

SERFF Tracking Number: MCHX-126016220 State: Arkansas  
Filing Company: Time Insurance Company State Tracking Number: 41391  
Company Tracking Number: 4131.AR  
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.004 Short Term  
Product Name: 135.001.XX Rev 09/2008 TIC Short Term Medical - In  
Project Name/Number: 135.001.XX Rev 09/2008 TIC Short Term Medical - Individual /135.001.XX Rev 09/2008 TIC Short Term Medical - Individual

## Filing at a Glance

Company: Time Insurance Company

Product Name: 135.001.XX Rev 09/2008 TIC SERFF Tr Num: MCHX-126016220 State: Arkansas

Short Term Medical - In

TOI: H16I Individual Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 41391  
Closed

Sub-TOI: H16I.004 Short Term

Co Tr Num: 4131.AR

State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Author: SPI McHughConsulting

Disposition Date: 02/17/2009

Date Submitted: 01/30/2009

Disposition Status: Approved-Closed

Implementation Date Requested: 02/28/2009

Implementation Date:

State Filing Description:

## General Information

Project Name: 135.001.XX Rev 09/2008 TIC Short Term Medical - Individual

Status of Filing in Domicile: Not Filed

Project Number: 135.001.XX Rev 09/2008 TIC Short Term Medical - Individual

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 02/17/2009

Explanation for Other Group Market Type:

State Status Changed: 02/17/2009

Deemer Date:

Created By: SPI McHughConsulting

Submitted By: SPI McHughConsulting

Corresponding Filing Tracking Number:

Filing Description:

REVISIONS TO PREVIOUSLY APPROVED FORMS

TIME INSURANCE COMPANY - NAIC #69477; FEIN 39-0658730

Policy Amendment Form 4131.AR

Benefit Summary Form 135.BNS.AR Rev. 09/2008

Application for Insurance Form 28786.AR (Rev. 1/2009)

SERFF Tracking Number: MCHX-126016220 State: Arkansas  
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## Statement of Variability

### Actuarial Memorandum and Rates

McHugh Consulting Resources, Inc. has been requested to file the enclosed forms on behalf of Time Insurance Company. We have provided an authorization letter for your files.

Enclosed is the filing of a new Amendment that revises Short Term Medical Policy Form 135.001.AR which was previously approved by your office on 5/10/04. These revisions will be incorporated into new policies issued after the date of your approval. Existing policies that are currently in force will not be changed. The revisions that are being made have been marked for your ease in reference. We are also enclosing revisions to related forms that were previously approved with Short Term Medical Policy Form 135.001.AR.

Assurant Health is comprised of Time Insurance Company and John Alden Life Insurance Company. The above-captioned forms will be marketed by Time Insurance Company. We are also submitting Policy Amendment Form 4133.AR and related forms to you, under separate cover, which will be marketed by John Alden Life Insurance Company. The forms are identical for each Company. The only differences are to the form numbers and Company names. Because these filings are identical, we respectfully request that the same Analyst review both filings.

All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. The actual wording of each provision will remain the same.

Our state of domicile for Time Insurance Company and John Alden Life Insurance Company is Wisconsin. The state of Wisconsin does not require the filing of forms with their office that are being marketed for out-of-state use.

Upon approval, the amended forms will be used to market short term medical insurance to individuals in your state. Coverage will be offered by independent agents licensed in your state as well as by direct marketing methods.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at the number listed below.

## Company and Contact

### Filing Contact Information

Jane Neal, Compliance Assistant                      mcr@mchughconsulting.com  
McHugh Consulting Resources                      215-230-7960 [Phone]

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350 South Main Street, Suite 103 215-230-7961 [FAX]  
 Doylestown, PA 18901

**Filing Company Information**

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

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

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**Filing Fees**

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Time Insurance Company	\$100.00	01/30/2009	25395802

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/17/2009	02/17/2009

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	02/03/2009	02/03/2009	SPI McHughConsulting	02/13/2009	02/13/2009

*SERFF Tracking Number:* MCHX-126016220      *State:* Arkansas  
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## **Disposition**

Disposition Date: 02/17/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Authorization letter	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Form Listing	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	AR Compliance Rule 19	Approved-Closed	Yes
Supporting Document	AR Compliance Rule 49	Approved-Closed	Yes
Supporting Document	Form 4131.AR Red Line	Approved-Closed	Yes
Supporting Document	FORM 135.BNS.AR Rev. 09/2008 Red Line	Approved-Closed	Yes
Supporting Document	FORM 26776.AR Rev. 09/2008 Red Line	Approved-Closed	Yes
Supporting Document	Rates	Approved-Closed	Yes
Supporting Document	02.13.09 Resubmission	Approved-Closed	Yes
Form	Policy Amendment	Approved-Closed	Yes
Form	Benefit Summary	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form (revised)	Application for Insurance	Approved-Closed	Yes
Form	Application for Insurance	Replaced	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 02/03/2009

Submitted Date 02/03/2009

Respond By Date

Dear Jane Neal,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application for Insurance, Form 28786.AR (Rev. 1/2009) (Form)

Comment: The fraud statement is not in compliance with ACA 23-66-503. Arkansas does not allow the language, "is guilty of a felony of the third degree".

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 02/13/2009  
 Submitted Date 02/13/2009

Dear Rosalind Minor,

### Comments:

Please find attached a response to your February 3, 2009, objection letter.

### Response 1

Comments: Please find attached:

#### Related Objection 1

Applies To:

- Application for Insurance, Form 28786.AR (Rev. 1/2009) (Form)

Comment:

The fraud statement is not in compliance with ACA 23-66-503. Arkansas does not allow the language, "is guilty of a felony of the third degree".

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: 02.13.09 Resubmission

Comment:

#### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Application for Insurance	Form 28786.AR (Rev. 1/2009)		Application/Enrollment Form	Revised		50.500	Form 28786_AR (Rev_1_2009).PDF

### Previous Version

<i>SERFF Tracking Number:</i>	<i>MCHX-126016220</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Time Insurance Company</i>	<i>State Tracking Number:</i>	<i>41391</i>
<i>Company Tracking Number:</i>	<i>4131.AR</i>		
<i>TOI:</i>	<i>H161 Individual Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H161.004 Short Term</i>
<i>Product Name:</i>	<i>135.001.XX Rev 09/2008 TIC Short Term Medical - In</i>		
<i>Project Name/Number:</i>	<i>135.001.XX Rev 09/2008 TIC Short Term Medical - Individual /135.001.XX Rev 09/2008 TIC Short Term Medical - Individual</i>		
<i>Application for Insurance</i>	<i>Form</i>	<i>Application/Enrollment Form</i>	<i>Initial 50.500 Form</i>
	<i>28786.AR</i>	<i>Form</i>	<i>28786_AR</i>
	<i>(Rev. 1/2009)</i>		<i>(Rev_1_2009).P</i>
			<i>DF</i>

No Rate/Rule Schedule items changed.

Sincerely,  
SPI McHughConsulting

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## Form Schedule

### Lead Form Number: Form 4131.AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/17/2009	Form 4131.AR	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Policy Amendment	Initial		51.800	Form 4131_AR.PD F
Approved-Closed 02/17/2009	FORM 135.BNS.A R Rev. 09/2008	Schedule Pages	Benefit Summary	Initial		0.000	FORM 135_BNS_AR Rev_ 09_2008.PDF
Approved-Closed 02/17/2009	FORM 26776.AR Rev. 09/2008	Outline of Coverage	Outline of Coverage	Initial		0.000	FORM 26776_AR Rev_ 09_2008.PDF
Approved-Closed 02/17/2009	Form 28786.AR (Rev. 1/2009)	Application/ Enrollment Form	Application for Insurance	Revised	Replaced Form #: Previous Filing #:	50.500	Form 28786_AR (Rev_ 1_2009).PDF

## POLICY AMENDMENT

The policy is amended to incorporate the provisions as described below. The following provisions are subject to all the terms, limits and conditions in the policy, except to the extent specifically modified by this Amendment.

*The Definitions section in the policy is amended to revise the following definitions:*

**COINSURANCE:** The amount of Covered Expense that is paid by Us after any applicable [Copayment] [and/or] [Deductible] [is] [are] satisfied. You are responsible for paying any Coinsurance balance that is not paid by Us. [The Coinsurance, as shown in the Benefit Summary, applies separately to each Insured during a Benefit Period.] It applies to all Covered Expense unless otherwise noted in this policy or a rider to this policy. The payment of Covered Expense is subject to the Lifetime Maximum Benefit or any other maximum benefit for those services under the policy, whichever is less.

**COVERED EXPENSE:** An allowable charge that is covered by this policy and We determine is:

1. Incurred for services, treatment or supplies prescribed by a Health Care Practitioner; and
2. Incurred for Medically Necessary care; and
3. Incurred by an Insured while this policy is in force as the result of a Sickness[, or] an Injury [or for preventive medicine services as outlined in the Preventive Medicine Services provision or elsewhere in the Benefits section]. [Benefits are available from the first day Covered Expenses are incurred for an Injury that is sustained on or after the Effective Date of Your coverage. Benefits are available for a Sickness that first manifests itself after the Waiting Period, as shown in the Benefit Summary. A Sickness manifests itself if You receive medical treatment or consultation for it or have signs or symptoms of it. [Benefits are available for preventive medicine services after the Waiting Period.]]

Covered Expense is incurred on the date the service is received or rendered. Covered Expense does not include any charge in excess of the Reasonable and Customary Amount.

**HEALTH CARE PRACTITIONER:** A person licensed by the state in which the Covered Expense is rendered to [provide preventive medicine services or] treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed. A Health Care Practitioner does not include a member of the Insured's Immediate Family.

**[OUT-OF-POCKET LIMIT:** The sum of the Covered Expenses for which We do not pay benefits during a Benefit Period because of the [Deductible and] Coinsurance. When Covered Expenses equal to the Out-of-Pocket Limit have been incurred and processed by Us, the Individual Out-of-Pocket Limit will be satisfied for the remainder of the Benefit Period, as shown in the Benefit Summary. [The Out-of-Pocket Limit applies separately to each Insured during a Benefit Period, except as otherwise provided by this policy.] [We will consider each Insured's Individual Out-of-Pocket Limit to be satisfied during a Benefit Period when the total amount of Covered Expenses applied to the Individual Out-of-Pocket Limit, for all family members covered under the same Family Plan, equals the maximum Family Out-of-Pocket Limit, as shown in the Benefit Summary.]

The following do not count toward satisfying the Out-of-Pocket Limit: [any Deductible;] [any prescription drug Deductible;] [any Copayment;] [any prescription drug Copayment;] [any penalty applied under the Authorization Provisions section;] [charges incurred after the maximum amount has been paid for a benefit under this plan;] [and] any amount in excess of the Reasonable and Customary Amount.]

**[WAITING PERIOD:** A Waiting Period for Sickness [or preventive medicine services] only applies if it is shown in Your Benefit Summary. A Waiting Period is the period of time that must pass before an Insured is eligible to be covered for Sickness [or preventive medicine services] under the terms of this plan. [The Waiting Period applies separately to each Insured during a Benefit Period, except as otherwise provided by this policy.] Benefits are

available from the first day Covered Expenses are incurred for [preventive medicine services or for] an Injury that is sustained on or after the Effective Date of Your coverage.]

*The Benefits section in the policy is amended to revise the lead in statements:*

After You have paid any Deductible [and/or Copayment], We will pay benefits for Covered Expenses at the Coinsurance amount shown in the Benefit Summary up to the Out-of-Pocket Limit and subject to the Lifetime Maximum Benefit or any other maximum benefit for those services under the policy, whichever is less, for each Insured during a Benefit Period. Any applicable Deductibles [and/or Copayments] and the Covered Expenses to which they apply are shown in the Benefit Summary. Benefits are subject to all the terms, limits and conditions in this policy. Only the services and supplies listed in this policy will be considered Covered Expenses.

Your policy provides benefits for the following Covered Expenses:

*The Benefits section in the policy is amended to provide benefits for the following Covered Expenses:*

[18.] **[Preventive Medicine Services:** Covered Expenses for preventive medicine services are for the routine well care services shown in the Benefit Summary that are not a Covered Expense elsewhere in the plan. These services must be provided in accordance with the guidelines established by the United States Preventative Services Task Force or the Advisory Committee on Immunization Practices on the date the service is incurred. Coverage does not include routine well newborn care at birth.

The maximum benefit for Covered Expenses for preventive medicine services is shown in the Benefit Summary.]

*The Authorization Provisions section in the policy is amended to revise the following provision:*

**REDUCTION OF PAYMENT:** These authorization requirements are included to assist You in obtaining the most appropriate medical care. Follow the requirements described above so You can receive the full benefits of Your policy. If You do not obtain authorization for the services listed above or if the course of treatment is not performed in the manner authorized, Your benefits will be reduced for otherwise Covered Expenses by [\$2,500] or [50%], whichever is the lesser amount. The reduced amount, or any portion thereof, will not be applied to any Deductible, Out-of-Pocket Limit and Coinsurance determination.

In addition, NO benefits will be paid for expenses:

1. That are not for Medically Necessary services; or
2. That are otherwise not considered Covered Expense[; or
3. For Organ Transplant or Marrow Reconstitution or Support if the procedure was not authorized prior to the beginning of the transplant evaluation, testing, preparative treatment or donor search].

*The Pre-Existing Conditions Limitation section in the policy is deleted and replaced with the following provision:*

We will not pay benefits during Your Benefit Period for charges incurred due to a Pre-Existing Condition. We will not pay benefits during Your Benefit Period for charges related to or due to a complication of a Pre-Existing Condition. Benefits are subject to all the terms, limits and conditions in this policy.

*The Exclusions section in the policy is amended to revise the following exclusions:*

- [2.] [Charges for Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury, even if You did not intend to cause the harm which resulted from the action which led to the self-inflicted Sickness or Injury. This exclusion applies whether You were sane or insane at the time of the suicide, attempted suicide or self-inflicted Sickness or Injury.]
- [7.] [Charges for dental care, including dental braces and dental appliances, unless a Hospital stay is required due to Injury from an accidental blow to the mouth causing trauma to sound, natural teeth, the gums or supporting structures of the teeth. A sound, natural tooth has no decay and has never had a filling, root canal therapy or crown. Inpatient Hospital care must be the least expensive setting needed to produce a professionally adequate result and the Hospital charges only are Covered Expense. The treatment must be received while the policy is in force.]

- [9.] [Charges for the following:
- [a.] [Eyeglasses, contact lenses, eye exams, eye refraction or eye surgery for correction of refraction error; vision therapy; or artificial hearing devices.]
  - [b.] [Preventive treatment including, but not limited to, routine physical exams and immunizations, unless otherwise noted as a Covered Expense in [the Preventive Medicine Services provision or elsewhere in] this policy or a rider to this policy.]
  - [c.] [Treatment, services or supplies to address: Smoking cessation; snoring or sleep disorders; the treatment or prevention of hair loss; change in skin pigmentation; or cognitive enhancement.]
  - [d.] [Weight reduction or weight control programs or treatment; surgery for weight control, obesity or morbid obesity; or any type of gastric bypass surgery.]
  - [e.] [Therapy or treatment for learning disorders or disabilities or developmental delays.]
  - [f.] [Custodial Care; respite care; rest care; or supportive care.]
  - [g.] [Private duty nursing services rendered during Hospital confinement; or standby Health Care Practitioners.]
  - [h.] [Sales tax or gross receipt tax; provider administrative expenses including, but not limited to, charges for claim filing, contacting utilization review organizations and case management fees.]]
- [15.] [Treatment or services required due to Injury received while engaging in any hazardous [occupation or other] activity including, but not limited to: Participating, instructing, demonstrating, guiding or accompanying others in [parachute jumping,] [hang-gliding,] [bungee jumping,] [flight in an aircraft other than a regularly scheduled flight by an airline,] [racing any motorized [or non-motorized] vehicle,] [rock or mountain climbing,] [hunting,] [parkour,] [free running] [and] [extreme sports]. [Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.]]
- [16.] [Treatment or services required due to Injury received while engaging in any hazardous [occupation or other] activity [for which compensation is received in any form, including sponsorship] including, but not limited to: Participating, instructing, demonstrating, guiding or accompanying others in [skiing,] [horse riding,] [rodeo activities,] [professional [or semi-professional] [contact] sports,] [adult sporting competition at a national or international level] [and] [extreme sports]. [Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.]]
- [17.] [Treatment or services required due to Injury sustained while participating in any [interscholastic] [or] [inter-collegiate] sport, contest or competition [or while [practicing,] [exercising,] [undergoing conditioning or physical preparation]] for any such sport, contest or competition.]
- [21.] [Expenses incurred outside of the United States or its possessions or Canada [unless the Optional Travel Benefit Rider is included in this policy].]
- [22.] [Charges that are: Incurred for Experimental or Investigational Treatment; in excess of the Reasonable and Customary Amount; not Medically Necessary.]
- [29.] [Charges for foot conditions including, but not limited to: Care of corns; bunions, except capsular or bone surgery; calluses; toenails; and foot supportive devices, including orthotics and corrective shoes.]
- [38.] [Charges for reproductive or sexual treatment including, but not limited to: Normal pregnancy or childbirth; routine well baby care, including Hospital nursery charges at birth, except as provided in the Benefits section; abortion, except as otherwise covered in the Complications of Pregnancy provision in the Benefits section; infertility diagnosis and treatment for males and females including, but not limited to, drugs and medications, artificial insemination, in-vitro fertilization and reversal of sterilization; sterilization and drugs or devices used directly or indirectly to promote or prevent conception; genetic testing or counseling including, but not limited to, amniocentesis and chorionic villi testing; and treatment of sexual dysfunction or inadequacy.]

The Exclusions section in the policy is amended to delete the exclusions numbered 1, 3, 8, 12, 18, 20, 23, 24, 25, 26, 27, 30, 31, 32, 34, 35 and 37. The remainder of the exclusions are renumbered to appear sequentially.

*The Other Provisions section in the policy is amended to revise the following provisions:*

**ELIGIBILITY FOR COVERAGE:** You [and Your Covered Dependents] may be covered under this certificate upon approval under Our coverage criteria, provided that [coverage was requested for each person at time of the Primary Insured's enrollment, except as otherwise provided by this certificate, and provided] all persons covered are:

- [1.] [U.S. citizens residing in the United States [or foreign residents who have been living in the United States [for at least [one year]]] at the time of enrollment for coverage under this plan [and who have proof of [alien registration or other] [appropriate visas] [or] [required documentation];] and]
- [2.] [Between the ages of [30 days] and [age 64 and 11 months]; and]
- [3.] [Not currently incarcerated; and]
- [4.] [Not engaged in hazardous activities for pay].

**RIGHT TO COLLECT INFORMATION:** You must cooperate with Us and, when asked, assist Us by:

1. Authorizing the release of medical information including the names of all providers from whom You have received treatment, services, medications or supplies; and
2. Providing information regarding the circumstances of Your claim; and
3. Providing information about other insurance coverage and benefits; and
4. [Providing medical records from all providers located outside of the United States from whom You have received treatment, services, medications or supplies. An English language translation of the claims, medical records and proof of loss, as outlined in the Notice/Proof of Loss provision in the Claims section, must be received by Us. You are responsible for obtaining this information at Your expense; and]
- [5.] Having an examination completed when requested.

**Your refusal to provide information requested is cause for denial of claims or termination of this coverage.**

*The Other Provisions section in the policy is amended to add the following provision:*

**[INCENTIVES, REBATES AND CONTRIBUTIONS:** We may elect to furnish [or participate in programs with other organizations which furnish] Insureds [that meet common criteria or requirements determined by Us] with ["premium holidays" or programs where premiums, fees, plan benefit limits will be discounted, credited, refunded, waived or otherwise adjusted] [or] [where other gifts or] items of value [that] may be offered or provided to You at no charge or at a discount] for a period of time determined by Us.]

The policy is changed only as stated in this Amendment. Nothing contained in this Amendment will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the policy other than as stated above.

The Effective Date of this Amendment is the Effective Date of the policy.

*Joseph Wagner*

Secretary

**TIME INSURANCE COMPANY**

[501 West Michigan  
Milwaukee, WI 53203]

**BENEFIT SUMMARY**

Short Term Major Medical Expense Coverage  
Policy or Certificate Number: [1234567]  
Effective Date: [09/01/2008]  
Form Number: [145.001.XX]  
Payment Option: [Monthly]

[Agent Data  
Agency Number: [12345678 9 99 99]  
Agent Name: [Mike Smith  
123 North Street  
Milwaukee, WI 53215]]

Type of Plan: [Single Plan – If You have a single Plan on the  
Effective Date of coverage, a Covered Dependent cannot be  
added after Your Effective Date][Family Plan]

**INSURED INFORMATION**

Primary Insured	Birthdate	Age	Sex	
[John Doe 123 South 10th Street [Milwaukee, WI 53215]	[06/12/1962]	[41]	[M]	[Effective Date: [09/01/2008]]

[Additional Insured(s): [Jane Doe]	[07/10/1962]	[41]	[F]	[Effective Date: [09/01/2008]]
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[William Doe]	[10/28/1995]	[7]	[M]	[Effective Date: [09/01/2008]]
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**BENEFITS**

[Waiting Period:]	[3 days from Effective Date for Sickness] [and [[30] days from Effective Date for] preventive medicine services]
Lifetime Maximum Benefit:	[\$2,000,000]
[Individual Deductible [Per Benefit Period]:	[\$250] for each Insured]
[Family Deductible [Per Benefit Period]:	[\$750] for each Family]
[Per Cause Deductible:	[\$100] for each Occurrence]
[Coinsurance:]	[80% of \$10,000]
[Individual Out-of-Pocket Limit:	[\$2,000]
[Family Out-of-Pocket Limit:	[\$5,000]
[Per Cause Limit:	[\$100,000]
[Copayment:	[\$50 per Emergency room visit in a Hospital – waived if admitted for inpatient stay]]
Inpatient Hospital Services:	[up to Lifetime Maximum Benefit]
Outpatient Hospital Services:	[up to Lifetime Maximum Benefit]
Health Care Practitioner Services:	
• Surgical:	[up to Lifetime Maximum Benefit]
• Anesthesia:	[up to Lifetime Maximum Benefit]
• Per Office Visit:	[up to Lifetime Maximum Benefit]
Reconstructive Surgery:	[up to Lifetime Maximum Benefit]
Inpatient Rehabilitation Programs:	[up to 30 days per Benefit Period]
Skilled Nursing Facility Care:	[up to 30 days per Benefit Period]
Home Health Care:	[up to 40 visits per Benefit Period]
Outpatient Physical Medicine Services:	[up to 10 visits per Benefit Period]
Ambulance Services:	[up to Lifetime Maximum Benefit]
X-ray and Laboratory Services:	[up to Lifetime Maximum Benefit]
[Preventive Medicine Services:]	[up to \$[100] per Benefit Period for each [Insured] [Covered Dependent child age [10 days] through age [18]] [for charges that are not shown as a Covered Expense elsewhere in the plan]]
• [[Immunizations] [for] [Covered Dependent children]	

[age [10 days] through age [18]] [Insureds] [as recommended by the Advisory Committee on Immunization Practices]

- [Routine well child care services] [for Covered Dependent children] [age [10 days] through age [18]] [as recommended by the United States Preventative Services Task Force]
- [Routine well adult care services] [as recommended by the United States Preventative Services Task Force]
- [Pap smears with chlamydia screening]
- [Mammography screening]
- [Stool for occult blood testing]
- [Prostate specific antigen screening]
- [Fasting glucose testing]
- [Lipid profile testing]
- [Urinalysis testing]
- [Complete blood count (or component parts) testing]
- [Tuberculin skin testing with purified protein derivative]
- [Flexible sigmoidoscopy and barium enema (or colonoscopy)]
- [Other routine well services] [as described below]

[Prescription Drug Deductible]	\$100 per Benefit Period]
[Prescription Drug Copayment]	\$10 for each prescription drug ordered or refilled]
[Prescription Drug Maximum Benefit]	\$1,000 per Benefit Period]
[Reasonable and Customary Amount Determination]	Medicare DRG]

**PREMIUM SUMMARY**

[Initial Benefit Period/Benefit Period]:	[35 Days]
[Initial Premium/Premium]:	[\$70.56]
[Initial Benefit Period Term Date/ Benefit Period Term Date 11:59 PM]:	[10/06/2008]
[Installment Premium/Subsequent Payments:]	[\$60.48] Installment/Subsequent payments due monthly
[Maximum Benefit Period (185 Days)]:	[03/05/2009]

**[OPTIONAL RIDER(S)]**

Form	Description	Coverage	Premium
[Rider 8100.XX	Travel Benefit	Included	\$50.00]
[Rider 8101.XX	Accident Medical Expense	[\$250] per Accident	\$60.00]
[Rider 8102.XX	Term Life Insurance	[\$10,000] for Primary Insured	\$30.00]
		[\$5,000] for Spouse	\$15.00]
[Rider 8103.XX	Waiver of Pre-Existing Conditions	Included	\$30.00]
[Rider 8131.AR	Optional Benefits for AR Residents	Included	\$xx.xx]]

**TIME INSURANCE COMPANY**

[501 West Michigan  
Milwaukee, WI 53203]

**SHORT TERM MAJOR MEDICAL EXPENSE COVERAGE POLICY - FORM 135  
OUTLINE OF COVERAGE**

This outline of coverage provides a brief description of the important features of Your policy. This is not the insurance contract. The policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is important that You READ YOUR POLICY CAREFULLY!

**MAJOR MEDICAL EXPENSE COVERAGE:** The policy is designed to provide coverage for major Hospital, medical, and surgical expenses incurred as a result of Medically Necessary care for a covered Sickness or Injury during a Benefit Period.

[**AUTHORIZATION REQUIREMENT:** To be eligible to receive the maximum benefits available read the Authorization Provisions section in the policy carefully. Authorization is required for all Hospital, Skilled Nursing Facility and inpatient rehabilitation admissions, outpatient or day surgeries, [transplants,] home health care, outpatient Physical Medicine visits and monthly rental or purchase of durable medical equipment that exceeds \$500. Authorization is also required for treatment of Mental Illness and for treatment of Developmental Disorders, if such coverage is purchased for an additional premium through optional Rider 8131.AR. Failure to follow the Authorization Provisions could result in no payment or a reduction in benefits.]

**PAYMENT OF BENEFITS:** After the [Deductible] [and/or any] [Copayment] is satisfied, We will pay benefits for Covered Expenses at the Coinsurance amount up to the Lifetime Maximum Benefit, or any other limitations as set forth in the policy, for each Insured during a Benefit Period. Benefits are subject to all the terms, limits and conditions in the policy.

<b>[COVERAGE INFORMATION</b>				
Individual Deductible \$ _____	Family Deductible \$ _____	[Copayment \$ _____]	Prescription Drug Deductible \$ _____	[Prescription Drug Copayment \$ _____]
Coinsurance ____ % of \$ _____	Lifetime Maximum Benefit \$ _____	Benefit Period _____ Days	[Waiting Period] [ ____ Days for Sickness] [ ____ Days for Preventive Medicine Services]	
Inpatient Hospital Services: _____ Outpatient Hospital Services: _____ Health Care Practitioner Services: Surgical: _____ Anesthesia: _____ Per Office Visit: _____ Reconstructive Surgery: _____		Inpatient Rehabilitation: _____ Skilled Nursing Facility: _____ Home Health Care: _____ Outpatient Physical Medicine: _____ Ambulance: _____ X-ray and Lab: _____ Prescription Drugs: _____		
<b>PREMIUM INFORMATION</b>				
Premium Payment Mode: _____ TOTAL MODAL PREMIUM AMOUNT: \$ _____]				

**BENEFIT PERIOD:** The length of time the policy is in force. The policy is not renewable.

**COINSURANCE:** The amount of Covered Expense that is paid by Us after any applicable [Copayment] [and/or] [Deductible] [is] [are] satisfied. You are responsible for paying any Coinsurance balance that is not paid by Us. The Coinsurance applies separately to each Insured during a Benefit Period. The payment of Covered Expense is subject to the Lifetime Maximum Benefit or any other maximum benefit for those services under the policy,

whichever is less.

**OTHER INSURANCE LIMITATION:** Total benefits paid on an Insured's behalf are limited to no more than the actual medical charges. Thus, if an Insured is entitled to benefits through any other medical or dental plan, We will take those benefits into account before We pay Our benefits, in accordance with the Other Insurance Limitation provision in the Exclusions and Limitations section of the policy.

**COVERED EXPENSES:** Charges for services, treatment or supplies prescribed by a Health Care Practitioner. Services must be received and charges must be incurred by You or Your Covered Dependents while the policy is in force. Covered Expense must be Medically Necessary and does not include any charge in excess of the Reasonable and Customary Amount. [Benefits are available from the first day Covered Expenses are incurred for an Injury that is sustained on or after the Effective Date of the coverage. Benefits are available for a Sickness that first manifests itself after any Waiting Period. A Sickness manifests itself if You receive medical treatment or consultation for it or have signs or symptoms of it. [Benefits are available for preventive medicine services after the Waiting Period.]]

**REASONABLE AND CUSTOMARY AMOUNT:** The lesser of: 1) The actual charge; or 2) What the provider would accept for the same service or supply in the absence of insurance; or 3) The reasonable amount as determined by John Alden Life Insurance Company, based on factors such as: a) the amount of resources expended to deliver the service or supply; or b) the amount charged for the same or comparable service or supply in a community similar to where the service or supply is furnished; or c) the costs incurred by providers in a community similar to where the service or supply is furnished and the amount by which such service or supply is commonly marked up by providers; or d) charging protocols and billing practices generally accepted by the medical community or specialty groups, including charging protocols and billing practices related to Medicare; or e) inflation trends by geographic region; or 4) Another schedule or method of deriving charges, as identified in the policy].

**BENEFITS PROVIDED BY THE POLICY:** Only the services and supplies listed in the policy will be considered Covered Expenses. The policy provides benefits for the following Covered Expenses:

- **[Inpatient Hospital Services:** Room, board and routine nursing services that are provided to all inpatients while confined in a semi-private room, ward, coronary care or other intensive care unit in a Hospital. If You are in a private room, We will pay benefits based on the Hospital's most common daily charge for a semi-private room. [The maximum benefit is shown on page one.]]
- **[Outpatient Hospital Services:** Services performed in a Hospital's outpatient department or in a Free-Standing Ambulatory Surgical Facility. [The maximum benefit is shown on page one.]]
- **[Health Care Practitioner Services, Surgical and Anesthesia Services:** Surgical services, anesthesia services and Health Care Practitioner services (not including office visits). [The maximum benefit is shown on page one. Office visits to a Health Care Practitioner are shown separately.]]
- **[Reconstructive Surgery:** Reconstructive surgery to restore function for conditions resulting from accidental Injury provided the Injury occurred while the Insured is covered under the policy. Reconstructive surgery that is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part if the trauma, infection or other diseases occurred or had their onset while the Insured was covered under the policy. Reconstructive surgery because of congenital illness or anomaly of a Covered Dependent child, born while the policy is in force, that resulted in a functional defect. [The maximum benefit is shown on page one.]]
- **[Inpatient Rehabilitation Programs:** Inpatient rehabilitation includes, but is not limited to, physical, occupational and speech therapy provided on an inpatient basis in a facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitative Facilities when the confinement is in lieu of acute hospitalization. [The maximum benefit is shown on page one.]]
- **[Skilled Nursing Facility Care:** Care in a Skilled Nursing Facility when the confinement is in lieu of acute

hospitalization or when admitted to the Skilled Nursing Facility within [14] days after a Hospital confinement of at least [3] days for the same condition. The maximum daily benefit for care in a Skilled Nursing Facility will not exceed: 1) one-half of the semi-private Hospital room rate for the Hospital confinement; or 2) one-half of the most common semi-private Hospital room rate for the area in which You live if You were not previously Hospital confined. [The maximum benefit is shown on page one.]]

- **[Home Health Care:** Home health care visits provided by a state licensed or Medicare certified home health agency. One visit consists of up to [4 hours] of home health aide service within a 24-hour period. [The maximum benefit is shown on page one.]]
- **[Outpatient Physical Medicine Services:** Outpatient Physical Medicine includes, but is not limited to: physical, speech or occupational therapy; pulmonary or cardiac rehabilitation therapy; or adjustments and manipulations provided in the outpatient department of a Hospital, by a licensed or certified home health care agency or by a licensed therapist in Your home. One visit consists of up to [4 hours] of therapy within a [24-hour] period. [The maximum benefit is shown on page one.]]
- **[Ambulance Services:** Ambulance service for one trip to the nearest Hospital that is able to treat the Sickness or Injury. [The maximum benefit is shown on page one.]]
- **[X-ray and Laboratory Services:** X-ray, radioactive treatment and laboratory charges. [The maximum benefit is shown on page one.] [This includes 1 screening mammography exam per Benefit Period for a covered female, age 35 or over [for a maximum benefit of [\$60].]]
- **[Durable Medical Equipment and Supplies:** Rental, up to the purchase price, or purchase of a basic non-electric wheelchair, basic non-electric hospital bed or basic crutches; the initial permanent basic artificial limb or eye; oxygen and the equipment needed to administer oxygen; casts, orthopedic braces, splints, dressings and sutures; and the initial external breast prosthesis needed because of Medically Necessary surgical removal of all or part of the breast provided the surgery was performed while the Insured was covered under the policy. [There is up to a maximum benefit of [\$1,000] per Benefit Period] for all of the items listed above combined.]]
- **[Blood Product Transfusions:** Whole blood, blood plasma and blood products if not replaced.]
- **[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction:** Surgical and non-surgical treatment of temporomandibular or craniomandibular joint dysfunction, except for the treatment and services outlined in the policy. The combined maximum for all surgical and non-surgical treatment is limited to [\$1,000] for each Insured per Benefit Period. Optional Rider 8131.AR can be purchased for an additional premium to cover services provided by a physician or dentist for the Medically Necessary diagnosis, surgical and non-surgical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including TMJ and CMJ. If this optional benefit is purchased through Rider 8131.AR, coverage of these types of musculoskeletal disorders will be considered on the same basis as any other covered Sickness under the policy.]
- **[Complications of Pregnancy:** The following complications arising from a pregnancy that began after the Effective Date of coverage are considered on the same basis as any other covered Sickness: 1) conditions, requiring Hospital confinement (when pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, including: acute nephritis, nephrosis, cardiac decompensation, and missed abortion, and similar medical and surgical conditions of comparable severity; and 2) non-elective caesarean section delivery, ectopic pregnancy which is terminated, spontaneous termination of pregnancy (miscarriage) that occurs during a period of gestation in which a viable birth is not possible. No benefits will be paid for: false labor; premature labor; high risk pregnancy or delivery; elective caesarean section delivery; occasional spotting; Health Care Practitioner prescribed rest; morning sickness; hyperemesis gravidarum; pre-eclampsia; placenta previa; or similar conditions that occur in a difficult pregnancy.
- **[Prescription Drugs:** Drugs and medicines that are fully approved by the U.S. Food and Drug

Administration, are received on an outpatient basis, require the written prescription of a Health Care Practitioner for treatment of a condition that is a Covered Expense under the policy and are dispensed by a licensed pharmacy. [The maximum benefit is shown on page one.]

- **[AIDS/HIV Services:** Treatment of AIDS, AIDS Related Complex (ARC) or related immunodeficiency disorders up to a maximum benefit of [\$10,000] for each Insured per Benefit Period.]
- **[Transplantation Benefit:** Certain human organ/tissue transplants or replacements as listed in the policy and donor expenses provided that the transplant is the result of a Sickness or Injury that had its onset after the Effective Date of the policy. The maximum transplant benefit per Benefit Period is [\$100,000] for all transplants, combined transplants, and sequential transplants and the maximum benefit for donor expenses is [\$10,000].]
- **[Preventive Medicine Services:** Covered Expenses for preventive medicine services are for the routine well care services shown in the Benefit Summary that are not a Covered Expense elsewhere in the plan. These services must be provided in accordance with the guidelines established by the United States Preventative Services Task Force or the Advisory Committee on Immunization Practices on the date the service is incurred. Coverage does not include routine well newborn care at birth.]
- **Diabetes Benefit:** Medically Necessary equipment, services, supplies and self-management training incurred for treatment of diabetes.
- **Medical Foods:** Medically Necessary amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas for the treatment of phenylketonuria (PKU) if the cost of these products, for an individual or family, exceeds the \$2,400 per person annual income tax credit allowed under Arkansas law.
- **[Newborn Child Services:** Services for a newborn child who is born while the policy is in force and is a Covered Dependent, as follows:
  1. Treatment of a Sickness, Injury, medically diagnosed congenital defect and premature birth; and
  2. Tests for hypothyroidism, PKU, galactosemia, sickle-cell anemia, and any other metabolic disorder for which screening is performed by or for the State of Arkansas; and
  3. Any additional testing of a newborn child that is mandated by Arkansas law; and
  4. Routine nursery care and pediatric charges for a well newborn child for up to 5 full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time.]
- **Child Wellness Services:** Periodic preventive care visits for Covered Dependents under the age of 19, at the following age intervals:
  1. One visit each at birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months; and
  2. One visit per Benefit Period from the age of 2 years through 18 years.

Preventive care visits include medical history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests. Only those services provided by or under the supervision of one Health Care Practitioner during the course of one visit will be covered. Immunization services recommended by a Health Care Practitioner are not subject to any Deductible, Copayment, or coinsurance provisions of the policy.]
- **Mental Illness and Developmental Disorders Benefit:** No coverage is available for treatment of Mental Illness or for treatment of Developmental Disorders unless such coverage is purchased for an additional premium through optional Rider 8132.AR. If this optional benefit is purchased, Covered Expenses are for the Medically Necessary diagnosis and treatment of Mental Illness and Developmental Disorders which will be considered on the same basis as any other covered Sickness under the policy.

- **Psychological Examiners Benefit:** This coverage can be purchased for an additional premium through optional Rider 8132.AR only if the optional Mental Illness and Developmental Disorders Benefit is also purchased for an additional premium as indicated in the provision above. If this additional optional benefit is purchased, Covered Expenses for diagnosis and treatment of Mental Illness will be considered regardless of whether such services are provided by a Health Care Practitioner or by a psychological examiner.

PRE-EXISTING CONDITIONS LIMITATION: No benefits will be provided during the term of the policy for any Pre-Existing Condition or due to a complication of a Pre-Existing Condition. A Pre-Existing Condition is a medical condition due to Sickness or Injury for which the Insured received medical treatment or advice from a provider within the [5 year] period immediately preceding the Effective Date of coverage, regardless of whether the condition was diagnosed or not diagnosed; or that produced signs or symptoms within the [5-year] period immediately preceding the Effective Date of coverage. The signs or symptoms must have been significant enough to establish manifestation or onset by one of the following tests: 1) The signs or symptoms would have allowed one learned in medicine to make a diagnosis of the disorder; or 2) The signs or symptoms should have caused an ordinarily prudent person to seek diagnosis or treatment. A pregnancy that existed on the day before Your Effective Date of coverage is also considered a Pre-Existing Condition.

[WAITING PERIOD LIMITATION: We will not pay benefits during the term of the policy for charges incurred due to a Sickness that manifests itself before any Waiting Period [or for preventive medicine services that are incurred during a Waiting Period]. Benefits are available from the first day Covered Expenses are incurred for [preventive medicine services or for] an Injury that is sustained on or after the Effective Date of Your coverage.]

EXCLUSIONS: The policy does not cover any of the following:

- [Charges for Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury, even if You did not intend to cause the harm which resulted from the action which led to the self-inflicted Sickness or Injury. This exclusion applies whether You were sane or insane at the time of the suicide, attempted suicide or self-inflicted Sickness or Injury.]
- [Sickness or Injury to the extent that benefits are paid by Medicare or any other government law or program, except Medicaid (Medi-Cal in California); or medical coverage under any automobile or no fault insurance.]
- [Sickness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when You do not file a claim for benefits.]
- [Treatment of Sickness or Injury caused by or contributed to by: 1) War or any act of war; or 2) Participation in the military service of any country. Any premium paid for a time not covered will be returned pro-rata.]
- [Charges for dental care, including dental braces and dental appliances unless a Hospital stay is required due to Injury from an accidental blow to the mouth causing trauma to sound, natural teeth, the gums or supporting structures of the teeth. A sound, natural tooth has no decay and has never had a filling, root canal therapy or crown. Inpatient Hospital care must be the least expensive setting needed to produce a professionally adequate result and the Hospital charges only are Covered Expense. The treatment must be received while the policy is in force.]
- [Charges for:
  - [1.] [Eyeglasses, contact lenses, eye exams, eye refraction or eye surgery for correction of refraction error; vision therapy; or artificial hearing devices.]
  - [2.] [Preventive treatment including, but not limited to, routine physical exams and immunizations, unless otherwise noted as a Covered Expense in [the Preventive Medicine Services provision or elsewhere in] the policy or a rider to the policy.]
  - [3.] [Treatment, services or supplies to address: Smoking cessation; snoring or sleep disorders; the treatment or prevention of hair loss; change in skin pigmentation; or cognitive enhancement.]

- [4.] [Weight reduction or weight control programs or treatment; surgery for weight control, obesity or morbid obesity; or any type of gastric bypass surgery.]
- [5.] [Therapy or treatment for learning disorders or disabilities or developmental delays.]
- [6.] [Custodial Care; respite care; rest care; or supportive care.]
- [7.] [Private duty nursing services rendered during Hospital confinement; or standby Health Care Practitioners.]
- [8.] [Sales tax or gross receipt tax; provider administrative expenses including, but not limited to, charges for claim filing, contacting utilization review organizations and case management fees.]]

- [Cosmetic treatment or reconstructive or plastic surgery that is primarily a cosmetic procedure, including medical or surgical complications arising therefrom, except as provided in the Benefits section of the policy.]
- [Treatment of Mental Illness or Substance Abuse, whether organic or non-organic, chemical or non-chemical, biological or non-biological in origin and irrespective of cause, basis or inducement, unless otherwise noted as a Covered Expense in the policy or a rider to the policy.]
- [Treatment or services rendered by, or supplies purchased from, a member of Your Immediate Family or an employer.]
- [Treatment or services required due to accidental Injury sustained [in operating a motor vehicle] while the Insured's blood alcohol level, as defined by law, exceeds that level permitted by law or otherwise violates legal standards for a person operating a motor vehicle in the state where the Injury occurred. This exclusion applies whether or not [the Injury occurred in connection with an incident involving the operation of a motor vehicle, and whether or not] the Insured is charged with any violation in connection with the accident.]
- [Treatment or services required due to Injury received while engaging in any hazardous [occupation or other] activity including, but not limited to: Participating, instructing, demonstrating, guiding or accompanying others in [parachute jumping,] [hang-gliding,] [bungee jumping,] [flight in an aircraft other than a regularly scheduled flight by an airline,] [racing any motorized [or non-motorized] vehicle,] [rock or mountain climbing,] [hunting,] [parkour,] [free running] [and] [extreme sports]. [Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.]
- [Treatment or services required due to Injury received while engaging in any hazardous [occupation or other] activity [for which compensation is received in any form, including sponsorship], including, but not limited to: Participating, instructing, demonstrating, guiding or accompanying others in [skiing,] [horse riding,] [rodeo activities,] [professional [or semi-professional] [contact] sports,] [adult sporting competition at a national or international level] [or] [extreme sports]. [Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.]]
- [Treatment or services required due to Injury sustained while participating in any [interscholastic] [or] [inter-collegiate] sport, contest or competition [or while [practicing,] [exercising,] [undergoing conditioning or physical preparation]] for any such sport, contest or competition.]
- [Expense incurred due to Sickness or Injury of which a contributing cause was the Insured's voluntary attempt to commit, participation in or commission of a felony, whether or not charged, or as a consequence of the Insured's being under the influence of illegal narcotics or non-prescribed controlled substances.]
- [Expenses incurred outside of the United States or its possessions or Canada [unless the Optional Travel Benefit Rider is included in the policy].]

- [Charges that are: Incurred for Experimental or Investigational Treatment; in excess of the Reasonable and Customary Amount; not Medically Necessary.]
- Transplants[, except as covered in the Benefits section of the policy].
- [Charges for foot conditions including, but not limited to: Care of corns; bunions, except capsular or bone surgery; calluses; toenails; and foot supportive devices, including orthotics and corrective shoes.]
- Prophylactic treatment or services. Prophylactic means any surgery or other procedure performed to prevent a disease process from becoming evident in the organ or tissue at a later date.
- [Drugs and medicines [received on an outpatient basis], except as covered in the Benefits section.] [Drugs prescribed for treatment of a Sickness or an Injury that is not covered under this policy.]
- [Charges for reproductive or sexual treatment including, but not limited to: Normal pregnancy or childbirth; routine well baby care, including Hospital nursery charges at birth except as provided in the Benefits section of the policy; abortion, except as otherwise covered in the Complications of Pregnancy provision; infertility diagnosis and treatment for males and females including, but not limited to, drugs and medications, artificial insemination, in-vitro fertilization and reversal of sterilization; sterilization and drugs or devices used directly or indirectly to promote or prevent conception; genetic testing or counseling including, but not limited to, amniocentesis and chorionic villi testing; and treatment of sexual dysfunction or inadequacy.]

**RENEWABILITY PROVISION:** The policy is not renewable. Coverage is in force only for the Benefit Period You selected which is shown on page one.

**PREMIUM:** The first page shows the total premium for the coverage You selected. The premium amount will not change while the policy is in force.

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Licensed Agent's Signature

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Date

**Short Term Medical Enrollment Form**

**Time Insurance Company - ARKANSAS**

REQUESTED EFFECTIVE DATE  
 MONTH DAY YEAR

[Note: Effective date is assigned by Time Insurance Company. [The effective date is the later of:

CERTIFICATE/POLICY NUMBER

1.) The day after: a) the date this form is signed; b) the date this form is postmarked for mailing to Time Insurance Company; or c) the date we receive your enrollment request by electronic transmission in our home office, OR 2.) If dates cannot be determined, the day we receive this form by mail. **The agent cannot assign an effective date different than this.]]**

APPLICANT'S NAME (Print Last, First, Middle)			GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER
STREET ADDRESS			CITY, STATE, ZIP CODE		
SPOUSE'S NAME (If to be insured)			GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER
CHILDREN (Name) (If to be insured)	BIRTH DATE	NAME	BIRTH DATE	NAME	BIRTH DATE
1.		2.		3.	

**NOTE: The plan cannot be issued if YES is answered to any questions. Under no circumstances can coverage become effective prior to the date this application is signed.**

Answer the following questions completely and accurately. Yes No

- [Will you or any person to be insured have any other hospital, Major Medical, or group health insurance in force on the effective date of this plan?  Yes  No]
- [Have/Are you, your spouse, or any person to be insured:  Yes  No]
  - ◆ [been denied insurance due to any health reasons that are still present?]
  - ◆ [now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?]
- [For any of the following conditions within the last [5] years, have you or any person to be insured received any abnormal test results or medical or surgical treatment, or consulted a health care professional, or taken medication for:  Yes  No]
  - ◆ [heart disorder [including but not limited to heart attack or chest pain]?]
  - ◆ [emphysema[,] [Chronic Obstructive Pulmonary Disease (COPD)]?]
  - ◆ [Crohn's disease[,] [ulcerative colitis] [or] [hepatitis (B or C)]?]
  - ◆ [AIDS [or] [tested positive for HIV]?]
  - ◆ [stroke [hypertension] [or high blood pressure]?]
  - ◆ [kidney disorder[,] [excluding kidney stones]?]
  - ◆ [diabetes[,] [except Gestational Diabetes]?]
  - ◆ [cancer [or] [tumor] [except Basal Cell Skin Cancer which has been removed]?]
  - ◆ [alcoholism, chemical dependency, drug or alcohol abuse?]

LENGTH OF COVERAGE	DEDUCTIBLE AMOUNT	LIFETIME MAXIMUM	PAYMENT OPTION	COINSURANCE	TOTAL
<input type="checkbox"/> Up to 6 months	<input type="checkbox"/> \$250* <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$500 <input type="checkbox"/> \$2,500	<input type="checkbox"/> \$2 Million <input type="checkbox"/> \$5 Million	<input type="checkbox"/> Single payment:  _____ Days	<input type="checkbox"/> 100%* <input type="checkbox"/> 80% <input type="checkbox"/> 50%	
<i>* not available with 100% Rate of Payment</i>			<input type="checkbox"/> Monthly payment	<i>* not available on policies longer than 6 months</i>	
<input type="checkbox"/> Up to 12 months	<input type="checkbox"/> \$500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$1 Million <input type="checkbox"/> \$2 Million			

OPTIONAL RIDERS (Additional premium required) I hereby select these optional benefits:  TMJ Benefits  Mental Illness Benefits

Term Life for Insured  Term Life for Insured and Spouse  Accident Medical Expense

**IF REQUESTING LIFE INSURANCE COVERAGE**  
 Beneficiary for Primary Insured \_\_\_\_\_  
FULL NAME RELATIONSHIP  
 (The Primary Insured is the beneficiary of any Spouse Life Insurance.)

The undersigned attests that the information above is true to the best of his/her knowledge. The undersigned realizes that any false, or inaccurate statement or misrepresentation in the enrollment form may result in claim denial or contract rescission. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. The undersigned understands that the plan applied for will not pay benefits for any expenses incurred on account of any condition which manifested itself before the effective date. The undersigned also understands that this is not a continuation of any previous medical plan, including any prior Short Term Medical plan. I understand that benefits may be reduced under the policy if I have other insurance coverage. [The undersigned also attests that all persons to be covered do not have pending medical appointments, or any medical condition not disclosed above.]

If I am self employed or an employee of an employer with 50 or fewer employees, I warrant premiums for this coverage are not: (1) Paid or reimbursed by my employer or, (2) To the best of my knowledge, treated as tax-deductible by my employer or me as related to an employer benefit plan (Internal Revenue Code sections 106,125,162 or 213).

[In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any medically related facility, insurance company, the Medical Information Bureau, employer, or consumer reporting agency to give to Time Insurance Company (or to any consumer reporting agency authorized by Time Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical care, advice or treatment.]

[I agree that a photographic copy of this authorization shall be valid for two years from the date signed.]

[I acknowledge receiving the Fair Credit Reporting Act Pre-Notification, the notification regarding the Medical Information Bureau, the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage for Health Insurance, if required.]

PRIMARY PHYSICIAN'S NAME (IF ANY) \_\_\_\_\_ PRIMARY PHYSICIAN'S TELEPHONE NUMBER \_\_\_\_\_

APPLICANT'S SIGNATURE \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

DAY TELEPHONE NUMBER \_\_\_\_\_ EVENING TELEPHONE NUMBER \_\_\_\_\_

SERFF Tracking Number: MCHX-126016220 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 41391  
 Company Tracking Number: 4131.AR  
 TOI: H161 Individual Health - Major Medical Sub-TOI: H161.004 Short Term  
 Product Name: 135.001.XX Rev 09/2008 TIC Short Term Medical - In  
 Project Name/Number: 135.001.XX Rev 09/2008 TIC Short Term Medical - Individual /135.001.XX Rev 09/2008 TIC Short Term Medical - Individual

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	02/17/2009
<b>Comments:</b>		
<b>Attachment:</b> AR Readability Certificate.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	02/17/2009
<b>Comments:</b> see forms tab		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Outline of Coverage	Approved-Closed	02/17/2009
<b>Comments:</b> see forms tab		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Authorization letter	Approved-Closed	02/17/2009
<b>Comments:</b>		
<b>Attachment:</b> Authorization letter.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Cover Letter	Approved-Closed	02/17/2009
<b>Comments:</b>		
<b>Attachment:</b> Cover Letter.PDF		

SERFF Tracking Number: MCHX-126016220 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 41391  
 Company Tracking Number: 4131.AR  
 TOI: H161 Individual Health - Major Medical Sub-TOI: H161.004 Short Term  
 Product Name: 135.001.XX Rev 09/2008 TIC Short Term Medical - In  
 Project Name/Number: 135.001.XX Rev 09/2008 TIC Short Term Medical - Individual /135.001.XX Rev 09/2008 TIC Short Term Medical - Individual

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	Form Listing	Approved-Closed	02/17/2009
<b>Comments:</b>			
<b>Attachment:</b>			
	Form Listing.PDF		

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	Statement of Variability	Approved-Closed	02/17/2009
<b>Comments:</b>			
<b>Attachment:</b>			
	Statement of Variability.PDF		

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	AR Compliance Rule 19	Approved-Closed	02/17/2009
<b>Comments:</b>			
<b>Attachment:</b>			
	AR Compliance Rule 19.PDF		

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	AR Compliance Rule 49	Approved-Closed	02/17/2009
<b>Comments:</b>			
<b>Attachment:</b>			
	AR Compliance Rule 49.PDF		

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	Form 4131.AR Red Line	Approved-Closed	02/17/2009
<b>Comments:</b>			
<b>Attachment:</b>			

SERFF Tracking Number: MCHX-126016220 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 41391  
 Company Tracking Number: 4131.AR  
 TOI: H161 Individual Health - Major Medical Sub-TOI: H161.004 Short Term  
 Product Name: 135.001.XX Rev 09/2008 TIC Short Term Medical - In  
 Project Name/Number: 135.001.XX Rev 09/2008 TIC Short Term Medical - Individual /135.001.XX Rev 09/2008 TIC Short Term Medical - Individual  
 Form 4131\_AR Red Line.PDF

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	FORM 135.BNS.AR Rev. 09/2008 Red Line	Approved-Closed	02/17/2009
<b>Comments:</b>			
<b>Attachment:</b>	FORM 135_BNS_AR Rev_ 09_2008 Red Line.PDF		

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	FORM 26776.AR Rev. 09/2008 Red Line	Approved-Closed	02/17/2009
<b>Comments:</b>			
<b>Attachment:</b>	FORM 26776_AR Rev_ 09_2008 Red Line.PDF		

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	Rates	Approved-Closed	02/17/2009
<b>Comments:</b>			
<b>Attachment:</b>	Rates.PDF		

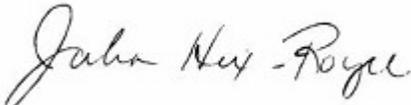
		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	02.13.09 Resubmission	Approved-Closed	02/17/2009
<b>Comments:</b>			
<b>Attachment:</b>	02_13_09 Resubmission.PDF		

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

**COMPANY NAME:** Time Insurance Company

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

<b>Form Number</b>	<b>Score</b>
Form 28786.AR (Rev. 1/2009)	50.5
Form 4131.AR	51.8

Signed:   
Name: Julia Hix-Royer  
Title: Vice President, Product Compliance  
Date: 1.20.09



**ASSURANT**  
Health

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

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

January 2009

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

Dear Sir or Madam,

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

Best Regards,

Julia Hix-Royer  
Vice President, Product Compliance  
Assurant Health

.....  
**McHugh Consulting Resources, Inc.**

January 30, 2009

**Submitted via SERFF**

Julie Benafield Bowman  
Insurance Commissioner  
Life and Health Division  
Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201-1904

RE: **REVISIONS TO PREVIOUSLY APPROVED FORMS**  
**TIME INSURANCE COMPANY - NAIC #69477; FEIN 39-0658730**  
Policy Amendment FORM 4131.AR  
Benefit Summary Form FORM 135.BNS.AR Rev. 09/2008  
Application for Insurance Form 28786.AR (Rev. 1/2009)  
  
Statement of Variability  
Actuarial Memorandum and Rates

Dear Commissioner Bowman:

McHugh Consulting Resources, Inc. has been requested to file the enclosed forms on behalf of Time Insurance Company. We have provided an authorization letter for your files.

Enclosed is the filing of a new Amendment that revises Short Term Medical Policy Form 135.001.AR which was previously approved by your office on 5/10/04. These revisions will be incorporated into new policies issued after the date of your approval. Existing policies that are currently in force will not be changed. The revisions that are being made have been marked for your ease in reference. We are also enclosing revisions to related forms that were previously approved with Short Term Medical Policy Form 135.001.AR.

Assurant Health is comprised of Time Insurance Company and John Alden Life Insurance Company. The above-captioned forms will be marketed by Time Insurance Company. We are also submitting Policy Amendment Form 4133.AR and related forms to you, under separate cover, which will be marketed by John Alden Life Insurance Company. The forms are identical for each Company. The only differences are to the form numbers and Company names. Because these filings are identical, we respectfully request that the same Analyst review both filings.



All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. The actual wording of each provision will remain the same.

Our state of domicile for Time Insurance Company and John Alden Life Insurance Company is Wisconsin. The state of Wisconsin does not require the filing of forms with their office that are being marketed for out-of-state use.

Upon approval, the amended forms will be used to market short term medical insurance to individuals in your state. Coverage will be offered by independent agents licensed in your state as well as by direct marketing methods.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at the number listed below.

Sincerely,

A handwritten signature in black ink that reads "Betty Dabrowski". The signature is written in a cursive, flowing style.

Betty Dabrowski  
Consultant  
Telephone: (215) 230-7960  
Fax: (215) 230-7961  
[mcr@mchughconsulting.com](mailto:mcr@mchughconsulting.com)

# SHORT TERM MEDICAL INSURANCE FORMS LISTING

Time Insurance Company

<b>FORM NUMBER FOR APPROVAL</b>	<b>FORM TITLE AND/OR DESCRIPTION</b>
Form 4131.AR	Policy Amendment Form
FORM 135.BNS.AR Rev. 09/2008	Benefit Summary
FORM 26776.AR Rev. 09/2008	Outline of Coverage
Form 28786.AR (Rev. 1/2009)	Application for Insurance Form



**ASSURANT**  
Health

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

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

### **STATEMENT OF VARIABILITY**

The variable and adaptable items in the form(s) have been bracketed to provide:

- A number of benefit options and/or items which customarily vary according to the policyholder's specific plan of insurance, which will allow us to deliver a customized contract to our customers reflecting all benefit options selected, helping to alleviate any ambiguity on the part of the customers as to what is covered and how it is covered.
  - Flexibility in utilizing provisions.
  - Future flexibility to adjust to changing regulatory and market needs.
1. All bracketed numbers (excluding form numbers) are variable, subject to the confines of state and federal law. Bracketed benefit amounts, illustrated as a range, list of amounts or otherwise, are variable and can fluctuate to provide a richer benefit to the insured than what is represented in the approved document.
  2. All bracketed text varies to the extent that such language may be:
    - a. included as shown;
    - b. omitted in its entirety;
    - c. rearranged; or
    - d. transferred to another provision, section or page.
  3. All bracketed numbers and/or text will be varied only:
    - a. within any statutory or regulatory requirements; and
    - b. under the condition that the numerical value(s) and benefit language is within the intent and framework of the actual approved provision.

We also reserve the right to amend the form(s) to correct any minor clerical or typographical errors we may have overlooked prior to approval, and to revise any phraseology to clarify the intent within the confines of the law.

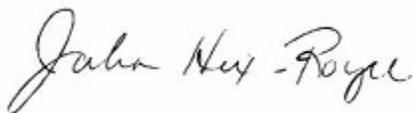
Assurant Health markets products underwritten by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.

## Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Time Insurance Company

Form Number(s):  
Policy Amendment Form 4131.AR  
Benefit Summary Form 135.BNS.AR Rev. 09/2008  
Application for Insurance Form 28786.AR (Rev. 1/2009)  
Outline of Coverage FORM 26776.AR Rev. 09/2008

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



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

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

Vice President, Product Compliance  
\_\_\_\_\_

Title

1.20.09  
\_\_\_\_\_  
Date

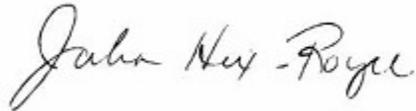
## CERTIFICATE OF COMPLIANCE

Insurer: Time Insurance Company

### Form Numbers

Policy Amendment Form 4131.AR  
Benefit Summary Form 135.BNS.AR Rev. 09/2008  
Application for Insurance Form 28786.AR (Rev. 1/2009)  
Outline of Coverage FORM 26776.AR Rev. 09/2008

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



---

Signature of Company Officer  
Julia Hix-Royer

---

Name  
Vice President, Product Compliance

---

Title

---

1.20.09  
Date

## POLICY AMENDMENT

The policy is amended to incorporate the provisions as described below. The following provisions are subject to all the terms, limits and conditions in the policy, except to the extent specifically modified by this Amendment.

The Definitions section in the policy is amended to revise the following definitions:

**COINSURANCE:** The amount of Covered Expense that is paid by Us after any applicable [Copayment] [and/or] [Deductible] [is] [are] satisfied. You are responsible for paying any Coinsurance balance that is not paid by Us. [The Coinsurance, as shown in the Benefit Summary, applies separately to each Insured during a Benefit Period.] It applies to all Covered Expense unless otherwise noted in this policy or a rider to this policy. The payment of Covered Expense is subject to the Lifetime Maximum Benefit or any other maximum benefit for those services under the policy, whichever is less.

Deleted: **RATE OF PAYMENT**

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Deleted: must be

Deleted: by You before We will pay the Rate of Payment

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**COVERED EXPENSE:** An allowable charge that is covered by this policy and We determine is:

1. Incurred for services, treatment or supplies prescribed by a Health Care Practitioner; and
2. Incurred for Medically Necessary care; and
3. Incurred by an Insured while this policy is in force as the result of a Sickness [,or] an Injury [or for preventive medicine services as outlined in the Preventive Medicine Services provision or elsewhere in the Benefits section]. [Benefits are available from the first day Covered Expenses are incurred for an Injury that is sustained on or after the Effective Date of Your coverage. Benefits are available for a Sickness that first manifests itself after the Waiting Period, as shown in the Benefit Summary. A Sickness manifests itself if You receive medical treatment or consultation for it or have signs or symptoms of it. [Benefits are available for preventive medicine services after the Waiting Period.]]

Covered Expense is incurred on the date the service is received or rendered. Covered Expense does not include any charge in excess of the Reasonable and Customary Amount.

**HEALTH CARE PRACTITIONER:** A person licensed by the state in which the Covered Expense is rendered to [provide preventive medicine services or] treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed. A Health Care Practitioner does not include a member of the Insured's Immediate Family.

**[OUT-OF-POCKET LIMIT:** The sum of the Covered Expenses for which We do not pay benefits during a Benefit Period because of the [Deductible and] Coinsurance. When Covered Expenses equal to the Out-of-Pocket Limit have been incurred and processed by Us, the Individual Out-of-Pocket Limit will be satisfied for the remainder of the Benefit Period, as shown in the Benefit Summary. [The Out-of-Pocket Limit applies separately to each Insured during a Benefit Period, except as otherwise provided by this policy.] [We will consider each Insured's Individual Out-of-Pocket Limit to be satisfied during a Benefit Period when the total amount of Covered Expenses applied to the Individual Out-of-Pocket Limit, for all family members covered under the same Family Plan, equals the maximum Family Out-of-Pocket Limit, as shown in the Benefit Summary.]

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The following do not count toward satisfying the Out-of-Pocket Limit: [any Deductible;] [any prescription drug Deductible;] [any Copayment;] [any prescription drug Copayment;] [any penalty applied under the Authorization Provisions section;] [charges incurred after the maximum amount has been paid for a benefit under this plan;] [and] any amount in excess of the Reasonable and Customary Amount.]

**[WAITING PERIOD:** A Waiting Period for Sickness [or preventive medicine services] only applies if it is shown in Your Benefit Summary. A Waiting Period is the period of time that must pass before an Insured is eligible to be covered for Sickness [or preventive medicine services] under the terms of this plan. [The Waiting Period applies separately to each Insured during a Benefit Period, except as otherwise provided by this policy.] Benefits are available from the first day Covered Expenses are incurred for [preventive medicine services or for] an Injury that is sustained on or after the Effective Date of Your coverage.]

The Benefits section in the policy is amended to revise the lead in statements:

After You have paid any Deductible [and/or Copayment], We will pay benefits for Covered Expenses at the Coinsurance amount shown in the Benefit Summary up to the Out-of-Pocket Limit and subject to the Lifetime Maximum Benefit or any other maximum benefit for those services under the policy, whichever is less, for each Insured during a Benefit Period. Any applicable Deductibles [and/or Copayments] and the Covered Expenses to which they apply are shown in the Benefit Summary. Benefits are subject to all the terms, limits and conditions in this policy. Only the services and supplies listed in this policy will be considered Covered Expenses.

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Your policy provides benefits for the following Covered Expenses:

The Benefits section in the policy is amended to provide benefits for the following Covered Expenses:

[18.] Preventive Medicine Services: Covered Expenses for preventive medicine services are for the routine well care services shown in the Benefit Summary that are not a Covered Expense elsewhere in the plan. These services must be provided in accordance with the guidelines established by the United States Preventative Services Task Force or the Advisory Committee on Immunization Practices on the date the service is incurred. Coverage does not include routine well newborn care at birth.

The maximum benefit for Covered Expenses for preventive medicine services is shown in the Benefit Summary.]

The Authorization Provisions section in the policy is amended to revise the following provision:

**REDUCTION OF PAYMENT:** These authorization requirements are included to assist You in obtaining the most appropriate medical care. Follow the requirements described above so You can receive the full benefits of Your policy. If You do not obtain authorization for the services listed above or if the course of treatment is not performed in the manner authorized, Your benefits will be reduced for otherwise Covered Expenses by [\$2,500] or [50%], whichever is the lesser amount. The reduced amount, or any portion thereof, will not be applied to any Deductible, Out-of-Pocket Limit and Coinsurance determination.

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In addition, NO benefits will be paid for expenses:

1. That are not for Medically Necessary services; or
2. That are otherwise not considered Covered Expense; or
3. For Organ Transplant or Marrow Reconstitution or Support if the procedure was not authorized prior to the beginning of the transplant evaluation, testing, preparative treatment or donor search].

The Pre-Existing Conditions Limitation section in the policy is deleted and replaced with the following provision:

We will not pay benefits during Your Benefit Period for charges incurred due to a Pre-Existing Condition. We will not pay benefits during Your Benefit Period for charges related to or due to a complication of a Pre-Existing Condition. Benefits are subject to all the terms, limits and conditions in this policy.

The Exclusions section in the policy is amended to revise the following exclusions:

[2.] Charges for Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury, even if You did not intend to cause the harm which resulted from the action which led to the self-inflicted Sickness or Injury. This exclusion applies whether You were sane or insane at the time of the suicide, attempted suicide or self-inflicted Sickness or Injury.]

[7.] Charges for dental care, including dental braces and dental appliances, unless a Hospital stay is required due to Injury from an accidental blow to the mouth causing trauma to sound, natural teeth, the gums or supporting structures of the teeth. A sound, natural tooth has no decay and has never had a filling, root canal therapy or crown. Inpatient Hospital care must be the least expensive setting needed to produce a professionally adequate result and the Hospital charges only are Covered Expense. The treatment must be received while the policy is in force.]

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[9.] Charges for the following:

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- [a.] ~~Eye~~glasses, contact lenses, eye exams, eye refraction or eye surgery for correction of refraction error; vision therapy; or artificial hearing devices.]
- [b.] Preventive treatment including, but not limited to, routine physical exams and immunizations, unless otherwise noted as a Covered Expense in [the Preventive Medicine Services provision or elsewhere in](#) this policy or a rider to this policy.]
- [c.] Treatment, services or supplies to address: ~~Smoking cessation; snoring or sleep disorders; the treatment or prevention of hair loss; change in skin pigmentation; or cognitive enhancement.~~
- [d.] Weight reduction or weight control programs or treatment; ~~surgery for weight control, obesity or morbid obesity; or any type of gastric bypass surgery.~~
- [e.] Therapy or treatment for learning disorders or disabilities or developmental delays.]
- [f.] [Custodial Care; respite care; rest care; or supportive care.](#)
- [g.] [Private duty nursing services rendered during Hospital confinement; or standby Health Care Practitioners.](#)
- [h.] Sales tax or gross receipt tax; provider administrative expenses including, but not limited to, charges for claim filing, contacting utilization review organizations ~~and~~ case management fees.]]

Deleted: quality of life or lifestyle concerns including, but not limited to

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- [15.] Treatment or services required due to Injury received while engaging in any hazardous [occupation or other] activity including, ~~but not limited to:~~ Participating, instructing, demonstrating, guiding or accompanying others in [parachute jumping,] [hang-gliding,] [bungee jumping,] [flight in an aircraft other than a regularly scheduled flight by an airline,] [racing any motorized [or non-motorized] vehicle,] [rock or mountain climbing,] [hunting,] [parkour,] [free running] ~~and~~ [extreme sports]. [Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.]]

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- [16.] Treatment or services required due to Injury received while engaging in any hazardous [occupation or other] activity [for which compensation is received [in any form, including sponsorship](#)] including, ~~but not limited to:~~ Participating, instructing, demonstrating, guiding or accompanying others in [skiing,] [horse riding,] [rodeo activities,] [professional [or semi-professional] contact sports,] [adult sporting competition at a national or international level] ~~and~~ [extreme sports]. [Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.]]

Deleted: the following

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- [17.] Treatment or services required due to Injury sustained while participating in any [interscholastic] [or] [inter-collegiate] sport, contest or competition [or while [practicing,] [exercising,] [undergoing conditioning or physical preparation]] for any such sport, contest or competition.]

- [21.] Expenses incurred outside of the United States or its possessions or Canada [unless the Optional Travel Benefit Rider is included in this policy].]

- [22.] [Charges that are: Incurred](#) for Experimental or Investigational Treatment; [in excess of the Reasonable and Customary Amount; not Medically Necessary.](#)

- [29.] [Charges for foot conditions](#) including, ~~but not limited to:~~ Care of corns; bunions, ~~except capsular or bone surgery; calluses; toenails; and foot supportive devices, including orthotics and corrective shoes.~~

Deleted: Services or supplies for foot care

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Deleted: or calluses

- [38.] [Charges for reproductive or sexual treatment including, but not limited to: Normal pregnancy or childbirth; routine well baby care, including Hospital nursery charges at birth,](#) except as provided in the Benefits section; ~~abortion, except as otherwise covered in the Complications of Pregnancy provision in the Benefits section; infertility diagnosis and treatment for males and females including, but not limited to, drugs and medications, artificial insemination, in-vitro fertilization and reversal of sterilization; sterilization and drugs or devices used directly or indirectly to promote or prevent conception; genetic testing or counseling including, but not limited to, amniocentesis and chorionic villi testing; and treatment of sexual dysfunction or inadequacy.~~

[The Exclusions section in the policy is amended to delete the exclusions numbered 1, 3, 8, 12, 18, 20, 23, 24, 25, 26, 27, 30, 31, 32, 34, 35 and 37. The remainder of the exclusions are renumbered to appear sequentially.](#)

*The Other Provisions section in the policy is amended to revise the following provisions:*

**ELIGIBILITY FOR COVERAGE:** You [and Your Covered Dependents] may be covered under this certificate upon approval under Our coverage criteria, provided that [coverage was requested for each person at time of the Primary Insured's enrollment, except as otherwise provided by this certificate, and provided] all persons covered are:

- [1.] [U.S. citizens residing in the United States [or foreign residents who have been living in the United States [for at least [one year]]] at the time of enrollment for coverage under this plan [and who have proof of [alien registration or other] [appropriate visas] [or] [required documentation];] and]
- [2.] [Between the ages of [30 days] and [age 64 and 11 months]; and]
- [3.] [Not currently incarcerated; and]
- [4.] [Not engaged in hazardous activities for pay].

**RIGHT TO COLLECT INFORMATION:** You must cooperate with Us and, when asked, assist Us by:

1. Authorizing the release of medical information including the names of all providers from whom You have received treatment, services, medications or supplies; and
2. Providing information regarding the circumstances of Your claim; and
3. Providing information about other insurance coverage and benefits; and
4. Providing medical records from all providers located outside of the United States from whom You have received treatment, services, medications or supplies. An English language translation of the claims, medical records and proof of loss, as outlined in the Notice/Proof of Loss provision in the Claims section, must be received by Us. You are responsible for obtaining this information at Your expense; and]
- [5.] Having an examination completed when requested.

**Your refusal to provide information requested is cause for denial of claims or termination of this coverage.**

*The Other Provisions section in the policy is amended to add the following provision:*

**INCENTIVES, REBATES AND CONTRIBUTIONS:** We may elect to furnish [or participate in programs with other organizations which furnish] Insureds [that meet common criteria or requirements determined by Us] with ["premium holidays" or programs where premiums, fees, plan benefit limits will be discounted, credited, refunded, waived or otherwise adjusted] [or] [where other gifts or] items of value [that] may be offered or provided to You at no charge or at a discount] for a period of time determined by Us.]

The policy is changed only as stated in this Amendment. Nothing contained in this Amendment will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the policy other than as stated above.

The Effective Date of this Amendment is the Effective Date of the policy.

*Hoppe-Wagner*

Secretary

**TIME INSURANCE COMPANY**

[501 West Michigan  
Milwaukee, WI 53203]

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A Stock Company

**BENEFIT SUMMARY**

Short Term Major Medical Expense Coverage  
Policy or Certificate Number: [1234567]  
Effective Date: [09/01/2008]  
Form Number: [145.001.XX]  
Payment Option: [Monthly]

[Agent Data  
Agency Number: [12345678 9 99 99]  
Agent Name: [Mike Smith  
123 North Street  
Milwaukee, WI 53215]]

Deleted: [Waiting Period: [3 days  
from Effective Date for Sickness]

Type of Plan: [Single Plan – If You have a single Plan on the  
Effective Date of coverage, a Covered Dependent cannot be  
added after Your Effective Date][Family Plan]

**INSURED INFORMATION**

Primary Insured      Birthdate      Age      Sex  
[John Doe              [06/12/1962]      [41]      [M]              [Effective Date: [09/01/2008]]  
123 South 10th Street  
[Milwaukee, WI 53215]

Deleted: [Waiting Period: [3 days  
from Effective Date for Sickness]

[Additional Insured(s):  
[Jane Doe]              [07/10/1962]      [41]      [F]              [Effective Date: [09/01/2008]]

[William Doe]              [10/28/1995]      [7]      [M]              [Effective Date: [09/01/2008]]

Deleted: [Waiting Period: [3 days  
from Effective Date for Sickness] ¶

Deleted: [Waiting Period: [3 days  
from Effective Date for Sickness]

**BENEFITS**

[Waiting Period:]

[3 days from Effective Date for Sickness] and [30] days  
from Effective Date for preventive medicine services]

Lifetime Maximum Benefit:

[\$2,000,000]

Individual Deductible [Per Benefit Period]:

[\$250] for each Insured]

Family Deductible [Per Benefit Period]:

[\$750] for each Family]

Per Cause Deductible:

[\$100] for each Occurrence]

[Coinsurance:]

[80% of \$10,000]

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Individual Out-of-Pocket Limit:

[\$2,000]

Family Out-of-Pocket Limit:

[\$5,000]

Per Cause Limit:

[\$100,000]

Copayment:

[\$50 per Emergency room visit in a Hospital – waived if  
admitted for inpatient stay]

Inpatient Hospital Services:

[up to Lifetime Maximum Benefit]

Outpatient Hospital Services:

[up to Lifetime Maximum Benefit]

Health Care Practitioner Services:

• Surgical:

[up to Lifetime Maximum Benefit]

• Anesthesia:

[up to Lifetime Maximum Benefit]

• Per Office Visit:

[up to Lifetime Maximum Benefit]

Reconstructive Surgery:

[up to Lifetime Maximum Benefit]

Inpatient Rehabilitation Programs:

[up to 30 days per Benefit Period]

Skilled Nursing Facility Care:

[up to 30 days per Benefit Period]

Home Health Care:

[up to 40 visits per Benefit Period]

Outpatient Physical Medicine Services:

[up to 10 visits per Benefit Period]

Ambulance Services:

[up to Lifetime Maximum Benefit]

X-ray and Laboratory Services:

[up to Lifetime Maximum Benefit]

[Preventive Medicine Services:]

[up to \$100] per Benefit Period for each [Insured] [Covered  
Dependent child age [10 days] through age [18]] [for  
charges that are not shown as a Covered Expense  
elsewhere in the plan]

• [Immunizations] [for] [Covered Dependent children]

- [\[age \[10 days\] through age \[18\]\] \[Insureds\] \[as recommended by the Advisory Committee on Immunization Practices\]](#)
- [\[Routine well child care services\] \[for Covered Dependent children\] \[age \[10 days\] through age \[18\]\] \[as recommended by the United States Preventative Services Task Force\]](#)
- [\[Routine well adult care services\] \[as recommended by the United States Preventative Services Task Force\]](#)
- [\[Pap smears with chlamydia screening\]](#)
- [\[Mammography screening\]](#)
- [\[Stool for occult blood testing\]](#)
- [\[Prostate specific antigen screening\]](#)
- [\[Fasting glucose testing\]](#)
- [\[Lipid profile testing\]](#)
- [\[Urinalysis testing\]](#)
- [\[Complete blood count \(or component parts\) testing\]](#)
- [\[Tuberculin skin testing with purified protein derivative\]](#)
- [\[Flexible sigmoidoscopy and barium enema \[or colonoscopy\]](#)
- [\[Other routine well services\] \[as described below\]](#)

[Prescription Drug Deductible	\$100 per Benefit Period]
[Prescription Drug Copayment	\$10 for each prescription drug ordered or refilled]
[Prescription Drug Maximum Benefit	\$1,000 per Benefit Period]
[Reasonable and Customary Amount Determination	Medicare DRG]

#### PREMIUM SUMMARY

[Initial Benefit Period/Benefit Period]:	[35 Days]
[Initial Premium/Premium]:	[\$70.56]
[Initial Benefit Period Term Date/ Benefit Period Term Date 11:59 PM]:	[10/06/2008]
[Installment Premium/Subsequent Payments:]	[\$60.48] Installment/Subsequent payments due monthly
[Maximum Benefit Period (185 Days):	[03/05/2009]

#### [OPTIONAL RIDER(S)]

Form	Description	Coverage	Premium
[Rider 8100.XX	Travel Benefit	Included	\$50.00]
[Rider 8101.XX	Accident Medical Expense	[\$250] per Accident	\$60.00]
[Rider 8102.XX	Term Life Insurance	[\$10,000] for Primary Insured	\$30.00]
		[\$5,000] for Spouse	\$15.00]
[Rider 8103.XX	Waiver of Pre-Existing Conditions	Included	\$30.00]
<u>[Rider 8131.AR</u>	<u>Optional Benefits for AR Residents</u>	<u>Included</u>	<u>\$xx.xx]</u>

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**TIME INSURANCE COMPANY**

[501 West Michigan  
Milwaukee, WI 53203]

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**SHORT TERM MAJOR MEDICAL EXPENSE COVERAGE POLICY - FORM 135  
OUTLINE OF COVERAGE**

This outline of coverage provides a brief description of the important features of Your policy. This is not the insurance contract. The policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is important that You READ YOUR POLICY CAREFULLY!

**MAJOR MEDICAL EXPENSE COVERAGE:** The policy is designed to provide coverage for major Hospital, medical, and surgical expenses incurred as a result of Medically Necessary care for a covered Sickness or Injury during a Benefit Period.

**[AUTHORIZATION REQUIREMENT:** To be eligible to receive the maximum benefits available read the Authorization Provisions section in the policy carefully. Authorization is required for all Hospital, Skilled Nursing Facility and inpatient rehabilitation admissions, outpatient or day surgeries, [transplants,] home health care, outpatient Physical Medicine visits and monthly rental or purchase of durable medical equipment that exceeds \$500. Authorization is also required for treatment of Mental Illness and for treatment of Developmental Disorders, if such coverage is purchased for an additional premium through optional Rider 8131.AR. Failure to follow the Authorization Provisions could result in no payment or a reduction in benefits.]

**PAYMENT OF BENEFITS:** After the [Deductible] [and/or any] [Copayment] is satisfied, We will pay benefits for Covered Expenses at the Coinsurance amount up to the Lifetime Maximum Benefit, or any other limitations as set forth in the policy, for each Insured during a Benefit Period. Benefits are subject to all the terms, limits and conditions in the policy.

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[COVERAGE INFORMATION				
Individual Deductible \$ _____	Family Deductible \$ _____	[Copayment \$ _____]	Prescription Drug Deductible \$ _____	[Prescription Drug Copayment \$ _____]
<u>Coinsurance</u> _____% of \$ _____	Lifetime Maximum Benefit \$ _____	Benefit Period _____ Days	[Waiting Period] [____ Days for Sickness] [____ Days for Preventive Medicine Services]	
Inpatient Hospital Services: _____ Outpatient Hospital Services: _____ Health Care Practitioner Services: Surgical: _____ Anesthesia: _____ Per Office Visit: _____ Reconstructive Surgery: _____		Inpatient Rehabilitation: _____ Skilled Nursing Facility: _____ Home Health Care: _____ Outpatient Physical Medicine: _____ Ambulance: _____ X-ray and Lab: _____ Prescription Drugs: _____		
[PREMIUM INFORMATION				
Premium Payment Mode: _____ TOTAL MODAL PREMIUM AMOUNT: \$ _____]				

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**BENEFIT PERIOD:** The length of time the policy is in force. The policy is not renewable.

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**COINSURANCE:** The amount of Covered Expense that is paid by Us after any applicable [Copayment] [and/or] [Deductible] [is] [are] satisfied. You are responsible for paying any Coinsurance balance that is not paid by Us. The Coinsurance applies separately to each Insured during a Benefit Period. The payment of Covered Expense is

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subject to the Lifetime Maximum Benefit or any other maximum benefit for those services under the policy, whichever is less.

**OTHER INSURANCE LIMITATION:** Total benefits paid on an Insured's behalf are limited to no more than the actual medical charges. Thus, if an Insured is entitled to benefits through any other medical or dental plan, We will take those benefits into account before We pay Our benefits, in accordance with the Other Insurance Limitation provision in the Exclusions and Limitations section of the policy.

**COVERED EXPENSES:** Charges for services, treatment or supplies prescribed by a Health Care Practitioner. Services must be received and charges must be incurred by You or Your Covered Dependents while the policy is in force. Covered Expense must be Medically Necessary and does not include any charge in excess of the Reasonable and Customary Amount. [Benefits are available from the first day Covered Expenses are incurred for an Injury that is sustained on or after the Effective Date of the coverage. Benefits are available for a Sickness that first manifests itself after any Waiting Period. A Sickness manifests itself if You receive medical treatment or consultation for it or have signs or symptoms of it. [\[Benefits are available for preventive medicine services after the Waiting Period.\]](#)]

**REASONABLE AND CUSTOMARY AMOUNT:** The lesser of: 1) The actual charge; or 2) What the provider would accept for the same service or supply in the absence of insurance; or 3) The reasonable amount as determined by John Alden Life Insurance Company, based on factors such as: a) the amount of resources expended to deliver the service or supply; or b) the amount charged for the same or comparable service or supply in a community similar to where the service or supply is furnished; or c) the costs incurred by providers in a community similar to where the service or supply is furnished and the amount by which such service or supply is commonly marked up by providers; or d) charging protocols and billing practices generally accepted by the medical community or specialty groups, including charging protocols and billing practices related to Medicare; or e) inflation trends by geographic region; or 4) Another schedule or method of deriving charges, as identified in the policy].

**BENEFITS PROVIDED BY THE POLICY:** Only the services and supplies listed in the policy will be considered Covered Expenses. The policy provides benefits for the following Covered Expenses:

- **[Inpatient Hospital Services:** Room, board and routine nursing services that are provided to all inpatients while confined in a semi-private room, ward, coronary care or other intensive care unit in a Hospital. If You are in a private room, We will pay benefits based on the Hospital's most common daily charge for a semi-private room. [The maximum benefit is shown on page one.]]
- **[Outpatient Hospital Services:** Services performed in a Hospital's outpatient department or in a Free-Standing Ambulatory Surgical Facility. [The maximum benefit is shown on page one.]]
- **[Health Care Practitioner Services, Surgical and Anesthesia Services:** Surgical services, anesthesia services and Health Care Practitioner services (not including office visits). [The maximum benefit is shown on page one. Office visits to a Health Care Practitioner are shown separately.]]
- **[Reconstructive Surgery:** Reconstructive surgery to restore function for conditions resulting from accidental Injury provided the Injury occurred while the Insured is covered under the policy. Reconstructive surgery that is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part if the trauma, infection or other diseases occurred or had their onset while the Insured was covered under the policy. Reconstructive surgery because of congenital illness or anomaly of a Covered Dependent child, born while the policy is in force, that resulted in a functional defect. [The maximum benefit is shown on page one.]]
- **[Inpatient Rehabilitation Programs:** Inpatient rehabilitation includes, but is not limited to, physical, occupational and speech therapy provided on an inpatient basis in a facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitative Facilities when the confinement is in lieu of acute hospitalization. [The maximum benefit is shown on page one.]]

- **[Skilled Nursing Facility Care:** Care in a Skilled Nursing Facility when the confinement is in lieu of acute hospitalization or when admitted to the Skilled Nursing Facility within [14] days after a Hospital confinement of at least [3] days for the same condition. The maximum daily benefit for care in a Skilled Nursing Facility will not exceed: 1) one-half of the semi-private Hospital room rate for the Hospital confinement; or 2) one-half of the most common semi-private Hospital room rate for the area in which You live if You were not previously Hospital confined. [The maximum benefit is shown on page one.]]
- **[Home Health Care:** Home health care visits provided by a state licensed or Medicare certified home health agency. One visit consists of up to [4 hours] of home health aide service within a 24-hour period. [The maximum benefit is shown on page one.]]
- **[Outpatient Physical Medicine Services:** Outpatient Physical Medicine includes, but is not limited to: physical, speech or occupational therapy; pulmonary or cardiac rehabilitation therapy; or adjustments and manipulations provided in the outpatient department of a Hospital, by a licensed or certified home health care agency or by a licensed therapist in Your home. One visit consists of up to [4 hours] of therapy within a [24-hour] period. [The maximum benefit is shown on page one.]]
- **[Ambulance Services:** Ambulance service for one trip to the nearest Hospital that is able to treat the Sickness or Injury. [The maximum benefit is shown on page one.]]
- **[X-ray and Laboratory Services:** X-ray, radioactive treatment and laboratory charges. [The maximum benefit is shown on page one.] [This includes 1 screening mammography exam per Benefit Period for a covered female, age 35 or over [for a maximum benefit of [\$60].]]
- **[Durable Medical Equipment and Supplies:** Rental, up to the purchase price, or purchase of a basic non-electric wheelchair, basic non-electric hospital bed or basic crutches; the initial permanent basic artificial limb or eye; oxygen and the equipment needed to administer oxygen; casts, orthopedic braces, splints, dressings and sutures; and the initial external breast prosthesis needed because of Medically Necessary surgical removal of all or part of the breast provided the surgery was performed while the Insured was covered under the policy. [There is up to a maximum benefit of [\$1,000] per Benefit Period] for all of the items listed above combined.]]
- **[Blood Product Transfusions:** Whole blood, blood plasma and blood products if not replaced.]
- **[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction:** Surgical and non-surgical treatment of temporomandibular or craniomandibular joint dysfunction, except for the treatment and services outlined in the policy. The combined maximum for all surgical and non-surgical treatment is limited to [\$1,000] for each Insured per Benefit Period. Optional Rider 8131.AR can be purchased for an additional premium to cover services provided by a physician or dentist for the Medically Necessary diagnosis, surgical and non-surgical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including TMJ and CMJ. If this optional benefit is purchased through Rider 8131.AR, coverage of these types of musculoskeletal disorders will be considered on the same basis as any other covered Sickness under the policy.]
- **[Complications of Pregnancy:** The following complications arising from a pregnancy that began after the Effective Date of coverage are considered on the same basis as any other covered Sickness: 1) conditions, requiring Hospital confinement (when pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, including: acute nephritis, nephrosis, cardiac decompensation, and missed abortion, and similar medical and surgical conditions of comparable severity; and 2) non-elective caesarean section delivery, ectopic pregnancy which is terminated, spontaneous termination of pregnancy (miscarriage) that occurs during a period of gestation in which a viable birth is not possible. No benefits will be paid for: false labor; premature labor; high risk pregnancy or delivery; elective caesarean section delivery; occasional spotting; Health Care Practitioner prescribed rest; morning sickness; hyperemesis gravidarum; pre-eclampsia; placenta previa; or similar conditions that occur in a difficult pregnancy.

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- **[Prescription Drugs:** Drugs and medicines that are fully approved by the U.S. Food and Drug Administration, are received on an outpatient basis, require the written prescription of a Health Care Practitioner for treatment of a condition that is a Covered Expense under the policy and are dispensed by a licensed pharmacy. [The maximum benefit is shown on page one.]
- **[AIDS/HIV Services:** Treatment of AIDS, AIDS Related Complex (ARC) or related immunodeficiency disorders up to a maximum benefit of [\$10,000] for each Insured per Benefit Period.]
- **[Transplantation Benefit:** Certain human organ/tissue transplants or replacements as listed in the policy and donor expenses provided that the transplant is the result of a Sickness or Injury that had its onset after the Effective Date of the policy. The maximum transplant benefit per Benefit Period is [\$100,000] for all transplants, combined transplants, and sequential transplants and the maximum benefit for donor expenses is [\$10,000].]
- **[Preventive Medicine Services:** Covered Expenses for preventive medicine services are for the routine well care services shown in the Benefit Summary that are not a Covered Expense elsewhere in the plan. These services must be provided in accordance with the guidelines established by the United States Preventative Services Task Force or the Advisory Committee on Immunization Practices on the date the service is incurred. Coverage does not include routine well newborn care at birth.
- **Diabetes Benefit:** Medically Necessary equipment, services, supplies and self-management training incurred for treatment of diabetes.
- **Medical Foods:** Medically Necessary amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas for the treatment of phenylketonuria (PKU) if the cost of these products, for an individual or family, exceeds the \$2,400 per person annual income tax credit allowed under Arkansas law.
- **[Newborn Child Services:** Services for a newborn child who is born while the policy is in force and is a Covered Dependent, as follows:
  1. Treatment of a Sickness, Injury, medically diagnosed congenital defect and premature birth; and
  2. Tests for hypothyroidism, PKU, galactosemia, sickle-cell anemia, and any other metabolic disorder for which screening is performed by or for the State of Arkansas; and
  3. Any additional testing of a newborn child that is mandated by Arkansas law; and
  4. Routine nursery care and pediatric charges for a well newborn child for up to 5 full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time.]
- **Child Wellness Services:** Periodic preventive care visits for Covered Dependents under the age of 19, at the following age intervals:
  1. One visit each at birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months; and
  2. One visit per Benefit Period from the age of 2 years through 18 years.

Preventive care visits include medical history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests. Only those services provided by or under the supervision of one Health Care Practitioner during the course of one visit will be covered. Immunization services recommended by a Health Care Practitioner are not subject to any Deductible, Copayment, or coinsurance provisions of the policy.]
- **Mental Illness and Developmental Disorders Benefit:** No coverage is available for treatment of Mental Illness or for treatment of Developmental Disorders unless such coverage is purchased for an additional premium through optional Rider 8132.AR. If this optional benefit is purchased, Covered Expenses are for the Medically Necessary diagnosis and treatment of Mental Illness and Developmental Disorders which will be considered on the same basis as any other covered Sickness under the policy.

- Psychological Examiners Benefit:** This coverage can be purchased for an additional premium through optional Rider 8132.AR only if the optional Mental Illness and Developmental Disorders Benefit is also purchased for an additional premium as indicated in the provision above. If this additional optional benefit is purchased, Covered Expenses for diagnosis and treatment of Mental Illness will be considered regardless of whether such services are provided by a Health Care Practitioner or by a psychological examiner.

PRE-EXISTING CONDITIONS LIMITATION: No benefits will be provided during the term of the policy for any Pre-Existing Condition or due to a complication of a Pre-Existing Condition. A Pre-Existing Condition is a medical condition due to Sickness or Injury for which the Insured received medical treatment or advice from a provider within the [5 year] period immediately preceding the Effective Date of coverage, regardless of whether the condition was diagnosed or not diagnosed; or that produced signs or symptoms within the [5-year] period immediately preceding the Effective Date of coverage. The signs or symptoms must have been significant enough to establish manifestation or onset by one of the following tests: 1) The signs or symptoms would have allowed one learned in medicine to make a diagnosis of the disorder; or 2) The signs or symptoms should have caused an ordinarily prudent person to seek diagnosis or treatment. A pregnancy that existed on the day before Your Effective Date of coverage is also considered a Pre-Existing Condition.

[WAITING PERIOD LIMITATION: We will not pay benefits during the term of the policy for charges incurred due to a Sickness that manifests itself before any Waiting Period for preventive medicine services that are incurred during a Waiting Period. Benefits are available from the first day Covered Expenses are incurred for preventive medicine services or for an Injury that is sustained on or after the Effective Date of Your coverage.]

EXCLUSIONS: The policy does not cover any of the following:

- Charges for Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury, even if You did not intend to cause the harm which resulted from the action which led to the self-inflicted Sickness or Injury. This exclusion applies whether You were sane or insane at the time of the suicide, attempted suicide or self-inflicted Sickness or Injury.
- Sickness or Injury to the extent that benefits are paid by Medicare or any other government law or program, except Medicaid (Medi-Cal in California); or medical coverage under any automobile or no fault insurance.
- Sickness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when You do not file a claim for benefits.
- Treatment of Sickness or Injury caused by or contributed to by: 1) War or any act of war; or 2) Participation in the military service of any country. Any premium paid for a time not covered will be returned pro-rata.
- Charges for dental care, including dental braces and dental appliances, unless a Hospital stay is required due to Injury from an accidental blow to the mouth causing trauma to sound, natural teeth, the gums or supporting structures of the teeth. A sound, natural tooth has no decay and has never had a filling, root canal therapy or crown. Inpatient Hospital care must be the least expensive setting needed to produce a professionally adequate result and the Hospital charges only are Covered Expense. The treatment must be received while the policy is in force.
- Charges for:
  - 1.] Eyeglasses, contact lenses, eye exams, eye refraction or eye surgery for correction of refraction error; vision therapy; or artificial hearing devices.
  - 2.] Preventive treatment including, but not limited to, routine physical exams and immunizations, unless otherwise noted as a Covered Expense in [the Preventive Medicine Services provision or elsewhere in] the policy or a rider to the policy.
  - 3.] Treatment, services or supplies to address: Smoking cessation; snoring or sleep disorders; the treatment or prevention of hair loss; change in skin pigmentation; or cognitive enhancement.
  - 4.] Weight reduction or weight control programs or treatment; surgery for weight control, obesity or morbid obesity; or any type of gastric bypass surgery.

Deleted: [Conditions for which claims were submitted under a prior Short Term Medical policy or certificate issued by Us that provided coverage that ended within 90 days before the Effective Date of the policy.] ¶

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Deleted: Treatment of temporomandibular or craniomandibular joint dysfunction, except as provided in the policy. ¶ Expense incurred that is not for treatment of Sickness or Injury. This includes, but is not limited to, c

Deleted: Normal pregnancy or childbirth; routine well baby care, including Hospital nursery charges at birth; or abortion, except as provided in the complications arising from pregnancy provision in the Benefits section of the policy. ¶

Deleted: Infertility diagnosis and treatment for males and females including, but not limited to, drugs and medications, artificial insemination, in-vitro fertilization and reversal of sterilization. ¶ Genetic testing or counseling including, but not limited to, amniocentesis and chorionic villi testing. ¶ Sex transformation; treatment of sexual function, dysfunction or inadequacy; or treatment to enhance sexual performance or desire. ¶ Treatment and medication to stimulate growth and growth hormones for any purpose. ¶

Deleted: quality of life or lifestyle concerns including, but not limited to

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Deleted: Sterilization and drugs or devices used directly or indirectly to promote or prevent conception. ¶

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- [5.] Therapy or treatment for learning disorders or disabilities or developmental delays.]
- [6.] Custodial Care; respite care; rest care; or supportive care.]
- [7.] Private duty nursing services rendered during Hospital confinement; or standby Health Care Practitioners.]
- [8.] Sales tax or gross receipt tax; provider administrative expenses including, but not limited to, charges for claim filing, contacting utilization review organizations and case management fees.]]

Deleted: All treatments for varicose veins.¶

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Deleted: Travel, transportation or living expenses.¶

- Cosmetic treatment or reconstructive or plastic surgery that is primarily a cosmetic procedure, including medical or surgical complications arising therefrom, except as provided in the Benefits section of the policy.]

- Treatment of Mental Illness or Substance Abuse, whether organic or non-organic, chemical or non-chemical, biological or non-biological in origin and irrespective of cause, basis or inducement, unless otherwise noted as a Covered Expense in the policy or a rider to the policy.]

- Treatment or services rendered by, or supplies purchased from, a member of Your Immediate Family or an employer.]

Deleted: Treatment, repair or removal of tonsils or adenoids, except on an Emergency basis.¶

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- Treatment or services required due to accidental Injury sustained [in operating a motor vehicle] while the Insured's blood alcohol level, as defined by law, exceeds that level permitted by law or otherwise violates legal standards for a person operating a motor vehicle in the state where the Injury occurred. This exclusion applies whether or not [the Injury occurred in connection with an incident involving the operation of a motor vehicle, and whether or not] the Insured is charged with any violation in connection with the accident.]

Deleted: Treatment or services required for Sickness or Injury resulting from consumption, abuse or overdose of alcoholic beverages or any illegal or controlled substance.¶

- Treatment or services required due to Injury received while engaging in any hazardous [occupation or other] activity including, but not limited to: Participating, instructing, demonstrating, guiding or accompanying others in [parachute jumping,] [hang-gliding,] [bungee jumping,] [flight in an aircraft other than a regularly scheduled flight by an airline,] [racing any motorized [or non-motorized] vehicle,] [rock or mountain climbing,] [hunting,] [parkour,] [free running] and [extreme sports]. [Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.]

Deleted: <#>Custodial Care; respite care; rest care; or supportive care.¶

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- Treatment or services required due to Injury received while engaging in any hazardous [occupation or other] activity [for which compensation is received in any form, including sponsorship], including, but not limited to: Participating, instructing, demonstrating, guiding or accompanying others in [skiing,] [horse riding,] [rodeo activities,] [professional [or semi-professional] [contact] sports,] [adult sporting competition at a national or international level] [or] [extreme sports]. [Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.]

Deleted: <#>Private duty nursing services rendered during Hospital confinement and charges for standby Health Care Practitioners.¶

<#>Dental braces, dental appliances, corrective shoes, repairs to or replacement of prosthetic devices, or orthotics, except as provided in the Benefits section of the policy.¶  
<#>Inpatient treatment of chronic pain disorders; biofeedback; repair of diastasis recti; reduction mammoplasty; revision of breast surgery for capsular contraction or replacement of prosthesis; orthognathic surgery; non-medical self-care or self-help programs.¶

- Treatment or services required due to Injury sustained while participating in any [interscholastic] [or] [inter-collegiate] sport, contest or competition [or while practicing,] [exercising,] [undergoing conditioning or physical preparation]] for any such sport, contest or competition.]

<#>¶  
<#>Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) and related immunodeficiency disorders[, except as provided in the Benefits section of the policy].¶

- Expense incurred due to Sickness or Injury of which a contributing cause was the Insured's voluntary attempt to commit, participation in or commission of a felony, whether or not charged, or as a consequence of the Insured's being under the influence of illegal narcotics or non-prescribed controlled substances.]

<#>¶

- Expenses incurred outside of the United States or its possessions or Canada [unless the Optional Travel Benefit Rider is included in the policy].]

<#>¶  
<#>[The first [\$2,500] or [50%], whichever is the lesser amount, of an otherwise Covered Expense not authorized in accordance with the Authorization Provisions section of the policy.]¶

- Charges that are: Incurred for Experimental or Investigational Treatment; in excess of the Reasonable and Customary Amount; not Medically Necessary.]

- Transplants[, except as covered in the Benefits section of the policy].]

- ~~[Charges for foot conditions including, but not limited to: Care of corns, bunions, except capsular or bone surgery; calluses; toenails; and foot supportive devices, including orthotics and corrective shoes.]~~
- ~~Prophylactic treatment or services. Prophylactic means any surgery or other procedure performed to prevent a disease process from becoming evident in the organ or tissue at a later date.~~
- ~~[Drugs and medicines [received on an outpatient basis], except as covered in the Benefits section.] [Drugs prescribed for treatment of a Sickness or an Injury that is not covered under this policy.]~~
- ~~[Charges for reproductive or sexual treatment including, but not limited to: Normal pregnancy or childbirth; routine well baby care, including Hospital nursery charges at birth except as provided in the Benefits section of the policy; abortion, except as otherwise covered in the Complications of Pregnancy provision; infertility diagnosis and treatment for males and females including, but not limited to, drugs and medications, artificial insemination, in-vitro fertilization and reversal of sterilization; sterilization and drugs or devices used directly or indirectly to promote or prevent conception; genetic testing or counseling including, but not limited to, amniocentesis and chorionic villi testing; and treatment of sexual dysfunction or inadequacy.]~~

~~RENEWABILITY PROVISION: The policy is not renewable. Coverage is in force only for the Benefit Period You selected which is shown on page one.~~

~~PREMIUM: The first page shows the total premium for the coverage You selected. The premium amount will not change while the policy is in force.~~

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Licensed Agent's Signature

\_\_\_\_\_  
Date

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Deleted: <#>Complications resulting from leaving an Inpatient or Outpatient facility against the advice of Your Health Care Practitioner; complications of any condition that existed prior to the Effective Date; or treatment for an excluded service or procedure.¶

¶  
<#>Treatment, services or supplies rendered or received when coverage under the policy is not in effect, except as provided under the Extension of Benefits provision.¶

¶  
<#>Any amount in excess of the Reasonable and Customary Amount, as determined by Us under the policy.¶

Deleted: <#>Treatment, services or supplies that are not Medically Necessary as determined by Us under the policy.¶

<#>Treatment, services or supplies that are prescribed, provided or furnished in a manner primarily for the convenience of the Insured or Health Care Practitioner.¶

¶  
<#>[Drugs prescribed for treatment of a Sickness or an Injury that is not covered under this policy.] [Drugs and medicines, except as covered in the Benefits section.] ¶

¶  
<#>Treatment, services or supplies not described in the Benefits section of the policy.¶

**TIME INSURANCE COMPANY**  
**FORM 135**  
**Proposed Rates for 03/01/2009**  
**(30 DAY MINIMUM; 360 DAY MAXIMUM)**  
**AR**

DAILY RATE									
Deductible									
AGE	\$250	\$500	\$750	\$1,000	\$1,750	\$2,500	\$3,500	\$5,000	\$7,500
0-14	2.21	1.45	1.35	1.25	1.05	0.95	0.80	0.68	0.65
15-19	2.81	1.90	1.65	1.55	1.35	1.25	1.10	1.03	0.85
20-24	2.51	1.70	1.60	1.50	1.20	1.10	0.95	0.88	0.80
25-29	2.66	1.69	1.49	1.38	1.18	0.97	0.95	0.78	0.70
30-34	2.86	1.90	1.55	1.35	1.18	1.05	1.00	0.78	0.70
35-39	3.31	2.26	1.95	1.70	1.40	1.20	1.10	1.03	0.80
40-44	3.81	2.51	2.21	2.01	1.65	1.45	1.25	1.13	1.05
45-49	4.42	2.96	2.71	2.51	2.11	1.75	1.50	1.43	1.25
50-54	6.03	4.02	3.66	3.36	2.86	2.51	2.16	1.98	1.75
55-59	7.83	5.47	4.97	4.42	3.81	3.26	2.81	2.59	2.26
60-64	12.81	8.59	7.83	7.08	5.92	5.07	4.37	4.10	3.11
Per Child	1.40	0.90	0.85	0.80	0.65	0.50	0.50	0.45	0.40

<u>PRODUCT factors</u>	
\$2 Million Max 6 month	1.00
\$2 Million Max 12 month	1.00
\$100,000 Max	0.72

<u>MAXIMUM POLICY DURATION factors</u>	
1 to 6 months	1.00
up to 12 months	1.30

<u>AREA FACTORS</u>	
<u>Zip</u>	<u>Factor</u>
All AR	1.70

<u>STOP LOSS factors</u>		
Core	Core	
\$2 Million Max	\$2 Million Max	Healthsaver
<u>Stop Loss</u>	<u>6 Months</u>	<u>12 Months</u>
\$10,000	1.00	1.00
\$20,000		1.00

<u>TREND FACTORS</u>	

<u>Core 6 Month</u>		<u>Core 12 Month</u>		<u>Healthsaver 6 and 12 Month</u>	
Max Benefit	Additional	Max Benefit	Additional	Lifetime	Lifetime
<u>Amount</u>	<u>Daily Rate</u>	<u>Amount</u>	<u>Daily Rate</u>	<u>Max Option</u>	<u>Max Factor</u>
\$2 Million	+ \$0.00	\$2 Million	+ \$0.00	\$100,000	1.00
				\$500,000	1.25

<u>MODAL FACTORS</u>	
Single Pay	1.00
Monthly Pay	1.28

<u>RATE OF PAYMENT</u>			
<u>FACTORS</u>	50%	80%	100%
250	0.800	1.100	N/A
500	0.880	1.100	1.250
750	0.800	1.000	N/A
1000	0.800	1.000	1.340
1750	0.800	1.000	N/A
2500	0.800	1.000	1.220
3500	N/A	N/A	1.220
5000	0.800	1.000	N/A
7500	0.800	1.000	N/A

<u>LIFE RIDER - optional</u>	
<u>Age</u>	<u>Daily Rate per Adult per Amount of Coverage \$25,000</u>
18-24	\$0.39
25-29	\$0.39
30-34	\$0.41
35-39	\$0.47
40-44	\$0.62
45-49	\$0.85
50-54	\$1.29
55-59	\$1.96
60-64	\$2.64

<u>AME RIDER - optional</u>	
<u>Deductible</u>	<u>Daily Rate per Person</u>
\$250	\$0.13
\$500	\$0.20
\$750	\$0.28
\$1,000	\$0.33
\$1,750	\$0.45
\$2,500	\$0.53

<u>Other Optional Riders</u>	
Travel	\$100
TMJ	\$33
Mental Illnes	\$536

<u>ADDITIONAL POLICY FEES</u>	
Application Fee	\$25

\$3,500	\$0.60
\$5,000	\$0.70
\$7,500	\$0.86

**RATE CALCULATION INSTRUCTIONS**

**1st Month**

**Subsequent Months**

Daily Rate \_\_\_\_\_

Daily Rate \_\_\_\_\_

X Product Factor \_\_\_\_\_

X Product Factor \_\_\_\_\_

X Area Factor \_\_\_\_\_

X Area Factor \_\_\_\_\_

X Trend Factor \_\_\_\_\_

X Trend Factor \_\_\_\_\_

X Modal Factor \_\_\_\_\_

X Modal Factor \_\_\_\_\_

X Rate of Payment Factor \_\_\_\_\_

X Rate of Payment Factor \_\_\_\_\_

X Maximum Policy Duration Factor \_\_\_\_\_

X Maximum Policy Duration Factor \_\_\_\_\_

X Stop Loss Factor \_\_\_\_\_

X Stop Loss Factor \_\_\_\_\_

X Lifetime Maximum Benefit Factor \_\_\_\_\_

X Lifetime Maximum Benefit Factor \_\_\_\_\_

+ Additional Lifetime Max Daily Rate \_\_\_\_\_

+ Additional Lifetime Max Daily Rate \_\_\_\_\_

+ Life Rider Daily Rate \_\_\_\_\_

+ Life Rider Daily Rate \_\_\_\_\_

+ AME Rider Daily Rate \_\_\_\_\_

+ AME Rider Daily Rate \_\_\_\_\_

= Subtotal \_\_\_\_\_

= Subtotal \_\_\_\_\_

X # of Days of Coverage \_\_\_\_\_

X # of Days of Coverage \_\_\_\_\_

+ State Mandated Riders \_\_\_\_\_

=Total Amount Due \_\_\_\_\_

al (Stop Here for Spouse/Dependents) \_\_\_\_\_

+ Application Fee (For Primary Only) \_\_\_\_\_

=Total Amount Due (Primary) \_\_\_\_\_

\*Not all factors and fees will apply to all policies, therefore this algorithm represents the maximum that could be charged, actual premiums may be less.

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# McHugh Consulting Resources, Inc.

February 13, 2009

**Submitted via SERFF**

Rosalind Minor  
Policy Reviewer  
Life and Health Division  
Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201-1904

RE: **RESUBMISSION – STATE FILE NO. 41391**  
**TIME INSURANCE COMPANY - NAIC #69477; FEIN 39-0658730**  
Policy Amendment FORM 4131.AR  
Benefit Summary Form FORM 135.BNS.AR Rev. 09/2008  
Application for Insurance Form 28786.AR (Rev. 1/2009)

**SERFF TRACKING NO. MCHX-126016220**

Dear Ms. Minor:

We are in receipt of your February 3, 2009 objection letter regarding the above-referenced filing submission.

Pursuant to your objection, we have revised the Fraud Warning on Application 28786.AR (Rev. 1/2009) to be compliant with ACA 23-66-503. The revised Application is attached for your review and approval.

We trust that this filing is now in compliance with Arkansas requirements.

Please contact us if you have any further questions or concerns regarding this filing submission.

Sincerely,



Katherine Hansen  
Consultant

SERFF Tracking Number: MCHX-126016220 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 41391  
 Company Tracking Number: 4131.AR  
 TOI: H161 Individual Health - Major Medical Sub-TOI: H161.004 Short Term  
 Product Name: 135.001.XX Rev 09/2008 TIC Short Term Medical - In  
 Project Name/Number: 135.001.XX Rev 09/2008 TIC Short Term Medical - Individual /135.001.XX Rev 09/2008 TIC Short Term Medical - Individual

## Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/30/2009	Form	Application for Insurance	02/13/2009	Form 28786_AR (Rev_1_2009).PDF (Superseded)

**Short Term Medical Enrollment Form**

**Time Insurance Company - ARKANSAS**

REQUESTED EFFECTIVE DATE  
 MONTH DAY YEAR

**[Note: Effective date is assigned by Time Insurance Company. [The effective date is the later of:**

CERTIFICATE/POLICY NUMBER

1.) The day after: a) the date this form is signed; b) the date this form is postmarked for mailing to Time Insurance Company; or c) the date we receive your enrollment request by electronic transmission in our home office, OR 2.) If dates cannot be determined, the day we receive this form by mail. **The agent cannot assign an effective date different than this.]]**

APPLICANT'S NAME (Print Last, First, Middle)			GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER
STREET ADDRESS			CITY, STATE, ZIP CODE		
SPOUSE'S NAME (If to be insured)			GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER
CHILDREN (Name) (If to be insured)	BIRTH DATE	NAME	BIRTH DATE	NAME	BIRTH DATE
1.		2.		3.	

**NOTE: The plan cannot be issued if YES is answered to any questions. Under no circumstances can coverage become effective prior to the date this application is signed.**

Answer the following questions completely and accurately. Yes No

- [Will you or any person to be insured have any other hospital, Major Medical, or group health insurance in force on the effective date of this plan?  Yes  No]
- [Have/Are you, your spouse, or any person to be insured:  Yes  No]
  - ◆ [been denied insurance due to any health reasons that are still present?]
  - ◆ [now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?]
- [For any of the following conditions within the last [5] years, have you or any person to be insured received any abnormal test results or medical or surgical treatment, or consulted a health care professional, or taken medication for:  Yes  No]
  - ◆ [heart disorder [including but not limited to heart attack or chest pain]?]
  - ◆ [emphysema[,] [Chronic Obstructive Pulmonary Disease (COPD)]?]
  - ◆ [Crohn's disease[,] [ulcerative colitis] [or] [hepatitis (B or C)]?]
  - ◆ [AIDS [or] [tested positive for HIV]?]
  - ◆ [stroke [hypertension] [or high blood pressure]?]
  - ◆ [kidney disorder[,] [excluding kidney stones]?]
  - ◆ [diabetes[,] [except Gestational Diabetes]?]
  - ◆ [cancer [or] [tumor] [except Basal Cell Skin Cancer which has been removed]?]
  - ◆ [alcoholism, chemical dependency, drug or alcohol abuse?]

LENGTH OF COVERAGE	DEDUCTIBLE AMOUNT	LIFETIME MAXIMUM	PAYMENT OPTION	COINSURANCE	TOTAL
<input type="checkbox"/> Up to 6 months	<input type="checkbox"/> \$250* <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$500 <input type="checkbox"/> \$2,500	<input type="checkbox"/> \$2 Million <input type="checkbox"/> \$5 Million	<input type="checkbox"/> Single payment:  _____ Days	<input type="checkbox"/> 100%* <input type="checkbox"/> 80% <input type="checkbox"/> 50%	
<i>* not available with 100% Rate of Payment</i>			<input type="checkbox"/> Monthly payment	<i>* not available on policies longer than 6 months</i>	
<input type="checkbox"/> Up to 12 months	<input type="checkbox"/> \$500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$1 Million <input type="checkbox"/> \$2 Million			

OPTIONAL RIDERS (Additional premium required) I hereby select these optional benefits:  TMJ Benefits  Mental Illness Benefits

Term Life for Insured  Term Life for Insured and Spouse  Accident Medical Expense

**IF REQUESTING LIFE INSURANCE COVERAGE**  
 Beneficiary for Primary Insured \_\_\_\_\_  
FULL NAME RELATIONSHIP  
 (The Primary Insured is the beneficiary of any Spouse Life Insurance.)

The undersigned attests that the information above is true to the best of his/her knowledge. The undersigned realizes that any false, or inaccurate statement or misrepresentation in the enrollment form may result in claim denial or contract rescission. Any person who injures, defrauds, or deceives any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. The undersigned understands that the plan applied for will not pay benefits for any expenses incurred on account of any condition which manifested itself before the effective date. The undersigned also understands that this is not a continuation of any previous medical plan, including any prior Short Term Medical plan. I understand that benefits may be reduced under the policy if I have other insurance coverage. [The undersigned also attests that all persons to be covered do not have pending medical appointments, or any medical condition not disclosed above.]

If I am self employed or an employee of an employer with 50 or fewer employees, I warrant premiums for this coverage are not: (1) Paid or reimbursed by my employer or, (2) To the best of my knowledge, treated as tax-deductible by my employer or me as related to an employer benefit plan (Internal Revenue Code sections 106,125,162 or 213).

[In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any medically related facility, insurance company, the Medical Information Bureau, employer, or consumer reporting agency to give to Time Insurance Company (or to any consumer reporting agency authorized by Time Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical care, advice or treatment.]

[I agree that a photographic copy of this authorization shall be valid for two years from the date signed.]

[I acknowledge receiving the Fair Credit Reporting Act Pre-Notification, the notification regarding the Medical Information Bureau, the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage for Health Insurance, if required.]

PRIMARY PHYSICIAN'S NAME (IF ANY) \_\_\_\_\_ PRIMARY PHYSICIAN'S TELEPHONE NUMBER \_\_\_\_\_

APPLICANT'S SIGNATURE \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

DAY TELEPHONE NUMBER \_\_\_\_\_ EVENING TELEPHONE NUMBER \_\_\_\_\_