefits	Matrix Insert
1707	Schedule of Benefits	Matrix Insert
1708	Schedule of Benefits	Matrix Insert
1709	Schedule of Benefits	Matrix Insert
1710	Schedule of Benefits	Matrix Insert
1711	Schedule of Benefits	Matrix Insert
1712	Schedule of Benefits	Matrix Insert
1713	Schedule of Benefits	Matrix Insert
1714	Schedule of Benefits	Matrix Insert
1715	Schedule of Benefits	Matrix Insert
1715.1	Schedule of Benefits	Matrix Insert
1716	Schedule of Benefits	Matrix Insert
1717	Schedule of Benefits	Matrix Insert
1718	Schedule of Benefits	Matrix Insert
1719	Schedule of Benefits	Matrix Insert
1720	Schedule of Benefits	Matrix Insert
1721	Schedule of Benefits	Matrix Insert
1722	Schedule of Benefits	Matrix Insert
1723	Schedule of Benefits	Matrix Insert
1724	Schedule of Benefits	Matrix Insert
1725	Schedule of Benefits	Matrix Insert
1726	Schedule of Benefits	Matrix Insert
1727	Schedule of Benefits	Matrix Insert
1728	Schedule of Benefits	Matrix Insert
1729	Schedule of Benefits	Matrix Insert
1730	Schedule of Benefits	Matrix Insert
1731	Schedule of Benefits	Matrix Insert
1732	Schedule of Benefits	Matrix Insert
1733	Schedule of Benefits	Matrix Insert
1734	Schedule of Benefits	Matrix Insert
1735	How We Pay Benefits	Matrix Insert
1736	How We Pay Benefits	Matrix Insert
1737	How We Pay Benefits	Matrix Insert
1738	How We Pay Benefits	Matrix Insert
1739	How We Pay Benefits	Matrix Insert
1740	How We Pay Benefits	Matrix Insert
1741	How We Pay Benefits	Matrix Insert
1742	How We Pay Benefits	Matrix Insert
1743	How We Pay Benefits	Matrix Insert
1744	How We Pay Benefits	Matrix Insert
1745	How We Pay Benefits	Matrix Insert
1746	How We Pay Benefits	Matrix Insert

MATRIX FILING LISTING

Group Medical Policy Series GN-71012-01 1/2008, et al

<u>Matrix Element</u>	<u>Title</u>	<u>Form Type</u>
1747	How We Pay Benefits	Matrix Insert
1748	How We Pay Benefits	Matrix Insert
1749	How We Pay Benefits	Matrix Insert
1750	How We Pay Benefits	Matrix Insert
1751	How We Pay Benefits	Matrix Insert
1752	How We Pay Benefits	Matrix Insert
1753	How We Pay Benefits	Matrix Insert
1754	Utilization Management	Matrix Insert
1755	Utilization Management	Matrix Insert
1756	Utilization Management	Matrix Insert
1757	Utilization Management	Matrix Insert
1758	Utilization Management	Matrix Insert
1759	Utilization Management	Matrix Insert
1760	Utilization Management	Matrix Insert
1761	Utilization Management	Matrix Insert
1762	Utilization Management	Matrix Insert
1763	Utilization Management	Matrix Insert
1764	Utilization Management	Matrix Insert
1765	Utilization Management	Matrix Insert
1766	Utilization Management	Matrix Insert
1767	Utilization Management	Matrix Insert
1768	Utilization Management	Matrix Insert
1769	Your Certificate Benefits	Matrix Insert
1770	Your Certificate Benefits	Matrix Insert
1771	Your Certificate Benefits	Matrix Insert
1772	Your Certificates Benefits	Matrix Insert
1773	Your Certificates Benefits	Matrix Insert
1774	Your Certificates Benefits	Matrix Insert
1775	Your Certificates Benefits	Matrix Insert
1776	Your Certificate Benefits	Matrix Insert
1777	Your Certificates Benefits	Matrix Insert
1778	Your Certificate Benefits	Matrix Insert
1779	Your Certificate Benefits	Matrix Insert
1780	Your Certificate Benefits	Matrix Insert
1781	Your Certificate Benefits	Matrix Insert
1782	Your Certificate Benefits	Matrix Insert
1783	Your Certificate Benefits	Matrix Insert
1784	Your Certificate Benefits	Matrix Insert
1785	Your Certificate Benefits	Matrix Insert
1786	Your Certificate Benefits	Matrix Insert
1787	Your Certificate Benefits	Matrix Insert
1788	Your Certificate Benefits	Matrix Insert
1789	Your Certificate Benefits	Matrix Insert
1790	Your Certificate Benefits	Matrix Insert
1791	Claims Payment	Matrix Insert
1792	Claims Payment	Matrix Insert
1793	Claims Payment	Matrix Insert
1794	Claims Payment	Matrix Insert

MATRIX FILING LISTING

Group Medical Policy Series GN-71012-01 1/2008, et al

<u>Matrix Element</u>	<u>Title</u>	<u>Form Type</u>
1795	Claims Payment	Matrix Insert
1796	Claims Payment	Matrix Insert
1797	Claims Payment	Matrix Insert
1798	Claims Payment	Matrix Insert
1799	Claims Payment	Matrix Insert
1800	Claims Payment	Matrix Insert
1801	Claims Payment	Matrix Insert
1802	Claims Payment	Matrix Insert
1803	Claims Payment	Matrix Insert
1804	Claims Payment	Matrix Insert
1806	Claims Payment	Matrix Insert
1807	Claims Payment	Matrix Insert
1808	Claims Payment	Matrix Insert
1809	Claims Payment	Matrix Insert
1810	Coordination of Benefits	Matrix Insert
1811	Coordination of Benefits	Matrix Insert
1812	Coordination of Benefits	Matrix Insert
1813	Coordination of Benefits	Matrix Insert
1814	Coordination of Benefits	Matrix Insert
1815	Coordination of Benefits	Matrix Insert
1816	Coordination of Benefits	Matrix Insert
1817	Coordination of Benefits	Matrix Insert
1818	Coordination of Benefits	Matrix Insert
1819	Coordination of Benefits	Matrix Insert
1820	Pre-existing Condition Limitation	Matrix Insert
1821	Pre-existing Condition Limitation	Matrix Insert
1822	Pre-existing Condition Limitation	Matrix Insert
1823	Limitations and Exclusions	Matrix Insert
1824	Limitations and Exclusions	Matrix Insert
1825	Limitations and Exclusions	Matrix Insert
1826	Limitations and Exclusions	Matrix Insert
1827	Limitations and Exclusions	Matrix Insert
1828	Limitations and Exclusions	Matrix Insert
1829	Limitations and Exclusions	Matrix Insert
1830	Limitations and Exclusions	Matrix Insert
1831	Limitations and Exclusions	Matrix Insert
1832	Limitations and Exclusions	Matrix Insert
1833	Limitations and Exclusions	Matrix Insert
1834	Limitations and Exclusions	Matrix Insert
1835	Limitations and Exclusions	Matrix Insert
1836	Limitations and Exclusions	Matrix Insert
1837	Termination Rights	Matrix Insert
1838	Termination Rights	Matrix Insert
1839	Termination Rights	Matrix Insert
1840	Termination Rights	Matrix Insert
1841	Transferring Coverage	Matrix Insert
1842	Transferring Coverage	Matrix Insert
1843	Transferring Coverage	Matrix Insert

MATRIX FILING LISTING

Group Medical Policy Series GN-71012-01 1/2008, et al

<u>Matrix Element</u>	<u>Title</u>	<u>Form Type</u>
1844	Transferring Coverage	Matrix Insert
1845	Premium Payment	Matrix Insert
1846	Premium Payment	Matrix Insert
1847	Premium Payment	Matrix Insert
1848	Premium Payment	Matrix Insert
1849	Changes to the Certificate	Matrix Insert
1850	Changes to the Certificate	Matrix Insert
1851	Changes to the Certificate	Matrix Insert
1852	Changes to the Certificate	Matrix Insert
1853	Changes to the Certificate	Matrix Insert
1854	Changes to the Certificate	Matrix Insert
1855	Changes to the Certificate	Matrix Insert
1856	Changes to the Certificate	Matrix Insert
1857	Changes to the Certificate	Matrix Insert
1858	Changes to the Certificate	Matrix Insert
1859	Changes to the Certificate	Matrix Insert
1860	Changes to the Certificate	Matrix Insert
1861	General Provisions	Matrix Insert
1862	General Provisions	Matrix Insert
1863	General Provisions	Matrix Insert
1864	General Provisions	Matrix Insert
1865	General Provisions	Matrix Insert
1866	General Provisions	Matrix Insert
1867	General Provisions	Matrix Insert
1868	Recovery Rights	Matrix Insert
1869	Recovery Rights	Matrix Insert
1870	Recovery Rights	Matrix Insert
1871	Recovery Rights	Matrix Insert
1872	Recovery Rights	Matrix Insert
1873	Definitions	Matrix Insert
1874	Definitions	Matrix Insert
1875	Definitions	Matrix Insert
1876	Definitions	Matrix Insert
1877	Definitions	Matrix Insert
1878	Definitions	Matrix Insert
1879	Definitions	Matrix Insert
1880	Definitions	Matrix Insert
1881	Definitions	Matrix Insert
1882	Definitions	Matrix Insert
1883	Definitions	Matrix Insert
1884	Definitions	Matrix Insert
1885	Definitions	Matrix Insert
1886	Definitions	Matrix Insert
1887	Definitions	Matrix Insert
1888	Definitions	Matrix Insert
1889	Definitions	Matrix Insert
1890	Definitions	Matrix Insert
1891	Definitions	Matrix Insert

MATRIX FILING LISTING

Group Medical Policy Series GN-71012-01 1/2008, et al

<u>Matrix Element</u>	<u>Title</u>	<u>Form Type</u>
1892	Definitions	Matrix Insert
1893	Definitions	Matrix Insert
1894	Definitions	Matrix Insert
1895	Definitions	Matrix Insert
1896	Definitions	Matrix Insert
1897	Definitions	Matrix Insert
1898	Definitions	Matrix Insert
1899	Definitions	Matrix Insert
1900	Definitions	Matrix Insert
1901	Definitions	Matrix Insert
1902	Definitions	Matrix Insert
1903	Definitions	Matrix Insert
1904	Definitions	Matrix Insert
1905	Definitions	Matrix Insert
1906	Definitions	Matrix Insert
1907	Definitions	Matrix Insert
1908	Definitions	Matrix Insert
1909	Definitions	Matrix Insert
1910	Definitions	Matrix Insert
1911	Definitions	Matrix Insert
1912	Definitions	Matrix Insert
1913	Definitions	Matrix Insert
1914	Definitions	Matrix Insert
1915	Definitions	Matrix Insert
1916	Definitions	Matrix Insert
1917	Definitions	Matrix Insert
1918	Definitions	Matrix Insert
1919	Definitions	Matrix Insert
1920	Definitions	Matrix Insert
1921	Definitions	Matrix Insert
1922	Definitions	Matrix Insert
1923	Definitions	Matrix Insert
1924	Definitions	Matrix Insert
1925	Definitions	Matrix Insert
1926	Definitions	Matrix Insert
1927	Definitions	Matrix Insert
1928	Definitions	Matrix Insert
1929	Definitions	Matrix Insert
1930	Definitions	Matrix Insert
1931	Definitions	Matrix Insert
1932	Definitions	Matrix Insert
1933	Definitions	Matrix Insert
1934	Definitions	Matrix Insert
1935	Definitions	Matrix Insert
1936	Definitions	Matrix Insert
1937	Definitions	Matrix Insert
1938	Definitions	Matrix Insert
1939	Definition	Matrix Insert

MATRIX FILING LISTING

Group Medical Policy Series GN-71012-01 1/2008, et al

<u>Matrix Element</u>	<u>Title</u>	<u>Form Type</u>
1940	Definitions	Matrix Insert
1941	Definitions	Matrix Insert
1942	Definitions	Matrix Insert
1943	Definitions	Matrix Insert
1944	Definitions	Matrix Insert
1945	Definitions	Matrix Insert
1946	Definitions	Matrix Insert
1947	Definitions	Matrix Insert
1948	Definitions	Matrix Insert
1949	Definitions	Matrix Insert
1950	Definitions	Matrix Insert
1951	Definitions	Matrix Insert
1952	Definitions	Matrix Insert
1953	Definitions	Matrix Insert
1954	Definitions	Matrix Insert
1955	Definitions	Matrix Insert
1956	Definitions	Matrix Insert
1957	Definitions	Matrix Insert
1958	Definitions	Matrix Insert
1959	Definitions	Matrix Insert
1960	Definitions	Matrix Insert
1961	Definitions	Matrix Insert
1962	Definitions	Matrix Insert
1963	Definitions	Matrix Insert
1964	Office Visit Copayment Rider	Matrix Insert
1965	Supplemental Accident Rider	Matrix Insert
1966	Term Life Insurance Rider	Matrix Insert
1967	Amendment	Matrix Insert
1968	Exclusion Rider	Matrix Insert
1969	Back Cover	Matrix Insert

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
----	---------------------------	----------

2.	Department Use Only	
	State Tracking ID	

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Humana Insurance Company N19 W24133 Riverwood Drive Ste 250 Waukesha, WI 53188	Wisconsin	Life, Accident & Health	119	73288	391263473	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Latunia Riley (Contract Analyst) Humana Insurance Company N19 W24133 Riverwood Drive Suite 250 Waukesha, WI 53188	800-289-0260 ext 2617	920-632-0029	lriley2@humana.com

5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
----	-----------------------	--

6.	Company Tracking Number	GN-71012-01 1/2008
----	-------------------------	--------------------

7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission Previous file # _____
----	---

8.	Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise
		Group <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input checked="" type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

9.	Type of Insurance	H16G Group Health-Major Medical
----	-------------------	---------------------------------

10.	Product Coding Matrix Filing Code	H16G.001A Any Size Group-PPO
-----	-----------------------------------	------------------------------

11.	Submitted Documents	<input checked="" type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input checked="" type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input checked="" type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input checked="" type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other
		Rates <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input checked="" type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input checked="" type="checkbox"/> Statement of Variability <input checked="" type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input checked="" type="checkbox"/> Other <u>Matrix Filing Listing, Variable</u>

Effective March 1, 2007

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number	GN-71012-01 1/2008	
This filing corresponds to rate filing company tracking number	N/A	

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Certificate Cover	GN-71012-01 1/2008	<input checked="" type="checkbox"/> Initial	N/A
	Certificate Section		<input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02	Table of Contents	GN-71012-01 TAB 1/2008	<input checked="" type="checkbox"/> Initial	N/A
	Certificate Section		<input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03	Schedule of Benefits	GN-71012-01 SCH 1/2008	<input checked="" type="checkbox"/> Initial	N/A
	Certificate Section		<input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04	How We Pay Benefits	GN-71012-01 PAY 1/2008	<input checked="" type="checkbox"/> Initial	N/A
	Certificate Section		<input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05	Utilization Management	GN-71012-01 UM 1/2008	<input checked="" type="checkbox"/> Initial	N/A
	Certificate Section		<input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06	Your Certificate Benefits	GN-71012-01 BEN 1/2008	<input checked="" type="checkbox"/> Initial	N/A
	Certificate Section		<input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07	Claims Payment	GN-71012-01 CLM 1/2008	<input checked="" type="checkbox"/> Initial	N/A
	Certificate Section		<input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08	Coordination of Benefits	GN-71012-01 COB 1/2008	<input checked="" type="checkbox"/> Initial	N/A
	Certificate Section		<input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09	Pre-Existing Condition Limitation	GN-71012-01 PRE-X 1/2008	<input checked="" type="checkbox"/> Initial	N/A
	Certificate Section		<input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10	Limitations and Exclusions	GN-71012-01 LE 1/2008	<input checked="" type="checkbox"/> Initial	N/A
	Certificate Section		<input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		GN-71012-01 1/2008
This filing corresponds to rate filing company tracking number		N/A

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Termination Rights	GN-71012-01 TER 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Section			
02	Transferring Coverage	GN-71012-01 TRANS 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Section			
03	Premium Payment	GN-71012-01 PREM 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Section			
04	Changes to the Certificate	GN-71012-01 CHG 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Section			
05	General Provisions	GN-71012-01 GP 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Section			
06	Recovery Rights	GN-71012-01 RR 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Section			
07	Definitions	GN-71012-01 DEF 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Section			
08	Arkansas Rider	AR-71012-01 LBP 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Rider			
09	Optional Mammography Rider	AR-71012-01 MAMM LBP 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Rider			
10	Optional Alcohol and Drug Dependency Rider	AR-71012-01 ADD LBP 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Rider			

LH FFA-1

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		GN-71012-01 1/2008
This filing corresponds to rate filing company tracking number		N/A

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Optional Mental Illness Rider	AR-71012-01 MI LBP 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Rider			
02	Optional Hospice Rider	AR-71012-01 HOS LBP 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Rider			
03	Optional Musculoskeletal Disorders Rider	AR-71012-01 MD LBP 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Rider			
04	Office Visit Copayment Rider	GN-71012-01 Copay 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Rider			
05	Supplemental Accident Rider	GN-71012-01 SAB 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Rider			
06	Term Life Insurance Rider	GN-71012-01 TLR 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Rider			
07	Amendment	GN-71012-01 AMEND 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Rider			
08	Exclusion Rider	GN-71012-01 EXC 1/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Rider			
09	Back Cover	GN-Back Cover	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Certificate Section			
10	Humana One PPO Annual Max Plan Enrollment Form	AR-71005 10/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Enrollment Form			

LH FFA-1

18. Rate Filing Attachment				
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number		GN-71012-01 1/2008		
Overall percentage rate indication (when applicable)		N/A		
Overall percentage rate impact for this filing		N/A %		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	

LH RFA-1



November 4, 2008

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

**RE: GROUP HEALTH INSURANCE FORM FILING
 HUMANA INSURANCE COMPANY
 POLICY SERIES: AR-71012-01 1/2008, et al.
 NAIC #73288
 FEIN #39-1263473**

Dear Ms. Minor:

This letter is in response to your Objection Letter dated November 3, 2008 concerning the above noted filing. I will respond to your concerns utilizing the SERFF Tracking number for easy reference.

HUMA-125880356

(Objection 1)

Your inquiry in regards to a "Policyholder shall accept or reject the optional coverage in writing on the application and that we must inform the policyholder that rejecting the option mean covered benefits provided to insured or enrollees will not include TMJ or craniomandibular disorder".

We hope to satisfy this objection by including an "informational" policyholder TMJ election form that would be sent to the policyholder to accept or reject this offer in writing that would comply with Arkansas 23-7-150. Therefore, we kindly ask that you accept the attached form for informational purposes only, as we will submit this form to the policyholder to complete accordingly.

(Objection 2)

With respect to benefits payable a PPO and Non-PPO, Humana Insurance Company therefore certify and comply that there will be no more than a 25% differential in payment of benefits that applies in accordance to Arkansas Bulletin 9-85.

If you have questions regarding this filing, please contact me by phone at 1-800-289-0260, extension 2617, by fax at 920-632-0029 or by e-mail at lriley2@humana.com.

Sincerely,
HUMANA INSURANCE COMPANY

Latunia Riley
Contract Analyst

September 11, 2008
Page 2 of 2
Enclosures

Optional Benefit Notice for the State of Arkansas

Group Policyholder: Peoples' Benefit Alliance

Group Policy Number: H101000

Pursuant to the laws of the State of Arkansas, You, the Administrator for the Peoples' Benefit Alliance, are hereby offered the following optional benefit for the Annual Max Plan policy:

Musculoskeletal Disorders Benefit

Benefits are payable for expenses incurred for the medically necessary surgical and non-surgical treatment of Musculoskeletal Disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and crainomandibular disorder the same as any other sickness.

Please return this notice with one of the following decisions indicated, within 30 days of receipt of this notice.

- () We have read the above and do not wish to provide this optional benefit
- () We have read the above and do wish to provide this optional benefit and understand that the initial monthly premium charge per primary insured for this additional coverage is \$XXXXXX.

Date: _____

Signature: _____

Printed Name: _____

Title: _____

Policyholder: Peoples' Benefit Alliance

GROUP INSURANCE APPLICATION

Application is hereby made to: Humana Insurance Company

For Group Insurance Policy No.: [12345]

Application is made by: [ABC Association]

The above referenced Association requests and accepts the Group Insurance Policy referenced above.

Musculoskeletal Disorder Benefit

Benefits are payable incurred for medically necessary surgical and non-surgical treatment of Musculoskeletal Disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and crainomandibular disorder the same as any other sickness.

- We have read the above and wish to decline the optional TMJ benefit

- We have read the above and do wish to accept and provide the optional TMJ benefit and understand that there will be an initial monthly premium charge per primary insured for this additional coverage.

Please note that rejection of the optional TMJ benefit means that covered benefits provided to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder.

The group Insurance application is attached to and made a part of the referenced Group Insurance Policy as of the Policy effective date.

Dated at: _____

[ABC ASSOCIATION]

Dated on: _____

BY: _____

(Name and Title of Person Signing
on behalf of the Association)

WITNESS: _____

SERFF Tracking Number: HUMA-125880356 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 40731
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: Annual Max Plan
 Project Name/Number: /

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	Arkansas	12/30/2008	AR LBP Certificate Resident Rider.pdf
No original date	Form	Arkansas	11/05/2008	AR LBP Certificate Resident Rider.pdf
No original date	Form	Arkansas	10/30/2008	AR LBP Certificate Resident Rider.pdf
No original date	Supporting Document	Response Letter	11/04/2008	AR AMP Response Letter-Signed.pdf

ARKANSAS RIDER

HUMANA INSURANCE COMPANY

Policyholder: [ABC Association]

Primary Insured: [John Doe]

Policy Number: [12345]

Effective Date: [January 1, 2008]

This rider is attached to and made part of the *certificate* to which it is attached. Except as modified below, all *certificate* terms, conditions, exclusions and limitations apply. Notwithstanding any other provisions of the *certificate*, expenses covered under this rider are not covered under any other provisions of the *certificate*.

The provisions in this rider are available to and are applicable to residents of the state of Arkansas. *Certificates* issued to residents of the state of Arkansas are amended by adding the following:

Children Health Supervision Services

We will provide coverage for *expenses incurred* for age-appropriate child health supervision *services* for a *covered dependent* child from birth to age 19 at the following intervals:

- Birth;
- 2 weeks;
- 2 months;
- 4 months;
- 6 months;
- 9 months;
- 12 months;
- 15 months;
- 18 months;
- 2 years;
- 3 years;
- 4 years;
- 5 years;
- 6 years;
- 8 years;
- 10 years;
- 12 years;
- 14 years;
- 16 years; and
- 18 years.

Services for child health supervision *services* are to be rendered during a periodic review and are only covered to the extent that such *services* are provided during the course of 1 visit by or under the supervision of a *healthcare practitioner services* for:

ARKANSAS RIDER

- Routine physical examinations including history, development assessment and anticipatory guidance; and
- Laboratory services in connection with routine physical examinations.

Covered expenses are subject to all *certificates* requirements including but not limited to any *copayment, deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

Appropriate immunizations are subject to all *certificate* requirements including but not limited to *certificate* maximums and are exempt from *deductible, coinsurance out-of-pocket limits* and benefit maximums.

Insert paragraph for Coinsurance Option Plan 75/55 **[Contraceptive Drugs and Devices**

Coverage is available for *expenses incurred* for the use of the contraceptive method. The FDA approved uses of contraceptive methods are:

- Implant systems;
- Devices;
- Oral; and
- Injectable medications.

Coverage will also be provided for consultations, exams, procedures and *services* provided on an outpatient basis that are related to the use of the contraceptive method.

Coverage will not be provided for abortion, abortifacient or any FDA approved emergency contraception.

Benefits for contraceptives are payable under this *certificate* the same as any other *Prescription drugs*. *Covered expenses* are subject to all *certificates* requirements including but not limited to any *copayment, deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.]

Definitions

The following has been added to the **Definitions** section:

Children's preventive healthcare services means *healthcare practitioner*-delivered or *healthcare practitioner* supervised *services* for eligible from birth through 18 years of age, with period preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory test, in keeping with prevailing medical standards for the purposes of the section.

Low protein modified food product means a food product that is specifically formulated to have less than 1 gram of protein per serving and intended to be used under the direction of a *healthcare practitioner* for the dietary treatment of an inherited metabolic disease.

Medical food means 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

ARKANSAS RIDER

to be consumed or administered enterally under the direction of a *healthcare practitioner*.

Dental Anesthesia

Coverage will be provided for *outpatient hospital* care and general anesthesia for dental procedures if it is certified that general anesthesia is required to safely perform the procedures and the *covered person* is:

- A *covered dependent* child under 7 years of age who is determined by 2 licensed dentist to require necessary dental treatment for a significantly complex dental condition;
- A *covered person* diagnosed with a serious mental or physical condition; or
- A *covered person* with significant behavior problems as determined by the *covered person's healthcare practitioner*.

Preauthorization is required to be considered *covered expenses*.

No coverage is provided for the treatment of temporomandibular joint (TMJ) disorders.

Covered expenses are subject to all *certificate* requirements including but not limited to any *deductible*, *coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

Dependents

The **Adding Dependents** provision in the **Changes to the Certificate** section is amended as follows:

- 1) The first paragraph is replaced with the following:
 - If a child is born to *you* or any *covered person*, *we* must be notified of the event in writing and receive any required premium within 90 of the event to avoid medical underwriting. If *we* do not receive notice and premium for the first 90 and forward, the child will not be a *covered person* under this *certificate*.
- 2) The second paragraph has been added:
 - If a child or newborn is adopted by *you* or any *covered person* or a child is placed with *you* for the purpose of adoption, *we* must be notified of the event in writing and receive any required premium within 60 days of the petition for adoption. Coverage shall terminate upon the dismissal or denial of a petition of adoption.

Inherited Metabolic Disorders

Coverage will be provided for phenylketonuria (PKU), galactosemia, organic acidemias and disorders of amino acid metabolism if:

- Medical food or low protein modified food are prescribed as for therapeutic treatment;
- Products are administered under the direction of a *healthcare practitioner*; and
- Cost of the medical food products for the *covered dependent* exceeds \$2,400 per year per *covered dependent*.

ARKANSAS RIDER

Benefits for *prescription* drug formulas are payable under this *certificate* the same as any other *Prescription drug*. *Covered expenses* are subject to all *certificate* requirements including but not limited to any *deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

Mastectomy Services

The **Mastectomy services** section has been revised by adding the following to the **Your Certificate Benefits** provision:

- Confinement in a licensed *healthcare facility* not less than 48 hours for inpatient care following a mastectomy or lymph node dissection until the completion of the appropriate period of stay for such inpatient care as determined by the attending *healthcare practitioner* in consultation with the patient.

Speech or Hearing Impairment

Coverage will be provided for *medically necessary* care and treatment of loss or impairment of speech or hearing by a licensed speech pathologist or audiologist

Coverage will not be provided for hearing instruments or devices.

Covered expenses are subject to all *certificate* requirements including but not limited to any *deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

[Signature of Officer]
[Typed Name of Officer]
[Title of Officer]

ARKANSAS RIDER

HUMANA INSURANCE COMPANY

Policyholder: [ABC Association]

Primary Insured: [John Doe]

Policy Number: [12345]

Effective Date: [January 1, 2008]

This rider is attached to and made part of the *certificate* to which it is attached. Except as modified below, all *certificate* terms, conditions, exclusions and limitations apply. Notwithstanding any other provisions of the *certificate*, expenses covered under this rider are not covered under any other provisions of the *certificate*.

The provisions in this rider are available to and are applicable to residents of the state of Arkansas. *Certificates* issued to residents of the state of Arkansas are amended by adding the following:

Children Health Supervision Services

We will provide coverage for *expenses incurred* for age-appropriate child health supervision *services* for a *covered dependent* child from birth to age 19 at the following intervals:

- Birth;
- 2 weeks;
- 2 months;
- 4 months;
- 6 months;
- 9 months;
- 12 months;
- 15 months;
- 18 months;
- 2 years;
- 3 years;
- 4 years;
- 5 years;
- 6 years;
- 8 years;
- 10 years;
- 12 years;
- 14 years;
- 16 years; and
- 18 years.

Services for child health supervision *services* are to be rendered during a periodic review and are only covered to the extent that such *services* are provided during the course of 1 visit by or under the supervision of a *healthcare practitioner services* for:

ARKANSAS RIDER

- Routine physical examinations including history, development assessment and anticipatory guidance;
- Appropriate immunizations; and
- Laboratory services in connection with routine physical examinations.

Covered expenses are subject to all *certificate* requirements including but not limited to *certificate* maximums are exempt from *deductible, coinsurance out-of-pocket limits* and benefit maximums.

Insert paragraph for Coinsurance Option Plan 75/55

[Contraceptive Drugs and Devices

Coverage is available for *expenses incurred* for the use of the contraceptive method. The FDA approved uses of contraceptive methods are:

- Implant systems;
- Devices;
- Oral; and
- Injectable medications.

Coverage will also be provided for consultations, exams, procedures and *services* provided on an outpatient basis that are related to the use of the contraceptive method.

Coverage will not be provided for abortion, abortifacient or any FDA approved emergency contraception.

Benefits for contraceptives are payable under this *certificate* the same as any other *Prescription drugs*. *Covered expenses* are subject to all *certificates* requirements including but not limited to any *copayment, deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.]

Definitions

The following has been added to the **Definitions** section:

Children's preventive healthcare services means *healthcare practitioner*-delivered or *healthcare practitioner* supervised *services* for eligible from birth through 18 years of age, with period preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory test, in keeping with prevailing medical standards for the purposes of the section.

Low protein modified food product means a food product that is specifically formulated to have less than 1 gram of protein per serving and intended to be used under the direction of a *healthcare practitioner* for the dietary treatment of an inherited metabolic disease.

Medical food means 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 *healthcare practitioner*.

ARKANSAS RIDER

Dental Anesthesia

Coverage will be provided for *outpatient hospital* care and general anesthesia for dental procedures if it is certified that general anesthesia is required to safely perform the procedures and the *covered person* is:

- A *covered dependent* child under 7 years of age who is determined by 2 licensed dentist to require necessary dental treatment for a significantly complex dental condition;
- A *covered person* diagnosed with a serious mental or physical condition; or
- A *covered person* with significant behavior problems as determined by the *covered person's* *healthcare practitioner*.

Preauthorization is required to be considered *covered expenses*.

No coverage is provided for the treatment of temporomandibular joint (TMJ) disorders.

Covered expenses are subject to all *certificate* requirements including but not limited to any *deductible*, *coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

Dependents

The **Adding Dependents** provision in the **Changes to the Certificate** section is amended as follows:

- 1) The first paragraph is replaced with the following:
 - If a child is born to *you* or any *covered person*, *we* must be notified of the event in writing and receive any required premium within 90 of the event to avoid medical underwriting. If *we* do not receive notice and premium for the first 90 and forward, the child will not be a *covered person* under this *certificate*.
- 2) The second paragraph has been added:
 - If a child or newborn is adopted by *you* or any *covered person* or a child is placed with *you* for the purpose of adoption, *we* must be notified of the event in writing and receive any required premium within 60 days of the petition for adoption. Coverage shall terminate upon the dismissal or denial of a petition of adoption.

Inherited Metabolic Disorders

Coverage will be provided for phenylketonuria (PKU), galactosemia, organic acidemias and disorders of amino acid metabolism if:

- Medical food or low protein modified food are prescribed as for therapeutic treatment;
- Products are administered under the direction of a *healthcare practitioner*; and
- Cost of the medical food products for the *covered dependent* exceeds \$2,400 per year per *covered dependent*.

ARKANSAS RIDER

Benefits for *prescription* drug formulas are payable under this *certificate* the same as any other *Prescription drug*. *Covered expenses* are subject to all *certificate* requirements including but not limited to any *deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

Mastectomy Services

The **Mastectomy services** section has been revised by adding the following to the **Your Certificate Benefits** provision:

- Confinement in a licensed *healthcare facility* not less than 48 hours for inpatient care following a mastectomy or lymph node dissection until the completion of the appropriate period of stay for such inpatient care as determined by the attending *healthcare practitioner* in consultation with the patient.

Speech or Hearing Impairment

Coverage will be provided for *medically necessary* care and treatment of loss or impairment of speech or hearing by a licensed speech pathologist or audiologist

Coverage will not be provided for hearing instruments or devices.

Covered expenses are subject to all *certificate* requirements including but not limited to any *deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

[Signature of Officer]
[Typed Name of Officer]
[Title of Officer]

ARKANSAS RIDER

HUMANA INSURANCE COMPANY

Policyholder: [ABC Association]

Primary Insured: [John Doe]

Policy Number: [12345]

Effective Date: [January 1, 2008]

This rider is attached to and made part of the *certificate* to which it is attached. Except as modified below, all *certificate* terms, conditions, exclusions and limitations apply. Notwithstanding any other provisions of the *certificate*, expenses covered under this rider are not covered under any other provisions of the *certificate*.

The provisions in this rider are available to and are applicable to residents of the state of Arkansas. *Certificates* issued to residents of the state of Arkansas are amended by adding the following:

Children Health Supervision Services

We will provide coverage for *expenses incurred* for age-appropriate child health supervision *services* for a *covered dependent* child from birth to age 19 at the following intervals:

- Birth;
- 2 weeks;
- 2 months;
- 4 months;
- 6 months;
- 9 months;
- 12 months;
- 15 months;
- 18 months;
- 2 years;
- 3 years;
- 4 years;
- 5 years;
- 6 years;
- 8 years;
- 10 years;
- 12 years;
- 14 years;
- 16 years; and
- 18 years.

Services for child health supervision *services* are to be rendered during a periodic review and are only covered to the extent that such *services* are provided during the course of 1 visit by or under the supervision of a *healthcare practitioner services* for:

ARKANSAS RIDER

- Routine physical examinations including history, development assessment and anticipatory guidance;
- Appropriate immunizations; and
- Laboratory services in connection with routine physical examinations.

Covered expenses are subject to all *certificate* requirements including but not limited to *certificate* maximums are exempt from *deductible, coinsurance out-of-pocket limits* and benefit maximums.

Contraceptive Drugs and Devices

Coverage is available for *expenses incurred* for the use of the contraceptive method. The FDA approved uses of contraceptive methods are:

- Implant systems;
- Devices;
- Oral; and
- Injectable medications.

Coverage will also be provided for consultations, exams, procedures and *services* provided on an outpatient basis that are related to the use of the contraceptive method.

Coverage will not be provided for abortion, abortifacient or any FDA approved emergency contraception.

Benefits for contraceptives are payable under this *certificate* the same as any other *Prescription drugs*. *Covered expenses* are subject to all *certificates* requirements including but not limited to any *copayment, deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

Definitions

The following has been added to the **Definitions** section:

Children's preventive healthcare services means *healthcare practitioner*-delivered or *healthcare practitioner* supervised *services* for eligible from birth through 18 years of age, with period preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory test, in keeping with prevailing medical standards for the purposes of the section.

Low protein modified food product means a food product that is specifically formulated to have less than 1 gram of protein per serving and intended to be used under the direction of a *healthcare practitioner* for the dietary treatment of an inherited metabolic disease.

Medical food means 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 *healthcare practitioner*.

ARKANSAS RIDER

Dental Anesthesia

Coverage will be provided for *outpatient hospital* care and general anesthesia for dental procedures if it is certified that general anesthesia is required to safely perform the procedures and the *covered person* is:

- A covered *dependent* child under 7 years of age who is determined by 2 licensed dentist to require necessary dental treatment for a significantly complex dental condition;
- A *covered person* diagnosed with a serious mental or physical condition; or
- A *covered person* with significant behavior problems as determined by the *covered person's* *healthcare practitioner*.

Preauthorization is required to be considered *covered expenses*.

No coverage is provided for the treatment of temporomandibular joint (TMJ) disorders.

Covered expenses are subject to all *certificate* requirements including but not limited to any *deductible*, *coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

Dependents

The **Adding Dependents** provision in the **Changes to the Certificate** section is amended as follows:

- 1) The first paragraph is replaced with the following:
 - If a child is born to *you* or any *covered person*, *we* must be notified of the event in writing and receive any required premium within 90 of the event to avoid medical underwriting. If *we* do not receive notice and premium for the first 90 and forward, the child will not be a *covered person* under this *certificate*.
- 2) The second paragraph has been added:
 - If a child or newborn is adopted by *you* or any *covered person* or a child is placed with *you* for the purpose of adoption, *we* must be notified of the event in writing and receive any required premium within 60 days of the petition for adoption. Coverage shall terminate upon the dismissal or denial of a petition of adoption.

Inherited Metabolic Disorders

Coverage will be provided for phenylketonuria (PKU), galactosemia, organic acidemias and disorders of amino acid metabolism if:

- Medical food or low protein modified food are prescribed as for therapeutic treatment;
- Products are administered under the direction of a *healthcare practitioner*; and
- Cost of the medical food products for the *covered dependent* exceeds \$2,400 per year per *covered dependent*.

Benefits for *prescription* drug formulas are payable under this *certificate* the same as any other

ARKANSAS RIDER

Prescription drug. Covered expenses are subject to all *certificate* requirements including but not limited to any *deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

Mastectomy Services

The **Mastectomy services** section has been revised by adding the following to the **Your Certificate Benefits** provision:

- Confinement in a licensed *healthcare facility* not less than 48 hours for inpatient care following a mastectomy or lymph node dissection until the completion of the appropriate period of stay for such inpatient care as determined by the attending *healthcare practitioner* in consultation with the patient.

Speech or Hearing Impairment

Coverage will be provided for *medically necessary* care and treatment of loss or impairment of speech or hearing by a licensed speech pathologist or audiologist

Coverage will not be provided for hearing instruments or devices.

Covered expenses are subject to all *certificate* requirements including but not limited to any *deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

[Signature of Officer]
[Typed Name of Officer]
[Title of Officer]

November 4, 2008

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

**RE: GROUP HEALTH INSURANCE FORM FILING
 HUMANA INSURANCE COMPANY
 POLICY SERIES: AR-71012-01 1/2008, et al.
 NAIC #73288
 FEIN #39-1263473**

Dear Ms. Minor:

This letter is in response to your Objection Letter dated November 3, 2008 concerning the above noted filing. I will respond to your concerns utilizing the SERFF Tracking number for easy reference.

HUMA-125880356

(Objection 1)

Your inquiry in regards to a "Policyholder shall accept or reject the optional coverage in writing on the application and that we must inform the policyholder that rejecting the option mean covered benefits provided to insured or enrollees will not include TMJ or craniomandibular disorder".

My response to your inquiry is that the enrollment form submitted is to be completed by the "certificate holder" and not the "policyholder".

(Objection 2)

With respect to benefits payable a PPO and Non-PPO, Humana Insurance Company therefore certify and comply that there will be no more than a 25% differential in payment of benefits that applies in accordance to Arkansas Bulletin 9-85.

If you have questions regarding this filing, please contact me by phone at 1-800-289-0260, extension 2617, by fax at 920-632-0029 or by e-mail at lriley2@humana.com.

Sincerely,
HUMANA INSURANCE COMPANY


Latunia Riley
Contract Analyst

Enclosures