

SERFF Tracking Number: CAIC-126085474 State: Arkansas  
Filing Company: Continental American Insurance Company State Tracking Number: 41889  
Company Tracking Number: 127  
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only  
Expense  
Product Name: Mid Med AR endorsement revised  
Project Name/Number: Mid Med AR endorsement revised/127

## Filing at a Glance

Company: Continental American Insurance Company

Product Name: Mid Med AR endorsement revised SERFF Tr Num: CAIC-126085474 State: ArkansasLH

TOI: H15G Group Health - Hospital/Surgical/Medical Expense SERFF Status: Closed State Tr Num: 41889

Sub-TOI: H15G.002 Large Group Only Co Tr Num: 127 State Status: Approved-Closed

Filing Type: Form Co Status: Reviewer(s): Rosalind Minor

Author: Ashley Gibson Disposition Date: 03/27/2009

Date Submitted: 03/23/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name: Mid Med AR endorsement revised

Project Number: 127

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 03/27/2009

Deemer Date:

Filing Description:

Please see attached submission letter.

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 03/27/2009

Corresponding Filing Tracking Number: 127

## Company and Contact

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**Filing Contact Information**

Ashley Gibson, Compliance Analyst companycompliance@caicworksite.com  
 2801 Devine Street (888) 730-2244 [Phone]  
 Columbia, SC 29205 (803) 929-4925[FAX]

**Filing Company Information**

Continental American Insurance Company CoCode: 71730 State of Domicile: South Carolina  
 2801 Devine Street Group Code: Company Type: LAH  
 Columbia, SC 29205 Group Name: Continental Amer Ins State ID Number:  
 Co  
 (803) 256-6265 ext. [Phone] FEIN Number: 57-0514130  
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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$20.00  
 Retaliatory? No  
 Fee Explanation: \$20.00 per filing separate forms.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Continental American Insurance Company	\$20.00	03/23/2009	26616148

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/27/2009	03/27/2009

### 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	03/25/2009	03/25/2009	Ashley Gibson	03/25/2009	03/25/2009

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## **Disposition**

Disposition Date: 03/27/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CAIC-126085474 State: Arkansas  
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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Submission Letter	Approved-Closed	Yes
<b>Supporting Document</b>	Certificate of Compliance	Approved-Closed	Yes
<b>Supporting Document</b>	Response Letter	Approved-Closed	Yes
<b>Form (revised)</b>	Arkansas Endorsement	Approved-Closed	Yes
<b>Form</b>	Arkansas Endorsement	Replaced	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 03/25/2009  
Submitted Date 03/25/2009

Respond By Date

Dear Ashley Gibson,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Arkansas Endorsement (Form)

Comment: Your letter states that with respect to the mandated offer for Children's Preventive Health Care, you offer more than the required coverage in your certificate.

Before approval is given to this submission, please verify that coverage for immunization are covered at 100% and is exempt from any copayment, coinsurance, deductible, or lollar limit as outlined under ACA 23-79-141(f)(2)(A).

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 03/25/2009  
Submitted Date 03/25/2009

Dear Rosalind Minor,

### Comments:

Please see attached response letter and revised endorsement.

### Response 1

Comments: Please see the attached response letter and attached endorsement.

### Related Objection 1

SERFF Tracking Number: CAIC-126085474 State: Arkansas  
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**Applies To:**

- Arkansas Endorsement (Form)

**Comment:**

Your letter states that with respect to the mandated offer for Children's Preventive Health Care, you offer more than the required coverage in your certificate.

Before approval is given to this submission, please verify that coverage for immunization are covered at 100% and is exempt from any copayment, coinsurance, deductible, or lollar limit as outlined under ACA 23-79-141(f)(2)(A).

**Changed Items:**

**Supporting Document Schedule Item Changes**

Satisfied -Name: Response Letter

Comment:

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Arkansas Endorsement	CAI1038A		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Revised	CAI1038A R 3-09	50	CAI1038A R Endorsement AR Revised 3-09.pdf

**Previous Version**

Arkansas Endorsement	CAI1038A		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		50	CAI1038A R Endorsement AR Revised 3-09.pdf
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No Rate/Rule Schedule items changed.

*SERFF Tracking Number:* CAIC-126085474                      *State:* Arkansas  
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Thank you and please let me know if there is anything else you need!

Sincerely,  
Ashley Gibson

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## Form Schedule

Lead Form Number: CAI1038AR 3-09

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	CAI1038AR 3-09	Policy/Cont	Arkansas ract/Fratern Endorsement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Revised	Replaced Form #: CAI1038AR 3-09 Previous Filing #: 127	50	CAI1038AR Endorsement AR Revised 3-09.pdf



2801 Devine Street, Columbia, South Carolina 29205  
800-433-3036

## AMENDATORY ENDORSEMENT

This amendatory endorsement is made a part of the Policy or Certificate to which it is attached and is subject to all terms and provisions of such Policy or Certificate not inconsistent herewith. This amendatory endorsement is applicable only to Insured Persons who are **residents** of the State of Arkansas on the Certificate Date and on the date the claim is incurred.

### **RENEWABILITY**

This Policy/Certificate may be renewed for further consecutive periods by payment of the renewal premium, in advance or as stated in the Grace Period Provision, at the renewal premium rates then in force. We will never refuse to renew this Certificate because of any change in a Covered Person's health or physical condition. We may refuse to renew the coverage of a covered employee or dependent if:

- (a) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;
- (b) the covered employee or dependent has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact, relating in any way to the health benefit plan, including claims for benefits under the health benefit plan;
- (c) We cease to offer health benefit plan coverage in the employer market and offer the option to purchase any other benefit plan; or

Medicare eligibility or entitlement is not a basis for non-renewal or termination of a health benefit plan issued to an employee. However, benefits may be subject to the Coordination of Benefits Provision.

If this Certificate is terminated in accordance with the above condition, a Covered Person's coverage will terminate at the end of the period for which premium has been paid, subject to the Grace Period Provision. Termination of this Certificate does not affect the claims which begin prior to the date of termination. All insurance periods start and end at 12:01 a.m. Standard Time, at Your residence.

We will not send written notice of any termination for non-payment of premium. Coverage stops for non-payment of premium at the end of the period for which premium was paid, subject to the Grace Period.

In Section 7, the following Mandated Benefits will be included

#### **I. BENEFITS FOR DIABETES COVERAGE**

Benefits will be paid the same as any other Sickness for Diabetes. Included is medical coverage for medically necessary equipment, supplies and services for the treatment of Type I, Type II, and gestational diabetes, when prescribed by a licensed physician.

Benefits will be subject to all Deductible, co-payment, coinsurance, limitations or any other provisions of the policy.

**II. BENEFITS FOR SELF-MANAGEMENT TRAINING COVERAGE**

Benefits will be paid the same as any other Sickness for Diabetes Self-Management Training. One diabetes self-management training is covered per lifetime training program per insured for diabetes self-management training when medically necessary as determined by a physician and when provided by an appropriately licensed health care professional upon certification by the health care professional providing the training that the insured patient has successfully completed the training.

In addition, additional diabetes self-management training is offered in the event that a physician prescribes additional diabetes self-management training and it is medically necessary because of a significant change in the insured's symptoms or conditions.

A licensed health care professional shall only provide diabetes self-management training within his or her scope of practice after having demonstrated expertise in diabetes care and treatment and after having completed an educational program required by his or her licensing board when that program is in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Diabetes self-management training shall be provided only upon prescription by a physician licensed.

Nothing in this provision shall be construed to prohibit us from selectively negotiating contracts with qualified providers of diabetes self-management training programs.

Benefits will be subject to all Deductible, co-payment, coinsurance, limitations or any other provisions of the policy.

**III. ROUTINE WELL CHILD CARE**

Benefits for eligible dependents from birth through eighteen (18) years of age are payable for child wellness services rendered during a periodic review. Child wellness services are covered to the extent that such services are provided by or under the supervision of a single Physician during the course of one visit. Covered services include: medical history; measurement of height, weight and head circumference; testing of blood pressure; sensory screening including vision and hearing; hereditary and metabolic screening in accordance with state law; developmental/behavioral assessment; immunizations consistent with prevailing American Academy of Pediatric Committee statements; tuberculin test; hematocrit or hemoglobin; urinalysis; and anticipatory guidance.

Benefits include twenty (20) visits at approximately the following age intervals:

- (A) Birth;
- (B) Two (2) weeks;
- (C) Two (2) months;
- (D) Four (4) months;
- (E) Six (6) months;
- (F) Nine (9) months;
- (G) Twelve (12) months;
- (H) Fifteen (15) months;
- (I) Eighteen (18) months;
- (J) Two (2) years;
- (K) Three (3) years;
- (L) Four (4) years;
- (M) Five (5) years;
- (N) Six (6) years;

(O) Eight (8) years;

(P) Ten (10) years;

(Q) Twelve (12) years;

(R) Fourteen (14) years;

(S) Sixteen (16) years; and

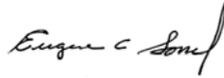
(T) Eighteen (18) years.

Benefits (with the exception of immunizations) will be subject to all Deductible, co-payment and coinsurance provisions of the policy.

This endorsement takes effect and expires concurrently with the policy or certificate to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

There are no other changes to the certificate.

In Witness Whereof, We have caused this Endorsement to be signed by



President

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## **Rate Information**

Rate data does NOT apply to filing.

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## Supporting Document Schedules

**Satisfied -Name:** Flesch Certification **Review Status:** Approved-Closed 03/27/2009  
**Comments:**  
**Attachment:**  
 CAIC Readability Certificate.pdf

**Satisfied -Name:** Application **Review Status:** Approved-Closed 03/27/2009  
**Comments:**  
 This application was filed and approved with previous filing. We are attaching for information for this filing.  
**Attachments:**  
 CAI1011 Enrollment App 7.9.08-Final.pdf  
 CAI1011 Enrollment App 7.9.08-Final John Doe.pdf

**Satisfied -Name:** Submission Letter **Review Status:** Approved-Closed 03/27/2009  
**Comments:**  
**Attachment:**  
 Submission Letter- Arkansas endorsement rev.pdf

**Satisfied -Name:** Certificate of Compliance **Review Status:** Approved-Closed 03/27/2009  
**Comments:**  
**Attachment:**  
 CAIC Cert of Compliance.pdf

**Satisfied -Name:** Response Letter **Review Status:** Approved-Closed 03/27/2009  
**Comments:**  
**Attachment:**  
 Response Letter- Arkansas endorsement rev 3-25-09.pdf



**READABILITY CERTIFICATION**

I, James J. Hennessy, hereby certify that the following form has the following combined with the policy, certificate, rider and application readability score as calculated by the Flesch Reading Ease Test: **50**.

**Form**

CAI1038AR 3-09      Endorsement

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James J. Hennessy, AIRC, ACP, CCP  
Vice President, Compliance, CAIC

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March 23, 2009

Date



**ENROLLMENT FORM**

Please Mail To: Post Office Box 2086  
Fort Mill, South Carolina 29716-2086

(866)-543-0896

FOR OFFICE USE ONLY		
PLAN	PLAN CODE	ID NUMBER
Mid Med		
Endorsement:		
EFFECTIVE DATE:		

Employee Name/Owner (First, MI, Last)		Social Security Number	Gender	Date of Birth
Street Address		City	State	Zip
Employer/Group #		Job Class	Location	Date of Hire
Hours Worked	Daytime Phone No.			
Are you actively at work? <input type="checkbox"/> YES <input type="checkbox"/> NO				

**ENROLLMENT INFORMATION**

<input type="checkbox"/> <b>New Enrollment</b> <input type="checkbox"/> <b>Change</b> <b>Special Circumstances:</b> Date: _____ Reason: _____	<b>Plan Selection:</b> <input type="checkbox"/> Basic <input type="checkbox"/> Enhanced <input type="checkbox"/> Other: _____
<b>Coverage Level (choose one):</b> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee Plus One <input type="checkbox"/> Employee and Family	
<b>Monthly Premium: \$ _____</b> <b>Section 125: <input type="checkbox"/> Yes <input type="checkbox"/> No</b>	

**DEPENDENT INFORMATION**

Please complete for all covered dependents.

No person can be insured under this policy as both a Member and a dependent, or as a dependent of more than one Member. Please complete the following information for each family member you wish to cover.

Relationship	First Name	M.I.	Last Name	S.S.#	Gender	Date of Birth	Full Time Student

I understand that Continental American Insurance Company will not pay benefits for any medical condition or illness due to a Pre-existing Condition for up to (12) months. The (12) month period will be reduced based on prior creditable coverage as shown by a Certificate of Prior Creditable Coverage which I must provide. A Pre-existing Condition is any disease, illness, Sickness or Injury that was diagnosed by consultation, advice or treatment within 6 months prior to the Effective Date of coverage for the Covered Person.

**This is Important - Please Read  
This Election for Coverage Cannot Be Processed Unless The Form Is Signed and Dated.**

A new Enrollment Form must be completed for any change such as name change, birth of a child, marriage, adoption of a child, addition of a covered dependent. The new form must be dated, signed and submitted electronically or by email to the Administrator.

I understand that Mid Medical Plan covered persons are covered by group insurance benefits. The group insurance benefits vary depending on the plan selected. These benefits are provided under a group insurance policy underwritten by Continental American Insurance Company and subject to the exclusions, limitations, terms and conditions of coverage as set forth in the insurance certificate which includes, but is not limited to, limitations for pre-existing conditions. This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is a limited medical plan that provides for limitations to the coverage and a reduced annual and life time limit. The limitations are disclosed in the policy and certificate which are made available at the time of enrollment.

I acknowledge that I have read the above Notice: \_\_\_\_\_

Date of Signature: \_\_\_\_\_

➤ **YES, I DO WANT THIS COVERAGE**

- I elect coverage for insurance for which I am or may become eligible under the terms of the group policy or policies issued to the policyholder by Continental American Insurance Company.
- All information submitted by me on this form at Continental American Insurance Company's request, to the best of my knowledge and belief, is true and complete.
- I am applying for coverage with Continental American Insurance Company. I authorize any physician, medical practitioner, hospital, clinic or medical-related facility or insurance company having information available as to diagnosis, treatment and prognosis regarding any physical, mental, drug or alcohol condition and/or treatment of me or my insured dependents to give/allow the Insurance Company or their legal representatives any and all such information.
- Any information obtained will not be released by the Insurance Company to any person or organization except to persons or organizations performing business or legal services in connection with my application or a claim for benefits or as may be otherwise lawfully required or as I may further authorize. I understand that this information obtained by the Insurance Company will be used to determine appropriate and accurate medical charges.
- Furthermore, I hereby authorize any physician or practitioner, hospital, or other organization, institution or person, that has any medical records or knowledge of me or my family, to give to Continental American Insurance Company such information (photocopy of this authorization shall be valid as the original).
- Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- I also understand that my coverage and that of my dependents, if any, will be subject to the pre-existing condition limitation and exclusion provision specified in the Master Policy and that this provision has been fully explained to me.

Total Monthly Insurance Amount: \$ \_\_\_\_\_

[Member/Employee] Acceptance: \_\_\_\_\_

Date of Signature: \_\_\_\_\_

➤ **No, I decline coverage for myself and/or spouse**

- I decline coverage because I am covered under another group policy of medical insurance.
- I decline coverage fro my spouse because he/she is covered under another group policy of medical insurance.
- I decline coverage but I do not have another group policy of medical insurance.

(Member/Employee) Declination: \_\_\_\_\_

Date of signature: \_\_\_\_\_

Agent Signature: \_\_\_\_\_

Date of Signature: \_\_\_\_\_



**ENROLLMENT FORM**

Please Mail To: Post Office Box 2086  
Fort Mill, South Carolina 29716-2086

(866)-543-0896

FOR OFFICE USE ONLY		
PLAN	PLAN CODE	ID NUMBER
Mid Med		
Endorsement:		
EFFECTIVE DATE:		

Employee Name/Owner (First, MI, Last) <b>John M. Doe</b>		Social Security Number 111-11-1111	Gender Male	Date of Birth 1-1-1981
Street Address 12 Main Street		City Lexington	State OR	Zip 29111
Employer/Group # 1234		Job Class A	Location Irmo, OR	Date of Hire 1-1-2001
Hours Worked 40 per week	Daytime Phone No. (803) 359-1111			
Are you actively at work? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				

**ENROLLMENT INFORMATION**

<input checked="" type="checkbox"/> <b>New Enrollment</b> <input type="checkbox"/> <b>Change</b> <b>Special Circumstances:</b> Date: _____ Reason: _____	<b>Plan Selection:</b> <input type="checkbox"/> Basic <input checked="" type="checkbox"/> Enhanced <input type="checkbox"/> Other: _____
<b>Coverage Level (choose one):</b> <input checked="" type="checkbox"/> Employee Only <input type="checkbox"/> Employee Plus One <input type="checkbox"/> Employee and Family	
<b>Monthly Premium: \$</b> <u>    xx.xx    </u> <b>Section 125:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

**DEPENDENT INFORMATION**

**Please complete for all covered dependents.**

No person can be insured under this policy as both a Member and a dependent, or as a dependent of more than one Member. Please complete the following information for each family member you wish to cover.

Relationship	First Name	M.I.	Last Name	S.S.#	Gender	Date of Birth	Full Time Student

I understand that Continental American Insurance Company will not pay benefits for any medical condition or illness due to a Pre-existing Condition for up to (12) months. The (12) month period will be reduced based on prior creditable coverage as shown by a Certificate of Prior Creditable Coverage which I must provide. A Pre-existing Condition is any disease, illness, Sickness or Injury that was diagnosed by consultation, advice or treatment within 6 months prior to the Effective Date of coverage for the Covered Person.

**This is Important - Please Read  
This Election for Coverage Cannot Be Processed Unless The Form Is Signed and Dated.**

A new Enrollment Form must be completed for any change such as name change, birth of a child, marriage, adoption of a child, addition of a covered dependent. The new form must be dated, signed and submitted electronically or by email to the Administrator.

I understand that Mid Medical Plan covered persons are covered by group insurance benefits. The group insurance benefits vary depending on the plan selected. These benefits are provided under a group insurance policy underwritten by Continental American Insurance Company and subject to the exclusions, limitations, terms and conditions of coverage as set forth in the insurance certificate which includes, but is not limited to, limitations for pre-existing conditions. This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is a limited medical plan that provides for limitations to the coverage and a reduced annual and life time limit. The limitations are disclosed in the policy and certificate which are made available at the time of enrollment.

I acknowledge that I have read the above Notice: John M. Doe

Date of Signature: October 15, 2008

➤ **YES, I DO WANT THIS COVERAGE**

- I elect coverage for insurance for which I am or may become eligible under the terms of the group policy or policies issued to the policyholder by Continental American Insurance Company.
- All information submitted by me on this form at Continental American Insurance Company's request, to the best of my knowledge and belief, is true and complete.
- I am applying for coverage with Continental American Insurance Company. I authorize any physician, medical practitioner, hospital, clinic or medical-related facility or insurance company having information available as to diagnosis, treatment and prognosis regarding any physical, mental, drug or alcohol condition and/or treatment of me or my insured dependents to give/allow the Insurance Company or their legal representatives any and all such information.
- Any information obtained will not be released by the Insurance Company to any person or organization except to persons or organizations performing business or legal services in connection with my application or a claim for benefits or as may be otherwise lawfully required or as I may further authorize. I understand that this information obtained by the Insurance Company will be used to determine appropriate and accurate medical charges.
- Furthermore, I hereby authorize any physician or practitioner, hospital, or other organization, institution or person, that has any medical records or knowledge of me or my family, to give to Continental American Insurance Company such information (photocopy of this authorization shall be valid as the original).
- Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- I also understand that my coverage and that of my dependents, if any, will be subject to the pre-existing condition limitation and exclusion provision specified in the Master Policy and that this provision has been fully explained to me.

Total Monthly Insurance Amount: \$ xx.xx

[Member/Employee] Acceptance: John M. Doe

Date of Signature: October 15, 2008

➤ **No, I decline coverage for myself and/or spouse**

- I decline coverage because I am covered under another group policy of medical insurance.
- I decline coverage fro my spouse because he/she is covered under another group policy of medical insurance.
- I decline coverage but I do not have another group policy of medical insurance.

(Member/Employee) Declination: \_\_\_\_\_

Date of signature: \_\_\_\_\_

Agent Signature: Ashley Agent

Date of Signature: October 15, 2008



2801 Devine Street, Columbia, South Carolina 29205

March 23, 2009

Ms. Rosalind Minor  
Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201-1904

**Re: Continental American Insurance Company  
FEIN 57-0514130 NAIC 71730**

Group Hospital/Medical Insurance Policy  
Forms:  
CAI1038AR 3-09- Endorsement

Dear Ms. Minor,

We recently filed our Group Hospital/ Medical Insurance Policy forms for approval for our employer groups. We received approval from the AR DOI on January 15, 2009 with SERFF tracking number CAIC- 125862108 and state tracking number 40584.

After reviewing the definition of Minimum Basic Benefit Policies which require the mandated offer for Children's preventive health care services, we do not believe we fall under this definition since we offer more than the required coverage. We have removed this mandated offer from our Arkansas specific endorsement for this product and it will replace the previously approved endorsement with form number CAI1038AR.

We appreciate your review and approval of the form filing. Thank you for your consideration in this matter. Please contact Ashley Gibson at 888-730-2244 ext: 4362 or at [CompanyCompliance@caicworksites.com](mailto:CompanyCompliance@caicworksites.com) if you need any additional information.

Sincerely,

James J. Hennessy, AIRC, ACP, CCP  
Vice President, Compliance, CAIC  
/ahg



**Continental American**  
**INSURANCE COMPANY**

2801 Devine Street, Columbia, South Carolina 29205

**CERTIFICATION OF COMPLIANCE**

I have reviewed or supervised the review of the form contained in the filing and hereby certify that to the best of my knowledge and belief they are in compliance with the applicable statues, regulations and bulletins of the State of Arkansas. I further certify that they will be revised and/or discontinued in the event of future changes in the statues, regulations, or bulletins which would prohibit the use of such forms.

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James J. Hennessy, AIRC, ACP, CCP  
Vice President, Compliance CAIC

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March 23, 2009

Date



2801 Devine Street, Columbia, South Carolina 29205

March 25, 2009

Ms. Rosalind Minor  
Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201-1904

**Re: Continental American Insurance Company  
FEIN 57-0514130 NAIC 71730**

Group Hospital/Medical Insurance Policy  
Forms:  
CAI1038AR 3-09- Endorsement

Dear Ms. Minor,

Per objection letter dated 3-25-09, we have revised the endorsement with the correct provision per ACA 23-79-141(f)(2)(A). We verify coverage for immunization is covered at 100% and is exempt from any copayments, coinsurance, deductible, or dollar limits as stated in the endorsement. Please see the revised Routine Well Child Care benefit provision in the amendment.

We appreciate your review and approval of the form filing. Thank you for your consideration in this matter. Please contact me at 888-730-2244 ext: 4362 or at [CompanyCompliance@caicworksites.com](mailto:CompanyCompliance@caicworksites.com) if you need any additional information.

Sincerely,

Ashley Gibson  
Compliance Analyst

SERFF Tracking Number: CAIC-126085474 State: Arkansas  
 Filing Company: Continental American Insurance Company State Tracking Number: 41889  
 Company Tracking Number: 127  
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only  
 Expense  
 Product Name: Mid Med AR endorsement revised  
 Project Name/Number: Mid Med AR endorsement revised/127

## Superseded Attachments

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

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Arkansas Endorsement	03/23/2009	CAI1038AR Endorsement AR Revised 3-09.pdf



2801 Devine Street, Columbia, South Carolina 29205  
800-433-3036

## AMENDATORY ENDORSEMENT

This amendatory endorsement is made a part of the Policy or Certificate to which it is attached and is subject to all terms and provisions of such Policy or Certificate not inconsistent herewith. This amendatory endorsement is applicable only to Insured Persons who are **residents** of the State of Arkansas on the Certificate Date and on the date the claim is incurred.

### **RENEWABILITY**

This Policy/Certificate may be renewed for further consecutive periods by payment of the renewal premium, in advance or as stated in the Grace Period Provision, at the renewal premium rates then in force. We will never refuse to renew this Certificate because of any change in a Covered Person's health or physical condition. We may refuse to renew the coverage of a covered employee or dependent if:

- (a) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;
- (b) the covered employee or dependent has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact, relating in any way to the health benefit plan, including claims for benefits under the health benefit plan;
- (c) We cease to offer health benefit plan coverage in the employer market and offer the option to purchase any other benefit plan; or

Medicare eligibility or entitlement is not a basis for non-renewal or termination of a health benefit plan issued to an employee. However, benefits may be subject to the Coordination of Benefits Provision.

If this Certificate is terminated in accordance with the above condition, a Covered Person's coverage will terminate at the end of the period for which premium has been paid, subject to the Grace Period Provision. Termination of this Certificate does not affect the claims which begin prior to the date of termination. All insurance periods start and end at 12:01 a.m. Standard Time, at Your residence.

We will not send written notice of any termination for non-payment of premium. Coverage stops for non-payment of premium at the end of the period for which premium was paid, subject to the Grace Period.

In Section 7, the following Mandated Benefits will be included

#### **I. BENEFITS FOR DIABETES COVERAGE**

Benefits will be paid the same as any other Sickness for Diabetes. Included is medical coverage for medically necessary equipment, supplies and services for the treatment of Type I, Type II, and gestational diabetes, when prescribed by a licensed physician.

Benefits will be subject to all Deductible, co-payment, coinsurance, limitations or any other provisions of the policy.

**II. BENEFITS FOR SELF-MANAGEMENT TRAINING COVERAGE**

Benefits will be paid the same as any other Sickness for Diabetes Self-Management Training. One diabetes self-management training is covered per lifetime training program per insured for diabetes self-management training when medically necessary as determined by a physician and when provided by an appropriately licensed health care professional upon certification by the health care professional providing the training that the insured patient has successfully completed the training.

In addition, additional diabetes self-management training is offered in the event that a physician prescribes additional diabetes self-management training and it is medically necessary because of a significant change in the insured's symptoms or conditions.

A licensed health care professional shall only provide diabetes self-management training within his or her scope of practice after having demonstrated expertise in diabetes care and treatment and after having completed an educational program required by his or her licensing board when that program is in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Diabetes self-management training shall be provided only upon prescription by a physician licensed.

Nothing in this provision shall be construed to prohibit us from selectively negotiating contracts with qualified providers of diabetes self-management training programs.

Benefits will be subject to all Deductible, co-payment, coinsurance, limitations or any other provisions of the policy.

This endorsement takes effect and expires concurrently with the policy or certificate to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

There are no other changes to the certificate.

In Witness Whereof, We have caused this Endorsement to be signed by



President