

SERFF Tracking Number: IADC-126086464 State: Arkansas
Filing Company: Standard Security Life Insurance Company of New York State Tracking Number: 41962
Company Tracking Number: SSL MMC PPO IACSB AR 0309
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.003A Small Group Only - PPO
Product Name: SSL MMC 0205 - schedule page
Project Name/Number: SSL 0309 schedule page/SSL MMC PPO IACSB AR 0309

Filing at a Glance

Company: Standard Security Life Insurance Company of New York

Product Name: SSL MMC 0205 - schedule page SERFF Tr Num: IADC-126086464 State: ArkansasLH

TOI: H16G Group Health - Major Medical SERFF Status: Closed State Tr Num: 41962

Sub-TOI: H16G.003A Small Group Only - PPO Co Tr Num: SSL MMC PPO IACSB AR 0309 State Status: Approved-Closed

Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
Author: Shellie Howard Disposition Date: 03/25/2009
Date Submitted: 03/24/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: SSL 0309 schedule page

Project Number: SSL MMC PPO IACSB AR 0309

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 03/25/2009

Deemer Date:

Filing Description:

March 24, 2009

Honorable Julie Benafield Bowman

Insurance Commissioner

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small

Group Market Type: Employer, Trust

Explanation for Other Group Market Type:

State Status Changed: 03/25/2009

Corresponding Filing Tracking Number: ICCI-125759352

SERFF Tracking Number: IADC-126086464 State: Arkansas
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State of Arkansas

Arkansas Department of Insurance

1200 W. Third St.

Little Rock, AR 72201-1904

RE: STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK - NAIC# 69078
FEIN# 13-5679267

Schedule of Benefits – SSL MMC PPO IACSB AR 0309

Dear Commissioner Benafield Bowman:

Enclosed for review and approval for use in your state is the above referenced Schedule of Benefits. This Schedule of Benefits is new and is not intended to replace any Schedule of Benefits previously approved by your Department.

The form is similar to the form SSL MMC PPO SB 0708 previously approved by the Department on August 18, 2008 under SERFF filing # ICCI-125759352. This Schedule of Benefits is intended to be used with Group Major Medical Expense Policy form SSL MMC 0205 previously approved by your Department on June 30, 2005. This Schedule of Benefits reflects additional deductibles and various coinsurance amounts.

Insurers Administrative Corporation is making this filing on behalf of Standard Security Life Insurance Company of New York. A filing authorization letter is attached. All correspondence should be addressed to Insurers Administrative Corporation, at the address shown below.

We certify that to the best of our knowledge and belief, that this form does not violate any laws or regulations of your state and does not contain any previously disapproved provisions. We also certify that the benefits payable between a PPO and a Non-PPO will not be more than a 25% differential.

These documents were prepared on a personal computer and will ultimately be printed from another data processing system that may cause some print style and/or page spacing changes. However, there will not be any changes to the non-variable text of the forms or to the general print size.

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Your prompt review of this submission will be greatly appreciated. If I can provide any additional information, please contact me at (602) 861-6070, or e-mail me at howards@iacusa.com. Thank you.

Company and Contact

Filing Contact Information

Shellie Howard, Forms Development & Compliance Specialist
 2101 W. Peoria Ave
 Phoenix, AZ 85029-4925
 howards@iacusa.com
 (602) 861-6070 [Phone]

Filing Company Information

Standard Security Life Insurance Company of New York
 485 Madison Avenue
 New York, NY 10022-4141
 (212) 355-4141 ext. [Phone]
 CoCode: 69078
 Group Code: 450
 Group Name:
 FEIN Number: 13-5679267
 State of Domicile: New York
 Company Type: Life and Health
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$20.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Security Life Insurance Company of New York	\$20.00	03/24/2009	26648788

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/25/2009	03/25/2009

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Disposition

Disposition Date: 03/25/2009

Implementation Date:

Status: Approved-Closed

Comment: The schedule is approved with the understanding that benefits payable a PPO and NON-PPO will comply with our Bulletin 9-85 which states in part that there can be no more than a 25% differential in payment between a PPO and NON-PPO.

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	SSL Filing Authorization	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes

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Form Schedule

Lead Form Number: SSL MMC PPO IACSB AR 0309

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SSL MMC PPO IACSB AR 0309	Schedule Pages	Schedule of Benefits	Initial			SSL MMC PPO IACSB AR 0309 For Filing 032409.pdf

SCHEDULE OF BENEFITS [PLAN NAME]

Lifetime Maximum Benefit for all Covered Charges combined	\$[1,000,000-5,000,000]
[Lifetime Maximum Benefit for In-Network Specified Covered Organ Transplants in a Centers of Excellence]	\$[1,000,000-5,000,000]
Lifetime Maximum Benefit for In-Network Specified Covered Organ Transplants	\$[200,000-400,000]
Lifetime Maximum Benefit for Out-of-Network Specified Covered Organ Transplants	\$[100,000-200,000]
[Lifetime Maximum Benefit for Mental, Nervous and Chemical Dependency Disorders combined]	\$[10,000-20,000]
Lifetime Maximum Benefit for Hospice Care	[0-6 months of Covered Charges]

MEDICAL DEDUCTIBLE, PER CALENDAR YEAR

[Deductible:	[IN-NETWORK] \$[500-10,000]	[OUT-OF-NETWORK] \$[1,000-30,000]]
	[OR]	
	In-Network	Out-of-Network
[Medical Services & Supplies [and Outpatient Surgical Services]]	\$[500 – 10,000]	\$[1,000 – 30,000]
[Inpatient Facility Confinement] [&] [Inpatient [and Outpatient]] [Surgical Services]	\$[500 – 10,000]	\$[1,000 – 30,000]]

[The In-Network and Out-of-Network Deductibles are accumulated separately. However, when the Out-of-Network Deductible is met for the Calendar Year, the In-Network Deductible will be deemed satisfied for the remainder of that Calendar Year.] [In addition, the Medical Services & Supplies [and Outpatient Surgical Services] and the Inpatient Facility Confinement [&] [Inpatient [and Outpatient] [Surgical Services] Calendar Year Deductibles accumulate separately.]

[Deductible Maximum: When [three (3)] individual Insured Persons in a family satisfy their In-Network or Out-of-Network Calendar Year Deductibles, the In-Network or Out-of-Network Deductibles for any remaining Insured Person in the family are deemed satisfied for the remainder of the Calendar Year.] [Employee and Dependents share one common Deductible amount for the Calendar Year.]]

[Additional Deductibles:

Failure to Pre-Certify Inpatient Care	\$[0-500]
Failure to Pre-Certify specified Prescription Medications	[no coverage for the specified medication]

[Notwithstanding anything to the contrary found in the Certificate, the additional Deductible for failure to pre certify does not accumulate toward the Calendar Year Deductible amounts or Out-Of-Pocket Maximum amounts.]

[OUT-OF-POCKET MAXIMUM, PER CALENDAR YEAR

In-Network	Out-of-Network
[\$1,000-5,000]	[\$2,000-15,000]

[OR]

[OUT-OF-POCKET MAXIMUM AMOUNT PER CALENDAR YEAR FOR EACH INSURED PERSON]

	[In Network]	[Out-Of-Network]
[Medical Services & Supplies & [Outpatient Surgical Services]]	[\$1,500-8,000]	[\$4,500-15,000]
[Inpatient Facility Confinement] [&] [Inpatient and Outpatient Surgical Services]	[\$4,000-8,000]	[\$10,000-24,000]

[The In-Network and Out-of-Network Calendar Year Out-of-Pocket Maximums are accumulated separately [.]], except when the Out-of-Network Calendar Year Out-of-Pocket Maximum is satisfied, the In-Network Out-of-Pocket Maximum will be deemed satisfied for the remainder of that Calendar Year.][In addition, Out-of-Pocket Calendar year Maximum Amounts for Medical Services & Supplies and Inpatient & Outpatient Surgical Services accumulate separately.] [The following Covered Charges do not accumulate toward the Maximum Out-of-Pocket Amount Per Calendar Year: (1) Expenses incurred for the Outpatient treatment of Mental, Nervous or Chemical Dependency Disorders; (2) Pre-Certification Deductibles; (3) [Outpatient] Copays; (4) Any Deductible amounts[;][.] [(5) In patient Out-of-Network Coinsurance]]

[Maximum Out-of-Pocket Amount per Calendar Year per insured family: Once any [two-three (2-3)] Insured Persons in an Insured family (an [Insured Person][Employee] and his or her Insured Dependents) have satisfied their individual Maximum Out-of-Pocket Amounts per Calendar Year, all other Insured Persons in the insured family will be deemed to have satisfied this requirement for the remainder of the Calendar Year]

[COPAYS][& COINSURANCE AND BENEFIT LIMITATIONS PER INSURED PERSON]

Physician office visit charge for examination and evaluation at In-Network providers only.		[None-\$50]
[Outpatient Diagnostic Lab, x-ray and test Copay per provider (In Network only)]		[None- \$50]
Emergency Room Copay <i>(waived if the Insured Person is admitted)[or the visit is determined to be Medically Necessary Emergency Care]</i>		[\$100-200]
Emergency Ambulance Services – Ground, Air, and Water		[\$100-200]]
	[In-Network]	[Out-of-Network]
[Inpatient Facility Confinement]	[\$200-500]	[\$200-1,000]
[Outpatient Surgery]	[\$200-500]	[\$200-1,000]

[COINSURANCE AND BENEFIT LIMITATIONS

All Benefit Limits are per Insured Person per Calendar Year]

	[In-Network Benefit] [After satisfaction of Your In-Network Calendar Year Deductible]	[Out-Of-Network Benefit] [After satisfaction of Your Out-of-Network Calendar Year Deductible]
MEDICAL SERVICES AND SUPPLIES		
Physician Office Visit or Free Standing Urgent Care Center Visit	[After \$20-50 Copay, then 100%][after] [100%, 90%, 80%, 70% after Deductible]	[After \$50-70 Copay, then 100%] [after] [70%, 60%, 50% after Deductible]
Outpatient Diagnostic Lab, X-ray and tests [not performed by LabOne]	[\$40 Copay, then 100% For Outpatient MRIs, CT scans and nuclear imaging testing, after \$200 Copay, then 100%] [After [\$20-50] Copay, then 100% after][up to \$150 per visit, then] [100%, 90%, 80%, 70% after Deductible]	[After \$70 Copay, then 70% For Outpatient MRIs, CT scans and nuclear imaging testing, after \$400 Copay, then 70%] [[After \$50-70 Copay,] [70%, 60%, 50% after Deductible]
[Outpatient Diagnostic Lab, X-ray and tests performed by LabOne]	[100%]	[N/A]
Physical, Speech, or Occupational Therapy	[After \$20-50 Copay, then 100%] [after] [100%, 90%, 80%, 70% after Deductible]	[[After \$50-70 Copay, then] [70%, 60%, 50% after Deductible]
Durable Medical Equipment	[After \$20-50 Copay, then 100%] [after] [100%, 90%, 80%, 70% after Deductible]	[[After \$50-70 Copay, then] [70%, 60%, 50% after Deductible]

Non-Surgical Back Treatment	[After \$20-50 Copay, then 100%] [after] [100%, 90%, 80%, 70% after Deductible]	[[After \$50-70 Copay, then] [70%, 60%, 50% after Deductible]
Outpatient Registered Nurse Services	[After \$20-50 Copay, then 100%] [after] [100%, 90%, 80%, 70% after Deductible]	[[After \$50-70 Copay, then] [70%, 60%, 50% after Deductible]
Home Health Care	[After \$20-50 Copay, then 100%] [after] [100%, 90%, 80%, 70% after Deductible]	[[After \$50-70 Copay, then] [70%, 60%, 50% after Deductible]
Hospice Care	[100%]	[100%]
[Cervical] Cytological & Mammography Screening Services	[100%]	[100%]

OUTPATIENT SURGICAL SERVICES (Outpatient surgery and related services when rendered at a outpatient facility)

Outpatient Hospital or Ambulatory Surgical Center Facility Services	[After \$200-500 Copay, then 100%] [100%, 90%, 80%, 70%] [after Deductible]	[After \$200-1,000 Copay, then] [70%, 60%, 50%] [after Deductible]
Surgery, Assistant Surgery, and Anesthesiology Services	[After \$200-500 Copay then 100%] [100%, 90%, 80%, 70%] [after Deductible]	[After \$200-1,000 Copay, then] [70%, 60%, 50%] [after Deductible]

FACILITY CHARGES (Inpatient surgical or other services when rendered at a inpatient facility)

Hospital Inpatient Facility Confinement	[After \$200-500 Copay then 100%] [100%, 90%, 80%, 70%] [after Deductible]	[After \$200-1,000 Copay, then] [70%, 60%, 50%] [after Deductible]
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Skilled Nursing Facility Services	[After \$200-500 Copay then 100%] [100%, 90%, 80%, 70%][after Deductible]	[After \$200-1,000 Copay, then] [70%, 60%, 50%] [after Deductible]
Physician services, including consultations and diagnostic testing	[After \$200-500 Copay then 100%] [100%, 90%, 80%, 70%][after Deductible]	[After \$200-1,000 Copay, then] [70%, 60%, 50%] [after Deductible]

EMERGENCY CARE

Emergency Room	[After \$200-500 Copay, then 100%,] [90%, 80%, 70%] [after Deductible]	[After \$200-1,000 Copay, then 100%] [90%, 80%, 70%, 50%][after Deductible]
Ambulance Services – Ground, Air, and Water	[After \$200-500 Copay, then 100%,] [90%, 80%, 70%] [after Deductible]	[After \$200-1,000 Copay, then 100%] [90%, 80%, 70%] [after Deductible]

MENTAL, NERVOUS AND CHEMICAL DEPENDENCY DISORDERS

Mental and Nervous Inpatient Care	[After \$200-500 Copay, then 100%,] [100%, 90%, 80%, 70%] [after Deductible]	[[After \$200-1,000 Copay, then 70%, 60%, 50%] [after Deductible]
[Mental, Nervous and Chemical Dependency Outpatient Care]	[After \$20-50 Copay, then] [50% after Deductible]	[[After \$50-70 Copay, then] [50% after Deductible]

HOSPITAL ROOM/DAILY RATE SCHEDULE (All applicable Deductibles and coinsurance will apply)

Private or Semi-Private Room	[Up to the Most Common Semi-Private Room Rate]	[Up to the Most Common Semi-Private Room Rate]
If the Hospital does not provide semi-Private rooms, the Hospital benefit will be paid at 90% of the Hospital's lowest priced Private room rate. In the event a private room is Medically Necessary due to a contagious disease, We will consider the cost of the private room as a Covered Charge.		
Intensive Care Unit	[Up to the Most Common ICU Rate]	[Up to 3 times the Most Common Semi-Private Room Rate]
Observation Room or Intermediate Care Unit	[Up to 2 times the Most Common Semi-Private Room Rate]	[Up to 2 times the Most Common Semi-Private Room Rate]

BENEFIT LIMITS

All Benefit Limits are per Insured Person per Calendar Year

[Calendar Year Maximum Benefit for all Covered Charges combined][, including organ transplants covered in a Centers of Excellence]	\$[100,000][1,000,000-5,000,000]
[Calendar Year Maximum Benefit for all Covered Charges for Outpatient [Treatment] [[Surgical] Services and Supplies]	\$[20,000-500,000]]
[Physician Office Visit or Free Standing Urgent Care Center	[Limited to [2-15] visits per Calendar Year]]
Physical, Speech, or Occupational Therapy	[30-60 treatments per Calendar Year for any one type of therapy and up to 60-90 treatments per Calendar Year for any combination of these therapies]
Non-Surgical Back Treatment	[Limited to \$500-1,000 maximum benefit per Calendar Year]
Home Health Care	[A maximum 60-90 visits per Calendar Year]
Hospice Care	[Limited to 0-6 months of Covered Charges.]
Low Protein Modified Food Products	Not to exceed \$2,400 per child
Skilled Nursing Facility Services	[Limited to \$100-200 daily and a maximum of 60 days per Calendar Year]
Mental and Nervous Inpatient Care	[A maximum 10-20 days per Calendar Year up to \$2,500-5,000 per Calendar Year]
[Mental and Nervous Outpatient Care]	[Daily maximum of \$50 not to exceed 25 visits per Calendar Year up to \$1,250 per Calendar Year]
[Mental, Nervous & Chemical Dependency Outpatient Care]	[Daily maximum of \$50 not to exceed 25 visits per Calendar Year up to \$1,250 per Calendar Year Maximum for Mental and Nervous Outpatient Care and Chemical Dependency Outpatient Care combined]
[Chemical Dependency Outpatient Care]	[Daily maximum of \$50 not to exceed 25 visits per Calendar Year up to \$1,250 per Calendar Year]
Organ Transplant Transportation Expense	[An allowance up to \$5,000-10,000 is available for transportation expenses per Transplant performed in a Center of Excellence]
[Oral Surgery	\$[5,000-10,000] per Calendar Year]

OPTIONAL BENEFITS

[Optional Wellness Benefit Rider	[YES/NO]
	[\$35-50 Copay, then 100% up to \$250-1,000]
[Optional 24-Hour Occupation Coverage Rider	[YES/NO]
[Optional Prescription Medication	[YES/NO]

Benefit Rider

[Prescription Medication Benefit]

[OPTION 1 – Rx Discount: No prescription drug card benefit.
Specialty Drugs included – discount only]

[or]

[OPTION 2 [RX Insurance] [RX Copay]

	[Your Share of the Cost]	
	Deductible	Copay
Per Generic Prescription Order or Refill	[None]	[\$10-50]
Per Formulary Brand Name Prescription Order or Refill	[\$250-\$5,000] per	[\$25-100]
Per Non-formulary Brand Name Prescription Order or Refill	Calendar Year*]	[\$40-150]
Specialty Drugs	[None]	\$50-200]

[* When [three (3)] individual Insured Persons in a family satisfy their Outpatient Prescription Medication Calendar Year Deductible, the remaining Outpatient Prescription Deductibles for any Insured Person in the family are deemed satisfied for the remainder of the Calendar Year.]

[or]

[OPTION 3

	Your Share of the Cost
Per Generic Prescription Order or Refill	\$10 Copay
Per Formulary Brand Name Prescription Order or Refill	\$25 Copay
Per Non-formulary Brand Name Prescription Order or Refill	\$40 Copay
Specialty Drugs	\$50 Copay]

[or]

[OPTION 4

Outpatient Prescription Medications, are covered by the plan subject to the same deductibles, coinsurance, out-of-pocket, and plan maximums as any other covered medical services. As such, and notwithstanding anything to the contrary found in this certificate, copayments by the insured under this option, accumulate to satisfy the plan's Calendar Year Deductible and Out-of-Pocket maximum amounts.
Specialty Drugs included]

[Optional Life and Accidental Death and Dismemberment Benefit Rider [YES/NO]]

Life Insurance Amount \$[10,000-100,000]
Accidental Death and Dismemberment Insurance The Principal Sum is equal to one times the Life Insurance Amount]

Ages 65-69 65% of selected amount
Ages 70-74 40% of selected amount
Ages 75-79 25% of selected amount
Ages 80-84 15% of selected amount
Ages 85+ 10% of selected amount]

[Optional Dependent Life Insurance]

Spouse Life Insurance Amount [\$2,000-5,000]

Children

Age 14 days, but less than 6 months	[\$ 100-500]
age 6 months, but less than 19 years	[\$1,000-2,000]
age 19 years, but less than 25 years (if a student attending school on a full-time basis)]	[\$1,000-2,000]

[Optional Supplemental Accident Coverage] [YES/NO]
 [100% up to a \$500-\$5,000 maximum benefit amount as specified on your Validation of Coverage Face Page]

[Optional Pregnancy Benefit] [YES/NO]

[Optional for groups of 5-14 (fewer where mandated), mandatory for 15+]	[In-Network Subject to Deductibles and coinsurance]	[Out-of-Network Subject to Deductibles and Coinsurance]
In-Vitro Fertilization lifetime maximum benefit - \$15,000]		

[Optional Weekly Disability Benefit] [YES/NO]
 [Benefits begin:
 Day 1 due to an accident [Up to a maximum benefit of \$[100-500] per week]
 Day 8 due to a sickness
 Up to 26 weeks per disability.]

[[Optional Dental Benefit Rider [YES/NO]

	Plan 1	Plan 2
Lifetime Deductible	[\$25-50]	[\$25-50]
Calendar Year Deductible	[\$50-100 for Basic and Major, \$50-100 for Orthodontia (Maximum of three per family)]	[\$50-100 for Basic and Major (Maximum of three per family)]
Calendar Year Maximum	[\$1,500-2,000 for Preventive, Basic and Major, \$1,000-2,000 for orthodontia]	[\$1,500-2,000 for Preventive, Basic and Major]
Lifetime Maximum	[\$1,000-2,000 for orthodontia]	
Waiting Periods		

Preventive and Basic	[None]	[None]
Major and Orthodontic(if included)	[12-24 months]	[12-24 months]
Covered Procedures		
Preventive Services (Type 1)	[Plan pays 100%]	[Plan pays 90%]
Basic Services (Type 2)	[Plan pays 80%]	[Plan pays 60%]
Major Service (Type 3)	[Plan pays 50%]	[Plan pays 50%]
Orthodontia (Type 4) (for children under age 19)	[Plan pays 50%]	[Not Covered]]

[[Optional Vision Benefit Rider

[YES/NO]]

	[In-Network Benefit]	[Out-Of-Network Benefit]	[Benefit Frequency]
[Vision Exam	[\$10.00 copay]	[Up to \$35.00]	[12-24 Months]
Contact Lenses			[12-24 Months]
Conventional	[\$115.00 Allowance + 15% discount of the balance over \$115.00]	[Up to 100.00]	
Disposable	[\$115.00 Allowance + 100% of the balance over \$115.00]	[Up to 100.00]	
Medically Necessary	[\$250.00 Allowance + 100% of the balance over \$250.00]	[Up to 200.00]	
Glasses Frames	[\$100.00 Allowance + 20% discount of the balance over \$100.00]	[Up to \$45.00]	[12-24 Months]
Glasses Lenses			[12-24 Months]
Single vision	[\$25.00 copay]	[Up to \$25.00]	
Bifocal	[\$25.00 copay]	[Up to \$40.00]	
Trifocal	[\$25.00 copay]	[Up to \$55.00]	
Lenticular	[\$25.00 copay]	[Up to \$55.00]	

In-Network Lens Options – Additional

Copays	[\$45.00]	[N/A]
Basic Progressives*	[\$35.00]	[N/A]
Basic Polycarbonate	[\$12.00]	[N/A]
Ultra violet	[\$45.00]	[N/A]
Basic Anti-Reflective	[\$12.00]	[N//A]
Tint (Solid & Gradient)	[\$15.00]	[N/A]
Basic Scratch-Resistance	[20% discount[[N/A]]
Other Add-Ons & Service		
*add-on to bifocal]		

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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 03/25/2009
Comments:
Attachment:
ARCertificate of Compliance.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 03/25/2009
Comments:
SSL-EEAPP 0205 (employee)
SSL-ERAPP 0205 (employer)

Both approved June 30, 2005

Satisfied -Name: SSL Filing Authorization **Review Status:** Approved-Closed 03/25/2009
Comments:
Attachment:
SSL Filing Authorization Letter 0309.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Standard Security Life Insurance Company of New York (SSL)

Form Number(s): SSL MMC PPO IACSB 0309

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

Signature of Company Officer:



Adam Vandervoort
Name

Secretary
Title

03/24/09
Date



Standard Security Life Insurance Company of New York
485 Madison Avenue
New York, NY 10022-5872
Telephone: (212) 355-4141

March 23, 2009

RE: Standard Security Life Insurance Company of New York
NAIC Company Number: 69078
NAIC Group Number: 0450
FEIN Number: 13-5679267

AUTHORIZATION STATEMENT

Standard Security Life Insurance Company of New York ("SSLICNY") hereby authorizes Insurers Administrative Corporation ("IAC"), to represent us in the submission of accident and health insurance Group Policy Forms, and related forms and rates, and to negotiate with the Department for their approval.

Sincerely,

A handwritten signature in black ink, appearing to read "Adam Vandervoort".

Adam C. Vandervoort
Secretary