

SERFF Tracking Number: AFDL-126244396 State: Arkansas
 Filing Company: American Fidelity Assurance Company State Tracking Number: 44247
 Company Tracking Number:
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
 Expense
 Product Name: FOS G-530.SA
 Project Name/Number: /

Filing at a Glance

Company: American Fidelity Assurance Company

Product Name: FOS G-530.SA SERFF Tr Num: AFDL-126244396 State: Arkansas
 TOI: H15G Group Health - SERFF Status: Closed-Approved- State Tr Num: 44247
 Hospital/Surgical/Medical Expense Closed
 Sub-TOI: H15G.002 Large Group Only Co Tr Num: State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor
 Author: Sue Joslyn Disposition Date: 12/17/2009
 Date Submitted: 12/03/2009 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Not Filed
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Group
 Submission Type: New Submission Group Market Size: Large
 Overall Rate Impact: Group Market Type: Employer
 Filing Status Changed: 12/17/2009 Explanation for Other Group Market Type:
 State Status Changed: 12/17/2009
 Deemer Date: Created By: Sue Joslyn
 Submitted By: Sue Joslyn Corresponding Filing Tracking Number:
 Filing Description:
 These forms are new and are not intended to replace any forms previously approved by the Department. The coverage will be marketed to employer/employee groups consisting of 51 or more employees.

Benefits provided by the policy include a combination of group Hospital/Surgical/Medical Expense coverage, along with Life and AD&D coverage, Dental Expense Benefits, Vision coverage, and Disability Income coverage.

Master Application Form A-1132, which was previously approved on 11-20-02, will also be used with the above captioned forms. Since this form was previously approved, it has not been included in this submission.

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Variable material is included within brackets. This material may be deleted, changed or paragraphs renumbered based upon the coverage or combination of coverages purchased by the employer or to allow for future revisions as may be required by federal or state legislation. No language will be changed so as to conflict with that required by the laws of your state. A range of variable amounts with respect to the Schedule of Benefits has been developed and is also enclosed, as is a statement of variability with respect to information contained in the policy/certificate.

Company and Contact

Filing Contact Information

Sue Joslyn, Compliance Analyst III
 5109 Ten Point Trail
 Wake Forest, NC 27587

sue.joslyn@af-group.com
 919-554-0686 [Phone]
 919-554-2513 [FAX]

Filing Company Information

American Fidelity Assurance Company
 2000 North Classen Blvd
 Oklahoma City, OK 73106
 (405) 523-2000 ext. [Phone]

CoCode: 60410
 Group Code:
 Group Name:
 FEIN Number: 73-0714500

State of Domicile: Oklahoma
 Company Type: LAH
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: \$50 for filing policy/certificate
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Fidelity Assurance Company	\$50.00	12/03/2009	32456240

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/17/2009	12/17/2009

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	12/10/2009	12/10/2009	Sue Joslyn	12/11/2009	12/11/2009

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Disposition

Disposition Date: 12/17/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Group Policy	Approved-Closed	Yes
Form (revised)	Group Certificate	Approved-Closed	Yes
Form	Group Certificate	Replaced	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 12/10/2009
Submitted Date 12/10/2009

Respond By Date

Dear Sue Joslyn,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Certificate, CG-530.SA(AR) (Form)

Comment:

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

Objection 2

- Group Certificate, CG-530.SA(AR) (Form)

Comment:

The policy/certificate must include a continuation of coverage provision that complies with ACA 23-86-114.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 12/11/2009
Submitted Date 12/11/2009

Dear Rosalind Minor,

Comments:

This is in response to your objection letter dated 12-10-09.

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Response 1

Comments: 1) Per 23-86-108(4) and your request, the handicapped child provision has been revised to remove the time limits for furnishing proof of incapacity. See revised pages 39 and 40 of the policy and page 39 of the certificate.

Related Objection 1

Applies To:
 - Group Certificate, CG-530.SA(AR) (Form)
 Comment:

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

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Certificate	CG-530.SA(A R)		Certificate	Initial		46.000	AR Certificate CG-530.SA(A R)(12-10-09 rev).pdf

Previous Version

Group Certificate	CG-530.SA(A R)		Certificate	Initial		46.000	AR Certificate CG-530.SA(A R).pdf
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No Rate/Rule Schedule items changed.

Response 2

Comments: 2) With respect to continuation of coverage pursuant to 23-86-114, the provision had not been included with the original filing since COBRA continuation would be more liberal than that required by the state statute. However, the forms have been revised to include the state continuation provision. See revised page 40 of the policy and page 39 of the certificate.

Related Objection 1

Applies To:

- Group Certificate, CG-530.SA(AR) (Form)

Comment:

The policy/certificate must include a continuation of coverage provision that complies with ACA 23-86-114.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Certificate	CG-530.SA(A R)		Certificate	Initial		46.000	AR Certificate CG-530.SA(A R)(12-10-09 rev).pdf
Previous Version							
Group Certificate	CG-530.SA(A R)		Certificate	Initial		46.000	AR Certificate CG-

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Product Name: FOS G-530.SA
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530.SA(A
R).pdf

No Rate/Rule Schedule items changed.

We trust this provides a satisfactory response to your objections. Thank you.

Sincerely,
Sue Joslyn

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/17/2009)	G-530.SA(AR)	Policy/Contract Certificate	Group Fraternal Certificate	Initial		46.000	AR Policy G-530.SA(AR).pdf AR Consumer Notice.pdf
Approved-Closed 12/17/2009)	CG-530.SA(AR)	Certificate	Group Certificate	Initial		46.000	AR Certificate CG-530.SA(AR)(12-10-0-9 rev).pdf

 **American Fidelity
Assurance Company**
A member of the American Fidelity Group

2000 North Classen Boulevard, Oklahoma City, Oklahoma 73106

POLICYHOLDER: [ABC Company]

POLICY NUMBER: [G-513.SA-9999]

American Fidelity Assurance Company (We, Us, Our) hereby certifies that it has issued and delivered to the Policyholder a group Policy, described in the Schedule of Benefits page. The group Policy covers certain eligible persons as described in the Policy. This booklet describes the benefits and provisions of the group Policy. The laws of the state of issue of the Policy govern the Policy. This booklet becomes your Certificate of insurance only if:

- (a) You are eligible for the insurance;
- (b) You are on Active Service on the date it is to take effect; and
- (c) You become insured in accordance with all of the provisions of the Policy.

The insurance is to be effective only if the required premium payments are made by You or on Your behalf to Us. (See Section 2, Eligibility and Effective Date provisions.) No agent may change the Policy or waive its provisions. This Certificate takes the place of any other Certificate previously issued to You under the group Policy. It should be kept in a safe place.

IN WITNESS WHEREOF American Fidelity Assurance Company has caused this Certificate to take effect on the Effective Date.


Secretary


President

**PLEASE READ THIS CERTIFICATE CAREFULLY.
THE HEALTH INSURANCE COVERAGE DESCRIBED HEREIN PROVIDES LIMITED BENEFITS;
IT DOES NOT PROVIDE COMPREHENSIVE COVERAGE.**

[WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.]

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SCHEDULE OF BENEFITS

SECTION 1 DEFINITIONS

GENERAL DEFINITIONS

The following definitions apply to all coverages provided under the Policy, as appropriate.

Accident (or **Accidental Injury**) means a sudden, unexpected and unintended event:

- (a) over which the Covered Person has no control; and
- (b) which results in bodily injury to a Covered Person; and
- (c) which is independent of any Sickness; and
- (d) which is caused by, or the result of, external means.

[Active Service] means that You are doing in the usual manner all of the regular duties of Your employment on a scheduled work day, and these duties are being done at one of the places of business where You normally do such duties, or at some location to which Your employment sends You.

You will be deemed to be in Active Service on each day You are actually performing services for the Policyholder, and on each day of regular paid vacation or on a regular non-working day, provided You are actively at work on the last preceding regular work day. With respect to any health coverage provided on an expense-incurred basis, You will also be deemed to be in Active Service on a day that You are absent from work during an approved leave under the Family and Medical Leave Act, or solely due to a Health Status-Related Factor.]

Calendar Year means the period from January 1 through December 31 of the same year.

Certificate means the individual certificate issued to You. It describes the coverage under the Policy.

Company (We, Us, Our) means American Fidelity Assurance Company.

Covered Person(s) means You and Your Dependents insured under the Policy.

Dependent means:

- (a) Your legally married spouse, or common law spouse (where permitted by law), [or Domestic Partner,] who lives with You; or
- (b) a natural, step, or adopted child of Yours. Such child must be under 25 years of age, and dependent on You for principal support and maintenance; or
- (c) a child placed for adoption with You, provided such child is under age 18 as of the date of placement, and would otherwise qualify under (b) above; or
- (d) notwithstanding any principal support and maintenance requirements, a child for whom You or Your covered spouse/common law spouse/[Domestic Partner] are required to provide coverage due to a Qualified Medical Child Support Order (QMCSO), provided such child would otherwise qualify under (b) above. A QMCSO will also include a judgment, decree, or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of law under state law and which satisfies the QMCSO requirements of ERISA (section 609[a]); or
- (e) a child who is not living with You, but for whom You are legally required to provide support, provided such child would otherwise qualify under (b) above.

The term Dependent does not include:

- (a) Your grandchild(ren); or
- (b) any child who is married.

[Domestic Partner] means a person of either sex who:

- (a) is at least 18 years of age; and
- (b) is competent to contract in his or her state of residency; and
- (c) shares the same residence as You; and
- (d) is not married to, legally separated from, or a domestic partner of, anyone else; and
- (e) is not related to You by blood in a way that would prevent marriage in their state of residency.

SECTION 1 DEFINITIONS

You and Your Domestic Partner must [be/have been] in an exclusive, committed relationship with each other [during the 12-month period immediately prior to enrollment for coverage, or] if You and Your Domestic Partner's state of residency provides for a registration process of domestic partnership:

- (a) neither You nor Your Domestic Partner may have previously registered as a Domestic Partner with Your state of residency, where such registration has not been terminated; and
- (b) both You and Your Domestic Partner must file such registration with respect to Your own relationship.]

Effective Date means, with respect to the Policy, the date the Policy becomes effective. With respect to each eligible person, Effective Date means the date such person's coverage takes effect under the Policy. The "Effective Date" will start at 12:01 a.m. at the main place of business of the Policyholder.

Enrollment Date means the Effective Date of coverage, or if earlier, the first day of any required waiting period.

Initial Eligibility Period means the 31-day period following completion of Your Waiting Period for Coverage, during which You may apply for coverage under the Policy.

Insured (You, Your) means any person who is eligible for insurance, as stated in the Schedule and described in Section 2, and is insured under the Policy by virtue of employment by the Policyholder.

[Normal Pay Date means the day of the week the Policyholder (or one of its subsidiaries) normally issues payroll. This date will remain the same regardless of a temporary change in the payday, which may occur due to holidays.]

Open Enrollment Period means that time each Plan Year that:

- (a) new enrollments may be made by existing employees; or
- (b) You may make changes to Your coverage election(s), or terminate coverage.

Physician means a practitioner of the healing arts who is practicing within the scope of his or her license in the state where so licensed.

The term Physician does not include a practitioner who:

- (a) is the Policyholder, or is employed or retained by the Policyholder; or
- (b) is living in the Covered Person's household; or
- (c) is related to the Covered Person by blood or marriage.

[Plan Year means the 12-month period the Policyholder establishes as the plan year for employee welfare benefits.]

Policy means the policy issued by Us to the Policyholder.

Policyholder means the employer who holds the Policy. The Policyholder is named on the face page of the Policy.

Schedule of Benefits (or Schedule) means the benefit schedule set forth in the Policy or Certificate.

Sickness means a bodily disorder, disease, physical or mental condition, functional nervous disorder, pregnancy, or Complication of Pregnancy:

- (a) that requires treatment by a Physician; and
- (b) for which treatment is rendered to such Covered Person.

SECTION 1 DEFINITIONS

The term Sickness, when used in connection with a newborn child, includes, but is not limited to:

- (a) prematurity;
- (b) congenital defects; and
- (c) birth abnormalities.

Special Enrollment Period means the [31-day/30-day] period that begins when a person is first eligible for Special Enrollment under HIPAA.

Total Disability (or **Totally Disabled**) means [You are unable to perform the material and substantial duties and functions of Your occupation. For a Dependent, "Totally Disabled" means] the inability to perform a majority of the normal activities of a person of like age who is in good health.

Waiting Period for Coverage means that period of time during which You must be continuously employed before Your coverage may begin. The Policyholder will determine the Waiting Period for Coverage, subject to Our underwriting guidelines and approval.

SECTION 1 DEFINITIONS

HEALTH INSURANCE

The following definitions apply to Health Insurance.

Complication of Pregnancy means:

- (a) Hospital confinement required to treat conditions such as the following:
 - (1) acute nephritis; or
 - (2) nephrosis; or
 - (3) cardiac decompensation; or
 - (4) HELLP syndrome; or
 - (5) uterine rupture; or
 - (6) amniotic fluid embolism; or
 - (7) chorioamnionitis; or
 - (8) fatty liver in pregnancy; or
 - (9) septic abortion; or
 - (10) placenta accreta; or
 - (11) gestational hypertension; or
 - (12) puerperal sepsis; or
 - (13) peripartum cardiomyopathy; or
 - (14) cholestasis in pregnancy; or
 - (15) thrombocytopenia in pregnancy; or
 - (16) placenta previa; or
 - (17) placental abruption; or
 - (18) acute cholecystitis and pancreatitis in pregnancy; or
 - (19) postpartum hemorrhage; or
 - (20) septic pelvic thrombophlebitis; or
 - (21) retained placenta; or
 - (22) venous air embolus associated with pregnancy; or
 - (23) miscarriage; or
 - (24) an emergency c-section required because of:
 - a. fetal or maternal distress during labor; or
 - b. severe pre-eclampsia; or
 - c. arrest of descent or dilatation; or
 - d. obstruction of the birth canal by fibroids or ovarian tumors; or
 - e. necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy.A c-section will not be considered to be an emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section; and
- (b) treatment, diagnosis or care for conditions, including the following, when the condition was caused by, necessary because of, or aggravated by the pregnancy:
 - (1) hyperthyroidism; or
 - (2) hepatitis B or C; or
 - (3) HIV; or
 - (4) Human Papilloma virus; or
 - (5) abnormal PAP; or
 - (6) syphilis; or
 - (7) Chlamydia; or
 - (8) herpes; or
 - (9) urinary tract infections; or
 - (10) thromboembolism; or
 - (11) appendicitis; or
 - (12) hypothyroidism; or
 - (13) pulmonary embolism, or
 - (14) sickle cell disease; or
 - (15) tuberculosis; or

SECTION 1 DEFINITIONS

- (16) migraine headaches; or
- (17) depression; or
- (18) acute myocarditis; or
- (19) asthma; or
- (20) maternal cytomegalovirus; or
- (21) urolithiasis; or
- (22) DVT prophylaxis; or
- (23) ovarian dermoid tumors; or
- (24) biliary atresia and/or cirrhosis; or
- (25) first trimester adnexal mass; or
- (26) hydatidiform mole; or
- (27) ectopic pregnancy.

Confinement (or Confined) means that period of time during any Hospital stay that the Covered Person is actually admitted on an inpatient basis, provided:

- (a) such Confinement is for at least 18 continuous hours in duration; and
- (b) at least one full day's room and board charge is made by the Hospital.

The term Confinement does not include that period of time during which a Covered Person is in:

- (a) a Hospital emergency room; or
- (b) an observation room; or
- (c) a free-standing surgical facility; or
- (d) an outpatient facility,

unless:

- (a) such Covered Person is admitted to the Hospital as an inpatient immediately thereafter; and
- (b) the conditions set forth for Confinement are met.

Covered Charges means those charges that:

- (a) are incurred by a Covered Person because of a covered Accident or Sickness; and
- (b) are for necessary treatment, services, and/or medical supplies, and are recommended by a Physician; and
- (c) are not more than:
 - (1) the Usual and Customary Charges; or
 - (2) the amount actually paid by or on behalf of the Covered Person and accepted by the provider for treatment, services and/or medical supplies provided; or
 - (3) any dollar limit set forth in the Schedule;and
- (d) are incurred while insured under the Policy, subject to any Extension of Benefits; and
- (e) are not excluded under Section 4, Exclusions.

Creditable Coverage means, with respect to an individual, coverage of an individual under:

- (a) a group health plan; or
- (b) health insurance coverage; or
- (c) Part A or Part B or Title XVIII of the Social Security Act (Medicare); or
- (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines); or
- (e) Chapter 55 of Title 10, United States Code (armed forces); or
- (f) a medical care program of the Indian Health Service, or of a tribal organization; or
- (g) a State health benefits risk pool; or
- (h) a health plan offered under Chapter 89 of Title 5, United States Code (U.S. government); or
- (i) a public health plan; or
- (j) a health benefit plan under Section 5(e) of the Peace Corps Act, 22 USC 2504(e).

Creditable Coverage does not mean:

SECTION 1 DEFINITIONS

- (a) accident only or disability income coverage; or
- (b) coverage issued as a supplement to liability insurance; or
- (c) liability insurance; or
- (d) Workers' Compensation or similar insurance; or
- (e) automobile medical payment insurance; or
- (f) credit only insurance; or
- (g) coverage for on-site medical clinics; or
- (h) other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

Deductible means the amount of Covered Charges, shown in the Schedule, for which We will pay no benefits during each Calendar Year.

Durable Medical Equipment means equipment which:

- (a) can withstand repeated use; and
- (b) is primarily and customarily used to serve a medical purpose; and
- (c) generally is not useful to a person in the absence of an illness or injury; and
- (d) is appropriate for use in the home.

Such equipment must:

- (a) be prescribed by the Covered Person's physician for the purpose of treating or accommodating an illness, injury, disease or its symptoms, in accordance with generally accepted standards of medical practice; and
- (b) be clinically appropriate, in terms of type, frequency, extent, site and duration and must be considered effective for the patient's illness, injury or disease,

and may not:

- (a) be primarily for the convenience of the patient, physician, or other health care provider; or
- (b) be more costly than an alternative service, sequence of services, device or equipment, at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease; or
- (c) be intended to be used for athletic or recreational activities as opposed to assisting the patient in the activities of daily living; or
- (d) be an additional feature or accessory, or is a non-standard or deluxe item that is primarily for the comfort and convenience of the patient (e.g., customized wheelchairs, electric vehicle lifts for wheelchairs, etc.); or
- (e) be a duplicative piece of equipment that is intended to be used as a backup device, for multiple residences, or for traveling, etc.

Health Status-Related Factor means any of the following:

- (a) health status; or
- (b) a medical condition (including both physical and mental illness); or
- (c) claims experience; or
- (d) receipt of health care; or
- (e) medical history; or
- (f) genetic information; or
- (g) evidence of insurability (including conditions arising out of acts of domestic violence); or
- (h) disability.

Hospital means a licensed institution that has on its premises:

- (a) permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician; and
- (b) 24-hour-a-day nursing service by graduate registered nurses; and
- (c) the patient's written history and medical records.

SECTION 1 DEFINITIONS

It shall also have laboratory, x-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians, or be accredited by the Joint Commission on Accreditation of Hospitals.

The term Hospital shall also include a duly licensed residential treatment facility for the treatment of mental or nervous Sickness, alcoholism, or drug abuse.

The term Hospital shall not include any institution used by the Covered Person as:

- (a) a place for rehabilitation; or
- (b) a place for rest or for the aged; or
- (c) a nursing or convalescent home; or
- (d) a long-term nursing unit or geriatrics ward; or
- (e) an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Intensive Care Unit (ICU) means an area of a Hospital that:

- (a) is kept separate from other Hospital facilities; and
- (b) is operated solely to give skilled care and treatment to critically ill patients; and
- (c) has special supplies and equipment necessary for immediate use; and
- (d) provides room, board, and constant observation and care by registered professional nurses or other highly-trained Hospital personnel.

Medical Condition means any condition, whether physical or mental, including, but not limited to:

- (a) any condition resulting from illness; or
- (b) injury (whether or not the injury is accidental); or
- (c) pregnancy; or
- (d) congenital malformation;

however, genetic information is not a Medical Condition.

Outpatient Surgical Facility means a facility that:

- (a) is licensed under the laws of the state in which it operates as an outpatient surgical center;
- (b) has an organized medical staff of Physicians; and
- (c) has permanent facilities that are equipped and operated for the main purpose of performing surgery; and
- (d) has continuous Physician and registered professional nursing services when a patient is in the facility; and
- (e) does not provide services or accommodations for patients to stay overnight.

The term Outpatient Surgical Facility shall include:

- (a) a freestanding outpatient surgical center; and
- (b) the outpatient surgical section of a Hospital; and
- (c) a Hospital emergency room.

The term Outpatient Surgical Facility shall not include a Physician's office.

[Pre-Existing Condition means a disease, injury, or physical, mental or nervous condition for which a Covered Person:

- (a) had treatment; or
- (b) incurred expense; or
- (c) took medication; or
- (d) received a diagnosis or advice from a Physician,

at any time during the six-month period immediately before the Enrollment Date of such Covered Person's coverage.

The term Pre-Existing Condition will also include conditions which are related to such disease, injury, or physical, mental or nervous condition.]

Prosthesis means an artificial device to replace or augment a missing or impaired part of the body.

SECTION 1 DEFINITIONS

The term Prosthesis does not include:

- (a) wigs and hair pieces for androgenetic alopecia (also known as male pattern baldness); or
- (b) any device or item used purely for cosmetic reasons, except:
 - (1) external or internal breast prostheses required as the result of a medically necessary mastectomy; or
 - (2) wigs or hairpieces (synthetic, human-hair, or blends) prescribed by a Physician as a prosthesis for hair loss due to injury, disease, or treatment of a disease, for the following conditions:
 - a. burns (2nd degree full thickness and 3rd degree burns with resulting permanent alopecia); or
 - b. lupus; or
 - c. alopecia areata with near complete or complete cranial hair loss; or
 - d. alopecia totalis; or
 - e. alopecia universalis; or
 - f. fungal infections not responsive to an appropriate (typically 6-week) course of antifungal treatment resulting in near complete or complete cranial hair loss; or
 - g. chemotherapy; or
 - h. radiation therapy;

Regular Care and Attendance means that the Covered Person is personally seen by a Physician each day of his or her Confinement.

Usual and Customary means those expenses for services and/or supplies essential to the care of a Covered Person which will be considered reasonable and customary if they are the amount normally charged by the service provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the geographic area where the services or supplies are received, per industry-accepted guidelines. In determining whether expenses are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications, unusual or extenuating circumstances.

[DENTAL INSURANCE

The following definitions apply to Dental Insurance.

Covered Charges means those charges that:

- (a) are incurred by a Covered Person because of a covered Accident or Sickness; and
- (b) are for necessary treatment, services, and/or medical supplies, and are recommended by a Physician; and
- (c) are not more than the Usual and Customary Charges, or the actual billed charge, or any dollar limit set forth in the Schedule; and
- (d) are incurred while insured under the Policy, subject to any Extension of Benefits; and
- (e) are not excluded under Section 4, Exclusions.

Creditable Coverage means, with respect to an individual, coverage of an individual under:

- (a) a group health plan; or
- (b) health insurance coverage; or
- (c) Part A or Part B or Title XVIII of the Social Security Act (Medicare); or
- (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines); or
- (e) Chapter 55 of Title 10, United States Code (armed forces); or
- (f) a medical care program of the Indian Health Service, or of a tribal organization; or
- (g) a State health benefits risk pool; or
- (h) a health plan offered under Chapter 89 of Title 5, United States Code (U.S. government); or
- (i) a public health plan; or

SECTION 1 DEFINITIONS

- (j) a health benefit plan under Section 5(e) of the Peace Corps Act, 22 USC 2504(e).

Creditable Coverage does not mean:

- (a) accident only or disability income coverage; or
- (b) coverage issued as a supplement to liability insurance; or
- (c) liability insurance; or
- (d) Workers' Compensation or similar insurance; or
- (e) automobile medical payment insurance; or
- (f) credit only insurance; or
- (g) coverage for on-site medical clinics; or
- (h) other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

Deductible means the amount of Covered Charges, shown in the Schedule, for which We will pay no benefits during each Calendar Year.

Dental Hygienist means a person trained and licensed by the state to perform dental prophylaxis under the direction of a Dentist.

Dentist means a person who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his or her license. For the purpose of this definition, a Physician will be considered to be a Dentist only when he or she performs any of the dental services described herein, and is operating within the scope of his or her license.

Health Status-Related Factor means any of the following:

- (a) health status; or
- (b) a medical condition (including both physical and mental illness); or
- (c) claims experience; or
- (d) receipt of health care; or
- (e) medical history; or
- (f) genetic information; or
- (g) evidence of insurability (including conditions arising out of acts of domestic violence); or
- (h) disability.

Medical Condition means any condition, whether physical or mental, including, but not limited to:

- (a) any condition resulting from illness; or
- (b) injury (whether or not the injury is accidental); or
- (c) pregnancy; or
- (d) congenital malformation;

however, genetic information is not a Medical Condition.

[Pre-Existing Condition means a disease, injury, or physical, mental or nervous condition for which a Covered Person:

- (a) had treatment; or
- (b) incurred expense; or
- (c) took medication; or
- (d) received a diagnosis or advice from a Physician,

at any time during the six-month period immediately before the Enrollment Date of such Covered Person's coverage.

The term Pre-Existing Condition will also include conditions which are related to such disease, injury, or physical, mental or nervous condition.]

Usual and Customary means those expenses for services and/or supplies essential to the care of a Covered Person which will be considered reasonable and customary if they are the amount normally

SECTION 1 DEFINITIONS

charged by the service provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the geographic area where the services or supplies are received, per industry-accepted guidelines. In determining whether expenses are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications, unusual or extenuating circumstances.]

[DISABILITY INCOME INSURANCE

The following definitions apply to Disability Income Insurance.

Disability Benefit means the weekly disability benefit for which You are eligible and paying premium.

Elimination Period means that period of time that starts after Your Effective Date of coverage, during which:

- (a) You are Totally Disabled; and
- (b) no Disability Benefit is payable.

Mental Illness means a psychiatric or psychological condition, regardless of cause, including but not limited to:

- (a) schizophrenia; and/or
- (b) depression; and/or
- (c) manic depressive or bipolar illness; and/or
- (d) anxiety; and/or
- (e) personality disorders; and/or
- (f) adjustment disorders or other conditions, usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

The term Mental Illness does not apply to dementia, if due to:

- (a) stroke; or
- (b) trauma; or
- (c) viral infection; or
- (d) Alzheimer's disease; or
- (e) other such conditions not listed above which are not usually treated by a mental health provider using psychotherapy, psychotropic drugs, or other similar modalities.

[Pre-Existing Condition means a disease, injury, or physical, mental or nervous condition for which a Covered Person:

- (a) had treatment; or
- (b) incurred expense; or
- (c) took medication; or
- (d) received a diagnosis or advice from a Physician,

at any time during the 12-month period immediately before the Effective Date of such Covered Person's coverage.

The term Pre-Existing Condition will also include conditions which are related to such disease, injury, or physical, mental or nervous condition.]

Regular Care and Attendance means that You are attended by a Physician at least once a month, or until the Physician determines You:

- (a) have reached a state where continuous medical care is unnecessary; and
- (b) are still Totally Disabled.

Successive Disabilities means those disabilities which result from the same or related causes for which benefits are payable under the Policy.

**SECTION 1
DEFINITIONS**

Weekly Base Compensation means Your weekly salary at the time of disability, including reported tips, exclusive of bonus or overtime earnings. If any weekly Disability Benefit is to be paid for less than a full week, the amount will be reduced pro rata on the basis that one day's benefit equals one-seventh (1/7th) of the Disability Benefit.]

SECTION 2 ELIGIBILITY AND EFFECTIVE DATE

[EMPLOYEE RE-ENROLLMENT ELIGIBILITY

[If Your coverage ends due to missed premium deductions, You may not re-enroll except during an Open Enrollment Period, or during a Special Enrollment Period.]

[If You voluntarily end coverage, You must satisfy a 24-month waiting period before becoming eligible for re-enrollment. You may then re-enroll during the 31-day period immediately following such 24-month waiting period, or during an Open Enrollment Period [or Special Enrollment Period] that follows the end of the 24-month waiting period.]

EMPLOYEE EFFECTIVE DATE

[Your Effective Date is the first day of the month following Your enrollment, provided:

- (a) Your enrollment process is complete; and
- (b) You were on Active Service as of the date coverage was to take effect;
- (c) if any portion of the premium is contributory, the first payroll deduction was made for Your coverage under the Policy; and
- (d) Your first premium has been accepted by Us./

Your Effective Date is the first day after the Normal Pay Date for which the first payroll deduction is taken for coverage under the Policy, provided:

- (a) Your enrollment process was complete; and
- (b) You were on Active Service as of the date coverage was to take effect; and
- (c) Your first premium has been accepted by Us./

Your Effective Date is [*as agreed upon between Us and the Policyholder*], provided:

- (a) Your enrollment process was complete; and
- (b) You were on Active Service as of the date coverage was to take effect; and
- (c) if any portion of the premium is contributory, the first payroll deduction was made for Your coverage under the Policy; and
- (d) Your first premium has been accepted by Us.]

DEPENDENT ELIGIBILITY

If You did not enroll Your Dependent(s) at the time of Your enrollment, Your Dependent(s) is/are eligible for enrollment for Dependent coverage (where available under the Policy) during an Open Enrollment Period, or during a Special Enrollment Period under HIPAA, as described at the end of this Section.

All dependents to be enrolled must meet the definition of Dependent, as stated in Section 1, except as described under Handicapped Child below.

[Domestic Partner]

Before coverage can be made effective for a Domestic Partner, You (and Your Domestic Partner, if required) must complete and sign the applicable employer-provided documentation regarding such relationship.]

Handicapped Child [(Applicable only to Health Insurance[and Dental Insurance.])]

Your handicapped child who is over the limiting age is eligible for enrollment if he or she has Creditable Coverage, unless there was a break in coverage of 63 days or more.

SECTION 2
ELIGIBILITY AND EFFECTIVE DATE

Dual Eligibility

In no event may a person be covered more than once under the Policy.

[Contributory Employee Coverage (You pay all or part of Your premium.)

If You or Your spouse/common law spouse[/Domestic Partner]:

- (a) are both eligible for coverage under the Policy as Insureds; and
- (b) have no Dependent children,

then:

- (a) You and Your spouse/common law spouse[/Domestic Partner] may both elect individual (employee only) coverage; or
- (b) either You or Your spouse/common law spouse[/Domestic Partner] may elect coverage for both (with the other spouse/common law spouse[/Domestic Partner] being covered as a Dependent), and the other spouse/common law spouse[/Domestic Partner] may not enroll for coverage.

If both You and Your spouse/common law spouse[/Domestic Partner]:

- (a) are eligible for coverage under the Policy as Insureds; and
- (b) have Dependent children,

either You or Your spouse/common law spouse[/Domestic Partner] (but not both) may elect Dependent coverage, and such Dependent coverage will not apply to the other spouse/common law spouse[/Domestic Partner.]

[Non-Contributory Employee Coverage (Employer pays 100% of Your premium.)

If You and Your spouse/common law spouse[/Domestic Partner]:

- (a) are both eligible for coverage under the Policy as Insureds; and
- (b) have no Dependent children,

You and Your spouse/common law spouse[/Domestic Partner] will both be covered as employees. Dependent coverage is not available or applicable in this situation.

If both You and Your spouse/common law spouse[/Domestic Partner]:

- (a) are eligible for coverage under the Policy as Insureds; and
- (b) have Dependent children,

You and Your spouse/common law spouse[/Domestic Partner] will both be covered as employees. Either You or Your spouse/common law spouse[/Domestic Partner] (but not both) may elect Dependent coverage, and such Dependent coverage will not apply to the other spouse/common law spouse[/Domestic Partner].

If an eligible employee has a Dependent child who is also eligible as an employee, both You and Your Dependent child will be covered as employees. If the employee elects Dependent coverage, such Dependent coverage will not apply to any Dependent child who is already covered as an employee.]

Dual Eligibility / Divorce [or Dissolution of Partnership]

If both You and Your spouse/common law spouse[/Domestic Partner] are covered as Insureds under the Policy, and have covered Dependent children, and later:

- (a) become divorced; [or
- (b) Your partnership is dissolved,]

the required conditions in the definition of Dependent (e.g., residence, support and maintenance) will be used to determine which parent may cover the Dependent(s). Any child who was a step-child of Yours will no longer be eligible for coverage, unless You have adopted such child.

Dual Eligibility / Termination of Employment

If You and Your spouse/common law spouse[/Domestic Partner] are covered as Insureds under the Policy and one of You terminates employment, the remaining employee will be permitted to immediately enroll the terminating spouse/common law spouse[/Domestic Partner] and any of his or her eligible Dependents who were enrolled under the terminating spouse/common law spouse[/Domestic Partner's] coverage. Such new coverage will be deemed continuation of prior coverage, and will not operate to

**SECTION 2
ELIGIBILITY AND EFFECTIVE DATE**

reduce or increase any coverage to which the person was entitled while enrolled as the employee or the Dependent of the terminated employee.

DEPENDENT ENROLLMENT

Dependent coverage may be elected by You:

- (a) completing the enrollment process for Dependent coverage within 31 days of the date the Dependent becomes eligible; and
- (b) authorizing the employer to deduct any required premium for Dependent coverage from Your paycheck.

Dependent coverage will not be made effective if enrollment is not complete.

DEPENDENT EFFECTIVE DATE

[The Effective Date for each eligible Dependent will be the first day of the month following his or her enrollment, provided:

- (a) such Dependent's enrollment process is complete; and
- (b) the first payroll deduction is made for such Dependent's coverage under the Policy; and
- (c) the first premium for such Dependent has been accepted by Us. /

The Effective Date for each eligible Dependent will be the first day after the Normal Pay Date for which the first payroll deduction is taken for such Dependent's coverage under the Policy, provided:

- (a) such Dependent's enrollment process is complete; and
- (b) the first premium for such Dependent has been accepted by Us. /

The Effective Date for each eligible Dependent will be *[as agreed upon between Us and the Policyholder]*, provided:

- (a) such Dependent's enrollment process is complete; and
- (b) the first payroll deduction is made for such Dependent's coverage under the Policy; and
- (c) the first premium for such Dependent has been accepted by Us.]

However, if on such date Your coverage has not yet taken effect, the Effective Date for Dependent coverage will be the same date Your coverage goes into effect.

Your newborn child will become insured for Accident or Sickness automatically on the day he or she is born, as long as Your coverage is in force on that date. The newborn child's coverage will not continue past the 90-day period following birth unless:

- (a) We are notified by the end of that 90-day period of the addition of such newborn or adopted child; and
- (b) any applicable additional premium is paid.

Your adopted child will become insured on:

- (a) the date of the filing of a petition for adoption if You apply for coverage and pay the applicable premium within 60 days after filing such petition; or
- (b) the moment of birth if the petition for adoption is filed and application for coverage, along with payment of the applicable premium is made, within 60 days after the birth.

[Applicable to Term Life Insurance and Vision Insurance only: If a Dependent is Totally Disabled on the date coverage (with respect to that particular Dependent) would otherwise take effect, the coverage of such Dependent will be deferred until the [first of the month/next payroll deduction period] following the Dependent's cessation of Total Disability.]

SPECIAL ENROLLMENT UNDER HIPAA (Health Insurance Portability and Accountability Act of 1996)

Special Enrollment under HIPAA is not applicable to:

- [(a) Term Life/Accidental Death and Dismemberment Insurance, Disability Income Insurance, or Vision Insurance; or

SECTION 2 ELIGIBILITY AND EFFECTIVE DATE

- (b)] Domestic Partners or same-sex spouses, or the dependents of such Domestic Partners or same-sex spouses.

Eligibility for Special Enrollment

An employee or Dependent is eligible for Special Enrollment under HIPAA if:

- (a) coverage under the Policy was declined when initially offered, due to such person having coverage under any group health plan or health insurance coverage; and
- (b) such person has now lost that coverage.

An employee or Dependent is also eligible for Special Enrollment under HIPAA if the employee:

- (a) gains a dependent child due to birth, adoption, or placement of a child with the employee for the purpose of adoption; or
- (b) marries.

Conditions for Special Enrollment

Loss of eligibility for coverage that is not COBRA continuation coverage

An employee may enroll during a Special Enrollment Period if loss of coverage was as the result of:

- (a) legal separation or divorce;
- (b) a reduction in the number of hours of employment;
- (c) termination of HMO (or other arrangement) in the individual market due to the employee no longer residing, living, or working in the covered service area;
- (d) termination of HMO (or other arrangement) in the group market due to the employee no longer residing, living, or working in the covered service area, and if no other benefit package is available to the employee;
- (e) incurring a claim that would meet or exceed a lifetime limit on all benefits; or
- (f) a situation in which a plan no longer offers any benefits to the class of similarly situated individuals, such class including the employee.

A Dependent may be enrolled during a Special Enrollment Period if loss of coverage was as the result of:

- (a) legal separation or divorce;
- (b) such Dependent's cessation of dependent status (e.g., attaining the maximum age to be eligible as a dependent child under the plan);
- (c) death of an employee;
- (d) termination of employment;
- (e) a reduction in the number of hours of employment;
- (f) termination of HMO (or other arrangement) in the individual market due to the employee no longer residing, living, or working in the service area;
- (g) termination of HMO (or other arrangement) in the group market due to the employee no longer residing, living, or working in the service area, and if no other benefit package is available to the employee;
- (h) incurring a claim that would meet or exceed a lifetime limit on all benefits; or
- (i) a situation in which a plan no longer offers any benefits to the class of similarly situated individuals, such class including the employee.

Special Enrollment is not available under any of the above conditions if loss of coverage is due to:

- (a) failure to pay premiums on a timely basis; or
- (b) termination of coverage due to cause (e.g., making a fraudulent claim, or an intentional misrepresentation of fact in connection with the plan).

Termination of employer contributions for coverage that is not COBRA continuation coverage

An employee or Dependent may enroll during a Special Enrollment Period if an employer's contributions towards the employee's or Dependent's coverage terminates. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or Dependent.

SECTION 2 ELIGIBILITY AND EFFECTIVE DATE

Exhaustion of COBRA continuation coverage

An employee or Dependent may enroll during a Special Enrollment Period if such person's COBRA continuation coverage was exhausted due to:

- (a) such person reaching the end of their maximum continuation period;
- (b) the failure of the employer or other responsible entity to remit premiums on a timely basis;
- (c) such person no longer residing, living, or working in the service area of an HMO or similar program, and there is no other COBRA continuation coverage available to such person;
- (d) such person incurring a claim that would meet or exceed a lifetime limit on all benefits, and there is no other COBRA continuation coverage available to such person.

Special Enrollment is not available under any of the above conditions if loss of coverage is due to:

- (a) failure to pay premiums on a timely basis; or
- (b) termination of coverage due to cause (e.g., making a fraudulent claim, or an intentional misrepresentation of fact in connection with the plan).

Marriage, birth, adoption, or placement for adoption

An employee or Dependent may enroll during a Special Enrollment Period if the employee:

- (a) gains a dependent child due to birth, adoption, or placement of a child for the purpose of adoption; or
- (b) marries.

Effective Date for Special Enrollment

With respect to a person whose coverage becomes effective as a result of a Special Enrollment under HIPAA, such coverage shall become effective:

- (a) in the case of marriage, the [first day of the first month following the] date of marriage; or
- (b) in the case of an eligible Dependent's birth, as of the date of such birth; or
- (c) in the case of an eligible Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption,

provided the usual Effective Date conditions are satisfied, as stated in EMPLOYEE EFFECTIVE DATE and/or DEPENDENT EFFECTIVE DATE above.

SECTION 3 BENEFIT PROVISIONS

HEALTH INSURANCE *(Applicable only if this coverage is not excluded in the Schedule.)*

We will pay Covered Charges for a service or supply that is described under one or more of the following listed categories of benefits, subject to any and all applicable maximum dollar and/or durational amounts. The service or supply must be provided for a covered Accident or Sickness. All benefit amounts and any applicable Deductibles, Coinsurance amounts, Co-payments, and maximums are shown in the Schedule.

Inpatient Benefits

Inpatient Benefits are payable for services and supplies that are provided to a Covered Person while Confined in a Hospital.

Room and Board Benefit

We will pay this benefit when a Covered Person is charged for room and board, regardless of the level of care (e.g. semi-private, private, intensive care). No benefit will be paid during any period such Covered Person is not under the Regular Care and Attendance of a Physician.

[Daily Hospital Indemnity Benefit (Not applicable to Dependents.)

If an Insured is Confined in a Hospital, We will pay the Daily Hospital Indemnity Benefit amount for each day of Confinement, for up to the Maximum Number of Days of Confinement. No benefit will be paid during any period the Covered Person is not under the Regular Care and Attendance of a Physician.]

Inpatient Physician Non-Surgical Services Benefit

We will pay this benefit for non-surgical services rendered by a Physician, including but not limited to:

- (a) regular consults and exams by the attending Physician; and
- (b) consults and exams by Physician specialists; and
- (c) readings and interpretations of diagnostic laboratory tests, screenings, and x-rays.

Inpatient Physician Surgical Services Benefit

We will pay this benefit for surgical services rendered on an inpatient basis by a Physician for a covered surgery.

If two or more surgical procedures are performed through the same incision or the same operative field, payment will be made only for the procedure of the larger benefit. If more than one procedure is performed, but each through separate incisions or in a separate operative field, the amount payable will be the benefit amount for the primary procedure, plus 50% of the amount payable for all other surgical procedures performed.

Inpatient Anesthetic Services and Anesthesia Benefit

We will pay this benefit for:

- (a) Physician's services for administration of anesthesia when the anesthesia is provided in connection with a covered surgery performed on an inpatient basis; and
- (b) the cost of such anesthesia.

This benefit is also payable with respect to dental surgical procedures only if such procedure is performed in a Hospital and the Covered Person:

- (a) is a child or adolescent who:
 - (1) is determined by a licensed dentist to require necessary dental treatment in a Hospital or ambulatory surgical center due to a significantly complex dental condition, or a developmental disability in which patient management in the dental office has proved to be ineffective; or
 - (2) is extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred, and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;

or

SECTION 3 BENEFIT PROVISIONS

- (b) has extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or
- (c) is one for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy; or
- (d) has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

Inpatient Miscellaneous Services and Supplies

We will pay this benefit for other covered services and supplies, including but not limited to:

- (a) facility charges other than room and board (e.g. recovery room); and
- (b) nursing services; and
- (c) treatment by radiologists and physiotherapists; and
- (d) therapy services; and
- (e) oxygen, and the equipment for its administration; and
- (f) blood and blood plasma, and its processing costs; and
- (g) medications and other pharmaceutical products, including associated supplies and administration; and
- (h) non-durable medical supplies (e.g. bandages, casts, splints); and
- (i) diagnostic laboratory tests, screenings, and x-rays; and
- (j) testing of newborns for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and other newborn tests which may become mandated by law; and
- (k) hospice services.

Outpatient Benefits

We will pay benefits for covered services and supplies received on an Outpatient basis that are not payable under another listed Benefit. This includes, but is not limited to:

- (a) outpatient facilities, such as ambulatory surgical centers or emergency care clinics (whether free-standing or located within a Hospital); and
- (b) treatment by radiologists and physiotherapists; and
- (c) therapy services; and
- (d) diagnostic laboratory tests, screenings, and x-rays; and
- (e) oxygen, and the rental equipment for its administration; and
- (f) medications and other pharmaceutical products, none of which are obtainable through a written prescription. This includes:
 - (1) nutritional supplements for the treatment and management of phenylketonuria and other inheritable diseases; and
 - (2) childhood immunizations, including their administration (exempt from deductible, coinsurance, or co-payments); and
 - (3) medications and supplies for the treatment of cancer, including their administration; and
 - (4) medications and supplies for the treatment of diabetes, including their administration, and supplies for the prevention of complications associated with diabetes;
- and
- (g) hospice services; and
- (h) non-durable medical supplies (e.g., bandages, casts, splints); and
- (i) any type of contraceptive, including its administration. (Contraceptives obtainable through a written prescription are payable under the Prescription Drug Card Benefit.)

[Benefits for services and supplies received while in an Emergency Room, for the treatment of Sickness, are payable only under the Emergency Room Sickness Benefit.]

[Benefits for services and supplies received while in an Emergency Room, for the treatment of an Accident, are payable under the Supplemental Accident Benefit.]

SECTION 3 BENEFIT PROVISIONS

Outpatient Physician Non-Surgical Services Benefit

We will pay this benefit for each time a Covered Person is charged for non-surgical services by a Physician during an office visit, or for a home health care visit. This benefit is also payable for visits for:

- (a) contraceptive services; and
- (b) diabetes self-management training; and
- (c) readings and interpretations of diagnostic laboratory tests, screenings, and x-rays; [and
- (d) treatment of loss or impairment of speech and hearing; and
- (e) well-child exams from birth through age 18, which includes up to 20 visits at approximately the following intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years; and
- (f) in-vitro fertilization, subject to the following:
 - (1) the patient is a Covered Person under the Policy and is insured for pregnancy benefits; and
 - (2) the patient's oocytes are fertilized only with the sperm of the Covered Person's spouse; and
 - (3) the patient and patient's spouse have a history of unexplained infertility of at least two years' duration; or
 - (3) the infertility is associated with one or more of the following:
 - a. endometriosis; or
 - b. exposure in utero to diethylstilbestrol (DES); or
 - c. blockage of or surgical removal of one or both fallopian tubes, not a result of voluntary sterilization; or
 - d. abnormal male factors contributing to the infertility; and
 - (4) the patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the Policy; and
 - (5) the in vitro fertilization procedures are performed at a medical facility that conforms to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimum standards for programs of in vitro fertilization;]

Outpatient Physician Surgical Services Benefit

We will pay this benefit for surgical services rendered on an outpatient basis by a Physician for a covered surgery.

If two or more surgical procedures are performed through the same incision or the same operative field, payment will be made only for the procedure of the larger benefit. If more than one procedure is performed, but each through separate incisions or in a separate operative field, the amount payable will be the benefit amount for the primary procedure, plus 50% of the amount payable for all other surgical procedures performed.

Outpatient Anesthetic Services and Anesthesia Benefit

We will pay this benefit for:

- (a) Physician's services for administration of anesthesia when the anesthesia is provided in connection with a covered surgery performed on an outpatient basis; and
- (b) the cost of such anesthesia.

This benefit is also payable with respect to dental surgical procedures only if such procedure is performed in an ambulatory surgical center and the Covered Person:

- (a) is a child or adolescent who:
 - (1) is determined by a licensed dentist to require necessary dental treatment in a Hospital or ambulatory surgical center due to a significantly complex dental condition, or a developmental disability in which patient management in the dental office has proved to be ineffective; or

SECTION 3 BENEFIT PROVISIONS

- (2) is extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred, and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;
- or
- (b) has extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or
- (c) is one for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy; or
- (d) has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

[Additional Benefits

These are separate benefits that do not count towards the Inpatient Maximum Benefit or the Outpatient Maximum Benefit, and are not subject to any other stated Deductible, Coinsurance, Co-Payment, or any other limitation, other than what is stated in the Schedule with respect to each benefit.]

[Hospital Admission Indemnity Benefit

We will pay this lump sum benefit once for each period of Confinement.]

[Intensive Care Unit Indemnity Benefit

We will pay this lump sum benefit once for each day of Confinement in an Intensive Care Unit of a Hospital.]

[Emergency Room Sickness Benefit

We will pay this benefit for each episode of care received in a Hospital emergency room, for the treatment of Sickness. No other benefit is payable under the Policy for services or supplies received, or for facility charges made, for care received in a Hospital emergency room, for the treatment of Sickness.]

[Supplemental Accident Benefit

We will pay this benefit for covered services and supplies received by a Covered Person, for the treatment of injury due to an Accident, but only after any and all other benefits are paid under the Policy. Charges for such services and supplies must be incurred within 90 days of the Accident. Outpatient prescription drugs are not included in this benefit, and are payable only under the Prescription Drug Card Benefit.]

[Wellness Benefit (applicable only to Covered Persons age 18 years or older)

We will pay this benefit for the following, when used for wellness purposes:

- (a) Physician office visits (including expense of administration of immunizations); and
- (b) x-ray and laboratory tests, including, but not limited to:
 - (1) mammograms; and
 - (2) pap smears; and
 - (3) CA-125 tests; and
 - (4) PSA tests/prostate cancer screening (not subject to any deductible); and
 - (5) urine tests; and
 - (6) bone mass tests; and
 - (7) blood tests; and
 - (8) colorectal cancer screening.]

[Prescription Drug Card Benefit

We will pay this benefit for each complete fill or refill of a medication or supply that is:

- (a) obtainable only with a written prescription; and
- (b) dispensed by a pharmacy.]

This benefit includes contraceptives.

SECTION 3 BENEFIT PROVISIONS

Durable Medical Equipment and Prosthesis Benefit

We will pay this benefit for:

- (a) equipment for the monitoring and treatment of diabetes (e.g. blood glucose monitors, insulin pumps, insulin infusion devices); and
- (b) hearing aids (not subject to any deductibles or co-payments); and
- (c) the purchase or rental of Durable Medical Equipment; and
- (d) the expense of a Prosthesis. This includes, but is not limited to external or internal breast prostheses required as the result of a medically necessary mastectomy.]

[TERM LIFE INSURANCE *(Applicable only if this coverage is not excluded in the Schedule.)*

If a Covered Person dies, We will pay the Death Benefit, subject to the provisions of the Policy. The amount of the Death Benefit is shown in the Schedule.

Payment of Death Benefit

With respect to Your death, payment of the Death Benefit will be made in a lump sum to the Beneficiary named by You. If more than one Beneficiary has been named:

- (a) the Death Benefit will be paid in equal shares to all named, living Beneficiaries; or,
- (b) if Your Beneficiary election indicates a different proportion of benefit payment, the Death Benefit will be paid as instructed by You.

With respect to the death of a Dependent, payment of the Death Benefit will be made in a lump sum to You.

We may pay benefits to someone other than You or Your Beneficiary if:

- (a) You or Your Beneficiary is a minor, or cannot give a valid release; or
- (b) no request for payment has been made by a duly appointed guardian; or
- (c) the person to whom payment will be made appears to have assumed Your, or Your Beneficiary's, care and main support.

We may pay up to \$250.00, or the maximum amount permitted by state law, whichever is greater, to any person appearing to be entitled to such payment by reason of having incurred funeral or other expenses incident to the last illness or death of the Covered Person.

Any payment We make is done so in good faith; it will fully discharge Us for the amount of such payment.]

[Naming and Changing a Beneficiary

You may name a Beneficiary to whom the Death Benefit will be paid. If You did not name a Beneficiary, or if there is no living Beneficiary at the time of Your death, the order of Beneficiary determination is as follows:

- (a) Your lawful spouse or common law spouse [or Domestic Partner]; then
- (b) Your child or children (in equal shares); then
- (c) Your parent or parents (in equal shares); then
- (d) Your brother(s) and/or sister(s) (in equal shares); then
- (e) Your estate.

For purposes of this provision, child, parent, brother and sister includes step or adopted child(ren), step-parent(s), step-brother(s) and step-sister(s), respectively.

You may name a new Beneficiary from time to time. The consent of the existing Beneficiary is not needed to make this or any other change in the Policy. (If the Beneficiary has been named irrevocable, see the next paragraph.) You must file a written request for the change. The change will not take effect until We receive and approve the request at Our home office. When received and approved, the change goes back to and takes effect as of the date such request was made. This will happen even if You die between the time the request is made and it is received and recorded by Us. However, any amount paid prior to receiving and recording such request will not be subject to the request for change.]

[If You apply for a conversion policy or apply for a different amount of insurance and name a new Beneficiary on that application, this will be considered a request for a change of Beneficiary. This means

SECTION 3 BENEFIT PROVISIONS

that the change in Beneficiary will apply to the Policy as well as to the conversion policy, even though the conversion policy itself or the changed amount may not yet have taken effect. (For more details about conversion, see the following Conversion Privilege provision.)

Irrevocable Beneficiary

You can make an irrevocable Beneficiary designation. This means that You give up the right to change the Beneficiary. You can get this right back if:

- (a) the Beneficiary gives written consent; or
- (b) the Beneficiary dies.

If an irrevocable Beneficiary designation is in effect, the rules about changing the Beneficiary stated above do not apply.

Conversion Privilege *(The Conversion Privilege is available only if We have a policy form approved in the Covered Person's state of residence, at the time application for conversion is made.)*

If insurance, or any portion of it, on a Covered Person ends because of:

- (a) Your termination of employment; or
- (b) Your termination of membership in a class eligible for coverage,

such Covered Person may convert to an individual life policy if:

- (a) written application is made for the individual policy; and
- (b) the first premium for the individual policy is paid to Us,

within 31 days after the date of termination.

The individual policy will be subject to the following conditions:

- (a) Proof of good health will not be required.
- (b) The policy will not have any disability or other supplementary benefits.
- (c) The Covered Person can choose any form, except term insurance, then in use by Us.
- (d) The amount cannot be more than the amount of life insurance which ceases because of such termination.
- (e) The rate will be Our customary rate, based on the form, the amount, the Covered Person's class of risk, and age at the time the individual policy takes effect.]

[Subject to the above conditions, the conversion privilege will also be available to:

- (a) a surviving Dependent, if any, upon Your death; and (This applies only to coverage under the Policy which terminates by reason of such death.)
- (b) Your Dependent, if termination of coverage is due to the Dependent no longer meeting the definition of Dependent. (This applies only if Dependent coverage terminates while You remain covered under the Policy.)

If insurance on any Covered Person stops because:

- (a) the Policy terminates; or
- (b) the Policy is changed so that a class of insured persons is terminated,

such person can convert; however, the Covered Person must have been insured under the Policy for at least five years immediately preceding the date of termination of insurance. Conversion is subject to the same rules outlined above, except the amount will not exceed the lesser of:

- (a) the amount of insurance ceasing; or
- (b) \$10,000.00.

If the Covered Person dies during the 31-day period in which he or she is entitled to a conversion policy but before such plan takes effect, an amount of life insurance shall be payable. The amount shall be that which the Covered Person would have been entitled to have issued under the conversion policy. The amount shall be payable as a claim under the Policy, whether or not application or premium payment on the conversion policy has been made.

This conversion privilege is in lieu of all other benefits under the Policy. The effective date of the conversion plan will be the 32nd day after the date that premiums were paid to under the Policy.

**SECTION 3
BENEFIT PROVISIONS**

If You have assigned all ownership rights absolutely to an assignee, then the assignee (instead of You) is entitled to exercise the conversion privilege.

You will be given notice of Your conversion right at least 15 days before the end of the 31-day conversion period. If such notice is not given, You have an additional period of time to exercise Your right. This period ends 15 days after the date You are given notice, but in no event shall the additional period extend beyond 60 days after the original 31-day period (for a total of 91 days). In no event, however, will insurance under the Policy be continued beyond the original 31-day period.

Notice shall mean written notice that is given or mailed to the You. Notice may be mailed by the Policyholder, or by Us, to Your last known address.

If You become Totally Disabled while covered under this Life Insurance Benefit, this coverage may be continued during the Total Disability subject to timely payment of the premium that You were required to pay had the Total Disability not occurred. Continued coverage will end the earlier of:

- (a) six months from the date the Total Disability began; or
- (b) discontinuance of the Policy; or
- (c) You cease to be Totally Disabled.

[ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE—Not applicable to Dependents.
(Applicable only if this coverage is not excluded in the Schedule.)

If You suffer loss of life, sight or limb(s) due to an accidental bodily injury, We will pay an Accidental Death and Dismemberment Benefit for such loss if the following conditions are met:

- (a) The loss must result directly from an injury. The injury must be caused by an Accident that occurs while the Policy is in force.
- (b) The loss must occur no later than 90 days after the date the injury was received.
- (c) The loss must not be excluded.
- (d) The loss of a hand or foot means the permanent severance at or above the wrist or ankle joint.
- (e) The loss of sight means total and irrecoverable loss of sight.

The benefit amount payable for a loss, which meets the conditions stated above, is as follows:

For Loss of Life.....	100% of the Principal Sum
For Loss of One Hand.....	50% of the Principal Sum
For Loss of One Foot	50% of the Principal Sum
For Loss of Sight of One Eye	50% of the Principal Sum
For Loss of more than one of the above in any one Accident	100% of the Principal Sum]

[The "Principal Sum" is the amount shown in the Schedule. Only one of the amounts, the greatest, will be paid for more than one loss resulting from the same accident.]

[DENTAL INSURANCE. *(Applicable only if this benefit is not excluded in the Schedule.)*

If a Covered Person incurs Covered Charges for dental expenses, We will pay the benefit amount shown in the Schedule of Dental Benefits, according to the Expense Class shown in such Schedule of Dental Benefits. A charge is incurred on the date that treatment is given, service is rendered, or a supply is furnished. The benefit amount is subject to:

- (a) the Calendar Year Deductible; and
- (b) the Calendar Year Maximum; and
- (c) the Alternative Benefits provision; and
- (d) all other applicable provisions of the Policy.

Unlisted Treatment, Services or Supplies

Benefits for treatment, services or supplies not listed in the Schedule of Dental Benefits will be determined by Us. The benefit will be based upon the extent and type of damage, and nature of materials used.

**SECTION 3
BENEFIT PROVISIONS**

Alternative Benefits

If various types of treatment are available, the Covered Dental Expenses will be limited to the Dental Service Benefit payable for the least expensive treatment that will produce a professionally adequate result as determined by Us.]

**SECTION 3
BENEFIT PROVISION**

[SCHEDULE OF DENTAL BENEFITS

SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS
DIAGNOSTIC & EVALUATION		
Office Visit	D0999	A
Periodic Oral Exam	D0120	A
Limited Oral Exam – Problem Focused	D0140	A
Comprehensive Oral Exam – Under age 3	D0145	A
Comprehensive Oral Exam – Age 3 or older	D0150	A
Extensive Oral Exam – Problem Focused	D0160	A
Reevaluation – Limited, Problem Focused	D0170	A
Comprehensive Periodontal Exam	D0180	A
Intraoral – Complete Series	D0210	A
Intraoral – Periapical – 1st Film	D0220	A
Intraoral – Periapical – Each Additional Film	D0230	A
Intraoral – Occlusal Film	D0240	A
Extraoral – 1st Film	D0250	A
Extraoral – Each Additional Film	D0260	A
Bitewing – 1 Film	D0270	A
Bitewing – 2 Films	D0272	A
Bitewing – 3 Films	D0273	A
Bitewing – 4 Films	D0274	A
Vertical Bitewings	D0277	A
Panoramic Film	D0330	A
Caries Susceptibility Test	D0425	A
Biopsy and Exam of Oral Tissue, Hard	D0430	A
Pulp Vitality Tests	D0460	A
Diagnostic Casts	D0470	A
PREVENTATIVE		
Prophylaxis – Age 14 or older	D1110	A
Prophylaxis – Under age 14	D1120	A
Fluoride (Prophylaxis Not Included) – Under age 19	D1203	A
Fluoride (Prophylaxis Not Included) – Age 19 or older	D1204	A
Sealant – Per Tooth	D1351	A
Space Maintainer – Fixed – Unilateral	D1510	A
Space Maintainer – Fixed – Bilateral	D1515	A
Space Maintainer – Removable – Unilateral	D1520	A
Space Maintainer – Removable – Bilateral	D1525	A
Re-cementation of Space Maintainer	D1550	A
RESTORATIVE DENTISTRY		
Amalgam – 1 Surface, Permanent	D2140	A
Amalgam – 2 Surfaces, Permanent	D2150	A
Amalgam – 3 Surfaces, Permanent	D2160	A
Amalgam – 4+ Surfaces, Permanent	D2161	A
Resin Composite – 1 Surface, Anterior	D2330	A
Resin Composite – 2 Surfaces, Anterior	D2331	A
Resin Composite – 3 Surfaces, Anterior	D2332	A
Resin Composite – 4+ Surfaces, Anterior	D2335	A
Resin Composite – 1 Surface, Posterior	D2391	A
Resin Composite – 2 Surfaces, Posterior	D2392	A
Resin Composite – 3 Surfaces, Posterior	D2393	A
Resin Composite – 4+ Surfaces, Posterior	D2394	A
Gold Foil – 1 Surface	D2410	B
Gold Foil – 2 Surfaces	D2420	B
Gold Foil – 3 Surfaces	D2430	B

SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS
ONLAYS, CROWNS, BRIDGES		
Inlay – Metallic – 1 Surface	D2510	B
Inlay – Metallic – 2 Surfaces	D2520	B
Inlay – Metallic – 3+ Surfaces	D2530	B
Onlay – Metallic – 2 Surfaces	D2542	B
Onlay – Metallic – 3 Surfaces	D2543	B
Onlay – Metallic – 4+ Surfaces	D2544	B
Inlay – Porcelain/Ceramic – 1 Surface	D2610	B
Inlay – Porcelain/Ceramic – 2 Surfaces	D2620	B
Inlay – Porcelain/Ceramic – 3+ Surfaces	D2630	B
Onlay – Porcelain/Ceramic – 2 Surfaces	D2642	B
Onlay – Porcelain/Ceramic – 3 Surfaces	D2643	B
Onlay – Porcelain/Ceramic – 4+ Surfaces	D2644	B
Inlay – Resin Composite – 1 Surface	D2650	B
Inlay – Resin Composite – 2 Surfaces	D2651	B
Inlay – Resin Composite – 3+ Surfaces	D2652	B
Onlay – Resin Composite – 2 Surfaces	D2662	B
Onlay – Resin Composite – 3 Surfaces	D2663	B
Crown – Resin – Laboratory	D2710	B
Crown – Resin with High Noble Metal	D2720	B
Crown – Resin with Base Metal	D2721	B
Crown – Resin with Noble Metal	D2722	B
Crown – Porcelain/Ceramic Substrate	D2740	B
Crown – Porcelain with High Noble Metal	D2750	B
Crown – Porcelain with Predominantly Base Metal	D2751	B
Crown – Porcelain With Noble Metal	D2752	B
Crown – 3/4 Cast High Noble Metal	D2780	B
Crown – 3/4 Cast Predominantly Base Metal	D2781	B
Crown – 3/4 Cast Noble Metal	D2782	B
Crown – 3/4 Porcelain/Ceramic	D2783	B
Crown – Full Cast High Noble Metal	D2790	B
Crown – Full Cast Predominantly Base Metal	D2791	B
Crown – Full Cast Noble Metal	D2792	B
Re-cement Inlay	D2910	A
Re-cement Crown	D2920	A
Core Build Up, Including any Pins	D2950	B
Pin Retention – Per Tooth, in Addition to Restoration	D2951	B
Cast Post and Core, in Addition to Crown	D2952	B
Cast Post and Core, Each Additional (Same Tooth)	D2953	B
Prefabricated Post and Core, in Addition to Crown	D2954	B
Each Additional Prefabricated Post, same tooth	D2957	B
Temporary Crown (fractured tooth)	D2970	B
Crown Repair	D2980	B
ENDODONTICS		
Pulp Cap – Direct	D3110	A
Pulp Cap – Indirect	D3120	A
Therapeutic Pulpotomy	D3220	A
Pulpal Debridement, Primary/Permanent	D3221	A
Pulpal Therapy – Anterior, Primary Tooth	D3230	A
Pulpal Therapy – Posterior, Primary Tooth	D3240	A
Root Canal – Anterior	D3310	B]

**SECTION 3
BENEFIT PROVISION**

[SCHEDULE OF DENTAL BENEFITS

SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS
Root Canal – Bicuspid	D3320	B
Root Canal – Molar	D3330	B
Retreatment of Previous RCT – Anterior	D3346	B
Retreatment of Previous RCT – Bicuspid	D3347	B
Retreatment of Previous RCT – Molar	D3348	B
Apexification/Recalcification – Initial Visit	D3351	B
Apexification/Recalcification – Interim Visit	D3352	B
Apexification/Recalcification – Final Visit	D3353	B
Apicoectomy/Periradicular – Anterior	D3410	B
Apicoectomy/Periradicular – Bicuspid, 1st Root	D3421	B
Apicoectomy/Periradicular – Molar, 1st Root	D3425	B
Apicoectomy/Periradicular, Each Additional Root	D3426	B
Retrograde Filling – Per Root	D3430	B
Root Amputation – Per Root	D3450	B
Hemisection (Including any Root Removal)	D3920	B
PERIODONTICS		
Gingivectomy/Gingivoplasty – 4+ teeth/quad	D4210	B
Gingivectomy/Gingivoplasty – 1-3 teeth/quad	D4211	B
Gingival Flap – Incl. Root Planing – 4+ teeth/quad	D4240	B
Gingival Flap – Incl. Root Planing – 1-3 teeth /quad	D4241	B
Crown Lengthening – Hard Tissue	D4249	B
Osseous Surgery – 4+ teeth/quad	D4260	B
Osseous Surgery – 1-3 teeth/quad	D4261	B
Pedicle Soft Tissue Graft Procedure	D4270	B
Free Soft Tissue Graft Procedure	D4271	B
Subepithelial Connective Tissue Graft Procedure	D4273	B
Distal/Proximal Wedge Procedure (no surgery)	D4274	B
Soft Tissue Allograft	D4275	B
Combined Connective Tissue/Double Pedicle Graft	D4276	B
Provisional Intracoronal Splint	D4320	B
Provisional Extracoronal Splint	D4321	B
Perio. Scaling & Root Planing – 4+ teeth/quad	D4341	B
Perio. Scaling & Root Planing – 1-3 teeth /quad	D4342	B
Full Mouth Debridement	D4355	B
Periodontal Maintenance Procedures	D4910	A
REMOVABLE PROSTHETICS		
Complete Denture – Upper	D5110	B
Complete Denture – Lower	D5120	B
Immediate Denture – Upper	D5130	B
Immediate Denture – Lower	D5140	B
Upper Partial Denture – Resin Base	D5211	B
Lower Partial Denture – Resin Base	D5212	B
Upper Partial – Cast Metal Frame, Resin Base	D5213	B
Lower Partial – Cast Metal Frame, Resin Base	D5214	B
Removable Unilateral Partial – 1 Piece Cast Metal	D5281	B
Adjust Complete Denture – Upper	D5410	A
Adjust Complete Denture – Lower	D5411	A

SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS
Adjust Partial Denture – Upper	D5421	A
Adjust Partial Denture – Lower	D5422	A
Repair Broken Complete Denture Base	D5510	A
Replace Missing or Broken Teeth, Complete Denture – Per Tooth	D5520	A
Repair Resin Denture Base, Complete Denture	D5610	A
Repair Cast Framework	D5620	A
Repair or Replace Broken Clasp	D5630	A
Replace Broken Teeth, Complete Denture – Per Tooth	D5640	A
Add Tooth to Existing Partial Denture	D5650	A
Add Clasp to Existing Partial Denture	D5660	A
Replace All Teeth and Acrylic on Cast Metal Framework (Upper)	D5670	A
Replace All Teeth and Acrylic on Cast Metal Framework (Lower)	D5671	A
Rebase Complete Upper Denture	D5710	A
Rebase Complete Lower Denture	D5711	A
Rebase Upper Partial Denture	D5720	A
Rebase Lower Partial Denture	D5721	A
Reline Complete Upper Denture (Chairside)	D5730	A
Reline Complete Lower Denture (Chairside)	D5731	A
Reline Upper Partial Denture (Chairside)	D5740	A
Reline Lower Partial Denture (Chairside)	D5741	A
Reline Complete Upper Denture (Laboratory)	D5750	A
Reline Complete Lower Denture (Laboratory)	D5751	A
Reline Upper Partial Denture (Laboratory)	D5760	A
Reline Lower Partial Denture (Laboratory)	D5761	A
Tissue Conditioning – Upper	D5850	A
Tissue Conditioning – Lower	D5851	A
PONTICS		
Pontic – Cast High Noble Metal	D6210	B
Pontic – Cast Predominantly Base Metal	D6211	B
Pontic – Cast Noble Metal	D6212	B
Pontic – Porcelain With High Noble Metal	D6240	B
Pontic – Porcelain With Predom Base Metal	D6241	B
Pontic – Porcelain With Noble Metal	D6242	B
Pontic – Porcelain/Ceramic	D6245	B
Retainer – Cast Metal or Resin Bonded Fixed Prosthesis	D6545	B
Retainer – Porcelain/Ceramic or Resin Bonded Fixed Prosthesis	D6548	B
Inlay – Porcelain/Ceramic, 2 Surfaces	D6600	B
Inlay – Porcelain/Ceramic, 3+ Surfaces	D6601	B
Inlay – Cast High Noble Metal, 2 Surfaces	D6602	B
Inlay – Cast High Noble Metal, 3+ Surfaces	D6603	B
Inlay – Cast Predom. Base Metal, 2 Surfaces	D6604	B
Inlay – Cast Predom. Base Metal, 3+ Surfaces	D6605	B
Inlay – Cast Noble Metal, 2 Surfaces	D6606	B
Inlay – Cast Noble Metal, 3+ Surfaces	D6607	B
Onlay – Porcelain/Ceramic, 2 Surfaces	D6608	B]

**SECTION 3
BENEFIT PROVISION**

[SCHEDULE OF DENTAL BENEFITS

SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS	SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS
Onlay – Porcelain/Ceramic, 3+ Surfaces	D6609	B	Surg. Exp. Of Impacted/Unerupted Tooth-Aid Erup	D7281	A
Onlay – Cast High Noble Metal, 2 Surfaces	D6610	B	Biopsy of Oral Tissue – Hard (Bone, Tooth)	D7285	A
Onlay – Cast High Noble Metal, 3+ Surfaces	D6611	B	Biopsy of Oral Tissue – Soft (All Others)	D7286	A
Onlay – Cast Predom. Base Metal, 2 Surfaces	D6612	B	Alveoplasty in Conjunction w/Extract-Per Quad	D7310	A
Onlay – Cast Predom. Base Metal, 3+ Surfaces	D6613	B	Alveoplasty not in Conjunct w/Extract-Per Quad	D7320	A
Onlay – Cast Noble Metal, 2 Surfaces	D6614	B	Vestibuloplasty-Ridge Ext (2nd Epithelialization)	D7340	B
Onlay – Cast Noble Metal, 3+ Surfaces	D6615	B	Vestibuloplasty-Ridge Ext (Grafts, Hypertissue)	D7350	B
Crown – Resin With High Noble Metal	D6720	B	Excision of Malignant Tumor-up to 1.25 cm	D7440	B
Crown – Resin With Base Metal	D6721	B	Excision of Malignant Tumor - > than 1.25cm	D7441	B
Crown – Resin With Noble Metal	D6722	B	Removal of Odontogenic Cyst/Tumor <=1.25cm	D7450	B
Crown – Porcelain/Ceramic Substrate	D6740	B	Removal of Odontogenic Cyst/Tumor > 1.25cm	D7451	B
Crown – Porcelain With High Noble Metal	D6750	B	Removal of Nonodontogenic Cyst/Tumor<=1.25cm	D7460	B
Crown – Porcelain With Predom Base Metal	D6751	B	Removal Nonodontogenic Cyst/Tumor> 1.25cm	D7461	B
Crown – Porcelain With Noble Metal	D6752	B	Removal of Lateral Exostosis – Per Site	D7471	B
Crown – 3/4 Cast High Noble Metal	D6780	B	Removal of Torus Palatinus	D7472	B
Crown – 3/4 Cast Predominantly Base Metal	D6781	B	Removal of Torus Mandibularus	D7473	B
Crown – 3/4 Cast Noble Metal	D6782	B	Surgical Reduction of Osseous Tuberosity	D7485	B
Crown – Full Cast High Noble Metal	D6790	B	Incision/Drain of Abscess – Intraoral Soft Tissue	D7510	A
Crown – Full Cast Predominantly Base Metal	D6791	B	Incision/Drain of Abscess – Extraoral Soft Tissue	D7520	A
Crown – Full Cast Noble Metal	D6792	B	Removal of Foreign Body, Skin, or Subc. Areolar Tissue	D7530	A
Re-cement Fixed Partial Denture	D6930	A	Sequestrectomy for Osteomyelitis	D7550	B
Cast Post and Core in Addition to Fixed Partial Denture Retainer	D6970	B	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body	D7560	B
Prefabricated Post and Core in Addition to Fixed Partial Denture Repair	D6972	B	Suture of Recent Small Wounds up to 5cm	D7910	B
Core Build Up for Retainer, Including any Pins	D6973	B	Frenulectomy (Frenectomy or Frenotomy), sep. proc.	D7960	B
Each Additional Cast Post – Same Tooth	D6976	B	Excision of Hyperplastic Tissue – Per Arch	D7970	B
Each Additional Prefabricated Post – Same Tooth	D6977	B	Excision of Pericoronal Gingiva	D7971	B
Fixed Partial Denture Repair	D6980	B	Surgical Reduction of Fibrous Tuberosity	D7972	B
ORAL SURGERY			Sialolithotomy	D7980	B
Coronal Remnants – Deciduous Tooth	D7111	A	Closure of Salivary Fistula	D7983	B
Extraction – Erupted Tooth or Exposed Root	D7140	A	MISCELLANEOUS SERVICES		
Surgical Removal of Erupted Tooth	D7210	A	Palliative (Emergency) Treatment of Pain	D9110	A
Removal of Impacted Tooth, Soft Tissue	D7220	A	General Anesthesia– First 30 Minutes	D9220	B
Removal of Impacted Tooth, Partially Bony	D7230	A	General Anesthesia– Each Additional 15 Minutes	D9221	B
Removal of Impacted Tooth, Completely Bony	D7240	A	IV Sedation/Analgesia – First 30 Min	D9241	B
Surgical Removal of Residual Tooth Roots	D7250	A	IV Sedation/Analgesia – Each Additional 15 Minutes	D9242	B
Oroantral Fistula Closure	D7260	A	Non-IV Conscious Sedation	D9248	B]
Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Teeth/Alveolus	D7270	B			
Tooth Transplantation and/or Stabilization	D7272	B			
Surgical Exp. Of Impacted/Unerupted Tooth-Ortho	D7280	A			

SECTION 3 BENEFIT PROVISION

[DISABILITY INCOME INSURANCE—Not applicable to Dependents.

(Applicable only if this coverage is not excluded in the Schedule.)

If You become Totally Disabled, We will pay a Disability Benefit, as shown in the Schedule, provided You are under the Regular Care and Attendance of a Physician.

Total Disability:

- (a) must be due to a covered Accident or Sickness; and
- (b) must begin while Your coverage is in force; and
- (c) will be considered to have started on the date You first receive personal treatment from a Physician, following continuous cessation of work.

Disability Benefits will be paid:

- (a) for only one disability when:
 - (1) more than one disability exists at the same time; or
 - (2) a disability results from two or more causes,
and
- (b) for each period of Total Disability that continues beyond the Elimination Period, not to exceed the Maximum Disability Period stated in the Schedule.

Successive Disabilities will be considered one period of disability unless separated by Your return to:

- (a) Active Service; or
- (b) any other occupation,

for at least [90 days]. A disability due to a different or unrelated cause will be considered a new period of disability.

Any disability that begins after termination of coverage:

- (a) will not be considered a Successive Disability; and
- (b) will not be covered under the Policy.

Any change in the Disability Benefit will apply only to new periods of disability that begin on or after such date.

Mental Illness / Limited Benefit

If You become Totally Disabled due to a Mental Illness, We will pay Disability Benefits for up to the Maximum Mental Illness Period shown in the Schedule.

Alcoholism and Drug Addiction / Limited Benefit

If You become Totally Disabled due to alcoholism or drug addiction, We will pay Disability Benefits for up to the Maximum Alcoholism/Drug Addiction Period shown in the Schedule.]

[VISION INSURANCE *(Applicable only if this coverage is not excluded in the Schedule.)*

If a Covered Person incurs charges for:

- (a) an eye examination; or
- (b) eyeglass lenses and/or frames, or contact lenses,

We will pay the applicable benefit shown in the Schedule. A charge is incurred on the date that treatment is given, service is rendered, or a supply is furnished.]

SECTION 4 EXCLUSIONS AND LIMITATIONS

HEALTH INSURANCE

With respect to Health Insurance, no benefits will be payable for, or as the result of:

- (a) suicide or any attempt thereat, while sane or insane, or any intentionally self-inflicted injury or Sickness. This exclusion does not apply if the loss is as a result of a Medical Condition, or an act of domestic violence; or
- (b) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner, within the scope of authority; or
- (c) committing, attempting to commit, or taking part in, a felony or assault; or engaging in an illegal occupation; or
- (d) participation in a contest of speed in power-driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding; or
- (e) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the Covered Person is not covered; or
- (f) air travel, except:
 - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
 - (2) as a passenger for transportation only and not as a pilot or crew member;or
- (g) experimental drugs, devices, treatments or surgery; or drugs or devices labeled "Caution - limited by federal law to investigational use." A treatment, procedure, or therapy will not be judged experimental if, at the time it is provided or performed:
 - (1) it is judged effective for treatment of the covered injury or Sickness; and
 - (2) it is approved by the American Medical Association or the appropriate medical specialty society for such treatment. Approval must not be on a limited or experimental basis.

This exclusion does not apply to a drug on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved by the federal Food and Drug Administration (FDA), provided all of the following are met:

- (1) the drug is approved by the FDA; and
- (2) the drug is recognized for treatment of the condition by:
 - a. scientific studies published in a peer-reviewed national professional medical journal; or
 - b. standard reference compendia.

This exclusion also does not apply to a drug, device, treatment, procedure, or therapy provided during any phase of a clinical trial for the treatment, palliation, or prevention of recurrence of cancer or other life-threatening conditions, provided such clinical trial is:

- (1) recommended by the Covered Person's treating Physician; and
- (2) approved by:
 - (a) the U.S. Food and Drug Administration (in the form of an Investigational New Drug Application); or
 - (b) one of the National Institutes of Health (NIH); or
 - (c) an NIH cooperative group or center; or
 - (d) an NIH cooperative group research entity that meets the criteria for NIH support grant eligibility; or
 - (e) the Coalition of National Cancer Cooperative Groups; or
 - (f) a National Cancer Institute cooperative group or center; or
 - (g) a panel of qualified clinical research experts from academic health institutions; or
 - (h) the Centers for Disease Control and Prevention; or
 - (i) the Agency for Healthcare Research and Quality; or
 - (j) the Centers for Medicare and Medicaid Services; or
 - (k) the U.S. Department of Veterans Affairs; or
 - (l) the U.S. Department of Defense; or

**SECTION 4
EXCLUSIONS AND LIMITATIONS**

and

- (1) there is no clearly superior, non-investigational treatment alternative; and
- (2) the available clinical or pre-clinical data provides a reasonable expectation that the treatment will be more effective than the non-investigational treatment alternative.

Treatment provided in a clinical trial must provide a therapeutic effect, and participation in such clinical trial must offer meaningful potential for significant clinical benefit to the Covered Person;

or]

- (h) rest care or rehabilitative care and treatment; or
 - (i) cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to:
 - (1) cosmetic surgery resulting from an Accident, provided initial treatment of the Covered Person is begun within 12 months of the date of the Accident; or
 - (2) reconstruction incidental to or following surgery resulting from a covered Accident or Sickness; or
 - (3) with respect to a covered Dependent child, correction of a congenital defect that results in a functional defect; or
 - (4) with respect to a medically necessary mastectomy:
 - a. all stages of reconstruction of the breast on which the mastectomy has been performed; or
 - b. surgery and reconstruction of the other breast to produce a symmetrical appearance; or
 - c. prostheses and treatment of physical complications for all stages of the mastectomy, including lymphademas;
- or
- (j) dental services, including treatment, extractions or dental x-rays, except as provided as the result of, and within 12 months of, an Accident; or
 - (k) hearing examinations, hearing aids (unless provided under the Durable Medical Equipment and Prosthesis Benefit), or the fitting of hearing aids; or
 - (l) routine eye examinations, or the purchase or fitting of any corrective eyewear; or
 - (m) voluntary abortion except, with respect only to You or Your covered Dependent spouse/common law spouse/[Domestic Partner]:
 - (1) where such person's life would be endangered if the fetus were carried to term; or
 - (2) where medical complications have arisen from an abortion;
- or
- [(n) routine newborn care, including routine nursery charges, except for up to five days in a Hospital nursery or until the mother's discharge following birth, whichever is earlier; or
 - (o) pregnancy of a Dependent child; or]
 - (p) the reversal of tubal ligation or vasectomy; or
 - (q) sex changes; or
 - [(r) infertility treatment, artificial insemination, in vitro fertilization (except as provided in the Policy), and test tube fertilization, including any related testing, medications, or Physician's services; or
 - (s) any Accident occurring while the Covered Person is intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the geographical area where the Accident took place); or
 - (t) treatment of exogenous obesity or weight control; or gastric bypass procedure; or any other surgical procedure for control of weight; or]
 - (u) air or ground ambulance service; or

SECTION 4 EXCLUSIONS AND LIMITATIONS

- (v) accident or sickness:
 - (1) arising out of and in the course of any occupation for compensation, wage or profit; or
 - (2) which qualifies for payment under Occupational Disease Law or similar law, whether or not application for such benefits has been made. Denial of payment under Occupational Disease Law or similar law does not automatically imply that a claim is payable under the Policy;
- or
- (w) routine physical examinations and immunizations related to employment, obtaining insurance, team sports, travel, school, camp, or pre-marital exams, after any Wellness Benefits provided under the Policy have been exhausted; or
- (x) treatment received during a period of time that coverage is not in force with respect to the Covered Person; or
- (y) with respect to a non-emergency Hospital admission during which a surgical procedure is scheduled and performed: Confinement, or services or treatment received more than 24 hours prior to admission; or
- (z) treatment that is not medically necessary, unless excepted elsewhere in the Policy; or
- (aa) any service or supply that is not described under one or more of the categories of benefits listed in the Benefit Provisions section.

In addition to the Exclusions and Limitations for Health Indemnity Insurance, no benefits will be payable under the Prescription Drug Card Benefit for:

- (a) drugs and medicines which may be lawfully obtained without a Physician's prescription; or
- (b) drugs, medicines or insulin, in whole or in part, used by, administered to, or provided to, a Covered Person:
 - (1) during an outpatient Physician's office visit;
 - (2) during a visit to a Hospital emergency room or Outpatient Surgical Facility; or
 - (3) while Confined in a Hospital, rest home, sanatorium, extended care facility, convalescent hospital, nursing home or similar institution;
- or
- (c) immunization agents (shots), biological sera, blood, or blood plasma; or
- (d) a fill or refill of a prescription exceeding a 30-day supply.]

[Pre-Existing Condition Limitation

No benefits will be paid for expenses resulting from services, supplies or treatment of Pre-Existing Conditions for the first 12 months from the Covered Person's Enrollment Date of coverage under the Policy. This exclusion will not apply to:

- (a) pregnancy; or
- (b) a newborn child who, as of the last day of the 30-day period beginning with the date of birth, is covered under Creditable Coverage; or
- (c) a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage.

Any pre-existing condition limitation period previously satisfied under Creditable Coverage will be counted to satisfy the 12-month Pre-Existing Condition limitation under the Policy, unless there was a break in coverage of 63 days or more. Waiting periods under a plan are not considered a break in coverage.]

[TERM LIFE INSURANCE

With respect to Term Life Insurance, no benefits will be payable as the result of suicide or any attempt thereat, while sane or insane; or any intentionally self-inflicted injury or sickness, unless the Covered Person has been continuously insured under the Policy for two years.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

With respect to Accidental Death and Dismemberment Insurance, no benefits will be payable as the result of:

**SECTION 4
EXCLUSIONS AND LIMITATIONS**

- (a) suicide or any attempt thereat, while sane or insane, or any intentionally self-inflicted injury or sickness; or
- (b) infection or disease, whether the infection or disease is the proximate or contributing cause of the loss; or (This does not apply to pyogenic infections which occur through an accidental wound or cut.)
- (c) voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a licensed Physician; or (Accidental ingestion of a poisonous substance is not excluded.)
- (d) air travel, except:
 - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
 - (2) as a passenger for transportation only and not as a pilot or crew member;or
- (e) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss that occurs while acting in a lawful manner within the scope of authority; or
- (f) committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation; or
- (g) participation in a contest of speed in power-driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding; or
- (h) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the Covered Person is not covered; or
- (i) any Accident occurring while the Covered Person is intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the laws of the geographical area where the Accident took place); or
- (j) accident or sickness:
 - (1) arising out of and in the course of any occupation for compensation, wage or profit; or
 - (2) which qualifies for payment under Occupational Disease Law or similar law, whether or not application for such benefits has been made. Denial of payment under Occupational Disease Law or similar law does not automatically imply that a claim is payable under the Policy.]

[DENTAL INSURANCE

With respect to Dental Insurance, no benefits will be payable as the result of:

- (a) suicide or any attempt thereat, while sane or insane, or any intentionally self-inflicted injury or Sickness; or
- (b) cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to:
 - (1) cosmetic surgery resulting from an accident, if initial treatment of the Covered Person is begun within 12 months of the date of the accident; or
 - (2) reconstruction incidental to or following surgery resulting from a covered Accident or Sickness; or
 - (3) correction of a congenital defect that results in a functional defect of a covered Dependent child;or
- (c) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority; or
- (d) committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation; or
- (e) participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding; or

SECTION 4 EXCLUSIONS AND LIMITATIONS

- (f) air travel, except:
 - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
 - (2) as a passenger for transportation only and not as a pilot or crew member;or
- (g) any Accident occurring while the Covered Person is intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the geographical area where the Accident took place); or
- (h) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the Covered Person is not covered; or
- (i) accident or sickness:
 - (1) arising out of and in the course of any occupation for compensation, wage or profit; or
 - (2) which qualifies for payment under Occupational Disease Law or similar law, whether or not application for such benefits has been made. Denial of payment under Occupational Disease Law or similar law does not automatically imply that a claim is payable under the Policy;or
- (j) treatment that is not medically necessary, unless excepted elsewhere in the Policy; or
- (k) [Class B] expenses, until the Covered Person has been continuously insured under this dental plan (or the dental plan this plan replaced) for 12 consecutive months; or
- (l) treatment started before coverage began; or
- (m) charges for initial installation for dentures or bridgework to replace teeth extracted prior to when coverage began; or
- (n) replacement of existing dentures or bridgework less than five years old, or for replacement because of loss or theft; or
- (o) charges for orthodontics; or
- (p) charges for services with respect to congenital malformations (other than for a newborn child of Yours); or
- (q) charges for dental care which is covered under any other part of this plan; or
- (r) charges by anyone other than a Dentist, except for charges for dental prophylaxis performed by a Dental Hygienist, under the supervision and direction of a Dentist; or
- (s) charges for more than one fluoride treatment, one dental prophylaxis, or one bite-wing x-ray in any six-month period; or
- (t) charges for more than one complete mouth x-ray in any two-year period; or
- (u) charges which the Covered Person is not legally required to pay, or charges which would not have been made if no coverage had existed.

Pre-Existing Condition Limitation

No benefits will be paid for expenses resulting from services, supplies or treatment of Pre-Existing Conditions for the first 12 months from the Covered Person's Enrollment Date of coverage under the Policy. This exclusion will not apply to:

- (a) pregnancy; or
- (b) a newborn child who, as of the last day of the 30-day period beginning with the date of birth, is covered under Creditable Coverage; or
- (c) a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage.

Any pre-existing condition limitation period previously satisfied under Creditable Coverage will be counted to satisfy the 12-month Pre-Existing Condition limitation under the Policy, unless there was a break in coverage of 63 days or more. Waiting periods under a plan are not considered a break in coverage.]

[DISABILITY INCOME INSURANCE

SECTION 4 EXCLUSIONS AND LIMITATIONS

With respect to Disability Income Insurance, no benefits will be payable as the result of:

- (a) suicide or any attempt thereat, while sane or insane, or any intentionally self-inflicted injury or Sickness; or
- (b) cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom; or
- (c) voluntary abortion, except where Your life would be endangered if the fetus were carried to term, or where medical complications have arisen from an abortion; or
- (d) Mental Illness, alcoholism, or drug addiction, except as described in the Schedule; or
- (e) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss, which occurs while acting in a lawful manner within the scope of authority; or
- (f) committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation; or
- (g) participation in a contest of speed in power-driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding; or
- (h) air travel, except:
 - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
 - (2) as a passenger for transportation only and not as a pilot or crew member;or
- (i) any Accident occurring while You are intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the geographical area where the Accident took place); or
- (j) sex changes; or
- (k) the reversal of tubal ligation or vasectomy; or
- (l) treatment of exogenous obesity or weight control; or gastric bypass procedure, or any other surgical procedure for control of weight; or
- (m) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period You are not covered; or
- (n) accident or sickness:
 - (1) arising out of and in the course of any occupation for compensation, wage or profit; or
 - (2) which qualifies for payment under Occupational Disease Law or similar law, whether or not application for such benefits has been made. Denial of payment under Occupational Disease Law or similar law does not automatically imply that a claim is payable under the Policy.

Additionally, no Disability Benefit will be paid:

- (a) for any period in which You are not under the Regular Care and Attendance of a Physician; or
- (b) if You should fail to follow the medical treatment advice of Your Physician as it pertains to Your disabling condition; or
- (c) during any period in which You are incarcerated.

Pre-Existing Condition Limitation

No benefits will be paid for Total Disability resulting from a Pre-Existing Condition that begins before You have been continuously covered under the Policy for one year.]

[VISION INSURANCE

With respect to Vision Insurance, no benefits will be payable as the result of:

- (a) any intentionally self-inflicted injury or Sickness; or
- (b) treatment solely for cosmetic purposes, or complications therefrom; or

SECTION 4
EXCLUSIONS AND LIMITATIONS

- (c) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss, which occurs while acting in a lawful manner within the scope of authority; or
- (d) committing, attempting to commit, or taking part in a felony or assault; or engaging in an illegal occupation; or
- (e) participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding; or
- (f) accident or sickness:
 - (1) arising out of and in the course of any occupation for compensation, wage or profit; or
 - (2) which qualifies for payment under Occupational Disease Law or similar law, whether or not application for such benefits has been made. Denial of payment under Occupational Disease Law or similar law does not automatically imply that a claim is payable under the Policy;or
- (g) treatment that is not medically necessary, unless excepted elsewhere in the Policy; or
- (h) treatment received during a period of time that coverage is not in force with respect to the Covered Person; or
- (i) charges for an eye examination performed by, or eyeglasses or contact lenses prescribed by, someone other than an optometrist or ophthalmologist; or
- (j) charges for sunglasses, safety glasses, or goggles, whether plain or prescription; or
- (k) charges for non-prescription contact lenses; or
- (l) charges for any type of eye procedure or surgery, or vision charges that may be covered under any other part of the Policy; or
- (m) charges that the Covered Person is not legally required to pay, or charges that would not have been made if no coverage had existed.]

SECTION 5 TERMINATION OF INSURANCE

INSURED

Your insurance will end on the earliest of:

- (a) the last day of the [payroll deduction period/month] during which You cease to be a member of a class eligible for coverage as shown in the Schedule; or
- (b) the end of the last period for which premium payment has been made to Us; or
- (c) the date You die; or
- (d) the date the Policy terminates; or
- (e) the last day of the [payroll deduction period/month] during which You retire or are pensioned; or
- (f) the last day of the [payroll deduction period/month] during which You terminate employment.

[With respect to Disability Income Insurance, if:

- (a) Your coverage ends as a result of Your termination of Active Service; and
- (b) such termination is caused by an Accident or Sickness for which Disability Benefits would be payable; and
- (c) Total Disability is established prior to the termination of Active Service,

then Disability Benefits will be paid as if such termination had not occurred. Additionally, termination of the Policy will have no effect on payment of benefits for a Total Disability that begins before the Policy is terminated.]

DEPENDENT

The insurance on a Dependent will cease on the earliest of:

- (a) the date Your coverage terminates; or
- (b) the end of the last period for which premium payment has been made to Us; or
- (c) the date the Dependent dies; or
- (d) with respect to a Dependent spouse/common law spouse[/Domestic Partner], the date such spouse/common law spouse[/Domestic Partner]:
 - (1) becomes divorced from; or
 - (2) becomes legally separated from; [or
 - (3) terminates his or her domestic partnership from,]You; or
- (e) with respect to a Dependent child, the date such child attains age 25; or
- (f) with respect to a Dependent child who has been placed with You for purposes of adoption, the earlier of:
 - (1) the date on which the petition for adoption has been dismissed or denied; or
 - (2) the date on which the placement is disrupted prior to legal adoption, and the child is removed from placement with You;or
- (g) with respect to a Dependent child who has been provided coverage pursuant to a Qualified Medical Child Support Order (QMCSO), the earlier of:
 - (1) the end of the period for which the QMCSO has required that coverage be provided; or
 - (2) the date on which the QMCSO is terminated,unless such child is otherwise eligible for coverage under the Policy; or
- (h) with respect to a step-child of Yours who You have not adopted, the date You:
 - (1) become divorced from; or
 - (2) become legally separated from; [or
 - (3) terminate Your domestic partnership from,]Your spouse/common law spouse[/Domestic Partner]; or
- (i) the date the Policy is modified so as to exclude Dependent coverage.

SECTION 5 TERMINATION OF INSURANCE

Handicapped Children [(Applicable only to Health Insurance and Dental Insurance.)]

With respect to termination of a child's coverage due to attainment of age 25, coverage will not terminate if such child is incapable of self-support because of a mental or physical handicap; however:

- (a) such child must remain dependent on You for principal support and maintenance; and
- (b) at Our request and expense, proof of such incapacity and dependency must be furnished.

With respect to a mentally or physically handicapped child who was older than age 25 when he or she first became covered under the Policy, coverage will not terminate, unless You fail to provide proof of continuing incapacity.

FRAUD

We shall have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

EXTENSION OF BENEFITS [(Applicable only to Health Insurance and Dental Insurance.)]

Whenever termination of coverage under this section occurs because of termination of Your employment, such termination shall be without prejudice to:

- (a) any Hospital Confinement which commenced while Your coverage was in force, [with respect to Health Insurance Benefits]; or
- (b) any covered treatment or service for which benefits would be provided under the [Health Insurance or Dental Insurance benefits of the] Policy, and which commenced while Your coverage was in force;

provided; however, that the Covered Person is, and continues to be, Hospital Confined or Totally Disabled. Such Extension of Benefits shall continue for up to 30 days.

This Extension of Benefits provision will not apply during any time a Covered Person is covered under a similar group health plan.

CONTINUATION OF COVERAGE (Applicable only to Health Insurance)

If a Covered Person's coverage under the Policy terminates due to termination of employment or change in marital status, coverage under the Policy may be continued, subject to the following:

- (a) the Covered Person must have been continuously insured under the policy for three months immediately prior to termination of employment or change in marital status; and
- (b) continued coverage must be requested, in writing, within 10 days after termination of employment or change in marital status; and
- (c) coverage may be continued until any Pre-Existing Condition would be covered under another contract or until the earliest of the following:
 - (1) 120 days after continuation coverage began; or
 - (2) the end of the period for which timely contribution has been made; or
 - (3) eligibility for Medicare; or
 - (4) the Policy terminates.

In lieu of continuation coverage or when continuation coverage has been exhausted, a Covered Person may be eligible for conversion coverage. This provision applies to the extent that COBRA does not apply.

CONVERSION PRIVILEGE (Applicable only to Health Insurance)

A Covered Person whose coverage under the Policy has been terminated for any reason, including discontinuance of the Policy in its entirety, may be eligible for conversion coverage. Conversion will not be available if coverage was terminated due to the Covered Person's failure to pay any required contribution or if the Policy is replaced by similar coverage within 31 days.

A Covered Person will not be eligible for conversion coverage if he/she is eligible for:

- (a) Medicare; or
- (b) full coverage under another group policy.

Written application and the initial premium for conversion coverage must be made to the designated conversion insurance carrier within 30 days after termination of coverage under the Policy.

SECTION 6 PREMIUMS

PREMIUM MODE AND DUE DATE

Premiums are payable by a mode of payment that has been agreed upon between the Policyholder and Us.

All premiums are payable on or before the date they are due, by the Policyholder. Premiums are not considered paid until they are received by Us[, or Our designated agent for receipt of premium]. We will not be responsible for claims incurred by Covered Persons during any period for which full premiums have not been paid by the Policyholder.

[MISSED PREMIUMS

In the event Your paycheck is not sufficient to cover the full amount of the payroll deduction premium for coverage under the Policy, You will be given the opportunity to make up [all of the/one or more] consecutive missed premium deductions (the "Missed Premium Period"), provided the following conditions are met:

- (a) Premium deductions must resume no later than the 35th day after the last weekly payroll-deducted premium, or no later than the 42nd day after the last bi-weekly payroll-deducted premium.
- (b) Payment may only be made with:
 - (1) a cashier's check; or
 - (2) a money order; or
 - (3) a personal check for which there are sufficient funds.
- (c) Payment must be in the full amount due for the [missed deduction periods for which You are paying/entire Missed Premium Period].
- (d) The Company-provided remittance form (Missed Premium Deduction Form) must be included with payment. Such form must be filled out completely.
- (e) Payment must be mailed to Us[, or Our administrator].

[You will have the option to pay for the entire Missed Premium Period, or just a portion of it. If You choose to pay for just a portion of the Missed Premium Period, You must pay for consecutive missed premium deductions, beginning with the first missed premium deduction/You must pay for the entire Missed Premium Period.] If no payroll deduction has ever occurred for coverage under the Policy, or if a Covered Person is no longer eligible, coverage may not be maintained by direct premiums.

During any period for which there is a missed premium deduction, coverage on You and Your covered Dependents (if any) will be placed in a suspended status. Coverage will not be cancelled unless it remains in a suspended (unpaid) status for more than 35 consecutive days, if deductions are weekly, or 42 days, if deductions are bi-weekly. If this happens, coverage on You and Your covered Dependents, if any, will be cancelled in accordance with the Termination provisions stated in Section 5. If such cancellation occurs, You will not be eligible to enroll for coverage again except as provided in Section 2.

Any claims filed for services or expenses incurred while coverage is suspended will not be considered for payment; however, any period during which coverage is suspended will count towards satisfaction of any applicable Pre-Existing Condition limitation period.]

SECTION 7 CLAIMS PROVISIONS

NOTICE OF CLAIM

Written notice of claim must be given to Us [or to Our claims administrator]. Specific information regarding where to direct notice of claim is included on Your identification card for coverage under the Policy. Notice should be made within 60 days after any loss covered by the Policy. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay.

CLAIM FORMS

Claim forms should be used for filing proof of loss. They will be sent to the claimant within 15 days following Our receipt of notice of claim. If claim forms are not supplied within 15 days, a claimant can give proof in writing, setting forth the nature and extent of the loss. Proof submitted in this manner will remain subject to the time stated in the Proof of Loss provision.

PROOF OF LOSS

[With respect to Disability Income Insurance, proof of loss must be given to Us within 90 days after termination of the period for which We are liable. For any other loss,] proof of loss must be given to Us within 90 days after such loss. Late proof may be accepted if:

- (a) it was not reasonably possible to give proof in that time; and
- (b) the proof is given within one year from the date of loss. This one-year limit will not apply in the absence of legal capacity.

TIME OF PAYMENT OF CLAIM

[With respect to Disability Income Insurance, benefits will accrue and be paid monthly, subject to satisfactory written proof of such loss. Any balance not paid when liability ends will be paid immediately upon receipt of satisfactory written proof of such loss.]

Initial benefit determinations will be rendered by [Us / Our claims administrator] within 30 days. If there are special circumstances beyond Our control [and/or Our claims administrator's control], the initial benefit determination shall be rendered as soon as possible, but no later than 45 days after receipt of Your claim.

In the event You receive an adverse benefit determination, such adverse benefit determination will be explained in writing and the explanation will include:

- (a) the specific reason for the adverse benefit determination; and
- (b) reference to the specific policy provision upon which the adverse benefit determination was based; and
- (c) a description of any additional information You might be required to provide and an explanation of why it is needed; and
- (d) an explanation of Our claim review procedure.

You, a Dependent, a beneficiary, or a duly authorized representative may appeal any adverse benefit determination by filing a request for review to the claims administrator. In connection with such a request, documents pertinent to the administration of the Policy may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout this review procedure.

Health [, Dental, and Vision] Claims

If You receive an adverse benefit determination, Your request for review must be filed within 180 days after receipt of the written notice of adverse benefit determination. A decision will be rendered by Us no later than 30 days after receipt of Your request for review. The decision, after the review, shall be in writing and shall include specific references to the pertinent policy provisions upon which the decision was based.

[Disability and Accidental Dismemberment Claims

If You receive an adverse benefit determination, Your request for review must be filed within 180 days after receipt of the written notice of adverse benefit determination. A decision will be rendered by Us no later than 45 days after receipt of Your request for review. The decision, after the review, shall be in writing and shall include specific references to the pertinent policy provisions upon which the decision was based.

**SECTION 7
CLAIMS PROVISIONS**

Life and Accidental Death Claims

If You receive an adverse benefit determination, Your request for review must be filed within 90 days after receipt of the written notice of adverse benefit determination. A decision will be rendered by Us no later than 90 days after receipt of Your request for review. If there are special circumstances beyond Our control and/or Our claims administrator, the decision shall be rendered as soon as possible, but no later than 120 days after receipt of the request for review. The decision, after the review, shall be in writing and shall include specific references to the pertinent policy provisions upon which the decision was based.]

PAYMENT OF BENEFITS

Health Insurance[, Dental Insurance, and Vision Insurance] benefits may be assigned to the provider(s) of such benefits. Otherwise, all benefits payable under the Policy will be paid to You. Accrued benefits that are not paid at Your death will be paid to Your beneficiary or estate.

If a Health Insurance[, Dental Expense Insurance, and/or Vision Insurance] benefit is to be paid to:

- (a) Your estate; or
- (b) Your beneficiary who is not competent to give a valid release,

We may pay up to \$1,000.00 of such benefit to one of Your relatives who is deemed by Us to be justly entitled to it. Such payment, made in good faith, fully discharges Us to the extent of the payment.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right to have a Covered Person examined by a Physician of Our choice as often as reasonably necessary while a claim is pending. We will pay for such examination. In case of death, We may request an autopsy where it is not forbidden by law.

SECTION 8 GENERAL PROVISIONS

CERTIFICATES

This Certificate describes:

- (a) the insurance benefits; and
- (b) to whom benefits will be paid; and
- (c) any limitations of the Policy; and
- (d) all other essential features of the Policy.

If We issue more than one Certificate to You, only the last one issued will be in effect.

INCONTESTABILITY / TIME LIMIT ON CERTAIN DEFENSES

We will rely on statements made by the Policyholder and You to be true and complete to the best knowledge and belief of such persons. All such statements are representations (and not warranties), if fraud was not intended. No such statements will be used to void the insurance, reduce benefits, or defend a claim under the Policy unless:

- (a) the statement is in writing, signed by the You; and
- (b) a copy of that statement is given to You or, in the event of Your death or incapacity, Your beneficiary.

The validity of the Policy cannot be contested after two years from its date of issue, except for nonpayment of premiums. Except for fraudulent misstatements in the application or enrollment form, We will not use any statement to void the insurance or deny a claim after insurance has been in force for two years during Your lifetime. However, this provision shall not preclude Our assertion, at any time, of defenses based on provisions in the Policy that relate to eligibility for coverage.

LEGAL ACTIONS

No legal action may be brought to recover benefits under the Policy:

- (a) within 60 days after written proof of loss has been furnished as required; or
- (b) more than three years from the time written proof of loss is required to be furnished.

CONFORMITY WITH STATE LAWS

A provision of the Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law as of the Effective Date.

MISSTATEMENT OF AGE

If the age of any Covered Person was misstated on the application or enrollment form for coverage:

- (a) the amount of benefits payable will be the amount shown in the Schedule. If necessary, the premium will be adjusted so that We will be paid any amount due based on such Covered Person's true age; and
- (b) coverage for such person will end when it would have, if We had known of such person's correct age. If We have accepted a premium on behalf of the person for a period after the date when coverage should have ended, the premium will be refunded. We will not pay any claims for services the person received after coverage should have ended.

CLERICAL ERROR

Any clerical error in record keeping will not keep insurance in force if it should have been terminated, nor will it terminate insurance that should have been kept in force. As soon as the error is found, any necessary premium adjustment will be made.

NON-PARTICIPATING

The Policy is non-participating, and does not share in Our profits or surplus. No dividends are payable under the Policy.

Notice to Group Health Plan Participants of Benefits Required Under the Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice to Group Health Plan Participants of Benefits Required Under the Women's Health and Cancer Rights Act of 1998

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains the most important provisions of the Act. Please review this information carefully. If your spouse is also covered, please make certain that she or he also has the opportunity to review this information.

The Women's Health and Cancer Rights Act of 1998 requires that all group health plans that provide medical and surgical benefits for a mastectomy also must provide coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for any complications in all stages of mastectomy, including lymphedema.

The Act requires that coverage be provided in a manner that is consistent with other benefits provided under the Plan. The coverage may be subject to annual deductibles and coinsurance provisions.

The Women's Health and Cancer Rights Act of 1998 will apply to group health plans for plan years beginning on or after October 21, 1998. To find out when your plan year begins, check your Summary Plan Description (SPD) or contact your plan administrator.

Please keep this information with your other group health plan documents.

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

HEALTH INSURANCE

INPATIENT BENEFITS	
Daily Hospital Indemnity Benefit	[see <i>Statement of Variability</i>] per day, up to [see <i>Statement of Variability</i>] days per Calendar Year
Inpatient Maximum Benefit	[see <i>Statement of Variability</i>]
Inpatient Deductible Applicable to all covered Inpatient services and supplies, unless stated otherwise.	[see <i>Statement of Variability</i>] per Covered Person per Calendar Year; maximum of [see <i>Statement of Variability</i>] Deductibles per family per Calendar Year]
Inpatient Coinsurance Applicable to all covered Inpatient services and supplies, unless stated otherwise.	After satisfaction of the Inpatient Deductible, the Company will pay [see <i>Statement of Variability</i>] of Covered Charges, up to the Inpatient Maximum Benefit.
Room and Board Benefit	Up to [see <i>Statement of Variability</i>]
Inpatient Physician Surgical Services Benefit	Up to [see <i>Statement of Variability</i>]
Inpatient Anesthetic Services and Anesthesia Benefit	Up to [see <i>Statement of Variability</i>]
Inpatient Physician Non-Surgical Services Benefit	Up to [see <i>Statement of Variability</i>]
Inpatient Miscellaneous Services and Supplies	Up to [see <i>Statement of Variability</i>]
OUTPATIENT BENEFITS	
Outpatient Maximum Benefit	[see <i>Statement of Variability</i>]
Outpatient Deductible Applicable to all covered Outpatient services and supplies, unless stated otherwise.	[see <i>Statement of Variability</i>] per Covered Person per Calendar Year; maximum of [see <i>Statement of Variability</i>] Deductibles per family per Calendar Year]
Outpatient Coinsurance Applicable to all covered Outpatient services and supplies, unless stated otherwise.	After satisfaction of the Outpatient Deductible, the Company will pay [see <i>Statement of Variability</i>] of Covered Charges, up to the Outpatient Maximum Benefit.
Outpatient Physician Surgical Services Benefit	Up to [see <i>Statement of Variability</i>]
Outpatient Anesthetic Services and Anesthesia Benefit	Up to [see <i>Statement of Variability</i>]
Outpatient Physicians' Non-Surgical Services Benefit This benefit is not subject to the Deductible.	Co-payment — [see <i>Statement of Variability</i>] Coinsurance — After the Co-payment, the Company will pay [see <i>Statement of Variability</i>] of Covered Charges.
All other covered Outpatient services and supplies	Subject to the Outpatient Deductible, Outpatient Coinsurance, and Outpatient Maximum Benefit.

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

HEALTH INSURANCE (continued)

ADDITIONAL BENEFITS	
<p>Durable Medical Equipment and Prosthesis Benefit This benefit is not subject to any Deductible, and will not reduce the Outpatient Maximum Benefit.</p>	<p>Coinsurance — [see <i>Statement of Variability</i>] Maximum Benefit — [see <i>Statement of Variability</i>] per Calendar Year</p>
<p>Hospital Admission Benefit This benefit is not subject to any Deductible, and will not reduce the Inpatient Maximum Benefit.</p>	<p>Lump Sum Benefit — [see <i>Statement of Variability</i>] Maximum Number of Admissions — [see <i>Statement of Variability</i>] per Calendar Year</p>
<p>Emergency Room Sickness Benefit This benefit is not subject to any Deductible, and will not reduce the Inpatient or Outpatient Maximum Benefit.</p>	<p>Co-payment — [see <i>Statement of Variability</i>] Coinsurance — [see <i>Statement of Variability</i>] Maximum Episodes of Care — [see <i>Statement of Variability</i>] per Calendar Year Maximum Benefit — [see <i>Statement of Variability</i>] per Episode of Care</p>
<p>Prescription Drug Card Benefit This benefit is not subject to any Deductible or Coinsurance, and will not reduce the Outpatient Maximum Benefit.</p>	<p>Co-payment — Generic Drugs: [see <i>Statement of Variability</i>] per fill/refill Branded Drugs: [see <i>Statement of Variability</i>] per fill/refill Maximum Benefit — [see <i>Statement of Variability</i>] per Calendar Year</p>
<p>Intensive Care Unit Benefit This benefit is not subject to any Deductible, and will not reduce the Inpatient Maximum Benefit.</p>	<p>Lump Sum Benefit — [see <i>Statement of Variability</i>] Maximum Number of Days — [see <i>Statement of Variability</i>] per Calendar Year</p>
<p>Supplemental Accident Benefit This benefit is not subject to any Deductible, and will not reduce the Inpatient or Outpatient Maximum Benefit.</p>	<p>Coinsurance — 100% Maximum Benefit — [see <i>Statement of Variability</i>] per Accident Maximum Number of Accidents — [see <i>Statement of Variability</i>] per Calendar Year</p>
<p>Wellness Benefit This benefit is applicable only to Covered Persons age 18 years or older. This benefit is not subject to any Deductible, and will not reduce the Outpatient Maximum Benefit.</p>	<p>Co-payment — [see <i>Statement of Variability</i>] Coinsurance — [see <i>Statement of Variability</i>] Maximum Benefit — Up to [see <i>Statement of Variability</i>] per Calendar Year</p>

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

[TERM LIFE INSURANCE

Insured Death Benefit^[1]	[see Statement of Variability]
Spouse Death Benefit^[2]	[see Statement of Variability]
Dependent Child Death Benefit^[2] (six months of age or older)	[see Statement of Variability]
Dependent Child Death Benefit^[2] (14 days to six months of age)	[see Statement of Variability]
Dependent Child Death Benefit^[2] (under 14 days of age)	[see Statement of Variability]

^[1]For Insureds age 65 or older, the Death Benefit will be 65% of the amount shown.]

^[2]At no time may a covered Dependent's Death Benefit exceed 50% of the Insured's Death Benefit, or the maximum amount permitted by law, whichever is greater. Any necessary reduction in a Dependent's Death Benefit will be effective on the same date that the Insured's Death Benefit reduces.]

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (not applicable to Dependents)

Insured Principal Sum^[1]	[see Statement of Variability]
--	--------------------------------

^[1]For Insureds age 65 or older, the Principal Sum will be 65% of the amount shown.]

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

[DENTAL INSURANCE

Calendar Year Deductible	[see <i>Statement of Variability</i>] per Covered Person
Percentage of Covered Charge Payable	Class A — [see <i>Statement of Variability</i>] Class B — [see <i>Statement of Variability</i>] [Class C — see <i>Statement of Variability</i>]
Calendar Year Maximum	Insured — [see <i>Statement of Variability</i>] Each Dependent — [see <i>Statement of Variability</i>]
Waiting Period for Class [B/C] Covered Charges	[see <i>Statement of Variability</i>]

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

**[DISABILITY INCOME INSURANCE
(not applicable to Dependents)**

Covered Percentage of Weekly Base Compensation	[see Statement of Variability]
Maximum Weekly Benefit	[see Statement of Variability]
Elimination Period	Accident — [see Statement of Variability] Sickness — [see Statement of Variability]
Maximum Disability Period	Accident — [see Statement of Variability] Sickness — [see Statement of Variability]
Maximum Mental Illness Period	[see Statement of Variability]
Maximum Alcoholism/Drug Addiction Period	[see Statement of Variability]
Successive Disabilities Period	[see Statement of Variability]

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

[VISION INSURANCE

Eye Examination	Actual charge, not to exceed [see <i>Statement of Variability</i>], and limited to one routine examination in any [see <i>Statement of Variability</i>].
Eyeglass Lenses (other than contact lenses)¹	Actual charge, not to exceed [see <i>Statement of Variability</i>] for singles lenses or [see <i>Statement of Variability</i>] for bifocal or trifocal lenses, and limited to one set of lenses in any [see <i>Statement of Variability</i>].
Frames¹	Actual charge, not to exceed [see <i>Statement of Variability</i>], and limited to one pair of frames in any [see <i>Statement of Variability</i>].
Contact Lenses¹	Actual charge, not to exceed [see <i>Statement of Variability</i>] pairs of disposable contact lenses in any [see <i>Statement of Variability</i>] period.

¹Benefits will be paid for only one of the following during the same time period: (a) frames with lenses or (b) contact lenses.]

SERFF Tracking Number: AFDL-126244396 State: Arkansas
 Filing Company: American Fidelity Assurance Company State Tracking Number: 44247
 Company Tracking Number:
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
 Expense
 Product Name: FOS G-530.SA
 Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	12/17/2009
Comments:			
Attachment:			
	AR Readability Certification.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	12/17/2009
Comments:			
	The application to be used with these forms is application form No. A-1132, which was previously approved by your Dept. on 11-20-02.		

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved-Closed	12/17/2009
Comments:			
Attachment:			
	G-530.SA Statement of Variability.pdf		



2000 N. Classen Boulevard, Oklahoma City, Oklahoma 73106

**CERTIFICATE OF READABILITY
ARKANSAS**

I hereby certify that forms G-530.SA(AR) and CG-530.SA(AR) meet the minimum Flesch reading ease score as required by ACA 23-80-206.

Signature

Ronald J. Byrne

Name

Sr. Vice President and Risk Manager

Title

12-3-09

Date

AMERICAN FIDELITY ASSURANCE COMPANY
Policy and Certificate – Variable Language Ranges
Policy Form G-530.SA series

Face Page	<ol style="list-style-type: none"> 1. The bracketed areas at the top reflect the information unique to each policyholder (i.e. policyholder name, policy number, etc.). 2. The fraud warning wording is bracketed to allow a change in wording, as required by state law. This wording will not be changed for any other reason.
Section 1	<ol style="list-style-type: none"> 1. General Definitions — Variable information may, or may not, be included, depending upon the benefit as elected by the policyholder (i.e. Domestic Partner coverage may or may not be elected; pre-existing condition definition may be more liberal, from 0 to 6 months, or not apply; coverage effective date on first of month/eligibility date, etc.) with remaining items to be re-numbered accordingly. 2. Specific Coverage Definitions — <ol style="list-style-type: none"> a. For any coverage that is not elected by the policyholder, the entire subsection related to such coverage will be omitted. b. The definition of Pre-Existing Conditions will standardly be included, unless negotiated with the policyholder that a Pre-Existing Condition limitation will not be included.
Section 2	<ol style="list-style-type: none"> 1. Bracketed information reflects the various options available to a policyholder, and the policy issued to a specific policyholder will then reflect only the option elected by that policyholder (e.g., contributory/non-contributory; first day of month/normal pay date; missed premium option; whether or not domestic partner coverage is elected, whether or not Life Insurance is elected, etc.).
Section 3	<ol style="list-style-type: none"> 1. The brackets allow for the policy issued to an employer to reflect only those coverages/benefits elected by that employer (e.g., if dental or vision benefits are not elected, then the policy issued to that employer will not reflect those benefits). Variable information (i.e., deductible information within dental benefit) allows for the policy to include deductible/calendar year maximum provisions or to have coverage provided without such provisions. 2. The Schedule of Dental Benefits has been bracketed to allow for additional procedures to be covered as needed or to allow for a change in the classification to the scheduled procedure.
Section 4	<ol style="list-style-type: none"> 1. For any coverage that is not elected by the policyholder, the entire subsection related to such coverage will be omitted. 2. Within each coverage subsection, any item that is bracketed will be included as worded, or omitted. This includes Pre-Existing Condition limitation language.
Section 5	<ol style="list-style-type: none"> 1. With respect to any bracketed text that applies to a coverage that is not elected by the policyholder, such text will be omitted. 2. Other bracketed variable text allows for variability with respect to coverage effective date, and whether or not domestic partners are covered.
Section 6	<ol style="list-style-type: none"> 1. The brackets around the 12-month rate guarantee allow for a range of 6-24 months, but will be no more frequent than allowed by state law. 2. Missed Premiums — If this option is not elected, this provision will not be included. Also, the brackets around the length of time for missed premium period allow for a time frame during which employees may make premium payments on their own if the hours worked for their paycheck is not sufficient to cover their contribution deduction.
Section 7	<ol style="list-style-type: none"> 1. With respect to any bracketed text that applies to a coverage that is not elected by the policyholder, such text will be omitted. 2. The brackets around the "company or the Company's claims administrator" allow for claims to be paid directly by the company or through a licensed administrator. The brackets also allow for the policy to include only those provisions applicable to the benefits elected by the policyholder (i.e. if Disability Insurance is not provided, the provisions specifically addressing this coverage will not be included, etc.

AMERICAN FIDELITY ASSURANCE COMPANY
Policy/Certificate Schedule of Benefits – Variable Language Ranges
Policy Form G-530.SA series

The following reflects the range of amounts/durations/quantity available, for the benefits available. An issued policy will reflect only those benefits elected by the Policyholder. The Policyholder may elect benefit amounts, etc. from the ranges shown.

Health Insurance

Benefit	Ranges
Daily Hospital Indemnity Benefit <i>(only benefit provided to Employee when “Dependent Only” coverage is sold)</i>	Maximum Benefit: \$50 — \$500 per day Maximum Number of Days: 15 – 30 days per Calendar Year
Inpatient Maximum Benefit	\$2,500 — \$75,000 per Calendar Year
Inpatient Deductible	Nil — \$1,000 per person per Calendar Year; maximum of 2 or 3 Deductibles per family per Calendar Year
Inpatient Coinsurance	50% — 100%
Room and Board Benefit	\$125 — \$2,500 per day
Inpatient Physician Surgical Services Benefit	\$200 — \$15,000 per Calendar Year
Inpatient Anesthetic Services and Anesthesia Benefit	\$40 — \$3,000 per Calendar Year
Inpatient Physician Non-Surgical Services Benefit	\$25 — \$250 per Day
Inpatient Miscellaneous Services and Supplies	\$50 — \$500 per Day
Outpatient Maximum Benefit	\$500 — \$7,500 per Calendar Year
Outpatient Deductible	Nil — \$500 per person per Calendar Year; maximum of 2 or 3 Deductibles per family per Calendar Year
Outpatient Coinsurance	50% — 100%
Outpatient Physician Surgical Services Benefit	\$200 — \$5,000 per Calendar Year
Outpatient Anesthetic Services and Anesthesia Benefit	\$40 — \$1,000 per Calendar Year
Outpatient Physicians’ Non-Surgical Services Benefit	Co-payment: Nil — \$50 Coinsurance: 50% — 100%
Durable Medical Equipment and Prosthesis Benefit	Coinsurance: 50% — 100% Calendar Year Maximum: \$50 — \$500
Hospital Admission Benefit	Lump Sum Benefit: \$200 — \$2,500 Maximum Number of Admissions: 2 – 5 per Calendar Year
Emergency Room Sickness Benefit	Co-payment: Nil — \$100 Coinsurance: 50% – 100% Maximum Episodes of Care: 1 — 5 per Calendar Year Maximum Benefit: \$100 – \$1,000 per episode of care
Prescription Drug Card Benefit	Co-payment: \$5 – \$30/generic; \$20 – \$100/branded; \$20 – \$200/non-formulary; mail-order subject to 2, 2.5 or 3 times co-payment and 90-day supply Per Fill Maximum: \$20 – \$150 Calendar Month Maximum: \$50 – \$500 Calendar Year Maximum: \$200 – \$5,000 overall; \$100 – \$4,900/generic; \$100 – \$4,900/branded; Nil/non-formulary
Intensive Care Unit Benefit	Lump Sum Benefit: \$125 – \$2,500 per day Maximum Number of Days: 5 – 120 days per Calendar Year

AMERICAN FIDELITY ASSURANCE COMPANY
Policy/Certificate Schedule of Benefits – Variable Language Ranges
Policy Form G-530.SA series

Supplemental Accident Benefit	Maximum Benefit: \$250 – \$5,000 per Accident Maximum Number of Accidents: 1 – 5 per Calendar Year
Wellness Benefit	Co-payment: Nil – \$50 Coinsurance: 50% – 100% Calendar Year Maximum: \$100 – \$1,000

Term Life Insurance/Accidental Death and Dismemberment Insurance

Benefit	Lowest Range	Highest Range
Insured Death Benefit	\$2,500	\$75,000
Spouse Death Benefit	\$1,250	\$5,000
Dependent Child Death Benefit (6 months or older)	\$250	\$5,000
Dependent Child Death Benefit (14 days to 6 months)	\$100	\$100
Dependent Child Death Benefit (under 14 days of age)	Nil	\$100
Reduction from Life Insurance Benefit amount for Insureds age 65 and over	65% of Death Benefit	No reduction
Accidental Death & Dismemberment Principal Sum (Insured Only)	Same as Death Benefit	Same as Death Benefit
Reduction of Principal Sum amount for Insureds age 65 and over	65% of Principal Sum	No reduction

Dental Insurance

Benefit	Lowest Range	Highest Range
Calendar Year Deductible	Nil	\$200
Percentage of covered charge payable – Class A Expenses	50%	100%
Percentage of covered charge payable – Class B Expenses	50%	100%
[Percentage of covered charge payable – Class C Expenses	50%	100%]
Calendar Year Maximum – Insured	\$250	\$2,500
Calendar Year Maximum – Each Dependent	\$250	\$2,500
Waiting Period for Class B/C covered charges to be payable (applicable only to Class C covered charges, when such Class is included)	No waiting period	12 months

Disability Income Insurance

Benefit	Lowest Range	Highest Range
Weekly Benefit	\$25	\$125
Benefit percentage of weekly base compensation	30%	75%
Maximum Disability Period – Accident	13 weeks	52 weeks
Maximum Disability Period – Sickness	13 weeks	52 weeks
Maximum Mental Illness Period	13 weeks	Cover same as any other illness
Maximum Alcoholism/Drug Addiction Period	13 weeks	Cover same as any other illness
Elimination Period – Accident	Nil	21 days
Elimination Period – Sickness	Nil	21 days
Successive Disabilities Period	1 month	3 months

AMERICAN FIDELITY ASSURANCE COMPANY
Policy/Certificate Schedule of Benefits – Variable Language Ranges
Policy Form G-530.SA series

Vision Insurance

Benefit	Lowest Range	Highest Range
Eye Examination: Actual charge not to exceed:	\$25	\$150
Limit of one routine exam during the following time frame:	6 months	24 months
Lenses		
Single lenses – actual charge, not to exceed	\$25	\$100
Bifocal or Trifocal – actual charge, not to exceed	\$50	\$150
Contact/non-disposable – actual charge, not to exceed	\$25	\$100
Limit of one of the above type of lenses during the following time frame:	6 months	24 months
Contact/disposable – actual charge, not to exceed	\$75	\$100
Number of pairs of disposable contact lenses per time frame	1	5
Time frame limit for the number of disposable contact lenses shown above	6 months	24 months
Frames – actual charge, not to exceed	\$20	\$100
Limit of one pair of frames during the following time frame	6 months	24 months

SERFF Tracking Number: AFDL-126244396 State: Arkansas
 Filing Company: American Fidelity Assurance Company State Tracking Number: 44247
 Company Tracking Number:
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
 Expense
 Product Name: FOS G-530.SA
 Project Name/Number: /

Superseded Schedule Items

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.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
12/03/2009	Form	Group Certificate	12/11/2009	AR Certificate CG-530.SA(AR).pdf (Superseded)

 **American Fidelity
Assurance Company**
A member of the American Fidelity Group

2000 North Classen Boulevard, Oklahoma City, Oklahoma 73106

POLICYHOLDER: [ABC Employer]
ADDRESS: [123 Anystreet, Anycity, Anystate]
POLICY NUMBER: [G-530.SA-9999]
POLICY EFFECTIVE DATE: [January 1, 2010]
POLICY ANNIVERSARY DATE: [January 1]
ISSUE DATE: [January 1, 2010]
STATE OF ISSUE: Arkansas

American Fidelity Assurance Company (herein called the Company), in consideration of the Application for this Group Policy and the timely payment of premiums, agrees, subject to the terms and conditions of the Policy, to insure eligible employees and their eligible Dependents under the Policy. All provisions set forth on the following pages are a part of the Policy. The Company and the Policyholder agree to all of the terms of the Policy.

This Policy takes effect on the Effective Date stated above, at 12:01 a.m. Standard Time, at the address of the Policyholder. The laws of the State of Issue govern this Policy. Subject to the terms and conditions of the Policy, the Policy can be renewed until the first Policy Anniversary Date by timely payment of the premium. Thereafter, the Policy can be renewed from month to month by timely payment of the required premium.

IN WITNESS WHEREOF American Fidelity Assurance Company has caused this Policy to take effect on the Effective Date.


Secretary


President

**PLEASE READ THIS POLICY CAREFULLY.
THE HEALTH INSURANCE COVERAGE DESCRIBED HEREIN PROVIDES LIMITED BENEFITS;
IT DOES NOT PROVIDE COMPREHENSIVE COVERAGE.**

[WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.]

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GENERAL DEFINITIONS

The following definitions apply to all coverages provided under the Policy, as appropriate.

Accident (or **Accidental Injury**) means a sudden, unexpected and unintended event:

- (a) over which the Covered Person has no control; and
- (b) which results in bodily injury to a Covered Person; and
- (c) which is independent of any Sickness; and
- (d) which is caused by, or the result of, external means.

[Active Service means that the Insured is doing in the usual manner all of the regular duties of his/her employment on a scheduled work day, and these duties are being done at one of the places of business where the Insured normally does such duties, or at some location to which the Insured's employment sends him/her.

The Insured will be deemed to be in Active Service on each day he/she is actually performing services for the Policyholder, and on each day of regular paid vacation or on a regular non-working day, provided the Insured is actively at work on the last preceding regular work day. With respect to any health coverage provided on an expense-incurred basis, the Insured will also be deemed to be in Active Service on a day that the Insured is absent from work during an approved leave under the Family and Medical Leave Act, or solely due to a Health Status-Related Factor.]

Calendar Year means the period from January 1 through December 31 of the same year.

Certificate means the individual certificate issued to the Insured. It describes the coverage under the Policy.

Company means American Fidelity Assurance Company.

Covered Person(s) means the Insured and the Insured's Dependents insured under the Policy.

Dependent means:

- (a) the Insured's legally married spouse, or common law spouse (where permitted by law), [or Domestic Partner,] who lives with the Insured; or
- (b) a natural, step, or adopted child of the Insured. Such child must be under 25 years of age, and dependent on the Insured for principal support and maintenance; or
- (c) a child placed for adoption with the Insured, provided such child is under age 18 as of the date of placement, and would otherwise qualify under (b) above; or
- (d) notwithstanding any principal support and maintenance requirements, a child for whom the Insured or the Insured's covered spouse/common law spouse/[Domestic Partner] is required to provide coverage due to a Qualified Medical Child Support Order (QMCSO), provided such child would otherwise qualify under (b) above. A QMCSO will also include a judgment, decree, or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of law under state law and which satisfies the QMCSO requirements of ERISA (section 609[a]); or
- (e) a child who is not living with the Insured, but for whom the Insured is legally required to provide support, provided such child would otherwise qualify under (b) above.

The term Dependent does not include:

- (a) a grandchild(ren); or
- (b) any child who is married.

[Domestic Partner means a person of either sex who:

- (a) is at least 18 years of age; and
- (b) is competent to contract in his or her state of residency; and
- (c) shares the same residence as the Insured; and

SECTION 1 DEFINITIONS

- (d) is not married to, legally separated from, or a domestic partner of, anyone else; and
- (e) is not related to the Insured by blood in a way that would prevent marriage in their state of residency.

The Insured and his/her Domestic Partner must [be/have been] in an exclusive, committed relationship with each other [during the 12-month period immediately prior to enrollment for coverage, or] if the Insured and his/her Domestic Partner's state of residency provides for a registration process of domestic partnership:

- (a) neither the Insured nor his/her Domestic Partner may have previously registered as a Domestic Partner with their state of residency, where such registration has not been terminated; and
- (b) both the Insured and his/her Domestic Partner must file such registration with respect to their own relationship.]

Effective Date means, with respect to the Policy, the date the Policy becomes effective. With respect to each eligible person, Effective Date means the date such person's coverage takes effect under the Policy. The "Effective Date" will start at 12:01 a.m. at the main place of business of the Policyholder.

Enrollment Date means the Effective Date of coverage, or if earlier, the first day of any required waiting period.

Initial Eligibility Period means the 31-day period following completion of the Insured's Waiting Period for Coverage, during which the Insured may apply for coverage under the Policy.

Insured means any person who is eligible for insurance, as stated in the Schedule and described in Section 2, and is insured under the Policy by virtue of employment by the Policyholder.

[Normal Pay Date means the day of the week the Policyholder (or one of its subsidiaries) normally issues payroll. This date will remain the same regardless of a temporary change in the payday, which may occur due to holidays.]

Open Enrollment Period means that time each Plan Year that:

- (a) new enrollments may be made by existing employees; or
- (b) an Insured may make changes to his/her coverage election(s), or terminate coverage.

Physician means a practitioner of the healing arts who is practicing within the scope of his or her license in the state where so licensed.

The term Physician does not include a practitioner who:

- (a) is the Policyholder, or is employed or retained by the Policyholder; or
- (b) is living in the Covered Person's household; or
- (c) is related to the Covered Person by blood or marriage.

[Plan Year means the 12-month period the Policyholder establishes as the plan year for employee welfare benefits.]

Policy means the policy issued by the Company to the Policyholder.

Policyholder means the employer who holds the Policy. The Policyholder is named on the face page of the Policy.

Schedule of Benefits (or Schedule) means the benefit schedule set forth in the Policy or Certificate.

SECTION 1 DEFINITIONS

Sickness means a bodily disorder, disease, physical or mental condition, functional nervous disorder, pregnancy, or Complication of Pregnancy:

- (a) that requires treatment by a Physician; and
- (b) for which treatment is rendered to such Covered Person.

The term Sickness, when used in connection with a newborn child, includes, but is not limited to:

- (a) prematurity;
- (b) congenital defects; and
- (c) birth abnormalities.

Special Enrollment Period means the [31-day/30-day] period that begins when a person is first eligible for Special Enrollment under HIPAA.

Total Disability (or Totally Disabled) means [the Insured is unable to perform the material and substantial duties and functions of his/her occupation. For a Dependent, "Totally Disabled" means] the inability to perform a majority of the normal activities of a person of like age who is in good health.

Waiting Period for Coverage means that period of time during which the Insured must be continuously employed before his/her coverage may begin. The Policyholder will determine the Waiting Period for Coverage, subject to the Company's underwriting guidelines and approval.

SECTION 1 DEFINITIONS

HEALTH INSURANCE

The following definitions apply to Health Insurance.

Complication of Pregnancy means:

- (a) Hospital confinement required to treat conditions such as the following:
 - (1) acute nephritis; or
 - (2) nephrosis; or
 - (3) cardiac decompensation; or
 - (4) HELLP syndrome; or
 - (5) uterine rupture; or
 - (6) amniotic fluid embolism; or
 - (7) chorioamnionitis; or
 - (8) fatty liver in pregnancy; or
 - (9) septic abortion; or
 - (10) placenta accreta; or
 - (11) gestational hypertension; or
 - (12) puerperal sepsis; or
 - (13) peripartum cardiomyopathy; or
 - (14) cholestasis in pregnancy; or
 - (15) thrombocytopenia in pregnancy; or
 - (16) placenta previa; or
 - (17) placental abruption; or
 - (18) acute cholecystitis and pancreatitis in pregnancy; or
 - (19) postpartum hemorrhage; or
 - (20) septic pelvic thrombophlebitis; or
 - (21) retained placenta; or
 - (22) venous air embolus associated with pregnancy; or
 - (23) miscarriage; or
 - (24) an emergency c-section required because of:
 - a. fetal or maternal distress during labor; or
 - b. severe pre-eclampsia; or
 - c. arrest of descent or dilatation; or
 - d. obstruction of the birth canal by fibroids or ovarian tumors; or
 - e. necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy.A c-section will not be considered to be an emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section; and
- (b) treatment, diagnosis or care for conditions, including the following, when the condition was caused by, necessary because of, or aggravated by the pregnancy:
 - (1) hyperthyroidism; or
 - (2) hepatitis B or C; or
 - (3) HIV; or
 - (4) Human Papilloma virus; or
 - (5) abnormal PAP; or
 - (6) syphilis; or
 - (7) Chlamydia; or
 - (8) herpes; or
 - (9) urinary tract infections; or
 - (10) thromboembolism; or
 - (11) appendicitis; or
 - (12) hypothyroidism; or
 - (13) pulmonary embolism, or
 - (14) sickle cell disease; or
 - (15) tuberculosis; or

SECTION 1 DEFINITIONS

- (16) migraine headaches; or
- (17) depression; or
- (18) acute myocarditis; or
- (19) asthma; or
- (20) maternal cytomegalovirus; or
- (21) urolithiasis; or
- (22) DVT prophylaxis; or
- (23) ovarian dermoid tumors; or
- (24) biliary atresia and/or cirrhosis; or
- (25) first trimester adnexal mass; or
- (26) hydatidiform mole; or
- (27) ectopic pregnancy.

Confinement (or Confined) means that period of time during any Hospital stay that the Covered Person is actually admitted on an inpatient basis, provided:

- (a) such Confinement is for at least 18 continuous hours in duration; and
- (b) at least one full day's room and board charge is made by the Hospital.

The term Confinement does not include that period of time during which a Covered Person is in:

- (a) a Hospital emergency room; or
- (b) an observation room; or
- (c) a free-standing surgical facility; or
- (d) an outpatient facility,

unless:

- (a) such Covered Person is admitted to the Hospital as an inpatient immediately thereafter; and
- (b) the conditions set forth for Confinement are met.

Covered Charges means those charges that:

- (a) are incurred by a Covered Person because of a covered Accident or Sickness; and
- (b) are for necessary treatment, services, and/or medical supplies, and are recommended by a Physician; and
- (c) are not more than:
 - (1) the Usual and Customary Charges; or
 - (2) the amount actually paid by or on behalf of the Covered Person and accepted by the provider for treatment, services and/or medical supplies provided; or
 - (3) any dollar limit set forth in the Schedule;and
- (d) are incurred while insured under the Policy, subject to any Extension of Benefits; and
- (e) are not excluded under Section 4, Exclusions.

Creditable Coverage means, with respect to an individual, coverage of an individual under:

- (a) a group health plan; or
- (b) health insurance coverage; or
- (c) Part A or Part B or Title XVIII of the Social Security Act (Medicare); or
- (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines); or
- (e) Chapter 55 of Title 10, United States Code (armed forces); or
- (f) a medical care program of the Indian Health Service, or of a tribal organization; or
- (g) a State health benefits risk pool; or
- (h) a health plan offered under Chapter 89 of Title 5, United States Code (U.S. government); or
- (i) a public health plan; or
- (j) a health benefit plan under Section 5(e) of the Peace Corps Act, 22 USC 2504(e).

Creditable Coverage does not mean:

SECTION 1 DEFINITIONS

- (a) accident only or disability income coverage; or
- (b) coverage issued as a supplement to liability insurance; or
- (c) liability insurance; or
- (d) Workers' Compensation or similar insurance; or
- (e) automobile medical payment insurance; or
- (f) credit only insurance; or
- (g) coverage for on-site medical clinics; or
- (h) other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

Deductible means the amount of Covered Charges, shown in the Schedule, for which the Company will pay no benefits during each Calendar Year.

Durable Medical Equipment means equipment which:

- (a) can withstand repeated use; and
- (b) is primarily and customarily used to serve a medical purpose; and
- (c) generally is not useful to a person in the absence of an illness or injury; and
- (d) is appropriate for use in the home.

Such equipment must:

- (a) be prescribed by the Covered Person's physician for the purpose of treating or accommodating an illness, injury, disease or its symptoms, in accordance with generally accepted standards of medical practice; and
- (b) be clinically appropriate, in terms of type, frequency, extent, site and duration and must be considered effective for the patient's illness, injury or disease,

and may not:

- (a) be primarily for the convenience of the patient, physician, or other health care provider; or
- (b) be more costly than an alternative service, sequence of services, device or equipment, at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease; or
- (c) be intended to be used for athletic or recreational activities as opposed to assisting the patient in the activities of daily living; or
- (d) be an additional feature or accessory, or is a non-standard or deluxe item that is primarily for the comfort and convenience of the patient (e.g., customized wheelchairs, electric vehicle lifts for wheelchairs, etc.); or
- (e) be a duplicative piece of equipment that is intended to be used as a backup device, for multiple residences, or for traveling, etc.

Health Status-Related Factor means any of the following:

- (a) health status; or
- (b) a medical condition (including both physical and mental illness); or
- (c) claims experience; or
- (d) receipt of health care; or
- (e) medical history; or
- (f) genetic information; or
- (g) evidence of insurability (including conditions arising out of acts of domestic violence); or
- (h) disability.

Hospital means a licensed institution that has on its premises:

- (a) permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician; and
- (b) 24-hour-a-day nursing service by graduate registered nurses; and
- (c) the patient's written history and medical records.

SECTION 1 DEFINITIONS

It shall also have laboratory, x-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians, or be accredited by the Joint Commission on Accreditation of Hospitals.

The term Hospital shall also include a duly licensed residential treatment facility for the treatment of mental or nervous Sickness, alcoholism, or drug abuse.

The term Hospital shall not include any institution used by the Insured as:

- (a) a place for rehabilitation; or
- (b) a place for rest or for the aged; or
- (c) a nursing or convalescent home; or
- (d) a long-term nursing unit or geriatrics ward; or
- (e) an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Intensive Care Unit (ICU) means an area of a Hospital that:

- (a) is kept separate from other Hospital facilities; and
- (b) is operated solely to give skilled care and treatment to critically ill patients; and
- (c) has special supplies and equipment necessary for immediate use; and
- (d) provides room, board, and constant observation and care by registered professional nurses or other highly-trained Hospital personnel.

Medical Condition means any condition, whether physical or mental, including, but not limited to:

- (a) any condition resulting from illness; or
- (b) injury (whether or not the injury is accidental); or
- (c) pregnancy; or
- (d) congenital malformation;

however, genetic information is not a Medical Condition.

Outpatient Surgical Facility means a facility that:

- (a) is licensed under the laws of the state in which it operates as an outpatient surgical center;
- (b) has an organized medical staff of Physicians; and
- (c) has permanent facilities that are equipped and operated for the main purpose of performing surgery; and
- (d) has continuous Physician and registered professional nursing services when a patient is in the facility; and
- (e) does not provide services or accommodations for patients to stay overnight.

The term Outpatient Surgical Facility shall include:

- (a) a freestanding outpatient surgical center; and
- (b) the outpatient surgical section of a Hospital; and
- (c) a Hospital emergency room.

The term Outpatient Surgical Facility shall not include a Physician's office.

[Pre-Existing Condition means a disease, injury, or physical, mental or nervous condition for which a Covered Person:

- (a) had treatment; or
- (b) incurred expense; or
- (c) took medication; or
- (d) received a diagnosis or advice from a Physician,

at any time during the six-month period immediately before the Enrollment Date of such Covered Person's coverage.

The term Pre-Existing Condition will also include conditions which are related to such disease, injury, or physical, mental or nervous condition.]

Prosthesis means an artificial device to replace or augment a missing or impaired part of the body.

SECTION 1 DEFINITIONS

The term Prosthesis does not include:

- (a) wigs and hair pieces for androgenetic alopecia (also known as male pattern baldness); or
- (b) any device or item used purely for cosmetic reasons, except:
 - (1) external or internal breast prostheses required as the result of a medically necessary mastectomy; or
 - (2) wigs or hairpieces (synthetic, human-hair, or blends) prescribed by a Physician as a prosthesis for hair loss due to injury, disease, or treatment of a disease, for the following conditions:
 - a. burns (2nd degree full thickness and 3rd degree burns with resulting permanent alopecia); or
 - b. lupus; or
 - c. alopecia areata with near complete or complete cranial hair loss; or
 - d. alopecia totalis; or
 - e. alopecia universalis; or
 - f. fungal infections not responsive to an appropriate (typically 6-week) course of antifungal treatment resulting in near complete or complete cranial hair loss; or
 - g. chemotherapy; or
 - h. radiation therapy;

Regular Care and Attendance means that the Covered Person is personally seen by a Physician each day of his or her Confinement.

Usual and Customary means those expenses for services and/or supplies essential to the care of a Covered Person which will be considered reasonable and customary if they are the amount normally charged by the service provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the geographic area where the services or supplies are received, per industry-accepted guidelines. In determining whether expenses are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications, unusual or extenuating circumstances.

[DENTAL INSURANCE

The following definitions apply to Dental Insurance.

Covered Charges means those charges that:

- (a) are incurred by a Covered Person because of a covered Accident or Sickness; and
- (b) are for necessary treatment, services, and/or medical supplies, and are recommended by a Physician; and
- (c) are not more than the Usual and Customary Charges, or the actual billed charge, or any dollar limit set forth in the Schedule; and
- (d) are incurred while insured under the Policy, subject to any Extension of Benefits; and
- (e) are not excluded under Section 4, Exclusions.

Creditable Coverage means, with respect to an individual, coverage of an individual under:

- (a) a group health plan; or
- (b) health insurance coverage; or
- (c) Part A or Part B or Title XVIII of the Social Security Act (Medicare); or
- (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines); or
- (e) Chapter 55 of Title 10, United States Code (armed forces); or
- (f) a medical care program of the Indian Health Service, or of a tribal organization; or
- (g) a State health benefits risk pool; or
- (h) a health plan offered under Chapter 89 of Title 5, United States Code (U.S. government); or
- (i) a public health plan; or

SECTION 1 DEFINITIONS

- (j) a health benefit plan under Section 5(e) of the Peace Corps Act, 22 USC 2504(e).

Creditable Coverage does not mean:

- (a) accident only or disability income coverage; or
- (b) coverage issued as a supplement to liability insurance; or
- (c) liability insurance; or
- (d) Workers' Compensation or similar insurance; or
- (e) automobile medical payment insurance; or
- (f) credit only insurance; or
- (g) coverage for on-site medical clinics; or
- (h) other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

Deductible means the amount of Covered Charges, shown in the Schedule, for which the Company will pay no benefits during each Calendar Year.

Dental Hygienist means a person trained and licensed by the state to perform dental prophylaxis under the direction of a Dentist.

Dentist means a person who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his/her license. For the purpose of this definition, a Physician will be considered to be a Dentist only when he or she performs any of the dental services described herein, and is operating within the scope of his/her license.

Health Status-Related Factor means any of the following:

- (a) health status; or
- (b) a medical condition (including both physical and mental illness); or
- (c) claims experience; or
- (d) receipt of health care; or
- (e) medical history; or
- (f) genetic information; or
- (g) evidence of insurability (including conditions arising out of acts of domestic violence); or
- (h) disability.

Medical Condition means any condition, whether physical or mental, including, but not limited to:

- (a) any condition resulting from illness; or
- (b) injury (whether or not the injury is accidental); or
- (c) pregnancy; or
- (d) congenital malformation;

however, genetic information is not a Medical Condition.

[Pre-Existing Condition means a disease, injury, or physical, mental or nervous condition for which a Covered Person:

- (a) had treatment; or
- (b) incurred expense; or
- (c) took medication; or
- (d) received a diagnosis or advice from a Physician,

at any time during the six-month period immediately before the Enrollment Date of such Covered Person's coverage.

The term Pre-Existing Condition will also include conditions which are related to such disease, injury, or physical, mental or nervous condition.]

Usual and Customary means those expenses for services and/or supplies essential to the care of a Covered Person which will be considered reasonable and customary if they are the amount normally

SECTION 1 DEFINITIONS

charged by the service provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the geographic area where the services or supplies are received, per industry-accepted guidelines. In determining whether expenses are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications, unusual or extenuating circumstances.]

[DISABILITY INCOME INSURANCE

The following definitions apply to Disability Income Insurance.

Disability Benefit means the weekly disability benefit for which the Insured is eligible and paying premium.

Elimination Period means that period of time that starts after the Insured's Effective Date of coverage, during which:

- (a) he/she is Totally Disabled; and
- (b) no Disability Benefit is payable.

Mental Illness means a psychiatric or psychological condition, regardless of cause, including but not limited to:

- (a) schizophrenia; and/or
- (b) depression; and/or
- (c) manic depressive or bipolar illness; and/or
- (d) anxiety; and/or
- (e) personality disorders; and/or
- (f) adjustment disorders or other conditions, usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

The term Mental Illness does not apply to dementia, if due to:

- (a) stroke; or
- (b) trauma; or
- (c) viral infection; or
- (d) Alzheimer's disease; or
- (e) other such conditions not listed above which are not usually treated by a mental health provider using psychotherapy, psychotropic drugs, or other similar modalities.

[Pre-Existing Condition means a disease, injury, or physical, mental or nervous condition for which an Insured:

- (a) had treatment; or
- (b) incurred expense; or
- (c) took medication; or
- (d) received a diagnosis or advice from a Physician,

at any time during the 12-month period immediately before the Effective Date of his/her coverage.

The term Pre-Existing Condition will also include conditions which are related to such disease, injury, or physical, mental or nervous condition.]

Regular Care and Attendance means that the Insured is attended by a Physician at least once a month, or until the Physician determines the Insured:

- (a) has reached a state where continuous medical care is unnecessary; and
- (b) is still Totally Disabled.

Successive Disabilities means those disabilities which result from the same or related causes for which benefits are payable under the Policy.

**SECTION 1
DEFINITIONS**

Weekly Base Compensation means the Insured's weekly salary at the time of disability, including reported tips, exclusive of bonus or overtime earnings. If any weekly Disability Benefit is to be paid for less than a full week, the amount will be reduced pro rata on the basis that one day's benefit equals one-seventh (1/7th) of the Disability Benefit.]

SECTION 2 ELIGIBILITY AND EFFECTIVE DATE

EMPLOYEE ELIGIBILITY

If a person:

- (a) is on Active Service as an employee of the Policyholder; and
- (b) qualifies as an eligible employee, as defined in the Policy,

such person is eligible to be insured under the Policy.

EMPLOYEE ENROLLMENT

After satisfying any applicable Waiting Period for Coverage, an eligible person may enroll for coverage under the Policy at any time during his/her Initial Eligibility Period. If such person does not enroll for coverage under the Policy during his/her Initial Eligibility Period, he/she may not enroll except during an Open Enrollment Period or during a Special Enrollment Period. (See Special Enrollment under HIPAA, at the end of this Section.) If enrolling during an Open Enrollment Period, or during a Special Enrollment Period, such person must also satisfy any applicable Waiting Period for Coverage. [If an eligible person enrolls and his/her coverage later ends due to missed premium deductions, he/she may not re-enroll except during an Open Enrollment Period, or during a Special Enrollment Period.]

[If an eligible person enrolls and later voluntarily ends coverage, he/she must satisfy a 24-month waiting period before becoming eligible for re-enrollment. Such person may then re-enroll during the 31-day period immediately following such 24-month waiting period, or during an Open Enrollment Period or Special Enrollment Period that follows the end of the 24-month waiting period.]

EMPLOYEE EFFECTIVE DATE

[An eligible person's Effective Date will be the first day of the month following his/her enrollment, provided:

- (a) his/her enrollment process is complete; and
- (b) he/she is on Active Service as of the date coverage is to take effect;
- (c) if any portion of the premium is contributory, the first payroll deduction is made for his/her coverage under the Policy; and
- (d) his/her first premium has been accepted by the Company./

An eligible person's Effective Date will be the first day after the Normal Pay Date for which the first payroll deduction is taken for coverage under the Policy, provided:

- (a) his/her enrollment process is complete; and
- (b) he/she is on Active Service as of the date coverage is to take effect; and
- (c) his/her first premium has been accepted by the Company./

An eligible person's Effective Date will be [*as agreed upon between the Company and the Policyholder*], provided:

- (a) his/her enrollment process is complete; and
- (b) he/she is on Active Service as of the date coverage is to take effect; and
- (c) if any portion of the premium is contributory, the first payroll deduction is made for his/her coverage under the Policy; and
- (d) his/her first premium has been accepted by the Company.]

DEPENDENT ELIGIBILITY

If and where Dependent coverage is available under the Policy, eligibility for such coverage will begin on the later of:

- (a) the date a person becomes eligible for insurance; or
- (b) the date such Dependent is eligible for a Special Enrollment under HIPAA, as described at the end of this Section.

All dependents to be enrolled must meet the definition of Dependent, as stated in Section 1, except as described under Handicapped Child below.

SECTION 2
ELIGIBILITY AND EFFECTIVE DATE

[Domestic Partner

Before coverage can be made effective for a Domestic Partner, the Insured (and his/her Domestic Partner, if required) must complete and sign the applicable employer-provided documentation regarding such relationship.]

Handicapped Child [(Applicable only to Health Insurance[and Dental Insurance.])]

An Insured's handicapped child who is over the limiting age is eligible for enrollment if he or she has Creditable Coverage, unless there was a break in coverage of 63 days or more.

Dual Eligibility

In no event may a person be covered more than once under the Policy.

[Contributory Employee Coverage (the Insured pays all or part of his/her premium.)

If the Insured and his/her spouse/common law spouse[/Domestic Partner]:

- (a) are both eligible for coverage under the Policy as Insureds; and
- (b) have no Dependent children,

then:

- (a) the Insured and his/her spouse/common law spouse[/Domestic Partner] may both elect individual (employee only) coverage; or
- (b) either the Insured or his/her spouse/common law spouse[/Domestic Partner] may elect coverage for both (with the other spouse/common law spouse[/Domestic Partner] being covered as a Dependent), and the other spouse/common law spouse[/Domestic Partner] may not enroll for coverage.

If both the Insured and his/her spouse/common law spouse[/Domestic Partner]:

- (a) are eligible for coverage under the Policy as Insureds; and
- (b) have Dependent children,

either the Insured or his/her spouse/common law spouse[/Domestic Partner] (but not both) may elect Dependent coverage, and such Dependent coverage will not apply to the other spouse/common law spouse[/Domestic Partner.]

[Non-Contributory Employee Coverage (Employer pays 100% of the Insured's premium.)

If the Insured and his/her spouse/common law spouse[/Domestic Partner]:

- (a) are both eligible for coverage under the Policy as Insureds; and
- (b) have no Dependent children,

the Insured and his/her spouse/common law spouse[/Domestic Partner] will both be covered as employees. Dependent coverage is not available or applicable in this situation.

If both the Insured and his/her spouse/common law spouse[/Domestic Partner]:

- (a) are eligible for coverage under the Policy as Insureds; and
- (b) have Dependent children,

the Insured and his/her spouse/common law spouse[/Domestic Partner] will both be covered as employees. Either the Insured or his/her spouse/common law spouse[/Domestic Partner] (but not both) may elect Dependent coverage, and such Dependent coverage will not apply to the other spouse/common law spouse[/Domestic Partner].

If an eligible employee has a Dependent child who is also eligible as an employee, both the Insured and his/her Dependent child will be covered as employees. If the employee elects Dependent coverage, such Dependent coverage will not apply to any Dependent child who is already covered as an employee.]

Dual Eligibility / Divorce [or Dissolution of Partnership]

If both the Insured and his/her spouse/common law spouse[/Domestic Partner] are covered as Insureds under the Policy, and have covered Dependent children, and later:

- (a) become divorced; [or
- (b) their partnership is dissolved,]

SECTION 2 ELIGIBILITY AND EFFECTIVE DATE

the required conditions in the definition of Dependent (e.g., residence, support and maintenance) will be used to determine which parent may cover the Dependent(s). Any child who was a step-child of the Insured will no longer be eligible for coverage, unless the Insured has adopted such child.

Dual Eligibility / Termination of Employment

If the Insured and his/her spouse/common law spouse[/Domestic Partner] are covered as Insureds under the Policy and one of them terminates employment, the remaining employee will be permitted to immediately enroll the terminating spouse/common law spouse[/Domestic Partner] and any of his or her eligible Dependents who were enrolled under the terminating spouse/common law spouse[/Domestic Partner's] coverage. Such new coverage will be deemed continuation of prior coverage, and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the employee or the Dependent of the terminated employee.

DEPENDENT ENROLLMENT

Dependent coverage may be elected by the Insured:

- (a) completing the enrollment process for Dependent coverage within 31 days of the date the Dependent becomes eligible; and
- (b) authorizing the employer to deduct any required premium for Dependent coverage from his/her paycheck.

Dependent coverage will not be made effective if enrollment is not complete.

DEPENDENT EFFECTIVE DATE

[The Effective Date for each eligible Dependent will be the first day of the month following his or her enrollment, provided:

- (a) such Dependent's enrollment process is complete; and
- (b) the first payroll deduction is made for such Dependent's coverage under the Policy; and
- (c) the first premium for such Dependent has been accepted by the Company. /

The Effective Date for each eligible Dependent will be the first day after the Normal Pay Date for which the first payroll deduction is taken for such Dependent's coverage under the Policy, provided:

- (a) such Dependent's enrollment process is complete; and
- (b) the first premium for such Dependent has been accepted by the Company. /

The Effective Date for each eligible Dependent will be [*as agreed upon between the Company and the Policyholder*], provided:

- (a) such Dependent's enrollment process is complete; and
- (b) the first payroll deduction is made for such Dependent's coverage under the Policy; and
- (c) the first premium for such Dependent has been accepted by the Company.]

However, if on such date the Insured's coverage has not yet taken effect, the Effective Date for Dependent coverage will be the same date the Insured's coverage goes into effect.

An Insured's newborn child will become insured for Accident or Sickness automatically on the day he or she is born, as long as the Insured's coverage is in force on that date. The newborn child's coverage will not continue past the 90-day period following birth unless:

- (a) the Company is notified by the end of that 90-day period of the addition of such newborn or adopted child; and
- (b) any applicable additional premium is paid.

An Insured's adopted child will become insured on:

- (a) the date of the filing of a petition for adoption if the Insured applies for coverage and pays the applicable premium within 60 days after filing such petition; or
- (b) the moment of birth if the petition for adoption is filed and application for coverage, along with payment of the applicable premium is made, within 60 days after the birth.

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[Applicable to Term Life Insurance and Vision Insurance only: If a Dependent is Totally Disabled on the date coverage (with respect to that particular Dependent) would otherwise take effect, the coverage of such Dependent will be deferred until the [first of the month/next payroll deduction period] following the Dependent's cessation of Total Disability.]

SPECIAL ENROLLMENT UNDER HIPAA (Health Insurance Portability and Accountability Act of 1996)

Special Enrollment under HIPAA is not applicable to:

- [(a) Term Life/Accidental Death and Dismemberment Insurance, Disability Income Insurance, or Vision Insurance; or
- (b)] Domestic Partners or same-sex spouses, or the dependents of such Domestic Partners or same-sex spouses.

Eligibility for Special Enrollment

An employee or Dependent is eligible for Special Enrollment under HIPAA if:

- (a) coverage under the Policy was declined when initially offered, due to such person having coverage under any group health plan or health insurance coverage; and
- (b) such person has now lost that coverage.

An employee or Dependent is also eligible for Special Enrollment under HIPAA if the employee:

- (a) gains a dependent child due to birth, adoption, or placement of a child with the employee for the purpose of adoption; or
- (b) marries.

Conditions for Special Enrollment

Loss of eligibility for coverage that is not COBRA continuation coverage

An employee may enroll during a Special Enrollment Period if loss of coverage was as the result of:

- (a) legal separation or divorce;
- (b) a reduction in the number of hours of employment;
- (c) termination of HMO (or other arrangement) in the individual market due to the employee no longer residing, living, or working in the covered service area;
- (d) termination of HMO (or other arrangement) in the group market due to the employee no longer residing, living, or working in the covered service area, and if no other benefit package is available to the employee;
- (e) incurring a claim that would meet or exceed a lifetime limit on all benefits; or
- (f) a situation in which a plan no longer offers any benefits to the class of similarly situated individuals, such class including the employee.

A Dependent may be enrolled during a Special Enrollment Period if loss of coverage was as the result of:

- (a) legal separation or divorce;
- (b) such Dependent's cessation of dependent status (e.g., attaining the maximum age to be eligible as a dependent child under the plan);
- (c) death of an employee;
- (d) termination of employment;
- (e) a reduction in the number of hours of employment;
- (f) termination of HMO (or other arrangement) in the individual market due to the employee no longer residing, living, or working in the service area;
- (g) termination of HMO (or other arrangement) in the group market due to the employee no longer residing, living, or working in the service area, and if no other benefit package is available to the employee;
- (h) incurring a claim that would meet or exceed a lifetime limit on all benefits; or
- (i) a situation in which a plan no longer offers any benefits to the class of similarly situated individuals, such class including the employee.

Special Enrollment is not available under any of the above conditions if loss of coverage is due to:

- (a) failure to pay premiums on a timely basis; or

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- (b) termination of coverage due to cause (e.g., making a fraudulent claim, or an intentional misrepresentation of fact in connection with the plan).

Termination of employer contributions for coverage that is not COBRA continuation coverage

An employee or Dependent may enroll during a Special Enrollment Period if an employer's contributions towards the employee's or Dependent's coverage terminates. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or Dependent.

Exhaustion of COBRA continuation coverage

An employee or Dependent may enroll during a Special Enrollment Period if such person's COBRA continuation coverage was exhausted due to:

- (a) such person reaching the end of their maximum continuation period;
- (b) the failure of the employer or other responsible entity to remit premiums on a timely basis;
- (c) such person no longer residing, living, or working in the service area of an HMO or similar program, and there is no other COBRA continuation coverage available to such person; or
- (d) such person incurring a claim that would meet or exceed a lifetime limit on all benefits, and there is no other COBRA continuation coverage available to such person.

Special Enrollment is not available under any of the above conditions if loss of coverage is due to:

- (a) failure to pay premiums on a timely basis; or
- (b) termination of coverage due to cause (e.g., making a fraudulent claim, or an intentional misrepresentation of fact in connection with the plan).

Marriage, birth, adoption, or placement for adoption

An employee or Dependent may enroll during a Special Enrollment Period if the employee:

- (a) gains a dependent child due to birth, adoption, or placement of a child for the purpose of adoption; or
- (b) marries.

Effective Date for Special Enrollment

With respect to a person whose coverage becomes effective as a result of a Special Enrollment under HIPAA, such coverage shall become effective:

- (a) in the case of marriage, the [first day of the first month following the] date of marriage; or
- (b) in the case of an eligible Dependent's birth, as of the date of such birth; or
- (c) in the case of an eligible Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption,

provided the usual Effective Date conditions are satisfied, as stated in EMPLOYEE EFFECTIVE DATE and/or DEPENDENT EFFECTIVE DATE above.

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HEALTH INSURANCE *(Applicable only if this coverage is not excluded in the Schedule.)*

The Company will pay Covered Charges for a service or supply that is described under one or more of the following listed categories of benefits, subject to any and all applicable maximum dollar and/or durational amounts. The service or supply must be provided for a covered Accident or Sickness. All benefit amounts and any applicable Deductibles, Coinsurance amounts, Co-payments, and maximums are shown in the Schedule.

Inpatient Benefits

Inpatient Benefits are payable for services and supplies that are provided to a Covered Person while Confined in a Hospital.

Room and Board Benefit

The Company will pay this benefit when a Covered Person is charged for room and board, regardless of the level of care (e.g. semi-private, private, intensive care). No benefit will be paid during any period such Covered Person is not under the Regular Care and Attendance of a Physician.

[Daily Hospital Indemnity Benefit (Not applicable to Dependents.)

If an Insured is Confined in a Hospital, the Company will pay the Daily Hospital Indemnity Benefit amount for each day of Confinement, for up to the Maximum Number of Days of Confinement. No benefit will be paid during any period the Covered Person is not under the Regular Care and Attendance of a Physician.]

Inpatient Physician Non-Surgical Services Benefit

The Company will pay this benefit for non-surgical services rendered by a Physician, including but not limited to:

- (a) regular consults and exams by the attending Physician; and
- (b) consults and exams by Physician specialists; and
- (c) readings and interpretations of diagnostic laboratory tests, screenings, and x-rays.

Inpatient Physician Surgical Services Benefit

The Company will pay this benefit for surgical services rendered on an inpatient basis by a Physician for a covered surgery.

If two or more surgical procedures are performed through the same incision or the same operative field, payment will be made only for the procedure of the larger benefit. If more than one procedure is performed, but each through separate incisions or in a separate operative field, the amount payable will be the benefit amount for the primary procedure, plus 50% of the amount payable for all other surgical procedures performed.

Inpatient Anesthetic Services and Anesthesia Benefit

The Company will pay this benefit for:

- (a) Physician's services for administration of anesthesia when the anesthesia is provided in connection with a covered surgery performed on an inpatient basis; and
- (b) the cost of such anesthesia.

This benefit is also payable with respect to dental surgical procedures only if such procedure is performed in a Hospital and the Covered Person:

- (a) is a child or adolescent who:
 - (1) is determined by a licensed dentist to require necessary dental treatment in a Hospital or ambulatory surgical center due to a significantly complex dental condition, or a developmental disability in which patient management in the dental office has proved to be ineffective; or
 - (2) is extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred, and for whom lack

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of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;

or

- (b) has extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or
- (c) is one for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy; or
- (d) has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

Inpatient Miscellaneous Services and Supplies

The Company will pay this benefit for other covered services and supplies, including but not limited to:

- (a) facility charges other than room and board (e.g. recovery room); and
- (b) nursing services; and
- (c) treatment by radiologists and physiotherapists; and
- (d) therapy services; and
- (e) oxygen, and the equipment for its administration; and
- (f) blood and blood plasma, and its processing costs; and
- (g) medications and other pharmaceutical products, including associated supplies and administration; and
- (h) non-durable medical supplies (e.g. bandages, casts, splints); and
- (i) diagnostic laboratory tests, screenings, and x-rays; and
- (j) testing of newborns for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and other newborn tests which may become mandated by law; and
- (k) hospice services.

Outpatient Benefits

The Company will pay benefits for covered services and supplies received on an Outpatient basis that are not payable under another listed Benefit. This includes, but is not limited to:

- (a) outpatient facilities, such as ambulatory surgical centers or emergency care clinics (whether free-standing or located within a Hospital); and
- (b) treatment by radiologists and physiotherapists; and
- (c) therapy services; and
- (d) diagnostic laboratory tests, screenings, and x-rays; and
- (e) oxygen, and the rental equipment for its administration; and
- (f) medications and other pharmaceutical products, none of which are obtainable through a written prescription. This includes:
 - (1) nutritional supplements for the treatment and management of phenylketonuria and other inheritable diseases; and
 - (2) childhood immunizations, including their administration (exempt from deductible coinsurance, or co-payment); and
 - (3) medications and supplies for the treatment of cancer, including their administration; and
 - (4) medications and supplies for the treatment of diabetes, including their administration, and supplies for the prevention of complications associated with diabetes;
- and
- (g) hospice services; and
- (h) non-durable medical supplies (e.g., bandages, casts, splints); and
- (i) any type of contraceptive, including its administration. (Contraceptives obtainable through a written prescription are payable under the Prescription Drug Card Benefit.)

[Benefits for services and supplies received while in an Emergency Room, for the treatment of Sickness, are payable only under the Emergency Room Sickness Benefit.]

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[Benefits for services and supplies received while in an Emergency Room, for the treatment of an Accident, are payable under the Supplemental Accident Benefit.]

Outpatient Physician Non-Surgical Services Benefit

The Company will pay this benefit for each time a Covered Person is charged for non-surgical services by a Physician during an office visit, or for a home health care visit. This benefit is also payable for visits for:

- (a) contraceptive services; and
- (b) diabetes self-management training; and
- (c) readings and interpretations of diagnostic laboratory tests, screenings, and x-rays; and
- (d) treatment of loss or impairment of speech and hearing; and
- (e) well-child exams from birth through age 18, which includes up to 20 visits at approximately the following intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years; and
- (f) in-vitro fertilization, subject to the following:
 - (1) the patient is a Covered Person under the Policy and is insured for pregnancy benefits; and
 - (2) the patient's oocytes are fertilized only with the sperm of the Covered Person's spouse; and
 - (3) the patient and patient's spouse have a history of unexplained infertility of at least two years' duration; or
 - (3) the infertility is associated with one or more of the following:
 - a. endometriosis; or
 - b. exposure in utero to diethylstilbestrol (DES); or
 - c. blockage of or surgical removal of one or both fallopian tubes, not a result of voluntary sterilization; or
 - d. abnormal male factors contributing to the infertility; and
 - (4) the patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the Policy; and
 - (5) the in vitro fertilization procedures are performed at a medical facility that conforms to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimum standards for programs of in vitro fertilization;]

Outpatient Physician Surgical Services Benefit

The Company will pay this benefit for surgical services rendered on an outpatient basis by a Physician for a covered surgery.

If two or more surgical procedures are performed through the same incision or the same operative field, payment will be made only for the procedure of the larger benefit. If more than one procedure is performed, but each through separate incisions or in a separate operative field, the amount payable will be the benefit amount for the primary procedure, plus 50% of the amount payable for all other surgical procedures performed.

Outpatient Anesthetic Services and Anesthesia Benefit

The Company will pay this benefit for:

- (a) Physician's services for administration of anesthesia when the anesthesia is provided in connection with a covered surgery performed on an outpatient basis; and
- (b) the cost of such anesthesia.

This benefit is also payable with respect to dental surgical procedures only if such procedure is performed in an ambulatory surgical center and the Covered Person:

- (a) is a child or adolescent who:
 - (1) is determined by a licensed dentist to require necessary dental treatment in a Hospital or ambulatory surgical center due to a significantly complex dental condition, or a

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- developmental disability in which patient management in the dental office has proved to be ineffective; or
- (2) is extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred, and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;
- or
- (b) has extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or
- (c) is one for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy; or
- (d) has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

[Additional Benefits

These are separate benefits that do not count towards the Inpatient Maximum Benefit or the Outpatient Maximum Benefit, and are not subject to any other stated Deductible, Coinsurance, Co-Payment, or any other limitation, other than what is stated in the Schedule with respect to each benefit.]

[Hospital Admission Indemnity Benefit

The Company will pay this lump sum benefit once for each period of Confinement.]

[Intensive Care Unit Indemnity Benefit

The Company will pay this lump sum benefit once for each day of Confinement in an Intensive Care Unit of a Hospital.]

[Emergency Room Sickness Benefit

The Company will pay this benefit for each episode of care received in a Hospital emergency room, for the treatment of Sickness. No other benefit is payable under the Policy for services or supplies received, or for facility charges made, for care received in a Hospital emergency room, for the treatment of Sickness.]

[Supplemental Accident Benefit

The Company will pay this benefit for covered services and supplies received by a Covered Person, for the treatment of injury due to an Accident, but only after any and all other benefits are paid under the Policy. Charges for such services and supplies must be incurred within 90 days of the Accident. Outpatient prescription drugs are not included in this benefit, and are payable only under the Prescription Drug Card Benefit.]

[Wellness Benefit (applicable only to Covered Persons age 18 years or older)

The Company will pay this benefit for the following, when used for wellness purposes:

- (a) Physician office visits (including expense of administration of immunizations); and
- (b) x-ray and laboratory tests, including, but not limited to:
- (1) mammograms; and
 - (2) pap smears; and
 - (3) CA-125 tests; and
 - (4) PSA tests/prostate cancer screening (not subject to any deductible); and
 - (5) urine tests; and
 - (6) bone mass tests; and
 - (7) blood tests; and
 - (8) colorectal cancer screening.]

[Prescription Drug Card Benefit

The Company will pay this benefit for each complete fill or refill of a medication or supply that is:

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- (a) obtainable only with a written prescription; and
- (b) dispensed by a pharmacy.

This benefit includes contraceptives.]

[Durable Medical Equipment and Prosthesis Benefit

The Company will pay this benefit for:

- (a) equipment for the monitoring and treatment of diabetes (e.g. blood glucose monitors, insulin pumps, insulin infusion devices); and
- (b) hearing aids (not subject to any deductibles or co-payments); and
- (b) the purchase or rental of Durable Medical Equipment; and
- (c) the expense of a Prosthesis. This includes, but is not limited to external or internal breast prostheses required as the result of a medically necessary mastectomy.]

[TERM LIFE INSURANCE *(Applicable only if this coverage is not excluded in the Schedule.)*

If a Covered Person dies, the Company will pay the Death Benefit, subject to the provisions of the Policy. The amount of the Death Benefit is shown in the Schedule.

Payment of Death Benefit

With respect to the death of the Insured, payment of the Death Benefit will be made in a lump sum to the Beneficiary named by the Insured. If more than one Beneficiary has been named:

- (a) the Death Benefit will be paid in equal shares to all named, living Beneficiaries; or,
- (b) if the Insured's Beneficiary election indicates a different proportion of benefit payment, the Death Benefit will be paid as instructed by the Insured.

With respect to the death of a Dependent, payment of the Death Benefit will be made in a lump sum to the Insured.

The Company may pay benefits to someone other than the Insured or his/her Beneficiary if:

- (a) the Insured's Beneficiary is a minor, or cannot give a valid release; or
- (b) no request for payment has been made by a duly appointed guardian; or
- (c) the person to whom payment will be made appears to have assumed the Insured's, or the Insured's Beneficiary's, care and main support.

The Company may pay up to \$250.00, or the maximum amount permitted by state law, whichever is greater, to any person appearing to be entitled to such payment by reason of having incurred funeral or other expenses incident to the last illness or death of the Covered Person.

Any payment the Company makes is done so in good faith; it will fully discharge the Company for the amount of such payment.]

[Naming and Changing a Beneficiary

The Insured may name a Beneficiary to whom the Death Benefit will be paid. If the Insured did not name a Beneficiary, or if there is no living Beneficiary at the time of the Insured's death, the order of Beneficiary determination is as follows:

- (a) the Insured's lawful spouse or common law spouse [or Domestic Partner]; then
- (b) the Insured's child or children (in equal shares); then
- (c) the Insured's parent or parents (in equal shares); then
- (d) the Insured's brother(s) and/or sister(s) (in equal shares); then
- (e) the Insured's estate.

For purposes of this provision, child, parent, brother and sister includes step or adopted child(ren), step-parent(s), step-brother(s) and step-sister(s), respectively.

The Insured may name a new Beneficiary from time to time. The consent of the existing Beneficiary is not needed to make this or any other change in the Policy. (If the Beneficiary has been named irrevocable, see the next paragraph.) The Insured must file a written request for the change. The change will not take effect until the Company receives and approves the request at its home office. When

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received and approved, the change goes back to and takes effect as of the date such request was made. This will happen even if the Insured dies between the time the request is made and it is received and recorded by the Company. However, any amount paid prior to receiving and recording such request will not be subject to the request for change.]

[If the Insured applies for a conversion policy or apply for a different amount of insurance and names a new Beneficiary on that application, this will be considered a request for a change of Beneficiary. This means that the change in Beneficiary will apply to the Policy as well as to the conversion policy, even though the conversion policy itself or the changed amount may not yet have taken effect. (For more details about conversion, see the following Conversion Privilege provision.)

Irrevocable Beneficiary

The Insured can make an irrevocable Beneficiary designation. This means that the Insured gives up the right to change the Beneficiary. The Insured can get this right back if:

- (a) the Beneficiary gives written consent; or
- (b) the Beneficiary dies.

If an irrevocable Beneficiary designation is in effect, the rules about changing the Beneficiary stated above do not apply.

Conversion Privilege *(The Conversion Privilege is available only if the Company has a policy form approved in the Covered Person's state of residence, at the time application for conversion is made.)*

If insurance, or any portion of it, on a Covered Person ends because of:

- (a) the Insured's termination of employment; or
- (b) the Insured's termination of membership in a class eligible for coverage,

such Covered Person may convert to an individual life policy if:

- (a) written application is made for the individual policy; and
- (b) the first premium for the individual policy is paid to the Company,

within 31 days after the date of termination.

The individual policy will be subject to the following conditions:

- (a) Proof of good health will not be required.
- (b) The policy will not have any disability or other supplementary benefits.
- (c) The Covered Person can choose any form, except term insurance, then in use by the Company.
- (d) The amount cannot be more than the amount of life insurance which ceases because of such termination.
- (e) The rate will be the Company's customary rate, based on the form, the amount, the Covered Person's class of risk, and age at the time the individual policy takes effect.]

[Subject to the above conditions, the conversion privilege will also be available to:

- (a) a surviving Dependent, if any, upon the Insured's death; and (This applies only to coverage under the Policy which terminates by reason of such death.)
- (b) the Insured's Dependent, if termination of coverage is due to the Dependent no longer meeting the definition of Dependent. (This applies only if Dependent coverage terminates while the Insured remains covered under the Policy.)

If insurance on any Covered Person stops because:

- (a) the Policy terminates; or
- (b) the Policy is changed so that a class of insured persons is terminated,

such person can convert; however, the Covered Person must have been insured under the Policy for at least five years immediately preceding the date of termination of insurance. Conversion is subject to the same rules outlined above, except the amount will not exceed the lesser of:

- (a) the amount of insurance ceasing; or
- (b) \$10,000.00.

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If the Covered Person dies during the 31-day period in which he or she is entitled to a conversion policy but before such plan takes effect, an amount of life insurance shall be payable. The amount shall be that which the Covered Person would have been entitled to have issued under the conversion policy. The amount shall be payable as a claim under the Policy, whether or not application or premium payment on the conversion policy has been made.

This conversion privilege is in lieu of all other benefits under the Policy. The effective date of the conversion plan will be the 32nd day after the date that premiums were paid to under the Policy.

If the Insured has assigned all ownership rights absolutely to an assignee, then the assignee (instead of the Insured) is entitled to exercise the conversion privilege.

The Insured will be given notice of his/her conversion right at least 15 days before the end of the 31-day conversion period. If such notice is not given, the Insured has an additional period of time to exercise his/her right. This period ends 15 days after the date the Insured is given notice, but in no event shall the additional period extend beyond 60 days after the original 31-day period (for a total of 91 days). In no event, however, will insurance under the Policy be continued beyond the original 31-day period.

Notice shall mean written notice that is given or mailed to the Insured. Notice may be mailed by the Policyholder, or by Company, to the Insured's last known address.

If the Insured becomes Totally Disabled while covered under this Life Insurance Benefit, this coverage may be continued during the Total Disability subject to timely payment of the premium that the Insured was required to pay had the Total Disability not occurred. Continued coverage will end the earlier of:

- (a) six months from the date the Total Disability began; or
- (b) discontinuance of the Policy; or
- (c) the Insured ceases to be Totally Disabled.

[ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE—Not applicable to Dependents.

(Applicable only if this coverage is not excluded in the Schedule.)

If the Insured suffers loss of life, sight or limb(s) due to an accidental bodily injury, the Company will pay an Accidental Death and Dismemberment Benefit for such loss if the following conditions are met:

- (a) The loss must result directly from an injury. The injury must be caused by an Accident that occurs while the Policy is in force.
- (b) The loss must occur no later than 90 days after the date the injury was received.
- (c) The loss must not be excluded.
- (d) The loss of a hand or foot means the permanent severance at or above the wrist or ankle joint.
- (e) The loss of sight means total and irrecoverable loss of sight.

The benefit amount payable for a loss, which meets the conditions stated above, is as follows:

For Loss of Life.....	100% of the Principal Sum
For Loss of One Hand.....	50% of the Principal Sum
For Loss of One Foot.....	50% of the Principal Sum
For Loss of Sight of One Eye.....	50% of the Principal Sum
For Loss of more than one of the above in any one Accident.....	100% of the Principal Sum]

[The "Principal Sum" is the amount shown in the Schedule. Only one of the amounts, the greatest, will be paid for more than one loss resulting from the same accident.]

[DENTAL INSURANCE. *(Applicable only if this benefit is not excluded in the Schedule.)*

If a Covered Person incurs Covered Charges for dental expenses, the Company will pay the benefit amount shown in the Schedule of Dental Benefits, according to the Expense Class shown in such Schedule of Dental Benefits. A charge is incurred on the date that treatment is given, service is rendered, or a supply is furnished. The benefit amount is subject to:

- (a) the Calendar Year Deductible; and
- (b) the Calendar Year Maximum; and

**SECTION 3
BENEFIT PROVISIONS**

- (c) the Alternative Benefits provision; and
- (d) all other applicable provisions of the Policy.

Unlisted Treatment, Services or Supplies

Benefits for treatment, services or supplies not listed in the Schedule of Dental Benefits will be determined by the Company. The benefit will be based upon the extent and type of damage, and nature of materials used.

Alternative Benefits

If various types of treatment are available, the Covered Dental Expenses will be limited to the Dental Service Benefit payable for the least expensive treatment that will produce a professionally adequate result as determined by the Company.]

**SECTION 3
BENEFIT PROVISION**

[SCHEDULE OF DENTAL BENEFITS

SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS
DIAGNOSTIC & EVALUATION		
Office Visit	D0999	A
Periodic Oral Exam	D0120	A
Limited Oral Exam – Problem Focused	D0140	A
Comprehensive Oral Exam – Under age 3	D0145	A
Comprehensive Oral Exam – Age 3 or older	D0150	A
Extensive Oral Exam – Problem Focused	D0160	A
Reevaluation – Limited, Problem Focused	D0170	A
Comprehensive Periodontal Exam	D0180	A
Intraoral – Complete Series	D0210	A
Intraoral – Periapical – 1st Film	D0220	A
Intraoral – Periapical – Each Additional Film	D0230	A
Intraoral – Occlusal Film	D0240	A
Extraoral – 1st Film	D0250	A
Extraoral – Each Additional Film	D0260	A
Bitewing – 1 Film	D0270	A
Bitewing – 2 Films	D0272	A
Bitewing – 3 Films	D0273	A
Bitewing – 4 Films	D0274	A
Vertical Bitewings	D0277	A
Panoramic Film	D0330	A
Caries Susceptibility Test	D0425	A
Biopsy and Exam of Oral Tissue, Hard	D0430	A
Pulp Vitality Tests	D0460	A
Diagnostic Casts	D0470	A
PREVENTATIVE		
Prophylaxis – Age 14 or older	D1110	A
Prophylaxis – Under age 14	D1120	A
Fluoride (Prophylaxis Not Included) – Under age 19	D1203	A
Fluoride (Prophylaxis Not Included) – Age 19 or older	D1204	A
Sealant – Per Tooth	D1351	A
Space Maintainer – Fixed – Unilateral	D1510	A
Space Maintainer – Fixed – Bilateral	D1515	A
Space Maintainer – Removable – Unilateral	D1520	A
Space Maintainer – Removable – Bilateral	D1525	A
Re-cementation of Space Maintainer	D1550	A
RESTORATIVE DENTISTRY		
Amalgam – 1 Surface, Permanent	D2140	A
Amalgam – 2 Surfaces, Permanent	D2150	A
Amalgam – 3 Surfaces, Permanent	D2160	A
Amalgam – 4+ Surfaces, Permanent	D2161	A
Resin Composite – 1 Surface, Anterior	D2330	A
Resin Composite – 2 Surfaces, Anterior	D2331	A
Resin Composite – 3 Surfaces, Anterior	D2332	A
Resin Composite – 4+ Surfaces, Anterior	D2335	A
Resin Composite – 1 Surface, Posterior	D2391	A
Resin Composite – 2 Surfaces, Posterior	D2392	A
Resin Composite – 3 Surfaces, Posterior	D2393	A
Resin Composite – 4+ Surfaces, Posterior	D2394	A
Gold Foil – 1 Surface	D2410	B
Gold Foil – 2 Surfaces	D2420	B
Gold Foil – 3 Surfaces	D2430	B

SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS
ONLAYS, CROWNS, BRIDGES		
Inlay – Metallic – 1 Surface	D2510	B
Inlay – Metallic – 2 Surfaces	D2520	B
Inlay – Metallic – 3+ Surfaces	D2530	B
Onlay – Metallic – 2 Surfaces	D2542	B
Onlay – Metallic – 3 Surfaces	D2543	B
Onlay – Metallic – 4+ Surfaces	D2544	B
Inlay – Porcelain/Ceramic – 1 Surface	D2610	B
Inlay – Porcelain/Ceramic – 2 Surfaces	D2620	B
Inlay – Porcelain/Ceramic – 3+ Surfaces	D2630	B
Onlay – Porcelain/Ceramic – 2 Surfaces	D2642	B
Onlay – Porcelain/Ceramic – 3 Surfaces	D2643	B
Onlay – Porcelain/Ceramic – 4+ Surfaces	D2644	B
Inlay – Resin Composite – 1 Surface	D2650	B
Inlay – Resin Composite – 2 Surfaces	D2651	B
Inlay – Resin Composite – 3+ Surfaces	D2652	B
Onlay – Resin Composite – 2 Surfaces	D2662	B
Onlay – Resin Composite – 3 Surfaces	D2663	B
Crown – Resin – Laboratory	D2710	B
Crown – Resin with High Noble Metal	D2720	B
Crown – Resin with Base Metal	D2721	B
Crown – Resin with Noble Metal	D2722	B
Crown – Porcelain/Ceramic Substrate	D2740	B
Crown – Porcelain with High Noble Metal	D2750	B
Crown – Porcelain with Predominantly Base Metal	D2751	B
Crown – Porcelain With Noble Metal	D2752	B
Crown – 3/4 Cast High Noble Metal	D2780	B
Crown – 3/4 Cast Predominantly Base Metal	D2781	B
Crown – 3/4 Cast Noble Metal	D2782	B
Crown – 3/4 Porcelain/Ceramic	D2783	B
Crown – Full Cast High Noble Metal	D2790	B
Crown – Full Cast Predominantly Base Metal	D2791	B
Crown – Full Cast Noble Metal	D2792	B
Re-cement Inlay	D2910	A
Re-cement Crown	D2920	A
Core Build Up, Including any Pins	D2950	B
Pin Retention – Per Tooth, in Addition to Restoration	D2951	B
Cast Post and Core, in Addition to Crown	D2952	B
Cast Post and Core, Each Additional (Same Tooth)	D2953	B
Prefabricated Post and Core, in Addition to Crown	D2954	B
Each Additional Prefabricated Post, same tooth	D2957	B
Temporary Crown (fractured tooth)	D2970	B
Crown Repair	D2980	B
ENDODONTICS		
Pulp Cap – Direct	D3110	A
Pulp Cap – Indirect	D3120	A
Therapeutic Pulpotomy	D3220	A
Pulpal Debridement, Primary/Permanent	D3221	A
Pulpal Therapy – Anterior, Primary Tooth	D3230	A
Pulpal Therapy – Posterior, Primary Tooth	D3240	A
Root Canal – Anterior	D3310	B]

**SECTION 3
BENEFIT PROVISION**

[SCHEDULE OF DENTAL BENEFITS

SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS
Root Canal – Bicuspid	D3320	B
Root Canal – Molar	D3330	B
Retreatment of Previous RCT – Anterior	D3346	B
Retreatment of Previous RCT – Bicuspid	D3347	B
Retreatment of Previous RCT – Molar	D3348	B
Apexification/Recalcification – Initial Visit	D3351	B
Apexification/Recalcification – Interim Visit	D3352	B
Apexification/Recalcification – Final Visit	D3353	B
Apicoectomy/Periradicular – Anterior	D3410	B
Apicoectomy/Periradicular – Bicuspid, 1st Root	D3421	B
Apicoectomy/Periradicular – Molar, 1st Root	D3425	B
Apicoectomy/Periradicular, Each Additional Root	D3426	B
Retrograde Filling – Per Root	D3430	B
Root Amputation – Per Root	D3450	B
Hemisection (Including any Root Removal)	D3920	B
PERIODONTICS		
Gingivectomy/Gingivoplasty – 4+ teeth/quad	D4210	B
Gingivectomy/Gingivoplasty – 1-3 teeth/quad	D4211	B
Gingival Flap – Incl. Root Planing – 4+ teeth/quad	D4240	B
Gingival Flap – Incl. Root Planing – 1-3 teeth /quad	D4241	B
Crown Lengthening – Hard Tissue	D4249	B
Osseous Surgery – 4+ teeth/quad	D4260	B
Osseous Surgery – 1-3 teeth/quad	D4261	B
Pedicle Soft Tissue Graft Procedure	D4270	B
Free Soft Tissue Graft Procedure	D4271	B
Subepithelial Connective Tissue Graft Procedure	D4273	B
Distal/Proximal Wedge Procedure (no surgery)	D4274	B
Soft Tissue Allograft	D4275	B
Combined Connective Tissue/Double Pedicle Graft	D4276	B
Provisional Intracoronal Splint	D4320	B
Provisional Extracoronal Splint	D4321	B
Perio. Scaling & Root Planing – 4+ teeth/quad	D4341	B
Perio. Scaling & Root Planing – 1-3 teeth /quad	D4342	B
Full Mouth Debridement	D4355	B
Periodontal Maintenance Procedures	D4910	A
REMOVABLE PROSTHETICS		
Complete Denture – Upper	D5110	B
Complete Denture – Lower	D5120	B
Immediate Denture – Upper	D5130	B
Immediate Denture – Lower	D5140	B
Upper Partial Denture – Resin Base	D5211	B
Lower Partial Denture – Resin Base	D5212	B
Upper Partial – Cast Metal Frame, Resin Base	D5213	B
Lower Partial – Cast Metal Frame, Resin Base	D5214	B
Removable Unilateral Partial – 1 Piece Cast Metal	D5281	B
Adjust Complete Denture – Upper	D5410	A
Adjust Complete Denture – Lower	D5411	A

SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS
Adjust Partial Denture – Upper	D5421	A
Adjust Partial Denture – Lower	D5422	A
Repair Broken Complete Denture Base	D5510	A
Replace Missing or Broken Teeth, Complete Denture – Per Tooth	D5520	A
Repair Resin Denture Base, Complete Denture	D5610	A
Repair Cast Framework	D5620	A
Repair or Replace Broken Clasp	D5630	A
Replace Broken Teeth, Complete Denture – Per Tooth	D5640	A
Add Tooth to Existing Partial Denture	D5650	A
Add Clasp to Existing Partial Denture	D5660	A
Replace All Teeth and Acrylic on Cast Metal Framework (Upper)	D5670	A
Replace All Teeth and Acrylic on Cast Metal Framework (Lower)	D5671	A
Rebase Complete Upper Denture	D5710	A
Rebase Complete Lower Denture	D5711	A
Rebase Upper Partial Denture	D5720	A
Rebase Lower Partial Denture	D5721	A
Reline Complete Upper Denture (Chairside)	D5730	A
Reline Complete Lower Denture (Chairside)	D5731	A
Reline Upper Partial Denture (Chairside)	D5740	A
Reline Lower Partial Denture (Chairside)	D5741	A
Reline Complete Upper Denture (Laboratory)	D5750	A
Reline Complete Lower Denture (Laboratory)	D5751	A
Reline Upper Partial Denture (Laboratory)	D5760	A
Reline Lower Partial Denture (Laboratory)	D5761	A
Tissue Conditioning – Upper	D5850	A
Tissue Conditioning – Lower	D5851	A
PONTICS		
Pontic – Cast High Noble Metal	D6210	B
Pontic – Cast Predominantly Base Metal	D6211	B
Pontic – Cast Noble Metal	D6212	B
Pontic – Porcelain With High Noble Metal	D6240	B
Pontic – Porcelain With Predom Base Metal	D6241	B
Pontic – Porcelain With Noble Metal	D6242	B
Pontic – Porcelain/Ceramic	D6245	B
Retainer – Cast Metal or Resin Bonded Fixed Prosthesis	D6545	B
Retainer – Porcelain/Ceramic or Resin Bonded Fixed Prosthesis	D6548	B
Inlay – Porcelain/Ceramic, 2 Surfaces	D6600	B
Inlay – Porcelain/Ceramic, 3+ Surfaces	D6601	B
Inlay – Cast High Noble Metal, 2 Surfaces	D6602	B
Inlay – Cast High Noble Metal, 3+ Surfaces	D6603	B
Inlay – Cast Predom. Base Metal, 2 Surfaces	D6604	B
Inlay – Cast Predom. Base Metal, 3+ Surfaces	D6605	B
Inlay – Cast Noble Metal, 2 Surfaces	D6606	B
Inlay – Cast Noble Metal, 3+ Surfaces	D6607	B
Onlay – Porcelain/Ceramic, 2 Surfaces	D6608	B]

**SECTION 3
BENEFIT PROVISION**

[SCHEDULE OF DENTAL BENEFITS

SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS	SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS
Onlay – Porcelain/Ceramic, 3+ Surfaces	D6609	B	Surg. Exp. Of Impacted/Unerupted Tooth-Aid Erup	D7281	A
Onlay – Cast High Noble Metal, 2 Surfaces	D6610	B	Biopsy of Oral Tissue – Hard (Bone, Tooth)	D7285	A
Onlay – Cast High Noble Metal, 3+ Surfaces	D6611	B	Biopsy of Oral Tissue – Soft (All Others)	D7286	A
Onlay – Cast Predom. Base Metal, 2 Surfaces	D6612	B	Alveoplasty in Conjunction w/Extract-Per Quad	D7310	A
Onlay – Cast Predom. Base Metal, 3+ Surfaces	D6613	B	Alveoplasty not in Conjunct w/Extract-Per Quad	D7320	A
Onlay – Cast Noble Metal, 2 Surfaces	D6614	B	Vestibuloplasty-Ridge Ext (2nd Epithelialization)	D7340	B
Onlay – Cast Noble Metal, 3+ Surfaces	D6615	B	Vestibuloplasty-Ridge Ext (Grafts, Hypertissue)	D7350	B
Crown – Resin With High Noble Metal	D6720	B	Excision of Malignant Tumor-up to 1.25 cm	D7440	B
Crown – Resin With Base Metal	D6721	B	Excision of Malignant Tumor - > than 1.25cm	D7441	B
Crown – Resin With Noble Metal	D6722	B	Removal of Odontogenic Cyst/Tumor <=1.25cm	D7450	B
Crown – Porcelain/Ceramic Substrate	D6740	B	Removal of Odontogenic Cyst/Tumor > 1.25cm	D7451	B
Crown – Porcelain With High Noble Metal	D6750	B	Removal of Nonodontogenic Cyst/Tumor<=1.25cm	D7460	B
Crown – Porcelain With Predom Base Metal	D6751	B	Removal Nonodontogenic Cyst/Tumor> 1.25cm	D7461	B
Crown – Porcelain With Noble Metal	D6752	B	Removal of Lateral Exostosis – Per Site	D7471	B
Crown – 3/4 Cast High Noble Metal	D6780	B	Removal of Torus Palatinus	D7472	B
Crown – 3/4 Cast Predominantly Base Metal	D6781	B	Removal of Torus Mandibularus	D7473	B
Crown – 3/4 Cast Noble Metal	D6782	B	Surgical Reduction of Osseous Tuberosity	D7485	B
Crown – Full Cast High Noble Metal	D6790	B	Incision/Drain of Abscess – Intraoral Soft Tissue	D7510	A
Crown – Full Cast Predominantly Base Metal	D6791	B	Incision/Drain of Abscess – Extraoral Soft Tissue	D7520	A
Crown – Full Cast Noble Metal	D6792	B	Removal of Foreign Body, Skin, or Subc. Areolar Tissue	D7530	A
Re-cement Fixed Partial Denture	D6930	A	Sequestrectomy for Osteomyelitis	D7550	B
Cast Post and Core in Addition to Fixed Partial Denture Retainer	D6970	B	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body	D7560	B
Prefabricated Post and Core in Addition to Fixed Partial Denture Repair	D6972	B	Suture of Recent Small Wounds up to 5cm	D7910	B
Core Build Up for Retainer, Including any Pins	D6973	B	Frenulectomy (Frenectomy or Frenotomy), sep. proc.	D7960	B
Each Additional Cast Post – Same Tooth	D6976	B	Excision of Hyperplastic Tissue – Per Arch	D7970	B
Each Additional Prefabricated Post – Same Tooth	D6977	B	Excision of Pericoronal Gingiva	D7971	B
Fixed Partial Denture Repair	D6980	B	Surgical Reduction of Fibrous Tuberosity	D7972	B
ORAL SURGERY			Sialolithotomy	D7980	B
Coronal Remnants – Deciduous Tooth	D7111	A	Closure of Salivary Fistula	D7983	B
Extraction – Erupted Tooth or Exposed Root	D7140	A	MISCELLANEOUS SERVICES		
Surgical Removal of Erupted Tooth	D7210	A	Palliative (Emergency) Treatment of Pain	D9110	A
Removal of Impacted Tooth, Soft Tissue	D7220	A	General Anesthesia– First 30 Minutes	D9220	B
Removal of Impacted Tooth, Partially Bony	D7230	A	General Anesthesia– Each Additional 15 Minutes	D9221	B
Removal of Impacted Tooth, Completely Bony	D7240	A	IV Sedation/Analgesia – First 30 Min	D9241	B
Surgical Removal of Residual Tooth Roots	D7250	A	IV Sedation/Analgesia – Each Additional 15 Minutes	D9242	B
Oroantral Fistula Closure	D7260	A	Non-IV Conscious Sedation	D9248	B]
Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Teeth/Alveolus	D7270	B			
Tooth Transplantation and/or Stabilization	D7272	B			
Surgical Exp. Of Impacted/Unerupted Tooth-Ortho	D7280	A			

SECTION 3 BENEFIT PROVISION

[DISABILITY INCOME INSURANCE—Not applicable to Dependents.

(Applicable only if this coverage is not excluded in the Schedule.)

If the Insured becomes Totally Disabled, the Company will pay a Disability Benefit, as shown in the Schedule, provided he/she is under the Regular Care and Attendance of a Physician.

Total Disability:

- (a) must be due to a covered Accident or Sickness; and
- (b) must begin while the Insured's coverage is in force; and
- (c) will be considered to have started on the date he/she first receives personal treatment from a Physician, following continuous cessation of work.

Disability Benefits will be paid:

- (a) for only one disability when:
 - (1) more than one disability exists at the same time; or
 - (2) a disability results from two or more causes,
and
- (b) for each period of Total Disability that continues beyond the Elimination Period, not to exceed the Maximum Disability Period stated in the Schedule.

Successive Disabilities will be considered one period of disability unless separated by the Insured's return to:

- (a) Active Service; or
- (b) any other occupation,

for at least [90 days]. A disability due to a different or unrelated cause will be considered a new period of disability.

Any disability that begins after termination of coverage:

- (a) will not be considered a Successive Disability; and
- (b) will not be covered under the Policy.

Any change in the Disability Benefit will apply only to new periods of disability that begin on or after such date.

Mental Illness / Limited Benefit

If the Insured becomes Totally Disabled due to a Mental Illness, the Company will pay Disability Benefits for up to the Maximum Mental Illness Period shown in the Schedule.

Alcoholism and Drug Addiction / Limited Benefit

If the Insured becomes Totally Disabled due to alcoholism or drug addiction, the Company will pay Disability Benefits for up to the Maximum Alcoholism/Drug Addiction Period shown in the Schedule.]

[VISION INSURANCE *(Applicable only if this coverage is not excluded in the Schedule.)*

If a Covered Person incurs charges for:

- (a) an eye examination; or
- (b) eyeglass lenses and/or frames, or contact lenses,

the Company will pay the applicable benefit shown in the Schedule. A charge is incurred on the date that treatment is given, service is rendered, or a supply is furnished.]

SECTION 4 EXCLUSIONS AND LIMITATIONS

HEALTH INSURANCE

With respect to Health Insurance, no benefits will be payable for, or as the result of:

- (a) suicide or any attempt thereat, while sane or insane, or any intentionally self-inflicted injury or Sickness. This exclusion does not apply if the loss is as a result of a Medical Condition, or an act of domestic violence; or
- (b) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner, within the scope of authority; or
- (c) committing, attempting to commit, or taking part in, a felony or assault; or engaging in an illegal occupation; or
- (d) participation in a contest of speed in power-driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding; or
- (e) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. The Company will refund the pro rata unearned premium for any such period the Covered Person is not covered; or
- (f) air travel, except:
 - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
 - (2) as a passenger for transportation only and not as a pilot or crew member;or
- (g) experimental drugs, devices, treatments or surgery; or drugs or devices labeled "Caution - limited by federal law to investigational use." A treatment, procedure, or therapy will not be judged experimental if, at the time it is provided or performed:
 - (1) it is judged effective for treatment of the covered injury or Sickness; and
 - (2) it is approved by the American Medical Association or the appropriate medical specialty society for such treatment. Approval must not be on a limited or experimental basis.

This exclusion does not apply to a drug on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved by the federal Food and Drug Administration (FDA), provided all of the following are met:

- (1) the drug is approved by the FDA; and
- (2) the drug is recognized for treatment of the condition by:
 - a. scientific studies published in a peer-reviewed national professional medical journal; or
 - b. standard reference compendia.

This exclusion also does not apply to a drug, device, treatment, procedure, or therapy provided during any phase of a clinical trial for the treatment, palliation, or prevention of recurrence of cancer or other life-threatening conditions, provided such clinical trial is:

- (1) recommended by the Covered Person's treating Physician; and
- (2) approved by:
 - (a) the U.S. Food and Drug Administration (in the form of an Investigational New Drug Application); or
 - (b) one of the National Institutes of Health (NIH); or
 - (c) an NIH cooperative group or center; or
 - (d) an NIH cooperative group research entity that meets the criteria for NIH support grant eligibility; or
 - (e) the Coalition of National Cancer Cooperative Groups; or
 - (f) a National Cancer Institute cooperative group or center; or
 - (g) a panel of qualified clinical research experts from academic health institutions; or
 - (h) the Centers for Disease Control and Prevention; or
 - (i) the Agency for Healthcare Research and Quality; or
 - (j) the Centers for Medicare and Medicaid Services; or
 - (k) the U.S. Department of Veterans Affairs; or
 - (l) the U.S. Department of Defense; or

**SECTION 4
EXCLUSIONS AND LIMITATIONS**

and

- (1) there is no clearly superior, non-investigational treatment alternative; and
- (2) the available clinical or pre-clinical data provides a reasonable expectation that the treatment will be more effective than the non-investigational treatment alternative.

Treatment provided in a clinical trial must provide a therapeutic effect, and participation in such clinical trial must offer meaningful potential for significant clinical benefit to the Covered Person;

or]

- (h) rest care or rehabilitative care and treatment; or
 - (i) cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to:
 - (1) cosmetic surgery resulting from an Accident, provided initial treatment of the Covered Person is begun within 12 months of the date of the Accident; or
 - (2) reconstruction incidental to or following surgery resulting from a covered Accident or Sickness; or
 - (3) with respect to a covered Dependent child, correction of a congenital defect that results in a functional defect; or
 - (4) with respect to a medically necessary mastectomy:
 - a. all stages of reconstruction of the breast on which the mastectomy has been performed; or
 - b. surgery and reconstruction of the other breast to produce a symmetrical appearance; or
 - c. prostheses and treatment of physical complications for all stages of the mastectomy, including lymphademas;
- or
- (j) dental services, including treatment, extractions or dental x-rays, except as provided as the result of, and within 12 months of, an Accident; or
 - (k) hearing examinations, hearing aids (unless provided under the Durable Medical Equipment and Prosthesis Benefit), or the fitting of hearing aids; or
 - (l) routine eye examinations, or the purchase or fitting of any corrective eyewear; or
 - (m) voluntary abortion except, with respect only to the Insured or his/her covered Dependent spouse/common law spouse/[Domestic Partner]:
 - (1) where such person's life would be endangered if the fetus were carried to term; or
 - (2) where medical complications have arisen from an abortion;
- or
- [(n) routine newborn care, including routine nursery charges, except for up to five days in a Hospital nursery or until the mother's discharge following birth, whichever is earlier; or
 - (o) pregnancy of a Dependent child; or]
 - (p) the reversal of tubal ligation or vasectomy; or
 - (q) sex changes; or
 - [(r) infertility treatment, artificial insemination, in vitro fertilization (except as provided in the Policy), and test tube fertilization, including any related testing, medications, or Physician's services; or
 - (s) any Accident occurring while the Covered Person is intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the geographical area where the Accident took place); or
 - (t) treatment of exogenous obesity or weight control; or gastric bypass procedure; or any other surgical procedure for control of weight; or]
 - (u) air or ground ambulance service; or

SECTION 4 EXCLUSIONS AND LIMITATIONS

- (v) accident or sickness:
 - (1) arising out of and in the course of any occupation for compensation, wage or profit; or
 - (2) which qualifies for payment under Occupational Disease Law or similar law, whether or not application for such benefits has been made. Denial of payment under Occupational Disease Law or similar law does not automatically imply that a claim is payable under the Policy;
- or
- (w) routine physical examinations and immunizations related to employment, obtaining insurance, team sports, travel, school, camp, or pre-marital exams, after any Wellness Benefits provided under the Policy have been exhausted; or
- (x) treatment received during a period of time that coverage is not in force with respect to the Covered Person; or
- (y) with respect to a non-emergency Hospital admission during which a surgical procedure is scheduled and performed: Confinement, or services or treatment received more than 24 hours prior to admission; or
- (z) treatment that is not medically necessary, unless excepted elsewhere in the Policy; or
- (aa) any service or supply that is not described under one or more of the categories of benefits listed in the Benefit Provisions section.

[In addition to the Exclusions and Limitations for Health Indemnity Insurance, no benefits will be payable under the Prescription Drug Card Benefit for:

- (a) drugs and medicines which may be lawfully obtained without a Physician's prescription; or
- (b) drugs, medicines or insulin, in whole or in part, used by, administered to, or provided to, a Covered Person:
 - (1) during an outpatient Physician's office visit;
 - (2) during a visit to a Hospital emergency room or Outpatient Surgical Facility; or
 - (3) while Confined in a Hospital, rest home, sanatorium, extended care facility, convalescent hospital, nursing home or similar institution;
- or
- (c) immunization agents (shots), biological sera, blood, or blood plasma; or
- (d) a fill or refill of a prescription exceeding a 30-day supply.]

[Pre-Existing Condition Limitation

No benefits will be paid for expenses resulting from services, supplies or treatment of Pre-Existing Conditions for the first 12 months from the Covered Person's Enrollment Date of coverage under the Policy. This exclusion will not apply to:

- (a) pregnancy; or
- (b) a newborn child who, as of the last day of the 30-day period beginning with the date of birth, is covered under Creditable Coverage; or
- (c) a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage.

Any pre-existing condition limitation period previously satisfied under Creditable Coverage will be counted to satisfy the 12-month Pre-Existing Condition limitation under the Policy, unless there was a break in coverage of 63 days or more. Waiting periods under a plan are not considered a break in coverage.]

[TERM LIFE INSURANCE

With respect to Term Life Insurance, no benefits will be payable as the result of suicide or any attempt thereat, while sane or insane; or any intentionally self-inflicted injury or sickness, unless the Covered Person has been continuously insured under the Policy for two years.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

With respect to Accidental Death and Dismemberment Insurance, no benefits will be payable as the result of:

SECTION 4 EXCLUSIONS AND LIMITATIONS

- (a) suicide or any attempt thereat, while sane or insane, or any intentionally self-inflicted injury or sickness; or
- (b) infection or disease, whether the infection or disease is the proximate or contributing cause of the loss; or (This does not apply to pyogenic infections which occur through an accidental wound or cut.)
- (c) voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a licensed Physician; or (Accidental ingestion of a poisonous substance is not excluded.)
- (d) air travel, except:
 - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
 - (2) as a passenger for transportation only and not as a pilot or crew member;or
- (e) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss that occurs while acting in a lawful manner within the scope of authority; or
- (f) committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation; or
- (g) participation in a contest of speed in power-driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding; or
- (h) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. The Company will refund the pro rata unearned premium for any such period the Covered Person is not covered; or
- (i) any Accident occurring while the Covered Person is intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the laws of the geographical area where the Accident took place); or
- (j) accident or sickness:
 - (1) arising out of and in the course of any occupation for compensation, wage or profit; or
 - (2) which qualifies for payment under Occupational Disease Law or similar law, whether or not application for such benefits has been made. Denial of payment under Occupational Disease Law or similar law does not automatically imply that a claim is payable under the Policy.]

[DENTAL INSURANCE

With respect to Dental Insurance, no benefits will be payable as the result of:

- (a) suicide or any attempt thereat, while sane or insane, or any intentionally self-inflicted injury or Sickness; or
- (b) cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to:
 - (1) cosmetic surgery resulting from an accident, if initial treatment of the Covered Person is begun within 12 months of the date of the accident; or
 - (2) reconstruction incidental to or following surgery resulting from a covered Accident or Sickness; or
 - (3) correction of a congenital defect that results in a functional defect of a covered Dependent child;or
- (c) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority; or
- (d) committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation; or
- (e) participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding; or

SECTION 4 EXCLUSIONS AND LIMITATIONS

- (f) air travel, except:
 - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
 - (2) as a passenger for transportation only and not as a pilot or crew member;or
- (g) any Accident occurring while the Covered Person is intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the geographical area where the Accident took place); or
- (h) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. The Company will refund the pro rata unearned premium for any such period the Covered Person is not covered; or
- (i) accident or sickness:
 - (1) arising out of and in the course of any occupation for compensation, wage or profit; or
 - (2) which qualifies for payment under Occupational Disease Law or similar law, whether or not application for such benefits has been made. Denial of payment under Occupational Disease Law or similar law does not automatically imply that a claim is payable under the Policy;or
- (j) treatment that is not medically necessary, unless excepted elsewhere in the Policy; or
- (k) [Class B] expenses, until the Covered Person has been continuously insured under this dental plan (or the dental plan this plan replaced) for 12 consecutive months; or
- (l) treatment started before coverage began; or
- (m) charges for initial installation for dentures or bridgework to replace teeth extracted prior to when coverage began; or
- (n) replacement of existing dentures or bridgework less than five years old, or for replacement because of loss or theft; or
- (o) charges for orthodontics; or
- (p) charges for services with respect to congenital malformations (other than for a newborn child of the Insured); or
- (q) charges for dental care which is covered under any other part of this plan; or
- (r) charges by anyone other than a Dentist, except for charges for dental prophylaxis performed by a Dental Hygienist, under the supervision and direction of a Dentist; or
- (s) charges for more than one fluoride treatment, one dental prophylaxis, or one bite-wing x-ray in any six-month period; or
- (t) charges for more than one complete mouth x-ray in any two-year period; or
- (u) charges which the Covered Person is not legally required to pay, or charges which would not have been made if no coverage had existed.

Pre-Existing Condition Limitation

No benefits will be paid for expenses resulting from services, supplies or treatment of Pre-Existing Conditions for the first 12 months from the Covered Person's Enrollment Date of coverage under the Policy. This exclusion will not apply to:

- (a) pregnancy; or
- (b) a newborn child who, as of the last day of the 30-day period beginning with the date of birth, is covered under Creditable Coverage; or
- (c) a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage.

Any pre-existing condition limitation period previously satisfied under Creditable Coverage will be counted to satisfy the 12-month Pre-Existing Condition limitation under the Policy, unless there was a break in coverage of 63 days or more. Waiting periods under a plan are not considered a break in coverage.]

[DISABILITY INCOME INSURANCE

SECTION 4 EXCLUSIONS AND LIMITATIONS

With respect to Disability Income Insurance, no benefits will be payable as the result of:

- (a) suicide or any attempt thereat, while sane or insane, or any intentionally self-inflicted injury or Sickness; or
- (b) cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom; or
- (c) voluntary abortion, except where the Insured's life would be endangered if the fetus were carried to term, or where medical complications have arisen from an abortion; or
- (d) Mental Illness, alcoholism, or drug addiction, except as described in the Schedule; or
- (e) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss, which occurs while acting in a lawful manner within the scope of authority; or
- (f) committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation; or
- (g) participation in a contest of speed in power-driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding; or
- (h) air travel, except:
 - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
 - (2) as a passenger for transportation only and not as a pilot or crew member;or
- (i) any Accident occurring while the Insured is intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the geographical area where the Accident took place); or
- (j) sex changes; or
- (k) the reversal of tubal ligation or vasectomy; or
- (l) treatment of exogenous obesity or weight control; or gastric bypass procedure, or any other surgical procedure for control of weight; or
- (m) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. The Company will refund the pro rata unearned premium for any such period the Insured is not covered; or
- (n) accident or sickness:
 - (1) arising out of and in the course of any occupation for compensation, wage or profit; or
 - (2) which qualifies for payment under Occupational Disease Law or similar law, whether or not application for such benefits has been made. Denial of payment under Occupational Disease Law or similar law does not automatically imply that a claim is payable under the Policy.

Additionally, no Disability Benefit will be paid:

- (a) for any period in which the Insured is not under the Regular Care and Attendance of a Physician; or
- (b) if the Insured should fail to follow the medical treatment advice of his/her Physician as it pertains to his/her disabling condition; or
- (c) during any period in which the Insured is incarcerated.

Pre-Existing Condition Limitation

No benefits will be paid for Total Disability resulting from a Pre-Existing Condition that begins before the Insured has been continuously covered under the Policy for one year.]

[VISION INSURANCE

With respect to Vision Insurance, no benefits will be payable as the result of:

- (a) any intentionally self-inflicted injury or Sickness; or
- (b) treatment solely for cosmetic purposes, or complications therefrom; or

SECTION 4
EXCLUSIONS AND LIMITATIONS

- (c) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss, which occurs while acting in a lawful manner within the scope of authority; or
- (d) committing, attempting to commit, or taking part in a felony or assault; or engaging in an illegal occupation; or
- (e) participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding; or
- (f) accident or sickness:
 - (1) arising out of and in the course of any occupation for compensation, wage or profit; or
 - (2) which qualifies for payment under Occupational Disease Law or similar law, whether or not application for such benefits has been made. Denial of payment under Occupational Disease Law or similar law does not automatically imply that a claim is payable under the Policy;or
- (g) treatment that is not medically necessary, unless excepted elsewhere in the Policy; or
- (h) treatment received during a period of time that coverage is not in force with respect to the Covered Person; or
- (i) charges for an eye examination performed by, or eyeglasses or contact lenses prescribed by, someone other than an optometrist or ophthalmologist; or
- (j) charges for sunglasses, safety glasses, or goggles, whether plain or prescription; or
- (k) charges for non-prescription contact lenses; or
- (l) charges for any type of eye procedure or surgery, or vision charges that may be covered under any other part of the Policy; or
- (m) charges that the Covered Person is not legally required to pay, or charges that would not have been made if no coverage had existed.]

SECTION 5 TERMINATION OF INSURANCE

INSURED

The Insured's insurance will end on the earliest of:

- (a) the last day of the [payroll deduction period/month] during which he/she ceases to be a member of a class eligible for coverage as shown in the Schedule; or
- (b) the end of the last period for which premium payment has been made to the Company; or
- (c) the date the Insured dies; or
- (d) the date the Policy terminates; or
- (e) the last day of the [payroll deduction period/month] during which the Insured retires or is pensioned; or
- (f) the last day of the [payroll deduction period/month] during which the Insured terminates employment.

[With respect to Disability Income Insurance, if:

- (a) the Insured's coverage ends as a result of his/her termination of Active Service; and
- (b) such termination is caused by an Accident or Sickness for which Disability Benefits would be payable; and
- (c) Total Disability is established prior to the termination of Active Service,

then Disability Benefits will be paid as if such termination had not occurred. Additionally, termination of the Policy will have no effect on payment of benefits for a Total Disability that begins before the Policy is terminated.]

DEPENDENT

The insurance on a Dependent will cease on the earliest of:

- (a) the date the Insured's coverage terminates; or
- (b) the end of the last period for which premium payment has been made to the Company; or
- (c) the date the Dependent dies; or
- (d) with respect to a Dependent spouse/common law spouse[/Domestic Partner], the date such spouse/common law spouse[/Domestic Partner]:
 - (1) becomes divorced from; or
 - (2) becomes legally separated from; [or
 - (3) terminates his or her domestic partnership from,]the Insured; or
- (e) with respect to a Dependent child, the date such child attains age 25; or
- (f) with respect to a Dependent child who has been placed with the Insured for purposes of adoption, the earlier of:
 - (1) the date on which the petition for adoption has been dismissed or denied; or
 - (2) the date on which the placement is disrupted prior to legal adoption, and the child is removed from placement with the Insured;or
- (g) with respect to a Dependent child who has been provided coverage pursuant to a Qualified Medical Child Support Order (QMCSO), the earlier of:
 - (1) the end of the period for which the QMCSO has required that coverage be provided; or
 - (2) the date on which the QMCSO is terminated,unless such child is otherwise eligible for coverage under the Policy; or
- (h) with respect to a step-child of the Insured whom the Insured has not adopted, the date the Insured:
 - (1) becomes divorced from; or
 - (2) becomes legally separated from; [or
 - (3) terminates his/her domestic partnership from,]his/her spouse/common law spouse[/Domestic Partner]: or
- (i) the date the Policy is modified so as to exclude Dependent coverage.

SECTION 5 TERMINATION OF INSURANCE

Handicapped Children [(Applicable only to Health Insurance and Dental Insurance.)]

With respect to termination of a child's coverage due to attainment of age 25, coverage will not terminate if such child is incapable of self-support because of a mental or physical handicap; however:

- (a) the Insured must provide:
 - (1) proof of incapacity within 31 days following the child's attainment of age 25; and
 - (2) proof of continuing incapacity once every 12 months for a child age 25 or older; and
- (b) such child must remain dependent on the Insured for principal support and maintenance.

With respect to a mentally or physically handicapped child who was older than age 25 when he or she first became covered under the Policy, coverage will not terminate, unless the Insured fails to provide proof of continuing incapacity once every 12 months for such child.

FRAUD

The Company shall have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

POLICY TERMINATION

The Policy is guaranteed renewable, at the option of the Policyholder; however, the Company may terminate the Policy:

- (a) immediately, in the event of fraud by the Policyholder; or
- (b) on any premium due date, in the event of:
 - (1) non-payment of premium; or
 - (2) non-adherence to any participation or employer contribution requirements.

The Company shall provide the Policyholder 31 days advance written notice of termination of the Policy.

The Policyholder may terminate the Policy on any premium due date, for any reason; however, the Policyholder must provide 31 days advance written notice to the Company.

EXTENSION OF BENEFITS [(Applicable only to Health Insurance and Dental Insurance.)]

Whenever termination of coverage under this section occurs because of termination of the Insured's employment, such termination shall be without prejudice to:

- (a) any Hospital Confinement which commenced while the Insured's coverage was in force, [with respect to Health Insurance Benefits]; or
- (b) any covered treatment or service for which benefits would be provided under the [Health Insurance or Dental Insurance benefits of the] Policy, and which commenced while the Insured's coverage was in force;

provided; however, that the Covered Person is, and continues to be, Hospital Confined or Totally Disabled. Such Extension of Benefits shall continue for up to 30 days.

This Extension of Benefits provision will not apply during any time a Covered Person is covered under a similar group health plan.

CONVERSION PRIVILEGE

A Covered Person whose coverage under the Policy has been terminated for any reason, including discontinuance of the Policy in its entirety, may be eligible for conversion coverage. Conversion will not be available if coverage was terminated due to the Covered Person's failure to pay any required contribution or if the Policy is replaced by similar coverage within 31 days.

A Covered Person will not be eligible for conversion coverage if he/she is eligible for:

- (a) Medicare; or
- (b) full coverage under another group policy.

Written application and the initial premium for conversion coverage must be made to the designated conversion insurance carrier within 30 days after termination of coverage under the Policy.

**SECTION 5
TERMINATION OF INSURANCE**

SECTION 6 PREMIUMS

PREMIUM MODE AND DUE DATE

Premiums are payable by a mode of payment that has been agreed upon between the Policyholder and the Company.

All premiums are payable on or before the date they are due, by the Policyholder. Premiums are not considered paid until they are received by the Company[, or the Company's designated agent for receipt of premium]. The Company will not be responsible for claims incurred by Covered Persons during any period for which full premiums have not been paid by the Policyholder, except as provided in the Grace Period provision below.

CHANGES TO PREMIUM RATES

The premium rates will not be changed during the first [12 months] of coverage, provided benefits remain unchanged. Thereafter, the Company may change the premium rates at any time.

If a change in benefits increases the Company's liability, premium rates may be changed on the date that the liability is increased, even if such change occurs during the first [12 months] of the Policy.

If the premium rates are changed, the Company will give at least [30 days] advance written notice to the Policyholder. If an increase takes place on other than a premium due date, a pro rata premium will be due on the date the increase takes place. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due, the coverage will automatically be discontinued as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

GRACE PERIOD

Except for the first premium, the Policyholder will have a grace period of 31 days to remit each premium payment. Coverage will stay in force during the grace period, but will terminate at the end of such grace period if the premium has not been paid. The Policyholder will still be required to pay all unpaid premium, including the premium due for the grace period.

The Policyholder may cancel the coverage under the Policy:

- (a) on any future premium due date; or
- (b) on any date during the grace period.

The Policyholder must provide written notice to the Company of such cancellation.

If coverage is cancelled on a premium due date, the grace period will not apply. If cancellation is during the grace period, the Policyholder will be liable for any unpaid premium, including the pro rata premium for that part of the grace period coverage was in force.

SECTION 6 PREMIUMS

[MISSED PREMIUMS

In the event the Insured's paycheck is not sufficient to cover the full amount of the payroll deduction premium for coverage under the Policy, the Insured will be given the opportunity to make up [all of the/one or more] consecutive missed premium deductions (the "Missed Premium Period"), provided the following conditions are met:

- (a) Premium deductions must resume no later than the 35th day after the last weekly payroll-deducted premium, or no later than the 42nd day after the last bi-weekly payroll-deducted premium.
- (b) Payment may only be made with:
 - (1) a cashier's check; or
 - (2) a money order; or
 - (3) a personal check for which there are sufficient funds.
- (c) Payment must be in the full amount due for the [missed deduction periods for which the Insured is paying/entire Missed Premium Period].
- (d) The Company-provided remittance form (Missed Premium Deduction Form) must be included with payment. Such form must be filled out completely.
- (e) Payment must be mailed to the Company[, or the Company's administrator].

[The Insured will have the option to pay for the entire Missed Premium Period, or just a portion of it. If the Insured chooses to pay for just a portion of the Missed Premium Period, the Insured must pay for consecutive missed premium deductions, beginning with the first missed premium deduction/ the Insured must pay for the entire Missed Premium Period.] If no payroll deduction has ever occurred for coverage under the Policy, or if a Covered Person is no longer eligible, coverage may not be maintained by direct premiums.

During any period for which there is a missed premium deduction, coverage on the Insured and the Insured's covered Dependents (if any) will be placed in a suspended status. Coverage will not be cancelled unless it remains in a suspended (unpaid) status for more than 35 consecutive days, if deductions are weekly, or 42 days, if deductions are bi-weekly. If this happens, coverage on the Insured and his/her covered Dependents, if any, will be cancelled in accordance with the Termination provisions stated in Section 5. If such cancellation occurs, the Insured will not be eligible to enroll for coverage again except as provided in Section 2.

Any claims filed for services or expenses incurred while coverage is suspended will not be considered for payment; however, any period during which coverage is suspended will count towards satisfaction of any applicable Pre-Existing Condition limitation period.]

SECTION 7 CLAIMS PROVISIONS

NOTICE OF CLAIM

Written notice of claim must be given to the Company[, or to the Company's claims administrator]. Specific information regarding where to direct notice of claim is included on the Insured's identification card for coverage under the Policy. Notice should be made within 60 days after any loss covered by the Policy. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay.

CLAIM FORMS

Claim forms should be used for filing proof of loss. They will be sent to the claimant within 15 days following the Company's receipt of notice of claim. If claim forms are not supplied within 15 days, a claimant can give proof in writing, setting forth the nature and extent of the loss. Proof submitted in this manner will remain subject to the time stated in the Proof of Loss provision.

PROOF OF LOSS

[With respect to Disability Income Insurance, proof of loss must be given to the Company within 90 days after termination of the period for which the Company is liable. For any other loss,] proof of loss must be given to the Company within 90 days after such loss. Late proof may be accepted if:

- (a) it was not reasonably possible to give proof in that time; and
- (b) the proof is given within one year from the date of loss. This one-year limit will not apply in the absence of legal capacity.

TIME OF PAYMENT OF CLAIM

[With respect to Disability Income Insurance, benefits will accrue and be paid monthly, subject to satisfactory written proof of such loss. Any balance not paid when liability ends will be paid immediately upon receipt of satisfactory written proof of such loss.]

Initial benefit determinations will be rendered by [the Company/the Company's claims administrator] within 30 days. If there are special circumstances beyond the Company's control [and/or the Company's claims administrator's control], the initial benefit determination shall be rendered as soon as possible, but no later than 45 days after receipt of the Insured's claim.

In the event the Insured receives an adverse benefit determination, such adverse benefit determination will be explained in writing and the explanation will include:

- (a) the specific reason for the adverse benefit determination; and
- (b) reference to the specific policy provision upon which the adverse benefit determination was based; and
- (c) a description of any additional information the Insured might be required to provide and an explanation of why it is needed; and
- (d) an explanation of the Company's claim review procedure.

The Insured, a Dependent, a beneficiary, or a duly authorized representative may appeal any adverse benefit determination by filing a request for review to the claims administrator. In connection with such a request, documents pertinent to the administration of the Policy may be reviewed, and issues outlining the basis of the appeal may be submitted. The Insured may have representation throughout this review procedure.

Health [, Dental, and Vision] Claims

If the Insured receives an adverse benefit determination, the Insured's requests for review must be filed within 180 days after receipt of the written notice of adverse benefit determination. A decision will be rendered by the Company no later than 30 days after receipt of the Insured's request for review. The decision, after the review, shall be in writing and shall include specific references to the pertinent policy provisions upon which the decision was based.

[Disability and Accidental Dismemberment Claims

If the Insured receives an adverse benefit determination, the Insured's request for review must be filed within 180 days after receipt of the written notice of adverse benefit determination. A decision will be rendered by the Company no later than 45 days after receipt of the Insured's request for review. The

**SECTION 7
CLAIMS PROVISIONS**

decision, after the review, shall be in writing and shall include specific references to the pertinent policy provisions upon which the decision was based.

Life and Accidental Death Claims

If the Insured receives an adverse benefit determination, the Insured's request for review must be filed within 90 days after receipt of the written notice of adverse benefit determination. A decision will be rendered by the Company no later than 90 days after receipt of the Insured's request for review. If there are special circumstances beyond the Company's control and/or the Company's claims administrator, the decision shall be rendered as soon as possible, but no later than 120 days after receipt of the request for review. The decision, after the review, shall be in writing and shall include specific references to the pertinent policy provisions upon which the decision was based.]

PAYMENT OF BENEFITS

Health Insurance[, Dental Insurance, and Vision Insurance] benefits may be assigned to the provider(s) of such benefits. Otherwise, all benefits payable under the Policy will be paid to the Insured. Accrued benefits that are not paid at the Insured's death will be paid to his/her beneficiary or estate.

If a Health Insurance[, Dental Expense Insurance, and/or Vision Insurance] benefit is to be paid to:

- (a) the Insured's estate; or
- (b) the Insured's beneficiary, who is not competent to give a valid release,

the Company may pay up to \$1,000.00 of such benefit to one of the Insured's relatives who is deemed by the Company to be justly entitled to it. Such payment, made in good faith, fully discharges the Company to the extent of the payment.

PHYSICAL EXAMINATION AND AUTOPSY

The Company has the right to have a Covered Person examined by a Physician of its choice as often as reasonably necessary while a claim is pending. The Company will pay for such examination. In case of death, the Company may request an autopsy where it is not forbidden by law.

SECTION 8 GENERAL PROVISIONS

ENTIRE CONTRACT

The entire contract shall include:

- (a) the Policy; and
- (b) the application of the Policyholder, attached to the Policy when issued; and
- (c) the Insureds' enrollment forms, if any; and
- (d) any and all attached endorsements, amendments, and/or riders.

CHANGES TO POLICY

The Policy or Certificate cannot be changed, and its terms cannot be waived or extended in any way, except by written endorsement or amendment. Such endorsement or amendment must be signed by:

- (a) the Company's President or Secretary; and
- (b) if the endorsement or amendment makes the terms of the Policy more restrictive, an officer of the Policyholder.

No agent may change the Policy or Certificate, or waive its provisions.

CERTIFICATES

The Company will furnish to the Policyholder a supply of individual Certificates for delivery to Insureds.

The Certificate will describe:

- (a) the insurance benefits; and
- (b) to whom benefits will be paid; and
- (c) any limitations of the Policy; and
- (d) all other essential features of the Policy.

If the Company issues more than one Certificate to the Insured, only the last one issued will be in effect.

NEW INSUREDS

To the group or class originally insured, there will be added from time to time all persons eligible and applying for insurance in such group or class.

INCONTESTABILITY / TIME LIMIT ON CERTAIN DEFENSES

The Company will rely on statements made by the Policyholder and the Insured to be true and complete to the best knowledge and belief of such persons. All such statements are representations (and not warranties), if fraud was not intended. No such statements will be used to void the insurance, reduce benefits, or defend a claim under the Policy unless:

- (a) the statement is in writing, signed by the Insured; and
- (b) a copy of that statement is given to the Insured or, in the event of the Insured's death or incapacity, his/her beneficiary.

The validity of the Policy cannot be contested after two years from its date of issue, except for nonpayment of premiums. Except for fraudulent misstatements in the application or enrollment form, the Company will not use any statement to void the insurance or deny a claim after insurance has been in force for two years during the Insured's lifetime. However, this provision shall not preclude the Company's assertion, at any time, of defenses based on provisions in the Policy that relate to eligibility for coverage.

LEGAL ACTIONS

No legal action may be brought to recover benefits under the Policy:

- (a) within 60 days after written proof of loss has been furnished as required; or
- (b) more than three years from the time written proof of loss is required to be furnished.

CONFORMITY WITH STATE LAWS

A provision of the Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law as of the Effective Date.

**SECTION 8
GENERAL PROVISIONS**

MISSTATEMENT OF AGE

If the age of any Covered Person was misstated on the application or enrollment form for coverage:

- (a) the amount of benefits payable will be the amount shown in the Schedule. If necessary, the premium will be adjusted so that the Company will be paid any amount due based on such Covered Person's true age; and
- (b) coverage for such person will end when it would have, if the Company had known of such person's correct age. If the Company has accepted a premium on behalf of the person for a period after the date when coverage should have ended, the premium will be refunded. The Company will not pay any claims for services the person received after coverage should have ended.

CLERICAL ERROR

Any clerical error in record keeping will not keep insurance in force if it should have been terminated, nor will it terminate insurance that should have been kept in force. As soon as the error is found, any necessary premium adjustment will be made.

NON-PARTICIPATING

The Policy is non-participating, and does not share in the Company's profits or surplus. No dividends are payable under the Policy.

Notice to Group Health Plan Participants of Benefits Required Under the Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice to Group Health Plan Participants of Benefits Required Under the Women's Health and Cancer Rights Act of 1998

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains the most important provisions of the Act. Please review this information carefully. If your spouse is also covered, please make certain that she or he also has the opportunity to review this information.

The Women's Health and Cancer Rights Act of 1998 requires that all group health plans that provide medical and surgical benefits for a mastectomy also must provide coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for any complications in all stages of mastectomy, including lymphedema.

The Act requires that coverage be provided in a manner that is consistent with other benefits provided under the Plan. The coverage may be subject to annual deductibles and coinsurance provisions.

The Women's Health and Cancer Rights Act of 1998 will apply to group health plans for plan years beginning on or after October 21, 1998. To find out when your plan year begins, check your Summary Plan Description (SPD) or contact your plan administrator.

Please keep this information with your other group health plan documents.

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

HEALTH INSURANCE

INPATIENT BENEFITS	
Daily Hospital Indemnity Benefit	[see <i>Statement of Variability</i>] per day, up to [see <i>Statement of Variability</i>] days per Calendar Year
Inpatient Maximum Benefit	[see <i>Statement of Variability</i>]
Inpatient Deductible Applicable to all covered Inpatient services and supplies, unless stated otherwise.	[see <i>Statement of Variability</i>] per Covered Person per Calendar Year; maximum of [see <i>Statement of Variability</i>] Deductibles per family per Calendar Year]
Inpatient Coinsurance Applicable to all covered Inpatient services and supplies, unless stated otherwise.	After satisfaction of the Inpatient Deductible, the Company will pay [see <i>Statement of Variability</i>] of Covered Charges, up to the Inpatient Maximum Benefit.
Room and Board Benefit	Up to [see <i>Statement of Variability</i>]
Inpatient Physician Surgical Services Benefit	Up to [see <i>Statement of Variability</i>]
Inpatient Anesthetic Services and Anesthesia Benefit	Up to [see <i>Statement of Variability</i>]
Inpatient Physician Non-Surgical Services Benefit	Up to [see <i>Statement of Variability</i>]
Inpatient Miscellaneous Services and Supplies	Up to [see <i>Statement of Variability</i>]
OUTPATIENT BENEFITS	
Outpatient Maximum Benefit	[see <i>Statement of Variability</i>]
Outpatient Deductible Applicable to all covered Outpatient services and supplies, unless stated otherwise.	[see <i>Statement of Variability</i>] per Covered Person per Calendar Year; maximum of [see <i>Statement of Variability</i>] Deductibles per family per Calendar Year]
Outpatient Coinsurance Applicable to all covered Outpatient services and supplies, unless stated otherwise.	After satisfaction of the Outpatient Deductible, the Company will pay [see <i>Statement of Variability</i>] of Covered Charges, up to the Outpatient Maximum Benefit.
Outpatient Physician Surgical Services Benefit	Up to [see <i>Statement of Variability</i>]
Outpatient Anesthetic Services and Anesthesia Benefit	Up to [see <i>Statement of Variability</i>]
Outpatient Physicians' Non-Surgical Services Benefit This benefit is not subject to the Deductible.	Co-payment — [see <i>Statement of Variability</i>] Coinsurance — After the Co-payment, the Company will pay [see <i>Statement of Variability</i>] of Covered Charges.
All other covered Outpatient services and supplies	Subject to the Outpatient Deductible, Outpatient Coinsurance, and Outpatient Maximum Benefit.

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

HEALTH INSURANCE (continued)

ADDITIONAL BENEFITS	
<p>Durable Medical Equipment and Prosthesis Benefit This benefit is not subject to any Deductible, and will not reduce the Outpatient Maximum Benefit.</p>	<p>Coinsurance — [see <i>Statement of Variability</i>] Maximum Benefit — [see <i>Statement of Variability</i>] per Calendar Year</p>
<p>Hospital Admission Benefit This benefit is not subject to any Deductible, and will not reduce the Inpatient Maximum Benefit.</p>	<p>Lump Sum Benefit — [see <i>Statement of Variability</i>] Maximum Number of Admissions — [see <i>Statement of Variability</i>] per Calendar Year</p>
<p>Emergency Room Sickness Benefit This benefit is not subject to any Deductible, and will not reduce the Inpatient or Outpatient Maximum Benefit.</p>	<p>Co-payment — [see <i>Statement of Variability</i>] Coinsurance — [see <i>Statement of Variability</i>] Maximum Episodes of Care — [see <i>Statement of Variability</i>] per Calendar Year Maximum Benefit — [see <i>Statement of Variability</i>] per Episode of Care</p>
<p>Prescription Drug Card Benefit This benefit is not subject to any Deductible or Coinsurance, and will not reduce the Outpatient Maximum Benefit.</p>	<p>Co-payment — Generic Drugs: [see <i>Statement of Variability</i>] per fill/refill Branded Drugs: [see <i>Statement of Variability</i>] per fill/refill Maximum Benefit — [see <i>Statement of Variability</i>] per Calendar Year</p>
<p>Intensive Care Unit Benefit This benefit is not subject to any Deductible, and will not reduce the Inpatient Maximum Benefit.</p>	<p>Lump Sum Benefit — [see <i>Statement of Variability</i>] Maximum Number of Days — [see <i>Statement of Variability</i>] per Calendar Year</p>
<p>Supplemental Accident Benefit This benefit is not subject to any Deductible, and will not reduce the Inpatient or Outpatient Maximum Benefit.</p>	<p>Coinsurance — 100% Maximum Benefit — [see <i>Statement of Variability</i>] per Accident Maximum Number of Accidents — [see <i>Statement of Variability</i>] per Calendar Year</p>
<p>Wellness Benefit This benefit is applicable only to Covered Persons age 18 years or older. This benefit is not subject to any Deductible, and will not reduce the Outpatient Maximum Benefit.</p>	<p>Co-payment — [see <i>Statement of Variability</i>] Coinsurance — [see <i>Statement of Variability</i>] Maximum Benefit — Up to [see <i>Statement of Variability</i>] per Calendar Year</p>

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

[TERM LIFE INSURANCE

Insured Death Benefit^[1]	[see Statement of Variability]
Spouse Death Benefit^[2]	[see Statement of Variability]
Dependent Child Death Benefit^[2] (six months of age or older)	[see Statement of Variability]
Dependent Child Death Benefit^[2] (14 days to six months of age)	[see Statement of Variability]
Dependent Child Death Benefit^[2] (under 14 days of age)	[see Statement of Variability]

^[1]For Insureds age 65 or older, the Death Benefit will be 65% of the amount shown.]

^[2]At no time may a covered Dependent's Death Benefit exceed 50% of the Insured's Death Benefit, or the maximum amount permitted by law, whichever is greater. Any necessary reduction in a Dependent's Death Benefit will be effective on the same date that the Insured's Death Benefit reduces.]

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (not applicable to Dependents)

Insured Principal Sum^[1]	[see Statement of Variability]
--	--------------------------------

^[1]For Insureds age 65 or older, the Principal Sum will be 65% of the amount shown.]

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

[DENTAL INSURANCE

Calendar Year Deductible	[see <i>Statement of Variability</i>] per Covered Person
Percentage of Covered Charge Payable	Class A — [see <i>Statement of Variability</i>] Class B — [see <i>Statement of Variability</i>] [Class C — see <i>Statement of Variability</i>]
Calendar Year Maximum	Insured — [see <i>Statement of Variability</i>] Each Dependent — [see <i>Statement of Variability</i>]
Waiting Period for Class [B/C] Covered Charges	[see <i>Statement of Variability</i>]

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

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**[DISABILITY INCOME INSURANCE
(not applicable to Dependents)**

Covered Percentage of Weekly Base Compensation	[see Statement of Variability]
Maximum Weekly Benefit	[see Statement of Variability]
Elimination Period	Accident — [see Statement of Variability] Sickness — [see Statement of Variability]
Maximum Disability Period	Accident — [see Statement of Variability] Sickness — [see Statement of Variability]
Maximum Mental Illness Period	[see Statement of Variability]
Maximum Alcoholism/Drug Addiction Period	[see Statement of Variability]
Successive Disabilities Period	[see Statement of Variability]

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

[VISION INSURANCE

Eye Examination	Actual charge, not to exceed [see <i>Statement of Variability</i>], and limited to one routine examination in any [see <i>Statement of Variability</i>].
Eyeglass Lenses (other than contact lenses)¹	Actual charge, not to exceed [see <i>Statement of Variability</i>] for singles lenses or [see <i>Statement of Variability</i>] for bifocal or trifocal lenses, and limited to one set of lenses in any [see <i>Statement of Variability</i>].
Frames¹	Actual charge, not to exceed [see <i>Statement of Variability</i>], and limited to one pair of frames in any [see <i>Statement of Variability</i>].
Contact Lenses¹	Actual charge, not to exceed [see <i>Statement of Variability</i>] pairs of disposable contact lenses in any [see <i>Statement of Variability</i>] period.

¹Benefits will be paid for only one of the following during the same time period: (a) frames with lenses or (b) contact lenses.]

 **American Fidelity
Assurance Company**
A member of the American Fidelity Group

2000 North Classen Boulevard, Oklahoma City, Oklahoma 73106

POLICYHOLDER: [ABC Company]

POLICY NUMBER: [G-513.SA-9999]

American Fidelity Assurance Company (We, Us, Our) hereby certifies that it has issued and delivered to the Policyholder a group Policy, described in the Schedule of Benefits page. The group Policy covers certain eligible persons as described in the Policy. This booklet describes the benefits and provisions of the group Policy. The laws of the state of issue of the Policy govern the Policy. This booklet becomes your Certificate of insurance only if:

- (a) You are eligible for the insurance;
- (b) You are on Active Service on the date it is to take effect; and
- (c) You become insured in accordance with all of the provisions of the Policy.

The insurance is to be effective only if the required premium payments are made by You or on Your behalf to Us. (See Section 2, Eligibility and Effective Date provisions.) No agent may change the Policy or waive its provisions. This Certificate takes the place of any other Certificate previously issued to You under the group Policy. It should be kept in a safe place.

IN WITNESS WHEREOF American Fidelity Assurance Company has caused this Certificate to take effect on the Effective Date.



Secretary



President

**PLEASE READ THIS CERTIFICATE CAREFULLY.
THE HEALTH INSURANCE COVERAGE DESCRIBED HEREIN PROVIDES LIMITED BENEFITS;
IT DOES NOT PROVIDE COMPREHENSIVE COVERAGE.**

[WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.]

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SCHEDULE OF BENEFITS

SECTION 1 DEFINITIONS

GENERAL DEFINITIONS

The following definitions apply to all coverages provided under the Policy, as appropriate.

Accident (or **Accidental Injury**) means a sudden, unexpected and unintended event:

- (a) over which the Covered Person has no control; and
- (b) which results in bodily injury to a Covered Person; and
- (c) which is independent of any Sickness; and
- (d) which is caused by, or the result of, external means.

[Active Service means that You are doing in the usual manner all of the regular duties of Your employment on a scheduled work day, and these duties are being done at one of the places of business where You normally do such duties, or at some location to which Your employment sends You.

You will be deemed to be in Active Service on each day You are actually performing services for the Policyholder, and on each day of regular paid vacation or on a regular non-working day, provided You are actively at work on the last preceding regular work day. With respect to any health coverage provided on an expense-incurred basis, You will also be deemed to be in Active Service on a day that You are absent from work during an approved leave under the Family and Medical Leave Act, or solely due to a Health Status-Related Factor.]

Calendar Year means the period from January 1 through December 31 of the same year.

Certificate means the individual certificate issued to You. It describes the coverage under the Policy.

Company (We, Us, Our) means American Fidelity Assurance Company.

Covered Person(s) means You and Your Dependents insured under the Policy.

Dependent means:

- (a) Your legally married spouse, or common law spouse (where permitted by law), [or Domestic Partner,] who lives with You; or
- (b) a natural, step, or adopted child of Yours. Such child must be under 25 years of age, and dependent on You for principal support and maintenance; or
- (c) a child placed for adoption with You, provided such child is under age 18 as of the date of placement, and would otherwise qualify under (b) above; or
- (d) notwithstanding any principal support and maintenance requirements, a child for whom You or Your covered spouse/common law spouse/[Domestic Partner] are required to provide coverage due to a Qualified Medical Child Support Order (QMCSO), provided such child would otherwise qualify under (b) above. A QMCSO will also include a judgment, decree, or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of law under state law and which satisfies the QMCSO requirements of ERISA (section 609[a]); or
- (e) a child who is not living with You, but for whom You are legally required to provide support, provided such child would otherwise qualify under (b) above.

The term Dependent does not include:

- (a) Your grandchild(ren); or
- (b) any child who is married.

[Domestic Partner means a person of either sex who:

- (a) is at least 18 years of age; and
- (b) is competent to contract in his or her state of residency; and
- (c) shares the same residence as You; and
- (d) is not married to, legally separated from, or a domestic partner of, anyone else; and
- (e) is not related to You by blood in a way that would prevent marriage in their state of residency.

SECTION 1 DEFINITIONS

You and Your Domestic Partner must [be/have been] in an exclusive, committed relationship with each other [during the 12-month period immediately prior to enrollment for coverage, or] if You and Your Domestic Partner's state of residency provides for a registration process of domestic partnership:

- (a) neither You nor Your Domestic Partner may have previously registered as a Domestic Partner with Your state of residency, where such registration has not been terminated; and
- (b) both You and Your Domestic Partner must file such registration with respect to Your own relationship.]

Effective Date means, with respect to the Policy, the date the Policy becomes effective. With respect to each eligible person, Effective Date means the date such person's coverage takes effect under the Policy. The "Effective Date" will start at 12:01 a.m. at the main place of business of the Policyholder.

Enrollment Date means the Effective Date of coverage, or if earlier, the first day of any required waiting period.

Initial Eligibility Period means the 31-day period following completion of Your Waiting Period for Coverage, during which You may apply for coverage under the Policy.

Insured (You, Your) means any person who is eligible for insurance, as stated in the Schedule and described in Section 2, and is insured under the Policy by virtue of employment by the Policyholder.

[Normal Pay Date means the day of the week the Policyholder (or one of its subsidiaries) normally issues payroll. This date will remain the same regardless of a temporary change in the payday, which may occur due to holidays.]

Open Enrollment Period means that time each Plan Year that:

- (a) new enrollments may be made by existing employees; or
- (b) You may make changes to Your coverage election(s), or terminate coverage.

Physician means a practitioner of the healing arts who is practicing within the scope of his or her license in the state where so licensed.

The term Physician does not include a practitioner who:

- (a) is the Policyholder, or is employed or retained by the Policyholder; or
- (b) is living in the Covered Person's household; or
- (c) is related to the Covered Person by blood or marriage.

[Plan Year means the 12-month period the Policyholder establishes as the plan year for employee welfare benefits.]

Policy means the policy issued by Us to the Policyholder.

Policyholder means the employer who holds the Policy. The Policyholder is named on the face page of the Policy.

Schedule of Benefits (or Schedule) means the benefit schedule set forth in the Policy or Certificate.

Sickness means a bodily disorder, disease, physical or mental condition, functional nervous disorder, pregnancy, or Complication of Pregnancy:

- (a) that requires treatment by a Physician; and
- (b) for which treatment is rendered to such Covered Person.

SECTION 1 DEFINITIONS

The term Sickness, when used in connection with a newborn child, includes, but is not limited to:

- (a) prematurity;
- (b) congenital defects; and
- (c) birth abnormalities.

Special Enrollment Period means the [31-day/30-day] period that begins when a person is first eligible for Special Enrollment under HIPAA.

Total Disability (or **Totally Disabled**) means [You are unable to perform the material and substantial duties and functions of Your occupation. For a Dependent, "Totally Disabled" means] the inability to perform a majority of the normal activities of a person of like age who is in good health.

Waiting Period for Coverage means that period of time during which You must be continuously employed before Your coverage may begin. The Policyholder will determine the Waiting Period for Coverage, subject to Our underwriting guidelines and approval.

SECTION 1 DEFINITIONS

HEALTH INSURANCE

The following definitions apply to Health Insurance.

Complication of Pregnancy means:

- (a) Hospital confinement required to treat conditions such as the following:
 - (1) acute nephritis; or
 - (2) nephrosis; or
 - (3) cardiac decompensation; or
 - (4) HELLP syndrome; or
 - (5) uterine rupture; or
 - (6) amniotic fluid embolism; or
 - (7) chorioamnionitis; or
 - (8) fatty liver in pregnancy; or
 - (9) septic abortion; or
 - (10) placenta accreta; or
 - (11) gestational hypertension; or
 - (12) puerperal sepsis; or
 - (13) peripartum cardiomyopathy; or
 - (14) cholestasis in pregnancy; or
 - (15) thrombocytopenia in pregnancy; or
 - (16) placenta previa; or
 - (17) placental abruption; or
 - (18) acute cholecystitis and pancreatitis in pregnancy; or
 - (19) postpartum hemorrhage; or
 - (20) septic pelvic thrombophlebitis; or
 - (21) retained placenta; or
 - (22) venous air embolus associated with pregnancy; or
 - (23) miscarriage; or
 - (24) an emergency c-section required because of:
 - a. fetal or maternal distress during labor; or
 - b. severe pre-eclampsia; or
 - c. arrest of descent or dilatation; or
 - d. obstruction of the birth canal by fibroids or ovarian tumors; or
 - e. necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy.A c-section will not be considered to be an emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section; and
- (b) treatment, diagnosis or care for conditions, including the following, when the condition was caused by, necessary because of, or aggravated by the pregnancy:
 - (1) hyperthyroidism; or
 - (2) hepatitis B or C; or
 - (3) HIV; or
 - (4) Human Papilloma virus; or
 - (5) abnormal PAP; or
 - (6) syphilis; or
 - (7) Chlamydia; or
 - (8) herpes; or
 - (9) urinary tract infections; or
 - (10) thromboembolism; or
 - (11) appendicitis; or
 - (12) hypothyroidism; or
 - (13) pulmonary embolism, or
 - (14) sickle cell disease; or
 - (15) tuberculosis; or

SECTION 1 DEFINITIONS

- (16) migraine headaches; or
- (17) depression; or
- (18) acute myocarditis; or
- (19) asthma; or
- (20) maternal cytomegalovirus; or
- (21) urolithiasis; or
- (22) DVT prophylaxis; or
- (23) ovarian dermoid tumors; or
- (24) biliary atresia and/or cirrhosis; or
- (25) first trimester adnexal mass; or
- (26) hydatidiform mole; or
- (27) ectopic pregnancy.

Confinement (or Confined) means that period of time during any Hospital stay that the Covered Person is actually admitted on an inpatient basis, provided:

- (a) such Confinement is for at least 18 continuous hours in duration; and
- (b) at least one full day's room and board charge is made by the Hospital.

The term Confinement does not include that period of time during which a Covered Person is in:

- (a) a Hospital emergency room; or
- (b) an observation room; or
- (c) a free-standing surgical facility; or
- (d) an outpatient facility,

unless:

- (a) such Covered Person is admitted to the Hospital as an inpatient immediately thereafter; and
- (b) the conditions set forth for Confinement are met.

Covered Charges means those charges that:

- (a) are incurred by a Covered Person because of a covered Accident or Sickness; and
- (b) are for necessary treatment, services, and/or medical supplies, and are recommended by a Physician; and
- (c) are not more than:
 - (1) the Usual and Customary Charges; or
 - (2) the amount actually paid by or on behalf of the Covered Person and accepted by the provider for treatment, services and/or medical supplies provided; or
 - (3) any dollar limit set forth in the Schedule;and
- (d) are incurred while insured under the Policy, subject to any Extension of Benefits; and
- (e) are not excluded under Section 4, Exclusions.

Creditable Coverage means, with respect to an individual, coverage of an individual under:

- (a) a group health plan; or
- (b) health insurance coverage; or
- (c) Part A or Part B or Title XVIII of the Social Security Act (Medicare); or
- (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines); or
- (e) Chapter 55 of Title 10, United States Code (armed forces); or
- (f) a medical care program of the Indian Health Service, or of a tribal organization; or
- (g) a State health benefits risk pool; or
- (h) a health plan offered under Chapter 89 of Title 5, United States Code (U.S. government); or
- (i) a public health plan; or
- (j) a health benefit plan under Section 5(e) of the Peace Corps Act, 22 USC 2504(e).

Creditable Coverage does not mean:

SECTION 1 DEFINITIONS

- (a) accident only or disability income coverage; or
- (b) coverage issued as a supplement to liability insurance; or
- (c) liability insurance; or
- (d) Workers' Compensation or similar insurance; or
- (e) automobile medical payment insurance; or
- (f) credit only insurance; or
- (g) coverage for on-site medical clinics; or
- (h) other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

Deductible means the amount of Covered Charges, shown in the Schedule, for which We will pay no benefits during each Calendar Year.

Durable Medical Equipment means equipment which:

- (a) can withstand repeated use; and
- (b) is primarily and customarily used to serve a medical purpose; and
- (c) generally is not useful to a person in the absence of an illness or injury; and
- (d) is appropriate for use in the home.

Such equipment must:

- (a) be prescribed by the Covered Person's physician for the purpose of treating or accommodating an illness, injury, disease or its symptoms, in accordance with generally accepted standards of medical practice; and
- (b) be clinically appropriate, in terms of type, frequency, extent, site and duration and must be considered effective for the patient's illness, injury or disease,

and may not:

- (a) be primarily for the convenience of the patient, physician, or other health care provider; or
- (b) be more costly than an alternative service, sequence of services, device or equipment, at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease; or
- (c) be intended to be used for athletic or recreational activities as opposed to assisting the patient in the activities of daily living; or
- (d) be an additional feature or accessory, or is a non-standard or deluxe item that is primarily for the comfort and convenience of the patient (e.g., customized wheelchairs, electric vehicle lifts for wheelchairs, etc.); or
- (e) be a duplicative piece of equipment that is intended to be used as a backup device, for multiple residences, or for traveling, etc.

Health Status-Related Factor means any of the following:

- (a) health status; or
- (b) a medical condition (including both physical and mental illness); or
- (c) claims experience; or
- (d) receipt of health care; or
- (e) medical history; or
- (f) genetic information; or
- (g) evidence of insurability (including conditions arising out of acts of domestic violence); or
- (h) disability.

Hospital means a licensed institution that has on its premises:

- (a) permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician; and
- (b) 24-hour-a-day nursing service by graduate registered nurses; and
- (c) the patient's written history and medical records.

SECTION 1 DEFINITIONS

It shall also have laboratory, x-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians, or be accredited by the Joint Commission on Accreditation of Hospitals.

The term Hospital shall also include a duly licensed residential treatment facility for the treatment of mental or nervous Sickness, alcoholism, or drug abuse.

The term Hospital shall not include any institution used by the Covered Person as:

- (a) a place for rehabilitation; or
- (b) a place for rest or for the aged; or
- (c) a nursing or convalescent home; or
- (d) a long-term nursing unit or geriatrics ward; or
- (e) an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Intensive Care Unit (ICU) means an area of a Hospital that:

- (a) is kept separate from other Hospital facilities; and
- (b) is operated solely to give skilled care and treatment to critically ill patients; and
- (c) has special supplies and equipment necessary for immediate use; and
- (d) provides room, board, and constant observation and care by registered professional nurses or other highly-trained Hospital personnel.

Medical Condition means any condition, whether physical or mental, including, but not limited to:

- (a) any condition resulting from illness; or
- (b) injury (whether or not the injury is accidental); or
- (c) pregnancy; or
- (d) congenital malformation;

however, genetic information is not a Medical Condition.

Outpatient Surgical Facility means a facility that:

- (a) is licensed under the laws of the state in which it operates as an outpatient surgical center;
- (b) has an organized medical staff of Physicians; and
- (c) has permanent facilities that are equipped and operated for the main purpose of performing surgery; and
- (d) has continuous Physician and registered professional nursing services when a patient is in the facility; and
- (e) does not provide services or accommodations for patients to stay overnight.

The term Outpatient Surgical Facility shall include:

- (a) a freestanding outpatient surgical center; and
- (b) the outpatient surgical section of a Hospital; and
- (c) a Hospital emergency room.

The term Outpatient Surgical Facility shall not include a Physician's office.

[Pre-Existing Condition means a disease, injury, or physical, mental or nervous condition for which a Covered Person:

- (a) had treatment; or
- (b) incurred expense; or
- (c) took medication; or
- (d) received a diagnosis or advice from a Physician,

at any time during the six-month period immediately before the Enrollment Date of such Covered Person's coverage.

The term Pre-Existing Condition will also include conditions which are related to such disease, injury, or physical, mental or nervous condition.]

Prosthesis means an artificial device to replace or augment a missing or impaired part of the body.

SECTION 1 DEFINITIONS

The term Prosthesis does not include:

- (a) wigs and hair pieces for androgenetic alopecia (also known as male pattern baldness); or
- (b) any device or item used purely for cosmetic reasons, except:
 - (1) external or internal breast prostheses required as the result of a medically necessary mastectomy; or
 - (2) wigs or hairpieces (synthetic, human-hair, or blends) prescribed by a Physician as a prosthesis for hair loss due to injury, disease, or treatment of a disease, for the following conditions:
 - a. burns (2nd degree full thickness and 3rd degree burns with resulting permanent alopecia); or
 - b. lupus; or
 - c. alopecia areata with near complete or complete cranial hair loss; or
 - d. alopecia totalis; or
 - e. alopecia universalis; or
 - f. fungal infections not responsive to an appropriate (typically 6-week) course of antifungal treatment resulting in near complete or complete cranial hair loss; or
 - g. chemotherapy; or
 - h. radiation therapy;

Regular Care and Attendance means that the Covered Person is personally seen by a Physician each day of his or her Confinement.

Usual and Customary means those expenses for services and/or supplies essential to the care of a Covered Person which will be considered reasonable and customary if they are the amount normally charged by the service provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the geographic area where the services or supplies are received, per industry-accepted guidelines. In determining whether expenses are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications, unusual or extenuating circumstances.

[DENTAL INSURANCE

The following definitions apply to Dental Insurance.

Covered Charges means those charges that:

- (a) are incurred by a Covered Person because of a covered Accident or Sickness; and
- (b) are for necessary treatment, services, and/or medical supplies, and are recommended by a Physician; and
- (c) are not more than the Usual and Customary Charges, or the actual billed charge, or any dollar limit set forth in the Schedule; and
- (d) are incurred while insured under the Policy, subject to any Extension of Benefits; and
- (e) are not excluded under Section 4, Exclusions.

Creditable Coverage means, with respect to an individual, coverage of an individual under:

- (a) a group health plan; or
- (b) health insurance coverage; or
- (c) Part A or Part B or Title XVIII of the Social Security Act (Medicare); or
- (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines); or
- (e) Chapter 55 of Title 10, United States Code (armed forces); or
- (f) a medical care program of the Indian Health Service, or of a tribal organization; or
- (g) a State health benefits risk pool; or
- (h) a health plan offered under Chapter 89 of Title 5, United States Code (U.S. government); or
- (i) a public health plan; or

SECTION 1 DEFINITIONS

- (j) a health benefit plan under Section 5(e) of the Peace Corps Act, 22 USC 2504(e).

Creditable Coverage does not mean:

- (a) accident only or disability income coverage; or
- (b) coverage issued as a supplement to liability insurance; or
- (c) liability insurance; or
- (d) Workers' Compensation or similar insurance; or
- (e) automobile medical payment insurance; or
- (f) credit only insurance; or
- (g) coverage for on-site medical clinics; or
- (h) other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

Deductible means the amount of Covered Charges, shown in the Schedule, for which We will pay no benefits during each Calendar Year.

Dental Hygienist means a person trained and licensed by the state to perform dental prophylaxis under the direction of a Dentist.

Dentist means a person who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his or her license. For the purpose of this definition, a Physician will be considered to be a Dentist only when he or she performs any of the dental services described herein, and is operating within the scope of his or her license.

Health Status-Related Factor means any of the following:

- (a) health status; or
- (b) a medical condition (including both physical and mental illness); or
- (c) claims experience; or
- (d) receipt of health care; or
- (e) medical history; or
- (f) genetic information; or
- (g) evidence of insurability (including conditions arising out of acts of domestic violence); or
- (h) disability.

Medical Condition means any condition, whether physical or mental, including, but not limited to:

- (a) any condition resulting from illness; or
- (b) injury (whether or not the injury is accidental); or
- (c) pregnancy; or
- (d) congenital malformation;

however, genetic information is not a Medical Condition.

[Pre-Existing Condition means a disease, injury, or physical, mental or nervous condition for which a Covered Person:

- (a) had treatment; or
- (b) incurred expense; or
- (c) took medication; or
- (d) received a diagnosis or advice from a Physician,

at any time during the six-month period immediately before the Enrollment Date of such Covered Person's coverage.

The term Pre-Existing Condition will also include conditions which are related to such disease, injury, or physical, mental or nervous condition.]

Usual and Customary means those expenses for services and/or supplies essential to the care of a Covered Person which will be considered reasonable and customary if they are the amount normally

SECTION 1 DEFINITIONS

charged by the service provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the geographic area where the services or supplies are received, per industry-accepted guidelines. In determining whether expenses are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications, unusual or extenuating circumstances.]

[DISABILITY INCOME INSURANCE

The following definitions apply to Disability Income Insurance.

Disability Benefit means the weekly disability benefit for which You are eligible and paying premium.

Elimination Period means that period of time that starts after Your Effective Date of coverage, during which:

- (a) You are Totally Disabled; and
- (b) no Disability Benefit is payable.

Mental Illness means a psychiatric or psychological condition, regardless of cause, including but not limited to:

- (a) schizophrenia; and/or
- (b) depression; and/or
- (c) manic depressive or bipolar illness; and/or
- (d) anxiety; and/or
- (e) personality disorders; and/or
- (f) adjustment disorders or other conditions, usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

The term Mental Illness does not apply to dementia, if due to:

- (a) stroke; or
- (b) trauma; or
- (c) viral infection; or
- (d) Alzheimer's disease; or
- (e) other such conditions not listed above which are not usually treated by a mental health provider using psychotherapy, psychotropic drugs, or other similar modalities.

[Pre-Existing Condition means a disease, injury, or physical, mental or nervous condition for which a Covered Person:

- (a) had treatment; or
- (b) incurred expense; or
- (c) took medication; or
- (d) received a diagnosis or advice from a Physician,

at any time during the 12-month period immediately before the Effective Date of such Covered Person's coverage.

The term Pre-Existing Condition will also include conditions which are related to such disease, injury, or physical, mental or nervous condition.]

Regular Care and Attendance means that You are attended by a Physician at least once a month, or until the Physician determines You:

- (a) have reached a state where continuous medical care is unnecessary; and
- (b) are still Totally Disabled.

Successive Disabilities means those disabilities which result from the same or related causes for which benefits are payable under the Policy.

**SECTION 1
DEFINITIONS**

Weekly Base Compensation means Your weekly salary at the time of disability, including reported tips, exclusive of bonus or overtime earnings. If any weekly Disability Benefit is to be paid for less than a full week, the amount will be reduced pro rata on the basis that one day's benefit equals one-seventh (1/7th) of the Disability Benefit.]

SECTION 2 ELIGIBILITY AND EFFECTIVE DATE

[EMPLOYEE RE-ENROLLMENT ELIGIBILITY

[If Your coverage ends due to missed premium deductions, You may not re-enroll except during an Open Enrollment Period, or during a Special Enrollment Period.]

[If You voluntarily end coverage, You must satisfy a 24-month waiting period before becoming eligible for re-enrollment. You may then re-enroll during the 31-day period immediately following such 24-month waiting period, or during an Open Enrollment Period [or Special Enrollment Period] that follows the end of the 24-month waiting period.]

EMPLOYEE EFFECTIVE DATE

[Your Effective Date is the first day of the month following Your enrollment, provided:

- (a) Your enrollment process is complete; and
- (b) You were on Active Service as of the date coverage was to take effect;
- (c) if any portion of the premium is contributory, the first payroll deduction was made for Your coverage under the Policy; and
- (d) Your first premium has been accepted by Us./

Your Effective Date is the first day after the Normal Pay Date for which the first payroll deduction is taken for coverage under the Policy, provided:

- (a) Your enrollment process was complete; and
- (b) You were on Active Service as of the date coverage was to take effect; and
- (c) Your first premium has been accepted by Us./

Your Effective Date is [*as agreed upon between Us and the Policyholder*], provided:

- (a) Your enrollment process was complete; and
- (b) You were on Active Service as of the date coverage was to take effect; and
- (c) if any portion of the premium is contributory, the first payroll deduction was made for Your coverage under the Policy; and
- (d) Your first premium has been accepted by Us.]

DEPENDENT ELIGIBILITY

If You did not enroll Your Dependent(s) at the time of Your enrollment, Your Dependent(s) is/are eligible for enrollment for Dependent coverage (where available under the Policy) during an Open Enrollment Period, or during a Special Enrollment Period under HIPAA, as described at the end of this Section.

All dependents to be enrolled must meet the definition of Dependent, as stated in Section 1, except as described under Handicapped Child below.

[Domestic Partner]

Before coverage can be made effective for a Domestic Partner, You (and Your Domestic Partner, if required) must complete and sign the applicable employer-provided documentation regarding such relationship.]

Handicapped Child [(Applicable only to Health Insurance[and Dental Insurance.])]

Your handicapped child who is over the limiting age is eligible for enrollment if he or she has Creditable Coverage, unless there was a break in coverage of 63 days or more.

SECTION 2
ELIGIBILITY AND EFFECTIVE DATE

Dual Eligibility

In no event may a person be covered more than once under the Policy.

[Contributory Employee Coverage (You pay all or part of Your premium.)

If You or Your spouse/common law spouse[/Domestic Partner]:

- (a) are both eligible for coverage under the Policy as Insureds; and
- (b) have no Dependent children,

then:

- (a) You and Your spouse/common law spouse[/Domestic Partner] may both elect individual (employee only) coverage; or
- (b) either You or Your spouse/common law spouse[/Domestic Partner] may elect coverage for both (with the other spouse/common law spouse[/Domestic Partner] being covered as a Dependent), and the other spouse/common law spouse[/Domestic Partner] may not enroll for coverage.

If both You and Your spouse/common law spouse[/Domestic Partner]:

- (a) are eligible for coverage under the Policy as Insureds; and
- (b) have Dependent children,

either You or Your spouse/common law spouse[/Domestic Partner] (but not both) may elect Dependent coverage, and such Dependent coverage will not apply to the other spouse/common law spouse[/Domestic Partner.]

[Non-Contributory Employee Coverage (Employer pays 100% of Your premium.)

If You and Your spouse/common law spouse[/Domestic Partner]:

- (a) are both eligible for coverage under the Policy as Insureds; and
- (b) have no Dependent children,

You and Your spouse/common law spouse[/Domestic Partner] will both be covered as employees. Dependent coverage is not available or applicable in this situation.

If both You and Your spouse/common law spouse[/Domestic Partner]:

- (a) are eligible for coverage under the Policy as Insureds; and
- (b) have Dependent children,

You and Your spouse/common law spouse[/Domestic Partner] will both be covered as employees. Either You or Your spouse/common law spouse[/Domestic Partner] (but not both) may elect Dependent coverage, and such Dependent coverage will not apply to the other spouse/common law spouse[/Domestic Partner].

If an eligible employee has a Dependent child who is also eligible as an employee, both You and Your Dependent child will be covered as employees. If the employee elects Dependent coverage, such Dependent coverage will not apply to any Dependent child who is already covered as an employee.]

Dual Eligibility / Divorce [or Dissolution of Partnership]

If both You and Your spouse/common law spouse[/Domestic Partner] are covered as Insureds under the Policy, and have covered Dependent children, and later:

- (a) become divorced; [or
- (b) Your partnership is dissolved,]

the required conditions in the definition of Dependent (e.g., residence, support and maintenance) will be used to determine which parent may cover the Dependent(s). Any child who was a step-child of Yours will no longer be eligible for coverage, unless You have adopted such child.

Dual Eligibility / Termination of Employment

If You and Your spouse/common law spouse[/Domestic Partner] are covered as Insureds under the Policy and one of You terminates employment, the remaining employee will be permitted to immediately enroll the terminating spouse/common law spouse[/Domestic Partner] and any of his or her eligible Dependents who were enrolled under the terminating spouse/common law spouse[/Domestic Partner's] coverage. Such new coverage will be deemed continuation of prior coverage, and will not operate to

**SECTION 2
ELIGIBILITY AND EFFECTIVE DATE**

reduce or increase any coverage to which the person was entitled while enrolled as the employee or the Dependent of the terminated employee.

DEPENDENT ENROLLMENT

Dependent coverage may be elected by You:

- (a) completing the enrollment process for Dependent coverage within 31 days of the date the Dependent becomes eligible; and
- (b) authorizing the employer to deduct any required premium for Dependent coverage from Your paycheck.

Dependent coverage will not be made effective if enrollment is not complete.

DEPENDENT EFFECTIVE DATE

[The Effective Date for each eligible Dependent will be the first day of the month following his or her enrollment, provided:

- (a) such Dependent's enrollment process is complete; and
- (b) the first payroll deduction is made for such Dependent's coverage under the Policy; and
- (c) the first premium for such Dependent has been accepted by Us. /

The Effective Date for each eligible Dependent will be the first day after the Normal Pay Date for which the first payroll deduction is taken for such Dependent's coverage under the Policy, provided:

- (a) such Dependent's enrollment process is complete; and
- (b) the first premium for such Dependent has been accepted by Us. /

The Effective Date for each eligible Dependent will be *[as agreed upon between Us and the Policyholder]*, provided:

- (a) such Dependent's enrollment process is complete; and
- (b) the first payroll deduction is made for such Dependent's coverage under the Policy; and
- (c) the first premium for such Dependent has been accepted by Us.]

However, if on such date Your coverage has not yet taken effect, the Effective Date for Dependent coverage will be the same date Your coverage goes into effect.

Your newborn child will become insured for Accident or Sickness automatically on the day he or she is born, as long as Your coverage is in force on that date. The newborn child's coverage will not continue past the 90-day period following birth unless:

- (a) We are notified by the end of that 90-day period of the addition of such newborn or adopted child; and
- (b) any applicable additional premium is paid.

Your adopted child will become insured on:

- (a) the date of the filing of a petition for adoption if You apply for coverage and pay the applicable premium within 60 days after filing such petition; or
- (b) the moment of birth if the petition for adoption is filed and application for coverage, along with payment of the applicable premium is made, within 60 days after the birth.

[Applicable to Term Life Insurance and Vision Insurance only: If a Dependent is Totally Disabled on the date coverage (with respect to that particular Dependent) would otherwise take effect, the coverage of such Dependent will be deferred until the [first of the month/next payroll deduction period] following the Dependent's cessation of Total Disability.]

SPECIAL ENROLLMENT UNDER HIPAA (Health Insurance Portability and Accountability Act of 1996)

Special Enrollment under HIPAA is not applicable to:

- [(a) Term Life/Accidental Death and Dismemberment Insurance, Disability Income Insurance, or Vision Insurance; or

SECTION 2 ELIGIBILITY AND EFFECTIVE DATE

- (b)] Domestic Partners or same-sex spouses, or the dependents of such Domestic Partners or same-sex spouses.

Eligibility for Special Enrollment

An employee or Dependent is eligible for Special Enrollment under HIPAA if:

- (a) coverage under the Policy was declined when initially offered, due to such person having coverage under any group health plan or health insurance coverage; and
- (b) such person has now lost that coverage.

An employee or Dependent is also eligible for Special Enrollment under HIPAA if the employee:

- (a) gains a dependent child due to birth, adoption, or placement of a child with the employee for the purpose of adoption; or
- (b) marries.

Conditions for Special Enrollment

Loss of eligibility for coverage that is not COBRA continuation coverage

An employee may enroll during a Special Enrollment Period if loss of coverage was as the result of:

- (a) legal separation or divorce;
- (b) a reduction in the number of hours of employment;
- (c) termination of HMO (or other arrangement) in the individual market due to the employee no longer residing, living, or working in the covered service area;
- (d) termination of HMO (or other arrangement) in the group market due to the employee no longer residing, living, or working in the covered service area, and if no other benefit package is available to the employee;
- (e) incurring a claim that would meet or exceed a lifetime limit on all benefits; or
- (f) a situation in which a plan no longer offers any benefits to the class of similarly situated individuals, such class including the employee.

A Dependent may be enrolled during a Special Enrollment Period if loss of coverage was as the result of:

- (a) legal separation or divorce;
- (b) such Dependent's cessation of dependent status (e.g., attaining the maximum age to be eligible as a dependent child under the plan);
- (c) death of an employee;
- (d) termination of employment;
- (e) a reduction in the number of hours of employment;
- (f) termination of HMO (or other arrangement) in the individual market due to the employee no longer residing, living, or working in the service area;
- (g) termination of HMO (or other arrangement) in the group market due to the employee no longer residing, living, or working in the service area, and if no other benefit package is available to the employee;
- (h) incurring a claim that would meet or exceed a lifetime limit on all benefits; or
- (i) a situation in which a plan no longer offers any benefits to the class of similarly situated individuals, such class including the employee.

Special Enrollment is not available under any of the above conditions if loss of coverage is due to:

- (a) failure to pay premiums on a timely basis; or
- (b) termination of coverage due to cause (e.g., making a fraudulent claim, or an intentional misrepresentation of fact in connection with the plan).

Termination of employer contributions for coverage that is not COBRA continuation coverage

An employee or Dependent may enroll during a Special Enrollment Period if an employer's contributions towards the employee's or Dependent's coverage terminates. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or Dependent.

SECTION 2 ELIGIBILITY AND EFFECTIVE DATE

Exhaustion of COBRA continuation coverage

An employee or Dependent may enroll during a Special Enrollment Period if such person's COBRA continuation coverage was exhausted due to:

- (a) such person reaching the end of their maximum continuation period;
- (b) the failure of the employer or other responsible entity to remit premiums on a timely basis;
- (c) such person no longer residing, living, or working in the service area of an HMO or similar program, and there is no other COBRA continuation coverage available to such person;
- (d) such person incurring a claim that would meet or exceed a lifetime limit on all benefits, and there is no other COBRA continuation coverage available to such person.

Special Enrollment is not available under any of the above conditions if loss of coverage is due to:

- (a) failure to pay premiums on a timely basis; or
- (b) termination of coverage due to cause (e.g., making a fraudulent claim, or an intentional misrepresentation of fact in connection with the plan).

Marriage, birth, adoption, or placement for adoption

An employee or Dependent may enroll during a Special Enrollment Period if the employee:

- (a) gains a dependent child due to birth, adoption, or placement of a child for the purpose of adoption; or
- (b) marries.

Effective Date for Special Enrollment

With respect to a person whose coverage becomes effective as a result of a Special Enrollment under HIPAA, such coverage shall become effective:

- (a) in the case of marriage, the [first day of the first month following the] date of marriage; or
- (b) in the case of an eligible Dependent's birth, as of the date of such birth; or
- (c) in the case of an eligible Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption,

provided the usual Effective Date conditions are satisfied, as stated in EMPLOYEE EFFECTIVE DATE and/or DEPENDENT EFFECTIVE DATE above.

SECTION 3 BENEFIT PROVISIONS

HEALTH INSURANCE *(Applicable only if this coverage is not excluded in the Schedule.)*

We will pay Covered Charges for a service or supply that is described under one or more of the following listed categories of benefits, subject to any and all applicable maximum dollar and/or durational amounts. The service or supply must be provided for a covered Accident or Sickness. All benefit amounts and any applicable Deductibles, Coinsurance amounts, Co-payments, and maximums are shown in the Schedule.

Inpatient Benefits

Inpatient Benefits are payable for services and supplies that are provided to a Covered Person while Confined in a Hospital.

Room and Board Benefit

We will pay this benefit when a Covered Person is charged for room and board, regardless of the level of care (e.g. semi-private, private, intensive care). No benefit will be paid during any period such Covered Person is not under the Regular Care and Attendance of a Physician.

[Daily Hospital Indemnity Benefit (Not applicable to Dependents.)

If an Insured is Confined in a Hospital, We will pay the Daily Hospital Indemnity Benefit amount for each day of Confinement, for up to the Maximum Number of Days of Confinement. No benefit will be paid during any period the Covered Person is not under the Regular Care and Attendance of a Physician.]

Inpatient Physician Non-Surgical Services Benefit

We will pay this benefit for non-surgical services rendered by a Physician, including but not limited to:

- (a) regular consults and exams by the attending Physician; and
- (b) consults and exams by Physician specialists; and
- (c) readings and interpretations of diagnostic laboratory tests, screenings, and x-rays.

Inpatient Physician Surgical Services Benefit

We will pay this benefit for surgical services rendered on an inpatient basis by a Physician for a covered surgery.

If two or more surgical procedures are performed through the same incision or the same operative field, payment will be made only for the procedure of the larger benefit. If more than one procedure is performed, but each through separate incisions or in a separate operative field, the amount payable will be the benefit amount for the primary procedure, plus 50% of the amount payable for all other surgical procedures performed.

Inpatient Anesthetic Services and Anesthesia Benefit

We will pay this benefit for:

- (a) Physician's services for administration of anesthesia when the anesthesia is provided in connection with a covered surgery performed on an inpatient basis; and
- (b) the cost of such anesthesia.

This benefit is also payable with respect to dental surgical procedures only if such procedure is performed in a Hospital and the Covered Person:

- (a) is a child or adolescent who:
 - (1) is determined by a licensed dentist to require necessary dental treatment in a Hospital or ambulatory surgical center due to a significantly complex dental condition, or a developmental disability in which patient management in the dental office has proved to be ineffective; or
 - (2) is extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred, and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;

or

SECTION 3 BENEFIT PROVISIONS

- (b) has extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or
- (c) is one for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy; or
- (d) has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

Inpatient Miscellaneous Services and Supplies

We will pay this benefit for other covered services and supplies, including but not limited to:

- (a) facility charges other than room and board (e.g. recovery room); and
- (b) nursing services; and
- (c) treatment by radiologists and physiotherapists; and
- (d) therapy services; and
- (e) oxygen, and the equipment for its administration; and
- (f) blood and blood plasma, and its processing costs; and
- (g) medications and other pharmaceutical products, including associated supplies and administration; and
- (h) non-durable medical supplies (e.g. bandages, casts, splints); and
- (i) diagnostic laboratory tests, screenings, and x-rays; and
- (j) testing of newborns for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and other newborn tests which may become mandated by law; and
- (k) hospice services.

Outpatient Benefits

We will pay benefits for covered services and supplies received on an Outpatient basis that are not payable under another listed Benefit. This includes, but is not limited to:

- (a) outpatient facilities, such as ambulatory surgical centers or emergency care clinics (whether free-standing or located within a Hospital); and
- (b) treatment by radiologists and physiotherapists; and
- (c) therapy services; and
- (d) diagnostic laboratory tests, screenings, and x-rays; and
- (e) oxygen, and the rental equipment for its administration; and
- (f) medications and other pharmaceutical products, none of which are obtainable through a written prescription. This includes:
 - (1) nutritional supplements for the treatment and management of phenylketonuria and other inheritable diseases; and
 - (2) childhood immunizations, including their administration (exempt from deductible, coinsurance, or co-payments); and
 - (3) medications and supplies for the treatment of cancer, including their administration; and
 - (4) medications and supplies for the treatment of diabetes, including their administration, and supplies for the prevention of complications associated with diabetes;and
- (g) hospice services; and
- (h) non-durable medical supplies (e.g., bandages, casts, splints); and
- (i) any type of contraceptive, including its administration. (Contraceptives obtainable through a written prescription are payable under the Prescription Drug Card Benefit.)

[Benefits for services and supplies received while in an Emergency Room, for the treatment of Sickness, are payable only under the Emergency Room Sickness Benefit.]

[Benefits for services and supplies received while in an Emergency Room, for the treatment of an Accident, are payable under the Supplemental Accident Benefit.]

SECTION 3 BENEFIT PROVISIONS

Outpatient Physician Non-Surgical Services Benefit

We will pay this benefit for each time a Covered Person is charged for non-surgical services by a Physician during an office visit, or for a home health care visit. This benefit is also payable for visits for:

- (a) contraceptive services; and
- (b) diabetes self-management training; and
- (c) readings and interpretations of diagnostic laboratory tests, screenings, and x-rays; [and
- (d) treatment of loss or impairment of speech and hearing; and
- (e) well-child exams from birth through age 18, which includes up to 20 visits at approximately the following intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years; and
- (f) in-vitro fertilization, subject to the following:
 - (1) the patient is a Covered Person under the Policy and is insured for pregnancy benefits; and
 - (2) the patient's oocytes are fertilized only with the sperm of the Covered Person's spouse; and
 - (3) the patient and patient's spouse have a history of unexplained infertility of at least two years' duration; or
 - (3) the infertility is associated with one or more of the following:
 - a. endometriosis; or
 - b. exposure in utero to diethylstilbestrol (DES); or
 - c. blockage of or surgical removal of one or both fallopian tubes, not a result of voluntary sterilization; or
 - d. abnormal male factors contributing to the infertility; and
 - (4) the patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the Policy; and
 - (5) the in vitro fertilization procedures are performed at a medical facility that conforms to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimum standards for programs of in vitro fertilization;]

Outpatient Physician Surgical Services Benefit

We will pay this benefit for surgical services rendered on an outpatient basis by a Physician for a covered surgery.

If two or more surgical procedures are performed through the same incision or the same operative field, payment will be made only for the procedure of the larger benefit. If more than one procedure is performed, but each through separate incisions or in a separate operative field, the amount payable will be the benefit amount for the primary procedure, plus 50% of the amount payable for all other surgical procedures performed.

Outpatient Anesthetic Services and Anesthesia Benefit

We will pay this benefit for:

- (a) Physician's services for administration of anesthesia when the anesthesia is provided in connection with a covered surgery performed on an outpatient basis; and
- (b) the cost of such anesthesia.

This benefit is also payable with respect to dental surgical procedures only if such procedure is performed in an ambulatory surgical center and the Covered Person:

- (a) is a child or adolescent who:
 - (1) is determined by a licensed dentist to require necessary dental treatment in a Hospital or ambulatory surgical center due to a significantly complex dental condition, or a developmental disability in which patient management in the dental office has proved to be ineffective; or

SECTION 3 BENEFIT PROVISIONS

- (2) is extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred, and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;
- or
- (b) has extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or
- (c) is one for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy; or
- (d) has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

[Additional Benefits

These are separate benefits that do not count towards the Inpatient Maximum Benefit or the Outpatient Maximum Benefit, and are not subject to any other stated Deductible, Coinsurance, Co-Payment, or any other limitation, other than what is stated in the Schedule with respect to each benefit.]

[Hospital Admission Indemnity Benefit

We will pay this lump sum benefit once for each period of Confinement.]

[Intensive Care Unit Indemnity Benefit

We will pay this lump sum benefit once for each day of Confinement in an Intensive Care Unit of a Hospital.]

[Emergency Room Sickness Benefit

We will pay this benefit for each episode of care received in a Hospital emergency room, for the treatment of Sickness. No other benefit is payable under the Policy for services or supplies received, or for facility charges made, for care received in a Hospital emergency room, for the treatment of Sickness.]

[Supplemental Accident Benefit

We will pay this benefit for covered services and supplies received by a Covered Person, for the treatment of injury due to an Accident, but only after any and all other benefits are paid under the Policy. Charges for such services and supplies must be incurred within 90 days of the Accident. Outpatient prescription drugs are not included in this benefit, and are payable only under the Prescription Drug Card Benefit.]

[Wellness Benefit (applicable only to Covered Persons age 18 years or older)

We will pay this benefit for the following, when used for wellness purposes:

- (a) Physician office visits (including expense of administration of immunizations); and
- (b) x-ray and laboratory tests, including, but not limited to:
 - (1) mammograms; and
 - (2) pap smears; and
 - (3) CA-125 tests; and
 - (4) PSA tests/prostate cancer screening (not subject to any deductible); and
 - (5) urine tests; and
 - (6) bone mass tests; and
 - (7) blood tests; and
 - (8) colorectal cancer screening.]

[Prescription Drug Card Benefit

We will pay this benefit for each complete fill or refill of a medication or supply that is:

- (a) obtainable only with a written prescription; and
- (b) dispensed by a pharmacy.]

This benefit includes contraceptives.

SECTION 3 BENEFIT PROVISIONS

Durable Medical Equipment and Prosthesis Benefit

We will pay this benefit for:

- (a) equipment for the monitoring and treatment of diabetes (e.g. blood glucose monitors, insulin pumps, insulin infusion devices); and
- (b) hearing aids (not subject to any deductibles or co-payments); and
- (c) the purchase or rental of Durable Medical Equipment; and
- (d) the expense of a Prosthesis. This includes, but is not limited to external or internal breast prostheses required as the result of a medically necessary mastectomy.]

[TERM LIFE INSURANCE *(Applicable only if this coverage is not excluded in the Schedule.)*

If a Covered Person dies, We will pay the Death Benefit, subject to the provisions of the Policy. The amount of the Death Benefit is shown in the Schedule.

Payment of Death Benefit

With respect to Your death, payment of the Death Benefit will be made in a lump sum to the Beneficiary named by You. If more than one Beneficiary has been named:

- (a) the Death Benefit will be paid in equal shares to all named, living Beneficiaries; or,
- (b) if Your Beneficiary election indicates a different proportion of benefit payment, the Death Benefit will be paid as instructed by You.

With respect to the death of a Dependent, payment of the Death Benefit will be made in a lump sum to You.

We may pay benefits to someone other than You or Your Beneficiary if:

- (a) You or Your Beneficiary is a minor, or cannot give a valid release; or
- (b) no request for payment has been made by a duly appointed guardian; or
- (c) the person to whom payment will be made appears to have assumed Your, or Your Beneficiary's, care and main support.

We may pay up to \$250.00, or the maximum amount permitted by state law, whichever is greater, to any person appearing to be entitled to such payment by reason of having incurred funeral or other expenses incident to the last illness or death of the Covered Person.

Any payment We make is done so in good faith; it will fully discharge Us for the amount of such payment.]

[Naming and Changing a Beneficiary

You may name a Beneficiary to whom the Death Benefit will be paid. If You did not name a Beneficiary, or if there is no living Beneficiary at the time of Your death, the order of Beneficiary determination is as follows:

- (a) Your lawful spouse or common law spouse [or Domestic Partner]; then
- (b) Your child or children (in equal shares); then
- (c) Your parent or parents (in equal shares); then
- (d) Your brother(s) and/or sister(s) (in equal shares); then
- (e) Your estate.

For purposes of this provision, child, parent, brother and sister includes step or adopted child(ren), step-parent(s), step-brother(s) and step-sister(s), respectively.

You may name a new Beneficiary from time to time. The consent of the existing Beneficiary is not needed to make this or any other change in the Policy. (If the Beneficiary has been named irrevocable, see the next paragraph.) You must file a written request for the change. The change will not take effect until We receive and approve the request at Our home office. When received and approved, the change goes back to and takes effect as of the date such request was made. This will happen even if You die between the time the request is made and it is received and recorded by Us. However, any amount paid prior to receiving and recording such request will not be subject to the request for change.]

[If You apply for a conversion policy or apply for a different amount of insurance and name a new Beneficiary on that application, this will be considered a request for a change of Beneficiary. This means

SECTION 3 BENEFIT PROVISIONS

that the change in Beneficiary will apply to the Policy as well as to the conversion policy, even though the conversion policy itself or the changed amount may not yet have taken effect. (For more details about conversion, see the following Conversion Privilege provision.)

Irrevocable Beneficiary

You can make an irrevocable Beneficiary designation. This means that You give up the right to change the Beneficiary. You can get this right back if:

- (a) the Beneficiary gives written consent; or
- (b) the Beneficiary dies.

If an irrevocable Beneficiary designation is in effect, the rules about changing the Beneficiary stated above do not apply.

Conversion Privilege *(The Conversion Privilege is available only if We have a policy form approved in the Covered Person's state of residence, at the time application for conversion is made.)*

If insurance, or any portion of it, on a Covered Person ends because of:

- (a) Your termination of employment; or
- (b) Your termination of membership in a class eligible for coverage,

such Covered Person may convert to an individual life policy if:

- (a) written application is made for the individual policy; and
- (b) the first premium for the individual policy is paid to Us,

within 31 days after the date of termination.

The individual policy will be subject to the following conditions:

- (a) Proof of good health will not be required.
- (b) The policy will not have any disability or other supplementary benefits.
- (c) The Covered Person can choose any form, except term insurance, then in use by Us.
- (d) The amount cannot be more than the amount of life insurance which ceases because of such termination.
- (e) The rate will be Our customary rate, based on the form, the amount, the Covered Person's class of risk, and age at the time the individual policy takes effect.]

[Subject to the above conditions, the conversion privilege will also be available to:

- (a) a surviving Dependent, if any, upon Your death; and (This applies only to coverage under the Policy which terminates by reason of such death.)
- (b) Your Dependent, if termination of coverage is due to the Dependent no longer meeting the definition of Dependent. (This applies only if Dependent coverage terminates while You remain covered under the Policy.)

If insurance on any Covered Person stops because:

- (a) the Policy terminates; or
- (b) the Policy is changed so that a class of insured persons is terminated,

such person can convert; however, the Covered Person must have been insured under the Policy for at least five years immediately preceding the date of termination of insurance. Conversion is subject to the same rules outlined above, except the amount will not exceed the lesser of:

- (a) the amount of insurance ceasing; or
- (b) \$10,000.00.

If the Covered Person dies during the 31-day period in which he or she is entitled to a conversion policy but before such plan takes effect, an amount of life insurance shall be payable. The amount shall be that which the Covered Person would have been entitled to have issued under the conversion policy. The amount shall be payable as a claim under the Policy, whether or not application or premium payment on the conversion policy has been made.

This conversion privilege is in lieu of all other benefits under the Policy. The effective date of the conversion plan will be the 32nd day after the date that premiums were paid to under the Policy.

**SECTION 3
BENEFIT PROVISIONS**

If You have assigned all ownership rights absolutely to an assignee, then the assignee (instead of You) is entitled to exercise the conversion privilege.

You will be given notice of Your conversion right at least 15 days before the end of the 31-day conversion period. If such notice is not given, You have an additional period of time to exercise Your right. This period ends 15 days after the date You are given notice, but in no event shall the additional period extend beyond 60 days after the original 31-day period (for a total of 91 days). In no event, however, will insurance under the Policy be continued beyond the original 31-day period.

Notice shall mean written notice that is given or mailed to the You. Notice may be mailed by the Policyholder, or by Us, to Your last known address.

If You become Totally Disabled while covered under this Life Insurance Benefit, this coverage may be continued during the Total Disability subject to timely payment of the premium that You were required to pay had the Total Disability not occurred. Continued coverage will end the earlier of:

- (a) six months from the date the Total Disability began; or
- (b) discontinuance of the Policy; or
- (c) You cease to be Totally Disabled.

[ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE—Not applicable to Dependents.
(Applicable only if this coverage is not excluded in the Schedule.)

If You suffer loss of life, sight or limb(s) due to an accidental bodily injury, We will pay an Accidental Death and Dismemberment Benefit for such loss if the following conditions are met:

- (a) The loss must result directly from an injury. The injury must be caused by an Accident that occurs while the Policy is in force.
- (b) The loss must occur no later than 90 days after the date the injury was received.
- (c) The loss must not be excluded.
- (d) The loss of a hand or foot means the permanent severance at or above the wrist or ankle joint.
- (e) The loss of sight means total and irrecoverable loss of sight.

The benefit amount payable for a loss, which meets the conditions stated above, is as follows:

For Loss of Life.....	100% of the Principal Sum
For Loss of One Hand.....	50% of the Principal Sum
For Loss of One Foot	50% of the Principal Sum
For Loss of Sight of One Eye	50% of the Principal Sum
For Loss of more than one of the above in any one Accident	100% of the Principal Sum]

[The "Principal Sum" is the amount shown in the Schedule. Only one of the amounts, the greatest, will be paid for more than one loss resulting from the same accident.]

[DENTAL INSURANCE. *(Applicable only if this benefit is not excluded in the Schedule.)*

If a Covered Person incurs Covered Charges for dental expenses, We will pay the benefit amount shown in the Schedule of Dental Benefits, according to the Expense Class shown in such Schedule of Dental Benefits. A charge is incurred on the date that treatment is given, service is rendered, or a supply is furnished. The benefit amount is subject to:

- (a) the Calendar Year Deductible; and
- (b) the Calendar Year Maximum; and
- (c) the Alternative Benefits provision; and
- (d) all other applicable provisions of the Policy.

Unlisted Treatment, Services or Supplies

Benefits for treatment, services or supplies not listed in the Schedule of Dental Benefits will be determined by Us. The benefit will be based upon the extent and type of damage, and nature of materials used.

**SECTION 3
BENEFIT PROVISIONS**

Alternative Benefits

If various types of treatment are available, the Covered Dental Expenses will be limited to the Dental Service Benefit payable for the least expensive treatment that will produce a professionally adequate result as determined by Us.]

**SECTION 3
BENEFIT PROVISION**

[SCHEDULE OF DENTAL BENEFITS

SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS
DIAGNOSTIC & EVALUATION		
Office Visit	D0999	A
Periodic Oral Exam	D0120	A
Limited Oral Exam – Problem Focused	D0140	A
Comprehensive Oral Exam – Under age 3	D0145	A
Comprehensive Oral Exam – Age 3 or older	D0150	A
Extensive Oral Exam – Problem Focused	D0160	A
Reevaluation – Limited, Problem Focused	D0170	A
Comprehensive Periodontal Exam	D0180	A
Intraoral – Complete Series	D0210	A
Intraoral – Periapical – 1st Film	D0220	A
Intraoral – Periapical – Each Additional Film	D0230	A
Intraoral – Occlusal Film	D0240	A
Extraoral – 1st Film	D0250	A
Extraoral – Each Additional Film	D0260	A
Bitewing – 1 Film	D0270	A
Bitewing – 2 Films	D0272	A
Bitewing – 3 Films	D0273	A
Bitewing – 4 Films	D0274	A
Vertical Bitewings	D0277	A
Panoramic Film	D0330	A
Caries Susceptibility Test	D0425	A
Biopsy and Exam of Oral Tissue, Hard	D0430	A
Pulp Vitality Tests	D0460	A
Diagnostic Casts	D0470	A
PREVENTATIVE		
Prophylaxis – Age 14 or older	D1110	A
Prophylaxis – Under age 14	D1120	A
Fluoride (Prophylaxis Not Included) – Under age 19	D1203	A
Fluoride (Prophylaxis Not Included) – Age 19 or older	D1204	A
Sealant – Per Tooth	D1351	A
Space Maintainer – Fixed – Unilateral	D1510	A
Space Maintainer – Fixed – Bilateral	D1515	A
Space Maintainer – Removable – Unilateral	D1520	A
Space Maintainer – Removable – Bilateral	D1525	A
Re-cementation of Space Maintainer	D1550	A
RESTORATIVE DENTISTRY		
Amalgam – 1 Surface, Permanent	D2140	A
Amalgam – 2 Surfaces, Permanent	D2150	A
Amalgam – 3 Surfaces, Permanent	D2160	A
Amalgam – 4+ Surfaces, Permanent	D2161	A
Resin Composite – 1 Surface, Anterior	D2330	A
Resin Composite – 2 Surfaces, Anterior	D2331	A
Resin Composite – 3 Surfaces, Anterior	D2332	A
Resin Composite – 4+ Surfaces, Anterior	D2335	A
Resin Composite – 1 Surface, Posterior	D2391	A
Resin Composite – 2 Surfaces, Posterior	D2392	A
Resin Composite – 3 Surfaces, Posterior	D2393	A
Resin Composite – 4+ Surfaces, Posterior	D2394	A
Gold Foil – 1 Surface	D2410	B
Gold Foil – 2 Surfaces	D2420	B
Gold Foil – 3 Surfaces	D2430	B

SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS
ONLAYS, CROWNS, BRIDGES		
Inlay – Metallic – 1 Surface	D2510	B
Inlay – Metallic – 2 Surfaces	D2520	B
Inlay – Metallic – 3+ Surfaces	D2530	B
Onlay – Metallic – 2 Surfaces	D2542	B
Onlay – Metallic – 3 Surfaces	D2543	B
Onlay – Metallic – 4+ Surfaces	D2544	B
Inlay – Porcelain/Ceramic – 1 Surface	D2610	B
Inlay – Porcelain/Ceramic – 2 Surfaces	D2620	B
Inlay – Porcelain/Ceramic – 3+ Surfaces	D2630	B
Onlay – Porcelain/Ceramic – 2 Surfaces	D2642	B
Onlay – Porcelain/Ceramic – 3 Surfaces	D2643	B
Onlay – Porcelain/Ceramic – 4+ Surfaces	D2644	B
Inlay – Resin Composite – 1 Surface	D2650	B
Inlay – Resin Composite – 2 Surfaces	D2651	B
Inlay – Resin Composite – 3+ Surfaces	D2652	B
Onlay – Resin Composite – 2 Surfaces	D2662	B
Onlay – Resin Composite – 3 Surfaces	D2663	B
Crown – Resin – Laboratory	D2710	B
Crown – Resin with High Noble Metal	D2720	B
Crown – Resin with Base Metal	D2721	B
Crown – Resin with Noble Metal	D2722	B
Crown – Porcelain/Ceramic Substrate	D2740	B
Crown – Porcelain with High Noble Metal	D2750	B
Crown – Porcelain with Predominantly Base Metal	D2751	B
Crown – Porcelain With Noble Metal	D2752	B
Crown – 3/4 Cast High Noble Metal	D2780	B
Crown – 3/4 Cast Predominantly Base Metal	D2781	B
Crown – 3/4 Cast Noble Metal	D2782	B
Crown – 3/4 Porcelain/Ceramic	D2783	B
Crown – Full Cast High Noble Metal	D2790	B
Crown – Full Cast Predominantly Base Metal	D2791	B
Crown – Full Cast Noble Metal	D2792	B
Re-cement Inlay	D2910	A
Re-cement Crown	D2920	A
Core Build Up, Including any Pins	D2950	B
Pin Retention – Per Tooth, in Addition to Restoration	D2951	B
Cast Post and Core, in Addition to Crown	D2952	B
Cast Post and Core, Each Additional (Same Tooth)	D2953	B
Prefabricated Post and Core, in Addition to Crown	D2954	B
Each Additional Prefabricated Post, same tooth	D2957	B
Temporary Crown (fractured tooth)	D2970	B
Crown Repair	D2980	B
ENDODONTICS		
Pulp Cap – Direct	D3110	A
Pulp Cap – Indirect	D3120	A
Therapeutic Pulpotomy	D3220	A
Pulpal Debridement, Primary/Permanent	D3221	A
Pulpal Therapy – Anterior, Primary Tooth	D3230	A
Pulpal Therapy – Posterior, Primary Tooth	D3240	A
Root Canal – Anterior	D3310	B]

**SECTION 3
BENEFIT PROVISION**

[SCHEDULE OF DENTAL BENEFITS

SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS
Root Canal – Bicuspid	D3320	B
Root Canal – Molar	D3330	B
Retreatment of Previous RCT – Anterior	D3346	B
Retreatment of Previous RCT – Bicuspid	D3347	B
Retreatment of Previous RCT – Molar	D3348	B
Apexification/Recalcification – Initial Visit	D3351	B
Apexification/Recalcification – Interim Visit	D3352	B
Apexification/Recalcification – Final Visit	D3353	B
Apicoectomy/Periradicular – Anterior	D3410	B
Apicoectomy/Periradicular – Bicuspid, 1st Root	D3421	B
Apicoectomy/Periradicular – Molar, 1st Root	D3425	B
Apicoectomy/Periradicular, Each Additional Root	D3426	B
Retrograde Filling – Per Root	D3430	B
Root Amputation – Per Root	D3450	B
Hemisection (Including any Root Removal)	D3920	B
PERIODONTICS		
Gingivectomy/Gingivoplasty – 4+ teeth/quad	D4210	B
Gingivectomy/Gingivoplasty – 1-3 teeth/quad	D4211	B
Gingival Flap – Incl. Root Planing – 4+ teeth/quad	D4240	B
Gingival Flap – Incl. Root Planing – 1-3 teeth /quad	D4241	B
Crown Lengthening – Hard Tissue	D4249	B
Osseous Surgery – 4+ teeth/quad	D4260	B
Osseous Surgery – 1-3 teeth/quad	D4261	B
Pedicle Soft Tissue Graft Procedure	D4270	B
Free Soft Tissue Graft Procedure	D4271	B
Subepithelial Connective Tissue Graft Procedure	D4273	B
Distal/Proximal Wedge Procedure (no surgery)	D4274	B
Soft Tissue Allograft	D4275	B
Combined Connective Tissue/Double Pedicle Graft	D4276	B
Provisional Intracoronal Splint	D4320	B
Provisional Extracoronal Splint	D4321	B
Perio. Scaling & Root Planing – 4+ teeth/quad	D4341	B
Perio. Scaling & Root Planing – 1-3 teeth /quad	D4342	B
Full Mouth Debridement	D4355	B
Periodontal Maintenance Procedures	D4910	A
REMOVABLE PROSTHETICS		
Complete Denture – Upper	D5110	B
Complete Denture – Lower	D5120	B
Immediate Denture – Upper	D5130	B
Immediate Denture – Lower	D5140	B
Upper Partial Denture – Resin Base	D5211	B
Lower Partial Denture – Resin Base	D5212	B
Upper Partial – Cast Metal Frame, Resin Base	D5213	B
Lower Partial – Cast Metal Frame, Resin Base	D5214	B
Removable Unilateral Partial – 1 Piece Cast Metal	D5281	B
Adjust Complete Denture – Upper	D5410	A
Adjust Complete Denture – Lower	D5411	A

SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS
Adjust Partial Denture – Upper	D5421	A
Adjust Partial Denture – Lower	D5422	A
Repair Broken Complete Denture Base	D5510	A
Replace Missing or Broken Teeth, Complete Denture – Per Tooth	D5520	A
Repair Resin Denture Base, Complete Denture	D5610	A
Repair Cast Framework	D5620	A
Repair or Replace Broken Clasp	D5630	A
Replace Broken Teeth, Complete Denture – Per Tooth	D5640	A
Add Tooth to Existing Partial Denture	D5650	A
Add Clasp to Existing Partial Denture	D5660	A
Replace All Teeth and Acrylic on Cast Metal Framework (Upper)	D5670	A
Replace All Teeth and Acrylic on Cast Metal Framework (Lower)	D5671	A
Rebase Complete Upper Denture	D5710	A
Rebase Complete Lower Denture	D5711	A
Rebase Upper Partial Denture	D5720	A
Rebase Lower Partial Denture	D5721	A
Reline Complete Upper Denture (Chairside)	D5730	A
Reline Complete Lower Denture (Chairside)	D5731	A
Reline Upper Partial Denture (Chairside)	D5740	A
Reline Lower Partial Denture (Chairside)	D5741	A
Reline Complete Upper Denture (Laboratory)	D5750	A
Reline Complete Lower Denture (Laboratory)	D5751	A
Reline Upper Partial Denture (Laboratory)	D5760	A
Reline Lower Partial Denture (Laboratory)	D5761	A
Tissue Conditioning – Upper	D5850	A
Tissue Conditioning – Lower	D5851	A
PONTICS		
Pontic – Cast High Noble Metal	D6210	B
Pontic – Cast Predominantly Base Metal	D6211	B
Pontic – Cast Noble Metal	D6212	B
Pontic – Porcelain With High Noble Metal	D6240	B
Pontic – Porcelain With Predom Base Metal	D6241	B
Pontic – Porcelain With Noble Metal	D6242	B
Pontic – Porcelain/Ceramic	D6245	B
Retainer – Cast Metal or Resin Bonded Fixed Prosthesis	D6545	B
Retainer – Porcelain/Ceramic or Resin Bonded Fixed Prosthesis	D6548	B
Inlay – Porcelain/Ceramic, 2 Surfaces	D6600	B
Inlay – Porcelain/Ceramic, 3+ Surfaces	D6601	B
Inlay – Cast High Noble Metal, 2 Surfaces	D6602	B
Inlay – Cast High Noble Metal, 3+ Surfaces	D6603	B
Inlay – Cast Predom. Base Metal, 2 Surfaces	D6604	B
Inlay – Cast Predom. Base Metal, 3+ Surfaces	D6605	B
Inlay – Cast Noble Metal, 2 Surfaces	D6606	B
Inlay – Cast Noble Metal, 3+ Surfaces	D6607	B
Onlay – Porcelain/Ceramic, 2 Surfaces	D6608	B]

**SECTION 3
BENEFIT PROVISION**

[SCHEDULE OF DENTAL BENEFITS

SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS	SERVICE / SUPPLY	ADA CODE	EXPENSE CLASS
Onlay – Porcelain/Ceramic, 3+ Surfaces	D6609	B	Surg. Exp. Of Impacted/Unerupted Tooth-Aid Erup	D7281	A
Onlay – Cast High Noble Metal, 2 Surfaces	D6610	B	Biopsy of Oral Tissue – Hard (Bone, Tooth)	D7285	A
Onlay – Cast High Noble Metal, 3+ Surfaces	D6611	B	Biopsy of Oral Tissue – Soft (All Others)	D7286	A
Onlay – Cast Predom. Base Metal, 2 Surfaces	D6612	B	Alveoplasty in Conjunction w/Extract-Per Quad	D7310	A
Onlay – Cast Predom. Base Metal, 3+ Surfaces	D6613	B	Alveoplasty not in Conjunct w/Extract-Per Quad	D7320	A
Onlay – Cast Noble Metal, 2 Surfaces	D6614	B	Vestibuloplasty-Ridge Ext (2nd Epithelialization)	D7340	B
Onlay – Cast Noble Metal, 3+ Surfaces	D6615	B	Vestibuloplasty-Ridge Ext (Grafts, Hypertissue)	D7350	B
Crown – Resin With High Noble Metal	D6720	B	Excision of Malignant Tumor-up to 1.25 cm	D7440	B
Crown – Resin With Base Metal	D6721	B	Excision of Malignant Tumor - > than 1.25cm	D7441	B
Crown – Resin With Noble Metal	D6722	B	Removal of Odontogenic Cyst/Tumor <=1.25cm	D7450	B
Crown – Porcelain/Ceramic Substrate	D6740	B	Removal of Odontogenic Cyst/Tumor > 1.25cm	D7451	B
Crown – Porcelain With High Noble Metal	D6750	B	Removal of Nonodontogenic Cyst/Tumor<=1.25cm	D7460	B
Crown – Porcelain With Predom Base Metal	D6751	B	Removal Nonodontogenic Cyst/Tumor> 1.25cm	D7461	B
Crown – Porcelain With Noble Metal	D6752	B	Removal of Lateral Exostosis – Per Site	D7471	B
Crown – 3/4 Cast High Noble Metal	D6780	B	Removal of Torus Palatinus	D7472	B
Crown – 3/4 Cast Predominantly Base Metal	D6781	B	Removal of Torus Mandibularus	D7473	B
Crown – 3/4 Cast Noble Metal	D6782	B	Surgical Reduction of Osseous Tuberosity	D7485	B
Crown – Full Cast High Noble Metal	D6790	B	Incision/Drain of Abscess – Intraoral Soft Tissue	D7510	A
Crown – Full Cast Predominantly Base Metal	D6791	B	Incision/Drain of Abscess – Extraoral Soft Tissue	D7520	A
Crown – Full Cast Noble Metal	D6792	B	Removal of Foreign Body, Skin, or Subc. Areolar Tissue	D7530	A
Re-cement Fixed Partial Denture	D6930	A	Sequestrectomy for Osteomyelitis	D7550	B
Cast Post and Core in Addition to Fixed Partial Denture Retainer	D6970	B	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body	D7560	B
Prefabricated Post and Core in Addition to Fixed Partial Denture Repair	D6972	B	Suture of Recent Small Wounds up to 5cm	D7910	B
Core Build Up for Retainer, Including any Pins	D6973	B	Frenulectomy (Frenectomy or Frenotomy), sep. proc.	D7960	B
Each Additional Cast Post – Same Tooth	D6976	B	Excision of Hyperplastic Tissue – Per Arch	D7970	B
Each Additional Prefabricated Post – Same Tooth	D6977	B	Excision of Pericoronal Gingiva	D7971	B
Fixed Partial Denture Repair	D6980	B	Surgical Reduction of Fibrous Tuberosity	D7972	B
ORAL SURGERY			Sialolithotomy	D7980	B
Coronal Remnants – Deciduous Tooth	D7111	A	Closure of Salivary Fistula	D7983	B
Extraction – Erupted Tooth or Exposed Root	D7140	A	MISCELLANEOUS SERVICES		
Surgical Removal of Erupted Tooth	D7210	A	Palliative (Emergency) Treatment of Pain	D9110	A
Removal of Impacted Tooth, Soft Tissue	D7220	A	General Anesthesia– First 30 Minutes	D9220	B
Removal of Impacted Tooth, Partially Bony	D7230	A	General Anesthesia– Each Additional 15 Minutes	D9221	B
Removal of Impacted Tooth, Completely Bony	D7240	A	IV Sedation/Analgesia – First 30 Min	D9241	B
Surgical Removal of Residual Tooth Roots	D7250	A	IV Sedation/Analgesia – Each Additional 15 Minutes	D9242	B
Oroantral Fistula Closure	D7260	A	Non-IV Conscious Sedation	D9248	B]
Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Teeth/Alveolus	D7270	B			
Tooth Transplantation and/or Stabilization	D7272	B			
Surgical Exp. Of Impacted/Unerupted Tooth-Ortho	D7280	A			

**SECTION 3
BENEFIT PROVISION**

[DISABILITY INCOME INSURANCE—Not applicable to Dependents.

(Applicable only if this coverage is not excluded in the Schedule.)

If You become Totally Disabled, We will pay a Disability Benefit, as shown in the Schedule, provided You are under the Regular Care and Attendance of a Physician.

Total Disability:

- (a) must be due to a covered Accident or Sickness; and
- (b) must begin while Your coverage is in force; and
- (c) will be considered to have started on the date You first receive personal treatment from a Physician, following continuous cessation of work.

Disability Benefits will be paid:

- (a) for only one disability when:
 - (1) more than one disability exists at the same time; or
 - (2) a disability results from two or more causes,and
- (b) for each period of Total Disability that continues beyond the Elimination Period, not to exceed the Maximum Disability Period stated in the Schedule.

Successive Disabilities will be considered one period of disability unless separated by Your return to:

- (a) Active Service; or
- (b) any other occupation,

for at least [90 days]. A disability due to a different or unrelated cause will be considered a new period of disability.

Any disability that begins after termination of coverage:

- (a) will not be considered a Successive Disability; and
- (b) will not be covered under the Policy.

Any change in the Disability Benefit will apply only to new periods of disability that begin on or after such date.

Mental Illness / Limited Benefit

If You become Totally Disabled due to a Mental Illness, We will pay Disability Benefits for up to the Maximum Mental Illness Period shown in the Schedule.

Alcoholism and Drug Addiction / Limited Benefit

If You become Totally Disabled due to alcoholism or drug addiction, We will pay Disability Benefits for up to the Maximum Alcoholism/Drug Addiction Period shown in the Schedule.]

[VISION INSURANCE *(Applicable only if this coverage is not excluded in the Schedule.)*

If a Covered Person incurs charges for:

- (a) an eye examination; or
- (b) eyeglass lenses and/or frames, or contact lenses,

We will pay the applicable benefit shown in the Schedule. A charge is incurred on the date that treatment is given, service is rendered, or a supply is furnished.]

SECTION 4 EXCLUSIONS AND LIMITATIONS

HEALTH INSURANCE

With respect to Health Insurance, no benefits will be payable for, or as the result of:

- (a) suicide or any attempt thereat, while sane or insane, or any intentionally self-inflicted injury or Sickness. This exclusion does not apply if the loss is as a result of a Medical Condition, or an act of domestic violence; or
- (b) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner, within the scope of authority; or
- (c) committing, attempting to commit, or taking part in, a felony or assault; or engaging in an illegal occupation; or
- (d) participation in a contest of speed in power-driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding; or
- (e) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the Covered Person is not covered; or
- (f) air travel, except:
 - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
 - (2) as a passenger for transportation only and not as a pilot or crew member;or
- (g) experimental drugs, devices, treatments or surgery; or drugs or devices labeled "Caution - limited by federal law to investigational use." A treatment, procedure, or therapy will not be judged experimental if, at the time it is provided or performed:
 - (1) it is judged effective for treatment of the covered injury or Sickness; and
 - (2) it is approved by the American Medical Association or the appropriate medical specialty society for such treatment. Approval must not be on a limited or experimental basis.

This exclusion does not apply to a drug on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved by the federal Food and Drug Administration (FDA), provided all of the following are met:

- (1) the drug is approved by the FDA; and
- (2) the drug is recognized for treatment of the condition by:
 - a. scientific studies published in a peer-reviewed national professional medical journal; or
 - b. standard reference compendia.

This exclusion also does not apply to a drug, device, treatment, procedure, or therapy provided during any phase of a clinical trial for the treatment, palliation, or prevention of recurrence of cancer or other life-threatening conditions, provided such clinical trial is:

- (1) recommended by the Covered Person's treating Physician; and
- (2) approved by:
 - (a) the U.S. Food and Drug Administration (in the form of an Investigational New Drug Application); or
 - (b) one of the National Institutes of Health (NIH); or
 - (c) an NIH cooperative group or center; or
 - (d) an NIH cooperative group research entity that meets the criteria for NIH support grant eligibility; or
 - (e) the Coalition of National Cancer Cooperative Groups; or
 - (f) a National Cancer Institute cooperative group or center; or
 - (g) a panel of qualified clinical research experts from academic health institutions; or
 - (h) the Centers for Disease Control and Prevention; or
 - (i) the Agency for Healthcare Research and Quality; or
 - (j) the Centers for Medicare and Medicaid Services; or
 - (k) the U.S. Department of Veterans Affairs; or
 - (l) the U.S. Department of Defense; or

**SECTION 4
EXCLUSIONS AND LIMITATIONS**

and

- (1) there is no clearly superior, non-investigational treatment alternative; and
- (2) the available clinical or pre-clinical data provides a reasonable expectation that the treatment will be more effective than the non-investigational treatment alternative.

Treatment provided in a clinical trial must provide a therapeutic effect, and participation in such clinical trial must offer meaningful potential for significant clinical benefit to the Covered Person;

or]

- (h) rest care or rehabilitative care and treatment; or
 - (i) cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to:
 - (1) cosmetic surgery resulting from an Accident, provided initial treatment of the Covered Person is begun within 12 months of the date of the Accident; or
 - (2) reconstruction incidental to or following surgery resulting from a covered Accident or Sickness; or
 - (3) with respect to a covered Dependent child, correction of a congenital defect that results in a functional defect; or
 - (4) with respect to a medically necessary mastectomy:
 - a. all stages of reconstruction of the breast on which the mastectomy has been performed; or
 - b. surgery and reconstruction of the other breast to produce a symmetrical appearance; or
 - c. prostheses and treatment of physical complications for all stages of the mastectomy, including lymphademas;
- or
- (j) dental services, including treatment, extractions or dental x-rays, except as provided as the result of, and within 12 months of, an Accident; or
 - (k) hearing examinations, hearing aids (unless provided under the Durable Medical Equipment and Prosthesis Benefit), or the fitting of hearing aids; or
 - (l) routine eye examinations, or the purchase or fitting of any corrective eyewear; or
 - (m) voluntary abortion except, with respect only to You or Your covered Dependent spouse/common law spouse/[Domestic Partner]:
 - (1) where such person's life would be endangered if the fetus were carried to term; or
 - (2) where medical complications have arisen from an abortion;
- or
- [(n) routine newborn care, including routine nursery charges, except for up to five days in a Hospital nursery or until the mother's discharge following birth, whichever is earlier; or
 - (o) pregnancy of a Dependent child; or]
 - (p) the reversal of tubal ligation or vasectomy; or
 - (q) sex changes; or
 - [(r) infertility treatment, artificial insemination, in vitro fertilization (except as provided in the Policy), and test tube fertilization, including any related testing, medications, or Physician's services; or
 - (s) any Accident occurring while the Covered Person is intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the geographical area where the Accident took place); or
 - (t) treatment of exogenous obesity or weight control; or gastric bypass procedure; or any other surgical procedure for control of weight; or]
 - (u) air or ground ambulance service; or

SECTION 4 EXCLUSIONS AND LIMITATIONS

- (v) accident or sickness:
 - (1) arising out of and in the course of any occupation for compensation, wage or profit; or
 - (2) which qualifies for payment under Occupational Disease Law or similar law, whether or not application for such benefits has been made. Denial of payment under Occupational Disease Law or similar law does not automatically imply that a claim is payable under the Policy;
- or
- (w) routine physical examinations and immunizations related to employment, obtaining insurance, team sports, travel, school, camp, or pre-marital exams, after any Wellness Benefits provided under the Policy have been exhausted; or
- (x) treatment received during a period of time that coverage is not in force with respect to the Covered Person; or
- (y) with respect to a non-emergency Hospital admission during which a surgical procedure is scheduled and performed: Confinement, or services or treatment received more than 24 hours prior to admission; or
- (z) treatment that is not medically necessary, unless excepted elsewhere in the Policy; or
- (aa) any service or supply that is not described under one or more of the categories of benefits listed in the Benefit Provisions section.

In addition to the Exclusions and Limitations for Health Indemnity Insurance, no benefits will be payable under the Prescription Drug Card Benefit for:

- (a) drugs and medicines which may be lawfully obtained without a Physician's prescription; or
- (b) drugs, medicines or insulin, in whole or in part, used by, administered to, or provided to, a Covered Person:
 - (1) during an outpatient Physician's office visit;
 - (2) during a visit to a Hospital emergency room or Outpatient Surgical Facility; or
 - (3) while Confined in a Hospital, rest home, sanatorium, extended care facility, convalescent hospital, nursing home or similar institution;
- or
- (c) immunization agents (shots), biological sera, blood, or blood plasma; or
- (d) a fill or refill of a prescription exceeding a 30-day supply.]

[Pre-Existing Condition Limitation

No benefits will be paid for expenses resulting from services, supplies or treatment of Pre-Existing Conditions for the first 12 months from the Covered Person's Enrollment Date of coverage under the Policy. This exclusion will not apply to:

- (a) pregnancy; or
- (b) a newborn child who, as of the last day of the 30-day period beginning with the date of birth, is covered under Creditable Coverage; or
- (c) a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage.

Any pre-existing condition limitation period previously satisfied under Creditable Coverage will be counted to satisfy the 12-month Pre-Existing Condition limitation under the Policy, unless there was a break in coverage of 63 days or more. Waiting periods under a plan are not considered a break in coverage.]

[TERM LIFE INSURANCE

With respect to Term Life Insurance, no benefits will be payable as the result of suicide or any attempt thereat, while sane or insane; or any intentionally self-inflicted injury or sickness, unless the Covered Person has been continuously insured under the Policy for two years.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

With respect to Accidental Death and Dismemberment Insurance, no benefits will be payable as the result of:

**SECTION 4
EXCLUSIONS AND LIMITATIONS**

- (a) suicide or any attempt thereat, while sane or insane, or any intentionally self-inflicted injury or sickness; or
- (b) infection or disease, whether the infection or disease is the proximate or contributing cause of the loss; or (This does not apply to pyogenic infections which occur through an accidental wound or cut.)
- (c) voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a licensed Physician; or (Accidental ingestion of a poisonous substance is not excluded.)
- (d) air travel, except:
 - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
 - (2) as a passenger for transportation only and not as a pilot or crew member;or
- (e) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss that occurs while acting in a lawful manner within the scope of authority; or
- (f) committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation; or
- (g) participation in a contest of speed in power-driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding; or
- (h) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the Covered Person is not covered; or
- (i) any Accident occurring while the Covered Person is intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the laws of the geographical area where the Accident took place); or
- (j) accident or sickness:
 - (1) arising out of and in the course of any occupation for compensation, wage or profit; or
 - (2) which qualifies for payment under Occupational Disease Law or similar law, whether or not application for such benefits has been made. Denial of payment under Occupational Disease Law or similar law does not automatically imply that a claim is payable under the Policy.]

[DENTAL INSURANCE

With respect to Dental Insurance, no benefits will be payable as the result of:

- (a) suicide or any attempt thereat, while sane or insane, or any intentionally self-inflicted injury or Sickness; or
- (b) cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to:
 - (1) cosmetic surgery resulting from an accident, if initial treatment of the Covered Person is begun within 12 months of the date of the accident; or
 - (2) reconstruction incidental to or following surgery resulting from a covered Accident or Sickness; or
 - (3) correction of a congenital defect that results in a functional defect of a covered Dependent child;or
- (c) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority; or
- (d) committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation; or
- (e) participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding; or

SECTION 4 EXCLUSIONS AND LIMITATIONS

- (f) air travel, except:
 - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
 - (2) as a passenger for transportation only and not as a pilot or crew member;or
- (g) any Accident occurring while the Covered Person is intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the geographical area where the Accident took place); or
- (h) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the Covered Person is not covered; or
- (i) accident or sickness:
 - (1) arising out of and in the course of any occupation for compensation, wage or profit; or
 - (2) which qualifies for payment under Occupational Disease Law or similar law, whether or not application for such benefits has been made. Denial of payment under Occupational Disease Law or similar law does not automatically imply that a claim is payable under the Policy;or
- (j) treatment that is not medically necessary, unless excepted elsewhere in the Policy; or
- (k) [Class B] expenses, until the Covered Person has been continuously insured under this dental plan (or the dental plan this plan replaced) for 12 consecutive months; or
- (l) treatment started before coverage began; or
- (m) charges for initial installation for dentures or bridgework to replace teeth extracted prior to when coverage began; or
- (n) replacement of existing dentures or bridgework less than five years old, or for replacement because of loss or theft; or
- (o) charges for orthodontics; or
- (p) charges for services with respect to congenital malformations (other than for a newborn child of Yours); or
- (q) charges for dental care which is covered under any other part of this plan; or
- (r) charges by anyone other than a Dentist, except for charges for dental prophylaxis performed by a Dental Hygienist, under the supervision and direction of a Dentist; or
- (s) charges for more than one fluoride treatment, one dental prophylaxis, or one bite-wing x-ray in any six-month period; or
- (t) charges for more than one complete mouth x-ray in any two-year period; or
- (u) charges which the Covered Person is not legally required to pay, or charges which would not have been made if no coverage had existed.

Pre-Existing Condition Limitation

No benefits will be paid for expenses resulting from services, supplies or treatment of Pre-Existing Conditions for the first 12 months from the Covered Person's Enrollment Date of coverage under the Policy. This exclusion will not apply to:

- (a) pregnancy; or
- (b) a newborn child who, as of the last day of the 30-day period beginning with the date of birth, is covered under Creditable Coverage; or
- (c) a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage.

Any pre-existing condition limitation period previously satisfied under Creditable Coverage will be counted to satisfy the 12-month Pre-Existing Condition limitation under the Policy, unless there was a break in coverage of 63 days or more. Waiting periods under a plan are not considered a break in coverage.]

[DISABILITY INCOME INSURANCE

SECTION 4 EXCLUSIONS AND LIMITATIONS

With respect to Disability Income Insurance, no benefits will be payable as the result of:

- (a) suicide or any attempt thereat, while sane or insane, or any intentionally self-inflicted injury or Sickness; or
- (b) cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom; or
- (c) voluntary abortion, except where Your life would be endangered if the fetus were carried to term, or where medical complications have arisen from an abortion; or
- (d) Mental Illness, alcoholism, or drug addiction, except as described in the Schedule; or
- (e) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss, which occurs while acting in a lawful manner within the scope of authority; or
- (f) committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation; or
- (g) participation in a contest of speed in power-driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding; or
- (h) air travel, except:
 - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
 - (2) as a passenger for transportation only and not as a pilot or crew member;or
- (i) any Accident occurring while You are intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the geographical area where the Accident took place); or
- (j) sex changes; or
- (k) the reversal of tubal ligation or vasectomy; or
- (l) treatment of exogenous obesity or weight control; or gastric bypass procedure, or any other surgical procedure for control of weight; or
- (m) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period You are not covered; or
- (n) accident or sickness:
 - (1) arising out of and in the course of any occupation for compensation, wage or profit; or
 - (2) which qualifies for payment under Occupational Disease Law or similar law, whether or not application for such benefits has been made. Denial of payment under Occupational Disease Law or similar law does not automatically imply that a claim is payable under the Policy.

Additionally, no Disability Benefit will be paid:

- (a) for any period in which You are not under the Regular Care and Attendance of a Physician; or
- (b) if You should fail to follow the medical treatment advice of Your Physician as it pertains to Your disabling condition; or
- (c) during any period in which You are incarcerated.

Pre-Existing Condition Limitation

No benefits will be paid for Total Disability resulting from a Pre-Existing Condition that begins before You have been continuously covered under the Policy for one year.]

[VISION INSURANCE

With respect to Vision Insurance, no benefits will be payable as the result of:

- (a) any intentionally self-inflicted injury or Sickness; or
- (b) treatment solely for cosmetic purposes, or complications therefrom; or

SECTION 4
EXCLUSIONS AND LIMITATIONS

- (c) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss, which occurs while acting in a lawful manner within the scope of authority; or
- (d) committing, attempting to commit, or taking part in a felony or assault; or engaging in an illegal occupation; or
- (e) participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding; or
- (f) accident or sickness:
 - (1) arising out of and in the course of any occupation for compensation, wage or profit; or
 - (2) which qualifies for payment under Occupational Disease Law or similar law, whether or not application for such benefits has been made. Denial of payment under Occupational Disease Law or similar law does not automatically imply that a claim is payable under the Policy;or
- (g) treatment that is not medically necessary, unless excepted elsewhere in the Policy; or
- (h) treatment received during a period of time that coverage is not in force with respect to the Covered Person; or
- (i) charges for an eye examination performed by, or eyeglasses or contact lenses prescribed by, someone other than an optometrist or ophthalmologist; or
- (j) charges for sunglasses, safety glasses, or goggles, whether plain or prescription; or
- (k) charges for non-prescription contact lenses; or
- (l) charges for any type of eye procedure or surgery, or vision charges that may be covered under any other part of the Policy; or
- (m) charges that the Covered Person is not legally required to pay, or charges that would not have been made if no coverage had existed.]

SECTION 5 TERMINATION OF INSURANCE

INSURED

Your insurance will end on the earliest of:

- (a) the last day of the [payroll deduction period/month] during which You cease to be a member of a class eligible for coverage as shown in the Schedule; or
- (b) the end of the last period for which premium payment has been made to Us; or
- (c) the date You die; or
- (d) the date the Policy terminates; or
- (e) the last day of the [payroll deduction period/month] during which You retire or are pensioned; or
- (f) the last day of the [payroll deduction period/month] during which You terminate employment.

[With respect to Disability Income Insurance, if:

- (a) Your coverage ends as a result of Your termination of Active Service; and
- (b) such termination is caused by an Accident or Sickness for which Disability Benefits would be payable; and
- (c) Total Disability is established prior to the termination of Active Service,

then Disability Benefits will be paid as if such termination had not occurred. Additionally, termination of the Policy will have no effect on payment of benefits for a Total Disability that begins before the Policy is terminated.]

DEPENDENT

The insurance on a Dependent will cease on the earliest of:

- (a) the date Your coverage terminates; or
- (b) the end of the last period for which premium payment has been made to Us; or
- (c) the date the Dependent dies; or
- (d) with respect to a Dependent spouse/common law spouse[/Domestic Partner], the date such spouse/common law spouse[/Domestic Partner]:
 - (1) becomes divorced from; or
 - (2) becomes legally separated from; [or
 - (3) terminates his or her domestic partnership from,]You; or
- (e) with respect to a Dependent child, the date such child attains age 25; or
- (f) with respect to a Dependent child who has been placed with You for purposes of adoption, the earlier of:
 - (1) the date on which the petition for adoption has been dismissed or denied; or
 - (2) the date on which the placement is disrupted prior to legal adoption, and the child is removed from placement with You;or
- (g) with respect to a Dependent child who has been provided coverage pursuant to a Qualified Medical Child Support Order (QMCSO), the earlier of:
 - (1) the end of the period for which the QMCSO has required that coverage be provided; or
 - (2) the date on which the QMCSO is terminated,unless such child is otherwise eligible for coverage under the Policy; or
- (h) with respect to a step-child of Yours who You have not adopted, the date You:
 - (1) become divorced from; or
 - (2) become legally separated from; [or
 - (3) terminate Your domestic partnership from,]Your spouse/common law spouse[/Domestic Partner]; or
- (i) the date the Policy is modified so as to exclude Dependent coverage.

SECTION 5 TERMINATION OF INSURANCE

Handicapped Children [(Applicable only to Health Insurance and Dental Insurance.)]

With respect to termination of a child's coverage due to attainment of age 25, coverage will not terminate if such child is incapable of self-support because of a mental or physical handicap; however:

- (a) You must provide:
 - (1) proof of incapacity within 31 days following the child's attainment of age 25; and
 - (2) proof of continuing incapacity once every 12 months for a child age 25 or older; and
- (b) such child must remain dependent on You for principal support and maintenance.

With respect to a mentally or physically handicapped child who was older than age 25 when he or she first became covered under the Policy, coverage will not terminate, unless You fail to provide proof of continuing incapacity once every 12 months for such child.

FRAUD

We shall have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

EXTENSION OF BENEFITS [(Applicable only to Health Insurance and Dental Insurance.)]

Whenever termination of coverage under this section occurs because of termination of Your employment, such termination shall be without prejudice to:

- (a) any Hospital Confinement which commenced while Your coverage was in force, [with respect to Health Insurance Benefits]; or
- (b) any covered treatment or service for which benefits would be provided under the [Health Insurance or Dental Insurance benefits of the] Policy, and which commenced while Your coverage was in force;

provided; however, that the Covered Person is, and continues to be, Hospital Confined or Totally Disabled. Such Extension of Benefits shall continue for up to 30 days.

This Extension of Benefits provision will not apply during any time a Covered Person is covered under a similar group health plan.

CONVERSION PRIVILEGE

A Covered Person whose coverage under the Policy has been terminated for any reason, including discontinuance of the Policy in its entirety, may be eligible for conversion coverage. Conversion will not be available if coverage was terminated due to the Covered Person's failure to pay any required contribution or if the Policy is replaced by similar coverage within 31 days.

A Covered Person will not be eligible for conversion coverage if he/she is eligible for:

- (a) Medicare; or
- (b) full coverage under another group policy.

Written application and the initial premium for conversion coverage must be made to the designated conversion insurance carrier within 30 days after termination of coverage under the Policy.

SECTION 6 PREMIUMS

PREMIUM MODE AND DUE DATE

Premiums are payable by a mode of payment that has been agreed upon between the Policyholder and Us.

All premiums are payable on or before the date they are due, by the Policyholder. Premiums are not considered paid until they are received by Us[, or Our designated agent for receipt of premium]. We will not be responsible for claims incurred by Covered Persons during any period for which full premiums have not been paid by the Policyholder.

[MISSED PREMIUMS

In the event Your paycheck is not sufficient to cover the full amount of the payroll deduction premium for coverage under the Policy, You will be given the opportunity to make up [all of the/one or more] consecutive missed premium deductions (the "Missed Premium Period"), provided the following conditions are met:

- (a) Premium deductions must resume no later than the 35th day after the last weekly payroll-deducted premium, or no later than the 42nd day after the last bi-weekly payroll-deducted premium.
- (b) Payment may only be made with:
 - (1) a cashier's check; or
 - (2) a money order; or
 - (3) a personal check for which there are sufficient funds.
- (c) Payment must be in the full amount due for the [missed deduction periods for which You are paying/entire Missed Premium Period].
- (d) The Company-provided remittance form (Missed Premium Deduction Form) must be included with payment. Such form must be filled out completely.
- (e) Payment must be mailed to Us[, or Our administrator].

[You will have the option to pay for the entire Missed Premium Period, or just a portion of it. If You choose to pay for just a portion of the Missed Premium Period, You must pay for consecutive missed premium deductions, beginning with the first missed premium deduction/You must pay for the entire Missed Premium Period.] If no payroll deduction has ever occurred for coverage under the Policy, or if a Covered Person is no longer eligible, coverage may not be maintained by direct premiums.

During any period for which there is a missed premium deduction, coverage on You and Your covered Dependents (if any) will be placed in a suspended status. Coverage will not be cancelled unless it remains in a suspended (unpaid) status for more than 35 consecutive days, if deductions are weekly, or 42 days, if deductions are bi-weekly. If this happens, coverage on You and Your covered Dependents, if any, will be cancelled in accordance with the Termination provisions stated in Section 5. If such cancellation occurs, You will not be eligible to enroll for coverage again except as provided in Section 2.

Any claims filed for services or expenses incurred while coverage is suspended will not be considered for payment; however, any period during which coverage is suspended will count towards satisfaction of any applicable Pre-Existing Condition limitation period.]

SECTION 7 CLAIMS PROVISIONS

NOTICE OF CLAIM

Written notice of claim must be given to Us [or to Our claims administrator]. Specific information regarding where to direct notice of claim is included on Your identification card for coverage under the Policy. Notice should be made within 60 days after any loss covered by the Policy. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay.

CLAIM FORMS

Claim forms should be used for filing proof of loss. They will be sent to the claimant within 15 days following Our receipt of notice of claim. If claim forms are not supplied within 15 days, a claimant can give proof in writing, setting forth the nature and extent of the loss. Proof submitted in this manner will remain subject to the time stated in the Proof of Loss provision.

PROOF OF LOSS

[With respect to Disability Income Insurance, proof of loss must be given to Us within 90 days after termination of the period for which We are liable. For any other loss,] proof of loss must be given to Us within 90 days after such loss. Late proof may be accepted if:

- (a) it was not reasonably possible to give proof in that time; and
- (b) the proof is given within one year from the date of loss. This one-year limit will not apply in the absence of legal capacity.

TIME OF PAYMENT OF CLAIM

[With respect to Disability Income Insurance, benefits will accrue and be paid monthly, subject to satisfactory written proof of such loss. Any balance not paid when liability ends will be paid immediately upon receipt of satisfactory written proof of such loss.]

Initial benefit determinations will be rendered by [Us / Our claims administrator] within 30 days. If there are special circumstances beyond Our control [and/or Our claims administrator's control], the initial benefit determination shall be rendered as soon as possible, but no later than 45 days after receipt of Your claim.

In the event You receive an adverse benefit determination, such adverse benefit determination will be explained in writing and the explanation will include:

- (a) the specific reason for the adverse benefit determination; and
- (b) reference to the specific policy provision upon which the adverse benefit determination was based; and
- (c) a description of any additional information You might be required to provide and an explanation of why it is needed; and
- (d) an explanation of Our claim review procedure.

You, a Dependent, a beneficiary, or a duly authorized representative may appeal any adverse benefit determination by filing a request for review to the claims administrator. In connection with such a request, documents pertinent to the administration of the Policy may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout this review procedure.

Health [, Dental, and Vision] Claims

If You receive an adverse benefit determination, Your request for review must be filed within 180 days after receipt of the written notice of adverse benefit determination. A decision will be rendered by Us no later than 30 days after receipt of Your request for review. The decision, after the review, shall be in writing and shall include specific references to the pertinent policy provisions upon which the decision was based.

[Disability and Accidental Dismemberment Claims

If You receive an adverse benefit determination, Your request for review must be filed within 180 days after receipt of the written notice of adverse benefit determination. A decision will be rendered by Us no later than 45 days after receipt of Your request for review. The decision, after the review, shall be in writing and shall include specific references to the pertinent policy provisions upon which the decision was based.

**SECTION 7
CLAIMS PROVISIONS**

Life and Accidental Death Claims

If You receive an adverse benefit determination, Your request for review must be filed within 90 days after receipt of the written notice of adverse benefit determination. A decision will be rendered by Us no later than 90 days after receipt of Your request for review. If there are special circumstances beyond Our control and/or Our claims administrator, the decision shall be rendered as soon as possible, but no later than 120 days after receipt of the request for review. The decision, after the review, shall be in writing and shall include specific references to the pertinent policy provisions upon which the decision was based.]

PAYMENT OF BENEFITS

Health Insurance[, Dental Insurance, and Vision Insurance] benefits may be assigned to the provider(s) of such benefits. Otherwise, all benefits payable under the Policy will be paid to You. Accrued benefits that are not paid at Your death will be paid to Your beneficiary or estate.

If a Health Insurance[, Dental Expense Insurance, and/or Vision Insurance] benefit is to be paid to:

- (a) Your estate; or
- (b) Your beneficiary who is not competent to give a valid release,

We may pay up to \$1,000.00 of such benefit to one of Your relatives who is deemed by Us to be justly entitled to it. Such payment, made in good faith, fully discharges Us to the extent of the payment.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right to have a Covered Person examined by a Physician of Our choice as often as reasonably necessary while a claim is pending. We will pay for such examination. In case of death, We may request an autopsy where it is not forbidden by law.

SECTION 8 GENERAL PROVISIONS

CERTIFICATES

This Certificate describes:

- (a) the insurance benefits; and
- (b) to whom benefits will be paid; and
- (c) any limitations of the Policy; and
- (d) all other essential features of the Policy.

If We issue more than one Certificate to You, only the last one issued will be in effect.

INCONTESTABILITY / TIME LIMIT ON CERTAIN DEFENSES

We will rely on statements made by the Policyholder and You to be true and complete to the best knowledge and belief of such persons. All such statements are representations (and not warranties), if fraud was not intended. No such statements will be used to void the insurance, reduce benefits, or defend a claim under the Policy unless:

- (a) the statement is in writing, signed by the You; and
- (b) a copy of that statement is given to You or, in the event of Your death or incapacity, Your beneficiary.

The validity of the Policy cannot be contested after two years from its date of issue, except for nonpayment of premiums. Except for fraudulent misstatements in the application or enrollment form, We will not use any statement to void the insurance or deny a claim after insurance has been in force for two years during Your lifetime. However, this provision shall not preclude Our assertion, at any time, of defenses based on provisions in the Policy that relate to eligibility for coverage.

LEGAL ACTIONS

No legal action may be brought to recover benefits under the Policy:

- (a) within 60 days after written proof of loss has been furnished as required; or
- (b) more than three years from the time written proof of loss is required to be furnished.

CONFORMITY WITH STATE LAWS

A provision of the Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law as of the Effective Date.

MISSTATEMENT OF AGE

If the age of any Covered Person was misstated on the application or enrollment form for coverage:

- (a) the amount of benefits payable will be the amount shown in the Schedule. If necessary, the premium will be adjusted so that We will be paid any amount due based on such Covered Person's true age; and
- (b) coverage for such person will end when it would have, if We had known of such person's correct age. If We have accepted a premium on behalf of the person for a period after the date when coverage should have ended, the premium will be refunded. We will not pay any claims for services the person received after coverage should have ended.

CLERICAL ERROR

Any clerical error in record keeping will not keep insurance in force if it should have been terminated, nor will it terminate insurance that should have been kept in force. As soon as the error is found, any necessary premium adjustment will be made.

NON-PARTICIPATING

The Policy is non-participating, and does not share in Our profits or surplus. No dividends are payable under the Policy.

Notice to Group Health Plan Participants of Benefits Required Under the Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice to Group Health Plan Participants of Benefits Required Under the Women's Health and Cancer Rights Act of 1998

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains the most important provisions of the Act. Please review this information carefully. If your spouse is also covered, please make certain that she or he also has the opportunity to review this information.

The Women's Health and Cancer Rights Act of 1998 requires that all group health plans that provide medical and surgical benefits for a mastectomy also must provide coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for any complications in all stages of mastectomy, including lymphedema.

The Act requires that coverage be provided in a manner that is consistent with other benefits provided under the Plan. The coverage may be subject to annual deductibles and coinsurance provisions.

The Women's Health and Cancer Rights Act of 1998 will apply to group health plans for plan years beginning on or after October 21, 1998. To find out when your plan year begins, check your Summary Plan Description (SPD) or contact your plan administrator.

Please keep this information with your other group health plan documents.

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

HEALTH INSURANCE

INPATIENT BENEFITS	
Daily Hospital Indemnity Benefit	[see <i>Statement of Variability</i>] per day, up to [see <i>Statement of Variability</i>] days per Calendar Year
Inpatient Maximum Benefit	[see <i>Statement of Variability</i>]
Inpatient Deductible Applicable to all covered Inpatient services and supplies, unless stated otherwise.	[see <i>Statement of Variability</i>] per Covered Person per Calendar Year; maximum of [see <i>Statement of Variability</i>] Deductibles per family per Calendar Year]
Inpatient Coinsurance Applicable to all covered Inpatient services and supplies, unless stated otherwise.	After satisfaction of the Inpatient Deductible, the Company will pay [see <i>Statement of Variability</i>] of Covered Charges, up to the Inpatient Maximum Benefit.
Room and Board Benefit	Up to [see <i>Statement of Variability</i>]
Inpatient Physician Surgical Services Benefit	Up to [see <i>Statement of Variability</i>]
Inpatient Anesthetic Services and Anesthesia Benefit	Up to [see <i>Statement of Variability</i>]
Inpatient Physician Non-Surgical Services Benefit	Up to [see <i>Statement of Variability</i>]
Inpatient Miscellaneous Services and Supplies	Up to [see <i>Statement of Variability</i>]
OUTPATIENT BENEFITS	
Outpatient Maximum Benefit	[see <i>Statement of Variability</i>]
Outpatient Deductible Applicable to all covered Outpatient services and supplies, unless stated otherwise.	[see <i>Statement of Variability</i>] per Covered Person per Calendar Year; maximum of [see <i>Statement of Variability</i>] Deductibles per family per Calendar Year]
Outpatient Coinsurance Applicable to all covered Outpatient services and supplies, unless stated otherwise.	After satisfaction of the Outpatient Deductible, the Company will pay [see <i>Statement of Variability</i>] of Covered Charges, up to the Outpatient Maximum Benefit.
Outpatient Physician Surgical Services Benefit	Up to [see <i>Statement of Variability</i>]
Outpatient Anesthetic Services and Anesthesia Benefit	Up to [see <i>Statement of Variability</i>]
Outpatient Physicians' Non-Surgical Services Benefit This benefit is not subject to the Deductible.	Co-payment — [see <i>Statement of Variability</i>] Coinsurance — After the Co-payment, the Company will pay [see <i>Statement of Variability</i>] of Covered Charges.
All other covered Outpatient services and supplies	Subject to the Outpatient Deductible, Outpatient Coinsurance, and Outpatient Maximum Benefit.

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

HEALTH INSURANCE (continued)

ADDITIONAL BENEFITS	
<p>Durable Medical Equipment and Prosthesis Benefit This benefit is not subject to any Deductible, and will not reduce the Outpatient Maximum Benefit.</p>	<p>Coinsurance — [see <i>Statement of Variability</i>] Maximum Benefit — [see <i>Statement of Variability</i>] per Calendar Year</p>
<p>Hospital Admission Benefit This benefit is not subject to any Deductible, and will not reduce the Inpatient Maximum Benefit.</p>	<p>Lump Sum Benefit — [see <i>Statement of Variability</i>] Maximum Number of Admissions — [see <i>Statement of Variability</i>] per Calendar Year</p>
<p>Emergency Room Sickness Benefit This benefit is not subject to any Deductible, and will not reduce the Inpatient or Outpatient Maximum Benefit.</p>	<p>Co-payment — [see <i>Statement of Variability</i>] Coinsurance — [see <i>Statement of Variability</i>] Maximum Episodes of Care — [see <i>Statement of Variability</i>] per Calendar Year Maximum Benefit — [see <i>Statement of Variability</i>] per Episode of Care</p>
<p>Prescription Drug Card Benefit This benefit is not subject to any Deductible or Coinsurance, and will not reduce the Outpatient Maximum Benefit.</p>	<p>Co-payment — Generic Drugs: [see <i>Statement of Variability</i>] per fill/refill Branded Drugs: [see <i>Statement of Variability</i>] per fill/refill Maximum Benefit — [see <i>Statement of Variability</i>] per Calendar Year</p>
<p>Intensive Care Unit Benefit This benefit is not subject to any Deductible, and will not reduce the Inpatient Maximum Benefit.</p>	<p>Lump Sum Benefit — [see <i>Statement of Variability</i>] Maximum Number of Days — [see <i>Statement of Variability</i>] per Calendar Year</p>
<p>Supplemental Accident Benefit This benefit is not subject to any Deductible, and will not reduce the Inpatient or Outpatient Maximum Benefit.</p>	<p>Coinsurance — 100% Maximum Benefit — [see <i>Statement of Variability</i>] per Accident Maximum Number of Accidents — [see <i>Statement of Variability</i>] per Calendar Year</p>
<p>Wellness Benefit This benefit is applicable only to Covered Persons age 18 years or older. This benefit is not subject to any Deductible, and will not reduce the Outpatient Maximum Benefit.</p>	<p>Co-payment — [see <i>Statement of Variability</i>] Coinsurance — [see <i>Statement of Variability</i>] Maximum Benefit — Up to [see <i>Statement of Variability</i>] per Calendar Year</p>

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

[TERM LIFE INSURANCE

Insured Death Benefit^[1]	[see Statement of Variability]
Spouse Death Benefit^[2]	[see Statement of Variability]
Dependent Child Death Benefit^[2] (six months of age or older)	[see Statement of Variability]
Dependent Child Death Benefit^[2] (14 days to six months of age)	[see Statement of Variability]
Dependent Child Death Benefit^[2] (under 14 days of age)	[see Statement of Variability]

[¹For Insureds age 65 or older, the Death Benefit will be 65% of the amount shown.]

[²At no time may a covered Dependent's Death Benefit exceed 50% of the Insured's Death Benefit, or the maximum amount permitted by law, whichever is greater. Any necessary reduction in a Dependent's Death Benefit will be effective on the same date that the Insured's Death Benefit reduces.]

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (not applicable to Dependents)

Insured Principal Sum^[1]	[see Statement of Variability]
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[¹For Insureds age 65 or older, the Principal Sum will be 65% of the amount shown.]

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

[DENTAL INSURANCE

Calendar Year Deductible	[see <i>Statement of Variability</i>] per Covered Person
Percentage of Covered Charge Payable	Class A — [see <i>Statement of Variability</i>] Class B — [see <i>Statement of Variability</i>] [Class C — see <i>Statement of Variability</i>]
Calendar Year Maximum	Insured — [see <i>Statement of Variability</i>] Each Dependent — [see <i>Statement of Variability</i>]
Waiting Period for Class [B/C] Covered Charges	[see <i>Statement of Variability</i>]

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

[DISABILITY INCOME INSURANCE (not applicable to Dependents)

Covered Percentage of Weekly Base Compensation	[see Statement of Variability]
Maximum Weekly Benefit	[see Statement of Variability]
Elimination Period	Accident — [see Statement of Variability] Sickness — [see Statement of Variability]
Maximum Disability Period	Accident — [see Statement of Variability] Sickness — [see Statement of Variability]
Maximum Mental Illness Period	[see Statement of Variability]
Maximum Alcoholism/Drug Addiction Period	[see Statement of Variability]
Successive Disabilities Period	[see Statement of Variability]

SCHEDULE OF BENEFITS

Definition of Eligible Persons:

[Eligibility is determined by the Policyholder or Subscribing Employer Unit, but will meet any state-required minimum requirements.]

[VISION INSURANCE

Eye Examination	Actual charge, not to exceed [see <i>Statement of Variability</i>], and limited to one routine examination in any [see <i>Statement of Variability</i>].
Eyeglass Lenses (other than contact lenses)¹	Actual charge, not to exceed [see <i>Statement of Variability</i>] for singles lenses or [see <i>Statement of Variability</i>] for bifocal or trifocal lenses, and limited to one set of lenses in any [see <i>Statement of Variability</i>].
Frames¹	Actual charge, not to exceed [see <i>Statement of Variability</i>], and limited to one pair of frames in any [see <i>Statement of Variability</i>].
Contact Lenses¹	Actual charge, not to exceed [see <i>Statement of Variability</i>] pairs of disposable contact lenses in any [see <i>Statement of Variability</i>] period.

¹Benefits will be paid for only one of the following during the same time period: (a) frames with lenses or (b) contact lenses.]