

SERFF Tracking Number: CMPL-126037052 State: Arkansas  
Filing Company: PAN-AMERICAN LIFE INSURANCE State Tracking Number: 41558  
COMPANY  
Company Tracking Number: PAN AM REV 1-2009  
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity  
Product Name: Pan AM Rev 1-2009  
Project Name/Number: Pan AM Rev 1-2009 /Pan AM Rev 1-2009

## Filing at a Glance

Company: PAN-AMERICAN LIFE INSURANCE COMPANY

Product Name: Pan AM Rev 1-2009 SERFF Tr Num: CMPL-126037052 State: Arkansas  
TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed-Approved- State Tr Num: 41558  
Closed

Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: PAN AM REV 1-2009 State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Rosalind Minor  
Author: Nancy French Disposition Date: 02/19/2009  
Date Submitted: 02/16/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval  
State Filing Description:

Implementation Date:

## General Information

Project Name: Pan AM Rev 1-2009  
Project Number: Pan AM Rev 1-2009  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:  
Filing Status Changed: 02/19/2009

Status of Filing in Domicile:  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type: Group  
Group Market Size: Large  
Group Market Type: Employer  
Explanation for Other Group Market Type:  
State Status Changed: 02/19/2009  
Created By: Nancy French  
Corresponding Filing Tracking Number:

Deemer Date:  
Submitted By: Nancy French  
Filing Description:

This filing is being made by Compliance Research Services, LLC on behalf of Pan-American Life Insurance Company (referred to in this letter as Pan-American.) A letter of filing authorization is attached. All correspondence should be addressed to me at Compliance Research Services.

We are submitting the above for your review and approval. These forms amend certificate form MMPAL-2008-C previously approved by your Department on August 19, 2008, SERFF State Tracking Number 39652. These amendments replace the current state amendment (Form ABSTAMDT-08-AR) also approved by your Department on August 19, 2008 and are effective for claims incurred on or after January 1, 2009. The new amendments contain all the

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changes which were on the prior state amendment and also contain various new changes. A summary of the changes is shown in the last page of this letter. The major change is the offering of three plans from which an employee must choose effective January 1, and which are reflected by amendment to the Summary of Benefits and description of Covered Services. The prior plan of benefits will not be available after December 31, 2008. The amendments are identical with the exception of the Summary of Benefits.

All forms are in final format. However, because Pan-American uses various fonts and layouts, we reserve the right to format the pages to conform to their printer's requirements. No change in language or reduction in font size will occur, only a possible page break, or renumbering of pages. Pan-American also requests the right to change the paper size or to issue the forms in electronic format.

These forms are new and do not replace or supersede any forms currently on file with your Department.

If you have any questions concerning this filing, please contact me at the phone number or email address shown below.

Sincerely,

J. David Simon, CLU  
President  
513-984-6050  
dsimon@crssolutionsgroup.com

- Face Page - New 1-800 number;
- Who Is An Eligible Employee - Change 90 day waiting period to 3 months;
- Definitions - New definition of Hospital;
- Definitions -New definition of Primary Care Physician;
- Definitions -New definition of Specialist Care Physician;

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- Definitions -New definition of Urgent Care Clinic;
- Summary of Benefits - New Calendar Year Deductible/Overall Plan Maximum for three new plans;
- Summary of Benefits - New Hospital Inpatient Benefit has changed.
- Summary of Benefits - Outpatient Surgical/Diagnostic/Therapeutic Services added;
- Summary of Benefits – Primary Care, Specialist Care, Urgent Care Doctor’s visit clarified
- Summary of Benefits - Emergency visits benefit clarified;
- Summary of Benefits - Family deductible wording clarified Explanation of Important Plan Changes;
- Covered Services – Outpatient Surgical, Diagnostic, Therapeutic and Therapeutic Services added
- Covered Services - – Primary Care, Specialist Care and Urgent Care benefit wording added;
- Covered Services - Clarified the Spinal Disorder Treatment Benefit;
- Covered Services - Moved mammogram and pap smear benefit wording from Other Covered Benefit to the Routine Preventive services benefit.
- Covered Services – Emergency Care Services renamed and reworded
- Description of Network and Non-network Benefits – Network Benefits reworded
- Conversion – clarification of who is eligible for conversion.

## Company and Contact

### Filing Contact Information

Nancy French, Product Manager nrfrench@crssolutionsgroup.com  
 10921 Reed Hartman Highway 513-984-6050 [Phone]  
 Suite 334 513-984-7212 [FAX]  
 Cincinnati, OH 45242

### Filing Company Information

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

PAN-AMERICAN LIFE INSURANCE CoCode: 67539 State of Domicile: Louisiana  
 COMPANY  
 P O Box 60219 Group Code: Company Type:  
 601 Poydras Pan American Life Center Group Name: State ID Number:  
 New Orleans, LA 70160-0219 FEIN Number: 72-0281240  
 (513) 984-6050 ext. [Phone]

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## Filing Fees

SERFF Tracking Number: CMPL-126037052 State: Arkansas  
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Fee Required? Yes  
Fee Amount: \$60.00  
Retaliatory? No  
Fee Explanation: 3 forms at \$20.00 each = 60  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
PAN-AMERICAN LIFE INSURANCE	\$60.00	02/16/2009	25753311
COMPANY			

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## Correspondence Summary

### Dispositions

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

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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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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Authorization	Approved-Closed	Yes
Form	Arkansas Certificate Amendment Elite Plan	Approved-Closed	Yes
Form	Arkansas Certificate Amendment Plus Plan	Approved-Closed	Yes
Form	Arkansas Certificate Amendment Std Plan	Approved-Closed	Yes

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## Form Schedule

**Lead Form Number: MMPAL-2008-C-AMDT-1-AR**

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/19/2009	MMPAL-2008-C-AMDT-1-AR	Certificate	Arkansas Certificate Amendment Elite Plan	Initial			AB Arkansas Certificate Amendment Elite Plan 010109 Filing Copy.pdf
Approved-Closed 02/19/2009	MMPAL-2008-C-AMDT-2-AR	Certificate	Arkansas Certificate Amendment Plus Plan	Initial			AB Arkansas Certificate Amendment Plus Plan 010109 Filing Copy.pdf
Approved-Closed 02/19/2009	MMPAL-2008-C-AMDT-3-AR	Certificate	Arkansas Certificate Amendment Std Plan	Initial			AB Arkansas Certificate Amendment Std Plan 010109 Filing Copy.pdf

**PAN-AMERICAN LIFE INSURANCE COMPANY**

**PAN-AMERICAN LIFE CENTER  
601 Poydras Street  
New Orleans, Louisiana 70130  
TOLL FREE: 1-866-781-6736**

**GROUP HOSPITAL, SURGICAL AND MEDICAL CERTIFICATE AMENDMENT  
FOR RESIDENTS OF THE STATE OF ARKANSAS**

ATTACHED TO AND MADE A PART OF THE CERTIFICATE ISSUED TO EMPLOYEES OF SPECTAGUARD ACQUISITIONS, LLC DBA ALLIEDBARTON SECURITY SERVICES.

POLICYHOLDER PLAN NO. \_\_\_\_\_

**TELEPHONE NUMBER FOR INQUIRIES**

**If You have questions about this policy, need information about coverage, or need assistance resolving a complaint, please call the following toll free number: 1-866-781-6736**

This amendment is effective for claims incurred on or after January 1, 2009.

If you reside permanently in the state of Arkansas, the Certificate/booklet to which this Amendment is attached and becomes a part is amended as stated below to conform to the requirements of the state of Arkansas. In the event of a conflict between the Certificate/booklet and this Amendment, the provisions resulting in greater benefits will be in effect.

The following changes apply:

- The following subsections in the **SECTION I: ENROLLMENT AND EFFECTIVE DATE OF COVERAGE** are changed to read as follows:
- **WHO IS AN ELIGIBLE EMPLOYEE?**

Employees working at least an average of 35 hours per week who have completed 3 months of employment.

**TO BE ELIGIBLE TO ENROLL AS A DEPENDENT, YOU MUST:**

1. Be the legal spouse of the Member; or
2. Be the natural child, step-child, or adopted child of the Member; or the child for whom the Member is the legal guardian, or the child who is the subject of a lawsuit for adoption by the Member, if the Member has the legal responsibility for the health of the child, or the child supported pursuant to a court order imposed on the Member (including a qualified medical child support order) or a grandchild of the Member who is also a Dependent of the Member for federal income tax purposes, provided that child:
  - a. Is unmarried and legally dependent upon the Member for support;
  - b. Has not reached age nineteen (19);
  - c. Is age nineteen (19) but less than age twenty-five (25) and is a full-time student; or
  - d. Is age nineteen (19) or older and is incapable of self-sustaining support because of mental retardation or a physical handicap which existed prior to attaining nineteen (19) years of age. You must submit proof of the child's condition and dependence to Us after the date the child ceases to qualify as a Dependent under section (b) above.

A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 20 or more hours weekly for six or more months.

## ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

### B. Enrollment after an Open Enrollment Period

1. If, after the Open Enrollment Period, You become eligible for coverage as a Member or a Dependent, You may enroll as a Member within thirty-one (31) days of the day on which You met the eligibility criteria. To enroll, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, Your effective date of coverage will be the day on which You meet the eligibility criteria.
2. If You are a Member who is enrolled for Employee coverage only, You may enroll a newborn child prior to the birth of the child or within thirty-one (31) days after the child's birth. Newborn children of the Member are covered for the first thirty-one (31) days after birth. To enroll a newborn child, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, the effective date of coverage for Your newborn child will be the date of his birth.
3. If You are a Member who is enrolled for Employee and family coverage, You may enroll a newborn child prior to the birth of the child or within ninety (90) days after the child's birth. Newborn children of the Member are covered for the first ninety (90) days after birth. To enroll a newborn child, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, the effective date of coverage for Your newborn child will be the date of his birth.
4. If You are a Member who is enrolled for Employee coverage only, You may enroll an adopted child or child for whom You have been granted legal guardianship within thirty-one (31) days of the date the child is legally placed with You for adoption or within thirty-one (31) days of the date You are granted legal guardianship. To enroll an adopted child or a child for whom You are the legal guardian, You must submit an Enrollment Application, together with any additional premium due.
5. If You are a Member who is enrolled for Employee and family coverage, You may enroll an adopted child or child for whom You have been granted legal guardianship within sixty (60) days of the date the child is legally placed with You for adoption or within sixty (60) days of the date You are granted legal guardianship. To enroll an adopted child or a child for whom You are the legal guardian, You must submit an Enrollment Application, together with any additional premium due.

### F. Late Enrollee

A "Late Enrollee" is a person (including Yourself) for whom You do not elect coverage within 31 days of the date the person becomes eligible for such coverage.

An eligible Employee or Dependent will be required to provide proof of good health, at his cost, if he applies for coverage more than thirty-one (31) days after he becomes eligible or if he applies for reinstatement of coverage that was cancelled at his request.

Exceptions:

- A person will not be considered to be a Late Enrollee if all of the following are met:
    - You did not elect coverage for the person involved within 31 days of the date You were first eligible (or during an open enrollment) because at that time the person was covered under other creditable coverage; and
  - the person loses such coverage because:
    - a. of termination of employment in a class eligible for such coverage;
    - b. of reduction in hours of employment;
    - c. Your spouse dies;
    - d. You and Your spouse divorce or are legally separated;
    - e. such coverage was COBRA continuation and such continuation was exhausted; or
    - f. the other plan terminates due to the employer's failure to pay the premium or for any other reason; and
  - You elect coverage within 31 days of the date the person loses coverage for one of the above reasons.
- If You are not considered a Late Enrollee, coverage will become effective on the date of the election. Any limitation as to a

preexisting condition may apply.

### **Additional Exceptions**

Also, a person will not be considered a Late Enrollee if You did not elect, when the person was first eligible, coverage for:

- A child who meets the definition of a Dependent, but You elect it later in compliance with a court order requiring You to provide such coverage for Your Dependent child. Such coverage will become effective on the date specified by the Policyholder. Any limitation as to a preexisting condition may apply.
- A spouse, but You elect it later and within 31 days of a court order requiring You to provide such coverage for Your Dependent spouse. Such coverage will become effective on the date of the court order. Any limitation as to a preexisting condition may apply.
- Yourself and You subsequently acquire a Dependent, through marriage, and You subsequently elect coverage for Yourself and any such Dependent within 31 days of acquiring such Dependent. Such coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.
- Yourself and You subsequently acquire a Dependent, through birth, adoption, or placement for adoption, and You subsequently elect coverage for Yourself and any such Dependent within 31 days of acquiring such Dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with You for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.
- Yourself and Your spouse and You subsequently acquire a Dependent through birth, adoption, or placement for adoption, and You subsequently elect coverage for Yourself, Your spouse, and any such Dependent within 90 days of acquiring such Dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with You for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

### **G. Special Rules Which Apply to an Adopted Child**

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of Dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date Your coverage becomes effective; and
- You make written request for coverage for the child within 31 days (60 days if You already have Dependents covered) of the date the child is placed with You for adoption.

Coverage for the child will become effective on the date the child is placed with You for adoption. If request is not made within such 31 days (60 days if You already have Dependents covered), coverage for the child will be subject to all of the terms of this Plan.

- The definition of **HOSPITAL** is changed to read as follows:

An institution, operated as required by law, which is all of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.
- Is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or by the American Osteopathic Hospital Association.

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

- The following definitions are added to the **DEFINITIONS** section:

MMPAL-2008-C-AMDT-3-AR

**PRIMARY CARE DOCTOR/PHYSICIAN**

A Physician who specializes in general internal medicine, family medicine, general pediatrics, obstetrics and gynecology.

**SPECIALIST CARE DOCTOR/PHYSICIAN**

A Physician who is not a Primary Care Physician and who provides Covered Services within the range of his or her medical specialty.

**URGENT CARE CLINIC**

A facility, other than a Hospital, that provides Covered Services that are required to prevent serious deterioration of Your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

- **SECTION 3 – THE SUMMARY OF BENEFITS** is deleted in its entirety and replaced with the following:

**SECTION 3  
SUMMARY OF BENEFITS/COVERED SERVICES  
PAN-AMERICAN OPEN ACCESS ELITE PLAN**

Calendar Year Deductible      Calendar Year Deductible-Family  
Network:                    \$200                    Network:                    \$400  
Non-Network:            \$400                    Non-Network:            \$800

Emergency Room-Sickness Visits Calendar Year Maximum  
After Deductible: \$1,000 (combined for Network or Non-Network Coverage)

Overall Maximum per Calendar Year (does not include Inpatient Facility Expenses)  
Inpatient & Outpatient:    \$100,000 (combined for Network and Non-Network Coverage)  
Outpatient Limited to: \$10,000 (combined for Network and Non-Network Coverage)

COVERED SERVICE	CO-PAY AMOUNT	NEED TO MEET CALENDAR YEAR DEDUCTIBLE?	NETWORK COVERAGE	NON-NETWORK COVERAGE
Hospital Inpatient. This benefit pays 100% of charges after the deductible for a total of 30 days each Calendar Year up to the following: \$3,000 per day for days 1-30 of Hospital Confinement.	\$0	Yes	100%	100%
Physician Inpatient Services.	\$0	Yes	80%	60%
Outpatient Surgery, Diagnostic, and Therapeutic Services	\$0	Yes	80%	60%
Outpatient Facility Expenses.	\$0	Yes	80%	60%
Private Duty Nursing Expenses.	\$0	Yes	80%	60%
Home Health Care Expenses.	\$0	Yes	80%	60%
Hospice Care Expenses.	\$0	Yes	80%	60%
Primary Care Doctor’s Office Visits (Non-Surgical).	\$20 per visit	No	100%	80%
Specialist Care Doctor’s Office Visits (Non-Surgical).	\$20 per visit	No	100%	80%

Urgent Care Clinic Doctor's Office Visits (Non-Surgical).	\$20 per visit	No	100%	80%
Spinal Disorder Treatment Expenses. Calendar Year maximum of 2 visits.	\$0	Yes	80%	60%
Routine Preventive Care. This benefit has a combined (Network or Non-Network) Calendar Year maximum of \$500.	\$10 per visit for Network. \$0 per visit for Non-Network	No	100%	80%
Ambulance Services Expenses.	\$0	Yes	80%	60%
Emergency Care Services.	\$0	Yes	80%	60%
Other Medical Expenses.	\$0	Yes	80%	60%

Pregnancy Coverage: Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending Physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider. Charges for such post-delivery home visits will be paid at 100% and will not be subject to any Calendar Year Deductible.
- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, Your Physician, or other health care provider may obtain such certification by calling the number shown on Your ID Card.

Preexisting Conditions

A "preexisting condition" is an injury or disease for which a person:

- received treatment or services; or
- took prescribed drugs or medicines;

during the 90 days immediately preceding the person's effective date of coverage (or, if the Plan requires You to serve a probationary period, the 90 days immediately preceding the first day of the probationary period). See the Effective Date of Coverage or Late Enrollee section of the Policy and Certificate, whichever applies, to determine a person's effective date of coverage.

For the first 365 days following such date, Covered Services do not include any expenses for treatment of a preexisting condition.

With respect to a Late Enrollee, a preexisting condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period prior to enrollment. For the first 18 months after a Late Enrollee's enrollment date, Covered Services do not include any expenses for treatment of a preexisting condition.

Special Rules As To A Preexisting Condition:

If a person had creditable coverage, then the preexisting limitation period under this Plan will be reduced by the number of days of prior creditable coverage.

As used above: "continuous creditable coverage" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Members' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.

LIMITATIONS:

Not covered are charges for a service or supply furnished by a Participating Provider that exceeds the negotiated charge agreed to by Participating Providers.

## Explanation of Some Important Plan Provisions

### Network and Non-Network Coverage Year Deductible

This is the amount of Network and Non-Network care, and other health care Covered Services You pay each Calendar Year before benefits are paid.

### Network and Non-Network Care Family Coverage Year Deductible Limit

This limit applies to all Covered Services incurred for Network, Non-Network Care, and other health care by the Employee or his/her covered dependents. After that limit is reached, the Employee and his/her covered dependents will be deemed to have met separate Network and Non-Network coverage year Deductibles. The Network and Non-Network Family Coverage Year Deductible Limit is shown in the Summary of Benefits.

- The following provisions are hereby added to **SECTION 3 – COVERED SERVICES:**

## **OUTPATIENT SURGERY, DIAGNOSTIC/THERAPEUTIC AND THERAPEUTIC SERVICES**

### **OUTPATIENT SURGICAL SERVICES**

This benefit pays for Covered Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

Surgeries performed in a Doctor's Office will be paid under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

### **OUTPATIENT DIAGNOSTIC SERVICES**

When ordered by a Physician, this benefit pays for Covered Services received on an outpatient basis at a Hospital or Alternate Facility for lab and radiology/x-ray, mammograms, bone mass measurement services, pap test, prostate cancer examination and testing.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Physician's office, benefits are described under the Doctor's Office Visits Services below. It does not include CT Scans, PET Scans, MRI's, or nuclear medicine.

### **OUTPATIENT DIAGNOSTIC/THERAPEUTIC SERVICES-CT SCANS, PET SCANS, MRI AND NUCLEAR MEDICINE**

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

Outpatient Diagnostic Services performed for CT Scans, PET Scans, MRI's, and Nuclear Medicine in a Doctor's Office will be paid under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

### **OUTPATIENT THERAPEUTIC TREATMENTS**

This benefit includes Covered Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, the charge required for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Doctor's Office, benefits are described under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

- The **PHYSICIAN OFFICE VISITS** provision is renamed and changed to read as follows:

#### **PRIMARY CARE DOCTOR'S OFFICE VISITS (NON-SURGICAL)**

We will pay for Covered Services received in a Primary Care Doctor's office for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Doctor's Office Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

A Primary Care Doctor specializes in general internal medicine, family medicine, general pediatrics, obstetrics and gynecology.

#### **SPECIALIST CARE DOCTOR'S OFFICE VISITS (NON-SURGICAL)**

We will pay for Covered Services received in a Specialist Care Doctor's office for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Doctor's Office Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

A Specialist Care Doctor is a Doctor who is not a Primary Care Physician and who provides Covered Services within the range of his or her medical specialty.

#### **URGENT CARE CLINIC VISITS (NON-SURGICAL)**

We will pay for Covered Services received in an Urgent Care Clinic for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Urgent Care Clinic Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

An Urgent Care Clinic provides services at a facility, other than a Hospital, and provides Covered Services that are required to prevent serious deterioration of the Covered Person's health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

- The **SPINAL DISORDER TREATMENT BENEFIT PROVISION** is changed to read as follows:

Covered Services include charges incurred for:

1. manipulative (adjustive) treatment; or
2. other physical treatment;

of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not more than the Spinal Disorder Treatment Maximum Visits per Coverage Year will be payable for all expenses incurred in connection with such treatment.

The maximum does not apply to expenses incurred:

- while the person is a full time inpatient in a hospital
- for treatment of scoliosis
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating physician.

- The **ROUTINE PREVENTIVE CARE EXPENSES** benefit is changed to read as follows:

Covered Services include charges made by a Physician for preventive care exams performed on a Covered Person for a reason other than to diagnose or treat a suspected or identified injury or disease.

Included as a part of the exam are:

1. X-rays, lab, and other tests given in connection with the exam; and
2. materials for the administration of immunizations for infectious disease and testing for tuberculosis.

Covered expenses for routine preventive care provided under this benefit include, but are not limited to, those charges made for:

1. Physical exams.
2. Cytological screening
3. Prostate specific antigen tests and digital rectal exams.
4. Bone mass density measurements.
5. Colon cancer examinations and laboratory tests for:
  - a. Covered persons who are fifty (50) years of age or older;
  - b. Covered persons who are less than fifty (50) years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and
  - c. Covered persons experiencing the following symptoms of colorectal cancer as determined by a licensed physician:
    - (1) Bleeding from the rectum or blood in the stool; or
    - (2) A change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.
6. Mammograms  
All costs associated with a mammogram every year for women 40 years of age or older and with any mammogram based on a physician's recommendation for women under 40 years of age.
7. Routine Pap Smears  
Covered Services include charges incurred for:
  - a. one routine gynecological exam each Calendar Year; and
  - b. an annual routine Pap smear.

Not included under this benefit are any exams; or other preventive services and supplies; which are specifically covered elsewhere in this Plan.

The most that will be paid for all covered routine preventive care expenses incurred by a Covered Person in a Calendar Year under this benefit is the Routine Preventive Care Maximum.

- The Emergency Room Sickness Visits provision is changed to read as follows:

#### **EMERGENCY CARE SERVICES**

We will pay for Covered Services incurred for Emergency Care due to an Illness or Injury for services Medically Necessary that do not result in Hospital Confinement. Emergency room benefits for an Illness will be paid for a Covered Person but will not exceed the annual Calendar Year maximum shown in the Summary of Benefits.

- The **OTHER MEDICAL EXPENSES** is changed to read as follows:

1. Covered Services include charges incurred by a Covered Person for equipment, supplies and outpatient self-management training and education for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law.

Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthotics.

Outpatient self-management training and education shall be provided under the supervision of a licensed health care professional with expertise in diabetes. Coverage for self-management education and education relating to diet and prescribed by a licensed Physician includes:

- a. visits medically necessary upon the diagnosis of diabetes;
  - b. visits under circumstances whereby a Physician identifies or diagnoses a significant change in the Covered Person's symptoms or conditions that necessitates changes in a Covered Person's self-management; and
  - c. visits where a new medication or therapeutic process relating to the Covered Person's treatment and/or management of diabetes has been identified as medically necessary by a Physician.
2. Formulas that are equivalent to a prescription drug necessary for the therapeutic treatment of rare hereditary genetic metabolic disorders. As used in this provision: Rare hereditary genetic metabolic disorders are phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.
  3. The following charges when incurred by a Dependent child are included as Covered Services even though not incurred in

connection with the treatment of a disease or injury.

#### Children's Preventive Health Care Services

Physician-delivered or physician-supervised services for eligible dependents from birth through age eighteen (18) years of age, with Periodic Preventive Care Visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards for the purposes of this section.

Periodic Preventive Care Visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice, provided at the following age intervals:

- A. Birth;
- B. Two (2) weeks;
- C. Two (2) months;
- D. Four (4) months;
- E. Six (6) months;
- F. Nine (9) months;
- G. Twelve (12) months;
- H. Fifteen (15) months;
- I. Eighteen (18) months
- J. Two (2) years;
- K. Three (3) years;
- L. Four (4) years;
- M. Five (5) years;
- N. Six (6) years;
- O. Eight (8) years;
- P. Ten (10) years;
- Q. Twelve (12) years;
- R. Fourteen (14) years;
- S. Sixteen (16) years; and
- T. Eighteen (18) years.

Benefits for recommended immunization services are payable at 100% with no deductible, copayment, coinsurance or maximum limit.

- 4. Covered Services include charges incurred for outpatient In Vitro Fertilization expenses, even though not incurred for treatment of a disease or injury by a female employee or by the dependent wife of a male employee. Expenses incurred for cryo preservation are also included.

Benefits are provided on the same basis as any other illness if all of the following tests are met:

- a. The procedures are performed while she is not confined in a hospital or any other facility as an inpatient.
- b. Her oocytes are fertilized with her husband's sperm.
- c. She and her husband have a history of infertility which has lasted at least 2 years or the infertility is associated with one or more of these conditions.
  - 1) Endometriosis;
  - 2) Exposure in utero to diethylstilbestrol; known as DES;
  - 3) Surgical removal, other than for voluntary sterilization, of one or both fallopian tubes. This is known as lateral or bilateral salpingectomy; or
  - 4) Abnormal male factors contributing to the infertility.
- d. She has been unable to attain a successful pregnancy through any less costly treatments for which coverage is available under this plan.
- e. The in vitro fertilization procedures are performed:
  - 1) at a medical facility licensed or certified by the Arkansas Department of Health; or
  - 2) certified by the Arkansas Department of Health as either:
    - a) meeting the guidelines for in vitro clinics set by the American College of Obstetricians and Gynecologists, or
    - b) meeting the American Fertility Society's minimal standards for programs of in vitro fertilization.

Not more than the In Vitro Fertilization Maximum will be paid in connection with all in vitro fertilization procedures in the person's lifetime.

5. Covered Services include charges incurred the necessary care and treatment of loss or impairment of speech or hearing payable on the same basis as any other illness.

Loss or impairment of speech or hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification.

Coverage is not provided for hearing instruments or devices.

- **SECTION 4: DESCRIPTION OF NETWORK AND NON-NETWORK BENEFITS, the NETWORK BENEFITS** provision is changed to read as follows:

#### **NETWORK BENEFITS**

Network benefits are generally paid at a higher level than Non-Network benefits. Network benefits are payable for Covered Services which are either of the following:

- Provided by or under the direction of a Network Physician or other Network Provider in the Physician's office or at a Network facility.
  - Emergency Care Services.
- The following exclusions in **SECTION 5: GENERAL EXCLUSIONS AND LIMITATIONS** are changed to read as follows:

Exclusion 7. under Expenses not covered is changed to read:

7. Dental services or supplies, except for the following procedures:
  - a. to repair damage to sound natural teeth Accidentally injured while the person is a Covered Person and the repair is done within 12 months from the date of the Injury;
  - b. to remove impacted, unerupted teeth;
  - c. Reconstructive Surgery for Craniofacial Abnormalities for dependent children under age 18; and
  - d. Anesthesia and dental care in a hospital or ambulatory surgical center for a covered person for which the provider treating the patient certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedure and who:
    - (1) is a child under age seven who is determined by two licensed dentists, to require without delay necessary dental treatment for a significantly complex dental condition; or
    - (2) is a person with a diagnosed serious mental or physical condition; or
    - (3) is a person with a significant behavioral problem as determined by the Covered Person's physician.

Exclusion 13. under Expenses not covered is changed to read:

13. Services or supplies for:
  - a. diagnosis and testing of fertility or infertility other than In Vitro Fertilization;
  - b. reversal of sterilization procedure; or
  - c. artificial insemination;

- The following provision in **SECTION 6: TERMINATION OF COVERAGE** is changed to read as follows:

#### **LIMITED EXTENSION DUE TO TOTAL DISABILITY**

A Covered Person's benefits will continue to be payable under the Plan when the Policy terminates, if he;

- A. Is Totally Disabled; and
- B. Is confined to a Hospital for the disabling Illness or Injury at the date the Policy would otherwise terminate.

Benefits paid under this extension will be paid until the earliest of these dates:

- A. The date which is ninety (90) days from the date coverage would have otherwise terminated; or
- B. The date the Covered Person is no longer Hospital confined; or
- C. The date on which the disabled person's Medical Benefit has reached the applicable maximum under the Plan.

This extension of coverage applies only to the disabled person and no premium is due.

- **SECTION 9: CONTINUATION OF COVERAGE** is changed to read as follows:

As an alternative to continuation of coverage under COBRA, the following continuation provisions are available to the following Covered Persons:

- Employees whose coverage ends for any reason other than termination of this policy or termination of the class in which the employee was insured.
- The surviving spouse or divorced spouse of an employee whose coverage would otherwise terminate as a result of the divorce or the death of the employee.

Continuation is not available to:

- Employees whose coverage ends because of failure to pay any required contribution towards the cost of their coverage under the policy.
- Covered Persons who are eligible for Medicare.
- Covered Persons whose coverage is replaced by another group medical plan within 31 days after coverage under this policy terminates.
- Covered Persons who have not been insured for at least three months on the date their coverage under this policy ends.

Continuation of coverage is subject to payment of premium to the Policyholder by the Covered Person. The premium will be the amount of premium the Policyholder would pay for the coverage if the Covered Person was insured under this policy in the absence of this continuation provision, including amounts paid towards premium by the Policyholder and by the employee.

Coverage under this policy may be continued for up to 120 days after the month in which coverage under this policy would otherwise terminate except:

- Covered Persons whose coverage would end as a result of the divorce or death of the employee may continue coverage for up to 15 months after the end of the month in which coverage under this policy would otherwise terminate. Such continuation is subject to the Covered Person paying premium to the Policyholder in advance in three month increments.
- Covered Persons who are pregnant when coverage under this policy would otherwise terminate may continue coverage subject to the Covered Person paying premium to the Policyholder in advance in three month increments. Coverage may be continued for up to six months after the pregnancy ends, or if longer, the end of the second three month period following the three month period in which the pregnancy ends.

A Covered Person is eligible for Conversion at the end of this continuation period.

- **SECTION 10 – CONVERSION** is changed to read as follows:

Any Employee whose insurance under this Policy has been terminated for any reason, including discontinuance of this Policy in its entirety or discontinuance of an insured class will be entitled to have issued by Us an individual policy of health insurance (hereafter referred to as the "converted policy"). This provision only applies to individuals whose coverage terminates at the end of any COBRA or state continuation provision provided in the Policy. The converted policy may provide levels which are substantially similar to those provide under this Policy.

A Employee will not be entitled to have a converted policy issued if termination of the insurance under this Policy occurred for any of the following reasons:

- a. the Employee failed to pay any required contribution;
- b. any discontinued group coverage was immediately replaced by similar group coverage unless such person was declined coverage under the replacing group coverage; or

- c. The person is, or could be, covered for Medicare benefits or similar benefits provided by any state or federal law, similar benefits provided on a group or individual basis or any benefits provided above which, together with the benefits provided under the conversion policy, would result in over-insurance.

Written application for the converted policy must be made and the first premium paid to Us not later than thirty-one (31) days after such termination. The converted policy will be issued without evidence of insurability.

The effective date of the converted policy will be the day following the termination of insurance under this Policy. The converted policy will cover the Employee and any dependents who were covered by this Policy on the date of termination of insurance.

This conversion privilege may be exercised at the Employee's option at the end of any COBRA or state continuation of coverage provision provided under the group policy and will be available to the following:

1. the surviving spouse, if any, of the Employee with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or
  2. the spouse of the Employee with respect to the spouse and children whose coverage terminates because the spouse ceases to be a qualified family member and while the Employee remains insured under the group policy, or
  3. a child solely upon termination of the coverage by reason of ceasing to be a qualified family member under the group policy, or
  4. the former spouse whose coverage under the group policy terminates by reason of an entry of a valid decree of divorce between the insured and spouse.
- The **TIME PAYMENT OF CLAIMS** provision in **SECTION 12: UNIFORM CLAIMS PROVISION** is changed to read as follows:

**TIME PAYMENT OF CLAIMS**

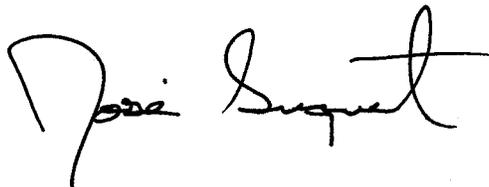
Benefits payable under the Plan will be paid immediately after receipt of due written proof of claim. If all essential information needed to make a determination on the claim is not received, then the thirty (60) days will not be effective until all required information is received by Us.

Except as amended herein, all terms, conditions, limitations and exclusions of the Policy to which this Amendment is attached will remain in full force and effect.

Payment of premium on or after the effective date of this Amendment shall constitute acceptance by the Plan Sponsor and Plan Participant of the modifications contained herein.

IN WITNESS WHEREOF, the Insurance Company has caused this Amendment to be executed by its President.

PAN-AMERICAN LIFE INSURANCE COMPANY



Chairman of the Board  
President and Chief Executive Officer

**PAN-AMERICAN LIFE INSURANCE COMPANY**

**PAN-AMERICAN LIFE CENTER  
601 Poydras Street  
New Orleans, Louisiana 70130  
TOLL FREE: 1-866-781-6736**

**GROUP HOSPITAL, SURGICAL AND MEDICAL CERTIFICATE AMENDMENT  
FOR RESIDENTS OF THE STATE OF ARKANSAS**

ATTACHED TO AND MADE A PART OF THE CERTIFICATE ISSUED TO EMPLOYEES OF SPECTAGUARD ACQUISITIONS, LLC DBA ALLIEDBARTON SECURITY SERVICES.

POLICYHOLDER PLAN NO. \_\_\_\_\_

**TELEPHONE NUMBER FOR INQUIRIES**

**If You have questions about this policy, need information about coverage, or need assistance resolving a complaint, please call the following toll free number: 1-866-781-6736**

This amendment is effective for claims incurred on or after January 1, 2009.

If you reside permanently in the state of Arkansas, the Certificate/booklet to which this Amendment is attached and becomes a part is amended as stated below to conform to the requirements of the state of Arkansas. In the event of a conflict between the Certificate/booklet and this Amendment, the provisions resulting in greater benefits will be in effect.

The following changes apply:

- The following subsections in the **SECTION I: ENROLLMENT AND EFFECTIVE DATE OF COVERAGE** are changed to read as follows:
- **WHO IS AN ELIGIBLE EMPLOYEE?**

Employees working at least an average of 35 hours per week who have completed 3 months of employment.

**TO BE ELIGIBLE TO ENROLL AS A DEPENDENT, YOU MUST:**

1. Be the legal spouse of the Member; or
2. Be the natural child, step-child, or adopted child of the Member; or the child for whom the Member is the legal guardian, or the child who is the subject of a lawsuit for adoption by the Member, if the Member has the legal responsibility for the health of the child, or the child supported pursuant to a court order imposed on the Member (including a qualified medical child support order) or a grandchild of the Member who is also a Dependent of the Member for federal income tax purposes, provided that child:
  - a. Is unmarried and legally dependent upon the Member for support;
  - b. Has not reached age nineteen (19);
  - c. Is age nineteen (19) but less than age twenty-five (25) and is a full-time student; or
  - d. Is age nineteen (19) or older and is incapable of self-sustaining support because of mental retardation or a physical handicap which existed prior to attaining nineteen (19) years of age. You must submit proof of the child's condition and dependence to Us after the date the child ceases to qualify as a Dependent under section (b) above.

A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 20 or more hours weekly for six or more months.

## ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

### B. Enrollment after an Open Enrollment Period

1. If, after the Open Enrollment Period, You become eligible for coverage as a Member or a Dependent, You may enroll as a Member within thirty-one (31) days of the day on which You met the eligibility criteria. To enroll, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, Your effective date of coverage will be the day on which You meet the eligibility criteria.
2. If You are a Member who is enrolled for Employee coverage only, You may enroll a newborn child prior to the birth of the child or within thirty-one (31) days after the child's birth. Newborn children of the Member are covered for the first thirty-one (31) days after birth. To enroll a newborn child, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, the effective date of coverage for Your newborn child will be the date of his birth.
3. If You are a Member who is enrolled for Employee and family coverage, You may enroll a newborn child prior to the birth of the child or within ninety (90) days after the child's birth. Newborn children of the Member are covered for the first ninety (90) days after birth. To enroll a newborn child, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, the effective date of coverage for Your newborn child will be the date of his birth.
4. If You are a Member who is enrolled for Employee coverage only, You may enroll an adopted child or child for whom You have been granted legal guardianship within thirty-one (31) days of the date the child is legally placed with You for adoption or within thirty-one (31) days of the date You are granted legal guardianship. To enroll an adopted child or a child for whom You are the legal guardian, You must submit an Enrollment Application, together with any additional premium due.
5. If You are a Member who is enrolled for Employee and family coverage, You may enroll an adopted child or child for whom You have been granted legal guardianship within sixty (60) days of the date the child is legally placed with You for adoption or within sixty (60) days of the date You are granted legal guardianship. To enroll an adopted child or a child for whom You are the legal guardian, You must submit an Enrollment Application, together with any additional premium due.

### F. Late Enrollee

A "Late Enrollee" is a person (including Yourself) for whom You do not elect coverage within 31 days of the date the person becomes eligible for such coverage.

An eligible Employee or Dependent will be required to provide proof of good health, at his cost, if he applies for coverage more than thirty-one (31) days after he becomes eligible or if he applies for reinstatement of coverage that was cancelled at his request.

Exceptions:

- A person will not be considered to be a Late Enrollee if all of the following are met:
    - You did not elect coverage for the person involved within 31 days of the date You were first eligible (or during an open enrollment) because at that time the person was covered under other creditable coverage; and
  - the person loses such coverage because:
    - a. of termination of employment in a class eligible for such coverage;
    - b. of reduction in hours of employment;
    - c. Your spouse dies;
    - d. You and Your spouse divorce or are legally separated;
    - e. such coverage was COBRA continuation and such continuation was exhausted; or
    - f. the other plan terminates due to the employer's failure to pay the premium or for any other reason; and
  - You elect coverage within 31 days of the date the person loses coverage for one of the above reasons.
- If You are not considered a Late Enrollee, coverage will become effective on the date of the election. Any limitation as to a

preexisting condition may apply.

### **Additional Exceptions**

Also, a person will not be considered a Late Enrollee if You did not elect, when the person was first eligible, coverage for:

- A child who meets the definition of a Dependent, but You elect it later in compliance with a court order requiring You to provide such coverage for Your Dependent child. Such coverage will become effective on the date specified by the Policyholder. Any limitation as to a preexisting condition may apply.
- A spouse, but You elect it later and within 31 days of a court order requiring You to provide such coverage for Your Dependent spouse. Such coverage will become effective on the date of the court order. Any limitation as to a preexisting condition may apply.
- Yourself and You subsequently acquire a Dependent, through marriage, and You subsequently elect coverage for Yourself and any such Dependent within 31 days of acquiring such Dependent. Such coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.
- Yourself and You subsequently acquire a Dependent, through birth, adoption, or placement for adoption, and You subsequently elect coverage for Yourself and any such Dependent within 31 days of acquiring such Dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with You for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.
- Yourself and Your spouse and You subsequently acquire a Dependent through birth, adoption, or placement for adoption, and You subsequently elect coverage for Yourself, Your spouse, and any such Dependent within 90 days of acquiring such Dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with You for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

### **G. Special Rules Which Apply to an Adopted Child**

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of Dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date Your coverage becomes effective; and
- You make written request for coverage for the child within 31 days (60 days if You already have Dependents covered) of the date the child is placed with You for adoption.

Coverage for the child will become effective on the date the child is placed with You for adoption. If request is not made within such 31 days (60 days if You already have Dependents covered), coverage for the child will be subject to all of the terms of this Plan.

- The definition of **HOSPITAL** is changed to read as follows:

An institution, operated as required by law, which is all of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.
- Is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or by the American Osteopathic Hospital Association.

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

- The following definitions are added to the **DEFINITIONS** section:

MMPAL-2008-C-AMDT-2-AR

**PRIMARY CARE DOCTOR/PHYSICIAN**

A Physician who specializes in general internal medicine, family medicine, general pediatrics, obstetrics and gynecology.

**SPECIALIST CARE DOCTOR/PHYSICIAN**

A Physician who is not a Primary Care Physician and who provides Covered Services within the range of his or her medical specialty.

**URGENT CARE CLINIC**

A facility, other than a Hospital, that provides Covered Services that are required to prevent serious deterioration of Your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

- **SECTION 3 – THE SUMMARY OF BENEFITS** is deleted in its entirety and replaced with the following:

**SECTION 3  
SUMMARY OF BENEFITS/COVERED SERVICES  
PAN-AMERICAN OPEN ACCESS PLUS PLAN**

Calendar Year Deductible      Calendar Year Deductible-Family  
Network:                    \$250                    Network:                    \$500  
Non-Network:            \$500                    Non-Network:            \$1,000

Emergency Room-Sickness Visits Calendar Year Maximum  
After Deductible: \$1,000 (combined for Network or Non-Network Coverage)

Overall Maximum per Calendar Year (does not include Inpatient Facility Expenses)  
Inpatient & Outpatient:    \$50,000 (combined for Network and Non-Network Coverage)  
Outpatient Limited to: \$7,500 (combined for Network and Non-Network Coverage)

COVERED SERVICE	CO-PAY AMOUNT	NEED TO MEET CALENDAR YEAR DEDUCTIBLE?	NETWORK COVERAGE	NON-NETWORK COVERAGE
Hospital Inpatient. This benefit pays 100% of charges after the deductible for a total of 30 days each Calendar Year up to the following: \$2,000 per day for days 1-30 of Hospital Confinement.	\$0	Yes	100%	100%
Physician Inpatient Services.	\$0	Yes	80%	60%
Outpatient Surgery, Diagnostic, and Therapeutic Services	\$0	Yes	80%	60%
Outpatient Facility Expenses.	\$0	Yes	80%	60%
Private Duty Nursing Expenses.	\$0	Yes	80%	60%
Home Health Care Expenses.	\$0	Yes	80%	60%
Hospice Care Expenses.	\$0	Yes	80%	60%
Primary Care Doctor’s Office Visits (Non-Surgical).	\$20 per visit	No	100%	80%
Specialist Care Doctor’s Office Visits (Non-Surgical).	\$20 per visit	No	100%	80%

Urgent Care Clinic Doctor's Office Visits (Non-Surgical).	\$20 per visit	No	100%	80%
Spinal Disorder Treatment Expenses. Calendar Year maximum of 2 visits.	\$0	Yes	80%	60%
Routine Preventive Care. This benefit has a combined (Network or Non-Network) Calendar Year maximum of \$250.	\$10 per visit for Network. \$0 per visit for Non-Network	No	100%	80%
Ambulance Services Expenses.	\$0	Yes	80%	60%
Emergency Care Services.	\$0	Yes	80%	60%
Other Medical Expenses.	\$0	Yes	80%	60%

Pregnancy Coverage: Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending Physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider. Charges for such post-delivery home visits will be paid at 100% and will not be subject to any Calendar Year Deductible.
- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, Your Physician, or other health care provider may obtain such certification by calling the number shown on Your ID Card.

#### Preexisting Conditions

A "preexisting condition" is an injury or disease for which a person:

- received treatment or services; or
- took prescribed drugs or medicines;

during the 90 days immediately preceding the person's effective date of coverage (or, if the Plan requires You to serve a probationary period, the 90 days immediately preceding the first day of the probationary period). See the Effective Date of Coverage or Late Enrollee section of the Policy and Certificate, whichever applies, to determine a person's effective date of coverage.

For the first 365 days following such date, Covered Services do not include any expenses for treatment of a preexisting condition.

With respect to a Late Enrollee, a preexisting condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period prior to enrollment. For the first 18 months after a Late Enrollee's enrollment date, Covered Services do not include any expenses for treatment of a preexisting condition.

#### Special Rules As To A Preexisting Condition:

If a person had creditable coverage, then the preexisting limitation period under this Plan will be reduced by the number of days of prior creditable coverage.

As used above: "continuous creditable coverage" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Members' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.

#### LIMITATIONS:

Not covered are charges for a service or supply furnished by a Participating Provider that exceeds the negotiated charge agreed to by Participating Providers.

## Explanation of Some Important Plan Provisions

### Network and Non-Network Coverage Year Deductible

This is the amount of Network and Non-Network care, and other health care Covered Services You pay each Calendar Year before benefits are paid.

### Network and Non-Network Care Family Coverage Year Deductible Limit

This limit applies to all Covered Services incurred for Network, Non-Network Care, and other health care by the Employee or his/her covered dependents. After that limit is reached, the Employee and his/her covered dependents will be deemed to have met separate Network and Non-Network coverage year Deductibles. The Network and Non-Network Family Coverage Year Deductible Limit is shown in the Summary of Benefits.

- The following provisions are hereby added to **SECTION 3 – COVERED SERVICES:**

## **OUTPATIENT SURGERY, DIAGNOSTIC/THERAPEUTIC AND THERAPEUTIC SERVICES**

### **OUTPATIENT SURGICAL SERVICES**

This benefit pays for Covered Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

Surgeries performed in a Doctor's Office will be paid under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

### **OUTPATIENT DIAGNOSTIC SERVICES**

When ordered by a Physician, this benefit pays for Covered Services received on an outpatient basis at a Hospital or Alternate Facility for lab and radiology/x-ray, mammograms, bone mass measurement services, pap test, prostate cancer examination and testing.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Physician's office, benefits are described under the Doctor's Office Visits Services below. It does not include CT Scans, PET Scans, MRI's, or nuclear medicine.

### **OUTPATIENT DIAGNOSTIC/THERAPEUTIC SERVICES-CT SCANS, PET SCANS, MRI AND NUCLEAR MEDICINE**

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

Outpatient Diagnostic Services performed for CT Scans, PET Scans, MRI's, and Nuclear Medicine in a Doctor's Office will be paid under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

### **OUTPATIENT THERAPEUTIC TREATMENTS**

This benefit includes Covered Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, the charge required for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Doctor's Office, benefits are described under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

- The **PHYSICIAN OFFICE VISITS** provision is renamed and changed to read as follows:

#### **PRIMARY CARE DOCTOR'S OFFICE VISITS (NON-SURGICAL)**

We will pay for Covered Services received in a Primary Care Doctor's office for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Doctor's Office Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

A Primary Care Doctor specializes in general internal medicine, family medicine, general pediatrics, obstetrics and gynecology.

#### **SPECIALIST CARE DOCTOR'S OFFICE VISITS (NON-SURGICAL)**

We will pay for Covered Services received in a Specialist Care Doctor's office for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Doctor's Office Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

A Specialist Care Doctor is a Doctor who is not a Primary Care Physician and who provides Covered Services within the range of his or her medical specialty.

#### **URGENT CARE CLINIC VISITS (NON-SURGICAL)**

We will pay for Covered Services received in an Urgent Care Clinic for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Urgent Care Clinic Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

An Urgent Care Clinic provides services at a facility, other than a Hospital, and provides Covered Services that are required to prevent serious deterioration of the Covered Person's health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

- The **SPINAL DISORDER TREATMENT BENEFIT PROVISION** is changed to read as follows:

Covered Services include charges incurred for:

1. manipulative (adjustive) treatment; or
2. other physical treatment;

of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not more than the Spinal Disorder Treatment Maximum Visits per Coverage Year will be payable for all expenses incurred in connection with such treatment.

The maximum does not apply to expenses incurred:

- while the person is a full time inpatient in a hospital
- for treatment of scoliosis
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating physician.

- The **ROUTINE PREVENTIVE CARE EXPENSES** benefit is changed to read as follows:

Covered Services include charges made by a Physician for preventive care exams performed on a Covered Person for a reason other than to diagnose or treat a suspected or identified injury or disease.

Included as a part of the exam are:

1. X-rays, lab, and other tests given in connection with the exam; and
2. materials for the administration of immunizations for infectious disease and testing for tuberculosis.

Covered expenses for routine preventive care provided under this benefit include, but are not limited to, those charges made for:

1. Physical exams.
2. Cytological screening
3. Prostate specific antigen tests and digital rectal exams.
4. Bone mass density measurements.
5. Colon cancer examinations and laboratory tests for:
  - a. Covered persons who are fifty (50) years of age or older;
  - b. Covered persons who are less than fifty (50) years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and
  - c. Covered persons experiencing the following symptoms of colorectal cancer as determined by a licensed physician:
    - (1) Bleeding from the rectum or blood in the stool; or
    - (2) A change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.
6. Mammograms  
All costs associated with a mammogram every year for women 40 years of age or older and with any mammogram based on a physician's recommendation for women under 40 years of age.
7. Routine Pap Smears  
Covered Services include charges incurred for:
  - a. one routine gynecological exam each Calendar Year; and
  - b. an annual routine Pap smear.

Not included under this benefit are any exams; or other preventive services and supplies; which are specifically covered elsewhere in this Plan.

The most that will be paid for all covered routine preventive care expenses incurred by a Covered Person in a Calendar Year under this benefit is the Routine Preventive Care Maximum.

- The Emergency Room Sickness Visits provision is changed to read as follows:

#### **EMERGENCY CARE SERVICES**

We will pay for Covered Services incurred for Emergency Care due to an Illness or Injury for services Medically Necessary that do not result in Hospital Confinement. Emergency room benefits for an Illness will be paid for a Covered Person but will not exceed the annual Calendar Year maximum shown in the Summary of Benefits.

- The **OTHER MEDICAL EXPENSES** is changed to read as follows:

1. Covered Services include charges incurred by a Covered Person for equipment, supplies and outpatient self-management training and education for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law.

Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthotics.

Outpatient self-management training and education shall be provided under the supervision of a licensed health care professional with expertise in diabetes. Coverage for self-management education and education relating to diet and prescribed by a licensed Physician includes:

- a. visits medically necessary upon the diagnosis of diabetes;
  - b. visits under circumstances whereby a Physician identifies or diagnoses a significant change in the Covered Person's symptoms or conditions that necessitates changes in a Covered Person's self-management; and
  - c. visits where a new medication or therapeutic process relating to the Covered Person's treatment and/or management of diabetes has been identified as medically necessary by a Physician.
2. Formulas that are equivalent to a prescription drug necessary for the therapeutic treatment of rare hereditary genetic metabolic disorders. As used in this provision: Rare hereditary genetic metabolic disorders are phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.
  3. The following charges when incurred by a Dependent child are included as Covered Services even though not incurred in

connection with the treatment of a disease or injury.

#### Children's Preventive Health Care Services

Physician-delivered or physician-supervised services for eligible dependents from birth through age eighteen (18) years of age, with Periodic Preventive Care Visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards for the purposes of this section.

Periodic Preventive Care Visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice, provided at the following age intervals:

- A. Birth;
- B. Two (2) weeks;
- C. Two (2) months;
- D. Four (4) months;
- E. Six (6) months;
- F. Nine (9) months;
- G. Twelve (12) months;
- H. Fifteen (15) months;
- I. Eighteen (18) months
- J. Two (2) years;
- K. Three (3) years;
- L. Four (4) years;
- M. Five (5) years;
- N. Six (6) years;
- O. Eight (8) years;
- P. Ten (10) years;
- Q. Twelve (12) years;
- R. Fourteen (14) years;
- S. Sixteen (16) years; and
- T. Eighteen (18) years.

Benefits for recommended immunization services are payable at 100% with no deductible, copayment, coinsurance or maximum limit.

- 4. Covered Services include charges incurred for outpatient In Vitro Fertilization expenses, even though not incurred for treatment of a disease or injury by a female employee or by the dependent wife of a male employee. Expenses incurred for cryo preservation are also included.

Benefits are provided on the same basis as any other illness if all of the following tests are met:

- a. The procedures are performed while she is not confined in a hospital or any other facility as an inpatient.
- b. Her oocytes are fertilized with her husband's sperm.
- c. She and her husband have a history of infertility which has lasted at least 2 years or the infertility is associated with one or more of these conditions.
  - 1) Endometriosis;
  - 2) Exposure in utero to diethylstilbestrol; known as DES;
  - 3) Surgical removal, other than for voluntary sterilization, of one or both fallopian tubes. This is known as lateral or bilateral salpingectomy; or
  - 4) Abnormal male factors contributing to the infertility.
- d. She has been unable to attain a successful pregnancy through any less costly treatments for which coverage is available under this plan.
- e. The in vitro fertilization procedures are performed:
  - 1) at a medical facility licensed or certified by the Arkansas Department of Health; or
  - 2) certified by the Arkansas Department of Health as either:
    - a) meeting the guidelines for in vitro clinics set by the American College of Obstetricians and Gynecologists, or
    - b) meeting the American Fertility Society's minimal standards for programs of in vitro fertilization.

Not more than the In Vitro Fertilization Maximum will be paid in connection with all in vitro fertilization procedures in the person's lifetime.

5. Covered Services include charges incurred the necessary care and treatment of loss or impairment of speech or hearing payable on the same basis as any other illness.

Loss or impairment of speech or hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification.

Coverage is not provided for hearing instruments or devices.

- **SECTION 4: DESCRIPTION OF NETWORK AND NON-NETWORK BENEFITS, the NETWORK BENEFITS** provision is changed to read as follows:

#### **NETWORK BENEFITS**

Network benefits are generally paid at a higher level than Non-Network benefits. Network benefits are payable for Covered Services which are either of the following:

- Provided by or under the direction of a Network Physician or other Network Provider in the Physician's office or at a Network facility.
  - Emergency Care Services.
- The following exclusions in **SECTION 5: GENERAL EXCLUSIONS AND LIMITATIONS** are changed to read as follows:

Exclusion 7. under Expenses not covered is changed to read:

7. Dental services or supplies, except for the following procedures:
  - a. to repair damage to sound natural teeth Accidentally injured while the person is a Covered Person and the repair is done within 12 months from the date of the Injury;
  - b. to remove impacted, unerupted teeth;
  - c. Reconstructive Surgery for Craniofacial Abnormalities for dependent children under age 18; and
  - d. Anesthesia and dental care in a hospital or ambulatory surgical center for a covered person for which the provider treating the patient certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedure and who:
    - (1) is a child under age seven who is determined by two licensed dentists, to require without delay necessary dental treatment for a significantly complex dental condition; or
    - (2) is a person with a diagnosed serious mental or physical condition; or
    - (3) is a person with a significant behavioral problem as determined by the Covered Person's physician.

Exclusion 13. under Expenses not covered is changed to read:

13. Services or supplies for:
  - a. diagnosis and testing of fertility or infertility other than In Vitro Fertilization;
  - b. reversal of sterilization procedure; or
  - c. artificial insemination;

- The following provision in **SECTION 6: TERMINATION OF COVERAGE** is changed to read as follows:

#### **LIMITED EXTENSION DUE TO TOTAL DISABILITY**

A Covered Person's benefits will continue to be payable under the Plan when the Policy terminates, if he;

- A. Is Totally Disabled; and
- B. Is confined to a Hospital for the disabling Illness or Injury at the date the Policy would otherwise terminate.

Benefits paid under this extension will be paid until the earliest of these dates:

- A. The date which is ninety (90) days from the date coverage would have otherwise terminated; or
- B. The date the Covered Person is no longer Hospital confined; or
- C. The date on which the disabled person's Medical Benefit has reached the applicable maximum under the Plan.

This extension of coverage applies only to the disabled person and no premium is due.

- **SECTION 9: CONTINUATION OF COVERAGE** is changed to read as follows:

As an alternative to continuation of coverage under COBRA, the following continuation provisions are available to the following Covered Persons:

- Employees whose coverage ends for any reason other than termination of this policy or termination of the class in which the employee was insured.
- The surviving spouse or divorced spouse of an employee whose coverage would otherwise terminate as a result of the divorce or the death of the employee.

Continuation is not available to:

- Employees whose coverage ends because of failure to pay any required contribution towards the cost of their coverage under the policy.
- Covered Persons who are eligible for Medicare.
- Covered Persons whose coverage is replaced by another group medical plan within 31 days after coverage under this policy terminates.
- Covered Persons who have not been insured for at least three months on the date their coverage under this policy ends.

Continuation of coverage is subject to payment of premium to the Policyholder by the Covered Person. The premium will be the amount of premium the Policyholder would pay for the coverage if the Covered Person was insured under this policy in the absence of this continuation provision, including amounts paid towards premium by the Policyholder and by the employee.

Coverage under this policy may be continued for up to 120 days after the month in which coverage under this policy would otherwise terminate except:

- Covered Persons whose coverage would end as a result of the divorce or death of the employee may continue coverage for up to 15 months after the end of the month in which coverage under this policy would otherwise terminate. Such continuation is subject to the Covered Person paying premium to the Policyholder in advance in three month increments.
- Covered Persons who are pregnant when coverage under this policy would otherwise terminate may continue coverage subject to the Covered Person paying premium to the Policyholder in advance in three month increments. Coverage may be continued for up to six months after the pregnancy ends, or if longer, the end of the second three month period following the three month period in which the pregnancy ends.

A Covered Person is eligible for Conversion at the end of this continuation period.

- **SECTION 10 – CONVERSION** is changed to read as follows:

Any Employee whose insurance under this Policy has been terminated for any reason, including discontinuance of this Policy in its entirety or discontinuance of an insured class will be entitled to have issued by Us an individual policy of health insurance (hereafter referred to as the "converted policy"). This provision only applies to individuals whose coverage terminates at the end of any COBRA or state continuation provision provided in the Policy. The converted policy may provide levels which are substantially similar to those provide under this Policy.

A Employee will not be entitled to have a converted policy issued if termination of the insurance under this Policy occurred for any of the following reasons:

- a. the Employee failed to pay any required contribution;
- b. any discontinued group coverage was immediately replaced by similar group coverage unless such person was declined coverage under the replacing group coverage; or

- c. The person is, or could be, covered for Medicare benefits or similar benefits provided by any state or federal law, similar benefits provided on a group or individual basis or any benefits provided above which, together with the benefits provided under the conversion policy, would result in over-insurance.

Written application for the converted policy must be made and the first premium paid to Us not later than thirty-one (31) days after such termination. The converted policy will be issued without evidence of insurability.

The effective date of the converted policy will be the day following the termination of insurance under this Policy. The converted policy will cover the Employee and any dependents who were covered by this Policy on the date of termination of insurance.

This conversion privilege may be exercised at the Employee's option at the end of any COBRA or state continuation of coverage provision provided under the group policy and will be available to the following:

1. the surviving spouse, if any, of the Employee with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or
  2. the spouse of the Employee with respect to the spouse and children whose coverage terminates because the spouse ceases to be a qualified family member and while the Employee remains insured under the group policy, or
  3. a child solely upon termination of the coverage by reason of ceasing to be a qualified family member under the group policy, or
  4. the former spouse whose coverage under the group policy terminates by reason of an entry of a valid decree of divorce between the insured and spouse.
- The **TIME PAYMENT OF CLAIMS** provision in **SECTION 12: UNIFORM CLAIMS PROVISION** is changed to read as follows:

**TIME PAYMENT OF CLAIMS**

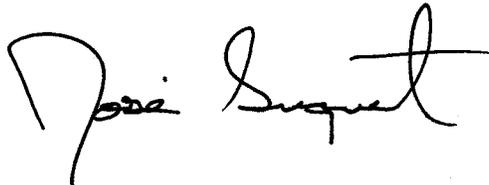
Benefits payable under the Plan will be paid immediately after receipt of due written proof of claim. If all essential information needed to make a determination on the claim is not received, then the thirty (60) days will not be effective until all required information is received by Us.

Except as amended herein, all terms, conditions, limitations and exclusions of the Policy to which this Amendment is attached will remain in full force and effect.

Payment of premium on or after the effective date of this Amendment shall constitute acceptance by the Plan Sponsor and Plan Participant of the modifications contained herein.

IN WITNESS WHEREOF, the Insurance Company has caused this Amendment to be executed by its President.

PAN-AMERICAN LIFE INSURANCE COMPANY



Chairman of the Board  
President and Chief Executive Officer

**PAN-AMERICAN LIFE INSURANCE COMPANY**

**PAN-AMERICAN LIFE CENTER  
601 Poydras Street  
New Orleans, Louisiana 70130  
TOLL FREE: 1-866-781-6736**

**GROUP HOSPITAL, SURGICAL AND MEDICAL CERTIFICATE AMENDMENT  
FOR RESIDENTS OF THE STATE OF ARKANSAS**

ATTACHED TO AND MADE A PART OF THE CERTIFICATE ISSUED TO EMPLOYEES OF SPECTAGUARD ACQUISITIONS, LLC DBA ALLIEDBARTON SECURITY SERVICES.

POLICYHOLDER PLAN NO. \_\_\_\_\_

**TELEPHONE NUMBER FOR INQUIRIES**

**If You have questions about this policy, need information about coverage, or need assistance resolving a complaint, please call the following toll free number: 1-866-781-6736**

This amendment is effective for claims incurred on or after January 1, 2009.

If you reside permanently in the state of Arkansas, the Certificate/booklet to which this Amendment is attached and becomes a part is amended as stated below to conform to the requirements of the state of Arkansas. In the event of a conflict between the Certificate/booklet and this Amendment, the provisions resulting in greater benefits will be in effect.

The following changes apply:

- The following subsections in the **SECTION I: ENROLLMENT AND EFFECTIVE DATE OF COVERAGE** are changed to read as follows:
- **WHO IS AN ELIGIBLE EMPLOYEE?**

Employees working at least an average of 35 hours per week who have completed 3 months of employment.

**TO BE ELIGIBLE TO ENROLL AS A DEPENDENT, YOU MUST:**

1. Be the legal spouse of the Member; or
2. Be the natural child, step-child, or adopted child of the Member; or the child for whom the Member is the legal guardian, or the child who is the subject of a lawsuit for adoption by the Member, if the Member has the legal responsibility for the health of the child, or the child supported pursuant to a court order imposed on the Member (including a qualified medical child support order) or a grandchild of the Member who is also a Dependent of the Member for federal income tax purposes, provided that child:
  - a. Is unmarried and legally dependent upon the Member for support;
  - b. Has not reached age nineteen (19);
  - c. Is age nineteen (19) but less than age twenty-five (25) and is a full-time student; or
  - d. Is age nineteen (19) or older and is incapable of self-sustaining support because of mental retardation or a physical handicap which existed prior to attaining nineteen (19) years of age. You must submit proof of the child's condition and dependence to Us after the date the child ceases to qualify as a Dependent under section (b) above.

A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 20 or more hours weekly for six or more months.

## ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

### B. Enrollment after an Open Enrollment Period

1. If, after the Open Enrollment Period, You become eligible for coverage as a Member or a Dependent, You may enroll as a Member within thirty-one (31) days of the day on which You met the eligibility criteria. To enroll, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, Your effective date of coverage will be the day on which You meet the eligibility criteria.
2. If You are a Member who is enrolled for Employee coverage only, You may enroll a newborn child prior to the birth of the child or within thirty-one (31) days after the child's birth. Newborn children of the Member are covered for the first thirty-one (31) days after birth. To enroll a newborn child, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, the effective date of coverage for Your newborn child will be the date of his birth.
3. If You are a Member who is enrolled for Employee and family coverage, You may enroll a newborn child prior to the birth of the child or within ninety (90) days after the child's birth. Newborn children of the Member are covered for the first ninety (90) days after birth. To enroll a newborn child, You must submit an Enrollment Application, together with any additional premium due. If so enrolled, the effective date of coverage for Your newborn child will be the date of his birth.
4. If You are a Member who is enrolled for Employee coverage only, You may enroll an adopted child or child for whom You have been granted legal guardianship within thirty-one (31) days of the date the child is legally placed with You for adoption or within thirty-one (31) days of the date You are granted legal guardianship. To enroll an adopted child or a child for whom You are the legal guardian, You must submit an Enrollment Application, together with any additional premium due.
5. If You are a Member who is enrolled for Employee and family coverage, You may enroll an adopted child or child for whom You have been granted legal guardianship within sixty (60) days of the date the child is legally placed with You for adoption or within sixty (60) days of the date You are granted legal guardianship. To enroll an adopted child or a child for whom You are the legal guardian, You must submit an Enrollment Application, together with any additional premium due.

### F. Late Enrollee

A "Late Enrollee" is a person (including Yourself) for whom You do not elect coverage within 31 days of the date the person becomes eligible for such coverage.

An eligible Employee or Dependent will be required to provide proof of good health, at his cost, if he applies for coverage more than thirty-one (31) days after he becomes eligible or if he applies for reinstatement of coverage that was cancelled at his request.

Exceptions:

- A person will not be considered to be a Late Enrollee if all of the following are met:
  - You did not elect coverage for the person involved within 31 days of the date You were first eligible (or during an open enrollment) because at that time the person was covered under other creditable coverage; and
- the person loses such coverage because:
  - a. of termination of employment in a class eligible for such coverage;
  - b. of reduction in hours of employment;
  - c. Your spouse dies;
  - d. You and Your spouse divorce or are legally separated;
  - e. such coverage was COBRA continuation and such continuation was exhausted; or
  - f. the other plan terminates due to the employer's failure to pay the premium or for any other reason; and
- You elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

If You are not considered a Late Enrollee, coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

### **Additional Exceptions**

Also, a person will not be considered a Late Enrollee if You did not elect, when the person was first eligible, coverage for:

- A child who meets the definition of a Dependent, but You elect it later in compliance with a court order requiring You to provide such coverage for Your Dependent child. Such coverage will become effective on the date specified by the Policyholder. Any limitation as to a preexisting condition may apply.
- A spouse, but You elect it later and within 31 days of a court order requiring You to provide such coverage for Your Dependent spouse. Such coverage will become effective on the date of the court order. Any limitation as to a preexisting condition may apply.
- Yourself and You subsequently acquire a Dependent, through marriage, and You subsequently elect coverage for Yourself and any such Dependent within 31 days of acquiring such Dependent. Such coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.
- Yourself and You subsequently acquire a Dependent, through birth, adoption, or placement for adoption, and You subsequently elect coverage for Yourself and any such Dependent within 31 days of acquiring such Dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with You for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.
- Yourself and Your spouse and You subsequently acquire a Dependent through birth, adoption, or placement for adoption, and You subsequently elect coverage for Yourself, Your spouse, and any such Dependent within 90 days of acquiring such Dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with You for adoption, whichever is applicable. Any limitation as to a preexisting condition may apply.

### **G. Special Rules Which Apply to an Adopted Child**

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of Dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date Your coverage becomes effective; and
- You make written request for coverage for the child within 31 days (60 days if You already have Dependents covered) of the date the child is placed with You for adoption.

Coverage for the child will become effective on the date the child is placed with You for adoption. If request is not made within such 31 days (60 days if You already have Dependents covered), coverage for the child will be subject to all of the terms of this Plan.

- The definition of **HOSPITAL** is changed to read as follows:

An institution, operated as required by law, which is all of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.
- Is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or by the American Osteopathic Hospital Association.

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

- The following definitions are added to the **DEFINITIONS** section:

**PRIMARY CARE DOCTOR/PHYSICIAN**

A Physician who specializes in general internal medicine, family medicine, general pediatrics, obstetrics and gynecology.

**SPECIALIST CARE DOCTOR/PHYSICIAN**

A Physician who is not a Primary Care Physician and who provides Covered Services within the range of his or her medical specialty.

**URGENT CARE CLINIC**

A facility, other than a Hospital, that provides Covered Services that are required to prevent serious deterioration of Your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

- **SECTION 3 – THE SUMMARY OF BENEFITS** is deleted in its entirety and replaced with the following:

**SECTION 3  
SUMMARY OF BENEFITS/COVERED SERVICES  
PAN-AMERICAN OPEN ACCESS STANDARD PLAN**

Calendar Year Deductible	Calendar Year Deductible-Family
Network: \$200	Network: \$500
Non-Network: \$400	Non-Network: \$1,000

Overall Maximum per Calendar Year

Inpatient & Outpatient: \$25,000 (combined for Network and Non-Network Coverage)

Outpatient Limited to: \$3,000 (combined for Network and Non-Network Coverage)

Lifetime Maximum for In Vitro Fertilization: \$15,000

COVERED SERVICE	CO-PAY AMOUNT	NEED TO MEET CALENDAR YEAR DEDUCTIBLE?	NETWORK COVERAGE	NON-NETWORK COVERAGE
Hospital Inpatient. After the deductible is met, this benefit pays up to \$1,500 per day for room and board in a Hospital. For a Hospital confinement stay in the intensive care unit, the	\$0	Yes	80%	60%

benefit will pay up to \$2,000 per day.				
Physician Inpatient Services.	\$0	Yes	80%	60%
Outpatient Surgery, Diagnostic, and Therapeutic Services	\$0	Yes	80%	60%
Outpatient Facility Expenses.	\$0	Yes	80%	60%
Private Duty Nursing Expenses.	\$0	Yes	80%	60%
Home Health Care Expenses.	\$0	Yes	80%	60%
Hospice Care Expenses.	\$0	Yes	80%	60%
Primary Care Doctor's Office Visits (Non-Surgical).	\$15 per visit	No	100%	80%
Specialist Care Doctor's Office Visits (Non-Surgical).	\$30 per visit	No	100%	80%
Urgent Care Clinic Doctor's Office Visits (Non-Surgical).	\$35 per visit	No	100%	80%
Spinal Disorder Treatment Expenses. Calendar Year maximum of 2 visits.	\$0	Yes	80%	60%
Routine Preventive Care. This benefit has a combined (Network or Non-Network) Calendar Year maximum of \$150.	\$15 per visit	No	80%	60%
Ambulance Services Expenses.	\$0	Yes	80%	60%
Emergency Care Services.	\$0	Yes	80%	60%
Other Medical Expenses.	\$0	Yes	80%	60%

Pregnancy Coverage: Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending Physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider. Charges for such post-delivery home visits will be paid at 100% and will not be subject to any Calendar Year Deductible.
- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, Your Physician, or other health care provider may obtain such certification by calling the number shown on Your ID Card.

#### Preexisting Conditions

A "preexisting condition" is an injury or disease for which a person:

- received treatment or services; or
- took prescribed drugs or medicines;

during the 90 days immediately preceding the person's effective date of coverage (or, if the Plan requires You to serve a probationary period, the 90 days immediately preceding the first day of the probationary period). See the Effective Date of Coverage or Late Enrollee section of the Policy and Certificate, whichever applies, to determine a person's effective date of coverage.

For the first 365 days following such date, Covered Services do not include any expenses for treatment of a preexisting condition.

With respect to a Late Enrollee, a preexisting condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period prior to enrollment. For the first 18 months after a Late Enrollee's enrollment date, Covered Services do not include any expenses for treatment of a preexisting condition.



## Special Rules As To A Preexisting Condition:

If a person had creditable coverage, then the preexisting limitation period under this Plan will be reduced by the number of days of prior creditable coverage.

As used above: "continuous creditable coverage" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Members' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.

## LIMITATIONS:

Not covered are charges for a service or supply furnished by a Participating Provider that exceeds the negotiated charge agreed to by Participating Providers.

### Explanation of Some Important Plan Provisions

#### Network and Non-Network Coverage Year Deductible

This is the amount of Network and Non-Network care, and other health care Covered Services You pay each Calendar Year before benefits are paid.

#### Network and Non-Network Care Family Coverage Year Deductible Limit

This limit applies to all Covered Services incurred for Network, Non-Network Care, and other health care by the Employee or his/her covered dependents. After that limit is reached, the Employee and his/her covered dependents will be deemed to have met separate Network and Non-Network coverage year Deductibles. The Network and Non-Network Family Coverage Year Deductible Limit is shown in the Summary of Benefits.

- The following provisions are hereby added to **SECTION 3 – COVERED SERVICES:**

### **OUTPATIENT SURGERY, DIAGNOSTIC/THERAPEUTIC AND THERAPEUTIC SERVICES**

#### **OUTPATIENT SURGICAL SERVICES**

This benefit pays for Covered Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

Surgeries performed in a Doctor's Office will be paid under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

#### **OUTPATIENT DIAGNOSTIC SERVICES**

When ordered by a Physician, this benefit pays for Covered Services received on an outpatient basis at a Hospital or Alternate Facility for lab and radiology/x-ray, mammograms, bone mass measurement services, pap test, prostate cancer examination and testing.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Physician's office, benefits are described under the Doctor's Office Visits Services below. It does not include CT Scans, PET Scans, MRI's, or nuclear medicine.

#### **OUTPATIENT DIAGNOSTIC/THERAPEUTIC SERVICES-CT SCANS, PET SCANS, MRI AND NUCLEAR MEDICINE**

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

Outpatient Diagnostic Services performed for CT Scans, PET Scans, MRI's, and Nuclear Medicine in a Doctor's Office will be paid under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

## **OUTPATIENT THERAPEUTIC TREATMENTS**

This benefit includes Covered Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, the charge required for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Doctor's Office, benefits are described under the Outpatient Surgery, Diagnostic/Therapeutic and Therapeutic Services Benefit.

- The **PHYSICIAN OFFICE VISITS** provision is renamed and changed to read as follows:

### **PRIMARY CARE DOCTOR'S OFFICE VISITS (NON-SURGICAL)**

We will pay for Covered Services received in a Primary Care Doctor's office for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Doctor's Office Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

A Primary Care Doctor specializes in general internal medicine, family medicine, general pediatrics, obstetrics and gynecology.

### **SPECIALIST CARE DOCTOR'S OFFICE VISITS (NON-SURGICAL)**

We will pay for Covered Services received in a Specialist Care Doctor's office for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Doctor's Office Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

A Specialist Care Doctor is a Doctor who is not a Primary Care Physician and who provides Covered Services within the range of his or her medical specialty.

### **URGENT CARE CLINIC VISITS (NON-SURGICAL)**

We will pay for Covered Services received in an Urgent Care Clinic for the treatment of a Sickness or Injury. The visit must be on an outpatient and non-surgical basis.

Urgent Care Clinic Visits will be paid only if expenses incurred are not as a result of benefits excluded from coverage.

An Urgent Care Clinic provides services at a facility, other than a Hospital, and provides Covered Services that are required to prevent serious deterioration of the Covered Person's health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

- The **SPINAL DISORDER TREATMENT BENEFIT PROVISION** is changed to read as follows:

Covered Services include charges incurred for:

1. manipulative (adjustive) treatment; or
2. other physical treatment;

of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not more than the Spinal Disorder Treatment Maximum Visits per Coverage Year will be payable for all expenses incurred in connection with such treatment.

The maximum does not apply to expenses incurred:

- while the person is a full time inpatient in a hospital
- for treatment of scoliosis
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating physician.

- The **ROUTINE PREVENTIVE CARE EXPENSES** benefit is changed to read as follows:

Covered Services include charges made by a Physician for preventive care exams performed on a Covered Person for a reason other than to diagnose or treat a suspected or identified injury or disease.

Included as a part of the exam are:

1. X-rays, lab, and other tests given in connection with the exam; and
2. materials for the administration of immunizations for infectious disease and testing for tuberculosis.

Covered expenses for routine preventive care provided under this benefit include, but are not limited to, those charges made for:

1. Physical exams.
2. Cytological screening
3. Prostate specific antigen tests and digital rectal exams.
4. Bone mass density measurements.
5. Colon cancer examinations and laboratory tests for:
  - a. Covered persons who are fifty (50) years of age or older;
  - b. Covered persons who are less than fifty (50) years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and
  - c. Covered persons experiencing the following symptoms of colorectal cancer as determined by a licensed physician:
    - (1) Bleeding from the rectum or blood in the stool; or
    - (2) A change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.
6. Mammograms  
All costs associated with a mammogram every year for women 40 years of age or older and with any mammogram based on a physician's recommendation for women under 40 years of age.
7. Routine Pap Smears  
Covered Services include charges incurred for:
  - a. one routine gynecological exam each Calendar Year; and
  - b. an annual routine Pap smear.

Not included under this benefit are any exams; or other preventive services and supplies; which are specifically covered elsewhere in this Plan.

The most that will be paid for all covered routine preventive care expenses incurred by a Covered Person in a Calendar Year under this benefit is the Routine Preventive Care Maximum.

- The Emergency Room Sickness Visits provision is changed to read as follows:

### **EMERGENCY CARE SERVICES**

We will pay for Covered Services incurred for Emergency Care due to an Illness or Injury for services Medically Necessary that do not result in Hospital Confinement. Emergency room benefits for an Illness will be paid for a Covered Person but will not exceed the annual Calendar Year maximum shown in the Summary of Benefits.

- The **OTHER MEDICAL EXPENSES** is changed to read as follows:

1. Covered Services include charges incurred by a Covered Person for equipment, supplies and outpatient self-management training and education for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law.

Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids,

syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthotics.

Outpatient self-management training and education shall be provided under the supervision of a licensed health care professional with expertise in diabetes. Coverage for self-management education and education relating to diet and prescribed by a licensed Physician includes:

- a. visits medically necessary upon the diagnosis of diabetes;
  - b. visits under circumstances whereby a Physician identifies or diagnoses a significant change in the Covered Person's symptoms or conditions that necessitates changes in a Covered Person's self-management; and
  - c. visits where a new medication or therapeutic process relating to the Covered Person's treatment and/or management of diabetes has been identified as medically necessary by a Physician.
2. Formulas that are equivalent to a prescription drug necessary for the therapeutic treatment of rare hereditary genetic metabolic disorders. As used in this provision: Rare hereditary genetic metabolic disorders are phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.
  3. The following charges when incurred by a Dependent child are included as Covered Services even though not incurred in connection with the treatment of a disease or injury.

#### Children's Preventive Health Care Services

Physician-delivered or physician-supervised services for eligible dependents from birth through age eighteen (18) years of age, with Periodic Preventive Care Visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards for the purposes of this section.

Periodic Preventive Care Visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice, provided at the following age intervals:

- A. Birth;
- B. Two (2) weeks;
- C. Two (2) months;
- D. Four (4) months;
- E. Six (6) months;
- F. Nine (9) months;
- G. Twelve (12) months;
- H. Fifteen (15) months;
- I. Eighteen (18) months
- J. Two (2) years;
- K. Three (3) years;
- L. Four (4) years;
- M. Five (5) years;
- N. Six (6) years;
- O. Eight (8) years;
- P. Ten (10) years;
- Q. Twelve (12) years;
- R. Fourteen (14) years;
- S. Sixteen (16) years; and
- T. Eighteen (18) years.

Benefits for recommended immunization services are payable at 100% with no deductible, copayment, coinsurance or maximum limit.

4. Covered Services include charges incurred for outpatient In Vitro Fertilization expenses, even though not incurred for treatment of a disease or injury by a female employee or by the dependent wife of a male employee. Expenses incurred for cryo preservation are also included.

Benefits are provided on the same basis as any other illness if all of the following tests are met:

- a. The procedures are performed while she is not confined in a hospital or any other facility as an inpatient.

- b. Her oocytes are fertilized with her husband's sperm.
- c. She and her husband have a history of infertility which has lasted at least 2 years or the infertility is associated with one or more of these conditions.
  - 1) Endometriosis;
  - 2) Exposure in utero to diethylstilbestrol; known as DES;
  - 3) Surgical removal, other than for voluntary sterilization, of one or both fallopian tubes. This is known as lateral or bilateral salpingectomy; or
  - 4) Abnormal male factors contributing to the infertility.
- d. She has been unable to attain a successful pregnancy through any less costly treatments for which coverage is available under this plan.
- e. The in vitro fertilization procedures are performed:
  - 1) at a medical facility licensed or certified by the Arkansas Department of Health; or
  - 2) certified by the Arkansas Department of Health as either:
    - a) meeting the guidelines for in vitro clinics set by the American College of Obstetricians and Gynecologists, or
    - b) meeting the American Fertility Society's minimal standards for programs of in vitro fertilization.

Not more than the In Vitro Fertilization Maximum will be paid in connection with all in vitro fertilization procedures in the person's lifetime.

- 5. Covered Services include charges incurred the necessary care and treatment of loss or impairment of speech or hearing payable on the same basis as any other illness.

Loss or impairment of speech or hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification.

Coverage is not provided for hearing instruments or devices.

- **SECTION 4: DESCRIPTION OF NETWORK AND NON-NETWORK BENEFITS, the NETWORK BENEFITS** provision is changed to read as follows:

#### **NETWORK BENEFITS**

Network benefits are generally paid at a higher level than Non-Network benefits. Network benefits are payable for Covered Services which are either of the following:

- Provided by or under the direction of a Network Physician or other Network Provider in the Physician's office or at a Network facility.
- Emergency Care Services.

- The following exclusions in **SECTION 5: GENERAL EXCLUSIONS AND LIMITATIONS** are changed to read as follows:

Exclusion 7. under Expenses not covered is changed to read:

- 7. Dental services or supplies, except for the following procedures:
  - a. to repair damage to sound natural teeth Accidentally injured while the person is a Covered Person and the repair is done within 12 months from the date of the Injury;
  - b. to remove impacted, unerupted teeth;
  - c. Reconstructive Surgery for Craniofacial Abnormalities for dependent children under age 18; and
  - d. Anesthesia and dental care in a hospital or ambulatory surgical center for a covered person for which the provider treating the patient certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedure and who:
    - (1) is a child under age seven who is determined by two licensed dentists, to require without delay necessary dental treatment for a significantly complex dental condition; or
    - (2) is a person with a diagnosed serious mental or physical condition; or
    - (3) is a person with a significant behavioral problem as determined by the Covered Person's physician.

Exclusion 13. under Expenses not covered is changed to read:

13. Services or supplies for:
  - a. diagnosis and testing of fertility or infertility other than In Vitro Fertilization;
  - b. reversal of sterilization procedure; or
  - c. artificial insemination;

- The following provision in **SECTION 6: TERMINATION OF COVERAGE** is changed to read as follows:

**LIMITED EXTENSION DUE TO TOTAL DISABILITY**

A Covered Person's benefits will continue to be payable under the Plan when the Policy terminates, if he;

- A. Is Totally Disabled; and
- B. Is confined to a Hospital for the disabling Illness or Injury at the date the Policy would otherwise terminate.

Benefits paid under this extension will be paid until the earliest of these dates:

- A. The date which is ninety (90) days from the date coverage would have otherwise terminated; or
- B. The date the Covered Person is no longer Hospital confined; or
- C. The date on which the disabled person's Medical Benefit has reached the applicable maximum under the Plan.

This extension of coverage applies only to the disabled person and no premium is due.

- **SECTION 9: CONTINUATION OF COVERAGE** is changed to read as follows:

As an alternative to continuation of coverage under COBRA, the following continuation provisions are available to the following Covered Persons:

- Employees whose coverage ends for any reason other than termination of this policy or termination of the class in which the employee was insured.
- The surviving spouse or divorced spouse of an employee whose coverage would otherwise terminate as a result of the divorce or the death of the employee.

Continuation is not available to:

- Employees whose coverage ends because of failure to pay any required contribution towards the cost of their coverage under the policy.
- Covered Persons who are eligible for Medicare.
- Covered Persons whose coverage is replaced by another group medical plan within 31 days after coverage under this policy terminates.
- Covered Persons who have not been insured for at least three months on the date their coverage under this policy ends.

Continuation of coverage is subject to payment of premium to the Policyholder by the Covered Person. The premium will be the amount of premium the Policyholder would pay for the coverage if the Covered Person was insured under this policy in the absence of this continuation provision, including amounts paid towards premium by the Policyholder and by the employee.

Coverage under this policy may be continued for up to 120 days after the month in which coverage under this policy would otherwise terminate except:

- Covered Persons whose coverage would end as a result of the divorce or death of the employee may continue coverage for up to 15 months after the end of the month in which coverage under this policy would otherwise terminate. Such continuation is subject to the Covered Person paying premium to the Policyholder in advance in three month increments.
- Covered Persons who are pregnant when coverage under this policy would otherwise terminate may continue coverage subject to the Covered Person paying premium to the Policyholder in advance in three month increments. Coverage may be continued for up to six months after the pregnancy ends, or if longer, the end of the second three month period following the three month period in which the pregnancy ends.

A Covered Person is eligible for Conversion at the end of this continuation period.

- **SECTION 10 – CONVERSION** is changed to read as follows:

Any Employee whose insurance under this Policy has been terminated for any reason, including discontinuance of this Policy in its entirety or discontinuance of an insured class will be entitled to have issued by Us an individual policy of health insurance (hereafter referred to as the "converted policy"). This provision only applies to individuals whose coverage terminates at the end of any COBRA or state continuation provision provided in the Policy. The converted policy may provide levels which are substantially similar to those provide under this Policy.

A Employee will not be entitled to have a converted policy issued if termination of the insurance under this Policy occurred for any of the following reasons:

- a. the Employee failed to pay any required contribution;
- b. any discontinued group coverage was immediately replaced by similar group coverage unless such person was declined coverage under the replacing group coverage; or
- c. The person is, or could be, covered for Medicare benefits or similar benefits provided by any state or federal law, similar benefits provided on a group or individual basis or any benefits provided above which, together with the benefits provided under the conversion policy, would result in over-insurance.

Written application for the converted policy must be made and the first premium paid to Us not later than thirty-one (31) days after such termination. The converted policy will be issued without evidence of insurability.

The effective date of the converted policy will be the day following the termination of insurance under this Policy. The converted policy will cover the Employee and any dependents who were covered by this Policy on the date of termination of insurance.

This conversion privilege may be exercised at the Employee's option at the end of any COBRA or state continuation of coverage provision provided under the group policy and will be available to the following:

1. the surviving spouse, if any, of the Employee with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or
  2. the spouse of the Employee with respect to the spouse and children whose coverage terminates because the spouse ceases to be a qualified family member and while the Employee remains insured under the group policy, or
  3. a child solely upon termination of the coverage by reason of ceasing to be a qualified family member under the group policy, or
  4. the former spouse whose coverage under the group policy terminates by reason of an entry of a valid decree of divorce between the insured and spouse.
- The **TIME PAYMENT OF CLAIMS** provision in **SECTION 12: UNIFORM CLAIMS PROVISION** is changed to read as follows:

#### **TIME PAYMENT OF CLAIMS**

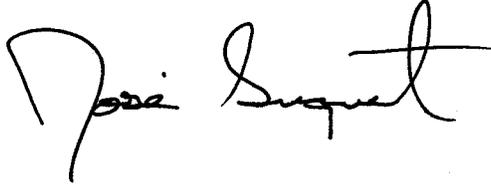
Benefits payable under the Plan will be paid immediately after receipt of due written proof of claim. If all essential information needed to make a determination on the claim is not received, then the thirty (60) days will not be effective until all required information is received by Us.

Except as amended herein, all terms, conditions, limitations and exclusions of the Policy to which this Amendment is attached will remain in full force and effect.

Payment of premium on or after the effective date of this Amendment shall constitute acceptance by the Plan Sponsor and Plan Participant of the modifications contained herein.

IN WITNESS WHEREOF, the Insurance Company has caused this Amendment to be executed by its President.

PAN-AMERICAN LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Jose Siquel". The signature is fluid and cursive, with a large initial "J" and a long horizontal stroke at the end.

Chairman of the Board  
President and Chief Executive Officer

<i>SERFF Tracking Number:</i>	<i>CMPL-126037052</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>PAN-AMERICAN LIFE INSURANCE</i>	<i>State Tracking Number:</i>	<i>41558</i>
	<i>COMPANY</i>		
<i>Company Tracking Number:</i>	<i>PAN AM REV 1-2009</i>		
<i>TOI:</i>	<i>H14G Group Health - Hospital Indemnity</i>	<i>Sub-TOI:</i>	<i>H14G.000 Health - Hospital Indemnity</i>
<i>Product Name:</i>	<i>Pan AM Rev 1-2009</i>		
<i>Project Name/Number:</i>	<i>Pan AM Rev 1-2009 /Pan AM Rev 1-2009</i>		

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	02/19/2009
<b>Comments:</b>			
<b>Attachment:</b>			
	AB AR Jan 1 Changes Readability.pdf		

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	Application	Approved-Closed	02/19/2009
<b>Comments:</b>			
	complete details located under CMPL-125719806		

Form A-4501-LMM Disposition Date: 08/19/2008

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	Certification/Notice	Approved-Closed	02/19/2009
<b>Comments:</b>			
<b>Attachment:</b>			
	AR_AR Certif of Compliance with Rule 19.pdf		

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	Authorization	Approved-Closed	02/19/2009
<b>Comments:</b>			
<b>Attachment:</b>			
	AB Filing Authorization.pdf		

**PAN-AMERICAN LIFE INSURANCE COMPANY**

**READABILITY CERTIFICATION**

**SINGLE CASE FILING**

This is to certify that the form(s) listed below have achieved at least the minimum required score on the Flesch Reading Ease Test.

<b><u>Form Number and Name</u></b>	<b><u>Score</u></b>
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LIST OF FORMS

MMPAL-2008-C-AMDT-1-AR	49
MMPAL-2008-C-AMDT-2-AR	48
MMPAL-2008-C-AMDT-3-AR	48

  
**Jennifer LaFleur**  
**Associate Actuary**

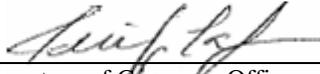
**February 9, 2009**

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

Insurer: Pan-American Life Insurance Company

Form Number(s): MMPAL-2008-C-AMDT-1-AR  
MMPAL-2008-C-AMDT-2-AR  
MMPAL-2008-C-AMDT-3-AR

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



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

Jennifer LaFleur

\_\_\_\_\_  
Name

Associate Actuary

\_\_\_\_\_  
Title

February 9, 2009

\_\_\_\_\_  
Date



July 2, 2008

NAIC Company Code: 67539

Re: Forms MMPAL-2008-C, et al

To: All Departments of Insurance

Pan-American Life Insurance Company hereby authorizes Compliance Research Services, LLC to represent us in the submission of the above-referenced forms and to negotiate with insurance departments for their approval.

Sincerely,

A handwritten signature in cursive script, appearing to read "Jennifer Lafleur".

Jennifer Lafleur  
Associate Actuary  
Pan-American Life Insurance Company