

SERFF Tracking Number: AMRP-126036054 State: Arkansas  
Filing Company: World Insurance Company State Tracking Number: 41556  
Company Tracking Number: R4803W-REV  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other  
Product Name: Critical Illness Benefit Rider  
Project Name/Number: R4803W-REV/R4803W-REV

## Filing at a Glance

Company: World Insurance Company

Product Name: Critical Illness Benefit Rider

TOI: H16G Group Health - Major Medical

Sub-TOI: H16G.001C Any Size Group - Other

Filing Type: Form

SERFF Tr Num: AMRP-126036054 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 41556

Co Tr Num: R4803W-REV

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Authors: Norm Von Seggern, Susan Disposition Date: 02/19/2009

Falk, Jamie Mueller, Michele Kulish

Danielson

Date Submitted: 02/16/2009

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested:

State Filing Description:

## General Information

Project Name: R4803W-REV

Project Number: R4803W-REV

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 02/19/2009

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Association, Other

Explanation for Other Group Market Type: Non-  
employer association group

State Status Changed: 02/19/2009

Created By: Jamie Mueller

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Jamie Mueller

Filing Description:

See cover letter in the supporting documentation tab

## Company and Contact

### Filing Contact Information

Jamie Mueller,

jamie.mueller@americanenterprise.com

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601 6th Ave. 515-558-6569 [Phone]  
 Des Moines, IA 50309

**Filing Company Information**

World Insurance Company CoCode: 70629 State of Domicile: Nebraska  
 11808 Grant Street Group Code: 3527 Company Type: Life and Health  
 Omaha, NE 68103-8000 Group Name: American Enterprise State ID Number:  
 (402) 496-8289 ext. [Phone] FEIN Number: 47-0339860

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$40.00  
 Retaliatory? No  
 Fee Explanation: \$20.00 x 1 rider  
 \$20.00 x 1 policy change  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
World Insurance Company	\$40.00	02/16/2009	25742512

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/19/2009	02/19/2009

<i>SERFF Tracking Number:</i>	<i>AMRP-126036054</i>	<i>State:</i>	<i>Arkansas</i>
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## **Disposition**

Disposition Date: 02/19/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Cover Letter	Approved-Closed	Yes
<b>Form</b>	Critical Illness Benefit Rider	Approved-Closed	Yes
<b>Form</b>	Schedule of Benefits	Approved-Closed	Yes

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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 02/19/2009	R4803W-REV	Certificate	Critical Illness Benefit Rider	Initial			R4803W-REV.pdf
Approved-Closed 02/19/2009	AC4800W	Schedule	Schedule of Benefits	Other Pages	Other Explanation: Amended Schedule of Benefits-See Cover Letter		Schedule of Benefits AC4800W.pdf



P.O. Box 3160  
Omaha, NE 68103-0160  
(402) 496-8000

## CRITICAL ILLNESS BENEFIT RIDER

This rider is made a part of the Certificate to which it is attached. It is subject to all of the provisions in the Certificate not in conflict with the provisions of this rider.

### Additional Definitions for this Rider

In addition to the Definitions in the Certificate, the following Definitions also apply to this rider:

**Activities of Daily Living.** Activities such as bathing, dressing, toileting, transferring, continence and eating.

“Bathing” means cleaning the body by tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of the tub or shower, reaching head and body parts for soaping, rinsing, and drying.

“Dressing” means putting on and taking off, fastening and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings/ garments and artificial limbs or splints.

“Toileting” means getting on and off the toilet or commode and emptying the commode, managing clothing and wiping and cleaning body after toileting, and assistance with using and emptying bedpans and urinals.

“Transferring” means moving from one sitting or lying position to another sitting or lying position, e.g., from bed to wheelchair or sofa, coming to a standing position or repositioning to promote circulation and prevent skin breakdown.

“Continence” means the ability to control bowel and bladder as well as use of ostomy or catheter receptacles, and apply diapers and disposable barrier pads.

“Eating” means reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meal.

**Beneficiary.** Any person named in our records to receive the benefits of this coverage upon your death. The Beneficiary is as named in the Application for coverage, unless later changed as provided in this rider. Any benefit unpaid at death may be paid to either the Insured’s Beneficiary or estate.

**Blindness.** Permanent and uncorrectable loss of sight in both eyes such that the corrected visual acuity is worse than 20/200 in both eyes or the field of vision must be less than 20 degrees in both eyes. A physician, who is an ophthalmologist, must certify such blindness. Please note, being registered blind may not be a valid claim.

**Covered Critical Illness Condition.** Only those health conditions set out in the Covered Expenses and Administration of Benefits sections of this rider and defined in this Definitions section, and resulting from Illness or Injury.

**Diagnosis.** The conclusive determination of the Covered Critical Illness Condition through the use of clinical and/or laboratory findings. When payment of benefits under this rider is contingent upon the surgical Treatment of covered conditions (as in benefits for the First Coronary Artery Bypass Surgery or Major Organ Transplant Surgery), we will consider the conclusive determination to be the date the Covered Person has such surgical Treatment.

**Eligible Person.** You or any Covered Dependent who is 19 years of age or older at the time coverage is issued or when added to the base coverage at a later date.

**End-Stage Renal Failure Diagnosis.** The first ever Diagnosis of chronic irreversible failure of the function of both kidneys requiring regular hemodialysis or peritoneal dialysis at least weekly. The End-Stage Renal Failure Diagnosis must be made by a Physician who is a board-certified nephrologist.

**First Angioplasty.** The first ever balloon Angioplasty, endarterectomy, insertion of stents or laser Treatment to correct narrowing or blockage of one or more coronary arteries. Such procedure must be at the direction of a Physician who is a board-certified cardiologist.

**First Coronary Artery Bypass Surgery.** The first ever coronary artery revascularization surgery by way of thoracotomy to correct the narrowing or blockage of one or more coronary arteries with bypass grafts. First Coronary Artery Bypass Surgery does not mean balloon Angioplasty, insertion of stents, laser relief or any other heart or vascular procedure not specifically meeting the above criteria.

**Heart Attack Diagnosis (Acute Myocardial Infarction, Coronary Thrombosis or Occlusion).** The first ever Diagnosis of the death of a portion of the heart muscle as a result of inadequate blood supply. Such Diagnosis must be established by all of the following criteria: clinical history; confirmatory new electrocardiogram (ECG) changes; and diagnostic elevation of the cardiac enzyme CK/MB. Elevated levels of Troponin will not be considered to be diagnostic evidence of a Heart Attack. The definition of Heart Attack Diagnosis shall not be construed to mean congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease or any other dysfunction of the cardiovascular system.

**Life-Threatening Cancer Conditions Diagnosis.** Types of cancer manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. The term Life-Threatening Cancer includes leukemia (other than low risk or intermediate risk chronic lymphocytic leukemia or less than Stage 3 of Modified Rai staging system) and Hodgkin's disease (except Stage 1 Hodgkin's).

The following types of cancer are not considered Life-Threatening Cancer:

1. Premalignant conditions or conditions with malignant potential;
2. Carcinoma in situ;
3. Cervical dysplasia CIN-1, CIN-2, CIN-3;
4. Benign tumors or polyps;
5. All skin cancer, including hyperkeratosis, basal cell carcinoma, squamous cell carcinoma, and melanoma that is Diagnosed as Clark's Level I or II or Breslow less than 1.5 mm, unless there is evidence of metastasis;
6. Prostatic cancers which are histologically described as TNM classification T1 or are of another equivalent or lesser classification;
7. Papillary micro carcinoma of the thyroid;
8. Stage 0 transitional carcinoma of the bladder;
9. Intraductal noninvasive carcinoma of the breast;
10. Kaposi's sarcoma.

We will require a pathological Diagnosis. When a pathological Diagnosis cannot be made, a clinical Diagnosis may be accepted. However, you must provide medical evidence that sustains the clinical Diagnosis.

**Loss of Limbs.** The total and permanent loss of the use of two or more limbs as a result of dismemberment. Dismemberment means the severance of an arm above the elbow or a leg above the knee.

**Major Organ Transplant Surgery.** Clinically definitive evidence of the failure of a Covered Person's liver, kidney, lung, entire heart, pancreas, or bone marrow that requires the malfunctioning organ to be replaced with an

organ from a suitable human donor under generally accepted medical procedures. Services must be performed by a Physician who is board-certified to provide such services.

**Multiple Sclerosis Diagnosis.** Clinically definitive evidence of the occurrence of two or more episodes of well-defined neurological abnormalities (from medical history and neurological examination) resulting in the impairment of motor or sensory function. Diagnosis must be supported by modern imaging and investigative techniques confirming lesions at more than one site within the central nervous system and no other neurological disease better explains the findings. Neurological abnormalities in this context must be evidenced by the typical symptoms of demyelination with resultant impairment of the brain stem or spinal cord. A Physician who is a board-certified neurologist must make the definitive Diagnosis of Multiple Sclerosis.

**Permanent Paralysis Diagnosis (Hemiplegia, Paraplegia or Quadriplegia).** The complete and permanent loss of the use of one leg and one arm on one side of the body (hemiplegia) or both legs and/or both arms (paraplegia or quadriplegia) due to a covered Injury. The loss of use must be deemed to be permanent and must be supported by appropriate neurological evidence. A Physician who is a board-certified neurologist must make the definitive Diagnosis of Permanent Paralysis.

**Stroke.** A cerebrovascular event resulting in permanent neurological damage including infarction of brain tissue, hemorrhage, or embolization from an extracranial source. The Stroke must be positively Diagnosed by a Physician based upon documented neurological deficits and confirmatory neuroimaging studies. Such neurological deficits must persist for at least 30 days following the occurrence of the Stroke. Stroke does not mean cerebral symptoms due to transient ischemic attack, reversible neurological deficit, migraine, cerebral Injury resulting from trauma or hypoxia, and vascular disease affecting the eye, optic nerve, or vestibular functions or other cerebrovascular insufficiency.

### **Covered Expenses under This Rider**

Covered Expenses under this rider are expenses a Covered Person Incurs after first being Diagnosed with, or having surgery for, a Covered Critical Illness Condition that first manifests while this coverage is In Force.

### **Administration of Benefits**

1. We will pay the following benefits for Covered Critical Illness Conditions.
  - a. 10% of the Critical Illness Lifetime Maximum Benefit Amount (shown on the Schedule of Benefits) for the First Angioplasty. If a benefit is paid under this provision, no further benefits will be paid for subsequent Angioplasties. The Critical Illness Lifetime Maximum Benefit Amount will then be reduced by the amount of this payment.
  - b. 25% of the Critical Illness Lifetime Maximum Benefit Amount for the First Coronary Artery Bypass Surgery. Subsequent Coronary Artery Bypass Surgeries will not be covered under this provision. The Critical Illness Lifetime Maximum Benefit Amount will then be reduced by the amount of this payment.
  - c. 100% of the Critical Illness Lifetime Maximum Benefit Amount, less any amount previously paid, when for the first time a Covered Person:
    - (1) Is Diagnosed with End-Stage Renal Failure;
    - (2) Is Diagnosed as having a Heart Attack (Acute Myocardial Infarction, Coronary Thrombosis or Occlusion);
    - (3) Undergoes Major Organ Transplant Surgery;
    - (4) Is Diagnosed as having Multiple Sclerosis with neurological abnormalities that have existed for a period of at least 180 days and which result in the inability to perform one or more Activities of Daily Living;
    - (5) Is Diagnosed as having Permanent Paralysis (Hemiplegia, Paraplegia, or Quadriplegia) due to a covered Injury. The Paralysis must have existed for a period of at least 180 days;
    - (6) Is Diagnosed as having a Stroke;

- (7) Is Diagnosed with a Life-Threatening Cancer Condition;
  - (8) Suffers Loss of Limbs as a result of dismemberment.
  - (9) are diagnosed with blindness.
2. Reduction of Benefits. When a Covered Person attains age 70, the applicable Critical Illness Lifetime Benefit Amount is reduced to 50% of the amount that otherwise would be payable. Benefits are paid based on the Critical Illness Lifetime Maximum Benefit Amount in effect on the date of Diagnosis or date of surgery.
  3. Any preauthorization requirement in the Certificate does not apply to the benefits in this rider.
  4. The Coordination of Benefits provision in the Certificate does not apply to the benefits provided in this rider.
  5. Change of Beneficiary. You may change the Beneficiary of the benefits of this rider at any time while this Certificate and rider are in force. The change must be made in writing and sent to us. The Beneficiary's consent is not required for this or any other change in the Certificate, unless the designation of the Beneficiary is irrevocable. The change will take effect on the date you sign it. However, a change will not apply to any payment or other action we may have taken before we receive the change. A change cancels all prior Beneficiary designations.
  6. Loss of life benefits are payable in accordance with the Beneficiary designation in effect at the time of payment. Any other benefit unpaid at death may be paid to either the insured's Beneficiary or estate.

#### **Exclusions and Limitations**

1. The Critical Illness Lifetime Maximum Benefit Amount for each Covered Person is shown on the Schedule of Benefits. In no event shall the benefits paid for any one Covered Person exceed the Critical Illness Lifetime Maximum Benefit Amount, regardless of the number of Covered Critical Illness Conditions.
2. We will not pay benefits under the rider for loss incurred as a result of any condition not specifically listed as a Covered Critical Illness Condition in the this rider.

#### **Termination of this Rider**

This rider will terminate on the earlier of:

1. The date on which the Certificate to which this rider is attached terminates; or
2. The premium due date following the date on which we receive your written request to cancel this rider; or
3. The date the Critical Illness Lifetime Maximum Benefit amount has been paid for a Covered Person.



Mary K. Durand  
Secretary

## Schedule of Benefits

This Schedule of Benefits provides important information about the benefits you have selected and out-of-pocket expenses for which you are responsible when you Incur Covered Expenses under your Certificate.

### SECTION 1. MAXIMUM BENEFITS

#### **A. Maximum Lifetime Benefit**

Maximum cumulative amount we will ever pay in benefits for your Covered Expenses: [\$250,000 to \$25,000,000]

#### **[B. Calendar Year Maximum Benefit**

Maximum amount we will pay in benefits during a Calendar Year for your Covered Expenses: [\$100,000 to \$5,000,000 ]

### SECTION 2. YOUR OUT-OF-POCKET EXPENSES

Your out-of-pocket expenses are the amounts you must pay each Calendar Year before Covered Expenses are payable by us. Depending on the benefit for which you are making a claim under this Certificate, you are responsible for paying one of (or a combination of) the following amounts before we have an obligation to pay benefits related to the claim.

#### **[A. Deductibles**

##### **Individual Deductible** (per Calendar Year per Covered Person)

Participating Provider: [\$0 to \$50,000]  
Nonparticipating Provider: [\$0 to \$100,000]

##### **Family [Aggregate] Deductible** (per Calendar Year)

Participating Provider: Your Participating Provider Family Deductible for a Calendar Year is satisfied when [two/three] family members each satisfy the Participating Provider Individual Deductible during that Calendar Year. At that point, no further Participating Provider Deductibles will apply for the covered family members for the remainder of the Calendar Year.

Nonparticipating Provider: Your Nonparticipating Provider Family Deductible for a Calendar Year is satisfied when [two/three] family members each satisfy the Nonparticipating Provider Individual Deductible during that Calendar Year. At that point, no further Nonparticipating Provider Deductibles will apply for the covered family members for the remainder of the Calendar Year.

**[B. Coinsurance Percentage (per Covered Person per Calendar Year)**

After you have satisfied the appropriate Deductible for Covered Expenses that are subject to the Certificate’s Deductible and Coinsurance, you are responsible for paying Coinsurance as described below. After you satisfy your Coinsurance obligation, we will pay 100% of the remainder of Covered Expenses through the end of the Calendar Year (subject to other limitations in the Certificate and this Schedule of Benefits).

Participating Provider: [50%/40%/30%/25%/20%/10%/0%] of the first [\$5,000 to \$50,000] of Covered Expenses.

Nonparticipating Provider: [50%/40%/30%/20%] of the first [\$10,000 to \$100,000] of Covered Expenses. ]

**[C. Copays and Access Fees**

Copays and Access Fees are defined in the Certificate. The dollar amounts for Copays and Access Fees are shown in Section 3 below. Copays and Access Fees do not apply toward satisfying the Deductible, Coinsurance Percentage amount or out-of-pocket limit. ]

**[D. Your Out-of-Pocket Limit**

Subject to other provisions, exclusions and limitations in the Certificate, the out-of-pocket limit is the maximum **Deductible and Coinsurance Percentage amount** a Covered Person will have to pay for Covered Expenses during a Calendar Year.

Participating Provider: [\$0 to \$100,000]

Nonparticipating Provider: [\$0 to \$100,000] ]

[ *(If product is an HSA, the following statement must be included on Schedule of Benefits)*

**PLEASE NOTE: ON EACH JANUARY 1<sup>ST</sup>, THE DEDUCTIBLE AND THE OUT-OF-POCKET LIMIT ARE INDEXED FOR INFLATION IN \$50 INCREMENTS, BASED ON THE NATIONAL CONSUMER PRICE INDEX. A CHANGE IN THE DEDUCTIBLE AND THE OUT-OF-POCKET COVERED EXPENSE LIMIT MAY AFFECT THE DOLLAR AMOUNTS SHOWN UNDER THE SECTION TITLED “YOUR OUT-OF-POCKET LIMIT.” ]**

**SECTION 3. SPECIFIC BENEFITS**

**[Inpatient Treatment**

Once you have satisfied the applicable Access Fee, Deductible and Coinsurance Percentage, we will pay benefits for Inpatient Covered Expenses up to the applicable Calendar Year maximum (subject to other provisions, exclusions and limitations in your Certificate).

Inpatient Access Fee per Confinement: [\$0 to \$1,000]

Maximum amount we pay in a Calendar Year per Covered Person for Inpatient Treatment: [\$100,000 to \$1,000,000 or N/A]

**Outpatient Treatment**

Once you have satisfied the applicable Access Fee, Deductible and Coinsurance Percentage, we will pay benefits for Outpatient Covered Expenses up to the applicable Calendar Year maximum (subject to other provisions, exclusions and limitations in your Certificate).

Outpatient Access Fee per visit: [\$0 to \$1,000]

Maximum amount we pay in a Calendar Year per Covered Person for Outpatient Treatment: [\$5,000 to \$50,000 or N/A ]

**[Emergency Room Benefit**

Once you have satisfied the applicable Access Fee, Deductible and Coinsurance Percentage, we will pay benefits for Emergency Room expenses (subject to other provisions, exclusions and limitations in the Certificate).

Emergency Room Access Fee per visit: [\$0 to \$500]

**Or**

Covered Expenses per Covered Person per Calendar Year: After the Access Fee, [100% ] of the next [\$1,000], with the remainder subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Emergency Room Access Fee per visit: [\$0 to \$500 ]

**[Diagnostic X-ray and Laboratory**

[Once you have satisfied the applicable Access Fee, Deductible and Coinsurance Percentage, we will pay benefits for Diagnostic X-Rays and Laboratory expenses up to the applicable Calendar Year maximum (subject to other provisions, exclusions and limitations in the Certificate).]

X-Ray and Laboratory Access Fee per service: [\$0 to \$500 or N/A]

Maximum amount we pay in a Calendar Year per Covered Person: [\$100 to \$10,000 or N/A]

**Or**

Covered Expenses per Covered Person per test/service: [After the Copay, we pay up to [100%] of the per test maximum.\*\*]

X-Ray and Laboratory Copay per test/service: [\$0 to \$500]

Maximum we pay per test/service ("per test maximum"): [\$100 to Unlimited]

Maximum amount we pay in a Calendar Year per Covered Person: [\$100 to \$10,000 or N/A]

\*\*We do not provide benefits for any Outpatient test/service expenses you Incur that exceed the per test maximum amount. In addition, any Outpatient expenses you Incur that exceed the per test maximum do not apply toward satisfying your Deductible. ]

**[Magnetic Resonance Imaging ("MRI") / Computerized-Tomography Scanning ("CAT") / Positron Emission Tomography ("PET")**

[Once you have satisfied the applicable Access Fee, Deductible and Coinsurance Percentage, we will pay benefits for MRI, CAT, and PET expenses up to the applicable Calendar Year Maximum (subject to other provisions, exclusions and limitations in the Certificate).]

MRI / CAT / PET Access Fee per service:	[\$0 or \$250 to \$1,000]
Maximum amount we pay in a Calendar Year per Covered Person:	[\$1,000 to \$25,000 or N/A ]
<b>Or</b>	
Covered Expenses per Covered Person per test/service:	[After Copay, we pay up to [100%] of the per test maximum**.]
MRI / CAT / PET Copay per test/service:	[\$0 or \$250 to \$1,000]
Maximum we pay per test/service ("per test maximum"):	[\$100 to Unlimited]
Maximum amount we pay in a Calendar Year per Covered Person:	[\$1,000 to \$25,000 or N/A]

\*\*We do not provide benefits for any Outpatient test/service expenses you Incur that exceed the per test maximum amount. In addition, any Outpatient expenses you Incur that exceed the per test maximum do not apply toward satisfying your Deductible. ]

**[Transplants**

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum lifetime amount we pay for this benefit per Covered Person at a Center of Excellence ("COE"):	[\$500,000 to \$5,000,000 or Subject to the Certificate's Maximum Lifetime Benefit]
Maximum amount we pay per Covered Person per transplant at a COE:	[\$500,000/\$1,000,000 or Subject to the Certificate's Maximum Lifetime Benefit]
Maximum transportation and living expenses we pay per covered transplant at a designated COE:	[\$5,000]
For transplants that are not performed at a COE, the maximum lifetime amount we will pay for this benefit per Covered Person is:	[\$100,000]
Maximum amount we pay per Covered Person per transplant when not performed at a COE:	[\$100,000] ]

**[Acute Rehabilitation**

Covered Expenses are subject to the Certificate’s Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.]

**[Urgent Care Facility**

Covered Expenses are subject to the Certificate’s Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.]

**[Ambulance Service (Local Ground)**

Covered Expenses are subject to the Certificate’s Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.]

**[Ambulance Service (Air)**

[Covered Expenses are subject to the Certificate’s Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.]

[Maximum amount we pay in a Calendar Year per covered Illness or Injury:] [\$5,000 to \$50,000 or N/A]

**Or**

[Covered Expenses are subject to the Certificate’s Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.]

[Maximum amount we pay in a Calendar Year per Covered Person per Calendar Year:] [\$5,000 to \$50,000 or N/A]

**[Emergency Foreign Travel Benefit**

Covered Expenses are subject to the Certificate’s Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum lifetime amount we pay for all covered Illnesses and/or Injuries under this benefit: [\$100,000] ]

**[Home Health Care**

Covered Expenses are subject to the Certificate’s Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum number of Home Health Care Visits per Calendar Year: [40 to 100] ]

**[Hospice Treatment and Services**

Covered Expenses are subject to the Certificate’s Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum we pay for Outpatient Hospice benefits, per day: [\$100 to \$500]

Maximum we pay for Treatment and Room and Board Expenses while an Inpatient in a Hospice Facility, per day: [\$200 to \$1,000]

Maximum lifetime benefit we pay for Inpatient and Outpatient Hospice Treatment (combined): [\$5,000 to \$50,000] ]

**[Outpatient Occupational, Physical and Speech Therapy**

[Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.]

[Maximum we pay per visit: [ \$50 to \$250 ]

Maximum we pay for all three types of therapy (combined),  
per Covered Person per Calendar Year: [ \$2,000 to \$25,000 ] ]

**[Skilled Care Facility Benefit**

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum number of days we pay per Calendar Year: [ 60 ] ]

**[Spinal Manipulation**

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum we pay per day of Treatment (including x-rays): [ \$50 to \$100 ]

Maximum for all Treatments and x-rays under this benefit, per  
Covered Person per Calendar Year: [ \$500 to \$2,500 ] ]

**[Sterilization**

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum lifetime benefit we will pay per Covered Person: [ \$500 ] ]

**[Treatment of Allergies**

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum Calendar Year benefit we will pay per Covered  
Person: [ \$500 ] ]

**[Treatment for Sleep Apnea**

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum lifetime benefit we will pay per Covered Person: [ \$2,000 to \$5,000 ] ]

**[Treatment for Growth Disorders**

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum lifetime benefit we will pay per Covered  
Dependent child: [ \$15,000 ] ]

**[Accident Expense Benefit**

Maximum amount we pay for this benefit, per Covered Person per Calendar Year: [\$500 - \$25,000] ]

**[Accidental Death Benefit**

Maximum amount we pay for this benefit: [\$1,000 - \$100,000] ]

**[Convalescent Care Benefit (Short Term)**

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum Benefit Period (number of days in a Covered Person's lifetime for which we pay benefit): [30/60/90/180/360 days per Covered Person]

Elimination Period: [20 to 90 days]

Daily Benefit Amount (maximum amount per day we pay for this benefit): [\$0 to \$500 per Covered Person (in \$10 increments)] ]

**[Critical Illness Benefit**

Critical Illness Maximum Lifetime Benefit: [\$10,000/ \$25,000/ \$50,000]

Specified Critical Illness and Specified Surgeries:	Percentage of Critical Illness Maximum Benefit Payable:
Angioplasty	[10%]
Coronary Artery Bypass Surgery	[25%]
Blindness	[100%]
End Stage Renal Failure	[100%]
Heart Attack	[100%]
Life-Threatening Cancer	[100%]
Loss of Limbs	[100%]
Major Organ Transplant Surgery	[100%]
Multiple Sclerosis	[100%]
Permanent Paralysis	[100%]
Stroke	[100%] ]

**[Decreasing Deductible**

First Certificate Year Decrease: [\$100 to \$5,000]

Second Certificate Year Decrease: [\$500 to \$10,000] ]

**[Maternity Expense Benefit**

Routine Pregnancy Benefit Amount: [\$250 to \$500 per Unit]

Number of Units: [1 to 20]

**Or**

Maternity Waiting Period: [0 to 9 months]

Maternity Benefit Deductible Amount: [\$1,000 to \$25,000]

Maternity Benefit Percentage: [50% to 100%] ]

**[Office Visit Benefit**

[Covered Expenses are subject to the Certificate’s Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.]

**Or**

[Participating Provider:

Maximum Benefit amount we pay per Covered Person per visit:

[ \$25/ \$50/ \$75/ \$100/ \$125/ \$150/ \$200/ \$250]

Maximum number of visits for which we will pay per Covered Person per Calendar Year:

[1 to 5 or N/A]

Nonparticipating Provider:

Maximum Benefit amount we pay per Covered Person per visit:

Maximum Benefit amount is 50% of the Participating Provider Maximum Benefit]

**Or**

[Participating Provider:

Covered Expenses per Covered Person per Calendar Year:

After Copay, [100%] of the next [1/2/3/4/ Unlimited Visits], with the remainder subject to the Certificate’s Participating Provider Calendar Year Deductible and Coinsurance Percentage.

Office Visit Copay:

[\$20/\$30/\$40/\$50/\$60]

Number of Office Copays Waived:

[0/1/2/3]

Nonparticipating Provider:

[Covered Expenses are subject to the Certificate’s Nonparticipating Provider Deductible and Coinsurance Percentage.] ]

**[Premium Discount for Good Health**

[Included/(if not included, item will not be listed) ]

**[Refund of Premium for Good Health]**

Consecutive Calendar Years:

Specified Percentage:

First:

[5%]

Second:

[10%]

Third and after:

[15% ]

**[Wellness Benefit**

Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

Maximum we pay per Covered Person per Calendar Year: [\$100 to \$2,500 or N/A]

[Preventive Dental Services applied against Wellness Benefit  
Maximum: [\$50/\$75/\$100] ]

[Waiting Period before this benefit is available: [None/6 months/12 months] ] ]

**Or**

**[Wellness Benefit**

Covered Expenses per Covered Person per Calendar Year: After Copay, [100%] of the Benefit Maximum per Calendar Year.

Wellness Copay per visit: [\$0 to 500]

Benefit Maximum in Year 1: [\$100 to \$2,500 or N/A]

Benefit Maximum in Year 2: [\$100 to \$2,500 or N/A]

Benefit Maximum in Year 3 and after: [\$100 to \$2,500 or N/A]

[Preventive Dental Services applied against Wellness Benefit  
Maximum: [\$50/\$75/\$100] ]

[Waiting Period before this benefit is available: [None/6 months/12 months] ] ]

**[Term Life Insurance Benefit Amount**

Insured: [\$15,000/ \$25,000/ \$50,000]

Covered Dependent: [\$7,500/\$12,500/\$25,000]

Covered Dependent Child - 14 days to 6 months old: [\$250/\$500/\$1,000]

Covered Dependent Child – 6 months to 18 years old: [\$1,000/\$2,000/\$5,000] ]

**[Outpatient Prescription Drug Benefit**

[Covered Expenses are subject to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.]

**Or**

[Prescription Drug Generic Copay: [\$0 to\$25]  
You do not have coverage for Brand Name Drugs or Specialty Medications.]

**Or**

[Prescription Drug Generic Copay: [\$0 to\$25]

Coverage for Specialty Medications is subject to your Certificate's Deductible and Coinsurance Percentage.

You do not have coverage for Brand Name Drugs.]

**Or**

Prescription Drug Generic Copay (or Prescription Drug Percentage):	The higher of [\$10 to \$20] or [10% to 50%]
Prescription Drug Brand Formulary Copay (or Prescription Drug Percentage):	The higher of [\$20 to \$35] or [10% to 50%]
Prescription Drug Brand Nonformulary Copay (or Prescription Drug Percentage):	The higher of [\$30 to \$50] or [10% to 50%]
Prescription Drug Deductible:	[\$250 to \$1000 or N/A]
Prescription Drug Generic Deductible:	[\$100 to \$300 or N/A]
Prescription Drug Brand Deductible:	[\$200 to \$500 to N/A]
Prescription Drug Brand Maximum:	[\$500 to \$2000 or N/A]

Coverage for Specialty Medications is subject to your Certificate's Deductible and Coinsurance Percentage.]

**Or**

Prescription Drug Generic Copay:	[\$10 to \$20]
Prescription Drug Brand Formulary Copay:	[\$20 to \$35]
Prescription Drug Brand Nonformulary Copay:	[\$30 to \$50]
Prescription Drug Deductible:	[\$250 to \$1000 or N/A]
Prescription Drug Generic Deductible:	[\$100 to \$300 or N/A]
Prescription Drug Brand Deductible:	[\$200 to \$500 or N/A]
Prescription Drug Brand Maximum:	[\$500 to \$2000 or N/A]

Coverage for Specialty Medications is subject to your Certificate's Deductible and Coinsurance Percentage.]

]

SERFF Tracking Number: AMRP-126036054 State: Arkansas  
 Filing Company: World Insurance Company State Tracking Number: 41556  
 Company Tracking Number: R4803W-REV  
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other  
 Product Name: Critical Illness Benefit Rider  
 Project Name/Number: R4803W-REV/R4803W-REV

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Flesch Certification	Approved-Closed	02/19/2009
<b>Bypass Reason:</b>	Not Applicable		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Application	Approved-Closed	02/19/2009
<b>Bypass Reason:</b>	Not Applicable		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Cover Letter	Approved-Closed	02/19/2009
<b>Comments:</b>			
<b>Attachment:</b>			
Cover Letter.pdf			



February 16, 2009

Hon. Julie Benefield Bowman, Commissioner of Insurance  
Insurance Division  
1200 W. Third St.  
Little Rock, AR 72201-1904

Attention: Rosalind Minor

Re: Informational Filing  
NAIC #70629  
Schedule of Benefits  
R4803W-REV – Critical Illness Rider

Dear Ms. Minor

Please find enclosed the above-captioned forms which are being submitted on an informational basis for your review. These forms will be used with Association Group certificate form AC4800W that was approved by your Department on June 23, 2008.

The Schedule of Benefits provides the variable material and is bracketed to indicate that such material is subject to change.

Rider form R4803W-REV replaces rider form R4803W which was approved on June 23, 2008. The new form includes a critical illness benefit for “blindness”.

The forms are in final print subject only to minor modifications in paper size, stock, color, border, font, company logo and adaptation to computer printing. Depending on printer capabilities, the application will be printed as either simplex or duplex.

Your earliest acknowledgement of this filing will be greatly appreciated.

Sincerely,

Jamie Mueller  
Compliance Analyst 3

World Insurance Company

**Phone:** (515) 558-6569 **Fax:** (515) 247-2470 **e-mail:** jamie.mueller@americanenterprise.com