

SERFF Tracking Number: CMPL-126317166 State: Arkansas
Filing Company: American Medical and Life Insurance Company State Tracking Number: 43573
Company Tracking Number: AMLI DC OT SHELF 9-2009
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: AMLI DC OT SHELF 9-2009
Project Name/Number: AMLI DC OT SHELF 9-2009/AMLI DC OT SHELF 9-2009

Filing at a Glance

Company: American Medical and Life Insurance Company

Product Name: AMLI DC OT SHELF 9-2009 SERFF Tr Num: CMPL-126317166 State: Arkansas

TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed-Approved-
Closed State Tr Num: 43573

Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: AMLI DC OT SHELF State Status: Approved-Closed
9-2009

Filing Type: Form

Reviewer(s): Rosalind Minor
Author: Nancy French Disposition Date: 09/30/2009
Date Submitted: 09/23/2009 Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: AMLI DC OT SHELF 9-2009

Project Number: AMLI DC OT SHELF 9-2009

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/30/2009

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type: Association

Explanation for Other Group Market Type:

State Status Changed: 09/30/2009

Created By: Nancy French

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Nancy French

Filing Description:

Re: American Medical and Life Insurance Company

NAIC #81418 FEIN #13-2562243

Out-of-State Association Filing of Group Accident and Sickness Benefit Forms:

- AMLI GRP LM 2009 CERT - DC, Certificate of Coverage
- AMLI GRP LM 2009 SCHED - DC, Group Accident and Sickness Health Insurance Certificate Schedule
- GRP LM 2009 AE DC AR (7/09), Amendatory Endorsement

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- AMLI GRP LM 2009 ENRL - DC, Enrollment Form

Dear Commissioner:

Compliance Research Services is pleased to submit the enclosed forms on behalf of American Medical and Life Insurance Company (AMLI). A letter of filing authorization is enclosed.

The purpose of this submission is to allow AMLI to provide group accident and sickness coverage to residents of your state who are members of the National Congress of Employers (NCE), a bona fide association based in the District of Columbia. It is our understanding that the association has been approved by your Department as having met your requirements. Coverage will be provided to individual association members and their dependents. It will not be issued to employers who are affiliated with the association.

The policy provides coverage for accidents, hospital confinement, hospital intensive care unit confinement, surgery, skilled nursing facility confinement, hospital admission, doctor office visit, preventive care, urgent care/emergency room, diagnostic tests, prescriptions, ambulance, mental health, chemical dependency, diabetes, accidental death and dismemberment, dental and term life.

Variable areas of the certificate are set off in brackets. These include "John Doe" information, the ranges of benefits that will be offered, and benefit options.

We have enclosed the certificate of coverage for your review and approval. It includes the mandated benefits required under the laws of the District of Columbia, the jurisdiction of issue of the master policy. The enclosed amendatory endorsement adds provisions that are required for certificates issued to association members who are residents of your state. Members will apply for coverage with the enclosed enrollment form.

The enclosed forms are new and do not replace any forms currently on file with your Department. We have included any transmittals and certifications required by your Department.

The forms are in final format. Initially, the forms will be issued in paper format. AMLI reserves the right to change the type style and paper size. We also request the right to make the forms available electronically. The forms may be used in a variety of electronic environments, including laptop and web based application process. Regardless of the enrollment process used, AMLI will adopt measures to secure both the integrity of the document once signed, and the confidentiality of any information transmitted, including transmission of information via secured socket layer/secured line. Information contained in the enrollment form will be transmitted to AMLI's administrative office electronically as well as the electronic signature of the enrollee. Current technology will be used to ensure that the confidential information is not compromised. All processes used will comply with the Uniform Electronic Transactions Act, and to the extent applicable, the Federal E-SIGN Act.

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AMLI hereby certifies that any electronic signature it obtains will be linked to the data on the electronic enrollment form in such a manner that the electronic signature is invalidated if any of the data on the application is changed. AMLI also certifies that such electronic signature intended for use with this enrollment form will not be affixed to or duplicated on any other document. A paper copy of the completed enrollment form, identical to the filed form, will be available upon request by the enrollee.

If you have questions concerning this filing, please contact me at 513-984-6050 or at dsimon@crssolutionsgroup.com.

Company and Contact

Filing Contact Information

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

Filing Company Information

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

American Medical and Life Insurance Company CoCode: 81418	State of Domicile: New York
8 West 38th Street - Suite 1002	Group Code:
New York, NY 10018	Group Name:
(513) 984-6050 ext. [Phone]	FEIN Number: 13-2562243
	Company Type:
	State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$80.00
 Retaliatory? No
 Fee Explanation: 20 x 4 = 80
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Medical and Life Insurance Company	\$80.00	09/23/2009	30781247

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/30/2009	09/30/2009

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	09/28/2009	09/28/2009	Nancy French	09/29/2009	09/29/2009

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Disposition

Disposition Date: 09/30/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Authorization	Approved-Closed	Yes
Supporting Document	Certification/Notice	Approved-Closed	Yes
Form	Certificate of Coverage	Approved-Closed	Yes
Form	Group Accident and Sickness Health Insurance Certificate Schedule	Approved-Closed	Yes
Form (revised)	Amendatory Endorsement	Approved-Closed	Yes
Form	Amendatory Endorsement	Replaced	Yes
Form (revised)	Enrollment Form	Approved-Closed	Yes
Form	Enrollment Form	Replaced	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 09/28/2009
Submitted Date 09/28/2009

Respond By Date
Dear Nancy French,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certificate of Coverage, AMLI GRP LM 2009 CERT - DC (Form)

Comment:

Since this is a Limited Benefit Plan, please add to the title of the insurance the word "Limited" in front of Group Accident and Sickness Health Insurance.

Thank you for your cooperation.

Please feel free to contact me if you have questions.

Sincerely,
Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 09/29/2009
Submitted Date 09/29/2009

Dear Rosalind Minor,

Comments:

Thank you for your review of the above referenced filing. This letter is intended to address the comments you have raised in connection with the American Medical filing.

Response 1

Comments: The forms have been revised to include the word "Limited" in the title pursuant to your request. Please refer to Amendatory Endorsement form GRP LM 2009 AE DC AR (7/09) and Enrollment form AMLI GRP LM 2009 ENRL DC AR (7/09).

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Related Objection 1

Applies To:

- Certificate of Coverage, AMLI GRP LM 2009 CERT - DC (Form)

Comment:

Since this is a Limited Benefit Plan, please add to the title of the insurance the word "Limited" in front of Group Accident and Sickness Health Insurance.

Thank you for your cooperation.

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
Amendatory Endorsement	GRP LM 2009 AE DC AR (7/09)		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		46.100	AR DC Shelf AE v2.pdf
Previous Version							
Amendatory Endorsement	• GRP LM 2009 AE DC AR (7/09)		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		46.100	AR DC Shelf AE.pdf
Enrollment Form	AMLI GRP LM 2009 ENRL DC AR (7/09)		Application/Enrollment Form	Initial		0.000	AR AMLI GRP LM 2009 ENRL DC Shelf v1.pdf
Previous Version							

<i>SERFF Tracking Number:</i>	<i>CMPL-126317166</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>American Medical and Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>43573</i>
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<i>TOI:</i>	<i>H14G Group Health - Hospital Indemnity</i>	<i>Sub-TOI:</i>	<i>H14G.000 Health - Hospital Indemnity</i>
<i>Product Name:</i>	<i>AMLI DC OT SHELF 9-2009</i>		
<i>Project Name/Number:</i>	<i>AMLI DC OT SHELF 9-2009/AMLI DC OT SHELF 9-2009</i>		
<i>Enrollment Form</i>	<i>AMLI GRP</i>	<i>Application/Enrollment</i>	<i>Initial</i>
	<i>LM 2009</i>	<i>Form</i>	<i>0.000</i>
	<i>ENRL -</i>		<i>AMLI GRP</i>
	<i>DC</i>		<i>LM 2009</i>
			<i>ENRL DC</i>
			<i>Shelf-John</i>
			<i>Doe.pdf</i>

No Rate/Rule Schedule items changed.

thank you

Sincerely,
Nancy French

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Form Schedule

Lead Form Number: AMLI GRP LM 2009 CERT - DC

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/30/2009	AMLI GRP LM 2009 CERT - DC	Certificate	Certificate of Coverage	Initial		49.000	AMLI GRP LM 2009 CERT DC Shelf.pdf
Approved-Closed 09/30/2009	AMLI GRP LM 2009 SCHED - DC	Schedule Pages	Group Accident and Sickness Health Insurance Certificate Schedule	Initial		45.800	AMLI GRP LM 2009 SCHED DC Shelf.pdf
Approved-Closed 09/30/2009	GRP LM 2009 AE DC AR (7/09)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Amendatory Endorsement	Initial		46.100	AR DC Shelf AE v2.pdf
Approved-Closed 09/30/2009	AMLI GRP LM 2009 ENRL DC AR (7/09)	Application/ Enrollment Form	Enrollment Form	Initial		0.000	AR AMLI GRP LM 2009 ENRL DC Shelf v1.pdf

American Medical and Life Insurance Company
New York, New York

GROUP ACCIDENT AND SICKNESS HEALTH INSURANCE

THIS COVERAGE PROVIDES BENEFITS DUE TO ACCIDENT AND SICKNESS. THIS CERTIFICATE EXPLAINS THE BENEFITS PROVIDED UNDER THE GROUP HEALTH INSURANCE POLICY. BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

CERTIFICATE OF COVERAGE

Issued under the terms of

Group Insurance Policy Number: [12345]

**Issued to: [XYZ Company]
(herein called the Holder)**

Policy Date: [January 1, 2006]

American Medical and Life Insurance Company hereby certifies that members of the class(es) eligible for insurance are insured under the above Policy as determined by the Eligibility and Effective Date provisions. Class is defined in the Certificate Schedule.

This Certificate is evidence of insurance provided under the Policy. All benefits are paid according to the terms of the Policy. This Certificate describes the essential features of the insurance coverage.

In this Certificate, the words "Named Insured" or "You" means a member of an eligible class as described on the Certificate Schedule, who is insured under the Policy and for whom premiums are remitted. The words Covered Person refer to any person covered under the Policy as described on the Certificate Schedule. The words We, Us, Our or Company refer to American Medical and Life Insurance Company. Policy means the Group Accident and Sickness Health Insurance contract owned by the Policy Holder and available for review by You. If the terms of Your Certificate of coverage and the Policy differ, the Policy will govern.

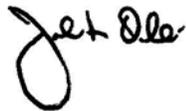
The Policy and this Certificate may be changed in whole or in part or cancelled as stated in the Policy. Such action may be taken without the consent of or notice to any Covered Person. Only an authorized officer at Our home office can approve a change. The approval must be in writing and endorsed on or attached to the Policy. No other person, including an agent, may change the Policy or Certificate or waive any of its provisions. Premiums are subject to periodic changes.

The male pronoun includes the female whenever used.

This Policy is delivered in and governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

TO OBTAIN INFORMATION YOU MAY CALL OUR TOLL FREE NUMBER: [1-800-XXX-XXXX]

For American Medical and Life Insurance Company:



Chairman, President and CEO



Executive Vice President & Chief Compliance Officer

**Please read this Certificate carefully.
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**

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CERTIFICATE SCHEDULE

The benefit specifications are shown on the following attachment(s) which are hereby made a part of this Certificate:

AMLI GRP LM 2007-SCHED - DC Certificate Schedule

GENERAL DEFINITIONS

Additional definitions may be contained in other Certificate benefit provision or any endorsement or rider.

Accident

Accident means an unintended or unforeseen bodily injury sustained by a Covered Person, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition.

Ancillary Services

Ancillary services means standard medical procedures that are reasonably necessary for the diagnosis and treatment of a patient.

Confined or Confinement

Confined or Confinement means the assignment to a bed as a resident inpatient in a Hospital or a licensed Skilled Nursing Facility on the advice of a Physician or Confinement in an Observation Unit within a Hospital for a period of no less than 20 continuous hours on the advice of a Physician.

Covered Accident

A *Covered Accident* is an Accident which:

- occurs after the effective date shown on the Certificate Schedule;
- occurs while this Certificate is in force; and
- is not excluded by name or specific description in this Certificate.

Covered Person(s). You and Your Dependents who are insured under the Group Policy.

Covered Sickness

A *Covered Sickness* means a Sickness which:

- occurs after the effective date shown on the Certificate Schedule;
- occurs while this Certificate is in force; and
- is not excluded by name or specific description in this Certificate.

Doctor or Physician

A *Doctor or Physician* means a legally qualified practitioner of the healing arts acting within the scope of his or her license and is not an Immediate Family Member.

For purposes of this definition, Immediate Family Member means a Covered Person's Spouse, son, daughter, mother, father, sister, or brother.

Emergency services

Emergency services means:

- Health care services furnished in the emergency department of a hospital for the treatment of a medical emergency;
- Ancillary services routinely available to the emergency department of a hospital for the treatment of a medical emergency; and

- Emergency medical services transportation.

Experimental/Investigational

A drug, device or medical care or treatment will be considered experimental/investigational if:

- The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
- Reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine the maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device, medical care or treatment. Benefits will be considered in accordance with the drug or device at the time it is given or when medical care is received.

We will not limit or deny coverage, or impose additional conditions on the payment for the coverage, of routine patient care costs of items, drugs, and services furnished to a Covered Person in connection with participation in an approved clinical trial. We will not pay for costs of items, services, or drugs that are customarily provided by the sponsors of an approved clinical trial,

"Approved clinical trial" means:

- A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
 - (i) The National Institutes of Health;
 - (ii) The Centers for Disease Control and Prevention;

- (iii) The Agency for Health Care Research and Quality;
- (iv) The Centers for Medicare and Medicaid Services;
- (v) A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS; or
- (vi) The Department of Defense, the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;
- A study or investigation approved by the Food and Drug Administration ("FDA"), including those conducted under an investigational new drug or device application reviewed by the FDA; or
- An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

Hospital

A *Hospital* means a short-term, acute general hospital that is:

- primarily engaged in providing, by or under continuous supervision of physicians, to inpatients diagnostic and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a physician or dentist;
- provides 24 hour nursing care by or under the supervision of RNs;
- has in effect a hospital review plan applicable to all patients which meets at least the standards set forth in Section 1861(k) of the United States Public Law 89-97 (42 USCA 1395x[k]);
- is duly licensed by the agency responsible for licensing such hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitatory care.

Hospital Intensive Care Unit

A *Hospital Intensive Care Unit* means a place which:

- is a specifically designated area of the Hospital called an Intensive Care Unit that is restricted to patients who are critically ill or injured and who require intensive, comprehensive observation and care;

- is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement
- is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the Intensive Care Unit on a 24-hour basis; and
- has a Physician assigned to the Intensive Care Unit on a full-time basis.

A Hospital Intensive Care Unit that meets the definition above may include Hospital units with the following names:

- Intensive Care Unit;
- Coronary Care Unit;
- Neonatal Intensive Care Unit;
- Pulmonary Care Unit;
- Burn Unit;
- Transplant Unit.

A Hospital Intensive Care Unit is not any of the following step-down units:

- a progressive care unit;
- an intermediate care unit;
- a private monitored room;
- a sub-acute Intensive Care Unit;
- an Observation Unit; or
- any facility not meeting the definition of a Hospital Intensive Care Unit as defined in this Certificate.

Medical Emergency

Medical emergency means the sudden onset or sudden worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Medically Necessary

Medically Necessary means a service or supply that is necessary and appropriate for the diagnosis or treatment of an Injury or Sickness based on generally accepted current medical practice. A service or supply will not be considered Medically Necessary if:

- it is provided only as a convenience to the Covered Person or provider;
- it is not appropriate treatment for the Covered Person's diagnosis or symptoms;
- it exceeds in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or

- it is experimental/investigational treatment.

The fact that a Physician may prescribe, authorize, or direct a service does not, of itself, make it Medically Necessary or covered by the Policy.

Named Insured

A *Named Insured* is a person who is a member of an eligible class and holds a certificate of coverage.

Observation Unit

An *Observation Unit* is a specified area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a Physician; and which

- is under the direct supervision of a Physician or registered nurse; and
- is staffed by nurses assigned specifically to that unit; and
- provides care seven days per week, 24 hours per day.

Policy Year

Policy Year means a consecutive 12-month period or any part of such period, beginning on the Certificate Effective Date and ending on the Certificate Anniversary Date as shown on the Certificate Schedule.

[Pre-existing Condition

Pre-existing condition means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received from a physician within a [6] month period preceding the effective date of coverage of the Covered Person.]

[Resource Based Relative Value System, referred to as RBRVS.

The methodology used by the federal government to determine benefits payable under Medicare. Medicare assigns a "Relative Value Unit" or RVU to thousands of procedure codes used to bill physician and other services. The total RVU is the sum of three component RVUs including the Work RVU, the Practice Expense RVU and the Malpractice RVU. The Work RVU takes into account factors such as the amount of time required to perform the service and the degree of skill required to perform it. The Practice Expense RVU takes into account the location of the service, e.g., office setting, outpatient setting, etc. The Malpractice RVU takes into account the malpractice cost associated with a particular practice. We will base benefits payable on RBRVS.]

Sickness

Sickness means an illness, infection, disease or any other abnormal physical condition not caused by an Accident.

Skilled Nursing Facility

Skilled Nursing Facility means a facility that is operated pursuant to law and is primarily engaged in providing

room and board accommodations and skilled nursing care under the supervision of a duly licensed Physician.

Waiting Period

Waiting period means the period of time a person must be [an active, full-time employee] [a member in good standing] of the Holder before becoming eligible for coverage. The Waiting Period is shown on the Certificate Schedule.

ELIGIBILITY AND EFFECTIVE DATE

Effective Dates of Coverage

Your coverage under the Policy will start at 12:01 a.m. Standard Time on the effective date of coverage shown on Your Certificate Schedule.

Eligibility

To be eligible to enroll in the coverage, an individual must:

- be a member of an eligible class as defined on the Certificate Schedule; and
- satisfy the waiting period shown on the Certificate Schedule, if applicable.

Enrollment

An individual who is a member of an eligible class may enroll for coverage during the eligibility period, as shown on the Certificate Schedule that follows the later of:

- the Certificate Effective Date;
- the date the individual first becomes a member of an eligible class;
- the date the individual completes the waiting period shown on the Certificate Schedule, if applicable.

An individual who fails to enroll during the eligibility period may enroll only during the annual Open Enrollment Period shown on the Certificate Schedule.

Delayed Effective Date of Coverage

The effective date of any Named Insured's coverage will be delayed for any Named Insured if they are not a member of an eligible class on the effective date shown on the Certificate Schedule. The coverage will be effective on the date that the Named Insured returns to status as a member of an eligible class. If this is Named Insured and Spouse coverage or family coverage, coverage on the Spouse and/or Dependent children will be effective on the date that the Named Insured returns to status as a member of an eligible class.

Who is Covered By This Certificate

If this is Named Insured coverage as shown on the Certificate Schedule, We insure You, the Named Insured.

If this is Named Insured and Spouse coverage as shown on the Certificate Schedule, We insure You and Your Spouse.

If this is family coverage, as shown on the Certificate Schedule, We insure You, Your Spouse (if applicable), and Your Dependent children.

Spouse means the person married to You on the day We issue Your Certificate.

Dependent children means:

- any unmarried natural children, step-children, legally adopted children or children placed into Your custody for adoption who is under the age of 19 years of age; and
- any unmarried children who are 19 years of age to age 26 years of age if the child:
 - a. is attending an accredited school full-time; and
 - b. chiefly dependent upon you for support and maintenance.

Adopted children and step children will be eligible for coverage on the same basis as natural children.

Coverage on a Dependent child will continue for a covered student who takes a leave of absence from school due to illness for a period of 12 months from the last day of attendance in school. However, coverage will not continue beyond the age at which coverage would otherwise terminate. In order to qualify for this continuation, the medical necessity of a leave of absence from school must be certified to by the student's attending Physician. Written documentation of the illness must be submitted to Us.

Coverage for the Named Insured's newborn children:

A child born to You or Your insured Spouse will automatically become insured as a Dependent. The child must be born to the Named Insured or to his Spouse while this Policy is in force. We will cover each newborn child from the moment of live birth. Such coverage includes:

- the necessary care and treatment of medically diagnosed congenital defects;
- birth abnormalities;
- prematurity.

Coverage for the Named Insured's adopted child(ren):

We will cover the Named Insured's adopted child(ren) from the moment of birth if You take physical custody of the infant upon the infant's release from the hospital and consent to the adoption has not been revoked. However, coverage of the initial hospital stay shall not be required where a natural parent has insurance coverage available for the infant's care.

A child adopted by You or Your insured Spouse will automatically become insured as a dependent. The effective date of the coverage will be the earlier of:

- the date of placement for the purpose of adoption; or

- the date on which You assume a legal obligation for total or partial support of the child.

Coverage for adopted children will be to the same extent as provided for other covered dependent children and will include the necessary care and treatment of pre-existing medical conditions.

Coverage will continue for the adopted child unless the placement is disrupted prior to the final adoption; and

- the child is permanently removed from placement;
- the legal obligation terminates; or
- You rescind, in writing, the agreement of adoption or agreement assuming financial responsibility.

For each newborn, step child and/or adopted child, You must:

- notify Us of his birth or placement in Your residence within 31 days of this occurrence;
- complete the required application for him; and
- pay the required premium for him, if any.

If a newborn is not enrolled within 31 days of birth coverage will be provided from the date that notice is given. Any additional premium required should be made to the Holder within 31 days of notification of birth or placement for the purposes of a step child and/ or adoption.

DESCRIPTION OF BENEFITS

[ACCIDENT MEDICAL BENEFIT

We will pay the Accidental Medical Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges due to injuries received in a Covered Accident. Covered charges are subject to:

- Accident Medical Benefit Deductible;
- The Accident Medical Benefit percent;
- Accident Medical Maximum Benefit amount; and
- the provisions of this Policy.

The Deductible, Accident Medical Benefit percent and Maximum Benefit for the Accident Medical Benefit are shown in the Certificate Schedule.

Covered charges for this benefit are:

- Hospital room and board and general nursing services;
- Hospital miscellaneous expense for medical services and supplies including emergency services;
- operating and recovery room;
- Physician charges for medical treatment including performing a surgical procedure;
- diagnostic tests performed by a Physician including laboratory fees and x-rays;
- the cost of giving an anesthetic;
- a private duty nurse;

- prescription drugs;
- rental of durable medical equipment (if the purchase price is less than the rental, the maximum amount payable will be the purchase price);
- artificial limbs, eyes and other prosthetic devices, except replacement;
- casts, splints, trusses, crutches and braces, except dental braces;
- oxygen and rental of equipment for the administration of oxygen;
- physiotherapy given by a licensed physical therapist acting within the scope of their license.

If a Covered Person is injured in a Covered Accident, this Accident Medical Benefit will cover any remaining expenses, not covered by the group policy according to the Schedule of Benefits and Policy Provisions.

The Accident Medical Benefit will be paid after other Benefits available under the Group Accident and Sickness Health Insurance has been exhausted.]

[HOSPITAL CONFINEMENT BENEFITS

Hospital Confinement Benefit

We will pay the Hospital Confinement Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and is Confined in a Hospital due to injuries received in a Covered Accident or due to a Covered Sickness. The Confinement to a Hospital must begin while the coverage is in force.

We will pay the amount shown on the Certificate Schedule for each day the Covered Person is confined, up to the Hospital Confinement Maximum Benefit shown on the Certificate Schedule.

We will not pay this benefit for:

- emergency room treatment;
- outpatient treatment; or
- Confinement of less than 20 hours to an Observation Unit.

We will not pay the Hospital Confinement benefit and the Hospital Intensive Care Unit Confinement benefit concurrently.

We will not pay for any Hospital Confinement of a newborn child of a Covered Person following birth unless the child is injured or sick.

Written proof of loss should include a Hospital bill verifying the patient's name, the dates of Hospital Confinement, the diagnosis and the charges incurred.]]

[Hospital Intensive Care Unit Confinement Benefit

We will pay the Hospital Intensive Care Unit Confinement Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and is Confined to a Hospital Intensive Care Unit as the result of injuries

received in a Covered Accident or due to a Covered Sickness. The Confinement to a Hospital Intensive Care Unit must begin while the coverage is in force.

We will pay the Hospital Intensive Care Unit benefit amount shown on the Certificate Schedule for each day a Covered Person is Confined, up to the Hospital Intensive Care Unit Maximum Benefit shown on the Certificate Schedule.

If a Covered Person is Confined to a Hospital care unit that does not meet the definition of a Hospital Intensive Care Unit, We will pay the Hospital Confinement benefit up to the maximum benefit period shown on the Certificate Schedule. We will not pay the Hospital Intensive Care Unit Confinement benefit and the Hospital Confinement benefit concurrently.

We will not pay for any Hospital Confinement of a newborn child of a Covered Person following birth unless the child is injured or sick.

Written proof of loss should include a Hospital bill verifying the patient's name, the dates of Hospital Confinement, the diagnosis and the charges incurred.]]

[Surgery With Anesthesia Benefit

We will pay the Surgery Benefit, shown on the Certificate Schedule, if any Covered Person undergoes a surgical procedure due to a Covered Accident or Covered Sickness. The procedure must be performed by a Physician using anesthesia administered by a licensed anesthesiologist or certified registered nurse anesthetist (CRNA). We will pay this benefit once per covered surgical procedure. If a Covered Person has more than one surgical procedure performed at the same time, We will pay only one surgical procedure benefit, even if caused by more than one Accident or Sickness. We will pay the benefit that has the highest dollar value. The surgical procedure must occur while the coverage is in force.

The Anesthesia Benefit is the surgery benefit times the percentage shown in the Certificate Schedule.

If a Covered Person has more than one surgery for the same Covered Accident or Covered Sickness in a 90-day time period, We will pay the benefit that has the highest dollar value. If We have already paid a lower benefit amount for the same Covered Accident or Covered Sickness, We will deduct the amount paid from the higher benefit amount and pay the difference.

Written proof of loss should include the surgeon's and the anesthesiologist's or certified registered nurse anesthetist's (CRNA's) itemized statement(s) verifying the patient's name, the surgical procedure code(s), the date of treatment, the diagnosis and the charges incurred.

This benefit is subject to the Surgery Maximum Benefit shown on the Certificate Schedule.

This benefit will not be paid for surgeries performed without anesthesia.]

[SKILLED NURSING FACILITY BENEFIT

We will pay the Skilled Nursing Facility Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and is Confined in a Skilled Nursing Facility due to injuries received in a Covered Accident or due to a Covered Sickness. Payment of this benefit will be in lieu of any Hospital Confinement benefit.

We will pay the Skilled Nursing Facility Benefit, shown on the Certificate Schedule, for each day a Covered Person is Confined, up to the Skilled Nursing Maximum Benefit shown on the Certificate Schedule.

We will not pay this benefit for:

- emergency room treatment;
- outpatient treatment; or
- Confinement of less than 20 hours to an Observation Unit.

We will not pay the Skilled Nursing Facility benefit, if the Covered Person is Hospital Confined.]

[HOSPITAL ADMISSION BENEFIT

We will pay the Hospital Admission Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges and is admitted to a Hospital as the result of injuries received in a Covered Accident or Covered Sickness while this coverage is in force. If admission is due to a Covered Accident, the Covered Person must be admitted within [six] [months] after the Covered Accident.

If a Covered Person is admitted to a Hospital and is discharged and admitted again for the same or related condition within 90 days, We will treat this later Hospital admission as a continuation of the previous Confinement. If more than 90 days have passed between the periods of Hospital Confinement, We will treat this later admission as a new and separate admission.

We will not pay this benefit for:

- emergency room treatment;
- outpatient treatment; or
- A stay of less than 20 hours in an Observation Unit.

This benefit is subject to the Hospital Admission Benefit Maximum Benefit, shown on the Certificate Schedule.]

DOCTOR'S OFFICE VISIT BENEFITS

Doctor's Office Visit

We will pay the Doctor's Office Visit Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and requires a Doctor's office visit due to

injuries received in a Covered Accident or due to a Covered Sickness. The visit must occur:

- while the coverage is in force; and
- after the waiting period. No benefits will be paid for visits during the waiting period.

For a visit due to injuries received in a Covered Accident, the visit must occur within 72 hours after the date of the Covered Accident.

Services must be rendered by a licensed Physician acting within the scope of their license.

Doctor's office visits include habilitative services for children if any Covered Person under the age of 21 years incurs charges for habilitative services. Benefits will not be provided for habilitative services actually delivered through early intervention or school services.

For the purposes of this provision, "habilitative services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function.

We will pay the Doctor's Office Visit benefit amount per visit shown on the Certificate Schedule, up to the Doctor's Office Visit Benefit Maximum Benefit, shown on the Certificate Schedule.

Written proof of loss should include bills verifying the patient name, the date of treatment, the diagnosis and the charges incurred.

PREVENTIVE CARE TEST BENEFIT

We will pay the Preventive Care Test Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and has one of the preventive care tests listed below performed:

- while the coverage is in force; and
- after the waiting period. No benefits will be paid for a Preventive Care Test performed during the waiting period.

This benefit is not subject to the limitations and exclusions listed in the Limitations and Exclusions section of this Policy.

We will pay the Preventive Care Test Benefit listed on the Certificate Schedule for one of only the following Preventive Care Tests (also referred to as "Tests" or "Test")

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy or virtual colonoscopy

- Eye exam performed by a licensed optometrist or ophthalmologist
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- PSA (blood test for prostate cancer)
- Serum Protein Electrophoresis (blood test for myeloma)
- Stress test on a bicycle or treadmill
- Thermography
- A baseline mammogram for women;
- An annual screening mammogram for women;
- An annual cervical cytologic screening for women;
- A cervical cytologic screening for women upon certification by an attending Physician that the test is Medically Necessary;
- A colorectal cancer screening that is in compliance with American Cancer Society colorectal cancer screening guidelines; and
- A prostate cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society for the ages, family histories, and frequencies referenced in such guidelines.
- for child health screening services for a Covered Person from birth to age 21. Services will be consistent with the standards and schedules of the American Academy of Pediatrics.

This benefit is subject to the Preventive Care Test Benefit Maximum Benefit shown on the Certificate Schedule.

Written proof of loss should include a billing statement from the medical provider conducting the test, verifying the patient's name, the type of Preventive Test performed and the date of treatment.

For the purposes of this provision:

- "Baseline mammogram" means a screening mammogram that is used as a comparison for future examinations;
- "Screening mammogram" means a low dose x-ray used to visualize the internal structure of the breast; and
- "Cytologic screening" means a pap test to detect cervical cancer through the simple microscopic examination of cells scraped from the surface of the cervix.

[URGENT CARE/EMERGENCY ROOM VISIT BENEFIT

We will pay the Urgent Care/Emergency Room Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and requires medical care from an urgent care facility or emergency room due to injuries received in a Covered Accident or due to a Covered Sickness. The visit must occur:

- while the coverage is in force; and
- after the waiting period. No benefits will be paid for visits during the waiting period.

For a visit due to injuries received in a Covered Accident, the visit must occur within 72 hours after the date of the Covered Accident.

Services must be rendered by a Physician.

We will pay the Urgent Care/Emergency Room benefit amount shown on the Certificate Schedule, up to the Urgent Care/Emergency Room Benefit Maximum Benefit, shown on the Certificate Schedule.

Written proof of loss should include bills verifying the patient name, the date of treatment, the diagnosis and the charges incurred.]

[DIAGNOSTIC, X-RAY AND LABORATORY TESTS BENEFIT

We will pay the Diagnostic Test Benefit shown on the Certificate Schedule when a Covered Person incurs charges for diagnostic, x-ray and/or laboratory testing caused by a Covered Accident or Covered Sickness.

Benefits are payable on a per day basis and are subject to:

- the Diagnostic Test Benefit amount per day;
- the maximum number of testing days per Policy Year, per Covered Person; and
- the definitions, limitations, exclusions and other provisions of the Policy.

The Diagnostic Test must be performed:

- while the coverage is in force;
- in a Hospital, ambulatory surgical center or Doctor's office; and
- after the waiting period. No benefits will be paid for a diagnostic test performed during the waiting period.

The Diagnostic Test must be ordered by a Physician because of a Covered Accident or Covered Sickness.

Benefits are payable subject to the Maximum Number of Testing days per Policy Year for each Covered Person shown in the Certificate Schedule.

This benefit is subject to the Diagnostic Tests, X-ray and Laboratory Benefit Maximum Benefit shown on the Certificate Schedule.

We will not pay the Preventive Care Test Benefit and the Diagnostic Test Benefit concurrently.

Benefits for Colonoscopy Test are limited to one test per Policy Year per Covered Person.

If a Covered Person has a procedure for which a benefit would be payable under the Surgery With Anesthesia benefit, We will pay only the Surgery With Anesthesia benefit.

Written proof of loss should include a billing statement from the medical provider conducting the Diagnostic Test, verifying the patient's name, the type of Diagnostic Test performed, the diagnosis and the charges incurred and the date of treatment.]

[PRESCRIPTION BENEFIT

We will pay the Prescription Benefit, shown on the Certificate Schedule, for a Covered Accident or Sickness if a Covered Person incurs charges for and has a prescription dispensed for medication prescribed for the Covered Person:

- while the coverage is in force; and
- after the waiting period. No benefits will be paid for a prescription ordered or dispensed during the waiting period.

The prescription must be ordered by a Physician and dispensed by a licensed pharmacist.

This benefit will be paid for any hormone replacement therapy that is prescribed or ordered for treating symptoms and conditions of menopause.

We will not pay this benefit for medication not requiring a prescription. Medication recommended by a Physician but which is available without a prescription (over the counter) will not be covered, even if the Physician writes a prescription for the over-the-counter medication.

This benefit is subject to the Prescription Benefit Maximum Benefit, shown on the Certificate Schedule.

Proof of Loss for the Prescription Benefit

Written proof of loss should include a pharmacy detailed receipt or mail order pharmaceutical statement showing the patient's name, the name of the prescription drug(s), the date the prescription(s) was filled and the charge(s) incurred.]

[AMBULANCE BENEFIT

We will pay the Ambulance Benefit shown on the Certificate Schedule, if a licensed professional ambulance company transports a Covered Person by ground or air transportation to or from a Hospital or between medical facilities, where treatment is received as the result of a Covered Sickness or Accident. The Covered Person must incur charges while the coverage is in force for professional ambulance service to receive this benefit. The ambulance transportation must be within 90 days after a Covered Sickness or Accident. We will pay this amount once per Covered Sickness or Accident.

This benefit is subject to the Ambulance Benefit Maximum Benefit, shown on the Certificate Schedule.]

MENTAL HEALTH BENEFITS

Inpatient Benefits

For Inpatient Benefits, We will pay the Mental Health Inpatient Benefit, shown on the Certificate Schedule, for each day of confinement if a Covered Person is confined to a Hospital or licensed institution to provide treatment for Mental Illness.

Benefits are subject to the Mental Health Inpatient Benefit Maximum Benefit shown on the Certificate Schedule.

Outpatient Benefits

For Outpatient Benefit, We will pay the Mental Health Outpatient Benefit, shown on the Certificate Schedule, for Covered Persons receiving treatment as a result of Mental Illness.

Benefits are subject to the Mental Health Outpatient Benefit Maximum shown on the Certificate Schedule.

Mental Illness means any mental condition including but not limited to affective disorders, neuroses, anxiety, stress, adjustment reactions, Alzheimer's disease and other organic senile dementias.

We will not pay any benefit for stays in a Half-Way house or other place that is not a licensed facility offering treatment for Mental Illness.

CHEMICAL ABUSE AND DEPENDENCY DIAGNOSIS AND TREATMENT BENEFIT

We will pay the Chemical Abuse and Dependency Diagnosis and Treatment Benefit, shown on the Certificate Schedule for Covered Persons receiving services provided in facilities which are accredited by the joint commission on accreditation of hospitals as alcoholism, substance abuse or chemical dependence treatment programs, for the treatment of Chemical Abuse and Chemical Dependency.

Benefits for detoxification services as a consequence of chemical dependence are subject to the Detoxification Maximum Benefit, shown on the Certificate Schedule, of 12 days of active treatment per Policy Year per Family.

Benefits for rehabilitation services are subject to the Rehabilitation Maximum Benefit, shown on the Certificate Schedule, of 60 days of inpatient care per Policy Year per Family.

For Outpatient Benefit, We will pay the Chemical Abuse and Dependence Outpatient Benefit, shown on the Certificate Schedule, for Covered Persons receiving outpatient services for Chemical Abuse and Dependency.

The term "chemical abuse" means alcohol and substance abuse.

DIABETES SUPPLIES, EQUIPMENT AND SELF-MANAGEMENT EDUCATION BENEFIT

We will pay the Diabetes Supplies, Equipment and Self-Management Education Benefit, shown on the Certificate Schedule, if any Covered Person incurs charges for the equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a Physician legally authorized to prescribe such item.

[[ACCIDENTAL DEATH [AND DISMEMBERMENT] BENEFIT

[Accidental Death Benefit

We will pay the Accidental Death Benefit, shown on the Certificate Schedule if a Covered Person is injured as the result of a Covered Accident, and the injury causes the Covered Person to die within 90 days after the Covered Accident.]

[Dismemberment Benefit

We will pay the Dismemberment Benefit amount shown on the Certificate Schedule if a Covered Person is injured as the result of a Covered Accident. Loss must occur within 90 days after the Covered Accident.

Only one amount will be paid for all losses resulting from one Accident. We will pay the largest benefit amount to which the Covered Person is entitled. Payment will be made to the Covered Person, or in the event of his death, to the named beneficiary.]

Proof of Loss

We must be given written proof of loss within 90 days after the covered loss occurs. If an authorized representative is not able to give Us written proof of loss within 90 days, it will not have a bearing on the claim if proof is given to Us as soon as it is reasonably possible except in the absence of legal capacity. Written proof of loss must include a claim form and if loss is due to death of a Covered Person, a certified copy of the death certificate.

Beneficiary

In the event of a benefit payable due to the Named Insured's death, the Accidental Death benefit will be paid to the Named Insured's beneficiary. The beneficiary is the person the Named Insured designated in the enrollment form as the beneficiary, unless it was changed at a later date. If a beneficiary was not named or if the person named is not living at the Named Insured's death, any Accidental Death benefit due will be paid in this order to:

The Insured's Spouse; or children; or parents; or brothers and sisters; or estate. In the event of a benefit payable due to the death of a Spouse or Dependent child, the Accidental Death benefit will be paid to the Named Insured, if living, otherwise to the estate of the insured Spouse or Dependent child.

If benefits are payable to a Covered Person's estate, We can pay benefits up to \$1,000 to someone related to the Covered Person by blood or marriage who We feel is fairly entitled to them. If We do this, We will have no responsibility for this payment because We made it in good faith.

Change of Beneficiary

The Named Insured can ask Us to change their beneficiary at any time. The Insured should notify Us, and We will send him the form to complete. The request must be witnessed by someone other than his present beneficiary or his proposed beneficiary and returned to Us at Our home office. The change must be approved by Us. If approved, it will go into effect the day he signed the request. The change will not have a bearing on any payment We make before We receive it.]

[DENTAL BENEFIT

We will pay the Maximum Covered Charge for the corresponding Dental Procedure listed on the Certificate Schedule for any Covered Person receiving the dental procedure. Any procedure not listed is excluded. If one or more of the listed procedures would be appropriate according to customary dental practice, the Maximum Covered Charge will be the amount allowable for the lesser charge.]

[TERM LIFE BENEFIT

We will pay the Term Life Benefit, shown on the Certificate for any Covered Person, who dies.]

LIMITATIONS AND EXCLUSIONS

We will not pay benefits for:

Treatment, services or supplies which:

- Are not Medically Necessary;
- Are not prescribed by a Doctor as necessary to treat Sickness or injury;
- Are experimental/investigational in nature, except as required by law;
- Are received without charge or legal obligation to pay; or
- Is provided by an immediate family member.

Additional Limitations and Exclusions

Except as specifically provided for in this Policy or any attached Riders, We will not pay benefits for Sickness or injuries that are caused by:

[Dental Procedures –Dental care or treatment except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.]

Elective Procedures and Cosmetic Surgery – Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. In the case of a Covered Person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, We will pay the Surgery Benefit, shown on the Certificate Schedule for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications at all stages of mastectomy, including lymphedemas.

Felony or Illegal Occupation Commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

[Manipulations of the Musculoskeletal System –care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation or of or in the vertebral column.]

Suicide or Injuries Which Any Covered Person Intentionally Does to Himself- suicide, attempted suicide or intentionally self-inflicted injury.

War or Act of War. War or act of war (whether declared or undeclared; participation in a felony, riot or insurrection; service in the Armed Forces or units auxiliary thereto. Losses as a result of acts of terrorism committed by individuals or groups will not be excluded from coverage unless the Covered Person who suffered the loss committed the act of terrorism.

Worker's Compensation –benefits provide under any State or Federal workers' compensation, employers' liability or occupational disease law.

[Pre-existing Condition Limitation

There is no coverage for a pre-existing condition for a continuous period of [6] months following the effective date of coverage under this Policy.

This limitation does not apply to:

- genetic information in the absence of a diagnosis of the condition related to such information;
- a newborn child who is enrolled in the plan within 30 days after birth; nor to a child who is adopted or placed for adoption before attaining 18 years of age; and as of the last day of the 30-

day period beginning on the date of birth, adoption or placement for adoption, is covered under creditable coverage; and

- pregnancy.

In determining whether a pre-existing condition limitation applies, We will credit the time the Covered Person was previously covered under creditable coverage, if the previous creditable coverage terminated less than 63-days prior to the effective date of the Covered Person's coverage under the Policy.

Creditable coverage includes (a) a group health plan; (b) health coverage; (c) Part A or Part B of title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) Chapter 55 of title 10, United States Code; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under chapter 89 of title 5, United States Code; (i) a public health plan, including health coverage provided under a plan established or maintained by a foreign country or political subdivision (as defined in regulations); (j) a health plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)) and coverage under S-CHIP.]

TERMINATION OF INSURANCE

Termination of a Named Insured's Coverage

The coverage on a Named Insured will terminate on the earliest of the following dates:

- the date the Policy terminates; or
- midnight on the last day, for which premium was paid, if premium is not paid by the end of the grace period, or
- 90 days after the date written notice was provided that the Named Insured is no longer in an eligible class; or
- the date the Named Insured's class is no longer included for insurance; or
- on the date the Named Insured asks Us to end their coverage.

If We discontinue to offer this coverage to a particular class we will provide the class the option to purchase other coverage currently offered in such market without regard to the claims experience of the class or any health related status to any insureds covered or new insureds who may become eligible for such coverage.

Extension of Benefits

Termination of coverage will not affect any claim that began while the coverage was in force.

If a Covered Person is Confined in a Hospital on the date coverage terminates We will continue to pay any applicable benefits until the earlier of

- the date the Covered Person is discharged from the Hospital; or
- 90 days after the date the coverage terminates.

When Coverage Ends on the Named Insured's Spouse and/or Dependents

If this is Named Insured and Spouse coverage or two-parent family coverage, coverage on the Named Insured's Spouse will end:

- if the Policy terminates;
- if the premiums are not paid for the Named Insured's Spouse when they are due;
- on the date the Named Insured asks Us to end their Spouse's coverage;
- on the date the Named Insured dies; or
- on the date the next premium is due after the Named Insured divorces their Spouse.

If this is family coverage, coverage on the Named Insured's dependents will end:

- if the Policy terminates;
- if the premium is not paid for the Named Insured's dependents when it is due;
- on the date the Named Insured asks Us to end their Dependent coverage; or
- on the date the Named Insured dies.

Coverage will end on each Dependent child when they no longer qualify as a Dependent as defined in the Certificate. It is the Named Insured's responsibility to notify Us if any Dependent no longer qualifies as an eligible Dependent. If this is family coverage and all of the dependents no longer qualify as eligible dependents and We are not notified, the extent of Our liability will be to refund premium for the time period for which they did not qualify. Coverage will not end on a Dependent child who reaches the limiting age if that child is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation as defined in the mental hygiene law or physical handicap and who became so incapable prior to the attainment of the age at which dependent coverage would otherwise terminate and who is dependent upon such employee or member for support and maintenance. Proof of retardation or the disability and dependency must be furnished to Us within 31 days of the child's attainment of the limiting age and subsequently, as may be required by Us. However, proof may not be required more often than annually after the first 2 years following the child's attainment of the limiting age.

PREMIUMS

When and Where to Pay Premiums

The premiums for the coverage must be paid to Us at Our home office when they are due. The initial rates for the coverage provided by the Policy are shown on the Certificate Schedule.

The premium due dates are based on:

- the effective date of the coverage shown on the Certificate Schedule; and
- the premium frequency.

The *premium frequency* is how often the premiums are paid.

Grace Period (If Premiums Are Not Paid When Due)

After the first premium, if the premium is not paid when it is due, it can be paid during the next 31 days. These 31 days are called the grace period. If the premium is not paid before the grace period ends, the coverage provided by the Policy will terminate at midnight on the last day for which premium was paid.

Our Right to Change Premiums

We have the right to change the premium We charge. If We plan to make a change, We will send You a notice at least 45 days before We make it.

A change in premium rate will not take effect before the end of the rate guarantee period shown on the Certificate Schedule. Provided, however, We may change premium rates at any time for reasons which affect the risk assumed, including the reasons shown below:

- a change occurs in the plan design;
- a division, subsidiary, or affiliated company is added or deleted;
- a substantial change occurs in the participation level of those eligible employees;
- the number of insureds changes by 25% or more; or
- a new law or a change in any existing law is enacted which applies to this plan.]

GENERAL PROVISIONS

Entire Contract; Changes

The Policy is a legal contract between the Holder and Us. The Policy is issued in consideration for the application(s) and payments, called premiums.

Whenever We use the word Policy, We mean the entire contract. The entire contract consists of:

- the Policy, the Certificate including the Certificate Schedule;
- the application(s), if any; and
- any attached riders or endorsements.

Riders and endorsements add provisions to or change the terms of the Policy.

Any changes made to the Policy must be attached in writing and signed by one of Our executive officers at Our home office. No agent or anyone else can change the coverage provided by the Policy or waive any of its provisions.

Incontestability

Any statement made by the Holder or a Named Insured, except for fraudulent misstatements, is considered a representation and not a warranty. A copy of the statement will be provided to the Holder or the Named Insured, whoever made the statement. No statement will be used to contest the Policy, the validity of coverage or reduce benefits unless it is in writing, signed by the Holder or Named Insured.

Coverage Provided by the Policy

We insure a Covered Person for loss according to the provisions of the Policy.

When making a benefit determination under the Policy, We have discretionary authority to determine the Covered Person's eligibility for the benefits and interpret the terms and provisions of the Policy.

Conformity with State Statutes

If any provision of the Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

HOW TO FILE A CLAIM/CLAIM PROVISIONS

How to File a Claim

A claim form must be completed within 90 days after the covered loss begins or as soon as it is reasonably possible. The claim form, along with proof of loss, should be sent to Us at Our home office.

If the Named Insured does not have a claim form, he must give Us a written statement describing the loss within 90 days after the covered loss begins or as soon as it is reasonably possible. The statement should include his name and Certificate Schedule Number as shown in the Certificate Schedule. It must also include proof of loss and how the loss occurred. The Named Insured should send the statement to Us at Our home

office. When We receive the statement describing the loss, We will send him claim forms within 15 days. If he does not receive claim forms, his written statement along with the proof of loss will be used to process his claim.

Proof of Loss

The Named Insured must give Us a written proof of loss within 90 days after the covered loss begins. If he is not able to give Us written proof of loss within 90 days, it will not have a bearing on this claim if proof is given to Us as soon as it is reasonably possible, except in the absence of legal capacity.

Refer to the applicable benefit section(s) for written proof of loss requirement.

Payment of Claim

Benefits will be paid to the Named Insured or to the designated beneficiary on record. If no named beneficiary is on record with Us all or any part of the benefits owed will be paid to the estate. In lieu of paying benefits to the estate We may, at Our option, pay benefits to any one or more of the following surviving relatives:

- spouse;
- mother;
- father
- child or children; and
- brothers or sisters.

If there are no survivors in any of these classes, We may pay benefits for expenses on account to a Hospital or Doctor's office or other person actually supporting him or her and who is deemed by Us to be entitled to payment. Any payments made in good faith will end Our liability to the extent of the payment.

Time of Payment of Claim

We will pay any benefits due not more than 60 days after We receive written proof of loss.

Physical Examinations

We can require that any Covered Person be examined by a Physician of Our choice at Our expense as often as it is reasonably necessary while his claim is pending.

Legal Action

We cannot be sued for benefits under the Policy until 60 days after written proof of loss has been given as required by the Policy or the expiration of 3 years from the time We receive written proof of loss.

**American Medical and Life Insurance Company
New York, New York**

GROUP ACCIDENT AND SICKNESS HEALTH INSURANCE CERTIFICATE SCHEDULE

[Named Insured: [John Employee]]

Certificate Schedule Number: [123]

Group Policy Number: [12345]

Policy Holder: [XYZ Company]

Certificate Effective Date: [January 1, 2006]

Certificate Anniversary Date: [January 1, of each year]

Open Enrollment Period: [January 1] through [December 31] during each Policy Year

1. Description of Eligible Classes

[[I. - All employees of [XYZ Company] who are working a minimum of [15 – 20] hours per week.]

[Active Employment means the named insured is working at the worksite for earnings that are paid regularly, and he is performing the material and substantial duties of his regular occupation. Normal vacation is considered active employment. The worksite must be:

- . • At the usual place of business;
- . • An alternative worksite; or
- . • A location to which the named insured's job requires him to travel.]

[I. - All active members of [ABC Association] as determined by bylaws or charter of the Association]

[II. Dependents of Named Insured as defined in the Policy.]

2. Eligibility Period: [31 days]

3. Waiting Period [0-90] days

4. Plan Type: [Employer/Association-Paid – Employer/Association Contributions 1 - 100 %] [Voluntary]

5. Coverage: [Named Insured] [Named Insured and Spouse] [Family]

6. Benefits:

[Accident Medical Benefit	
Accident Medical Benefit Deductible	[\$[250] per Policy Year per Covered Person
Accident Medical Benefit	[80]%
Accident Medical Maximum Benefit	[\$[500] per Policy Year per Covered Person]
[Hospital Confinement Benefits	
Hospital Confinement Benefit	[\$[300] per day of confinement
Maximum Benefit	[60] days per Policy Year per Family]
[Hospital Intensive Care Unit Confinement Benefit	[\$[600] per day of confinement
Maximum Benefit Period	Up to [15] days per Policy Year per Family]

[Surgery Benefit	
[Option 1: Maximum Benefit per Surgery	The lesser of the charge incurred or; \$[3,500]
Maximum Benefit	\$[20,000]] per Policy Year per Family]
[Option 2: Maximum Benefit per Surgery	[50% - 100%] [2006] RBRVS
Maximum Benefit	\$[3,500]] per Policy Year per Family]
Anesthesia Benefit	[25] % of surgical benefit.]
[Skilled Nursing Facility Benefit	
Skilled Nursing Facility Benefit	\$[200] per day of confinement
Maximum Benefit	Up to [60] days per Policy Year per Family]
[Hospital Admission Benefit	
Hospital Admission Benefit	\$[250 - \$2,000] per admission
Maximum Benefit	\$[2,000 – 10,000 in \$1,000 increments] per Policy Year per Family]
<u>Doctor's Office Visit Benefits</u>	
Doctor's Office Benefit	\$[50] per visit
Maximum Benefit	[3] visits per Policy Year per Covered Person
<u>Preventive Care Test Benefit</u>	
Preventive Care Test Benefit	\$[50] per Test
Maximum Benefit	[1] Tests per Policy Year per Covered Person
[Urgent Care/Emergency Room Benefit	
Urgent Care/Emergency Room Benefit	\$[50] per Visit
Maximum Benefit	[3] Visits per Policy Year per Covered Person]
[Diagnostic Tests, X-ray and Laboratory Benefit	
Diagnostic Test Benefit	\$[100] per day
Maximum Benefit	[3] Tests per Policy Year per Covered Person]
[Prescription Benefit	
Prescription Benefit	\$[20] per prescription
Maximum Benefit	[2] prescriptions per month per Covered Person]
[Ambulance Benefit	
Ambulance Benefit	\$[100] per covered sickness/accident per Covered Person
Maximum Number of Benefits	[3] per Policy Year per Family.]
<u>Mental Health Benefit</u>	
Mental Health Inpatient Benefit	\$[300] per day
Mental Health Inpatient Maximum Benefit	60 days per Policy Year per Family
Mental Health Outpatient Benefit	\$[50] per treatment
Mental Health Outpatient Maximum Benefit	\$[700] per Policy Year per Family

Chemical Abuse and Dependence Diagnosis and Treatment Benefit		
Chemical Abuse and Dependence Diagnosis and Treatment Benefit	[\$300] per day	
Detoxification Maximum Benefit	12 Days of Active Treatment per Policy Year per Family	
Inpatient Rehabilitation Maximum Benefit	60 Days per Policy Year per Family	
Chemical Abuse and Dependence Outpatient Benefit	[\$50] per treatment	
Diabetes Supplies, Equipment and Self-Management Education Benefit		
Diabetes Supplies, Equipment and Self-Management Education Benefit	[\$100] per Policy Year per Covered Person	
[Accidental Death [and Dismemberment Benefit]		
Accidental Death Benefit	[\$5,000]	
[Dismemberment Benefit	\$[5,000] Loss of both hands or both feet - 100% Loss of sight of both eyes - 100% Loss of one hand and one foot - 75% Loss of one hand and sight of one eye - 50% Loss of one foot and sight of one eye - 50% Loss of one hand - 25% Loss of one foot and sight of one eye - 25% Loss of sight of one eye - 25%]]]	
[Dental Benefit		
Dental Benefit Deductible	[\$50.00] per Policy Year per Covered Person	
Procedure Number	Description of Services Maximum Covered Charge	
PREVENTIVE PROCEDURES		
ORAL EXAMINATIONS		
D0120	Periodic oral examination (limited to one examination every 6 months) provided no other procedure is performed during the same visit	\$[17.00]
D0140	Limited oral evaluation/problem focused	\$[27.00]
D0150	Comprehensive oral evaluation (limited to one examination per coverage year)	\$[27.00]
D9110	Palliative (Emergency) treatment, per visit	\$[38.00]
X-RAY AND PATHOLOGY		
(Except for injuries, covered charge includes examination and diagnosis.)		
D0210	Intraoral (including bitewings) (limited to once every 3 years)	\$[40.00]
D0220	Intraoral - Single film/initial	\$[7.00]
D0230	Intraoral - Each additional	\$[7.00]
D0240	Intraoral occlusal view, maxillary or mandibular, each (limited to once every 36 consecutive months)	\$[10.00]
D0250	Extraoral – Single film/initial	\$[11.00]
D0260	Extraoral - Each additional	\$[9.00]
D0270	Bitewing – Single film (limited to once every 6 months)	\$[8.00]
D0272	Bitewing films, 2 films (limited to once every 6 months)	\$[12.00]
D0274	Bitewing films, 4 (limited to once every 6 months)	\$[17.00]
PROPHYLAXIS AND FLUORIDE APPLICATIONS		
D1110	Prophylaxis for individuals age 14 or over, treatments to include scaling and polishing (limited to one treatment every 6 months)	\$[30.00]
D1120	Prophylaxis for children under age 14 (limited to one treatment every 6 months)	\$[20.00]
D1203	Topical application of fluoride/child (limited to one treatment per 6 consecutive months)	\$[12.00]
D1204	Topical application of fluoride/adult (limited to one treatment per 6 consecutive months)	\$[12.00]
D1351	Sealant, per tooth	\$[16.00]

BASIC PROCEDURES

AMALGAM RESTORATIONS — PRIMARY/PERMANENT TEETH

D2140	Amalgam - 1 surface	\$[35.00]
D2150	Amalgam - 2 surfaces	\$[45.00]
D2160	Amalgam - 3 surfaces	\$[56.00]
D2161	Amalgam - 4 or more surfaces	\$[64.00]

SYNTHETIC RESTORATIONS

D2330	Resin-based composite - 1 surface, anterior	\$[42.00]
D2331	Resin-based composite - 2 surfaces, anterior	\$[55.00]
D2332	Resin-based composite - 3 surfaces, anterior	\$[67.00]
D2335	Resin-based composite - 4 or more surfaces, or involving incisal angle, anterior	\$[71.00]
D2390	Resin-based composite crown - anterior primary	\$[77.00]
D2391	Resin-based composite - 1 surface, posterior	\$[50.00]
D2392	Resin-based composite - 2 surfaces, posterior	\$[68.00]
D2393	Resin-based composite - 3 or more surfaces, posterior	\$[85.00]

ORAL SURGERY

(Includes local anesthesia and routine post-operative care).

EXTRACTIONS

D7140	Extraction - Erupted tooth of exposed root	\$[39.00]
D7220	Removal of impacted tooth – Soft tissue	\$[45.00]
D7230	Removal of impacted tooth – Partially bony	\$[70.00]
D7240	Removal of impacted tooth – Completely bony	\$[85.00]
D7241	Removal of impacted tooth – Completely bony with unusual surgical complications	\$[85.00]
D7250	Surgical removal of residual tooth roots	\$[30.00]
D7510	Incision and drainage of abscess	\$[45.00]
D9220	General anesthesia	\$[52.00]

PERIODONTICS

D4341	Periodontal scaling and root planing, per quadrant	\$[72.00]
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis	\$[50.00]
D4910	Periodontal maintenance procedures following active therapy, periodontal prophylactic	\$[3.00]

ENDODONTICS (excluding final restoration)

D3220	Therapeutic pulpotomy	\$[125.00]
D3310	Complete root canal therapy - Anterior	\$[125.00]
D3320	Complete root canal therapy – Bicuspid	\$[135.00]
D3330	Complete root canal therapy - Molar	\$[140.00]

[Term Life Benefit	\$[5,000]
[Riders]	
Ambulatory Care Rider	
Ambulatory Care Benefit	\$[250]
Maximum Benefit	
Rider Effective Date	
Hospice Treatment Rider	
Hospice Treatment Benefit	
Maximum Benefit	
Nursing Home Care Rider	
Nursing Home Benefit	
Maximum Benefit]	

- 7 Pre-existing Condition Limitation Period [12] months following the effective date of coverage under this Policy
8. Rates: See Attached Rate Sheet
9. Rate Guarantee Period A change in premium rate will not take effect before [12] months after the policy effective date



ARKANSAS AMENDATORY ENDORSEMENT

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

1. The face page of the Certificate is amended by the deletion of the title "GROUP ACCIDENT AND SICKNESS HEALTH INSURANCE". The title "LIMITED GROUP ACCIDENT AND SICKNESS HEALTH INSURANCE" is substituted in its place.
2. The disclosure statement at the top of the face page of the Certificate is deleted in its entirety. The following is substituted in its place.

THIS COVERAGE PROVIDES BENEFITS DUE TO ACCIDENT AND SICKNESS. THIS CERTIFICATE EXPLAINS THE BENEFITS PROVIDED UNDER THE LIMITED GROUP ACCIDENT AND SICKNESS HEALTH INSURANCE POLICY. BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE.

3. The third paragraph on the face page of the Certificate is deleted in its entirety. The following is substituted in its place:

In this Certificate, the words "Named Insured" or "You" means a member of an eligible class as described on the Certificate Schedule, who is insured under the Policy and for whom premiums are remitted. The words Covered Person refer to any person covered under the Policy as described on the Certificate Schedule. The words We, Us, Our or Company refer to American Medical and Life Insurance Company. Policy means the Limited Group Accident and Sickness Health Insurance contract owned by the Policy Holder and available for review by You. If the terms of Your Certificate of coverage and the Policy differ, the Policy will govern.

4. The Certificate Schedule is amended by the deletion of the title "GROUP ACCIDENT AND SICKNESS HEALTH INSURANCE CERTIFICATE SCHEDULE". The title "LIMITED GROUP ACCIDENT AND SICKNESS HEALTH INSURANCE CERTIFICATE SCHEDULE" is substituted in its place.
5. The "Coverage for the Named Insured's adopted child(ren)" provision in the "Eligibility and Effective Date" section is deleted in its entirety. The following shall be substituted in its place:

A child born to You or Your insured Spouse will automatically become insured as a Dependent. The child must be born to the Named Insured or to his Spouse while this Policy is in force. We will cover each newborn child from the moment of live birth. Such coverage includes:

- the necessary care and treatment of medically diagnosed congenital defects;
- birth abnormalities;
- prematurity;
- routine nursery care.

We will cover the Named Insured's adopted child(ren) from the moment of birth if You take physical custody of the infant upon the infant's release from the hospital and consent to the adoption has not been revoked. However, coverage of the initial hospital stay shall not be required where a natural parent has insurance coverage available for the infant's care.

A child adopted by You or Your insured Spouse will automatically become insured as a dependent. The effective date of the coverage will be the earlier of:

- the date of placement for the purpose of adoption; or
- the date on which You assume a legal obligation for total or partial support of the child.

Coverage for adopted children will be to the same extent as provided for other covered dependent children and will include the necessary care and treatment of pre-existing medical conditions.

Coverage will continue for the adopted child unless the placement is disrupted prior to the final adoption; and

- the child is permanently removed from placement;
- the legal obligation terminates; or
- You rescind, in writing, the agreement of adoption or agreement assuming financial responsibility.

For each newborn, step child and/or adopted child, You must:

- notify Us of his birth or placement in Your residence;
- complete the required application for him; and
- pay the required premium for him, if any.

If a newborn is not enrolled within 90 days of birth, coverage will be provided from the date that notice is given. Any Additional premium required should be made to the Holder within 90 days of notification of birth.

If an adopted child is not enrolled within 90 days of adoption, coverage will be provided from the date that notice is given. Any Additional premium required should be made to the Holder within 90 days of notification of placement for the purposes of adoption.

If a step child is not enrolled within 90 days of placement in Your residence, coverage will be provided from the date that notice is given. Any Additional premium required should be made to the Holder within 90 days of notification of placement.

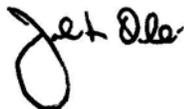
6. The "Time of Payment of Claim" provision in the "How to File a Claim/Claim Provisions" section is deleted in its entirety. The following shall be substituted in its place:

We will pay any benefits due not more than 30 days after We receive written proof of loss electronically or 45 days if the claim is submitted by other means.

There are no other changes to the certificate.

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

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



Chairman, President and CEO



Executive Vice President & Chief Compliance Officer

**American Medical and Life Insurance Company
New York, New York**

**LIMITED GROUP ACCIDENT AND SICKNESS HEALTH INSURANCE
ENROLLMENT FORM**

GENERAL INFORMATION

Applicant's Name: _____ Gender: _____ Date of Birth: _____ SSN: _____
 Home Address: _____ Phone: _____
 [Occupation/Job Title: _____ Employee Class: _____ Hire Date: _____ Hrs/Wk: _____
 Annual Salary: \$ _____ Employee ID: _____ Business Phone: _____
 Employer Name: _____
 Employer Address: _____ Section/Dept. #: _____]
 [Member Class: _____ Join Date: _____
 Member ID: _____ Section/Dept. #: _____]
 Plan: _____ [Units]: _____ Rider: _____ Monthly Premium: \$ _____
 Plan: _____ [Units]: _____ Rider: _____ Monthly Premium: \$ _____
 Plan: _____ [Units]: _____ Rider: _____ Monthly Premium: \$ _____

AD[&D] COVERAGE ELECTIONS*

Applicant: \$ _____ AD[&D] Yes No Spouse: \$ _____ AD[&D] Yes No Child(ren): \$ _____ AD[&D] Yes No

[Are you or any person to be covered Medicare eligible: Yes No
 Have you received the Guide to Health Insurance for People with Medicare? Yes No]

[SPOUSE AND DEPENDENT INFORMATION

Spouse/Dependent Name	Relationship to Applicant	Date of Birth	SSN

[*If you DO NOT ENROLL for AD&D coverage for you or your dependent(s) during the initial enrollment period, you will need to complete an evidence of insurability form, if required, for all amounts of coverage.]

BENEFICIARY INFORMATION

Beneficiary Name	Relationship to Applicant	Age	SSN	Benefit %	Primary	Contingent
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

[This Limited Accident and Sickness Medical Plan includes a Discount Program that is not health insurance. The Program provides discounts at certain healthcare providers for medical and ancillary services. The Program does not make payments directly to the provider of services, and members are obligated to pay the provider the discounted rate at the time of service. Participating Providers are subject to change without notice and are not available in all areas. Actual savings may vary. Not available to residents of all states.]

I understand that Limited Accident and Sickness Medical Plan covered persons are covered by group insurance benefits.

The group insurance benefits vary depending on plan selected. These benefits are provided under a group insurance policy underwritten by American Medical and Life Insurance Company and subject to the exclusions, limitations, terms and conditions of coverage as set forth in the insurance certificate which includes, but is not limited to, limitations for pre-existing conditions. This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is an accident and sickness medical plan that provides for limitations to the coverage for each benefit. The limitations are disclosed in the policy and certificate which are made available at the time of enrollment.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

DC Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Kansas and Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of fraud as determined by a court of law.

Louisiana Residents: 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.

New Jersey Residents: WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Texas Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application/enrollment form containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and confinement in prison.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signed at: City _____ State _____

Date

Signature of Applicant

SERFF Tracking Number: CMPL-126317166 State: Arkansas
 Filing Company: American Medical and Life Insurance Company State Tracking Number: 43573
 Company Tracking Number: AMLI DC OT SHELF 9-2009
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: AMLI DC OT SHELF 9-2009
 Project Name/Number: AMLI DC OT SHELF 9-2009/AMLI DC OT SHELF 9-2009

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	09/30/2009
Comments:		
Attachment: READABILITY CERTIFICATION.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	09/30/2009
Comments: included under the form schedule		

	Item Status:	Status Date:
Satisfied - Item: Authorization	Approved-Closed	09/30/2009
Comments:		
Attachment: FILING AUTHORIZATION LETTER - AMLI.pdf		

	Item Status:	Status Date:
Satisfied - Item: Certification/Notice	Approved-Closed	09/30/2009
Comments:		
Attachment: AR Certif of Compliance with Rule 19.pdf		

READABILITY CERTIFICATION

RE: American Medical and Life Insurance Company

NAIC # 81418

FEIN # 13-2562243

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

<u>Forms</u>		<u>Score</u>
AMLI GRP LM 2009 CERT - DC	Certificate of Coverage	49
AMLI GRP LM 2009 SCHED – DC	Certificate Schedule	45.8
GRP LM 2009 AE DC AR (7/09)	Amendatory Endorsement	46.1
AMLI GRP LM 2009 ENRL – DC	Enrollment Form	



Lorraine Classi
Executive VP

September 23, 2009



8 West 38th Street · Suite 1002
New York, NY 10018

Lorraine Classi
CHIEF COMPLIANCE OFFICER
646.223.9300 ext. 801
TOLL FREE 866.691.9353
FAX 212.354.9089
lclassi@usamli.com
www.usamli.com

February 12, 2009

NAIC Company Code: 81418

Re: Policies and Related Forms

To: All Departments of Insurance

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

Sincerely,

A handwritten signature in cursive script that reads 'L. Classi'.

Lorraine Classi
Chief Compliance Office

Certificate of Compliance with Arkansas Rule and Regulation 19

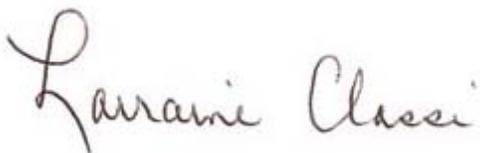
Insurer: American Medical and Life Insurance Company

Form Number(s):

Out-of-State Association Filing of Group Accident and Sickness Benefit
Forms:

- AMLI GRP LM 2009 CERT - DC, Certificate of Coverage
- AMLI GRP LM 2009 SCHED - DC, Group Accident and Sickness Health Insurance Certificate Schedule
- GRP LM 2009 AE DC AR (7/09), Amendatory Endorsement
- AMLI GRP LM 2009 ENRL - DC, Enrollment Form

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



Signature of Company Officer

Lorraine Classi

Name

Executive VP

Title

9-23-2009

Date

SERFF Tracking Number: CMPL-126317166 State: Arkansas
 Filing Company: American Medical and Life Insurance Company State Tracking Number: 43573
 Company Tracking Number: AMLI DC OT SHELF 9-2009
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: AMLI DC OT SHELF 9-2009
 Project Name/Number: AMLI DC OT SHELF 9-2009/AMLI DC OT SHELF 9-2009

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/23/2009	Form	Amendatory Endorsement	09/29/2009	AR DC Shelf AE.pdf (Superseded)
09/23/2009	Form	Enrollment Form	09/29/2009	AMLI GRP LM 2009 ENRL DC Shelf-John Doe.pdf (Superseded)



ARKANSAS AMENDATORY ENDORSEMENT

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1. The "Coverage for the Named Insured's adopted child(ren)" provision in the "Eligibility and Effective Date" section is deleted in its entirety. The following shall be substituted in its place:

A child born to You or Your insured Spouse will automatically become insured as a Dependent. The child must be born to the Named Insured or to his Spouse while this Policy is in force. We will cover each newborn child from the moment of live birth. Such coverage includes:

- the necessary care and treatment of medically diagnosed congenital defects;
- birth abnormalities;
- prematurity;
- routine nursery care.

We will cover the Named Insured's adopted child(ren) from the moment of birth if You take physical custody of the infant upon the infant's release from the hospital and consent to the adoption has not been revoked. However, coverage of the initial hospital stay shall not be required where a natural parent has insurance coverage available for the infant's care.

A child adopted by You or Your insured Spouse will automatically become insured as a dependent. The effective date of the coverage will be the earlier of:

- the date of placement for the purpose of adoption; or
- the date on which You assume a legal obligation for total or partial support of the child.

Coverage for adopted children will be to the same extent as provided for other covered dependent children and will include the necessary care and treatment of pre-existing medical conditions.

Coverage will continue for the adopted child unless the placement is disrupted prior to the final adoption; and

- the child is permanently removed from placement;
- the legal obligation terminates; or
- You rescind, in writing, the agreement of adoption or agreement assuming financial responsibility.

For each newborn, step child and/or adopted child, You must:

- notify Us of his birth or placement in Your residence;
- complete the required application for him; and
- pay the required premium for him, if any.

If a newborn is not enrolled within 90 days of birth, coverage will be provided from the date that notice is given. Any Additional premium required should be made to the Holder within 90 days of notification of birth.

If an adopted child is not enrolled within 90 days of adoption, coverage will be provided from the date that notice is given. Any Additional premium required should be made to the Holder within 90 days of notification of placement for the purposes of adoption.

If a step child is not enrolled within 90 days of placement in Your residence, coverage will be provided from the date that notice is given. Any Additional premium required should be made to the Holder within 90 days of notification of placement.

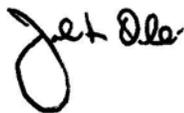
2. The "Time of Payment of Claim" provision in the "How to File a Claim/Claim Provisions" section is deleted in its entirety. The following shall be substituted in its place:

We will pay any benefits due not more than 30 days after We receive written proof of loss electronically or 45 days if the claim is submitted by other means.

There are no other changes to the certificate.

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

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



Chairman, President and CEO



Executive Vice President & Chief Compliance Officer

**American Medical and Life Insurance Company
New York, New York**

**GROUP ACCIDENT AND SICKNESS HEALTH INSURANCE
ENROLLMENT FORM**

GENERAL INFORMATION

Applicant's Name: [John Doe] Gender: [M] Date of Birth: [10-01-1973] SSN: [000-00-0000]
 Home Address: [123 Main Street, Anycity, Anystate 00000] Phone: [000-000-0000]
 [Occupation/Job Title: [accountant] Employee Class: [1] Hire Date: [10-01-2000] Hrs/Wk: [40]
 Annual Salary: \$[75,000] Employee ID: [1234] Business Phone: [000-000-0000]
 Employer Name: [ABC Company]
 Employer Address: [987 Oak Street, Anycity, Anystate 00000] Section/Dept. #: [N/A]
 [Member Class: [01] Join Date: [10-01-2000]
 Member ID: [55555] Section/Dept. #: [N/A]
 Plan: [01] [Units]: _____ Rider: _____ Monthly Premium: \$ 125.00
 Plan: _____ [Units]: _____ Rider: _____ Monthly Premium: \$ _____
 Plan: _____ [Units]: _____ Rider: _____ Monthly Premium: \$ _____

AD[&D] COVERAGE ELECTIONS*

Applicant: \$ _____ AD[&D] Yes No
 Spouse: \$ _____ AD[&D] Yes No
 Child(ren): \$ _____ AD[&D] Yes No

[Are you or any person to be covered Medicare eligible: Yes No
 Have you received the Guide to Health Insurance for People with Medicare? Yes No]

[SPOUSE AND DEPENDENT INFORMATION

Spouse/Dependent Name	Relationship to Applicant	Date of Birth	SSN
<u>[None]</u>			

[*If you DO NOT ENROLL for AD&D coverage for you or your dependent(s) during the initial enrollment period, you will need to complete an evidence of insurability form, if required, for all amounts of coverage.]

BENEFICIARY INFORMATION

Beneficiary Name	Relationship to Applicant	Age	SSN	Benefit %	Primary	Contingent
<u>[Jane Doe]</u>	<u>[spouse]</u>	<u>[30]</u>	<u>[000-00-0000]</u>	<u>[100]</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

[This Accident and Sickness Medical Plan includes a Discount Program that is not health insurance. The Program provides discounts at certain healthcare providers for medical and ancillary services. The Program does not make payments directly to the provider of services, and members are obligated to pay the provider the discounted rate at the time of service. Participating Providers are subject to change without notice and are not available in all areas. Actual savings may vary. Not available to residents of all states.]

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

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

DC Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Kansas and Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of fraud as determined by a court of law.

Louisiana Residents: 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.

New Jersey Residents: WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Texas Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application/enrollment form containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and confinement in prison.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signed at: City [Anycity] State [Anystate]

[10-01-2009]
Date

[John Doe]
Signature of Applicant