

<i>SERFF Tracking Number:</i>	<i>CMLX-126180557</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Companion Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42580</i>
<i>Company Tracking Number:</i>	<i>GHSAR0007701F01</i>		
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001C Any Size Group - Other</i>
<i>Product Name:</i>	<i>MMEN02GR09</i>		
<i>Project Name/Number:</i>	<i>MMEN02GR09/GHSAR0007701F01</i>		

Filing at a Glance

Company: Companion Life Insurance Company

Product Name: MMEN02GR09

TOI: H16G Group Health - Major Medical

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

Filing Type: Form

SERFF Tr Num: CMLX-126180557 State: ArkansasLH

SERFF Status: Closed

Co Tr Num: GHSAR0007701F01

Co Status:

Author: SPI CompanionLife

Date Submitted: 06/08/2009

State Tr Num: 42580

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 06/17/2009

Disposition Status: Approved-Closed

Implementation Date Requested: 07/08/2009

Implementation Date:

State Filing Description:

General Information

Project Name: MMEN02GR09

Project Number: GHSAR0007701F01

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/17/2009

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 06/17/2009

Corresponding Filing Tracking Number:

Deemer Date:

Filing Description:

Companion Life Insurance Company hereby files for approval the attached forms. We are in the process of assuming a block of business from Nippon Life Insurance Company of America. These forms are identical to the forms being used for the assumed business. The forms were previously filed and approved in your state for Nippon Life with one exception; i.e., the HMO Option has been deleted from the certificate. They will not replace any Companion Life Insurance Company forms.

Companion's properly licensed agents will market the policy to small and large employer groups in your state. We

SERFF Tracking Number: CMLX-126180557 State: Arkansas
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 Product Name: MMEN02GR09
 Project Name/Number: MMEN02GR09/GHSAR0007701F01

certify that all revisions to variable text will be in full compliance with applicable state law.

Company and Contact

Filing Contact Information

Vivian Frederic, Contracts Compliance Specialist
 7909 Parklane Rd
 Columbia, SC 29223-5666
 vivian.frederic@companiongroup.com
 (803) 735-1251 [Phone]
 (800) 836-5433[FAX]

Filing Company Information

Companion Life Insurance Company
 7909 Parklane Rd, Suite 200
 Columbia, SC 29223-5666
 (803) 735-1251 ext. [Phone]
 CoCode: 77828
 Group Code: 661
 Group Name: Companion Life Insurance Company
 FEIN Number: 57-0523959
 State of Domicile: South Carolina
 Company Type:
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Companion Life Insurance Company	\$50.00	06/08/2009	28421478

SERFF Tracking Number: CMLX-126180557 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/17/2009	06/17/2009

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	06/16/2009	06/16/2009	SPI CompanionLife	06/17/2009	06/17/2009
Pending Industry Response	Rosalind Minor	06/08/2009	06/08/2009	SPI CompanionLife	06/11/2009	06/11/2009

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<i>Product Name:</i>	<i>MMEN02GR09</i>		
<i>Project Name/Number:</i>	<i>MMEN02GR09/GHSAR0007701F01</i>		

Disposition

Disposition Date: 06/17/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CMLX-126180557 State: Arkansas
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 Product Name: MMEN02GR09
 Project Name/Number: MMEN02GR09/GHSAR0007701F01

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Group Medical Insurance Policy	Approved-Closed	Yes
Form	Group Medical Insurance Certificate	Approved-Closed	Yes
Form (revised)	Group Medical Insurance Application	Approved-Closed	Yes
Form	Group Medical Insurance Application	Filed-Closed	Yes
Form	Group Medical Insurance Application	Replaced	Yes
Form	Group Medical Insurance Enrollment Form	Approved-Closed	Yes
Form	Group Medical Insurance Enrollment Form - Large Groups	Approved-Closed	Yes

SERFF Tracking Number: CMLX-126180557 State: Arkansas
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TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: MMEN02GR09
Project Name/Number: MMEN02GR09/GHSAR0007701F01

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 06/16/2009

Submitted Date 06/16/2009

Respond By Date

Dear Vivian Frederic,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Medical Insurance Application (Form)

Comment:

As required by ACA 23-79-150(c) (2), the application shall specifically and conspicuously inform the policyholder that rejection of the option means that covered benefits provided to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State

Response Letter Date 06/17/2009

Submitted Date 06/17/2009

Dear Rosalind Minor,

Comments:

Thank you for your review of our filing.

Response 1

Comments: Attached is the revised application. We apologize for attaching the incorrect application with our last objection letter.

SERFF Tracking Number: CMLX-126180557 State: Arkansas
 Filing Company: Companion Life Insurance Company State Tracking Number: 42580
 Company Tracking Number: GHSAR0007701F01
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: MMEN02GR09
 Project Name/Number: MMEN02GR09/GHSAR0007701F01

Related Objection 1

Applies To:
 - Group Medical Insurance Application (Form)
 Comment:

As required by ACA 23-79-150(c) (2), the application shall specifically and conspicuously inform the policyholder that rejection of the option means that covered benefits provided to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Medical Insurance Application	CLIC-A-0105-AR		Application/Enrollment Form	Initial		0	CLIC-A-0105-AR.PDF
<i>Group Medical Insurance Application</i>	<i>CLIC-A-0105-AR</i>		<i>Application/Enrollment Form</i>	<i>Initial</i>		<i>0</i>	<i>CLIC-A-0105-AR.PDF</i>
<i>Group Medical Insurance Application</i>	<i>CLIC-A-0105-AR</i>		<i>Application/Enrollment Form</i>	<i>Initial</i>		<i>0</i>	<i>CLIC-A-0105-AR.PDF</i>

No Rate/Rule Schedule items changed.

If you have any questions or need additional information, please let us know.

Sincerely,
 SPI CompanionLife

SERFF Tracking Number: CMLX-126180557 State: Arkansas
Filing Company: Companion Life Insurance Company State Tracking Number: 42580
Company Tracking Number: GHSAR0007701F01
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: MMEN02GR09
Project Name/Number: MMEN02GR09/GHSAR0007701F01

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/08/2009
Submitted Date 06/08/2009

Respond By Date

Dear Vivian Frederic,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Medical Insurance Application (Form)
- Group Medical Insurance Enrollment Form (Form)
- Group Medical Insurance Enrollment Form - Large Groups (Form)

Comment:

With respect to the mandated offering for TMJ, ACA 23-79-150 (c)(2) requires that "The application shall specifically and conspicuously inform the policyholder that rejection of the option means that covered benefits provided to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 06/11/2009
Submitted Date 06/11/2009

Dear Rosalind Minor,

Comments:

Thank you for your review of our filing.

Response 1

Comments: We revised the application which is completed by the policyholder to include the statement required by ACA 23-79-150 (c)(2). Please note we did not revise the two enrollment forms as the enrollee does not have the option to

SERFF Tracking Number: CMLX-126180557 State: Arkansas
 Filing Company: Companion Life Insurance Company State Tracking Number: 42580
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 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: MMEN02GR09
 Project Name/Number: MMEN02GR09/GHSAR0007701F01

accept or reject the mandated offer for TMJ.

Related Objection 1

Applies To:

- Group Medical Insurance Application (Form)
- Group Medical Insurance Enrollment Form (Form)
- Group Medical Insurance Enrollment Form - Large Groups (Form)

Comment:

With respect to the mandated offering for TMJ, ACA 23-79-150 (c)(2) requires that "The application shall specifically and conspicuously inform the policyholder that rejection of the option means that covered benefits provided to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Medical Insurance Application	CLIC-A-0105-AR		Application/Enrollment Form	Initial		0	CLIC-A-0105-AR.PDF

Previous Version

Group Medical Insurance Application	CLIC-A-0105-AR		Application/Enrollment Form	Initial		0	CLIC-A-0105-AR.PDF
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No Rate/Rule Schedule items changed.

If you have any questions or need additional information, please let us know.

Sincerely,
 SPI CompanionLife

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 Filing Company: Companion Life Insurance Company State Tracking Number: 42580
 Company Tracking Number: GHSAR0007701F01
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: MMEN02GR09
 Project Name/Number: MMEN02GR09/GHSAR0007701F01

Form Schedule

Lead Form Number: CLIC-P-0105-1-AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	CLIC-P-0105-1-AR	Policy/Cont ract/Fratern al Certificate	Group Medical Insurance Policy	Initial		40	CLIC-P-0105-1-AR.PDF
Approved-Closed	CLIC-C-0105-1-AR	Certificate	Group Medical Insurance Certificate	Initial		40	CLIC-C-0105-1-AR.PDF
Approved-Closed	CLIC-A-0105-AR	Application/ Enrollment Form	Group Medical Insurance Application	Initial		0	CLIC-A-0105-AR.PDF
Approved-Closed	CLIC-0208-APP-AR	Application/ Enrollment Form	Group Medical Insurance Enrollment Form	Initial		0	CLIC-0208-APP-AR.PDF
Approved-Closed	CLIC-EF-0105-LG-AR	Application/ Enrollment Form	Group Medical Insurance Enrollment Form - Large Groups	Initial		0	CLIC-EF-0105-LG-AR.PDF



COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200, COLUMBIA, SC 29223-5666
P.O. BOX 100102, COLUMBIA, SC 29202-3102

Policyholder Service Office:
Company Life Insurance Company
c/o TOTAL PLAN SERVICES, INC.
14001 Dallas Parkway, Suite 700
Dallas, Texas 75240

If we fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Department of Insurance
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Telephone 501-371-2640 or 800-852-5494

Companion Life Insurance Company (called "we," "us," and "our") agrees with the Employer to pay benefits for Covered Charges in return for the application, which is attached, and payment of premium as it becomes due.

This Policy becomes effective at 12:01 AM Standard Time at the Employer's principal address shown on the application on the Effective Date shown below.

This Policy may be continued in effect by payment of premium at the rates we establish until the insurance ends as provided.

This Policy is governed by the laws of the jurisdiction shown below.

COMPANION LIFE INSURANCE COMPANY
Columbia, South Carolina 29223

MEDICAL CARE COVERAGE ADMINISTERED BY:
TOTAL PLAN SERVICES, INC.

President

This Policy is a legal contract between
the Employer and Companion Life Insurance Company.

READ THE POLICY CAREFULLY

EMPLOYER	[John Doe Company]
GROUP POLICY NUMBER	[11111111]
POLICY EFFECTIVE DATE	[July 1, 2009]
POLICY ANNIVERSARY DATE	[July 1 1]
JURISDICTION	State of Arkansas
PREMIUM DUE DATE	[1 st Day of Each Calendar Month]
COVERAGE PROVIDED	Medical Care Coverage

NONPARTICIPATING GROUP POLICY PROVIDING

MEDICAL CARE COVERAGE

TABLE OF CONTENTS

INCORPORATION OF PROVISIONS 3

CONTINUING MEDICAL CARE COVERAGE FOR MEMBERS ABSENT FROM WORK..... 3

INTEREST ON INSURANCE AMOUNTS 3

WHEN INSURANCE UNDER THIS POLICY ENDS 3

PREMIUM PAYMENTS 5

AGGREGATE PREMIUM 5

GRACE PERIOD..... 5

PREMIUM CALCULATION..... 5

CHANGES IN PREMIUM RATES..... 5

CONVERSION PRIVILEGE CHARGE..... 5

ENTIRE CONTRACT 6

INCONTESTABILITY..... 6

CHANGES IN POLICY 6

MISSTATEMENTS 6

CONFORMITY WITH LAW 7

INFORMATION TO BE FURNISHED BY EMPLOYER 7

CLERICAL ERROR..... 7

EMPLOYER NOT AGENT 7

ASSIGNMENT 7

INDIVIDUAL CERTIFICATES OF INSURANCE..... 7

NON-PARTICIPATING 7

WORKERS' COMPENSATION..... 7

WAIVER OF RIGHTS 7

INCORPORATION OF PROVISIONS

The provisions of the booklet-certificate(s) and rider(s) attached to the following pages are made a part of this Policy.

Second person pronouns in the booklet-certificate(s) and rider(s) refer to a Member who is a member of the class eligible for coverage under this Policy.

References to the male gender also include the female unless the context clearly indicates otherwise.

CONTINUING MEDICAL CARE COVERAGE FOR MEMBERS ABSENT FROM WORK

If a Member:

- is placed on part-time employment; or
- ceases to be a Full-Time Employee because the Member is sick or injured or because of layoff or approved leave of absence,

the Employer, acting on a basis which does not discriminate for or against any person, may consider such a Member as still eligible for coverage until the Employer notifies us differently or stops paying premiums for that Member. However, in any event, insurance cannot be continued in this way for longer than three months.

INTEREST ON INSURANCE AMOUNTS

We will pay interest on any benefits due under this Policy where, when, and at the rate required by law.

WHEN INSURANCE UNDER THIS POLICY ENDS

Participation and Contribution Requirements

The Policy is guaranteed renewable except for violation of participation and/or contribution rules and except for the reason stated in "Other Reasons for Termination" below. By giving the Employer written notice at least 30 days in advance, we have the right to end:

- ◆ all or any part of the Member Insurance under this Policy as of any Anniversary Date if:
 - [fewer than 2 Members are then insured; or
 - for an Employer with fewer than 6 eligible Members at that time, less than 100% of the eligible Members are then insured when Members are required to pay towards the cost of that insurance; or
 - for an Employer with 6-9 eligible Members at that time, more than one eligible Member is not then insured when Members are required to pay towards the cost of that insurance; or
 - for an Employer with 10 or more eligible Members at that time, less than 75% (rounded up) of the eligible Members who are employed by the Employer on a full-time basis at that time are then insured when Members are required to pay towards the cost of that insurance; or
 - less than 100% of the eligible Members are then insured when Members are not required to pay towards the cost of that insurance; or
 - for an Employer with fewer than 10 Members enrolled at that time, the Employer then contributes less than 75% of the cost of Member Insurance, or less than 50% of the cost of Member and Dependent Medical Care Coverage combined, whichever is less; or
 - for an Employer with 10 or more Members enrolled at that time, the Employer then contributes less than 50% of the cost of Member Insurance, or less than 25% of the cost of Member and Dependent Medical Care Coverage combined, whichever is less.]
- ◆ all or any part of the Dependent Insurance under this Policy as of any Anniversary Date if:
 - [all or the corresponding part of the Member Insurance under this Policy ends at that time; or

- less than 100% of the Members eligible for Dependent Insurance are then insured for Dependents when Members are not required to pay towards the cost of that insurance; or

- for an Employer with fewer than 10 Members enrolled for Member Insurance at that time, the Employer then contributes less than 75% of the cost of Member Insurance, or less than 50% of the cost of Member and Dependent Insurance combined, whichever is less; or
- for an Employer with 10 or more Members enrolled for Member Insurance at that time, the Employer then contributes less than 50% of the cost of Member Insurance, or less than 25% of the cost of Member and Dependent Insurance combined, whichever is less.]

[Solely for purposes of determining the total number of eligible Members and participation levels for Member Insurance where Members are required to pay towards the cost, a Member is considered ineligible if the Member declines or waives the insurance because he has Creditable Coverage through a source other than the Employer. If that Creditable Coverage ends, the Member again is considered eligible for these purposes.]

[Solely for purposes of determining the total number of eligible Members and participation levels for Member Insurance, a Member is considered ineligible if the Member declines or waives the insurance because he has Creditable Coverage through a source other than the Employer. If that Creditable Coverage ends, the Member again is eligible for these purposes.]

Solely for purposes of determining the participation levels for Dependent Insurance, a Member is considered ineligible if the Member declines or waives the insurance because all of his Dependents have Creditable Coverage through a source other than the Employer. If that Creditable Coverage ends for any of his Dependents, the Member is again considered eligible for these purposes.

Other Reasons for Termination

We have the right to end coverage under this Policy as of any Premium Due Date by giving the Employer written notice at least 30 days before that Date if:

- ◆ the Employer has failed to pay required premiums for coverage under this Policy, or has failed to pay such premiums in a timely manner, according to the terms of this Policy; or
- ◆ the Employer has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact, in connection with coverage under this Policy[. or]
- ◆ [with respect to coverage that includes PPO Plan provisions, the Employer no longer has any insured Member living, working, or residing in the service area of that PPO Plan][; or]
- ◆ [with respect to coverage made available only because of the Employer’s membership in a bona fide association, the Employer is no longer a member of that association][; or]
- ◆ termination of coverage as described below.

In the event we stop marketing this Medical Care Coverage product or we stop marketing Medical Care Coverage in the Employer’s market or in the Employer’s geographic area, we have the right to end this Policy. In such case, we will abide by all pertinent requirements of the federal Health Insurance Portability and Accountability Act of 1996 and any amendments (HIPAA) and all applicable state laws, including but not limited to advance-notice requirements and requirements (if any) to offer alternative coverage.

All coverage under this Policy will automatically end on the date provided under the GRACE PERIOD provision.

Other Provisions

The Employer can end this Policy as of any Premium Due Date by giving us written notice at least 30 days before that Date.

This Policy may be ended on any date by mutual agreement between the Employer and us.

Insurance will end as provided under WHEN INSURANCE UNDER THIS POLICY ENDS without the consent of, or notice to, any Member, Dependent, or Beneficiary, except such notice as may be specifically required under HIPAA or any applicable state laws.

PREMIUM PAYMENTS

The premiums due under this Policy are payable by the Employer directly to the Administrator as shown in this Policy.

The payment of any premium will not maintain the insurance in force beyond the day next following the Premium Due Date, except as provided under GRACE PERIOD.

The first premium is due on the Effective Date of this Policy. Premiums after the first are due on the Premium Due Date shown on the face page of this Policy.

When additional or increased insurance begins or insurance ends and it is due to a change in the terms of this Policy, any adjustment in the premium will be made as of the date the change is effective.

AGGREGATE PREMIUM

The aggregate premium due on any Premium Due Date is the sum of the amounts determined in accord with the provision of this Policy entitled PREMIUM CALCULATION.

GRACE PERIOD

A grace period of 31 days (without interest charge) will be granted to the Employer for the payment of any premium due after the first. This Policy will continue in effect during this period unless the Employer has given written notice to us that the insurance under this Policy is to be ended on the first day before the grace period would otherwise start.

If the premium is not paid by the end of the grace period, all insurance under this Policy will end on the last day of the grace period. The Employer will owe us all premiums then due and unpaid including the premium for the grace period.

If the Employer gives us written notice that insurance under this Policy is to be ended during the grace period but before it is over, all insurance will end on the date we receive the written notice or the date specified, if later. The Employer will owe us the pro-rata premium for the time the insurance was in effect during the grace period.

PREMIUM CALCULATION

The total premium for this Policy is obtained by multiplying the number of Members insured in each class times the applicable premium rates then in effect.

CHANGES IN PREMIUM RATES

We have the right to change any of the premium rates for any of the insurance included in this Policy. If an increase takes place on other than a Premium Due Date there will be due on the date the increase takes place a pro rata premium. The pro rata premium will be for the period from the date of the increase to the next Premium Due Date. We will give the Employer written notice at least 30 days before any premium rate change.

[CONVERSION PRIVILEGE CHARGE

There will be a charge payable by the Employer for including the CONVERSION PRIVILEGE in this Policy.

This conversion charge shall be determined by Us and may be changed as of any Premium Due Date by giving the Employer written notice at least 30 days before that Date.]

GENERAL PROVISIONS

ENTIRE CONTRACT

The entire contract consists of this Policy (which incorporates the provisions of the attached booklet-certificate(s), certificate declarations, and rider(s), the application of the Employer, and the applications (if any) made by the persons insured under this Policy. All statements made in the applications that are made a part of this Policy are representations and not warranties.

No statement made by a person insured under this Policy will be used to void insurance or deny a claim unless a copy is or has been given to that person or to his Beneficiary, if any.

INCONTESTABILITY

The validity of this Policy will be incontestable, except for non-payment of premium, after it has been in force for two years.

No statement made by a person insured under this Policy relating to his being insurable will be used to void the insurance for which the statement was made after such insurance has been in force for two years during his lifetime. In order to be used that statement must be in writing and signed by the insured person (parent or guardian of minors).

However, this Incontestability provision does not stop us from denying all or part of a claim for benefits based on the person's not being eligible to be insured or based on any other Policy provision.

CHANGES IN POLICY

No agent or person other than an officer of the Company has authority to change, alter or amend any of the terms or provisions of this Policy in any way. To be effective, all such changes must be in writing and signed by an officer of the Company.

The Company reserves the right to change this Policy as follows:

- The Policy may be amended or changed at any time to the extent necessary to meet the requirements of any law or regulation issued by the State of Arkansas or any governmental agency to which this Policy is subject.
- The Policy may be amended or changed at any time when the Company determines that such amendment is required for consistent application of policy provisions.
- The Policy may be amended or changed at any time by written agreement between the Employer and us.

Any changes will be made without the consent of, or notice to, any insured person or Beneficiary, if any.

Payment of premium beyond the effective date of the change constitutes the Employer's consent to the change.

MISSTATEMENTS

If any relevant fact as to a person to whom insurance relates is found to have been misstated, the true facts will be used to determine whether his insurance is in effect and in what amount. There will be a fair adjustment of premiums, recomputed based on the true facts as to that person.

CONFORMITY WITH LAW

If any Policy provision is contrary to the law of the jurisdiction in which it is delivered, such provision is hereby amended to the minimum extent to conform to that law.

The laws of some jurisdictions require that certain Policy provisions conform to the law of that jurisdiction with respect to persons permanently residing in that jurisdiction. If any such provision conflicts with such a law, that provision is hereby amended to the minimum extent needed to conform to that law. But the provision is amended only with respect to insured persons who permanently reside in that jurisdiction.

INFORMATION TO BE FURNISHED BY EMPLOYER

The Employer will furnish us with all information that pertains to this Policy.

We may inspect at all reasonable times (while this Policy is in effect and thereafter until all rights and payments have been made) any records of the Employer that have a bearing on the insurance or premiums.

CLERICAL ERROR

Clerical error (whether by the Employer or us) in keeping the records having to do with this Policy, or delays in making entries on the records, will not void the insurance of any person if that insurance would otherwise have been in effect. Such clerical error will not extend the insurance of any person if that insurance would otherwise have ended or been reduced as provided by this Policy.

When a clerical error is found, premiums and benefits will be adjusted based on the true facts and this Policy.

EMPLOYER NOT AGENT

The Employer will in no event be considered our agent for any purpose under this Policy.

ASSIGNMENT

No assignment of this Policy is binding upon us unless we agree to it in writing and not until it is filed with us at our Home Office.

INDIVIDUAL CERTIFICATES OF INSURANCE

We will issue to the Employer for delivery to each Member insured under this Policy a Certificate Of Insurance that states the insurance protection to which he is entitled and to whom the benefits are payable. The words "Certificate Of Insurance" will include the booklet-certificate, and any certificate riders, and certificate supplements.

NON-PARTICIPATING

The Policy is issued on a non-participating basis and does not share in our surplus earnings.

WORKERS' COMPENSATION

This policy is not in lieu of and does not affect any requirement for coverage by Workers' Compensation.

WAIVER OF RIGHTS

If we fail to enforce or correctly apply any provision of this Policy, this will not affect our right to enforce or correctly apply such provision at a later date. It will not affect our right to enforce or apply any other provision of this Policy.



COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200, COLUMBIA, SC 29223-5666
P.O. BOX 100102, COLUMBIA, SC 29202-3102

**Group Medical Care Insurance Certificate
(the Booklet)**

for Members of

**[ABC COMPANY]
(the Employer)**

Companion Life Insurance Company (called "we," "us," and "our") certifies that it has issued Group Policy No. [11111111] (the Policy) to insure certain Members (called "you" and "your") of the Employer. The Policy provides the benefits shown in the Schedule Of Benefits and described on the following pages for certain Members insured under the Policy. Members become insured under the Policy as provided herein. This Booklet, together with the Certificate Riders (if any) applying to Members, forms that Member's Certificate Of Insurance while insured under the Policy. It replaces any previous Certificates Of Insurance issued under the Policy to that Member. The benefits and provisions described on the following pages are subject in all respects to the terms and conditions of the Policy. The Policy alone constitutes the entire contract between the Employer and us.

The Policy Effective Date is [July 1, 2009].

The Policy Anniversary Date is [July 1].

The benefits outlined in this Booklet are effective as of [July 1, 2009].

COMPANION LIFE INSURANCE COMPANY

[Columbia, South Carolina 29223]

**MEDICAL CARE COVERAGE ADMINISTERED BY:
TOTAL PLAN SERVICES, INC.
14001 Dallas Parkway, Suite 700
Dallas, Texas 75240**

A handwritten signature in cursive script, appearing to read 'Susan Smith'.

President

TABLE OF CONTENTS

SCHEDULE OF BENEFITS [3]

PREFERRED PROVIDER (PPO) PROVISIONS..... [9]

UTILIZATION REVIEW (UR) PROGRAM..... [10]

ALTERNATIVE TREATMENT REVIEW PROGRAM [13]

REVIEW OF MEDICAL NECESSITY AND APPROPRTATENESS..... [14]

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION..... [15]

 WHO CAN BE INSURED [15]

 WHEN YOU ARE ELIGIBLE TO BE INSURED [15]

 WHEN YOUR INSURANCE BEGINS [15]

 WHEN YOU ARE ELIGIBLE FOR INSURANCE FOR YOUR DEPENDENTS..... [16]

 WHO ARE ELIGIBLE DEPENDENTS [16]

 WHEN INSURANCE FOR DEPENDENTS BEGINS [17]

 SPECIAL ENROLLMENT PERIODS [19]

 WHEN YOUR INSURANCE ENDS [21]

 WHEN INSURANCE FOR DEPENDENTS ENDS [21]

ARKANSAS STATE MANDATED CONTINUATION OF COVERAGE.....[22]

[COBRA CONTINUATION.....23]

[FEDERAL FAMILY AND MEDICAL LEAVE ACT.....27]

[UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT ACT.....28]

CONVERSION PRIVILEGE.....[29]

MEDICAL CARE INSURANCE FOR MEMBERS AND DEPENDENTS

 [SUPPLEMENTAL ACCIDENT EXPENSE BENEFITS30]

 MANDATED BENEFITS [31]

 ARKANSAS MANDATED BENEFITS [31]

 FEDERAL MANDATED BENEFITS [36]

 MENTAL DISORDERS AND ALCOHOLISM BENEFITS.....[37]

 MISCELLANEOUS MEDICAL EXPENSE BENEFITS.....[39]

 MAJOR MEDICAL EXPENSE BENEFITS.....[40]

 COVERED CHARGES FOR TREATMENT OF INJURY OR ILLNESS.....[40]

 TRANSPLANT PROGRAM COVERED CHARGES.....[42]

 OTHER COVERED CHARGES.....[42]

 LIMITS ON COVERED CHARGES.....[43]

 BENEFITS PAYABLE.....[43]

MEDICAL CARE BENEFIT EXCLUSIONS..... [44]

[PRESCRIPTION DRUG EXPENSE BENEFITS48]

[DENTAL EXPENSE BENEFITS50]

[VISION EXPENSE BENEFITS53]

COORDINATION OF MEDICAL [AND DENTAL] CARE BENEFITS..... [55]

CLAIMING BENEFITS [58]

DEFINITIONS [60]

[REPLACEMENT OF PRIOR COVERAGE [67]]

SCHEDULE OF BENEFITS

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

Eligible Members: [All full-time Employees of the Employer]

Eligibility Periods:

- Initial Members: [3 months of employment in a row as a full-time Employee]
- New Members: [3 months of employment in a row as a full-time Employee]

[Policy Month: The period of time that begins on the 1st day of each calendar month and ends on the day just before that date of the next month. The first Policy Month begins on the Policy Effective Date; the last Policy Month ends on the day the Policy ends.]

MEDICAL CARE COVERAGE FOR MEMBERS [AND DEPENDENTS]

[SUPPLEMENTAL ACCIDENT BENEFIT \$500]

MAJOR MEDICAL EXPENSE BENEFITS (PPO PLAN)

MAXIMUM BENEFITS

- Overall Lifetime Maximum Benefit for all Covered Charges: \$2,000,000
- [Calendar Year Maximum for all Covered Charges: \$1,000,000]
- Inside Lifetime Maximum Benefit for all Covered Charges for or in connection with, or as a consequence of Covered Transplants under the Transplant Program: \$ 500,000
- Inside Maximum Benefits for all Covered Charges for treatment of Mental Disorders: (For HIPAA small groups only – no inside dollar limits for large groups)
 - Calendar Year \$ 5,000
 - Lifetime \$ 25,000]
- [Inside Calendar Year Maximum Benefits for all covered charges for Treatment of Alcoholism \$ 1,000]

DEDUCTIBLES:

Hospital Benefit

Per Confinement Deductible

- Amount per Covered Person per Hospital Inpatient stay or Partial Hospitalization stay in a Covered Facility:
- Must be met from, and applies only to, the Covered Facility's Covered Charges for that stay, but not a stay as part of a Hospice Program.
- An Inpatient or Partial Hospitalization stay starting within 10 days after a prior stay for the same or related reasons is considered part of that prior stay for the purpose of applying this Deductible.

PREFERRED CHARGE – IN NETWORK	NON-PREFERRED CHARGE – OUT-OF-NETWORK
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*\$100	*\$100
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*This Deductible applies in addition to the Calendar Year Deductible.

Calendar Year Deductible

- Individual amount per Covered Person, per calendar year \$1,000 \$1,000]

SCHEDULE OF BENEFITS (Continued)

- [Amount per family, per calendar year Total of 3
In Network
Calendar Year
Deductibles Total of 3
Out of Network
Calendar Year
Deductibles

- Must be met from, and applies only to, Covered Charges incurred by or on behalf of that person in that calendar year, but not Covered Charges:
 - made by a Practitioner to which the Office Visit Co-payment applies;
 - made by an In Network Hospital or an In Network Practitioner for Covered Charges incurred in a Hospital emergency room;
 - if the person is not admitted as an Inpatient directly from the emergency room; and
 - for Covered Charges that do not exceed the Emergency Room Co-payment plus \$1,000
 - for a Hospice Program;
 - for mammography screenings to the extent benefits are payable under the Preventative Benefit (amounts in excess of the Preventative Benefit are subject to the Calendar Year Deductible);
 - for a Consulting Opinion that we request as part of the UR Program;
 - For treatment of Injury sustained while insured for charges incurred within 90 days after the date the Injury was sustained; or
 - for charges to the extent benefits are payable under the Supplemental Accident Benefit (amounts in excess of the Supplemental Accident Benefit are subject to the Calendar Year Deductible).

- Once 3 insured family members have each met their own Calendar Year Deductible during a calendar year, all other insured family members will be deemed to have met their Calendar Year Deductibles for the balance of that calendar year. "Family Members" include only you and those insured as your Dependents. Charges used to satisfy the individual and family maximum Calendar Year Deductibles that apply to In Network charges will not be used to satisfy the individual and family maximum Calendar Year Deductibles that apply to Out of Network charges and vice versa.

- [Covered Charges incurred while insured under the Policy in the last three months of a calendar year that were used to meet the Calendar Year Deductible will also be used to meet the Calendar Year Deductible for the next calendar year.]

COINSURANCE EXPENSE MAXIMUM

	PREFERRED CHARGE – IN NETWORK	NON-PREFERRED CHARGE – OUT- OF- NETWORK
Individual amount per Covered Person per calendar year:	\$2,000	\$2,000
Amount per family per calendar year	Total of 3 In Network Family Member Coinsurance Expense Maximums	Total of 3 Out of Network Family Member Coinsurance Expense Maximums

- Must be met from Coinsurance Expenses incurred by or on behalf of

that person in that calendar year.]

SCHEDULE OF BENEFITS (Continued)

- [Coinsurance Expenses are the amounts a Covered Person must pay for Covered Charges for which benefits would otherwise be payable under the Policy. Coinsurance Expenses do not include:
 - any amount applied to a Co-payment or a Deductible;
 - any charge, or part of a charge, that is not a Covered Charge;
 - charges for which no benefits are payable due to application of the Utilization Review Penalty.
 - Any charge for treatment of Mental Disorders incurred while the Covered Person is not admitted as an inpatient in a Hospital;
 - [Any charge for Prescription Drugs for which a benefit is payable under PRESCRIPTION DRUG EXPENSE BENEFITS.]
- Once 3 insured family members have each met their Coinsurance Expense Maximums during a calendar year, all insured family members will be deemed to have met their Coinsurance Expense Maximums for the balance of that calendar year. Charges used to satisfy the individual and family Coinsurance Expense Maximums that apply to In Network charges will not be used to satisfy the individual and family Coinsurance Expense Maximums that apply to Out of Network charges and vice versa.]

INSURED PERCENTAGES AND CO-PAYMENTS

COVERED CHARGES FOR INJURY AND ILLNESS, after Calendar Year Deductible, unless otherwise indicated below)

[Insured Percentage of Covered Charges incurred:

Hospital Benefit

	PREFERRED CHARGE – IN NETWORK	NON-PREFERRED CHARGE – OUT-OF- NETWORK
Hospital Daily Room Limit, Semi-private Rate	80%	60%
Intensive Care Unit Limit, up to Allowable Charge	80%	60%
Intermediate Care Unit Daily Rate Up to 1½ times semi-private rate	80%	60%
Hospital Emergency Room	\$150 Co-payment per Covered Person per outpatient visit, then:	\$150 Co-payment per Covered Person per outpatient visit, then:
First \$1,000 after Co-payment	100%	75%
	(Calendar Year Deductible does not apply to first \$1,000 after the Co-payment)	
Amount in excess of \$1,000 plus the Co-payment, after the Calendar Year Deductible	80%	55%

The In Network Emergency Room Co-payment must be met from, and applies only to, the Hospital’s or Practitioner’s Covered Charges for or in connection with that Visit, but not if the patient is admitted as an Inpatient directly from the emergency room. If the patient is admitted as an Inpatient, benefits are paid as any other hospital confinement.]

*When a Covered Person requires emergency treatment and cannot reasonably reach a Preferred Provider, benefits will be paid at the In Network level.]

SCHEDULE OF BENEFITS (Continued)

	PREFERRED CHARGE -- IN NETWORK	NON-PREFERRED CHARGE – OUT-OF- NETWORK
[Doctors Care Benefit		
Surgical Services, Hospital Inpatient	80%	60%
Surgical Services, Outpatient	80%	60%
Hospital Visits, per Visit	80%	60%
Office Visits, per Visit		
Primary Care Practitioners (OB/GYN, Pediatricians, Family Practitioners, Internal Medicine, and Dermatologists)	\$50 Co-payment per visit then 100% (Calendar Year Deductible not Applicable)	75% (Co-payment not applicable)
Specialists (all other practitioners)	\$100 Co-payment per visit, then 100% (Calendar Year Deductible not Applicable)	75% (Co-payment not applicable)
<p>The In Network Office Visit Co-payment does not apply to Covered Charges Incurred during a Practitioner’s Office Visit for: a Consulting Opinion that we request as part of the UR Program; adjustment or manipulation of the spine or soft tissues, treatment of Mental Disorders; or mammography screenings.</p> <p>Lab Tests and X-rays rendered on same day and billed by the same In Network practitioner as the office visit are payable at 100%.</p> <p>Also, the In Network Office Visit Co-payment does not apply to surgery, anesthesiology services, invasive diagnostic procedures, MRI exams, CAT scans, PET scans, cardiac imaging, radiation therapy, chemotherapy, or allergen immunotherapy (including serum and/or injections).</p> <p>However, if the above services are otherwise Covered Charges, the benefits for such Covered Charges will be determined under the headings: “Calendar Year Deductible” and “Insured Percentage”.</p> <p>Exception: Manipulative Therapy of Spine and Soft Tissue Subject to Deductible and Coinsurance with benefit limitations of \$25 per visit (all combined services) and limited to 2 visits per 7 consecutive days. Maximum of 52 visits per calendar year.</p>		
Home Health Care		
Up to \$75 per visit for Skilled Nursing; Maximum of 60 visits per calendar year for all services of combined Agencies	80%	60%
Preventative Benefit	100%	100%
Includes Routine Physical Exams, Well Baby Exams, X-Ray and Lab Test, Pap Smears, Mammograms, Immunizations, Gynecological Exams at 100% to a \$200 Maximum Per Calendar Year (Not subject to calendar year deductible)		

Hospice Care Benefit

Up to \$5000 lifetime

100%

75%]

SCHEDULE OF BENEFITS (Continued)

	PREFERRED CHARGE – IN NETWORK	NON-PREFERRED CHARGE – OUT-OF- NETWORK
[Nurses Care Benefit		
Up to 60 visits per calendar year (Refer to Home Health Care Benefit)	80%	60%
Skilled Nursing Facility		
Up to 90 days per calendar year.	80%	60%
Licensed Ambulance Services	100%	100%
Up to \$500 for each trip to or from nearest hospital where treatment can be performed.		
Physiotherapy Benefit		
Up to \$5,000 per Calendar Year	80%	60%
Mental/Nervous Benefit:		
[[small group]]		
Inpatient, up to 30 days per Calendar Year, up to Maximum Benefit	80%	60%
Outpatient, not to exceed 1 visit per 14 days	50%	50%
Inpatient and partial hospitalization subject to \$100 maximum allowable charge per visit with one inpatient visit per day.]	80%	60%
[[large group]]		
Inpatient, up to 30 days per Calendar Year, up to Maximum Benefit	80%	60%
Outpatient, not to exceed 1 visit per 14 days	50%	50%]
	DESIGNATED TRANSPLANT FACILITY	NON- DESIGNATED TRANSPLANT FACILITY
[Insured Percentage of Covered Charges incurred:		
• for, in connection with, or a consequence of Covered Transplants under the Transplant Program		
• before the Coinsurance Expense Maximum is met:	80%	55%
• after the Coinsurance Expense Maximum is met:	100%	100%
	PREFERRED CHARGE – IN NETWORK	NON-PREFERRED CHARGE – OUT-OF- NETWORK
• [for the first \$100 for a Consulting Opinion that we request as part of the UR Program:	100%	100%
• for treatment of Mental Disorders incurred while the Covered Person is not admitted as an inpatient in a Hospital:		
• before the Coinsurance Expense Maximum is met:	80%	60%
• after the Coinsurance Expense Maximum is met:	80%	60%
• for all other treatment, care, services, or supplies:		
• before the Coinsurance Expense Maximum is met:	80%	60%
• after the Coinsurance Expense Maximum is met	100%**	100%**]

SCHEDULE OF BENEFITS (Continued)

[** **UR Penalty:** The Insured Percentage of Covered Charges due to or for treatment, care, services, or supplies subject to Utilization Review (UR) is reduced by [25%] for failure to comply with the UR Program as stated in the Policy.]

[PRESCRIPTION DRUG EXPENSE BENEFITS

	Participating Pharmacy Co-payment
• Short-Term Supply Network	
• Generic Drugs	\$15
• Preferred Brand Name Drugs	\$25
• Non-preferred Brand Name Drugs	\$35
• Extended Supply Network	
• Generic Drugs	\$30
• Preferred Brand Name Drugs	\$50
• Non-preferred Brand Name Drugs	\$70]

[Deductible

- Per Calendar Year, Per Person: \$50
- Per Calendar Year, Per Family: \$150]

[Utilization Review is required for treatment, care, services, or supplies provided:

- for, during, or in connection with an Inpatient or Partial Hospitalization stay in a Covered Facility;
- for or in connection with Outpatient surgery or Outpatient invasive diagnostic testing in a Hospital or Ambulatory Surgical Center;
- through a Home Health Agency;
- as part of a Hospice Program;
- for or in connection with physical, occupational or speech therapy in a Hospital or freestanding rehabilitation facility;
- for or in connection with magnetic resonance imaging (MRI) or lithotripsy;
- for durable medical equipment;
- for growth hormones;
- for air ambulance and non emergency ambulance service;
- for sleep studies;
- for pain clinics;
- for treatment of a condition that no Preferred Provider in the PPO Area treats (in order for Preferred Charges to be payable);
- in observation units;
- for anti-rejection drugs to assist in maintaining transplanted organs, tissues, or cells;
- for or in connection with skeletal joint surgery, including temporomandibular joint (TMJ) surgery;
- [for or in connection with coverage for anesthesia and hospitalization for dental procedures;]
- for, in connection with, or as a consequence of Covered Transplants under the Transplant Program; or
- for or in connection with treatment of Alcoholism.]

[Provisions For Initial Covered Persons: Previous Insurer: DEF Insurance Company]

Administrator: [Total Plan Services, Inc., 14001 Dallas Parkway N, Suite 700, Dallas, Tx 75240; Phone: 1-800-969-5238.]

Utilization Review Program: [Strategic Health Development Corporation, 9315 N E 6th Avenue, Suite A1, Miami Shores, FL 33138; Phone: 1-800-874-2378, 24 hours a day.*]

Claims Office: [Total Plan Services, Inc., 14001 Dallas Parkway N, Suite 700, Dallas, Tx 75240; Phone: 1-800-969-5238.]

*** For Transplant Only:** [Strategic Health Development Corporation, 9315 NE 6th Avenue, Suite A1, Miami Shores, FL 33138; Phone: 1-800-874-2378, 24 hours a day.]

PREFERRED PROVIDER (PPO) PROVISIONS

Under the PPO Plan, the level of Major Medical Expense Benefits depends in part on whether the provider is defined as Preferred or Non-Preferred. Generally, a higher level of benefits applies to Preferred (as compared to Non-Preferred) Charges. See the SCHEDULE OF BENEFITS for details. This means that a Covered Person's out-of-pocket costs may be less if Preferred Providers are used.

Exceptions To Benefit Payment At Non-Preferred Charge Level

The following Non-Preferred Charges will be payable as though they were Preferred Charges:

1. Those made for treatment of a condition that no Preferred Provider treats, subject to Utilization Review requirements.
2. Those incurred in the PPO Area for Emergency Medical Treatment, but:
 - only if a person could not reasonably be expected to reach a Preferred Provider; and
 - only while a person could not reasonably be expected to transfer to a Preferred Provider.
3. Those incurred outside the PPO Area for treatment of a Member or Dependent while that Member or Dependent:
 - is permanently residing outside the PPO Area; or
 - is temporarily residing, or is traveling, outside the PPO Area for purposes other than obtaining treatment;but only if a person could not reasonably be expected:
 - to have gone to the PPO Area (as opposed to some other area) to obtain treatment; or
 - to have received treatment before leaving the PPO Area; or
 - to have delayed treatment until returning to the PPO Area.

[In the event of termination of a Preferred Provider, except for reasons of medical competence or professional behavior, we will reimburse the Preferred Provider or, if applicable, the Covered Person at the same PPO rate if, at the time of termination, the Covered Person has Special Circumstances.

This will not extend our obligation to reimburse at the PPO level of coverage for ongoing treatment of a Covered Person after the 90th day from the effective date of the termination, or beyond nine months in the case of a Covered Person who at the time of the termination has been diagnosed with a terminal illness.

"Special Circumstances" means a condition such that the treating Practitioner reasonably believes that discontinuing care by the treating Practitioner could cause harm to the patient. Special circumstances must be identified by the treating Practitioner, who must request that the Covered Person be permitted to continue treatment under the Practitioner's care and agree not to seek payment from the Covered Person of any amounts for which he would not be responsible if the Practitioner were still a Preferred Provider.

"PPO Area" means the geographic area served by Preferred Providers. Our determination of the extent of the PPO Area is final for the purpose of determining benefits payable under the Policy.]

Preferred Provider Directory

You will be given a Preferred Provider Directory, prepared to include the Preferred Providers in your area. This Directory will be updated periodically. The listing (or omission) of any provider in the Directory is not a guarantee that the provider is (or is not) a Preferred Provider. Also, a referral by a Preferred Provider to another provider is not a guarantee that the other provider is also Preferred.

Provider status may change. Actual provider status as Preferred or Non-Preferred is determined only by the Policy definition met at the time of service. **It is your responsibility to verify provider status each time you use a provider by calling the number listed in the Preferred Provider Directory.**

Other Provisions

We, or another organization chosen by us, may prepare some or all parts of the Preferred Provider Directory, or may update or distribute same.

Provider status as Preferred or Non-Preferred is not our endorsement of, nor commentary on, the quality of care provided. Provider choice is strictly the Covered Person's decision.

UTILIZATION REVIEW (UR) PROGRAM

Utilization Review (UR)

Utilization Review (UR) is a process by which we:

- determine whether certain types and levels of treatment, care, services, and supplies are Medically Necessary; and
- recommend cost-effective alternative types or levels of treatment, care, services, or supplies, where appropriate, for you (or your Dependent) and the attending Practitioner to consider.

UR applies to all Inpatient confinements and various Outpatient services and supplies, as described in the SCHEDULE OF BENEFITS.

If you fail to comply with UR Program requirements as stated in the Policy, including but not limited to timely notice requirements, a benefit penalty applies. The benefit penalty applies even if the treatment, care, services, or supplies are later determined to be Medically Necessary. (Note that under the Policy, benefits are **not** payable with respect to treatment, care, services, or supplies that are **not** Medically Necessary.)

The UR Program's timely notice requirements are described in this UR PROGRAM section of the Certificate.

We may choose a health care provider or review organization to conduct some or all of the Utilization Reviews or handle other aspects of the UR Program for us.

Certification

Certification is our confirmation, through the UR Program, of Medical Necessity And Appropriateness using established standards.

Certification does not mean that all charges incurred will be Covered Charges or that benefits will be payable for all Covered Charges incurred. All other terms, limits, and exclusions of the Policy apply.

We are not advising the Covered Person to change treatment plans based on whether or not treatment, care, services, or supplies are Certified or whether or not a Consulting Opinion confirms the medical need for surgery. Such a decision is the Covered Person's and should be made after consulting with the attending Practitioner.

How UR Affects Benefits

There is a penalty applied to benefits for Covered Charges due to or for the treatment, care, services, or supplies subject to UR if:

- Certification is not requested in a timely manner; or
- we request (with a maximum of three reminders, depending on the scheduled or actual service date) information normally needed to make the UR decision, the information is not provided within a reasonable amount of time (based on the scheduled or actual service date), and we find upon review that we cannot grant Certification on the basis of the available information; or
- Certification of the treatment, care, services, or supplies is not granted; or
- we ask for a Consulting Opinion but it is not obtained before surgery is done; or
- we ask for a Consulting Opinion and it is obtained before surgery is done, but it (or a second Consulting Opinion filed before surgery is done) does not confirm the medical need for surgery at that time.

The penalty for noncompliance with UR Program requirements is shown in the SCHEDULE OF BENEFITS, along with a list of the treatment, care, services, and supplies subject to UR. (Note, however, that charges for treatment, care, services, or supplies that are **not** Medically Necessary are **not** Covered Charges, and benefits are **not** payable for such charges.)

UTILIZATION REVIEW (UR) PROGRAM, Continued

Initial UR Requests

The Covered Person and his attending Practitioner may request Certification by calling Strategic Health Development (toll-free phone number shown in the SCHEDULE OF BENEFITS). State that the phone call is about UR or Certification. We encourage you to call during regular work hours (shown in the SCHEDULE OF BENEFITS), or to leave a message after hours for a return call from Strategic Health Development Corporation on the next workday. But in emergencies outside of regular work hours, you can use the emergency features of the phone message system to reach an “on-call” [Administrator] [staff member].

Non-Emergency Medical Treatment: Certification (other than for Emergency Medical Treatment) must be requested **at least 10 days prior to** an Inpatient admission or Outpatient service. If Certification is requested less than 10 days in advance, Certification for the proposed date will be denied if we cannot obtain the information needed to complete the review prior to that date.

Emergency Medical Treatment: Emergency Medical Treatment does not require **prior** Certification. However, Certification for Emergency Medical Treatment must be requested **within 48 hours after** an Inpatient admission or Outpatient service, even if the Covered Person is discharged or the service is completed before the request is made. If Certification is requested more than 48 hours after the Inpatient admission or Outpatient service, a penalty will be applied for Charges due to or for treatment, care, services, or supplies received prior to the time of the Certification request.

It is the Covered Person’s responsibility to make sure that any Certification request is made in a timely manner, even if a Practitioner, Covered Facility, or any other provider or person agrees to make the request for the Covered Person. If the request is not made in a timely manner, we cannot properly conduct the review and Certification will be denied.

Our Response To UR Requests

We will request the information we need, including pertinent clinical information, to make the UR decision. We will limit our requests to that information necessary to determine whether or not the treatment, care, services, or supplies may be Certified. We will consult with the attending Practitioner and a Doctor of Medicine or Osteopathy or Clinical Peer Reviewer of our choice as our established standards require.

We will promptly notify the Covered Person, the attending Practitioner, and the Covered Facility (if a facility is involved) of the UR decision. The notice will be in writing, sent by facsimile (fax) or by the United States mail service. However, where appropriate (based on the scheduled or actual service date), we may provide initial notice by telephone, with follow-up confirmation sent by fax or mail.

If A Scheduled Service Date Must Be Changed

Certification of a scheduled service is valid for the date(s) shown on the written notice of UR decision. If the scheduled service must be changed from the certified date(s) or outside the certified date range, Strategic Health Development Corporation must be notified.

If A Certified Inpatient Stay Or Series Of Outpatient Services Must Be Extended, Or The Needed Level Of Care Changes

Once an Inpatient stay or series of Outpatient services has been Certified and we have been notified of the actual admission or first service date, we will review the ongoing stay or series of services (a concurrent review). We will obtain information regarding any changes in the stay or services as originally Certified. We will Certify those changes if they are Medically Necessary.

It is the Covered Person’s responsibility to make sure that we are advised of the actual admission date or the actual first service date prior to any such changes. If we are not so advised, we cannot properly conduct the concurrent review and Certification will be denied for any such changes.

When And How A Consulting Opinion Is Used - As part of UR for certain types of surgery (other than for Emergency Medical Treatment), we will decide whether or not we need a Consulting Opinion. If we do, we will promptly ask the Covered Person to get one.

UTILIZATION REVIEW (UR) PROGRAM, Continued

If we ask for a Consulting Opinion, it must be obtained before surgery is done and filed with [the Administrator]. We will Certify or deny Certification based on whether or not that Opinion confirms the medical need for surgery at that time.

But if the first Consulting Opinion does not confirm the need, the Covered Person may choose to get a second Consulting Opinion. If that Opinion is also obtained in advance and filed with [the Administrator], we will Certify or deny Certification based on whether or not that Opinion confirms the need.

Disagreements Over A UR Decision - A Practitioner ordering or rendering a service may request informally that we reconsider a UR decision to deny Certification for that service. Also, the Covered Person or his authorized representative, or any Practitioner acting on the Covered Person's behalf may formally appeal any UR decision to deny Certification, whether or not we have informally reconsidered the decision.

Informal reconsiderations and formal appeals are both voluntary processes that follow procedures described in the Policy. They are not required or automatic. They must be initiated by a Practitioner (for an informal reconsideration or formal appeal), or by you or your Dependent or representative (for a formal appeal).

Informal Reconsideration Of A UR Decision - A Practitioner ordering or rendering a service for which Certification has been denied has the right to request informally that we reconsider the decision if:

- our original decision to deny Certification was made without peer to peer conversation between the Practitioner and a Doctor of Medicine or Osteopathy or Clinical Peer Reviewer of our choice; or
- additional information is available.

The Practitioner may request that we reconsider a UR decision by calling Strategic Health Development Corporation (phone number shown in the SCHEDULE OF BENEFITS). The Practitioner should state that the call is about a request to reconsider a UR decision or a denial of Certification. He will be given the opportunity to provide additional information and to discuss the decision with a Doctor of Medicine or Osteopathy or Clinical Peer Reviewer of our choice.

We will promptly notify the Practitioner by phone of the reconsidered UR decision, with written confirmation by fax or mail to the Covered Person and the Practitioner. If the informal reconsideration fails to resolve any differences of opinion, the Covered Person or his Practitioner has the right to formally appeal the decision.

Formal Appeal Of A UR Decision - The Covered Person or his authorized representative, or any Practitioner acting on the Covered Person's behalf, has the right to formally appeal a UR decision. However, this appeal process does not apply to denials based solely on the fact that the Policy clearly excludes benefits with respect to the service for which Certification has been denied.

A UR decision may be formally appealed by calling or writing the Administrator (phone number and address shown in the SCHEDULE OF BENEFITS). State that the call or letter is a request to appeal the decision. The person(s) appealing the decision will be given the opportunity to provide additional information for us to consider.

We will conduct a review with the attending Practitioner (or the Practitioner ordering or rendering the service) and a Doctor of Medicine or Osteopathy or Clinical Peer Reviewer of our choice, not involved in the original decision to deny Certification, as our established standards require. If that review fails to resolve any differences of opinion, we will conduct a second review with a Clinical Peer Reviewer of our choice, not involved in the first review. The Practitioner may submit any additional information for the Clinical Peer Reviewer to consider. If the second review upholds the decision to deny Certification and the Practitioner so requests, we will conduct a third review with a Clinical Peer Reviewer of our choice, not involved in the first or second review.

We will promptly notify the Covered Person or his representative, the involved Practitioner, and the Covered Facility (if a facility is involved) of our response to the appeal by fax or mail. However, where appropriate (based on the scheduled or actual service date), we may provide initial notice by telephone, with follow-up confirmation sent by fax or mail. If the formal appeal upholds the decision to deny Certification, the Covered Person or his representative or the involved Practitioner has the right to file a second-level formal grievance as described under Grievances in the CLAIMING BENEFITS section.

In order for us to consider a formal appeal of a UR decision, it must be requested within 60 days after the original UR decision to deny Certification.

ALTERNATIVE TREATMENT REVIEW PROGRAM

Alternative Treatment Review

There may be a way to provide a more appropriate level of treatment for some catastrophic or severe chronic Illnesses or Injuries than would otherwise be covered under the Policy.

[Case managers] will review claims for such Illnesses or Injuries to determine what appropriate levels of treatment may be advisable and what forms such treatment might take (an Alternative Treatment Review).

The Covered Person's case manager will consult with the Practitioners concerned and a panel of Doctors of Medicine or Osteopathy as needed. The alternative treatment would then be coordinated by the Covered Person's [case manager].

Type Of Injury Or Illness That May Receive An Alternative Treatment Review

A catastrophic or severe chronic Illness or Injury; such as (but not limited to):

- a head Injury requiring Inpatient care;
- a Mental Disorder requiring Inpatient care;
- a spinal cord Injury;
- a severe burn over 20% of the body;
- a cerebral vascular accident (CVA or stroke);
- an accident with multiple fractures;
- premature birth;
- a congenital defect that severely impairs a needed bodily function;
- brain damage suffered during surgery or during a cardiac arrest;
- a terminal Illness (prognosis of death within 6 months); or
- a long term progressive or chronic Illness that requires ongoing expert care, such as (but not limited to) congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), or "brittle" diabetes;

may receive an Alternative Treatment Review if, in our sole judgment, such a review is appropriate.

How to Request An Alternative Treatment Review

If a Covered Person suffers from a catastrophic or long-term Illness or Injury we will consider alternative treatment plans that the Covered Person or his Practitioner proposes. We may identify such plans to the Covered Person.

The Covered Person should not wait until a claim is submitted to have an alternate treatment review.

Alternate treatment plans may include some services, supplies or treatments that we do not usually cover. We must determine that the alternate treatment plan is Medically Necessary and cost effective. The Covered Person and his Practitioner must agree with the treatment plan. If all these conditions are met, we may offer benefits for services that are not routinely Covered Charges. However, we will not pay more for these services than the Policy maximum.

We decide whether to cover alternative treatment plans on a case-by-case basis. At any time, we have the right to stop providing benefits for an alternative treatment plan.

Other Provisions

We are not advising the Covered Person to alter plans for treatment based on an Alternative Treatment Review. Such a decision is the Covered Person's and should be made after consulting with the Practitioners concerned. The decision made may affect the amount of benefits payable under the Policy.

We may choose a health care provider or review organization to conduct some or all of the Alternative Treatment Reviews or handle other aspects of this program for us.

REVIEW OF MEDICAL NECESSITY AND APPROPRIATENESS

We have the right to review the Medical Necessity and appropriateness of:

1. inpatient admission to, proposed length of stay in, and continued stay in a Covered Facility; and
2. the level or type of treatment, care, services, and supplies received (or to be received) while either an Inpatient or an Outpatient;

for the purpose of determining benefits payable under the Policy.

We (or a health care provider or review organization of our choice) will conduct the review. We (or that provider or organization) will consult with a panel of Doctors of Medicine or Osteopathy as needed.

We are not advising the Covered Person to shorten or forgo an Inpatient confinement or to change the level or type of treatment, care, services, or supplies to be received while an Inpatient or an Outpatient on the basis of any such review. Such a decision is the Covered Person's and should be made after consulting with the Practitioners concerned. The decision made may affect the amount of benefits payable under the Policy.

We are exercising these review rights in part through the Utilization Review Program described in this Certificate. We still retain the review rights described in this Review Of Medical Necessity And Appropriateness provision for confinements or levels or types of treatment, care, services, or supplies not subject to the Utilization Review Program.

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

WHO CAN BE INSURED

To be eligible for coverage you must be a Member who Resides in the United States. Members of the Employer that are eligible to be insured under the Policy are shown in the SCHEDULE OF BENEFITS.

WHEN YOU ARE ELIGIBLE TO BE INSURED

You are eligible to be insured on the latest of:

- the Policy Effective Date;
- the date you become a full-time Member in an Eligible Class; [or]
- [the date you complete the Eligibility Period (if any).]

The Eligibility Period may differ for Initial and New Members. Initial Members are those who are full-time Members in an Eligible Class on the Policy Effective Date. New Members are those who become full-time Members in an Eligible Class after the Policy Effective Date.

The Eligibility Periods (if any) for Initial and New Members are shown in the SCHEDULE OF BENEFITS.

If Re-Employed

If, within 6 months after insurance under the Policy ends, you are re-employed, you are eligible to be insured on the date you re-enter an Eligible Class.

WHEN YOUR INSURANCE BEGINS

Noncontributory Plan

Insurance begins on [the first day of the Policy Month that coincides with or next follows] the date that you are first eligible.

However, your Noncontributory coverage will not be in effect if there is a waiver form on file with [the Administrator], signed by you when you refused insurance, stating that you refused it because you had other Creditable Coverage in effect at that time. If you revoke the waiver in writing and [the Administrator] receives your written revocation:

- on or before the date you are first eligible, insurance begins on [the first day of the Policy Month that coincides with or next follows] the date you are first eligible;
- within 31 days after the date you are first eligible, insurance begins on the first day of the Policy Month that coincides with or next follows the date [the Administrator] receives your written revocation.

If you revoke the waiver in writing and [the Administrator] receives your written revocation more than 31 days after the date you are first eligible, you are considered a Late Enrollee unless a Special Enrollment Period applies to you. Special Enrollment Periods are explained later in this section. As a Late Enrollee:

- your insurance begins on [the Policy Anniversary Date] that coincides with or next follows the date [the Administrator] receives your written revocation; and
- you may be subject to a longer Pre-Existing Condition exclusion than would apply if you were newly eligible. See the definition of Pre-Existing Condition in the Definitions section of this Booklet.

Contributory Plan

To become insured, you must fill out and sign our enrollment card and give it to the Employer.

Insurance begins on [the first day of the Policy Month that coincides with or next follows] the date:

- you are first eligible, if you submit the card on or before the date you are first eligible;
- you submit the card, if you submit it within 31 days after the date you are first eligible.

If you submit the card more than 31 days after the date you are first eligible, you are considered a Late Enrollee unless a Special Enrollment Period applies to you. Special Enrollment Periods are explained later in this section. As a Late Enrollee:

- your insurance begins on [the Policy Anniversary Date] that coincides with or next follows the date you submit the card; and
- you may be subject to a longer Pre-Existing Condition exclusion than would apply if you were newly eligible. See the definition of Pre-Existing Condition in the Definitions section of this Booklet.

WHEN YOU ARE ELIGIBLE FOR INSURANCE FOR YOUR DEPENDENTS

You are eligible for insurance for your Dependents on the later of:

- the date you are eligible to be insured; or
- the date you acquire an eligible Dependent.

WHO ARE ELIGIBLE DEPENDENTS

Eligible Dependents are:

- your spouse who is not legally separated from you; and
- each unmarried Child who is:
 - under age 19 years;
 - age 19 years but under age 24 years, if the Child (1) attends school full-time and (2) depends on you for more than half of his support; or
 - at and over the age limit shown if the Child: (1) is incapable of earning a living due to mental retardation or physical handicap on the day before reaching the age limit; (2) depends on you for more than half of his support on that day; (3) was insured under the Policy on that day; and (4) remains incapacitated and dependent as described. You must submit proof of such incapacity and dependency to us after the Child reaches that age limit. We can require proof of continued incapacity and dependency but not more than once each year after the 2 year period following the child's reaching that age limit.

"Child" includes only:

- your natural child, adopted child, child placed with you for adoption or any minor child under your charge, care and control for whom you have filed a petition for adoption;
- a child whom you are required to cover pursuant a court order; or
- your stepchild, grandchild, or other child who lives with you in a regular parent-child relationship and for whom you (or your spouse who lives with you) have permanent legal custody. Except for a stepchild, a regular parent-child relationship will not be deemed to exist if either of the child's parents resides with you.

No one can be insured as a Dependent of more than one Member. No one can be insured as a Dependent if eligible for insurance as a Member, with one exception: If you and your spouse can be insured as Members, one (and only one) of you may insure the other as a Dependent.

When Acquired - For the purposes of the Policy:

- a spouse is deemed acquired at the moment of marriage;
- a natural child is deemed acquired at the moment of birth;
- an adopted child or a child placed with you for adoption is deemed acquired:
 - on the date of the duly filed petition for adoption if you apply for insurance for the child within 60 days after the filing of such petition; or
 - from the moment of birth, if the duly filed petition for adoption and your application for the child's insurance is filed within 60 days after the child's date of birth.

If a final decree of adoption is not ultimately issued, we will deem such a child as placed with you only until the dismissal or denial of the petition for adoption.

- a stepchild, grandchild, or other child is deemed acquired at the moment he first meets the definition of "Child" shown in the provision "WHO ARE ELIGIBLE DEPENDENTS".

WHEN INSURANCE FOR DEPENDENTS BEGINS

Dependents on the Noncontributory Plan

Insurance begins for each then eligible Dependent on the **later** of:

- the date **your** insurance begins; or
- [the first day of the Policy Month that coincides with or next follows] the date you are first eligible for insurance for your Dependents.

However, Noncontributory coverage for [your Dependents] [your Dependent spouse (or Children)][a Dependent] will not be in effect if there is a waiver form on file with [the Administrator], signed by you when you refused insurance, stating that you refused it because [they] [the spouse (or Children)] [the Dependent] had other Creditable Coverage in effect at that time. If you revoke the waiver in writing and [the Administrator] receives the written revocation:

- on or before the date you are first eligible for that insurance, it begins on [the first day of the Policy Month that coincides with or next follows] the date you are first eligible for that insurance;
- within 31 days after the date you are first eligible for that insurance, it begins on [the first day of the Policy Month that coincides with or next follows] the date the Administrator receives your written revocation.

If you revoke the waiver in writing and [the Administrator] receives your written revocation more than 31 days after the date you are first eligible for that insurance, your Dependents are considered Late Enrollees unless a Special Enrollment Period applies to them. Special Enrollment Periods are explained later in this section. As Late Enrollees:

- insurance begins for them on [the Policy Anniversary Date] that coincides with or next follows the date [the Administrator] receives your written revocation; and
- they may be subject to a longer Pre-Existing Condition exclusion than would apply if they were newly eligible. See the definition of Pre-Existing Condition in the Definitions section of this Booklet.

Dependents on the Contributory Plan

To insure your Dependents, you must fill out and sign our enrollment card and give it to the Employer. Your request must include all your then eligible Dependents.

[If your spouse is your only Dependent when you first request Dependent insurance, you must request insurance when you acquire a Dependent Child in order to insure that Child. If one or more Children are your only Dependents when you first request Dependent insurance, you must request insurance when you get married in order to insure your spouse.]

[If you only have one eligible Dependent when you first request Dependent insurance, you must request insurance when you acquire a second Dependent in order to insure that Dependent.]

[Each time you acquire an additional Dependent after you first request Dependent insurance, you must request insurance for that Dependent in order to insure that Dependent.]

Insurance begins for each then eligible Dependent on the **later** of:

- the date **your** insurance begins; or
- [the first day of the Policy Month that coincides with or next follows] the date:
you are first eligible for insurance for your Dependents, if you submit the card on or before the date you are first eligible for Dependent insurance; or
- you submit the card, if you submit it within 31 days after the date you are first eligible for Dependent insurance.

If you submit the enrollment card more than 31 days after you are first eligible for insurance for your Dependents, they are considered Late Enrollees unless a Special Enrollment Period applies to them. Special Enrollment Periods are explained later in this section. As Late Enrollees:

- insurance begins for them on [the Policy Anniversary Date] that coincides with or next follows the date you submit the card; and

- they may be subject to a longer Pre-Existing Condition exclusion than would apply if they were newly eligible. See the definition of Pre-Existing Condition in the Definitions section of this Booklet.

WHEN INSURANCE FOR DEPENDENTS BEGINS, Continued

Other Dependent Insurance Provisions

While Coverage for Dependents Is in Effect

If a [Dependent] [Dependent Child] first becomes eligible while coverage for [your Dependents][one or more of your Dependent Children] [two or more of your Dependents] is in effect, that [Dependent's] [Child's] coverage will begin on the date he becomes eligible.

Newly Born Children

The following applies if, while your own coverage is in effect, you first become eligible for coverage for Dependents because of the birth of your natural child:

Coverage for such a child will begin at the moment of birth [if you notify the Administrator and pay the required premium contribution at, before, or within 90 days after the birth.] [unless you waive the insurance as described above].

The following applies if, while coverage for your Dependents is in effect, your natural child is born:

Coverage for such a child will begin at the moment of birth. [If an additional premium contribution is required, you must notify the Administrator and pay the added contribution within 90 days after the child's birth in order to have coverage continue beyond that 90 day period.]

Newly Adopted Children or Children Newly Placed for Adoption

The following applies if, while your own coverage is in effect, you first become eligible for coverage for Dependents because of your adoption (or the placement for adoption with you) of a child under age 18 years:

Except as provided below, coverage for such a child will begin on the date of the duly filed petition for adoption if you apply for insurance for the child within 60 days after the filing of such petition [if you notify the Administrator and pay the required premium contribution at, before, or within 90 days after the date of the duly filed petition for adoption [unless you waive the insurance as described above].

Coverage for such a child will begin from the moment of birth if the duly filed petition for adoption and your application for the child's insurance is filed within 60 days after the child's date of birth. [However, you must notify the Administrator and pay the required premium contribution at, before, or within 90 days after the date of the child's birth [unless you waive the insurance as described above].

The following applies if, while coverage for your Dependents is in effect, you adopt (or have placed with you for adoption) a child under age 18 years:

Except as provided below, coverage for such a child will begin on the date of the duly filed petition for adoption if you apply for insurance for the child within 60 days after the filing of such petition. [If an additional premium contribution is required, you must notify the Administrator and pay the added contribution within 90 days after the date of the duly filed petition for adoption in order to have coverage continue beyond that 90 day period.]

Coverage for such a child will begin from the moment of birth if the duly filed petition for adoption and your application for the child's insurance is filed within 60 days after the child's date of birth. . [If an additional premium contribution is required, you must notify the Administrator and pay the added contribution within 90 days after the date of the child's birth in order to have coverage continue beyond that 90 day period.]

With respect to a child whose coverage begins at the moment of birth, adoption, placement or the date a petition for adoption is filed for adoption (as the case may be):

- Benefits will be the same as those applicable to other children, including but not limited to the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
- A Pre-Existing Condition exclusion will not apply with respect to such a child if the child's coverage remains in effect from the moment of birth, adoption, or placement for adoption, without a break in coverage of longer than 63 days.

WHEN INSURANCE FOR DEPENDENTS BEGINS, Continued

You must inform us and the Employer in writing as each insured Dependent becomes ineligible. [The Employer has forms available for this purpose.] We will not give refunds or credits for your payment towards the cost of insurance for that Dependent for any period before the most recent of:

- the date that Dependent's insurance ends; or
- the most recent Policy Anniversary Date that precedes the date we are informed.

SPECIAL ENROLLMENT PERIODS

A person (you or your Dependent) will not be considered a Late Enrollee if a Special Enrollment Period applies to that person as described in this provision. Special Enrollment Periods apply to certain persons under certain circumstances when other coverage is lost or when a change in family status occurs.

Loss of Other Coverage

A Special Enrollment Period may apply to:

- you, if you are eligible but not insured under the Policy and you had other Creditable Coverage in effect when you previously declined or waived insurance under the Policy for yourself; or
- your Dependent, if you are insured under the Policy, that Dependent is eligible but not insured under the Policy, and that Dependent had other Creditable Coverage in effect when you previously declined or waived insurance under the Policy for that Dependent; or
- you and your Dependent, if both of you are eligible but not insured under the Policy and you or that Dependent had other Creditable Coverage in effect when you previously declined or waived insurance under the Policy for yourself or that Dependent.

For a Special Enrollment Period to apply in any of the above three situations:

- you must have stated, in writing at the time you declined or waived insurance under the Policy, that the other coverage was the reason you declined or waived insurance; and
- the other coverage must have been lost due to:
 - loss of eligibility for that coverage due to divorce, legal separation, death, termination of employment, or reduction of hours of employment; or
 - termination of employer contributions for that coverage for reasons other than the employee or dependent: (a) ceasing to pay contributions on a timely basis; or (b) being terminated from coverage for cause; or
 - with respect to continuation coverage under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 and any amendments (COBRA) or any similar federal or state law, the coverage has been ended for reasons other than the employee or dependent: (a) ceasing to pay contributions on a timely basis; or (b) being terminated from coverage for cause; and
- the enrollment card or written revocation of the waiver must be submitted by the 31st day after the date the other coverage ends.

When a Special Enrollment Period applies due to loss of other coverage, coverage under the Policy begins on the later of:

- the date the other coverage ends; or
- the first day of the calendar month that coincides with or next follows the date the enrollment card (or written revocation of the waiver) is submitted.

Change in Family Status

A Special Enrollment Period may apply to:

- you, if you are eligible but not insured under the Policy and you acquire a new Dependent through marriage, birth, adoption, or placement for adoption; or
- you and your newly-acquired Dependent, if you are eligible but not insured under the Policy and you acquire that new Dependent through marriage, birth, adoption, or placement for adoption; or

SPECIAL ENROLLMENT PERIODS, Continued

- your newly-acquired Dependent, if you are insured under the Policy and you acquire that new Dependent through marriage, birth, adoption, or placement for adoption; or
- your spouse, if you are insured under the Policy, he is eligible but not insured under the Policy, and you acquire a new Dependent Child through birth, adoption, or placement for adoption; or
- you and your spouse, if both of you are eligible but not insured under the Policy and you acquire a new Dependent Child through birth, adoption, or placement for adoption.

For a Special Enrollment Period to apply in any of the above five situations:

- “eligible but not insured” means that the person would be insured except that you previously declined or waived insurance for that person in writing; and
- “adoption or placement for adoption” refers only to the adoption or placement for adoption of a child under age 18 years; and
- the enrollment card or written revocation of the waiver must be submitted by the end of the 31st day after the date of the marriage, birth, adoption, or placement for adoption (as the case may be).

When a Special Enrollment Period applies due to marriage, coverage under the Policy begins on the later of:

- the date of the marriage; or
- first day of the calendar month that coincides with or next follows the date the enrollment card (or written revocation of the waiver) is submitted.

When a Special Enrollment Period applies due to birth, adoption, or placement for adoption, coverage under the Policy begins on the date of birth, adoption, or placement for adoption (as the case may be).

WHEN YOUR INSURANCE ENDS

Your insurance under the Policy will end on the earliest of:

1. the date the Policy ends;
2. the date the Policy is changed to end the insurance for the class of Members to which you belong;
3. [the date] [the last day of the Policy Month in which] you cease to be a member of the classes for whom coverage is provided;
4. the date that ends the period for which you last made any required payment towards the cost of your insurance;
5. [the date] [the last day of the Policy Month in which] you cease to be a Member;
6. [with respect to Noncontributory coverage being waived because of other Creditable Coverage, the date stated in the written waiver or [the date] [the last day of the Policy Month in which] [the Administrator] receives the written waiver (whichever is later).]

When your insurance ends, benefits payable for charges incurred while you were insured under the Policy will not be affected.

If You Cease Being a Member

If you cease being a Member because you are sick or injured or because of layoff or leave of absence, the Employer may (but is not required to) consider you as an eligible Member (and continue your insurance) for a certain length of time under certain circumstances.

If you cease to be a Member for any reason, you should ask the Employer what arrangements, if any, the Policy provides for your insurance to be continued.

WHEN INSURANCE FOR DEPENDENTS ENDS

Insurance for any Dependent will end on the earliest of:

1. the date on which the Policy ends;
2. the date on which the Policy is changed to end insurance for Dependents of the class of Members to which you belong;
3. the date which ends the period for which you last made any required payment towards the cost of insurance for your Dependents;
4. [the date] [the last day of the Policy Month in which] that Dependent ceases to be eligible in which event insurance ends for that Dependent only; or;
5. the date your own insurance under the Policy ends.
6. [with respect to Noncontributory coverage for your Dependents being waived because of other Creditable Coverage, the termination date stated in the written waiver or [the date] [the last day of the Policy Month in which] [the Administrator] receives the written waiver (whichever is later).]

When insurance for a Dependent ends, benefits payable for charges incurred while the Dependent was insured under the Policy will not be affected.

ARKANSAS STATE MANDATED CONTINUATION OF COVERAGE

You or your covered spouse may continue coverage under the Policy and that of your covered Dependents, if coverage would otherwise end because of termination of employment or because of a change in marital status.

Continued coverage will not include prescription drug or dental expense benefits.

Such coverage will be continued if the person:

- has been continuously covered under the Policy for the 3 month period prior to termination of employment or change in marital status;
- is not eligible for Medicare or is not fully covered (i.e., all Pre-Existing Conditions are covered) under any other group medical policy or contract.

Continuation will be allowed under this provision until all Pre-Existing Conditions are covered or would be covered under another group policy or contract or until termination pursuant to this continuation provision or pursuant to any applicable provisions of federal law.

To continue coverage the person must request continuation in writing within 10 days of termination of employment or change in marital status. Premiums must be paid on a monthly basis in advance in accordance with the terms of the Policy.

This continuation will end on the earliest of the following dates:

1. 120 days from date continuation began;
2. the end of the period for which premiums are paid on a timely basis;
3. the premium due date following the date the person becomes eligible for Medicare;
4. the date maximum benefits available under the Policy are paid for such person.
5. the date of termination of the Policy, however continuation will continue under any replacement policy.

Upon termination of this continuation, the person may have the right of conversion described in the **CONVERSION PRIVILEGE**. Any person who elects the conversion privilege waives the right to this continuation.

Continuation During Hospital Confinement

If the Policy ends and is replaced by a group health insurance plan issued by another insurer or self-funded health care plan, coverage under the Policy will continue for any Covered Person who is Hospital confined on the date the Policy ends. Continuation of such benefits are subject to all the terms and conditions of the Policy, except those relating to termination of benefits. Such benefits will continue until the Hospital confinement ends or until the maximum benefits available under the Policy are paid, whichever occurs first.

COBRA CONTINUATION

Federal Required Continuation - Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA applies to any employer (except the federal government and religious organizations) that: (a) maintains group health coverage; and (b) normally employed 20 or more employees on a typical business day during the preceding calendar year. For this purpose, “employee” means full-time employees and full-time equivalent for part-time employees.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that your group insurance allow qualified persons (described below) to continue group health coverage after it would normally end. The term “group health coverage” includes any medical, dental, vision care, and prescription drug coverages that are part of your insurance.

1. Qualified Persons/Qualifying Events

Continuation of group health coverage must be offered to the following persons if they would otherwise lose coverage as a result of the following events:

- a. a Member (and any covered Dependents) following the Member’s:
 - (1) termination of employment for a reason other than gross misconduct; or
 - (2) a reduction in work hours.

Note: Taking a family or medical leave under the federal Family & Medical Leave Act (FMLA) is not a qualifying event under COBRA. A Member qualifies for COBRA when the Member does not return to work after the end of FMLA leave; and

- b. a Member’s former spouse (and any Dependent Children) following a divorce or legal separation from the Member; and
- c. a Member’s surviving spouse (and any Dependent Children), following the Member’s death; and
- d. a Member’s Dependent Child following loss of status as a Dependent under the terms the plan (e.g., attaining the maximum age, marriage, joining the armed forces, etc.); and
- e. a Member’s spouse (and any Dependent Children) following the Member’s entitlement to Medicare; and
- f. a Member’s Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation due to termination of employment or reduction in work hours; and
- g. if the plan covers retired Members, a retired Member and his Dependents (or surviving Dependents) when retiree health benefits are “substantially eliminated” or terminated within one year before or after the Employer files Chapter 11 (United States Code) bankruptcy proceedings.

2. Maximum Continuation Period

Following a qualifying event, health coverage can continue up to the maximum continuation period. The maximum continuation period for a Member (and any Dependents) following a termination of employment or reduction in work hours is 18 months. The maximum continuation period for a Member’s Dependent Child that is born to or placed for adoption with the Member while on COBRA continuation will extend to the end of the Member’s maximum continuation period.

Following a termination of employment or reduction in work hours, a qualified person may request an 11-month extension of COBRA continuation. The maximum COBRA continuation will be 29 months (see Disabled Extension, Section 4).

When a Member becomes entitled to Medicare before employment terminates or work hours are reduced, the maximum continuation period for the Dependents will be the longer of:

- a. 36 months dating back to the Member’s entitlement to Medicare; or
- b. 18 months from the date of the qualifying event (termination of employment or reduction in work hours).

The maximum continuation period for qualified Dependents following a qualifying event described in 1.b. through 1.e. is 36 months.

COBRA CONTINUATION (Continued)

If the Policy covers retired Members and the qualifying event is the employer's bankruptcy filing, the following rules apply:

- a. If the retired Member is alive on the date of the qualifying event, the retired Member and his spouse and Dependent Children may continue coverage for the life of the retired Member. In addition, if the retired Member dies while covered under COBRA, the spouse or Dependent Children may continue coverage for an additional 36 months.
- b. If the retired Member is not alive on the date of the qualifying event, his spouse may continue coverage to the date of such spouse's death.

3. Second Qualifying Events

If during an 18- month continuation period (or, 29 months for qualified persons on the disabled extension), a second qualifying event described in 1.b. through 1.e. occurs, the maximum continuation period can be extended for the qualified Dependents up to 36 months. That is, following a second qualifying event, qualified Dependents may continue for up to a maximum of 36 months dating from the Member's termination of employment or reduction in work hours. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation may also be eligible for a second qualifying event that occurred prior to birth or placement for adoption.

4. Disabled Extension

Following a termination of employment or reduction in work hours, a qualified person (Member or Dependent) who has been determined disabled by the Social Security Administration either before or within 60 days after the qualifying event may request an extension of the continued coverage from 18 months to 29 months. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation must be determined disabled by the Social Security Administration within 60 days after the date of birth or placement for adoption. The disabled extension also applies to each qualified person (the disabled person and any family employees) who is not disabled and who is on COBRA continuation as a result of termination of employment or a reduction in work hours.

The 11-month extension for all qualified persons will end the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled, or (b) the date continuation would normally end as outlined in Section E below.

5. Termination of Continued Coverage

Continued coverage ends the earliest of the following:

- a. the date the maximum continuation period ends; or
- b. the date the qualified person enrolls in Medicare; however, this does not apply to a person who is already enrolled in Medicare on the date he elects COBRA or to a person who is on COBRA due to the employer's bankruptcy filing as described in 1 g; or
- c. the end of the last coverage period for which payment was made if payment is not made prior to the expiration of the grace period. (See Grace Period, Section 9.); or
- d. the date the Policy is terminated (and not replaced by another group health plan); or
- e. the date the qualified person becomes covered by and has satisfied the preexisting exclusion provision of another group health plan; however, this does not apply to a person who is already covered by the other group health plan on the date he elects COBRA.

Note: Persons who, after the date of COBRA continuation election become entitled to Medicare or become covered under another group health plan and have satisfied the preexisting exclusion provision, are not eligible for continued coverage. However, if the Policy covers retired Members, continued coverage for retired persons and their Dependents (or surviving Dependents) due to qualifying event 1 g above may not be terminated due to Medicare coverage.

COBRA CONTINUATION (Continued)

6. Employer/Plan Administrator Notification Requirement

When a Member or Dependent becomes ineligible and loses group health coverage due to termination of employment, reduction in work hours, death of the Member, the Member's entitlement to Medicare, or if the Policy covers retired Members, the commencement of the employer's Chapter 11 (United States Code) bankruptcy proceedings, the employer must notify the plan administrator of the qualifying event. The plan administrator must notify the qualified person of the right to COBRA continuation within 14 days after receiving notice of a qualifying event from the employer.

7. Qualified Person Notice and Election Requirement

Qualified persons must notify the employer within 60 days after (a) the date of a qualifying event (i.e., divorce, legal separation or a child ceases to be a Dependent Child under the terms of the Policy); (b) the date the qualified person would otherwise lose coverage as a result of a qualifying event; and (c) the date the qualified person is first informed of this notice obligation; otherwise the right to COBRA continuation ends. This 60-day notice period applies to initial and second qualifying events.

Qualified persons who request an extension of COBRA due to disability must submit a written request to the plan administrator before the 18-month COBRA continuation period ends and within 60 days after the latest of the following dates: (a) the date of disability determination by the Social Security Administration; (b) the date of the qualifying event; (c) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (d) the date the qualified person is first informed of this notice obligation; otherwise the right to the disabled extension ends. Qualified persons must also notify the plan administrator within 30 days after the date the Social Security Administration determines the qualified person is no longer disabled.

Notification of a qualifying event to the plan administrator must be in writing and must include the following information: (a) name and identification number of the Member and each qualified beneficiary; (b) type and date of initial or second qualifying event; (c) if the notice is for an extension due to disability, a copy of any letters from the Social Security Administration and the Notice of Determination; and (d) the name, address and daytime phone number of the qualified person (or legal representative) that the plan administrator may contact if additional information is needed to determine COBRA rights.

Within 14 days after receiving notice of a qualified event from the qualified person, the plan administrator must provide the qualified person with an election notice.

Qualified persons must make written election within 60 days after the later of: (a) the date group health coverage would normally end; or (b) the date of the plan administrator's election notice. The election notice must be returned to the plan administrator within this 60-day period; otherwise the right to elect COBRA continuation ends.

Each qualified person has an independent right to elect COBRA. A covered Member may elect COBRA continuation on behalf of his/her covered spouse. A covered Member, parent, or legal guardian may elect COBRA continuation on behalf of his/her covered Dependent Children.

To protect COBRA rights, the plan administrator must be informed of any address changes for covered Members and Dependents. Retain copies of any notices sent to the plan administrator.

8. Monthly Cost

Persons electing continued coverage can be required to pay 102% of the cost for the applicable coverage (COBRA permits the inclusion of a 2% billing fee). Persons who qualify for the disabled extension and are not part of the family unit that includes the disabled person can be required to continue to pay 102% of the cost for the applicable coverage during the disability extension. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person can be required to pay 148% of the cost for the applicable coverage (plus a 2% billing fee) for the 19th through the 29th month of coverage (or through the 36th month if a second qualifying event occurs during the disabled extension).

COBRA CONTINUATION (Continued)

9. Grace Period

Qualified persons have 45 days after the initial election to remit the first payment. The first payment must include all payments due when sent. All other payments (except for the first payment) will be timely if made within the Grace Period. "Grace Period" means the first 31-day period following a premium due date. Except for the first payment, a Grace Period of 31 days will be allowed for payment of premium. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made. The Company will be liable for any valid claims incurred during the Grace Period, if payment is made prior to the end of the Grace Period.

10. Policy Changes

Continued coverage will be subject to the same benefits and rate changes as the Policy.

11. Newly Acquired Dependents

A qualified person may elect coverage for a Dependent acquired during COBRA continuation. All enrollment and notification requirements that apply to Dependents of active Members apply to Dependents acquired by qualified persons during COBRA continuation.

Coverage for a newly acquired Dependent will end on the same dates as described for qualified persons in Section B above. Exception: Coverage for newly acquired Dependents, other than the Member's Dependent Child who is born to or placed for adoption with the Member, will not be extended as a result of a second qualifying event.

12. Contact Information

To notify the plan administrator of an initial or second qualifying event, request a disabled extension, request termination of COBRA, change of address, or request additional information concerning the Policy or COBRA, contact the following:

Group Health Plan: ABC Company Health Plan
Contact Name/Area: John Doe/ABC Company Benefits Department
Address: XXX
Phone Number: XXX-XXX-XXXX

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

Continuation

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects the plan. See your employer for details on this continuation provision.

FMLA and Other Continuation Provisions

If your employer is an Eligible Employer and if the continuation portion of the FMLA applies to your coverage, these FMLA continuation provisions:

- are in addition to any other continuation provisions of the plan, if any; and
- will run concurrently with any other continuation provisions of the plan for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Eligible Employee

Eligible Employee means a Member who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- The birth of a child of an Eligible Employee and in order to care for the child.
- The placement of a child with the Eligible Employee for adoption or foster care.
- To care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition".
- A "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job.

Reinstatement

An Eligible Employee's terminated coverage may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

See your employer for details on this reinstatement provision.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Federal law requires that if your coverage would otherwise end because you enter into active military duty, you may elect to continue coverage (including Dependents coverage) in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation

If active employment ends because you enter active military duty or inactive military duty for training, coverage may be continued until the earliest of:

- for you and your Dependents:
 - the date the plan is terminated; or
 - the end of the premium period for which premium is paid if you fail to make timely payment of a required contribution; or
 - the date 24 months after the date you enter active military duty; or
 - the date after the day in which you fail to return to active employment or apply for reemployment with the Employer.

- for your Dependents:
 - the date Dependent Medical Expense Coverage would otherwise cease as provided; or
 - any date desired, if requested by you before that date.

The continuation provision will be in addition to any other continuation provisions described in the plan for sickness, injury, layoff, or approved leave of absence, if any. If you qualify for both state and USERRA continuation, you may elect the state continuation when the USERRA ends.

Reinstatement

For Medical Expense Coverage, the reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA.

This is a general summary of the USERRA and how it affects your plan. See your employer for details on this continuation provision.

CONVERSION PRIVILEGE

After a Covered Person's coverage under the Policy ends for any reason he may obtain medical care coverage then being offered by us, or by an insurance company that we may designate, subject to our rules. A Covered Person is not entitled to conversion coverage if termination occurred because:

- of your failure to pay any required contribution; or
- if the Policy terminates and is replaced by similar coverage within 31 days.

Conditions

- The application must be made to [the Administrator] within 31 days after insurance under the policy ends.
- The first premium (at the rates then in use by us) must be paid within the same 31 day period.
- Evidence of good health is not required.
- The coverage, if issued, will become effective on the day after insurance under the policy ends.
- A person will not be covered if that person is or could have been (had timely application or enrollment been made) covered under any other policy, plan or program that provides benefits like those provided under the offered medical care coverage. "Plan or program" includes, but is not limited to, Medicare or any other governmental plan or program.

Important Notice

Benefits under the medical care coverage we offer in this CONVERSION PRIVILEGE provision are not the same as, and are generally more limited than, benefits under the Policy.

Premium rates for the medical care coverage we offer in this CONVERSION PRIVILEGE provision are, in most cases, substantially higher than premium rates for coverage under the Policy.

Materials describing the medical care coverage benefits and premium rates in detail are available from us upon request. Write to: [the Administrator].

MEDICAL CARE INSURANCE

SUPPLEMENTAL ACCIDENT EXPENSE BENEFITS

Benefits Payable

We will pay Covered Charges, not to exceed the Allowable Charges, made:

1. by a Hospital, Ambulatory Surgical Center, or Convenient Medical Care Center for required services and supplies;
2. by a Practitioner for medical or surgical care;
3. for Prescription Drugs;
4. for diagnostic x-ray and laboratory examinations;

as needed for Medically Necessary treatment of Injury sustained while insured under the Policy, but only for such Charges incurred within 90 days after that Injury. Treatment must begin within 72 hours after that Injury.

Supplemental Accident Expense Benefits are payable before any Major Medical Expense Benefits are payable for treatment of that Injury. We will not pay more than the Maximum Benefit for all such Charges incurred for all Injuries sustained by any one person in any one accident. The Maximum Benefit is shown in the SCHEDULE OF BENEFITS.

Dental Treatment Limits

Supplemental Accident Expense Benefits for dental treatment include only benefits for repair or initial replacement of natural teeth damaged or lost due to Injury sustained while insured under the Policy. Damage or loss must not be due to chewing or biting.

Exclusions

We will not pay Supplemental Accident Expense Benefits for any charges for which benefits are excluded under MEDICAL CARE BENEFIT EXCLUSIONS.

MEDICAL CARE INSURANCE

MANDATED BENEFITS

Covered Charges under MAJOR MEDICAL EXPENSE BENEFITS include the benefits described below. These benefits are subject to the MEDICAL CARE BENEFIT EXCLUSIONS and all other provisions of the Policy, unless otherwise noted.

Arkansas Mandated Benefits

- **Children's Preventive Health Care**

Covered Charges include charges for Children's Preventive Care Services rendered during a Periodic Review. Benefits will be paid for 20 Preventive Care Visits at approximately the following age intervals: birth, 2 months, 2 weeks, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years and 18 years. Benefits for Preventive Care Services:

- are limited to those services provided by or under the supervision of a single Physician during the course of one visit.
- will be reimbursed at levels that will not exceed those established for the same services under the Medicaid program of the State of Arkansas.
- except for recommended immunization services, are subject to Deductible and Insured Percentage amounts.

For periodic screening guidelines we will adhere to standards for the most current and recommended Periodicity Schedule of the American Academy of Pediatrics, and to the most current and recommended immunization and vaccine schedule of the Advisory Committee on Immunization Practices, the American Academy of Pediatrics and of the American Academy of Family Physicians for children and infants from birth to age 18 years. We will refer to the most current edition of the Arkansas Department of Human Services' Early and Periodic Screening Diagnosis & Treatment ("EPSDT") Manual.

For the purpose of this benefit:

Anticipatory guidance includes such things as visual evaluation (titmus machine or other ophthalmological testing not required), dental inspection for children under two years of age, and a nutritional assessment.

Children's Preventive Health Care means Physician-delivered or Physician-supervised services for a covered Dependent child from the moment of birth through 18 years of age. Periodic Preventive Care Visits include Medical History, Physical Examination, Developmental Assessment, Anticipatory Guidance and appropriate Immunizations and Laboratory Tests, in keeping with prevailing medical standards.

Developmental Assessment should be obtained by history and observation of the child, or by one recognized developmental test. This portion of the screening should include assessment of eye-hand coordination, gross motor function (walking, hopping, climbing), fine motor skills (use of finger dexterity and hand usage), speech development, daily living personal skills such as dressing, feeding and grooming oneself, behavioral development, and proofs of mind and body integration.

Lab Test/Immunizations means laboratory procedures and immunizations performed as appropriate for the child's age. A hematocrit or hemoglobin test is recommended for children one year of age and older and a urinalysis is recommended for children five years of age and older. Other laboratory procedures are to be performed if it is deemed appropriate by the child's age and/or health history (i.e., lead toxicity, sickle cell, tuberculin, pap smear).

Medical History is to be obtained from the parent, legal guardian, or other responsible adult who is familiar with the child's health history. The child's height and weight should also be recorded and compared with the ranges considered normal for children of that age.

Periodic Preventive Care Visits means routine tests and procedures for the purpose of detection of abnormalities or malfunctions of the bodily systems and parts according to accepted medical practices.

Physical Examination is performed to note obvious physical defects including orthopedic, genital, skin, and other observable deviations.

MANDATED BENEFITS (Continued)

• In Vitro Fertilization

Covered Charges include charges for in vitro fertilization procedures to the same extent as for other normal Pregnancy-related procedures not to exceed a lifetime maximum benefit of \$[15,000], subject to the following:

You or your spouse who is covered under the Policy must be the patient for the in vitro fertilization procedure. The patient's oocytes must be fertilized with the sperm of the patient's spouse. The patient and the patient's spouse must have a history of infertility of at least 5 continuous years duration or infertility must be associated with one or more of the following:

- endometriosis;
- exposure in utero to diethylstilbestrol (DES);
- blockage or surgical removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
- abnormal male factors contributing to the infertility.

• Newborn Infant Coverage

Covered Charges include charges for the Medically Necessary care and treatment of a newborn child for Injury or Illness including:

- congenital defects;
- tests for hypothyroidism and phenylketonuria;
- galactosemia;
- premature birth;
- disorder of metabolism for which screening is performed by the State of Arkansas;
- in the case of non-caucasian newborn infants, tests for sickle cell anemia;
- any testing of newborn infants hereafter mandated by law.

• [Coverage for Anesthesia and Hospitalization for Dental Procedures

Benefits are payable on the same basis as any other Sickness for payment of anesthesia and hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a hospital or ambulatory surgical facility, if the Practitioner treating the patient certifies that, because of the Covered Person's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedure(s) and the Covered Person is:

- A child under seven (7) years of age who is determined by two dentists licensed under the Arkansas Dental Practice Act to require, without delay, necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition;
- A person with a diagnosed serious mental or physical condition; or
- A person with a significant behavioral problem as determined by the covered person's physician. Benefits will be subject to the same Deductibles, coinsurance, copayments, medical necessity determinations, and other limitations as are applied to any other Sickness.

[We require prior authorization for hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered Sickness.]

If the Covered Person is covered under both a health benefit plan that provides dental benefits and a health benefit plan that provides medical benefits, the health benefit plan that includes dental benefits is the primary payer and the health benefit plan that provides medical benefits is the secondary payer.

The Benefit in this section does not apply to treatment rendered for temporomandibular joint disorders.]

MANDATED BENEFITS (Continued)

- **Treatment of Diabetes**

Covered Charges include charges for medical equipment, medical supplies, and diabetes self-management training solely for the management and treatment of Diabetes.

Benefits for Self-Management Training include one per lifetime training program per Covered Person with Diabetes for Diabetes Self-Management Training when Medically Necessary as determined by a Practitioner and when provided by a Health Care Provider upon certification by the Health Care Provider giving the training that the Covered Person has successfully completed the training.

In addition to the one (1) lifetime training program provided above, additional Diabetes Self-Management Training will be covered in the event that a Practitioner prescribes additional Diabetes Self-Management Training and it is Medically Necessary because of a significant change in the Covered Person's symptoms or conditions.

The Health Care Provider or Diabetes Educator shall only provide Diabetes Self-Management Training within his scope of practice after having demonstrated expertise in Diabetes care and treatment. The Practitioner or Diabetes Educator may only provide such training after having completed an education training program required by his licensing board when such program is in compliance with the National Standards for Diabetes Self-Management Education Program, developed by the American Diabetes Association. The Practitioner must issue a written prescription ordering the training for the Covered Person or his parent, spouse or legal guardian. The training must be successfully completed by the diabetic Covered Person and parent, spouse or legal guardian. The Health Care Provider must certify successful completion; and provide a written certification of such to the referring Practitioner and to us. We will not pay benefits unless and until the Health Care Provider provides certification that the Covered Person has successfully completed the Diabetes Self-Management Training.

The Diabetes education process for self-management training must include the following standards:

- a. Needs Assessment. The health care provider must conduct an individualized educational needs assessment with the participation of the patient, family, legal guardian, or support systems to be used in the development of the educational plan and interventions. The educational needs assessment shall include, but not be limited to, the following:
 - Health history;
 - Medical history;
 - Previous use of medication;
 - Diet history;
 - Current mental health status;
 - Use of health care delivery systems;
 - Life-style practices such as occupation, education, financial status, social and cultural and religious practices, health beliefs and attitudes or preventive behaviors;
 - Physical and psychological factors including age, mobility, visual acuity, manual dexterity, alertness, attention span, and ability to concentrate;
 - Barriers to learning such as education, literacy level, perceived learning needs, motivation to learn, and attitude;
 - Family and social support; and
 - Previous diabetes education, including actual knowledge and skills.
- b. Education Plan. The Health Care Provider must develop a written education plan in collaboration with the Covered Person, his parent, spouse or legal guardian from information obtained in the needs assessment, including the following:
 - Desired patient outcomes;
 - Measurable, behaviorally-stated learner objectives; and
 - Instructional methods.
- c. Education Intervention. The Health Care Provider must create an educational setting conducive to learning with adequate resources for space, teaching and audio-visual aids to facilitate the educational process. The Health Care Provider must use a planned content outline. The content outline must be provided based on the needs assessment.
- d. Evaluation of Learner Outcomes. The Health Care Provider must review and evaluate the degree to which the Covered Person with Diabetes is able to demonstrate Diabetes Self-Management skills as identified by behavioral objectives.
- e. Plan for Follow-up for Continuing Learning Needs. The Health Care Provider must review the educational plan and recommend any additional educational interventions to meet continuing learning needs.

- f. Documentation. The Health Care Provider must maintain written files and thereby completely and accurately document the educational experiences provided, and communicate such to the referring Practitioner.

MANDATED BENEFITS (Continued)

Diabetic equipment, supplies and appliances include the following that are prescribed by a Practitioner as Medically Necessary for the treatment of a Covered Person with Diabetes:

- a. Blood glucose monitors, which include all commercially available blood glucose monitors designed for patient use and for persons who have been diagnosed with diabetes;
- b. Blood glucose monitors for the legally blind, which include all commercially available blood glucose monitors designed for patient use with adaptive devices and for persons who are legally blind and have been diagnosed with diabetes;
- c. Test strips for glucose monitors, which include all test strips approved by the Federal Food and Drug Administration, glucose control solutions, lancet devices, and lancets for monitoring glycemic control;
- d. Visual reading and urine testing strips, which include visual reading strips for glucose, urine testing strips for ketones, or urine test strips for both glucose and ketones. Urine test strips for glucose only are not acceptable as the sole method or monitoring.
- e. Insulin, which includes all commercially available insulin preparations including insulin analog preparations available in either vial or cartridge.
- f. Injection aids, which include devices used to assist with insulin injection;
- g. Syringes, which include insulin syringes, pen-like insulin injection devices, pen needles for pen-like insulin injection devices;
- h. Insulin pumps as prescribed by the Practitioner and appurtenances thereto, which include insulin infusion pumps and supplies such as skin preparations, adhesive supplies, infusion sets, cartridges, batteries and other disposable supplies needed to maintain insulin pump therapy. These include durable and disposable devices used to assist in the injection of insulin;
- i. Oral agents for controlling the blood sugar level, which are prescription drugs;
- j. Podiatric appliances for prevention of complications associated with diabetes, which include therapeutic molded or depth-inlay shoes, replacement inserts, preventive devices, and shoe modifications for prevention and treatment.

For the purpose of the benefit:

Diabetes Self-Management Training means instruction in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalization and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association;

Diabetes means and includes Type 1, Type 2, or gestational diabetes, diabetes insipidus, and other specific types, and diabetes mellitus, a common chronic, serious systemic disorder of energy metabolism which includes a heterogeneous group of metabolic disorders that can be characterized by an elevated blood glucose level. The terms diabetes and diabetes mellitus are considered synonymous and defined to include Covered Persons using insulin and not using insulin and Covered persons with elevated blood glucose levels induced by pregnancy, or Covered Persons with other medical conditions or medical therapies that wholly or partially consist of elevated blood glucose levels.

Diabetes Educator or Health Care Provider means only a person, licensed by and who has completed the Arkansas State Board's educational program that is in compliance with the National Standards for Diabetes Self-Management Educational Programs as developed by the American Diabetes Association, and only those duly certified to instruct in diabetes self-management.

MANDATED BENEFITS (Continued)

- **Breast Reconstruction After Mastectomy**

Covered Charges include charges for the following treatment, care, services, and supplies in connection with a mastectomy covered under the Employer's group health plan, determined in consultation with the attending Practitioner and patient, subject to and consistent with Policy terms and conditions that generally apply to Covered Charges for treatment of physical Illness:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications at all stages of the mastectomy, including but not limited to lymphedemas.

- **Maternity Coverage**

Covered Charges include charges for a Hospital Inpatient stay for an insured Member or insured Dependent spouse and/or her newborn child in connection with childbirth of at least 48 hours after a vaginal delivery and at least 96 hours after a cesarean section delivery, unless the attending Practitioner decides to discharge the mother and/or child earlier, in consultation with the mother and/or the child's authorized representative. In order to qualify as Covered Charges, such charges will be subject to and consistent with Policy terms and conditions that generally apply to Covered Charges for treatment of physical Illness. The minimum 48- or 96-hour stay begins:

- at the time of delivery (the last delivery, in the case of multiple births), if delivery occurs in a Hospital;
- at the time of admission as a Hospital Inpatient in connection with childbirth, if delivery occurs outside a Hospital, where the attending Practitioner determines whether or not the admission is "in connection with childbirth."

We will not require the attending Practitioner to obtain authorization from us for prescribing the minimum **length** of stay described above. However, **all** Hospital Inpatient **admissions**, whether or not in connection with childbirth, must be Certified in a timely manner as described in the UTILIZATION REVIEW PROGRAM section or a benefit penalty will apply, except that such certification will not apply to the minimum length of stay described above.

- **Phenylketonuria**

Covered Charges include charges for amino acid modified preparations, low protein modified food products and formulas prescribed under the direction of a Practitioner for the therapeutic treatment of a Covered Person with phenylketonuria, galactosemia, organic acidemias or disorders of amino acid metabolism if:

- the medical food or low protein modified food products are prescribed as medically necessary for the therapeutic treatment of phenylketonuria; galactosemia, organic acidemias or disorders of amino acid metabolism;
- the products are administered under the direction of a Practitioner; and
- the cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the \$2,400 per year per person income tax credit allowed under Arkansas law.

For the purpose of this benefit:

Inherited metabolic disease means a disease caused by an inherited abnormality of body chemistry;

Low protein modified food product means a food product that is specifically formulated to have less than one (1) gram of protein per service and intended to be used under the direction of a Practitioner for the dietary treatment of an inherited metabolic disease;

Medical food means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Practitioner.

MANDATED BENEFITS (Continued)

- **Drugs for the Treatment of Cancer**

Covered Charges will include charges for prescription drugs approved by the federal Food and Drug Administration (FDA) for treatment of types of cancer not specifically noted in the approval of the drug, if the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one (1) or more such compendia:

- (A) The American Hospital Formulary Service drug information;
- (B) The United States Pharmacopoeia dispensing information; or

(2) The drug has been recognized as safe and effective for treatment of that specific type of cancer in two (2) articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature.

Benefits payable will not include charges for:

- any drug which the FDA has determined its use to be contraindicated; or
- any experimental or investigational drug not otherwise approved for any indication by the FDA.

- **For Loss or Impairment of Speech or Hearing**

Covered Charges for the Medically Necessary care and treatment for the Loss or Impairment of Speech or Hearing will be paid to the same extent as benefits provided for any other Illness covered under the Policy.

No benefits will be paid for hearing instruments or devices.

Loss or Impairment of Speech or Hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the State Board of Examiners in Speech Pathology and Audiology that fall within the scope of his area of certification.

[Federal Mandated Benefits

- **[Breast Reconstruction After Mastectomy – see description above under Arkansas Mandated Benefits.]**
- **[Maternity Coverage – see description above under Arkansas Mandated Benefits.]**

MENTAL DISORDERS AND ALCOHOLISM BENEFITS

The following benefits will be payable for Mental Disorders and Alcoholism. These benefits are payable instead of any other benefits described in the Policy.

- **Mental Disorders**

[Covered Charges for Medically Necessary care and treatment of Mental Disorders will be paid to the same extent as the benefits provided for other Illness. The following are covered, subject to an Insured Percentage of [80%]:

1. Inpatient confinement including Partial Hospitalization must be in a Hospital, psychiatric hospital, Outpatient psychiatric center licensed by the State Health Department or a Community Mental Health Center certified by the Arkansas Department of Human Services, Division of Mental Health Services.
2. Outpatient benefits will be provided for services furnished by:
 - a Hospital, psychiatric hospital, outpatient psychiatric center licensed by the Arkansas State Health Department or a Community Mental Health Center certified by the Department of Human Service, Division of Mental Health Services;
 - a Practitioner licensed under the Medical Practices Act;
 - a licensed psychologist; and
 - a Community Mental Health Center or other Mental Health Clinic certified by the Arkansas Department of Human Service, Division of Mental Health Services.]

[FOR HIPAA SMALL GROUPS

3. Covered Charges for treatment of Mental Disorders are limited to a maximum of \$7,500 per Covered Person per Calendar Year.]

[FOR HIPAA LARGE GROUPS

3. Covered Charges for treatment of Mental Disorders are limited to a maximum of:
 - 8 Inpatient/Partial Hospitalization days; and
 - 40 Outpatient visits.]

In the event Employer group status changes from small group to large group, the benefits will change accordingly. Claims incurred prior to such change in status will be considered in accordance with the group's status at the time the claim was incurred.]

[With respect to coverage for a Small Employer:

Covered Charges by or on behalf of Practitioners for treatment of Mental Disorders are limited to a maximum of:

- \$100 per Visit;
- one Inpatient or Partial Hospitalization Visit per day; and
- one Outpatient Visit in any 14 days in a row.

The Inside Maximum Benefits specified in the SCHEDULE OF BENEFITS also apply.]

[With respect to coverage for a Large Employer:

Covered Charges by or on behalf of Practitioners for treatment of Mental Disorders are limited to a maximum of:

- Inpatient - up to 30 days per Calendar Year, up to Maximum Benefit; and
- one Outpatient Visit in any 14 days in a row.]

MENTAL DISORDERS AND ALCOHOLISM BENEFITS (Continued)

- **Alcoholism Treatment**

[Covered Charges for the Medically Necessary care and treatment of Alcohol or Drug Dependency in a Hospital or an Alcohol and Drug Dependency Treatment Center will be payable to the same extent as the benefits provided for other illness.

Definitions

An Alcohol and Drug Dependency Treatment Center is a public or private facility or unit of a facility engaged in providing 24 hour treatment for substance abuse, and that provides a program for treatment of such abuse pursuant to a written treatment plan approved and monitored by a Practitioner, properly licensed or accredited by the Arkansas Department of Human Services/office on Alcohol and Drug Abuse Prevention.

The facility or unit may be: a) within a Hospital or psychiatric hospital or attached to or be a freestanding unit of a general Hospital or psychiatric hospital; or b) a freestanding facility specializing in such treatment, but it does not include halfway houses or recovery farms.

Alcohol or Drug Dependency means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

Covered Charges

Covered Charges for treatment of Alcohol and Drug Dependency are subject to the following:

- a maximum of \$6,000 for each 24 month period for each Covered Person;
- no more than \$3,000 will be paid in any 30 consecutive day period;
- a lifetime maximum of \$12,000 for each Covered Person while insured under the Policy.]

[Covered Charges will include charges for treatment of alcoholism on the same basis as any other condition, up to a maximum benefit of one thousand dollars (\$1,000) per calendar year.]

[MISCELLANEOUS MEDICAL EXPENSE BENEFITS

- **[For Diagnosis and Treatment of Musculoskeletal Disorders of Bone or Joint in Face, Neck or Head**

Covered Charges include the medically necessary diagnosis and treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head. This includes temporomandibular joint disorder and craniomandibular disorder. Treatment includes both surgical and nonsurgical procedures. Benefits are provided for these conditions whether they are the result of accident, trauma, congenital defect, developmental defect or pathology.]

MAJOR MEDICAL EXPENSE BENEFITS

Covered Charges For Treatment Of Injury Or Illness

A Covered Charge is the actual charge for Medically Necessary treatment of Injury or Illness, not to exceed the Allowable Charge, made:

1. by a Hospital on its own behalf for room, board, general nursing care, Intensive Care Accommodations, and other required services and supplies.
2. by a Practitioner for medical or surgical care, or by a Hospital on behalf of a Practitioner for Outpatient medical or surgical care.
3. by a Skilled Nursing Facility for room, board, and other required services and supplies for up to 90 days per calendar year.
4. by an Ambulatory Surgical Center for required services and supplies.
5. by or on behalf of a licensed or certified physical, occupational, or speech therapist for physical, occupational, or speech therapy, except a charge made by Home Health Agency. Charges for physical, occupational, and speech therapy are limited as shown in the LIMITS ON COVERED CHARGES provision.
6. by a Home Health Agency for:
 - part-time or intermittent Skilled Nursing Care services of a Nurse, up to \$[75] per Visit;
 - physical, respiratory, occupational, or speech therapy services of a licensed or certified physical, respiratory, occupational, or speech therapist;
 - services of a licensed home health aide for personal patient care and those incidental household services that are essential to patient care at home and that would have been performed if the patient were a Hospital or Skilled Nursing Facility Inpatient; and
 - infusion therapy services.

Such Covered Charges are limited to a maximum of [60] Visits per calendar year for all services by all Home Health Agencies combined. If more than one service provider is in the same home at the same time, each provider's services count as separate Visits. If a session with a provider lasts more than 2 hours (4 hours for a home health aide), each 2 hours (4 hours for a home health aide) of services in the session and any remaining portion of the session count as separate Visits.

The services must be:

- performed in your home;
 - ordered by your Practitioner; and
 - needed for treatment of an Injury or Illness for which treatment as a Hospital or Skilled Nursing Facility Inpatient would otherwise be Medically Necessary.
7. for licensed ambulance service to or from the nearest Hospital where the Injury or Illness can be treated, up to [\$500] [per trip]. Air ambulance up to [\$5,000] [per trip].
 8. for pacemakers and for prostheses or devices to replace natural arms, legs, hands, feet, joints, breasts, eyeballs, the lens of the eye (but only the initial replacement with a contact or internal lens), eardrums and middle ear bones (but not hearing aids), the palate, the larynx, teeth (but only as limited as shown under Limits On Covered Charges), heart valves, and blood vessels. Charges for prostheses or devices to replace body parts or organs not listed here are not Covered Charges. Charges to repair or replace pacemakers and listed prostheses or devices for any reason are not Covered Charges unless Medically Necessary.
 9. for ileostomy bags, colostomy bags, catheters, and urine bags and for medical supplies used solely in connection with those items.
 10. for casts, splints, trusses, braces (but not dental braces), and supports (but not arch supports). Charges for orthopedic or corrective shoes are not covered unless used with braces.

11. for oxygen and rental of equipment for its administration. We have the right in our sole judgment to consider as a Covered Charge the purchase price instead of the monthly rental.

Covered Charges For Treatment Of Injury Or Illness, Continued

12. for rental of wheelchair, hospital-type bed, and dialysis equipment. We have the right in our sole judgment to consider as a Covered Charge the purchase price instead of the monthly rental. The Covered Charge for wheelchair rental or purchase is limited to the Allowable Charge for a wheelchair with only those features that are Medically Necessary.
13. for rental of other durable equipment designed, made, and used solely for treatment of Injury or Illness, up to [\$100] per item per month. We have the right in our sole judgment to consider as a Covered Charge the purchase price instead of the monthly rental. Charges for equipment of types commonly used by those not Injured or Ill such as, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, ultraviolet lamps and exercise equipment are not Covered Charges.
14. for anesthetics or their administration.
15. for blood, blood plasma, and other solutions used intravenously to the extent not donated or otherwise replaced.
16. for diagnostic x-ray and laboratory examinations, including machine tests.
17. for radiotherapy, including use of x-rays, radium, cobalt, and other radioactive substances and chemotherapy (other than orally) as an integral part of cancer therapy.
18. by a Birth Center for required services and supplies.
19. by a Convenient Medical Care Center for required services and supplies.
20. by an Outpatient Dialysis Center for required services and supplies.
21. by a Practitioner for a Consulting Opinion and for Medically Necessary physical, diagnostic x-ray, and diagnostic laboratory examinations in connection with that Opinion. Charges for more than two Consulting Opinions on the need for any procedure at a given time are not Covered Charges.
22. as part of a Hospice Program for:
 - Inpatient room, board, general nursing care, and other required services and supplies;
 - Skilled Nursing Care provided in your home by a Nurse;
 - services of a licensed home health aide for patient care (not for general housekeeping);
 - other types of services and supplies Medically Necessary for patient care; and
 - bereavement counseling for the patient's Close Relatives within 3 months after the patient's death.

Such Covered Charges are limited to a lifetime maximum of \$[5,000.]

The following must be filed with us before services or supplies are received (unless we waive the requirement as part of the Utilization Review process):

- the attending Doctor of Medicine's or Osteopathy's written statement that the patient is terminally ill with a prognosis of death within 6 months or less;
 - the attending Doctor of Medicine's or Osteopathy's written statement that the services or supplies are palliative and not curative in nature; and
 - the Hospice's written, individualized plan of care for the patient.
23. for drugs or medicines which under applicable state law may only be dispensed upon the written prescription of a Practitioner[, except any drug or medicine for which a benefit is payable under the PRESCRIPTION DRUG EXPENSE BENEFITS section.]

Transplant Program Covered Charges

A Covered Transplant under the Transplant Program is the implantation in the human body of one of the following human organs or types of tissue or cells: heart, lung, liver, kidney, pancreas, bone marrow, or peripheral stem cells. Transplants of other single organs or types of tissues or cells are not Covered Transplants under the Transplant Program. Transplants of more than one human organ or type of tissue or cell in a single operative session (multiple transplants) are not Covered Transplants under the Transplant Program except for heart/lung in a single session and kidney/pancreas in a single session. (For Policy purposes, such a multiple transplant is considered one Covered Transplant.)

A Covered Charge under the Transplant Program is the actual charge for, in connection with, or as a consequence of a Medically Necessary Covered Transplant for treatment of Injury or Illness, not to exceed the Allowable Charge, made:

- for treatment, care, services, and supplies for the transplant patient as otherwise provided in this MAJOR MEDICAL EXPENSE BENEFITS section.
- for prescription drugs for the transplant patient [unless payable under in the PRESCRIPTION DRUG EXPENSE BENEFITS section.]
- for Medically Necessary services and supplies directly related to the removal, storage, and transportation of the donated organ, tissue, or cells, including but not limited to nephrectomies, hepatectomies, and HLA testing and listing service costs.
- for what, in the sole judgment of [Strategic Health Development Corporation] , are the reasonable and necessary costs of travel between the patient's home and the site of surgery for a Covered Transplant and the reasonable and necessary costs of lodging and meals in connection with such travel, for the patient and one other individual accompanying him, not to exceed \$[10,000] with respect to any one Covered Transplant and only if the site of surgery is outside a [50] mile radius from the patient's home. Itemized receipts for all such costs are required in order for benefits to be payable.

Benefits for Covered Charges under the Transplant Program will be paid as Major Medical or Prescription Drug Expense Benefits (as appropriate) applicable to the patient. However, the Utilization penalty will apply unless:

- **before any charges are incurred for or in connection with the Covered Transplant**, the Covered Transplant is Certified through the Utilization Review Program; and
- the treatment, care, services, or supplies for which the charges are made are Certified **in advance** through the Utilization Review Program.

In order to be Certified, the Covered Transplant and all related treatment, care, services, and supplies must meet all Policy terms and conditions, including but not limited to the requirements that, in the sole judgment of [Strategic Health Development Corporation] as based on our established standards, the Covered Transplant:

- is Medically Necessary treatment for an appropriate diagnosis;
- is not experimental, investigational, or unproven; and
- is not excluded under any of the Medical Care Benefit Exclusions or under any other Policy provisions.

Other Covered Charges

A Covered Charge is also the actual charge, not to exceed the Allowable Charge for the following services. The requirement that such services be Medically Necessary for treatment of Injury or Illness does not apply to these services:

1. for circumcision.
2. for vasectomy, tubal ligation, and other Prescription Contraceptives for a Member or Dependent Spouse (except for oral Prescription Contraceptives, that are covered under the PRESCRIPTION DRUG EXPENSE BENEFITS provision).
3. for pediatric attendance of a newborn child at its birth, but only if:
 - the child is delivered by caesarean section;
 - the Covered Facility in which it is born requires such attendance by a Practitioner; and
 - the Practitioner sends you a bill for his own services.
4. for routine care of a well newborn child under age 6 days by a Hospital and a Practitioner during the child's stay in the Hospital nursery just after birth (but only if the child's coverage under the Policy begins on his birth date, and only while the mother is an Inpatient at the same Hospital).

5. for mammography screenings of women 35 years of age or older for the presence of occult breast cancer, limited to one screening per calendar year (or more frequently upon recommendation of a Practitioner).

Limits On Covered Charges

1. Covered Charges per day for room, board, and general nursing care in a private room or in special accommodations other than Intensive Care Accommodations in a Covered Facility are limited to the Covered Facility's Average Semi-Private Charge.
2. Covered Charges by or on behalf of a Practitioner for dental treatment include only:
 - charges due to or for extraction of impacted teeth;
 - charges incurred within 180 days after an Injury sustained while insured for under the Policy for repair or initial replacement of natural teeth damaged or lost due to that Injury. Damage or loss must not be due to chewing or biting. Treatment must begin within 60 days after the Injury. Covered Charges for each repaired or replaced tooth is limited to a maximum of \$[200].
3. Covered Charges for the services of an assistant surgeon during an operative session are limited to 25% of the Covered Charges for the services of the surgeon during that session.
4. If a Covered Person undergoes two or more operations during any one time, Covered Services for the services of the Practitioner, facility, or other covered provider for each procedure will be based on:
 - 100% of the Allowable Charge for the primary operation; and
 - 50% of the Allowable Charge for the second operation; and
 - 25% of the Allowable Charge for each of the other operations.

This provision does not apply to two or more operations during any one time that are clinically identified and defined as a separate procedure.

5. Covered Charges for treatment of sleep disorders include only:
 - * charges for Outpatient treatment of insomnia (but not chronic insomnia);
 - * charges for Inpatient and Outpatient treatment of life threatening sleep disorders.
6. Covered Charges for physical, occupational, or speech therapy, except charges made by a Home Health Agency, are limited to a maximum of 60 Visits per calendar year for all types of therapy combined. Covered Charges for speech therapy are limited to charges for therapy to correct speech loss or damage that is clearly just a symptom of a separately diagnosed, underlying Injury or a separately diagnosed, underlying Illness such as (but not limited to) cancer of the larynx, cleft palate, or a cerebrovascular accident (CVA or stroke). Charges for physical, occupational, or speech therapy for chronic conditions or for maintenance are not Covered Charges.

Benefits Payable

We will pay the Insured Percentage of Covered Charges incurred by a Covered Person, after all applicable Deductibles have been met. No one Covered Charge, or part of a Covered Charge, can be used to meet more than one Deductible. You are responsible for all applicable Deductibles and for the non-Insured Percentage of such Charges. You are also responsible for any charge, or part of a charge, that is not deemed a Covered Charge under the Policy.

All benefits payable to or on behalf of any person under the Policy will not exceed the Maximum Benefits. This applies whether or not there is any interruption of that person's insurance under the Policy. See the SCHEDULE OF BENEFITS for provisions for Insured Percentages, Deductibles, and Maximum Benefits.

MEDICAL CARE BENEFIT EXCLUSIONS

We will not pay benefits for (and Major Medical Covered Charges do not include) any charges:

1. under the MAJOR MEDICAL EXPENSE BENEFITS provision for which benefits are payable under any other provision of the Policy. [This does not apply to Covered Charges exceeding any benefit payable under the SUPPLEMENTAL ACCIDENT MEDICAL EXPENSE section];
2. for care, services, or supplies not Medically Necessary for treatment of Injury, Illness, or other conditions specifically covered by the Policy;
3. for treatment, care, services, or supplies not recommended and approved by the attending Practitioner or that are furnished by a Practitioner outside the scope of his license;
4. by or on behalf of a Practitioner for treatment, care, or services not personally performed by or under the personal supervision and in the presence of that Practitioner;
5. by a Hospital on behalf of a Practitioner for Inpatient medical or surgical care;
6. for the services of medical personnel on standby status;
7. incurred while an Inpatient that are not consistent with the diagnosis of record;
8. made by you, a Close Relative, or any person who lives in your home;
9. for treatment due to active duty in the armed forces of any country;
10. for treatment due to war or act of war, declared or not;
11. for treatment due to taking part in a riot or insurrection or to committing or attempting to commit an assault or a felony;
12. for treatment, care, services, or supplies provided outside the United States of America, except for Emergency Medical Treatment;
13. incurred while coverage under the Policy is not in effect for the Covered Person except as may be specifically provided in the Policy;
14. for treatment of:
 - any Illness covered under any Worker's Compensation Law, occupational disease law, or similar law; or
 - any injury arising out of, or in the course of, doing any work for pay, profit, or gain, whether on the Covered Person's job or any other job;
15. for treatment, care, services, or supplies for which the Covered Person does not legally have to pay, except when payment of such benefits is required by law and then only to the extent required by law;
16. that would not have been made if the Covered Person were not insured under the Policy;
17. for, in connection with, or as a consequence of treatment, care, services, or supplies deemed in the sole judgment of [the Administrator] to be experimental, investigational, or unproven with respect to the patient's diagnosed Injury or Illness. Our determination that treatment, care, services, or supplies are experimental, investigational, or unproven is based on our established standards and is final for the purpose of determining benefits payable under the Policy. With respect to any such treatment, care, service, or supply, we reserve the right in our sole judgement to extend this exclusion for up to six months after the treatment, care, service, or supply first becomes nonexperimental, noninvestigational, and proven;
18. for custodial, convalescent, or sanatorium care or other care for the purpose of meeting personal needs (help in walking, bathing, dressing, eating, taking medicine, and so on), except for limited home health aide services through a Home

Health Agency or Hospice Program as specifically provided under the MAJOR MEDICAL EXPENSE BENEFITS provision;

MEDICAL CARE BENEFIT EXCLUSIONS, Continued

19. for travel, rest cures, supervision in protected settings, or other therapy that is primarily to change or control environment;
20. [for treatment of an intentionally self-inflicted bodily injury;]
21. for, in connection with, or as a consequence of transplants or implants of human, animal, or artificial organs, tissues, or cells, in whole or in part, except:
 - human, or artificial heart valves;
 - human or artificial blood vessels;
 - human skin or human corneas;
 - pacemakers and prosthetic devices as specifically provided under the MAJOR MEDICAL EXPENSE BENEFITS Covered Charge that addresses pacemakers, prostheses, and other devices;
 - human organs, tissues or cells as specifically provided under the MAJOR MEDICAL EXPENSE BENEFITS Transplant Program Covered Charges provision; or
 - antirejection drugs, [unless payable under the PRESCRIPTION DRUG EXPENSE BENEFITS section, to assist in maintaining transplanted human organs, tissues, or cells;]
22. for, in connection with, or as a consequence of solid organ transplants in patients with metastatic carcinomas;
23. for, in connection with, or as a consequence of the use of artificial hearts or ventricular assist devices associated with bringing a patient into compliance with transplant acceptance guidelines;
24. for, in connection with, or as a consequence of solid organ transplants where the diagnosed Illness or Injury arises from Alcoholism, Drug Addiction, or other chemical dependency, including but not limited to drug overdoses or alcoholic cirrhosis;
25. for refractive keratoplasty (including radial keratotomy), routine eye examinations, eye glasses, contact lenses or their fitting (unless for initial replacement of the lens of the eye), eye exercises, visual therapy, fusion therapy, visual aids or orthoptics, or any related examinations;
26. [for hearing aids or their fitting;]
27. [for treatment of the teeth or gums except as specifically provided in the Policy;]
28. for sex transformation;
29. due to or for plastic surgery, Cosmetic Surgery or reconstructive surgery, except:
 - a. correction of a congenital malformation of a Dependent Child insured under the Policy from birth;
 - b. surgery to correct bodily damage from Injury that occurred while the Covered Person is insured under the Policy and when such surgery is performed within 12 months from the date of the Injury; and
 - c. reconstructive breast surgery for a female Covered Person following a mastectomy that was performed while she is covered under the Policy;
30. for any of the following:
 - a. surgery to the upper or lower eyelid;
 - b. derma or chemo abrasion;
 - c. otoplasty or rhinoplasty;
 - d. augmentation or reduction of the breasts;
 - e. lift, stretch, or reduction of the abdomen, buttocks, thighs or upper arms;
 - f. penile implants;
 - g. scar revision or silicone injections to any body part; or
 - h. any surgery, service or supply primarily for the purpose of improving physical appearance;
31. [due to a Pre-Existing Condition;]

MEDICAL CARE BENEFIT EXCLUSIONS, Continued

32. for vitamins or food supplements, whether or not prescribed by a Practitioner;
33. for routine care of a newborn child except as specifically provided under the MANDATED BENEFITS and MAJOR MEDICAL EXPENSE BENEFITS (Other Covered Charges) provision;
34. for surgery to restore fertility when infertility is due to elective surgery;
35. for, in connection with, or as a result of, surgery and services to correct obesity; and, for or in connection with, weight loss programs;
36. for treatment of temporomandibular joint (TMJ) or craniomandibular dysfunction, regardless of cause, except for diagnostic x-ray studies, injection of the joint, or surgical procedures performed on the joint;
37. for treatment of sleep disorders except as specifically provided under the MAJOR MEDICAL EXPENSE BENEFITS provision;
38. for or due to the prevention of pregnancy in a Member or Dependent Spouse, except for Prescription Contraceptives as specifically provided under the MAJOR MEDICAL EXPENSE BENEFITS (Other Covered Charges) provision [and the PRESCRIPTION DRUG EXPENSE BENEFITS provision];
39. [for or due to the prevention of pregnancy in a Dependent Child;]
40. [for or due to any induced termination of Pregnancy (other than childbirth, a Non-Elective Abortion, or medical complications arising from any induced termination of Pregnancy) in a Member or Dependent Spouse;]
41. [due to Pregnancy or Complication Of Pregnancy, or for or due to any induced termination of Pregnancy in a Dependent child;]
42. for treatment and care of weak or flat feet, fallen or high arches, foot instability or imbalance, metatarsalgia, bunions, corns, callouses, toenails, or Hallux valgus; unless due to or for:
 - capsular or bone surgery;
 - complete or partial removal of nail roots;
 - treatment of metatarsalgia caused by disease; or
 - treatment of a metabolic or peripheral-vascular disease;
43. for treatment to reduce or stop use of tobacco, nicotine, or caffeine;
44. for private duty Skilled Nursing services except through a Home Health Agency or as part of a Hospice Program, as specifically provided under the MAJOR MEDICAL EXPENSE BENEFITS provision;
45. for treatment of infertility or sexual dysfunction regardless of cause, except as specifically provided under MANDATED BENEFITS and MAJOR MEDICAL EXPENSE BENEFITS Covered Charges for Treatment of Injury or Illness;
46. for medical supplies such as adhesive tape, antiseptics, or other common first aid supplies;
47. for treatment, care, services, or supplies furnished by a governmental plan or facility, unless the Covered Person is legally obligated to pay;
48. [for treatment due to the Covered Person riding in or on a motorized vehicle of any type designed primarily used for racing, speed tests or hazardous exhibition purposes;]
49. [for treatment due to Injury resulting from flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;]
50. for marriage counseling or any therapy or counseling for sexual dysfunction;

MEDICAL CARE BENEFIT EXCLUSIONS, Continued

51. for exercise equipment or programs regardless of their intended purpose;
52. for failure to keep an appointment or to complete claim forms;
53. [for acupuncture, acupressure, massage therapy, chelation therapy (except in the case of metal poisoning) or orthomolecular medicine;]
54. for biofeedback services;
55. for Inpatient physical therapy, rehabilitation, diagnostic x-rays and laboratory services or other diagnostic studies, except when such services cannot be rendered on an Outpatient basis;
56. for treatment arising from the voluntary taking of any gas or poison or the voluntary taking of any drug, sedative or narcotic, unless prescribed by a Practitioner and taken according to the prescribed dosage;
57. related to complications arising from treatment, care, services, or supplies otherwise excluded under the Policy; and
58. [for the purchase of home based artificial kidney equipment.]

PRESCRIPTION DRUG EXPENSE BENEFITS

Benefits Payable

We will pay benefits for Covered Prescription Drug Expenses. A Covered Prescription Drug Expense is the actual Charge for a Covered Prescription Drug, not to exceed the Allowable Charge, that is incurred while insured for this benefit. Benefits will be paid in the amount by which the Covered Prescription Drug Expense exceeds the [deductible and] co-payment. The co-payment is shown in the SCHEDULE OF BENEFITS and applies separately to each prescription and each refill. [The deductible is shown in the SCHEDULE OF BENEFITS and applies to each Covered Person each calendar year.]

Covered Prescription Drugs

The following are Covered Prescription Drugs:

- Legend Drugs.
- Compounded medications of which at least one ingredient is a Legend Drug.
- Insulin with prescription.
- Any other drug that under the applicable state law may only be dispensed upon the written prescription of a Practitioner.

The Covered Prescription Drugs must be prescribed for you (or your Dependent) by a Practitioner. The Covered Prescription Drugs must be Medically Necessary for treatment of Injury or Illness, except for oral Prescription Contraceptives for you (or your Dependent spouse). Supplies of Covered Prescription Drugs must be within the Eligible Quantity.

Eligible Quantity

The Eligible Quantity per prescription or refill is limited to the amount shown below:

1. [Participating Short-Term Supply Network Pharmacy: [30] days]
2. [Participating Extended Supply Network Pharmacy: [90] days]
3. [Non-Participating Pharmacy: [30] days]

How To Obtain Prescription Drugs

Covered prescription drugs are obtained through:

Participating Short-Term Supply Network Pharmacies: Participating Short-Term Supply Network Pharmacies are those pharmacies described as such in your insurance packet. You will be furnished a prescription drug card for use at these Pharmacies. The cards are individualized and will bear your name.

When the prescription drug card is used at a Participating Short-Term Supply Network Pharmacy, the Participating Pharmacy will dispense the drug upon receipt of your [deductible and] co-payment.

Participating Extended Supply Network Pharmacies: Participating Extended Supply Network Pharmacies are those pharmacies described as such in your insurance packet. To obtain a prescription through a Participating Extended Supply Network Pharmacy, you (or your Dependent) must follow the instructions given in your insurance packet.

Non-Participating Pharmacies: Non-Participating Pharmacies are those pharmacies that do not have agreements to dispense Prescription Drugs under a program agreed to by us. If such a pharmacy is used, you (or your Dependent) must pay for the prescription and follow the instructions given in your insurance packet on how to submit a claim for reimbursement.

NOTE REGARDING PARTICIPATING PHARMACIES: The Participating Pharmacies for the Short-Term Supply and Extended Supply Networks may be different. Not all Participating Pharmacies participate in each prescription drug program. Please refer to your insurance packet for a list of pharmacies participating in each program, or call the toll-free number in your packet for more information.

Since these pharmacies are not parties to the Policy, they bear no liabilities for its terms. In addition, we assume no responsibility for any action of any pharmacy, including, but not limited to when a Short-Term Supply Network Pharmacy

does not honor the prescription drug card. Our obligations under the Policy are limited to payment of the benefits that are provided by it in accordance with all its terms and provisions.

PRESCRIPTION DRUG EXPENSE BENEFITS, Continued

Prior Authorization: For certain drugs or classes of drugs, We reserve the right to require prior authorization before dispensing.

Definitions

Brand-Name Drug - a prescription drug that is known by the trade name under which it is advertised and sold.

[Brand Name Non-Preferred Drug – a prescription drug that is not a generic drug or a drug included on the list of Brand Name Preferred Drugs.]

[Brand Name Preferred Drug – a prescription drug that has been designated as such by the Company and is included on the list distributed to the Employer and Covered Persons.]

Generic Drug - a prescription drug that is known by its basic chemical name rather than a brand name. Its components are equivalent to a Brand-Name Drug.

Legend Drug - a drug obtainable only upon prescription by a Practitioner.

Prescription Drug Exclusions

The exclusions listed in the MEDICAL EXCLUSIONS section apply with respect to Prescription Drug Expense Benefits. In addition, charges for the items listed below are not Covered Prescription Drug Expenses. No benefits will be paid for such charges.

- Drugs or medicines that are not Medically Necessary for treatment of Injury, Illness, or other conditions specifically covered by the Policy;
- Items used to prevent or terminate pregnancy in a Member or Dependent Spouse (including, but not limited to, implants, injections, pills, diaphragms, jellies, creams, foams, or condoms), except for oral Prescription Contraceptives;
- Items used to prevent or terminate pregnancy (including, but not limited to, implants, injections, pills, diaphragms, jellies, creams, foams, or condoms) in a Dependent Child;
- Growth hormones in excess of \$[5,000] per calendar year;
- Non-legend drugs other than insulin;
- The administration or injection of any drug;
- Therapeutic devices or appliances, including hypodermic needles, syringes (unless for injection of insulin), support garments, and other non-medicinal substances, regardless of intended use;
- Prescriptions that an eligible person is entitled to receive without charge from any Worker's Compensation Laws or Occupational Disease Laws, or any municipal, state, or federal program, or any medication furnished by any other drug or medical service for which no charge is made to the member;
- Drugs labeled "Caution - limited by federal law to investigational use," or experimental drugs even though a charge is made to an individual*;
- Infertility drugs, immunization agents, biological sera, blood, or blood plasma;
- Medication that is to be taken by or administered to an individual, in whole or part, while he is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- Refills in excess of the number specified by the Practitioner, or any refill dispensed after one year from the Practitioner's order;
- Retin-A except up to and including the age of [25] years;
- Smoking deterrents, or drugs whose sole purpose is to promote or stimulate hair growth;
- Cosmetic drugs, health and beauty aids, cosmetics, anorexiant, and dietary supplements;
- Any covered drug that is consumed at the time and place of the prescription order.
- [Injectables other than insulin.]

*NOTE: We will not limit or exclude any drug approved by United States Food and Drug Administration (FDA) for use in the treatment of cancer on the basis that the drug has not been approved by the FDA for the treatment of the specific type of cancer for which it has been prescribed. Such drug must be: (1) recognized as safe and effective for treatment of the specific type of cancer for which it was prescribed in the American Hospital formulary Service drug information or the United States Pharmacopoeia dispensing information; unless the use is identified as not indicated in one or more such compendia; or (2) recognized as safe and effective for treatment of the specific type of cancer in two articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another

article from medical literature. Benefits include medically necessary services associated with the administration of such drug to the extent they are covered expenses. We will not cover any drug that: (a) the FDA has determined its use to be contraindicated for the treatment of the specific type of cancer for which the drug has been prescribed; or (b) has not been approved by the FDA.

DENTAL CARE EXPENSE BENEFITS

Insuring Clause: We will pay Eligible Expenses incurred by a Covered Person. We will pay such expenses in excess of any Deductible Amount at the Insurance Percentages shown on the SCHEDULE OF COVERAGE, but not to exceed the Maximum Benefits, also shown on the SCHEDULE OF COVERAGE.

Deductible: The Deductible is the amount of Eligible Expenses paid by each Covered Person before we begin to pay benefits. Except as stated below, this amount must be paid during each calendar year with respect to each Covered Person. Once the Deductible has been satisfied by [3] Covered Persons in the same family, then, the Deductible will not apply to any other members of that family who incur expenses after the date the Deductible has been satisfied.

Eligible Expenses: Eligible Expenses means the Reasonable and Customary charge for the following dental services. The SCHEDULE OF COVERAGE shows the Deductible, Insurance Percentage and Maximum Benefits.

There are five classes of Eligible Expenses.

- A. Diagnostic and Preventive:
 - 1) Diagnostic Services Include:
 - a) oral examinations, [2] per calendar year;
 - b) full mouth x-rays of at least [14] films, 1 in any period of [36] months;
 - c) Bitewing x-rays, [2] per calendar year; and
 - d) single tooth x-rays as needed.
 - 2) Preventive Services include:
 - a) prophylaxis for those [14] years and under, [2] per calendar year;
 - b) prophylaxis for those [14] years and over, including minor scaling and polishing, [2] per calendar year;
 - c) fluoride treatment with prophylaxis for dependents under [19] years, 1 per calendar year;
 - c) space maintainers and adjustments, within 6 months of installation, for Dependents under [16] years (applies to initial appliance only);
 - e) other sealant procedures designed to prevent dental decay and maintain dental health.
- B. Basic Dental Expenses
 - 1) Extractions.
 - 2) Endodontic treatment.
 - 3) Filings, primary and permanent teeth.
 - 4) Repair of dentures.
 - 5) Local anesthesia associated with other Eligible Expenses.
- C. Major Dental Expenses
 - 1) Inlays, onlays, crowns, bridges and gold fillings.
 - 2) Complete or partial dentures.
 - 3) Periodontia.
 - 4) Gingivectomy.
 - 5) Root canal.
- D. Special Dental Expenses - Treatment for Temporomandibular Joint Dysfunction Syndrome.
- [E. Child Orthodontia Expenses (Must begin before the 18th birthday.)
 - 1) Surgical therapy.
 - 2) Appliance therapy.
 - 3) Functional/myofunctional therapy.]

Pre-Certification Review: If the charge for a course of treatment is expected to be more than [\$200], the Covered Person may submit a dentist's statement to us in advance of such treatment. Such statement must: 1) describe the planned treatment; 2) detail the expected charge(s); and 3) be accompanied by existing diagnostic x-rays. We will then determine which parts of the treatment are Eligible Expenses, and state how much we will pay for the treatment.

If more than one treatment is available, we will pay for the least expensive method of treatment regardless of the method actually used. If a pre-certification review is not required, we will pay for the least expensive method of treatment regardless of the method actually used. Emergency treatment, oral examinations including prophylaxis, and dental x-rays are considered part of a course of treatment but such services may be rendered before pre-certification review is made.

DENTAL CARE EXPENSE BENEFITS (Continued)

Definitions: The following are in addition to the definitions of the Policy:

Dentist - means a legally licensed doctor of dental surgery, dental medicine, or dental science. Dentist is not a Close Relative of the Covered Person.

Dental Hygienist - means a person licensed as such and practicing within the scope of that license under the supervision of a Dentist. Dental Hygienist is not a Close Relative of the Covered Person.

Limitations and Exclusions: The following expenses are not covered, or are covered only to the extent shown in the SCHEDULE OF COVERAGE.

- 1) Dental services and supplies covered in whole or part by any other plan of benefits or service provided by Your Employer.
- 2) Treatment by other than a dentist, except for scaling and cleaning of the teeth and topical application of fluoride by a licensed Dental Hygienist under the guidance of a Dentist.
- 3) Porcelain or other veneer facings on crowns or pontics placed on or replacing teeth, except for the ten upper and lower anterior teeth;
- 4) Services of a cosmetic nature. Including personalization and characterization of dentures.
- 5) Replacement of a bridge or denture within five years of the original installation, except for replacement necessary because of the placement of a full opposing denture or the extraction of natural teeth. This does not apply to a bridge or denture in the oral cavity that is damaged beyond repair as a result of injury.
- 6) Replacement of lost, missing or stolen prosthetic devices.
- 7) Duplicate prosthetic devices or any other duplication of appliances.
- 8) Oral hygiene, plaque control program and dietary instruction.
- 9) Any service, treatment or supply furnished by the U.S. government or any of its agencies, except when there is a legal obligation to pay. Any service, treatment or supply furnished by a state, province or political subdivision, except when there is a legal obligation to pay.
- 10) Dentures during the first 12 months of coverage.
- 11) Treatment started before this insurance is in force as to the Covered Person
- 12) Treatment considered experimental in nature or implantology.
- 13) Orthodontic treatment or appliances, [except as shown].
- 14) Diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJ), except as shown.
- 15) Any service, treatment or supply as the result of any occupational injury or sickness;
- 16) Prosthetic Appliances when initial work begins prior to the effective date of insurance.
- 17) Missed office appointments.

Alternate Benefits: We have the option to determine payment of benefits based on one or more alternative procedures that would be appropriate for the dental condition being treated and accepted standards of dental practice. When we use an alternative procedure determination, payment of benefits will be based on the appropriate procedure with the lowest Reasonable and Customary charge.

Benefits may not be paid or may be reduced if: 1) the Covered Person is covered under another provision of the Policy that also pays benefits for the same Eligible Expense; or 2) the charge is more than the Reasonable and Customary charge; or 3) the Coordination of Benefits provision is applied; or 4) the Maximum Benefit has been paid.

DENTAL CARE EXPENSE BENEFITS (Continued)

Schedule of Benefits

[Calendar Year Deductible:

Per Covered Person for Classes B, C and D Combined	\$50
	Maximum 3 Per Family
Per Covered Person for Class E	\$50

Insurance Percentage:

Class A.	Diagnostic and Preventive Dental Expenses (no Deductible)	100%
B.	Basic Dental Expenses	80%
C.	Major Dental Expenses	50%
D.	Special Dental Expenses	50%
E.	Child Orthodontia Expenses	50%

Maximum Amounts:

Class E Child Orthodontia Expenses	\$100 Lifetime Maximum
Classes A, B, C and D Expenses combined	\$1,000 per Calendar Year

NOTE: Class A and B expenses - no waiting periods.
Class C, D and E expenses - a 12 month waiting period.]

VISION CARE EXPENSE BENEFITS

Insuring Clause: We will pay Eligible Expenses incurred by a Covered Person. If a Covered Person undergoes a Complete Visual Analysis or purchases any of the vision aids listed below, the Company will pay the actual cost charged to the Covered Person by the provider, but not more than the Maximum Payment Limits shown.

	Maximum Payment Limit
Complete Visual Analysis	\$ [50]
Single Vision Lenses (pair)	[50]
Bifocal Lenses (pair)	[75]
Trifocal Lenses (pair)	[100]
Lenticular Lenses (pair)	[150]
Frames	[100]
Contact Lenses (hard and soft):	

- a. The maximum payment for a pair of contact lenses will be [\$150] if the lenses are prescribed after cataract surgery or if vision in the better eye can be corrected to 20/70 or better only by use of contact lenses.
- b. If the contact lenses are chosen for reasons other than stated in a. above, the maximum payment for a pair of contact lenses will be equal to the maximum payment for Single Vision Lenses, not to exceed the following:
 - (1) Single Vision Lenses: Two lenses (one pair) in any period of [12] consecutive months; plus
 - (2) Frames: One set of frames in any period of [24] consecutive months.

In determining the maximum payment for contact lenses as described in b. above, the Single Vision Lenses amount will be included as of each [12]-month period; however, the Frames amount will be included only as of each [24]-month period.

Definitions

Complete Visual Analysis - A Complete Visual Analysis includes:

- a. case history and professional consultation; and
- b. examination for disease or abnormalities; and
- c. determination of the ranges of clear single vision; and
- d. measurement of refraction, eye muscle coordination, and balance; and
- e. special working distance analysis.

Optometrist - A person who is licensed to practice optometry.

Limitations

No benefits will be paid for:

- a. a visual analysis or vision aids that are not for Medically Necessary Care; or
- b. any part of a charge for a visual analysis or vision aids that exceeds Prevailing Charges; or
- c. a visual analysis performed by other than a Physician or Optometrist; or
- d. vision aids not prescribed by a Physician or Optometrist; or
- e. a visual analysis or vision aids provided by a person in the Member's or Dependent's Immediate Family; or
- f. sunglasses (prescribed or not); or
- g. duplication or replacement of a vision aid that is broken, lost, or stolen; or
- h. more than one Complete Visual Analysis in any period of [12] consecutive months; or
- i. more than two lenses (one pair) in any period of [12] consecutive months or one set of frames in any period of [24] consecutive months; or

VISION CARE EXPENSE BENEFITS (Continued)

- j. a visual analysis or vision aids for which the Member or Dependent has no financial liability or that would be provided at no charge in the absence of insurance; or
- k. a visual analysis or vision aids paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law) unless such charges are imposed against the person for such visual analysis or vision aids; or
- l. a visual analysis or vision aids provided as the result of a sickness or injury that is due to war or act of war; or
- m. a visual analysis or vision aids provided as a result of a sickness of injury that is due to participation in criminal activities; or
- n. a visual analysis or vision aids provided as the result of:
 - (1) an injury arising out of or in the course of any employment for wage or profit, if the Member or Dependent is eligible to be covered under a Workers' Compensation Act or other similar law; except this limitation will not apply to: partners, proprietors, or corporate officers who are not covered by a Workers' Compensation Act or other similar law; or
 - (2) a sickness covered by a Workers' Compensation Act or other similar law; or
- o. a visual analysis or vision aids covered by medical expense insurance issued under the Conversion Privilege of the Policy; or
- p. a visual analysis or vision aids provided outside the United States, unless the Member or Dependent is temporarily outside the United States for a period of six months or less for one of the following reasons:
 - (1) travel, provided the travel is for a reason other than securing vision care diagnosis or treatment; or
 - (2) a business assignment; or
 - (3) the person is:
 - (a) enrolled and attending an accredited school in a foreign country; or
 - (b) participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit.

COORDINATION OF MEDICAL [AND DENTAL] CARE BENEFITS

Scope

In this Coordination Of Benefits provision, "this Plan" refers to medical [and dental] coverage under the Policy.

Purpose

The purpose of your coverage under the Policy is to help pay medical bills. It is not intended that you receive benefits greater than your bills. If you or your Dependents are eligible to receive benefits under two or more Plans, benefits under one or more of those Plans may be reduced so that no more than 100% of the Allowable Expenses incurred during a calendar year will be paid by all Plans.

How Coordination Of Benefits Works

This Plan is primary to other Plans when, under the Order Of Benefit Payment Rules, it pays its benefits before those of the other Plans. If this Plan is primary to other Plans, we will pay benefits shown in the Policy without regard to coverage under those other Plans.

This Plan is secondary to other Plans when, under the Order Of Benefit Payment Rules, it pays its benefits after those of the other Plans. If this plan is secondary to other Plans, we will pay the **lesser** of:

- the benefits shown in the Policy without regard to coverage under those Plans; or
- an amount that, when added to the benefits payable by those other Plans, equals 100% of the Allowable Expenses incurred by the patient while insured under this Plan in a calendar year. But we will not pay any benefits if the benefits payable by those other Plans total 100% or more of the Allowable Expenses incurred by the patient.

Benefits payable by another Plan include benefits that would have been payable if a claim had been made. When a Plan's benefits are services, the reasonable cash value of each service will be considered a benefit payable.

This Plan may be primary to one Plan or Plans and also secondary to a different Plan or Plans.

Allowable Expense

An Allowable Expense is a Medically Necessary item of expense that is covered in part under at least one Plan. We will not coordinate benefits for services that are not Covered Charges under the Policy.

But Allowable Expenses do not include:

- [expenses (or the cash value of services) for routine eye examinations, eye glasses, contact lenses or their fitting (unless for initial replacement of the lenses of the eye), eye exercises, visual therapy, fusion therapy, visual aids or orthoptics, or any related examinations; or]
- [expenses (or the cash value of services) for treatment of the teeth or gums; or]
- the difference between the cost of a private hospital room and the cost of a semi-private room, unless the stay in the private room is Medically Necessary; or
- The amount of any reduction in benefits under a primary plan because a Covered Person does not comply with plan provisions. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services and preferred provider arrangements.

What Is A Plan

A Plan is any plan under which benefits (or services) for medical expenses (or treatment) are provided by:

- group insurance or group subscriber contracts or group-type contracts;
- uninsured arrangements of group or group-type coverage;
- group or group-type coverage through health maintenance organizations and other prepayment, group practice, and individual practice plans;

COORDINATION OF MEDICAL [AND DENTAL] CARE BENEFITS, Continued

- any governmental program (this includes, but is not limited to, coverage under Part B of Medicare that could have been obtained by application or enrollment even if application or enrollment was not actually made); or
- any coverage provided or required by law (this includes, but is not limited to, group, group-type, and individual automobile "No-Fault" coverage).

Group-type contracts (or coverage) are contracts (or coverage) that are not available to the general public and can be obtained and kept only because of membership in or connection with a particular organization or group.

But a Plan does not include:

- any individually underwritten and issued policy for which 100% of the premiums are paid by the insured, except for individual automobile "No-Fault" coverage or other individual coverage required or provided by law;
- any student accident plan;
- any group or group-type hospital indemnity coverage, unless designed or administered to give the insured the right to elect reimbursement type benefits at the time of claim;
- any state medical assistance plan under Medicaid (Title XIX of the United States Social Security Act, as amended); or
- any coverage required or provided by any law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan.

Order Of Benefit Payment Rules - is Plan determines whether it is primary or secondary to any other Plan by using the first of Rules that applies and that can determine an order of benefit payment:

1. **If the other Plan is Medicare:** Medicare always pays before this Plan except as required by federal law.
2. **For all Plans:** If the other Plan does not have a coordination of benefits provision, then the other Plan pays before this Plan.
3. **For all Plans:** If the other Plan has a coordination of benefits provision whose rules state that the other Plan pays before this Plan, then the other Plan pays before this Plan.
4. **For all Plans:** The Plan that covers the patient as an employee, member, or subscriber (that is, other than as a Dependent) pays before the Plan that covers the patient as a Dependent.
5. **For Plans that cover the patient as a Dependent (but not as a Dependent child of divorced or separated parents):** The Plan that covers the patient as a Dependent of an employee, member, or subscriber whose birthday (month and day, not year) falls earlier in a calendar year pays before the Plan that covers the patient as a Dependent of an employee, member, or subscriber whose birthday falls later in that year. But if both birthdays are the same, the Plan that has covered the employee, member, or subscriber longer pays before the Plan that has covered the other employee, member, or subscriber the shorter time. **NOTE:** This Rule does not apply when the other Plan has a Dependent rule based on gender instead of birthdays.
6. **For Plans that cover the patient as a Dependent (but not as a Dependent child of divorced or separated parents) when the other Plan's Dependent rule uses gender, not birthdays:** The Plan that covers the patient as a male's Dependent pays before the Plan that covers the female's Dependent.
7. **For Plans that cover a patient as a Dependent child of divorced or separated parents:** If one parent is responsible by court decree for the medical or dental expenses of the child and that parent's Plan has actual knowledge of the terms of the decree, that parent's Plan pays before the other Plans. **NOTE:** This Rule does not apply in any calendar year in which any benefits (or services) are actually paid (or provided) before that parent's Plan has actual knowledge of the terms of the decree.
8. **For plans that cover a patient as a Dependent child of divorced or separated parents:** The Plan of the parent with custody pays before the Plan of the parent without custody. But if the parent with custody has remarried, the Plan of the

parent with custody pays before the Plan of the spouse of that parent, which in turn pays before the Plan of the parent without custody.

COORDINATION OF MEDICAL [AND DENTAL] CARE BENEFITS, Continued

9. **For plans that cover a patient as a Dependent child of divorced or separated parents in which there is joint custody:** If the specific terms of a court decree state that the parents share joint custody, without stating that one of the parents is responsible for the health care expenses of the child we shall follow the Rules outlined above for Plans that cover the patient as a Dependent (but not as a Dependent child of divorced or separated parents).
10. **For all Plans:** The Plan that covers the patient as an employee who is neither laid-off nor retired (or as that employee's Dependent) pays before the Plan that covers the patient as a laid-off or retired employee (or as that employee's Dependent). **NOTE:** This Rule does not apply when the other Plan does not have a rule to determine the order of benefit payment based on whether or not the employee is laid-off or retired.
11. **For all Plans:** Whether a Plan covers the patient as an employee, member, or subscriber (that is, other than as a Dependent) or as that person's Dependent, the Plan that has covered an employee, member, or subscriber longer pays before the Plan that has covered an employee, member, or subscriber the shorter time.

Other Provisions

Small Claim Waiver – We will waive the investigation of possible other coverage for Coordination of Benefits on small claims of less than \$[100]. However, if additional liability is incurred that raises the small claim above \$[100], the entire liability may be included in the Coordination of Benefits computation.

Certain facts are needed to apply Coordination Of Benefits. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give us any facts we need to pay the claim.

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. We will not have to pay that amount again. If the amount of payments we make is more than we should have paid under this Coordination Of Benefits provision, we may recover the excess from one or more of:

- the person we paid or for whom we paid;
- insurance companies; or
- other organizations.

For the purposes of payment or recovery of the amounts in the above two paragraphs, if the other Plan's benefits are services, the reasonable cash value of each service under the Plan will be treated as the benefit payable for that service.

CLAIMING BENEFITS

To claim benefits, a completed claim form must be submitted with required proofs of loss. If a claim form is not furnished within 15 days after notice of claim, other written proof as to the occurrence, character, and extent of the loss may be submitted.

If all or part of a claim is denied, the claimant will be notified in writing as to:

- why the claim was denied with reference to the applicable Policy provisions;
- what added information is needed to complete the claim and why;
- the claim review process available to the claimant.

If the claimant then feels that the claim should not have been denied, the claimant has the right, upon written request, to:

- examine all non-confidential documents in the claim file;
- get copies of such documents (we may make a fair charge for them);
- submit written information to be considered in reviewing the claim.

The Employer (or a designated officer or employee of the Employer) is the "named fiduciary" for claims review required by the Member Retirement Income Security Act of 1974, if it applies.

All claims under the Policy are to be submitted directly to [the Administrator] (address and phone number shown in the SCHEDULE OF BENEFITS). For claims not filed by the provider, a claim form may be obtained from [the Administrator]. [The Administrator] will examine, process, and pay all claims that we decide are payable under the terms of the Policy.

Attach itemized bills for services not shown on the claim form. Be sure those bills show:

- name of patient;
- name of provider;
- date of treatment;
- kind of treatment;
- amount of charge.

If a bill is for a Consulting Opinion, be sure to have the provider so indicate on the bill.

When Claim Must Be Filed To Receive Benefits

The claimant has 90 days from the date of loss to file claim. We will not deny a claim filed after 90 days from the date of loss if the claim was filed just as soon as it was reasonably possible and, except in the absence of legal capacity, was filed within 1 year from the date proof is otherwise required.

Time of Payment Of Claims

All benefits payable under the Policy shall be payable within 30 days after receipt of the claimant's proof of loss.

Payment of Claims

Benefits provided for services provided by a Preferred Provider will be paid directly to the Preferred Provider if an assignment is made. All other benefits will be payable to you, unless before such payment, we receive a written assignment of benefits to a Practitioner or Covered Facility. Any benefits payable on or after your death will be paid to your estate.

Physical Examination/Autopsy

We have the right to have a Covered Person examined by a Practitioner of our choice as often we reasonably need to while a claim is pending. We will pay for such exam. In case of death, we may request an autopsy at our own expense, where it is not forbidden by law.

Legal Actions

No action at law or in equity may be brought to recover under the Policy before 60 days after proof of loss has been filed. No such action shall be brought at all unless brought within 3 years from the end of the time allowed for furnishing proof of loss.

CLAIMING BENEFITS, Continued

Grievances

A grievance process is available for review of any of our rules, decisions, or actions under the Policy that affect the Covered Person. A Covered Person or any authorized representative (including, but not limited to, a Practitioner) acting on the Covered Person's behalf may:

- request informally that we reconsider a rule, decision, or action; or
- file a formal grievance with respect to the rule, decision, or action, whether or not it has been informally reconsidered.

Informal reconsiderations and formal grievances are both voluntary processes that follow procedures described in the Policy. They are not required or automatic. They must be initiated by the Covered Person (or authorized representative) by contacting Customer Services at the Administrator (address and phone number shown in the SCHEDULE OF BENEFITS).

NOTE: To resolve disagreements over a Utilization Review decision, contact the Administrator and follow the procedures described under Disagreements Over A UR Decision, Informal Reconsideration Of A UR Decision, and Formal Appeal Of A UR Decision in the UTILIZATION REVIEW PROGRAM section.)

The grievance process does not apply to denials based solely on the fact that the Policy clearly excludes benefits with respect to a service for which a claim has been denied.

Informal Reconsideration: A Covered Person or his representative may request informally that we reconsider a rule, decision, or action by discussing the situation with the Administrator and presenting any additional information for us to consider. If the informal reconsideration fails to resolve any differences of opinion, the Covered Person or representative has the right to file a formal grievance.

First-Level Formal Grievance: A Covered Person or his representative may request formally that we reconsider a rule, decision, or action by filing a written statement of grievance, plus any written additional supporting information, with the Administrator. We will review the grievance internally (with only our own employees and representatives present) and notify the Covered Person or representative in writing of our decision. If our internal review upholds our original rule, decision, or action, the Covered Person or his representative has the right to file a second-level formal grievance.

In order for us to consider a first-level formal grievance, it must be filed within 12 months after the incident or matter in question occurred.

Second-Level Formal Grievance: (This process also is used for a second-level formal appeal of a utilization review (UR) decision.) A Covered Person or his representative may request formally that we reconsider our decision with respect to:

- a first-level formal grievance; or
- a formal appeal of a UR decision;

by filing a formal written appeal of the decision, plus any written additional supporting information, with the Administrator. We will convene our Grievance Appeal Committee to review the appeal and make a final decision. If the appeal involves a clinical medical issue, the Committee will include a Doctor of Medicine or Osteopathy or Clinical Peer Reviewer of our choice. The Committee will provide the Covered Person or representative with the opportunity to be heard before making its decision. We will notify the Covered Person or representative in writing of the Grievance Appeal Committee's decision.

In order for us to consider a second-level formal grievance, it must be filed within 60 days after we provide notice of our decision with respect to the first-level formal grievance (or the formal appeal of a UR decision).

For Policy purposes, the decision of the Grievance Appeal Committee is final.

DEFINITIONS

Alcoholism - mental and/or physical dependence on alcohol due to chronic and habitual use.

Allowable Charge – the Allowable Charge is based on amounts accepted by other providers in the area for like treatment, care, services, or supplies. For charges rendered by any In-Network or Preferred Provider (including, but not limited to, a Designated Transplant Facility), the Allowable Charge is the amount based on the fee schedule negotiated with the In-Network or Preferred Provider. Our determination of what is an Allowable Charge is final for the purpose of determining benefits payable under the Policy.

Ambulatory Surgical Center - a legally operated facility that specializes in surgical procedures, has a staff of Doctors of Medicine or Osteopathy, has registered nursing services, does not have facilities for patients to stay overnight, and is accredited by the Accreditation Association for Ambulatory Health Care or meets like standards.

Average Semi-Private Charge - the standard charge by the Covered Facility for one day's semi-private room and board; if the Covered Facility has more than one level of such charges, the average of such charges; if the Covered Facility has only private rooms, 90% of the lowest daily room charge; if the Covered Facility does not itemize charges, the pro rata share for one day's room and board as determined by us and based on the number of days as an Inpatient and Allowable Charges.

For a Skilled Nursing Facility or for an Ambulatory Surgical Center, the semi-private room and board charge used will be the average of the prevailing semi-private room and board charges of the Hospitals located in the area where the Skilled Nursing Facility or Ambulatory Surgical Center is located.

Birth Center - a legally operated facility that specializes in care during low risk pregnancy and low risk childbirth, prepares women to control pain during labor and childbirth primarily through psychological means, and discharges mothers and infants within 24 hours after birth. A Birth Center must have a staff of licensed certified nurse-midwives, have arrangements with Doctors of Medicine or Osteopathy and Hospitals for consultation, referral, transfer, and emergency transportation as needed in the event of complications, have equipment and trained personnel immediately available to provide emergency care, and be accredited by the Accreditation Association for Ambulatory Health Care or meet like standards.

Charge - a charge is deemed to be incurred on the date on which the treatment, care, service, or supply for which the charge is made is given or received. If it is not shown otherwise and a single charge is made for a series of treatments, services, supplies, or care sessions, each will be deemed to bear a pro rata share of the charge. However, with respect to a multiple-session diabetes self-management training program, the charge is not deemed to be incurred until the program is completed.

Clinical Peer Reviewer – a health care professional who holds an unrestricted license in a state of the United States, who is in the same or similar specialty as typically manages the medical condition, procedure, or treatment being subjected to utilization review, and who routinely provides the health care services being subjected to utilization review.

Close Relative - a parent, child, sister, or brother of you or your spouse.

Complication Of Pregnancy - non-elective caesarean section, Non-Elective Abortion, ectopic pregnancy that is terminated, spontaneous termination of pregnancy that occurs during a period of pregnancy in which a viable birth is not possible, or a grave condition (one usually requiring Hospital confinement) where the diagnosis is distinct from pregnancy but the condition is caused by or adversely affected by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, severe hyperemesis gravidarum, eclampsia, and similar conditions of like severity.

Such conditions do not include false labor, occasional spotting, rest prescribed by a Practitioner during the period of pregnancy, morning sickness, mild preeclampsia, and similar conditions of like severity associated with the management of a difficult pregnancy.

Consulting Opinion - the written opinion of a Practitioner, based on his physical examination of a patient, for the purpose of determining that patient's need for surgery or another procedure, but only if that Practitioner:

- is a board-certified specialist in the condition for which the procedure is proposed or has been referred to the Covered Person by a local medical society; and
- does not perform or assist with the procedure if it is performed; and

- does not have any business or financial association with the Practitioner performing the procedure if it is performed.

DEFINITIONS, Continued

Convenient Medical Care Center - a legally operated facility that specializes in prompt treatment of minor, non-life threatening Injury or Illness, provides nursing services, has a staff of Practitioners, and is accredited by the Accreditation Association for Ambulatory Health Care or meets like standards.

Cosmetic Surgery - a surgical procedure that results mainly in improving the appearance of an exterior part of the body.

Covered Charge - the actual charge for Medically Necessary treatment of Injury or Illness, not to exceed the Allowable Charge. We have the right to determine the Medical Necessity and Appropriateness of an inpatient admission to, proposed length of stay in, and continued stay in a Covered Facility; and the level or type of treatment, care, service, and supplies received (or to be received) while either an Inpatient or an Outpatient.

Covered Facility - a Hospital, Skilled Nursing Facility, Ambulatory Surgical Center, Home Health Agency, Birth Center, Convenient Medical Care Center, Outpatient Dialysis Center, Hospice and any other facility we are required by law to recognize.

Covered Person - a Member or Dependent who is eligible for coverage under the Policy and for whom the required premium has been paid. It generally includes you and your covered Dependents, if Dependent coverage is in effect.

Creditable Coverage - medical care coverage under:

- an employer-group health plan;
- a group or individual health insurance policy, certificate, contract, or HMO contract (including, but not limited to, coverage under the Policy);
- part A or part B of Title XVIII of the Social Security Act (Medicare);
- Title XIX of the Social Security Act (Medicaid), except coverage consisting solely of pediatric vaccine benefits under section 1928 of the Social Security Act;
- Title 10 U.S.C. Chapter 55 (CHAMPUS);
- a medical care program of the Indian Health Service or a tribal organization;
- a state-sponsored health benefits risk pool;
- Title 5 U.S.C. Chapter 89 (Federal Employees Health Benefits Program);
- a public health plan established or maintained by a state or a political subdivision of a state; or
- Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Creditable Coverage does not include:

- accident-only coverage, disability income coverage, or any combination thereof;
- coverage issued to supplement liability insurance;
- liability insurance (general or automobile);
- workers' compensation or similar insurance;
- automobile medical payment insurance;
- credit-only insurance (for example, mortgage insurance);
- coverage for on-site medical clinics;
- other similar coverage as specified by federal or state statutes or regulations under which benefits for medical care are secondary or incidental to other benefits;
- the following benefits, if offered separately:
- limited scope dental or vision benefits;
- benefits for long-term care, nursing home care, home health care, community based care, or any combination thereof; or
- other similar limited benefits as specified by federal or state statutes or regulations;
- hospital indemnity or other fixed-dollar indemnity coverage or specified disease or illness coverage, if offered as independent, noncoordinated benefits; or
- coverage issued to supplement Medicare, CHAMPUS, or an employer-group health plan, if offered as a separate policy.

DEFINITIONS, Continued

For any person, a “day of Creditable Coverage” is a day on which Creditable Coverage is in effect for that person from any and all sources. A day on which the person has Creditable Coverage in effect from two or more sources counts as a single day of Creditable Coverage. Days spent in an eligibility, waiting, or affiliation period before the effective date of coverage from any source do not count as days of Creditable Coverage from that source. (With respect to the Policy, these are the days, if any, on and after the Enrollment Date (as described in the definition of Pre-Existing Condition) and before the effective date of coverage under the Policy.)

This definition of Creditable Coverage is intended as a summary of coverage that, as required under the federal Health Insurance Portability and Accountability Act of 1996 and any amendments (HIPAA) and under certain state laws:

- may entitle a Covered Person to credit towards satisfaction of the Pre-Existing Condition exclusion period (as explained in the definition of Pre-Existing Condition); and
- if used as the reason for declining or waiving coverage under the Policy and then lost, may entitle a Covered Person to a Special Enrollment Period (as explained in the ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION section of the Policy).

If there is a question about the meaning of any part of this definition, we will rely on HIPAA and those state laws to resolve the matter. Creditable Coverage excludes all types and days of coverage that federal and state law permits us to exclude.

Proof of Creditable Coverage: In general, satisfactory proof of prior Creditable Coverage consists of valid Certificates of Creditable Coverage provided by the sources of that coverage. Each Certificate must include information sufficient for us to determine whether or not a Significant Break in coverage has occurred (including but not limited to information about eligibility, waiting, and affiliation periods) and how much credit to give towards satisfaction of the Pre-Existing Condition exclusion period. (See the definition of Pre-Existing Condition for more details.)

In general, you are entitled to have, or request, Certificates of Creditable Coverage from employer-group health plans and issuers of group and individual health insurance policies, certificates, contracts, and HMO contracts. We will assist you in obtaining a Certificate from the other issuer or plan, if necessary.

If you do not have and cannot obtain a valid, sufficiently informative Certificate, we will treat you as having provided such a Certificate if you (and your spouse, as required):

- attest to the period of Creditable Coverage;
- present relevant corroborating evidence of some Creditable Coverage during the period; and
- cooperate with our efforts to verify the coverage.

We will provide you with a Certificate of Creditable Coverage for coverage under the Policy when your coverage ends and when coverage for each Dependent ends (whether or not any continuation coverage is available). If continuation coverage is available and is elected under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 and any amendments (COBRA) or any similar federal or state law, we will also provide a Certificate when that coverage ends. We will also provide you with a Certificate if you request one before the end of the 24th month after the date this coverage ends or COBRA continuation coverage ends (whichever is later).

Designated Transplant Facility – with respect to a specified type of Covered Transplant, a Hospital designated by us that has entered into an agreement through a national organ transplant network to provide that type of Covered Transplant and related services. A Designated Transplant Facility will be determined by us and may or may not be located in the patient's geographic area.

[Domestic Partner – a Member's opposite or same sex life partner, provided the Member and the Domestic Partner furnish proof of joint residence and financial interdependence to the satisfaction of the Company; and

- a. the partner is not in the Armed Forces of any country; and
- b. the partner is not covered under the Policy as a Member; and
- c. the partner has attained the age of legal consent and at which he or she is legally able to contract; and
- d. neither the partner nor the Member is married under applicable law; and
- e. the partner is not a blood relative of the Member; and
- f. the partner lives together with the Member; and

g. the partner and the Member are each other's sole life partner and intend to remain so indefinitely; and

DEFINITIONS, Continued

- h. the partner and the Member are jointly responsible for each other's financial welfare; and
- i. the partner and the Member are not in their relationship solely for the purpose of obtaining insurance coverage.]

Drug Addiction - mental and/or physical dependence on drugs other than alcohol due to chronic and habitual use.

Emergency Medical Condition - a medical condition that manifests itself by acute symptoms of sufficient severity including, but not limited to, severe pain, that would cause a prudent lay person, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

- placing the health of the Covered Person, or with respect to a pregnant Covered Person, her health or that of her unborn child, in serious jeopardy;
- serious impairment to a bodily function;
- serious dysfunction of any bodily organ or part.

Emergency Medical Treatment – treatment, care, services, or supplies furnished or required to screen for, evaluate, and treat—until stabilized—an Emergency Medical Condition.

Home Health Agency a legally operated facility that mainly provides skilled nursing services to patients in their homes, operates under the direction of a Doctor of Medicine or Osteopathy, maintains clinical records, and qualifies as a home health agency under Medicare. It does not include any facility that mainly provides for care or treatment of Mental Disorders.

Hospice - a legally operated agency or facility, or special part of an agency or facility, that specializes in Hospice Programs, operates under the direction of a Doctor of Medicine or Osteopathy, and meets the standards of the National Hospice Organization or like standards.

Hospice Program - a centrally administered, coordinated program of Outpatient and/or Inpatient services to ease symptoms of terminally ill patients and provide support for those patients and their families. A team of health care professionals provides services that include, but are not limited to, nursing, therapy, and counseling. Nurses are on call 24 hours of every day. A Hospice Program does not offer curative treatment. A Hospice Program encourages home care, meets the standards of the National Hospice Organization or like standards, and is provided by a Hospice.

Hospital - a legally operated facility that mainly provides facilities for diagnosis and treatment of Injury or Illness, has a staff of Doctors of Medicine or Osteopathy, has 24 hour nursing services, has facilities for patients to stay overnight, has facilities for major surgery, and is accredited by the Joint Commission on Accreditation of Healthcare Organizations or meets federal qualifications for Medicare. The Hospital need not have facilities for major surgery if it specializes in physical rehabilitation of injured or sick persons or treatment of Mental Disorders.

A Hospital does not include a facility used mainly as an extended care facility or for schooling, training, custodial, or convalescent purposes.

Illness - a physical sickness, physical disease, premature birth, birth abnormalities, congenital defect that impairs a needed bodily function, Pregnancy, Complication Of Pregnancy, Alcoholism, Drug Addiction, or Mental Disorder.

Injury - an accidental bodily injury.

Inpatient - a person who is confined as a resident patient in a Covered Facility (other than for Partial Hospitalization) and who is charged for or receives at least one day's room and board in that Facility.

Intensive Care Accommodations - that part of a Hospital that is solely reserved for critically ill patients who need constant observation as prescribed by the attending Practitioner; provides room and board; has specialized registered nursing care and special equipment or supplies immediately available on a standby basis segregated from the rest of the Hospital facilities. These accommodations include neonatal care units.

DEFINITIONS, Continued

Medically Necessary or Medical Necessity – the most cost-effective level or type of treatment, care, service, or supply that is consistent with and appropriate for the Illness, Injury, or other condition under treatment or care, based on:

- the patient's overall medical history, condition, and prognosis; and
- current, generally accepted medical practice.

Even though a Practitioner prescribes, orders, recommends, or approves a level or type of treatment, care, service, or supply, the level or type may not be Medically Necessary as defined. Even though a level or type of treatment, care, service, or supply is useful or desirable for occupational, social, home life, or personal comfort reasons or for the convenience of the patient, the patient's family, or provider, the level or type may not be Medically Necessary as defined. Even if a level or type of treatment, care, service, or supply is Medically Necessary as defined, benefits are not payable unless all other Policy terms and conditions are met.

Medicare - the program of medical care benefits established by Title XVIII of the Social Security Act, as amended.

Member – [a Rotational Staff or Non-Rotational Staff who is] a Full-Time Employee for the Employer.

If the Employer is a corporation and you are a director of it, you are not a Member just because you are a director.

If the Employer is a partnership or a proprietorship and you are a partner or proprietor, you will be eligible to be considered a Member if you work at least 30 hours each week in the conduct of its business.

You will not be eligible to be insured under the Policy unless you are a Member in an Eligible Class as provided under WHO CAN BE INSURED.

Mental Disorder - a psychotic, neurotic, or personality disorder or other mental or emotional disease or disorder. For Policy purposes, Alcoholism and Drug Addiction are deemed not to be Mental Disorders.

Non-Designated Transplant Facility – with respect to a specified type of Covered Transplant, a Hospital that is not a Designated Transplant Facility for that type of Covered Transplant.

Non-Elective Abortion – the induced termination of pregnancy during a period of pregnancy in which a viable birth is not possible, where the termination occurs for one of the following reasons:

- the pregnancy, if continued to a period in which a viable birth is possible, would endanger the mother's life;
- the fetus has died in the uterus due to natural causes or accidental injury; or
- the fetus has congenital physical defects severe enough to make a viable birth not possible during any period of pregnancy.

Non-Preferred Charge - a Covered Charge for treatment, care, services, or supplies provided by a Non-Preferred Provider. Covered Charges are defined, with limits and exclusions, under MAJOR MEDICAL EXPENSE BENEFITS and MEDICAL CARE BENEFIT EXCLUSIONS.

Non-Preferred Provider - any provider not meeting the Policy definition of a Preferred Provider at the time treatment, care, services, or supplies are provided.

Nurse - a licensed registered nurse or a licensed practical nurse.

Outpatient - a person who receives treatment, care, services, or supplies other than in an Inpatient or Partial Hospitalization setting.

Outpatient Dialysis Center - a legally operated facility that specializes in Outpatient kidney dialysis, provides nursing services, has a staff of Practitioners, and is accredited by the Accreditation Association for Ambulatory Health Care or meets like standards.

Partial Hospitalization – an alternative to Inpatient treatment for Mental Disorders or Alcoholism where Inpatient treatment would otherwise be Medically Necessary. It consists of continuous treatment in a Covered Facility for at least 4 hours, but not

more than 16 hours, in any 24-hour period. For Policy purposes, each such treatment session is deemed one day of Partial Hospitalization.

DEFINITIONS, Continued

Practitioner - one who is a licensed Doctor of Medicine, Osteopathy, Dentistry, Chiropractic, Podiatry, or Optometry. Practitioner also includes a licensed psychologist, professional counselor, clinical social worker, optician, certified nurse-midwife, certified nurse-practitioner, or certified nurse-anesthetist and any other licensed practitioner we are required by law to recognize.

A Practitioner must practice within the scope of his license.

Charges by or on behalf of a Practitioner for certain services are limited or excluded by the Policy, no matter which type of Practitioner provides the service.

Pre-Existing Condition – any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was received or recommended within the 6-month period just before his Enrollment Date. However, pregnancy is not a Pre-Existing Condition. Genetic information is not a Pre-Existing Condition in the absence of a diagnosis of the condition related to the genetic information.

A condition is deemed no longer Pre-Existing on the date the person has been enrolled under the Policy for twelve (12) months (18 months for Late Enrollees) in a row starting on the Enrollment Date.

The Pre-Existing Condition exclusion will not apply to your natural Dependent Child, your Dependent Child adopted under the age of 18 years, or your Dependent Child placed for adoption under the age of 18 years if the following applies:

The Child's coverage under the Policy, or under prior Creditable Coverage, began no later than the 31st day after the birth, adoption, or placement for adoption (as the case may be) and has remained in effect from that moment without a Significant Break in coverage.

For the purpose of this Pre-Existing Condition definition, "Enrollment Date" means:

- for any Member whose coverage under the Policy begins (or who submits the enrollment card for such insurance) on or before the 31st day after the date he becomes eligible: the later of the Policy Effective Date or the most recent date he became a full-time Member in an Eligible Class (even if the Eligibility Period, if any, was not completed on that Enrollment Date);
- for any person who is a Dependent of an Member described above and whose coverage under the Policy begins on the same date as the Member's coverage: the later of the Member's Enrollment Date or the date the Member acquires the Dependent;
- for all other Members and Dependents (Late Enrollees or persons to whom a Special Enrollment Period applies): the most recent effective date of coverage under the Policy.

For the purpose of this Pre-Existing Condition definition, "Significant Break in coverage" means a period of 63 days or more during all of which the person did not have Creditable Coverage in effect from any source. However, with respect to Creditable Coverage from any source, if a person:

- is not a Late Enrollee with respect to that source; and
- is not a person to whom a Special Enrollment Period applies with respect to that source;

then days spent in an eligibility, waiting, or affiliation period before the effective date of coverage from that source are not counted as days in a Significant Break in coverage. (With respect to the Policy, these are the days, if any, on and after the Enrollment Date and before the effective date of coverage under the Policy.)

Credit Towards Satisfaction of Pre-Existing Condition Exclusion Period: For a person with prior Creditable Coverage, credit may be given towards satisfaction of the Pre-Existing Condition exclusion period under that prior coverage. Credit will be given for all days of prior Creditable Coverage for which you submit proof satisfactory to us, except days that occur before a Significant Break in coverage.

If you do not submit any evidence of prior Creditable Coverage for a person, the full Pre-Existing Condition exclusion period will apply to that person.

If you submit evidence to offset a person's entire Pre-Existing Condition exclusion period and we agree that the proof is satisfactory, the Pre-Existing Condition exclusion will not apply to that person.

DEFINITIONS, Continued

If you submit evidence for a person that covers less than the entire Pre-Existing Condition exclusion period, or if we do not agree that the proof for a person is satisfactory, we will advise you in writing as to:

- the length of the Pre-Existing Condition exclusion period we will apply to that person;
- what information we used to arrive at our decision; and
- the appeals procedure for you to follow if you disagree with our decision. You will be given a reasonable opportunity to submit additional evidence of Creditable Coverage.

Preferred Charge - a Covered Charge for treatment, care, services, or supplies provided by a Preferred Provider. Covered Charges are defined, with limits and exclusions, under MAJOR MEDICAL EXPENSE BENEFITS and MEDICAL CARE BENEFIT EXCLUSIONS.

Preferred Provider - Any provider deemed by us to be Preferred under the Policy with regard to a person at the time treatment, care, services, or supplies are provided to that person.

A Provider "deemed by us to be Preferred under the Policy with regard to a person" is a provider who both:

- meets certain criteria established by us; and
- appears on our master list of Preferred Providers applicable to that person, as updated.

We have the sole right to decide which master list of Preferred Providers is applicable to that person. We have the sole right to give a provider Preferred status under the Policy. We and the provider each have the right to withdraw the provider's Preferred status.

Pregnancy - pregnancy, childbirth (other than non-elective caesarean section), or a condition (other than a distinct Complication Of Pregnancy) associated with the management of a difficult pregnancy.

Prescription Contraceptive – a procedure, drug, device, or other item: (a) performed or used before an act of sexual intercourse for the purpose of preventing the act from resulting in pregnancy; and (b) obtainable by law only from (or under the direct supervision of) a Practitioner or with a Practitioner's written prescription.

Prescription Drugs - medicines that can only be obtained by law with a Practitioner's written prescription. For the purposes of the Policy, nitroglycerin, insulin, and syringes for injection of that insulin are also deemed to be Prescription Drugs.

Resides in the United States – a Member and his Dependent who:

- maintains a home in the United States; and
- lives in that home in the United States; and
- does not leave the United States for more than 6 consecutive months.

[Rotational Staff/Rotational Staff Member – any Member who is an active Full-Time Employee, as defined in this section, hired by the parent or affiliate of the Employer who has transferred to the Employer.]

Skilled Nursing Care - nursing care that requires the skills of, and can only be performed by, a Nurse or a health professional of equivalent or greater training to achieve the Medically Necessary result.

Skilled Nursing Facility - a legally operated facility, or a special wing of a facility, that mainly provides Skilled Nursing Care to Inpatients and that qualifies as a Skilled Nursing Facility under Medicare or could be so qualified if requested.

Sound, Natural Teeth - Any tooth or parts of a tooth that are organic and formed by the natural development of the body (that is, not manufactured). Organic portions of a tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp (nerve).

A Functioning tooth is a Natural Tooth that is performing its normal role in the chewing process in the patient's arch (upper or lower) and which is opposed in the other arch (upper or lower) by another Functioning Natural Tooth or prosthetic (artificial) replacement.

A Sound tooth is a Natural Tooth that is fully restored to function, does not have any decay, is not more susceptible to injury than a virgin tooth, and is without Periodontal disease.

Visit - a visit, session, appointment, home or office call, or other designated period during which the patient consults with or receives treatment, care, or other services from a Practitioner or other health care provider.

REPLACEMENT OF PRIOR COVERAGE

Credit Given To Initial Covered Persons For Calendar Year Deductible Satisfied Under Previous Coverage (Applies Only if a Previous Insurer Is Shown, And You And Your Dependents Are Initial Covered Persons As Defined)

Covered Charges:

- incurred by an Initial Covered Person; and
- used to satisfy the calendar year deductible under the Previous Coverage during the calendar year in which our Policy goes into effect (during the last 3 months of the preceding calendar year if our Policy goes into effect on January 1);

may be used to satisfy our Calendar Year Deductible for the calendar year in which our Policy goes into effect.

Definitions

Initial Covered Person - any Member (or Dependent) who is covered under our Policy on the Policy Effective Date and who was insured for medical care insurance under the Previous Coverage on the day just before that.

Previous Coverage - the policy issued to the Employer by the Previous Insurer that is replaced by our Policy on the Policy Effective Date. The Previous Insurer (if any) is shown in the SCHEDULE OF BENEFITS.



COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200
P.O. BOX 100102
COLUMBIA, SC 29202-3102

- Medical Care Insurance
- For Members and Dependents

\$_____ Initial deposit accompanies this Application.

It is requested that the group insurance herein applied for become effective on _____.

Optional Benefit Offers:

Do you ___ Accept ___ Reject Diagnosis and Treatment of Musculoskeletal Disorders of Bone or Joint in Face, Neck or Head benefit? **Rejection of this option means that covered benefits provided to enrollees will not include temporomandibular joint disorder or craniomandibular disorder.**

Do you ___ Accept ___ Reject Mental Disorder Treatment benefit? (Available as an alternative to benefits provided by the policy.)

Do you ___ Accept ___ Reject Alcohol or Drug Dependency Treatment benefit? (Available as an alternative to benefits provided by the policy.)

IT IS UNDERSTOOD AND AGREED THAT:

1. the group insurance will become effective on the date requested only if this Application is accepted at the Home Office of Companion Life Insurance Company in Columbia, South Carolina;
2. the conditions of eligibility, the conditions under which insurance for any person begins and ends, the insurance coverage, benefits, and amounts, the conditions under which the benefits will be payable, and other terms and conditions will be in accordance with the Policy issued and any amendments, riders, or endorsements thereto; and
3. the Policy issued and any amendments, riders, or endorsements thereto, together with the copy of this Application attached to the Policy and the individual applications, if any, of the persons to be insured, will constitute the entire contract.

Signed at _____, this _____ day of _____, 20_____.

 (Full or corporate name of Applicant)

 (Principal address of Applicant)

By _____

Title _____

 (Witness)

 (Licensed Resident Agent If Required By Law)



COMPANION LIFE INSURANCE COMPANY
 7909 PARKLANE ROAD, SUITE 200
 P.O. BOX 100102
 COLUMBIA, SC 29202-3102

A. Employee Information Coverage Applying For: **Medical Dental Vision Life Dependent Life Long Term Disability**

Print your name (last, first, middle initial) _____ Home phone number _____ Social Security number _____

Home address (street) _____ City _____ State _____ ZIP code _____

Date of birth _____ ~ male ~ married ~ female ~ single Occupation _____ Date of full time employment _____ Employee email address _____

Employer name _____ I am selecting coverage for: employee employee and spouse employee and children employee, spouse and child(ren)
 I am waiving coverage for: all spouse child(ren) Reason: _____

If coverage applied for replaces any individual or group health insurance, please provide the following:

The last date of coverage under that policy: _____

Name of carrier: _____ Policy #: _____

Is anyone applying for coverage eligible for Medicare A? ~ yes ~ no Medicare B? ~ yes ~ no

B. Health Information (Note: This information will not be used for any purpose prohibited by law.)

Please complete all information on you and family members applying for coverage. List additional children on a separate sheet and staple to this form.

Name (first MI last)	Relationship	Date of Birth	Gender	Height	Weight	Weight change in last year	Other Coverage	Student
	Employee					_____ loss _____ gain	Yes No	Yes No
	Spouse					_____ loss _____ gain	Yes No	Yes No
	Child						Yes No	Yes No
	Child						Yes No	Yes No

Answer only for those individuals requesting coverage. To prevent delays, answer each question and give full details to "yes" answers. All statements and descriptions on this form shall be deemed to be representations and not warranties.

1. ~ yes ~ no Does anyone smoke?

2. ~ yes ~ no Is anyone on whom coverage is requested currently receiving medical treatment, taking medication, or pregnant?

3. ~ yes ~ no Has anyone been told of a need, or possible need for, or is anyone planning or scheduled for, physical therapy, a specialist consultation, surgery, hospitalization, medical treatment, psychotherapy, counseling, EKG, stress test, CT/MRI scan, blood test or any other medical tests or examinations?

4. ~ yes ~ no Does anyone have any physical or mental birth defect, developmental or learning disability, behavior disorder, or physical or mental impairment or condition?

5. ~ yes ~ no **In the past 5 years**, has anyone:

- consulted a doctor, health care provider, or any medical specialist for persistent, lingering or prolonged fevers, night sweats, fatigue, tiredness or weakness?
- been told by a doctor, health care provider, counselor, therapist, or any medical specialist of the need to reduce or discontinue the use of alcohol or drugs, or been treated for the use of alcohol or drugs?
- been evaluated for infertility (male or female)?

6. ~ yes ~ no **In the past 10 years**, has anyone:

- had any surgery, hospitalization, observation room stay, or hospital emergency room treatment or minor emergency clinic, urgent care clinic or outpatient treatment?
- been to or consulted a doctor, chiropractor, counselor, therapist, health care provider or any medical specialist, had blood tests (other than for HIV antibody), other medical tests or been referred to a medical specialist?

7. **In the past 10 years**, has anyone on whom coverage is requested been diagnosed with or received treatment for any of the following (check all that apply)?

~ cancer	~ liver disorder	~ bone disorder	~ mental disorder	~ digestive disorder
~ tumors	~ kidney disorder	~ joint disorder	~ nervous disorder	~ infectious disease
~ heart condition	~ muscle disorder	~ urinary disorder	~ diabetes	~ multiple sclerosis / neurological disorder
~ high blood pressure	~ stroke	~ respiratory disorder	~ hepatitis	

8. ~ yes ~ no **In the past 10 years**, has anyone on whom coverage is requested been treated or diagnosed by a physician or tested positive for HIV antibody, Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?

Beneficiary for Life and AD&D _____ Relationship _____

Provide full details for all "yes" answers. If more space is needed, make a copy of this page and include it as an additional page. Sign and date all pages.

Name	Date diagnosed/treated	Duration of illness or condition
Diagnosis of illness or condition		
Any current symptoms or problems		
Names and addresses of doctors, hospitals or other providers		
Name	Date diagnosed/treated	Duration of illness or condition
Diagnosis of illness or condition		
Any current symptoms or problems		
Names and addresses of doctors, hospitals or other providers		
Name	Date diagnosed/treated	Duration of illness or condition
Diagnosis of illness or condition		
Any current symptoms or problems		
Names and addresses of doctors, hospitals or other providers		
Name	Date diagnosed/treated	Duration of illness or condition
Diagnosis of illness or condition		
Any current symptoms or problems		
Names and addresses of doctors, hospitals or other providers		
Name	Date diagnosed/treated	Duration of illness or condition
Diagnosis of illness or condition		
Any current symptoms or problems		
Names and addresses of doctors, hospitals or other providers		
Name	Date diagnosed/treated	Duration of illness or condition
Diagnosis of illness or condition		
Any current symptoms or problems		
Names and addresses of doctors, hospitals or other providers		

Provide full details for all "yes" answers. If more space is needed, make a copy of this page and include it as an additional page. Sign and date all pages.

Notice of Information Practices (To be read before completing the Health Information section)

In order to properly underwrite, we must collect information. We will do this by having you complete the Health Information section. In addition, we may contact sources other than you for personal data about any proposed insured, including spouse, employer, medical professionals or institutions, and insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, habits and other personal characteristic information.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, with your written authorization, we may provide data to government agencies (e.g., an insurance department of your state), or attending physicians. We may also provide statistical / unidentifiable information to insurance organizations who conduct large studies of insurance practices.

Your or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

- to find out what personal information is contained in the Companion Life files (medical information may be disclosed only to your attending physician).
- To correct or amend information in Companion Life files.

Upon written request, Companion Life will furnish to you (or your dependent) information concerning:

- The nature and scope of personal data in our records;
- The types of disclosures that may be made; and
- Rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written requests within 30 days from the date of receipt.

For further information about your file or rights, you may contact Group Operations, Medical Underwriting, Total Plan Services, Inc., 14001 Dallas Parkway North, Suite 700, Dallas, Tx 75240.

Authorization, Acknowledgment and Signatures

- I represent information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge and belief. They are a part of this request for coverage under the group policies. I agree Companion Life Insurance Company (Companion Life) is not liable for anyone's claim that happens or begins before the effective date of coverage by Companion Life.
- I have read, or had read to me, the questions and responses, and realize that any false statements, omissions and/or material misrepresentations regarding age or health information could cause coverages, if issued, to be cancelled as never effective.
- I understand all group policy provisions for medical coverage will apply. If approved for life and disability coverages, all group policy provisions will apply including, but not limited to, preexisting conditions restriction, and the period of limited activity provisions.
- I understand an agent or broker cannot change or waive any rates, benefits, or provisions of any group policy, if issued, without the written approval of an officer of Companion Life.
- I authorize any doctor, health care provider, hospital, clinic or medically related facility, insurance company, consumer reporting agency or employer, that has any personal information, including physical, mental, drug or alcohol use history, regarding me or any dependent, to give to Companion Life, its underwriters along with its agents and employees performing business transactions, any such data.
- I authorize Companion Life to release any such data as required by law. When signed in connection with any application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date shown below. I understand I may revoke this authorization for information not then obtained. A photocopy of this form may be as valid as the original.
- I understand the data obtained by use of this authorization will be used by Companion Life for claims administration and to determine eligibility for coverage. This information will not be used for any purposes prohibited by law.
- Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form containing any materially false information or conceals for the purpose of misleading, information concerning any fact materially thereto commits a fraudulent insurance act that is a crime. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

Employee signature required	Date signed
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Employer instructions

After this form has been completed and signed, make two copies, send the original to Companion Life Insurance Company, keep one copy for your records and give one copy to the employee.

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 Health Insurance Portability & Accountability Act of 1996 (H.R. 3103) provides for federal penalties of up to 5 years imprisonment for intentional misrepresentation of information in any application for healthcare benefits.



COMPANION LIFE INSURANCE COMPANY
 7909 PARKLANE ROAD, SUITE 200
 P.O. BOX 100102
 COLUMBIA, SC 29202-3102

EMPLOYEE GROUP ENROLLMENT FORM

NAME OF EMPLOYER: _____

Select One: ~New Enrollment ~Enrollment Change

Check Box(es) that apply: ~Reinstatement
 ~Add Newborns
 ~Special Enrollment (attach Certificate of Creditable Coverage)
 ~Late Enrollment (attach medical application enrollment form)

Current Status

Check Box(es) that apply: ~Currently working ~Disability
 ~COBRA ~Retired
 ~Continuation ~Other leave _____

Employee's Name (Last, First, MI)		Social Security Number	
Employee's FULL Address			
City		State	Zipcode
Birthdate / /	Marital Status: ~Single ~Married (Date) _____ ~Divorced ~Widowed ~Separated		
Date of Full Time Employment / /		Number of Hours Worked per Week	Sex: ~Male ~Female
Life Benefit:	Base Annual Salary	Occupation	~ hourly ~ salaried
Beneficiary Designation: (attach additional page if necessary)			
Full Name _____		Relationship _____	
Coverage Applying For:	Employee	Child(ren)	Spouse
Life	~	~	~
Dependent Life	~	~	~
Optional Life Benefit	~	~	~
Medical	~	~	~
Dental	~	~	~
Vision	~	~	~
Short Term Disability	~	~	~
Long Term Disability	~	~	~
For Dual Deductible Plans, what deductible amount is chosen? _____		Waiver: Coverage can only be declined if you pay part or all of the premium Employee Child(ren) Spouse Life ~ Dependent Life ~ ~ Medical ~ ~ ~ Dental ~ ~ ~ Vision ~ ~ ~ Short Term Disability ~ Long Term Disability ~	
		I have been offered the above coverage and wish to decline enrollment for the following reason(s): ~ Covered under another insurance plan ~ Other (please explain) _____	

COMPLETE ONLY IF APPLYING FOR DEPENDENT COVERAGE

Dependent's full Name	Sex	Relationship	Birthdate	Full Time Student
	~F ~M	Spouse		
	~F ~M	~Child/Step child ~Other		~Yes ~No
	~F ~M	~Child/Step child ~Other		~Yes ~No
	~F ~M	~Child/Step child ~Other		~Yes ~No

Please list additional dependents on a separate sheet of paper and staple to this form.
 PLEASE READ REVERSE SIDE FOR MORE IMPORTANT INFORMATION REGARDING YOUR RIGHT TO SPECIAL ENROLLMENT AND PRE-EXISTING CONDITION LIMITATIONS, THEN SIGN AND DATE ON THE DESIGNATED LINES.

**THIS FORM WILL NOT BE ACCEPTED BY COMPANION LIFE INSURANCE COMPANY
UNLESS SIGNED AND DATED BY THE INSURED/EMPLOYEE**

I hereby apply for insurance to which I am now or may become entitled under the provisions of the Group Insurance issued by the Insurance Company. I authorize my employer to deduct the required premium contribution, if any, from my earnings. I understand that my application for any life or disability income coverage is subject to approval by the Insurance Company. I understand that in the event I desire at a later date, such life or disability income coverage, previously cancelled or refused, I will be required to provide medical evidence at my own expense.

I understand that my medical coverage and that of my dependents, if any, will be subject to the pre-existing condition provision specified in the Certificate, and that this provision has been fully explained to me. I understand that in the event I desire at a later date, such medical coverage, previously cancelled or refused, I will be required to furnish a late enrollee form and may be subject to an 18-month pre-existing condition exclusion, unless I qualify for a Special Enrollment Period. Special Enrollment Periods are described in the Certificate.

I understand that one of the requirements for eligibility for any life or disability coverage on the effective date and for continued eligibility under the plan is that I be actively at work and usual place of business employed full time (usually at least thirty (30) hours per week) at my employer's place of business. I also understand that if any dependent being applied for is not able to carry on the normal activities of a person of like age and sex in good health or is hospital-confined on the effective date, any life coverage for such dependent will not become effective until he/she is able to carry on the normal activities of a person of like age and sex in good health. For medical coverage, I understand that I must be employed full time at my employer's place of business.

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 any treatment of myself or my insured dependents to give/allow the Insurance Company or their legal representatives any and all such information including but not limited to Precertification of outpatient procedure or service and hospital admission, Continued Stay Review, On-Site concurrent Review and patient visitation while I or my insured dependents are or have been a patient of a physician, hospital, clinic or medical-related facility. I understand that failure to precertify results in reduced or no benefits. This authorization will remain valid for 2 years after the date below. I understand that I may revoke this authorization at any time by notifying the Administrator in writing at the address shown on the Certificate.

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, claim, 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.

I hereby declare that the foregoing statements and answers made by me on behalf of myself and my dependents, if applying, are complete and true, and that they are correctly and fully recorded, and that no material circumstance or information has been intentionally withheld or omitted concerning myself and my dependents, if any, past and present state of health, and I agree that the answers and statements herein shall form a part of the certificate. I understand that any misstatements or failure to report information may be used as the basis of rescission of life or disability income Insurance for myself or my dependents, if any. I also understand that any life or disability income insurance will not be in force until the application is approved by the Insurance Company.

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 the Insurance Company or its Administrator such information (photocopy of this authorization shall be valid as the original).

As a condition to participating in and receiving benefits under the Insurance Plan I agree: 1. to reimburse the Company for any benefits paid to or on behalf of me and/or my dependents, if any, or that will be paid as a result of said injury or condition, when said benefits are recovered, in any form, from any person, corporation, entity, no fault coverage, uninsured coverage, underinsured coverage, other insurance policies or fund; and 2. without limiting the preceding, to subrogate the Company to any and all claims, causes of action or rights that they have or that may arise against any person, corporation and/or other entity who has or may have caused, contributed to/or aggravated the injury or condition for which I and/or my dependents, if any, claim an entitlement to benefits under this Policy, and to any claims, causes of action or rights they may have against any other no fault coverage, uninsured motorist coverage, other insurance policies or funds (without regard to the common fund or make whole doctrines).

Signature of employee (and parent of applicant if under age 18)

Date

PLEASE MAIL TO: TOTAL PLAN SERVICES 14001 DALLAS PARKWAY NORTH, STE 700 DALLAS, TX 75240

FOR OFFICE USE ONLY		
Effective Date	Group Number	Plan

SERFF Tracking Number: CMLX-126180557 *State:* Arkansas
Filing Company: Companion Life Insurance Company *State Tracking Number:* 42580
Company Tracking Number: GHSAR0007701F01
TOI: H16G Group Health - Major Medical *Sub-TOI:* H16G.001C Any Size Group - Other
Product Name: MMEN02GR09
Project Name/Number: MMEN02GR09/GHSAR0007701F01

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: CMLX-126180557 State: Arkansas
Filing Company: Companion Life Insurance Company State Tracking Number: 42580
Company Tracking Number: GHSAR0007701F01
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: MMEN02GR09
Project Name/Number: MMEN02GR09/GHSAR0007701F01

Supporting Document Schedules

Satisfied -Name: Flesch Certification

Comments:

Attachment:

AR - READABILITY CERTIFICATION.PDF

Review Status:

Approved-Closed

06/17/2009

Bypassed -Name: Application

Bypass Reason: Application attached under Form Schedule.

Comments:

Review Status:

Approved-Closed

06/17/2009

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Companion Life 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.

Form Number	Score
CLIC-P-0105-1-AR	40.2
CLIC-C-0105-1-AR	40.2
CLIC-A-0105-AR	0
CLIC-0208-APP-AR	0
CLIC-EF-0105-LG-AR	0

Signed: 
Name: Karl Kemmerlin
Title: Vice President and CFO
Date: June 8, 2009

SERFF Tracking Number: CMLX-126180557 State: Arkansas
 Filing Company: Companion Life Insurance Company State Tracking Number: 42580
 Company Tracking Number: GHSAR0007701F01
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: MMEN02GR09
 Project Name/Number: MMEN02GR09/GHSAR0007701F01

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	Group Medical Insurance Application	06/11/2009	CLIC-A-0105-AR.PDF
No original date	Form	Group Medical Insurance Application	06/08/2009	CLIC-A-0105-AR.PDF



COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200
P.O. BOX 100102
COLUMBIA, SC 29202-3102

- Medical Care Insurance
- For Members and Dependents

\$_____ Initial deposit accompanies this Application.

It is requested that the group insurance herein applied for become effective on _____.

Optional Benefit Offers:

Serious Mental Illness Benefit (Texas Small Employer Groups Only). Do you ___ Accept ___ Reject?

Loss or Impairment of Speech and Hearing Benefit. Do you ___ Accept ___ Reject?

In-Vitro Fertilization Benefit. Do you ___ Accept ___ Reject?

Developmental Delay Therapies for Children Benefit. Do you ___ Accept ___ Reject?

IT IS UNDERSTOOD AND AGREED THAT:

1. the group insurance will become effective on the date requested only if this Application is accepted by Companion Life Insurance Company;
2. the conditions of eligibility, the conditions under which insurance for any person begins and ends, the insurance coverage, benefits, and amounts, the conditions under which the benefits will be payable, and other terms and conditions will be in accordance with the Policy issued and any amendments, riders, or endorsements thereto; and
3. the Policy issued and any amendments, riders, or endorsements thereto, together with the copy of this Application attached to the Policy and the individual applications, if any, of the persons to be insured, will constitute the entire contract.

Signed at _____, this _____ day of _____, 20_____.

 (Full or corporate name of Applicant)

 (Principal address of Applicant)

By _____

Title _____

 (Witness)

 (Licensed Resident Agent If Required By Law)



COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200
P.O. BOX 100102
COLUMBIA, SC 29202-3102

- Medical Care Insurance
- For Members and Dependents

\$_____ Initial deposit accompanies this Application.

It is requested that the group insurance herein applied for become effective on _____.

Optional Benefit Offers:

Do you ___ Accept ___ Reject Diagnosis and Treatment of Musculoskeletal Disorders of Bone or Joint in Face, Neck or Head benefit?

Do you ___ Accept ___ Reject Mental Disorder Treatment benefit? (Available as an alternative to benefits provided by the policy.)

Do you ___ Accept ___ Reject Alcohol or Drug Dependency Treatment benefit? (Available as an alternative to benefits provided by the policy.)

IT IS UNDERSTOOD AND AGREED THAT:

1. the group insurance will become effective on the date requested only if this Application is accepted at the Home Office of Companion Life Insurance Company in Columbia, South Carolina;
2. the conditions of eligibility, the conditions under which insurance for any person begins and ends, the insurance coverage, benefits, and amounts, the conditions under which the benefits will be payable, and other terms and conditions will be in accordance with the Policy issued and any amendments, riders, or endorsements thereto; and
3. the Policy issued and any amendments, riders, or endorsements thereto, together with the copy of this Application attached to the Policy and the individual applications, if any, of the persons to be insured, will constitute the entire contract.

Signed at _____, this _____ day of _____, 20_____.

 (Full or corporate name of Applicant)

 (Principal address of Applicant)

By _____

Title _____

 (Witness)

 (Licensed Resident Agent If Required By Law)