

SERFF Tracking Number: CMPL-126439621 State: Arkansas  
 Filing Company: Starr Indemnity & Liability Company State Tracking Number: 44468  
 Company Tracking Number: STARR ILC GH IND NCE  
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only  
 Expense  
 Product Name: STARR ILC GH IND NCE  
 Project Name/Number: STARR ILC GH IND NCE /STARR ILC GH IND NCE

## Filing at a Glance

Company: Starr Indemnity & Liability Company

Product Name: STARR ILC GH IND NCE

TOI: H15G Group Health -

Hospital/Surgical/Medical Expense

Sub-TOI: H15G.002 Large Group Only

SERFF Tr Num: CMPL-126439621 State: Arkansas

SERFF Status: Closed-Approved- State Tr Num: 44468

Closed

Co Tr Num: STARR ILC GH IND State Status: Approved-Closed  
 NCE

Filing Type: Form

Author: Nancy French

Date Submitted: 01/04/2010

Reviewer(s): Rosalind Minor

Disposition Date: 01/21/2010

Disposition Status: Approved-  
 Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: STARR ILC GH IND NCE

Project Number: STARR ILC GH IND NCE

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 01/21/2010

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: 01/21/2010

Created By: Nancy French

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Nancy French

Filing Description:

Compliance Research Services is pleased to submit the enclosed forms on behalf of Starr Indemnity and Liability Company (Starr). A letter of filing authorization is enclosed.

The purpose of this submission is to allow Starr to provide group hospital, medical and surgery 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. Coverage will be provided to individual association members and their dependents. It will not be issued to employers who are affiliated with the association.

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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 required for certificates issued to association members who are residents of your state. Members will apply for coverage with the enclosed enrollment form.

The forms are in final format. Starr requests the right to change the type style and paper size or to issue the forms in electronic format.

We have included any transmittals and certifications required by your Department.

If you have questions concerning this filing, please contact me at 513-984-6050 or at [dsimon@crssolutionsgroup.com](mailto:dsimon@crssolutionsgroup.com).

Sincerely,

J. David Simon, CLU  
President

Starr Indemnity and Liability Company  
NAIC #38318 FEIN #75-1670124  
Group Hospital-Medical-Surgery  
ARKANSAS  
Forms List

Form Number Description

AH-70001CN-AR Certificate of Insurance  
AH-70017 Supplemental Accident Expense Benefit Rider  
AH-70018 Vision Benefit Rider  
AH-70003N Group Application  
AH-70007MN Enrollment Form

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 AH-70010N-AR Arkansas Endorsement  
 AH-70010N-ARO Arkansas Offer

## Company and Contact

### Filing Contact Information

Nancy French, Product Manager                      nfrench@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)

Starr Indemnity & Liability Company	CoCode: 38318	State of Domicile: Texas
c/o 90 Park Avenue, 7th Floor	Group Code:	Company Type:
New York, NY 10016	Group Name:	State ID Number:
(513) 984-6050 ext. [Phone]	FEIN Number: 75-1670124	

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$140.00
Retaliatory?	No
Fee Explanation:	20 x 7 = 140.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Starr Indemnity & Liability Company	\$140.00	01/04/2010	33239716

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/21/2010	01/21/2010

### 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	01/06/2010	01/06/2010	Nancy French	01/19/2010	01/19/2010

*SERFF Tracking Number:* CMPL-126439621      *State:* Arkansas  
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## **Disposition**

Disposition Date: 01/21/2010

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	ByLaws	Approved-Closed	Yes
Supporting Document	COC	Approved-Closed	Yes
Form	Certificate of Insurance	Approved-Closed	Yes
Form	Supplemental Accident Expense Benefit Rider	Approved-Closed	Yes
Form	Vision Benefit Rider	Approved-Closed	Yes
Form	Group Application	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form (revised)	Arkansas Endorsement	Approved-Closed	Yes
Form	Arkansas Endorsement	Replaced	Yes
Form	Arkansas Offer	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 01/06/2010  
Submitted Date 01/06/2010

Respond By Date

Dear Nancy French,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certificate of Insurance, AH-70001CN-AR (Form)

Comment:

Our Department does not allow exclusions for Acts of Terrorism. Please delete this exclusion.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 01/19/2010  
Submitted Date 01/19/2010

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: 1. The Exclusions and Limitations section has been revised by the deletion of the exclusion – “Acts of terrorism, unless committed by individuals or groups will not be excluded from coverage unless the Covered Person who suffered the loss committed the act of terrorism;”. Please refer to item 13 in Amendatory Endorsement form AH-70010N-AR.

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2. We have made one additional change in Amendatory Endorsement form AH-70010N-AR. Item 1 has been included in the Amendatory Endorsement in order that all Arkansas edits be included in this document. Item 1 amends the Schedule of Benefits by removing the limited benefits for Mental Illness.

**Related Objection 1**

Applies To:

- Certificate of Insurance, AH-70001CN-AR (Form)

Comment:

Our Department does not allow exclusions for Acts of Terrorism. Please delete this exclusion.

**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
Arkansas Endorsement	AH-70010N-AR		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		41.500	AH-70010N-AR END NCE 01.13.pdf

**Previous Version**

Arkansas Endorsement	AH-70010N-AR		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		41.500	AH-70010N-AR END NCE 12.23.pdf
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No Rate/Rule Schedule items changed.

Thank you



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## Form Schedule

### Lead Form Number: AH-70001CN-AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/21/2010	AH-70001CN-AR	Certificate	Certificate of Insurance	Initial		43.900	AH-70001CN Hospital Expense Cert NCE AR 12.23.pdf
Approved-Closed 01/21/2010	AH-70017	Certificate Amendment, Insert Page, Endorsement or Rider	Supplemental Accident Expense Benefit Rider	Initial		40.200	AH-70017 Hospital Expense Supp Ax Rider 12.07.pdf
Approved-Closed 01/21/2010	AH-70018	Certificate Amendment, Insert Page, Endorsement or Rider	Vision Benefit Rider	Initial		40.000	AH-70018 Hospital Expense Vision Rider 12.07.pdf
Approved-Closed 01/21/2010	AH-70003N	Application/Enrollment Form	Group Application	Initial			AH-70003N Policyholder Application 10.23.pdf
Approved-Closed 01/21/2010	AH-70007MN	Application/Enrollment Form	Enrollment Form	Initial			AH-70007MN Hospital Expense Enrollment NCE DC 10.27.pdf
Approved-Closed 01/21/2010	AH-70010N-AR	Certificate Amendment, Insert	Arkansas Endorsement	Initial		41.500	AH-70010N-AR END NCE 01.13.pdf

<i>SERFF Tracking Number:</i>	<i>CMPL-126439621</i>	<i>State:</i>	<i>Arkansas</i>
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	<i>Expense</i>		
<i>Product Name:</i>	<i>STARR ILC GH IND NCE</i>		
<i>Project Name/Number:</i>	<i>STARR ILC GH IND NCE /STARR ILC GH IND NCE</i>		
	<i>Page,</i>		
	<i>Endorseme</i>		
	<i>nt or Rider</i>		
<i>Approved- AH-</i>	<i>Other</i>	<i>Arkansas Offer</i>	<i>Initial</i>
<i>Closed 70010N-</i>			<i>40.100</i>
<i>01/21/2010 ARO</i>			<i>AH-70010N-AR Offer NCE</i>
			<i>12.23.pdf</i>



# Starr Indemnity & Liability Company

Dallas, Texas  
Administrative Office: [90 Park Avenue, 7<sup>th</sup> Floor, New York, NY 10016]

## CERTIFICATE OF INSURANCE

Group Policy Number: [012345] ("the policy"), has been issued to [The ABC Association] which we refer to as "the Policyholder". We will refer to Starr Indemnity & Liability Company as "We", "us", or "our".

The policy will be administered on our behalf by "the Administrator" [XYZ Administrator Company].

The policy was delivered in [XXXXXX] and will be governed by the laws thereof and, to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any of its amendments.

The Certificate of Insurance is evidence of the Insured's insurance under the policy and of its benefits. Everything contained in this Certificate of Insurance is subject to the provisions, definitions, and exceptions in the policy. The policy is on file with the "the Policyholder" and may be examined at any reasonable time. Only one of our executive officers can authorize a change to the policy.

This Certificate replaces all Certificates and Certificate Riders, if any, previously issued to the Insured under the policy.

Signed for STARR INDEMNITY & LIABILITY COMPANY BY:

[Honora M. Keane], General Counsel

[Charles H. Dangelo], President

### PLEASE READ THIS CERTIFICATE CAREFULLY

**THIS LIMITED HEALTH BENEFIT PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS CERTIFICATE AND CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE COVERED PERSON AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS.**

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**SCHEDULE OF BENEFITS**

1. POLICY INFORMATION  
 "The Policyholder":  
 Policy Effective Date:  
 Policy Anniversary Date:
2. ELIGIBLE PERSONS: An Eligible Person is an individual who meets the requirements of [one] of the Covered Classes shown below:

- |          |  |
|----------|--|
| [Class 1 | All members of an association who have applied and have been approved to receive medical benefits.]  |
| [Class 2 | All eligible spouses under [65] years of age and dependent children of [Class 1-2] insureds for whom application and premium has been received.] |

[Dependent Coverage: \_\_\_ Yes X No]

3. COVERAGE YEAR: Begins on each [JANUARY 1ST] and continues for the next 12 consecutive months, and ends on [DECEMBER 31<sup>st</sup>] of the [same] year.
4. EFFECTIVE DATE:  
 The following shall apply to eligible members of "the Policyholder" [and their eligible dependents], and will be in addition to the Effective Date language in the policy and/or certificate:  
  
 The later of the first of the month following the date all premium remittances equaling one month's premium have been made [and completion of the benefit Waiting Period of [0-30 days]].
5. COVERAGE AND BENEFIT AMOUNTS:

**Accidental Death Benefit**

Accidental Death Principal Sum for Member	[\$1,000 - \$25, 000]
Accidental Death Principal Sum for Spouse	50% of Member Benefit
Accidental Death Principal Sum for Child(ren)	25% of Member Benefit
Loss Period	Loss within [180-365] days from the date of the Accident]

**[Medical Expense Benefit Option –  
 Accident and Sickness – Inpatient [and Outpatient]**

Lifetime Maximum per Certificate of Insurance	\$[250,000 – 1,000,000]
Coverage Year Maximum Benefit per Certificate of Insurance	[\$[5,000 – 100,000]
Surgeons' Fees Maximum per Coverage Year	\$[5,000 – 25,000]
Anesthesiologists' Maximum per Coverage Year	[10 – 25]% of Surgeons' Fees Maximum per Coverage Year
Surgical Fee Schedule	[50-100] % of RBRVS

**Inpatient Benefits**

[Deductible \$[0 – 1,000] Per [Coverage Year] [Occurrence] [Hospital Confinement]]

[Percentage of Remaining Usual and Customary Charges Policy Pays] or [Coinsurance- paid by Insurance Company] [50-100%]

Benefit Limitations [(Up to 30 days per Confinement)]:  
[Hospital Room and Board Maximum Benefit] [\$300 – 2,500] Per Day  
[Percentage of Remaining Usual and Customary Charges Policy Pays]  
[Other Hospital Services Maximum Benefit] \$ [100-2,000] [Per Occurrence]]

**[[Supplemental] [Additional] Inpatient [Medical] [Hospital] Benefits<sup>1</sup>**

Maximum Benefit \$[100 - 1,000] Per Day  
Maximum Number of Days [1 - 5] Days Per Coverage Year

**[Outpatient Medical Expense Benefits]**

[Doctors' Office Visits Co-Pay/Maximum Payment] \$[10-500] [Co-Pay] [Per Visit] [Per Occurrence]]

[Coinsurance- paid by Insurance Company] [50-100%]  
[Maximum Number of Visits] [2 - 12] Visits per Coverage Year

[Outpatient X-ray & Lab Maximum (including interpretation)] \$[100 - 2,500] per Occurrence]

[Diagnostic Labs & X-ray procedures Benefits (including interpretation):  
Co-pay Per Procedure [First] [\$20 - \$50]

[Percentage of Remaining Usual and Customary Charges Policy Pays]  
[Coinsurance- paid by Insurance Company] [50 - 100%]

**Emergency Room Visits Benefits:**

Deductible – [Waived if due to an accident or results in hospital admission] [\$50 - 300] [Per Visit]

[Percentage of Remaining Usual and Customary Charges Policy Pays] [50% - 100%]]

[Coinsurance – paid by Insurance Company] [50% - 100%]]  
Emergency Room Maximum Benefit [\$50 - \$500] [Per Visit] [Per Occurrence]

Maximum Number of Visits [1-5] Visits per Coverage Year

Ambulance Benefit [\$50 - \$500] [Per Visit] [Per Occurrence]  
Maximum Number of Occurrences [1-5] Occurrences per Coverage Year

**Other Covered Medical Services:**

Maximum [Payment] [Benefit] \$[1,000 - 15,000] [Per Occurrence][Per Coverage Year]

**[Home Health Care]**

[Percentage of Remaining Usual and Customary Charges Policy Pays]  
[Coinsurance- paid by Insurance Company] [50% - 100%]]

**[Skilled Nursing Facility]**

[Percentage of Remaining Usual and Customary Charges Policy Pays]  
[Coinsurance- paid by Insurance Company] [50% - 100%]]

<sup>1</sup> [Supplemental] [Additional] inpatient [Medical] [Hospital] Benefits are payable only after the Base Inpatient Benefit is exhausted each [Coverage Year] [Occurrence] [Hospital Confinement].

[Hospice]

[Percentage of Remaining Usual and Customary Charges Policy Pays]  
[Coinsurance- paid by Insurance Company] [50% - 100%]

[Physical Therapy]

[Percentage of Remaining Usual and Customary Charges Policy Pays]  
[Coinsurance- paid by Insurance Company] [50% - 100%]

[Durable Medical Equipment]

[Percentage of Remaining Usual and Customary Charges Policy Pays]  
[Coinsurance- paid by Insurance Company] [50% - 100%]]

**Alcoholism and Drug Dependency Benefit**

Detoxification Maximum Benefit 12 Days of Active Treatment per Coverage Year per Certificate of Insurance

Alcoholism and Drug Dependency Inpatient Maximum Benefit 60 days per Coverage Year per Certificate of Insurance

Alcoholism and Drug Dependency Outpatient Maximum Benefit  
Coinsurance - paid by Insurance Company 75% for the first 40 Outpatient visits and 60% for any further visits per Coverage Year per Certificate of Insurance

**Wellness Visit Benefit**

Co-pay per visit	[\$10 - \$25]
Maximum Benefit per Coverage Year	[\$100 - \$500]
Coinsurance	[10 - 100%]
Maximum Visits per Coverage Year	[1 - 10]

**[Additional Optional Benefit Riders:**

[Vision Benefit Rider]

Vision Examination [25 - 100]  
 One examination every [12-36] months  
 Eyeglass Frames [25 - 100]  
 One frame every [12-36] months  
 Eyeglass Lenses per Pair [25 -100]  
 Single Vision  
 One pair every [12-36] months [25 -100]  
 Multi-focal  
 One pair every [12-36] months [25 - 100]  
 Contact Lenses per Pair  
 One pair every [12-36] months [25 -100]]

[Supplemental Accident Expense Benefit Rider] [100 - \$5,000]]

**[Medical Expense In Network Only Option -  
Accident and Sickness  
-Hospital and Surgical Benefits  
Network Provider: [ABC] Network**

**Inpatient Benefits**

Maximum Benefit \$[100,000 – 1,000,000] Per Coverage Year  
Deductible \$[1,000 – 25,000] Per Coverage Year

[Coinsurance- paid by Insurance Company] 100% of [ABC] Network Contracted Rate  
Benefit Limitations [(Up to 30 days per Confinement)]:

Hospital Room and Board Maximum Benefit	100% of [ABC] Network Contracted Rate
Inpatient and Outpatient Surgery	100% of [ABC] Network Contracted Rate
Surgeon's Fees Maximum Benefit	100% of [ABC] Network Contracted Rate
Anesthesiologists' Fees Maximum Benefit	100% of [ABC] Network Contracted Rate
Other Hospital Services Maximum Benefit	100% of [ABC] Network Contracted Rate

**Outpatient Doctors' Office Visits**

Outpatient Diagnostic Lab and X-ray (including interpretation) 100% of [ABC] Network Contracted Rate

**Outpatient surgery, Surgeon's Fees and Anesthesiologists' Fees**

100% of [ABC] Network Contracted Rate

**Other Covered Medical Services:**

Skilled Nursing Facility	100% of [ABC] Network Contracted Rate
Hospice	100% of [ABC] Network Contracted Rate
Emergency Room	100% of [ABC] Network Contracted Rate
Ambulance	100% of [ABC] Network Contracted Rate

6. PREMIUM PAYABLE: [ Weekly    \_\_\_ Monthly    Annual]

7. PREMIUMS:

[Premium Amount:	<input checked="" type="checkbox"/> Member Only	\$XX.XX
	<input type="checkbox"/> Member Plus One	\$XX.XX
	<input type="checkbox"/> Member and Spouse	\$XX.XX
	<input type="checkbox"/> Member and Child(ren)	\$XX.XX
	<input type="checkbox"/> Member and Family	\$XX.XX
	<input type="checkbox"/> Child(ren) of Member	\$XX.XX]

## GENERAL DEFINITIONS

"Accident" means a sudden, unforeseeable event, independent of Sickness that causes Injury to one or more Covered Persons.

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

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985.

"Complications of pregnancy" means: 1) Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and 2) Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

"Coverage Year" means the period of time, as stated on the Schedule of Benefits, from the date of Injury or first treatment of Sickness within which benefits will be paid.

"Covered Person" means any eligible person for whom coverage is in effect under the policy.

["Deductible" means the amount of eligible Medical Expenses which must be satisfied for each covered loss before benefits are payable under the policy.]

["Dependents" means: a) the Insured's lawful spouse, and b) the Insured's unmarried children who are less than age [22]. An unmarried child who is less than age [25] may also be included if the child is enrolled full-time in an accredited school or college. All references to the term "spouse" include "domestic partner". The term "domestic partner" means a person with whom the Insured maintains a committed relationship characterized by mutual caring and the sharing of a mutual residence and who has registered. Each partner must: 1) be at least 18 years old and competent to contract; 2) be the sole domestic partner of the other person; and 3) not be married.

Dependent children may include stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures and children for whom coverage has been court-ordered. Dependent children (other than those for whom coverage has been court-ordered) must: 1) have their principal residence with the Insured; and 2) chiefly rely on the Insured for support and maintenance.]

"Doctor" means any duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to perform the service for which claim is made.

"Emergency Services" means: 1) Health care services furnished in the emergency department of a hospital for the treatment of a Medical Emergency; 2) Ancillary Services routinely available to the emergency department of a hospital for the treatment of a Medical emergency; and 3) Emergency medical services transportation.

"Hospital" means an institution operated by law for the care and treatment of injured or sick persons; has organized facilities for diagnosis and surgery or has a contract with another hospital for these services; and has 24-hour nursing service. Hospital excludes any institution that is primarily a rest home, nursing home, convalescent home, a home for the aged, an alcoholism or drug addiction treatment facility, or a facility for treatment of mental disorders.

"Injury" means accidental bodily injury of a Covered Person caused by an Accident; and results in covered loss directly and independently of all other causes. All injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries, will be considered one Injury.

"Inpatient" means a person who incurs Medical Expenses for at least one day's room and board from a Hospital.

"Insured" means an eligible person for whom coverage is in effect under the policy.

"Intoxicant or Intoxicated" means blood alcohol level which equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Injury occurred.

["Loss Period" means that period of time, as stated on the Schedule of Benefits, from the date of an Accident within which a Covered Person must seek initial treatment for an Injury.]

"Maximum Benefit " means the total benefits payable under an applicable benefit provision.

"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: 1) Placing the patient's health in serious jeopardy; 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

"Medical Expense" means expenses incurred for Medically Necessary services and supplies. Not included are amounts in excess of Usual and Customary Charges.

"Medically Necessary" means the care, service or supply is prescribed by a Doctor for the diagnosis or treatment of an Injury or Sickness; and appropriate, according to conventional medical practice for the injury or Sickness in the locality in which care, service or supply is given. The fact that a Doctor may prescribe, authorize, or direct a service does not, of itself, make it Medically Necessary or covered by the policy.

["Member" means a person who has joined an association, is required to pay on a regular basis a specific amount of annual dues that are predetermined by the association, and has paid annual dues in good standing.]

"Occurrence" means each separate Accident or Sickness for which a Covered Person incurs covered Medical Expenses.

"Outpatient" means a person who incurs Medical Expenses at Doctors offices, freestanding clinics, or at Hospitals when not admitted as an Inpatient.

["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 [6/12] month period preceding the effective date of coverage of the Covered Person.]

"Policyholder" means the legal entity in whose name this Policy is issued as shown on the Policy cover.

"Resource Based Relative Value Schedule (RBRVS)" means a scale of national uniform relative value for all physicians' services. The method reflected in this scale determines provider reimbursement, taking into account, when assigning a weighted value to medical procedures or services, all resources that physicians use in providing care to patients, including physical or procedural, educational, mental (cognitive) and financial resources.

"Sickness" means illness or disease for which a Medical Expense is incurred while coverage is in force under the policy for the Covered Person. All related conditions and recurring symptoms of Sickness will be considered one Sickness. Sickness also includes Complications of Pregnancy.

"Totally Disabled" means the Covered Person is receiving medical treatment and is unable to perform all the substantial and material duties of his work. In respect to a dependent or unemployed spouse, Totally Disabled shall mean an Injury or Sickness that prevents the Covered Person from doing those activities that are normal for a person in good health of the same age and sex.

"Usual and Customary" means an amount that is both charged by a provider for a given service to the majority of his patients, and charged by the majority of providers within a community for the same service.

["Waiting Period" means the period of time during which benefits are not paid.]

## **INDIVIDUAL INSURING PROVISIONS**

### **Eligibility:**

Insured: Each person, as described on the Schedule of Benefits, who is eligible for coverage under the policy as an Insured.

Eligible Dependents: Coverage under the policy may also be extended to include:

- a.) the Insured's lawful spouse; and
- b.) the Insured's unmarried children who are less than age [19]. An unmarried child who is less than age [25] may also be included if the child is enrolled full-time in an accredited school or college.

Dependent children may include stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures and children for whom coverage has been court-ordered.

Dependent children (other than those for whom coverage has been court-ordered) must:

- a.) have their principal residence with the Insured; and
- b.) chiefly rely on the Insured for support and maintenance.

Newborn Child Coverage: A child of the Insured born while the Policy is in force is covered for Injury and Sickness (including necessary care and treatment of congenital defects, birth abnormality and premature birth), as well as routine newborn care for the first 31 days. The child is covered from the moment of birth until the 31st day of age. A notice of birth, together with the additional premium, must be submitted to us within 31 days of the birth in order to continue coverage for Injury or Sickness beyond the initial 31-day period.]

Adopted Child Coverage: A minor child who comes under the charge, care and control of the Insured while the policy is in force is covered for injury or Sickness, provided the Insured files a petition to adopt. The coverage of such child will be the same as provided for other members of the Insured's family. Such child shall be covered from the date of placement in the Insured's home if the insured applies for coverage and pays any required premium within 31 days after the date of placement. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. Such child's coverage will not be subject to any preexisting conditions limitation provided by this policy. Coverage for such minor child will continue unless the petition for adoption is dismissed or denied.]]

**Effective Date:**

Insured - Contributory: Individual insurance will become effective on the latest of:

- a.) the Policyholder's effective date, if the person is eligible, and application and premium have been received on or before that date; or
- b.) the date the person enrolls and application and premium are received within 31 days after the date he becomes eligible; or
- c.) as provided on the Schedule of Benefits.

[Dependents: Dependent insurance will become effective on the latest of:

- a.) the Insured's effective date, if the dependent is eligible as of the Insured's effective date and the Insured applies and pays premium for the dependent on or before that date; or
- b.) the date the Insured enrolls his dependent, if the dependent becomes eligible after the Insured's effective date, and application and premium are received within 31 days after the dependent becomes eligible; or
- c.) as provided on the Schedule of Benefits.

An eligible person may be enrolled only within 31 days after becoming eligible.

In no case will coverage for eligible dependents take effect before the Insured's. No dependent will be covered unless application has been made and the correct premium has been paid.]

**Termination:**

Insured: Coverage for an Insured will end on the earliest of:

- a.) the date the Insured is no longer eligible [unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid]; or
- b.) any premium due date, if full payment for the Insured's coverage is not made within 31 days following the premium due date (the Grace Period); or
- c.) the date the policy terminates; or
- d.) the date the Insured enters an armed service on full-time active duty. Premium shall be returned a pro-rata basis if we are notified in writing; or
- e.) the date the Insured becomes eligible for an employer-sponsored group medical benefit program, other than the Policy, regardless of whether or not the Insured participates in such program; or
- f.) the date the insured provides the Policyholder or us with written notice that he wants his coverage terminated.

[Dependents – Coverage for dependents will end on the earliest of:

- a.) the Insured's termination date; or
- b.) the date the dependent is no longer eligible [unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid].

Coverage will continue for any child who reaches the age limit and is both:

- a.) totally incapable of self-sustaining employment due to physical or mental handicap; and
- b.) chiefly dependent on the Insured for support and maintenance.

The Insured must give us proof of the child's incapacity and dependency within 31 days of the child reaching the age limit. We may require proof again from time to time but not more often than once a year after the 2 years that follow the child reaching the age limit.

In no case will coverage end later than the Insured's.]

Termination will not affect a claim for benefits for covered charges that were incurred while the Insured was covered under the policy.

**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 subject to applicable Benefit Maximums, Deductibles, Policy Limitations and Exclusions and Limitations, until the earlier of:

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

**DESCRIPTION OF BENEFITS**

**[Accidental Death Benefit**

If bodily Injury results in the loss of the Covered Person's life within the Loss Period stated on the Schedule of Benefits, we will pay the Principal Sum shown on the Schedule of Benefits.]

**[Per Coverage Year Medical Expense Benefit – Inpatient [and Outpatient]**

We will pay the applicable benefit percentage for the covered expenses described below, up to the applicable coverage year maximum. Benefits will be paid, after satisfaction of any applicable [deductible or] co-pay amount and subject to any applicable benefit limitation, for covered expenses that are incurred while the Covered Person's coverage is in force. The Covered Person must be under a Doctor's care, and the treatment must be Medically Necessary, for covered Injury or Sickness. Deductible amounts and benefit percentages, maximums, and limitations are indicated on the Schedule of Benefits.

Covered expenses include: [Hospital room and board charges; Inpatient surgery, surgeons' and anesthesiologists' fees; charges for other Hospital services (which include ancillary Hospital charges for pharmacy, medical or surgical supplies and devices, diagnostic laboratory and X-ray procedures, and operating and recovery room); [Outpatient Doctors' office visits fees; Outpatient 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. "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;] [Outpatient surgery, surgeons' and anesthesiologists' fees;] [charges for Outpatient diagnostic laboratory and X-ray procedures;], 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 Doctor legally authorized to prescribe such item, charges for 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, and charges for visits to an emergency room including coverage for a voluntary HIV screening test performed on a Covered Person while the Covered Person is receiving emergency medical services, other than HIV screening, at a hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the medical emergency which caused the Covered Person to seek emergency services. [and ambulance trips to and from the Hospital. Fees for Inpatient Doctors' visits and private duty nursing are not included as covered expenses.] Charges incurred by a

Covered Person for covered expenses are limited to Usual and Customary unless indicated otherwise on the Schedule of Benefits.

[[Supplemental] [Additional] Inpatient [Medical] [Hospital] Benefits are payable only after the Base Inpatient Benefit has been exhausted each coverage year. Once Supplemental Inpatient Benefits become payable, we will pay the applicable benefit percentage, indicated on the Schedule of Benefits for [only the following covered expenses: Hospital room and board charges, Inpatient surgeons' fees, and Inpatient anesthesiologists' fees. Other Hospital services are not covered under Supplemental Inpatient Benefits]. Covered expenses will be limited to the Usual and Customary charge incurred by the Covered Person. The Covered Person must continue to be under the care of a Doctor and the treatment must be Medically Necessary for covered Injury or Sickness. [Supplemental][Additional] inpatient [Medical] [Hospital] Benefits will be paid up to the applicable maximum shown on the Schedule of Benefits.]

Additional Definitions – Whenever used in this benefit:

"Approved clinical trial" means:

- a. 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;
- b. 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
- c. 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.

["Co-pay" means a specified amount that a Covered Person is responsible for paying, each time the covered expense is incurred, before benefits are payable under the policy. [When a covered expense is subject to a co-pay, a deductible will not be applied to that same expense].]

"Coverage year" means a consecutive 12-month period described on the Schedule of Benefits.

["Deductible" means the amount of covered expenses that must be paid by a Covered Person before benefits are payable under the policy This amount applies separately to each Covered Person and must be satisfied each coverage year; [except if, in any one coverage year, there are [3 or more] members of the Insured's family covered under the policy, then a family deductible will apply. The family deductible is cumulative. This means that all covered family members can contribute to the family deductible, however, no one Covered Person can contribute more than the per person deductible amount. Once the family deductible is satisfied, no deductible amount will be required for any other covered family member during that same coverage year.]]

## **[Per Occurrence Medical Expense Benefit - Inpatient [and Outpatient]**

We will pay the applicable benefit percentage for the covered expenses described below, up to the applicable maximum benefit. Benefits will be paid, after satisfaction of any applicable [deductible or] co-pay amount and subject to any applicable benefit limitation, for covered expenses that are incurred for up to [52] weeks after the Accident or onset of Sickness and while the Covered Person's coverage is in force. The Covered Person must be under a Doctor's care, and the treatment must be Medically Necessary, for covered Injury or Sickness. No benefit will be paid for any expense that is incurred more than 1 year from the date of the Accident or onset of Sickness. Deductible amounts and benefit percentages, maximums, and limitations are indicated on the Schedule of Benefits.

Covered expenses include: Hospital room and board charges; Inpatient surgery, surgeons' and anesthesiologists' fees, charges for other Hospital services (which include ancillary Hospital charges for pharmacy, medical or surgical supplies and devices, diagnostic laboratory and X-ray procedures, and operating and recovery room); [Outpatient Doctors' office visits fees; Outpatient 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. "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;] [Outpatient surgery, surgeons' and anesthesiologists' fees;] [charges for Outpatient diagnostic laboratory and X-ray procedures;] charges for 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, and charges for visits to an emergency room including coverage for a voluntary HIV screening test performed on a Covered Person while the Covered Person is receiving emergency medical services, other than HIV screening, at a hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the medical emergency which caused the Covered Person to seek emergency services; [and ambulance trips to and from the Hospital.] Fees for Inpatient Doctors' visits and private duty nursing are not included as covered expenses. Charges incurred by a Covered Person for Covered expenses are limited to Usual and Customary unless indicated otherwise on the Schedule of Benefits.

[[Supplemental] [Additional] Inpatient [Medical] [Hospital] Benefits are payable only after the Base Inpatient Benefit has been exhausted each occurrence. Once Supplemental Inpatient Benefits become payable, we will pay the applicable benefit percentage, indicated on the Schedule of Benefits, for [only the following covered expenses: Hospital room and board, Inpatient surgeons' fees, and Inpatient anesthesiologists' fees. Other Hospital services are not covered under Supplemental Inpatient Benefits]. The Covered Person must continue to be under the care of a Doctor and the treatment must be Medically Necessary for covered Injury or Sickness. [Supplemental] [Additional] Inpatient [Medical] [Hospital] Benefits will be paid up to the applicable maximum shown on the Schedule of Benefits.]

### Additional Definitions - Whenever used in this benefit:

"Approved clinical trial" means:

- a. 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;
- b. 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
- c. 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.

["Co-pay" means a specified amount that a Covered Person is responsible for paying, each time the covered expense is incurred, before benefits are payable under the policy. [When a covered expense is subject to a co-pay, a deductible will not be applied to that same expense.]]

["Deductible" means the amount of covered expenses that must be paid by a Covered Person before benefits are payable under the policy. This amount applies separately to each Covered Person and to each occurrence.]

"Occurrence" means each separate Accident or Sickness for which a Covered person incurs covered Medical Expenses.

#### **[Per Hospital Confinement Medical Expense Benefit – Inpatient**

We will pay the applicable benefit percentage for the covered expenses described below, up to the applicable maximum benefit. Benefits will be paid, [after satisfaction of any applicable deductible amount] and subject to any applicable benefit limitation, for covered expenses that are incurred while the Covered Person's coverage is in force. The Covered Person must be under a Doctor's care, and the treatment must be Medically Necessary, for covered Injury or Sickness. Deductible amounts and benefit percentages, maximums, and limitations are indicated on the Schedule of Benefits.

Covered expenses include: Hospital room and board; Inpatient surgery, surgeons' and anesthesiologists' fees; other Hospital services (which include ancillary Hospital charges for pharmacy, medical or surgical supplies and devices, laboratory and X-rays, and operating and recovery room), and Inpatient Doctors' visits that are billed directly by the Doctor. Fees for Inpatient Doctors' visits that are billed as an Inpatient service of the Hospital, and private duty nursing are not included as covered expenses. Charges incurred by a Covered Person for covered expenses are limited to Usual and Customary unless indicated otherwise on the Schedule of Benefits.

[[Supplemental] [Additional] Inpatient [Medical] [Hospital] Benefits are payable only after the Base Inpatient Benefit has been exhausted each Hospital confinement. Once Supplemental Inpatient Benefits become payable, we will pay the applicable benefit percentage, indicated on the Schedule of Benefits, for [only the following covered expenses: Hospital room and board, Inpatient surgeons' fees, and Inpatient anesthesiologists' fees. Other Hospital services, Inpatient Doctors' visits, and private duty nursing care are not covered under Supplemental Inpatient Benefits]. The Covered Person must continue to be under the care of a Doctor and the treatment must be Medically Necessary for covered Injury or Sickness. [Supplemental] [Additional] Inpatient [Medical] [Hospital] Benefits will be paid up to the applicable maximum shown on the Schedule of Benefits.]

Additional Definitions – Whenever used in this benefit:

["Deductible" means the amount of covered expenses that must be paid by a Covered Person before benefits are payable under the policy. This amount applies separately to each Covered Person and to each occurrence.]

"Hospital confinement" means each separate time a Covered Person is admitted to a Hospital as an Inpatient and incurs covered Medical Expenses [; except that if a Covered person is admitted to a Hospital within [7 days] of a preceding Hospital confinement for the same or related cause, the second admission will be considered a part of the first Hospital confinement].]

**[Other Covered Medical Services**

We will pay the applicable benefit percentage for the covered expenses described below, up to the maximum [payment] [benefit] [per occurrence]. Benefits will be paid, after satisfaction of any applicable [deductible or co-pay amount] and subject to any applicable benefit limitation, for covered expenses that are incurred while the Covered Person's coverage is in force. The Covered Person must be under a Doctor's care, and the treatment must be Medically Necessary, for covered Injury or Sickness. Deductible amounts and benefit percentages, maximums, and limitations are indicated on the Schedule of Benefits.

Covered expenses include: Home Health Care; Skilled Nursing Facility Care; Hospice Care; Physical Therapy; and Durable Medical Equipment. Charges incurred by a Covered Person for covered expenses are limited to Usual and Customary unless indicated otherwise on the Schedule of Benefits.]

**[Per Coverage Year Medical Expense Benefit In Network Only Option– Accident and Sickness – Hospital and Surgical Benefits – Network Provider: [ABC] Network**

We will pay 100% of the [ABC] Network Contracted Rate for the covered expenses described below, up to the applicable coverage year maximum. Benefits will be paid, after satisfaction of any applicable deductible amount and subject to any applicable benefit limitation, for covered expenses that are incurred while the Covered Person's coverage is in force. The Covered Person must be under a Doctor's care, and the treatment must be Medically Necessary, for covered Injury or Sickness. Deductible amounts and maximums, and any applicable limitations are indicated on the Schedule of Benefits.

Covered expenses include: Hospital room and board charges; Inpatient surgery, surgeons' and anesthesiologists' fees; charges for Other Hospital services (which include ancillary Hospital charges for pharmacy, medical or surgical supplies and devices, diagnostic laboratory and X-ray procedures, and operating and recovery room); Outpatient Doctors' office visits fees. Outpatient 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. "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; Outpatient surgery, surgeons' and anesthesiologists' fees; charges for Outpatient diagnostic laboratory and X-ray procedures; and charges for Other Covered Medical Services (which include Skilled Nursing Facility Care; Hospice Care; charges for 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, and charges for visits to an emergency room including coverage for a voluntary HIV screening test performed on a Covered Person while the Covered Person is receiving emergency medical services, other than HIV screening, at a hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the medical emergency which caused the Covered Person to seek emergency services and ambulance trips to and from the Hospital).

Additional Definitions – Whenever used in this benefit:

"Approved clinical trial" means:

- a. 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;
- b. 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
- c. 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.

"Coverage year" means a consecutive 12-month period described on the Schedule of Benefits.

"Deductible" means the amount of covered expenses that must be paid by a Covered Person before benefits are payable under the policy. This amount applies separately to each Covered Person and must be satisfied each coverage year; [except if, in any one coverage year, there are [3 or more] members of the Insured's family covered under the policy, then a family deductible will apply. The family deductible is cumulative. This means that all covered family members can contribute to the family deductible, however, no one Covered Person can contribute more than the per person deductible amount. Once the family deductible is satisfied, no deductible amount will be required for any other covered family member during that same coverage year.]

## **MENTAL HEALTH BENEFITS**

### **Inpatient Benefits**

For Covered Persons confined as an Inpatient to a licensed mental health facility due to Mental Illness we will pay benefits the same as any other Sickness, subject to the Mental Health Inpatient Maximum Benefit listed in the Schedule of Benefits which applies per Coverage Year per Certificate of Insurance.

### **Outpatient Benefits**

For Covered Persons seeking treatment for Mental Illness on an Outpatient basis at a licensed mental health facility, we will pay benefits the same as any other Sickness, subject to the Mental Health Outpatient Maximum Benefit listed in the Schedule of Benefits which applies per Coverage Year per Certificate of Insurance.

***Mental Illness*** means any psychiatric disease identified in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual.

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.

## **ALCOHOLISM AND DRUG DEPENDENCY BENEFIT**

### **Detoxification Benefits**

Benefits for the detoxification process where a Covered Person who is intoxicated by or dependent on drugs or alcohol or both is assisted through the period of time necessary to eliminate the intoxicating agent from the body, while keeping the physiological risk to the patient at a minimum, are subject to the Detoxification Maximum Benefit shown in the Schedule of Benefits.

### **Inpatient Benefits**

For Covered Persons confined as an Inpatient to a licensed alcoholism, substance abuse or chemical dependence treatment health facility due to alcoholism or drug dependency we will pay benefits the same as any other Sickness, subject to the Alcoholism and Drug Dependency Inpatient Maximum Benefit listed in the Schedule of Benefits which applies per Coverage Year per Certificate of Insurance.

### **Outpatient Benefits**

For Covered Persons seeking treatment for Alcoholism and Drug Dependency on an Outpatient basis at a licensed Outpatient treatment facility, we will pay the Alcoholism and Drug Dependency Outpatient Benefit shown in the Schedule of Benefits, which applies per treatment, subject to the Alcoholism and Drug Dependency Outpatient Maximum Benefit listed in the Schedule of Benefits which applies per Coverage Year per Certificate of Insurance.

## **WELLNESS VISIT BENEFIT**

Upon receipt of due proof that a Covered Person incurred expenses for a Wellness Visit, we will pay a Wellness Visit Benefit up to the maximum as shown in the Schedule of Benefits.

Additional Definitions – Whenever used in this benefit:

"Wellness Visit means an office visit for routine examinations or other preventative testing, including a baseline mammogram, a screening mammogram, cervical cytologic screening, diagnostic radiology/imaging, colorectal cancer screening, prostate cancer screening, and physical examination.

"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.

## **[CONTINUATION OF COVERAGE PRIVILEGE**

Coverage for Hospital, surgical and/or Medical Expenses incurred as a result of Injury or Sickness may be continued, under certain circumstances.

### **Eligibility:**

Insured: An Insured may elect to continue coverage for himself [and his covered dependents]. Coverage may be continued for 13 months if one of the following events occurs:

- a.) the Insured's employment is terminated for any reason other than gross misconduct; or
- b.) a reduction in an Insured's hours results in the loss of such coverage.

Disabled Insured: Insureds who are determined to be disabled under the Social Security Act within 60 days of the date they become eligible for continuation under this Part, may continue coverage for themselves [and their covered dependents] for up to 29 months.

[Dependents: A covered dependent may elect to continue coverage for a period of 36 months if one of the following events occurs:

- a.) the death of the Insured;
- b.) the divorce or legal separation of the insured and dependent spouse;
- c.) the Insured becomes entitled to Medicare benefits;
- d.) a dependent child is no longer a dependent child for the purposes of the plan.]

Evidence of Insurability is not required for this continuation of coverage. If a Covered Person exercises this option, it will be lieu of any continuation rights granted under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

### **Coverage:**

If a Covered person exercises this option, coverage will be identical in scope to the coverage provided in the policy.

### **Premiums:**

The Covered Person will pay premiums directly to the Policyholder with the option of paying in monthly installments. The premiums will not exceed 102 percent of the applicable premium for such period.

### **Notice Requirements:**

The Policyholder must notify us in writing within 31 days after the date:

- a.) the Insured dies; or
- b.) the Insured's employment is terminated, the Insured's hours are reduced; or
- c.) the Insured becomes entitled to Medicare benefits.

[Each covered dependent who wishes to continue coverage must notify us in writing within 60 days after the date:

- a.) of divorce or legal separation from the Insured, or
- b.) a dependent child is no longer a dependent child for the purposes of the plan.]

Upon our receipt of any such notice, we must give written notice of the right to continue coverage to any insured or his covered dependents within 14 days.

Each Insured [or covered dependent] who wish to continue coverage must notify us in writing within [60] days after the date he receives notice of his right to continue coverage.

**Termination:**

A Covered Person who exercises this option will not have his coverage interrupted or canceled or otherwise terminated until the date on which:

- a.) he fails to make premium payment in the time required to make that payment; or
- b.) he becomes eligible for substantially similar coverage under another group health plan, hospital or medical service subscriber contract, medical practice or other prepayment plan, or any other plan or program (including Medicare); or
- c.) the required period for continued coverage ends; or
- d.) the policy terminates; or
- e.) The Insured provides the Policyholder or us with written notice that he wants his coverage terminated.]

**[CONVERSION PRIVILEGE**

A Conversion Privilege will be given if:

- a.) coverage under the policy and any plan with similar benefits that it has replaced has been in effect continuously for the 3-month period prior to its ending; and
- b.) coverage under the policy ends for any reason other than non-payment of premium; and
- c.) the Covered Person is not eligible for or covered by:
  - a. Medicare;
  - b. similar coverage that replaced the terminating coverage within 31 days after the policy ends;
  - c. the type of coverage listed below under which benefits, when added to benefits of the conversion coverage, result in overinsurance according to our standards:
    - i. similar benefits under state or federal law or any arrangement of coverage for persons in an employer group whether insured or uninsured; or
    - ii. similar benefits of an individual policy; and
- d.) the Covered Person was not eligible for, or failed to elect, the Continuation of Coverage Privilege at termination of coverage under the policy.

To convert from coverage under the policy to conversion coverage, written application and first premium payment must be made no more than 31 days after coverage under the policy has ended. Medical evidence of insurability is not required. Questions concerning other coverage under which the person is eligible or is covered may be asked.

The conversion coverage will provide benefits:

- a.) that are of the same type as the benefits provided by the policy for Hospital, surgical or medical expenses; and
- b.) that meet the minimum requirements for a conversion policy in the state where the person resides on the date of conversion. Benefit amounts may be less than those provided by the policy, to the extent permitted by law.

Upon request we will provide full details of the conversion coverage. At our option, we may provide group insurance coverage that meets the above requirements instead of an individual conversion policy.]

## LIMITATIONS AND EXCLUSIONS

No benefits will be paid for loss caused by or resulting from

- [Normal pregnancy or childbirth, except for Complications of pregnancy;]
- [Nervous disorders, or substance abuse treatment, except as required by law;]
- [Intentionally self-inflicted injuries or sickness, suicide or any attempt thereat while sane or insane;]
- [Declared or undeclared war or any act thereof;]
- [Participation in a riot or insurrection;]
- [Acts of terrorism, unless committed by individuals or groups will not be excluded from coverage unless the Covered Person who suffered the loss committed the act of terrorism;]
- [Serving on full-time active duty in the Armed Forces of any country or international authority;]
- [The Covered Person's participation, commission of or attempt to commit a felony or criminal offense or to which a contributing cause was the Insured's being engaged in an illegal occupation;]
- [Flying other than as a fare paying passenger, as a pilot or crew member of any aircraft or travel or flight, including boarding or alighting, in any vehicle or device while being used for any test or experimental purposes or while being operated by, for or under the direction of any military authority other than the Military Airlift Command (MAC) of the United States or similar air transport service of any other country;]
- [Work-related Injury or Sickness, whether or not benefits are payable under any state or federal Workers' Compensation, employer's liability or occupational disease law or similar law;]
- [With respect to Accidental Death benefits, Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily Injury or accidental food poisoning.]

In addition to the above exclusions, no benefits will be paid for:

- [[Routine eye examinations or fitting of glasses or contact lenses unless such coverage is provided for under the Policy;]
- [Hearing examinations, or hearing aids, unless provided for under the policy;]
- [Treatment in a Hospital or facility owned or run by the United States Government, unless a charge is made for such services in the absence of insurance; or in a Hospital that does not unconditionally require payment;]
- [Dental exams, care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person's coverage is in force, and rendered within [6] months of the Accident;]
- [Expenses used to meet any deductible, or in excess of the percentages payable, or in excess of those expenses considered Usual and Customary;]
- [Services provided by a member of the Covered Person's immediate family;]
- [Expenses incurred to the extent that they are paid or payable under any automobile insurance policy without regard to fault. (Does not apply in any state where prohibited).]
  
- [Rest care or rehabilitative care and treatment, custodial care, and transportation;]
  
- [Cosmetic surgery or care, or treatment solely for cosmetic purposes, or complication therefrom. This exclusion does not apply to:
  - a. Cosmetic surgery resulting from an accident, if initial treatment of the Covered Person is

- begun within 12 months of the date of the Accident;
- b. Reconstruction incidental to or following surgery resulting from a covered Accident or Sickness or from trauma, infection or other diseases of the involved part;
  - c. Correction of a congenital disease or defect or anomaly that results in a functional defect of a covered Dependent child;
  - d. With respect to a mastectomy:
    - (1) All stages of reconstruction of the breast on which the mastectomy has been performed;
    - (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    - (3) Treatment of physical complications for all stages of the mastectomy, including lymphedema;]

[Immunization shots and routine examinations such as routine physical examinations or pre-marital examinations, except as required by law;]

[Examinations needed for employment, obtaining insurance, team sports, travel, school or camp;]

[Routine newborn care, including routine nursery charges, except as required benefits under state mandates;]

- [Voluntary abortion, unless
- a. The life of Covered Person or his spouse would be endangered if the fetus were carried to term; or
  - b. Medical complications have arisen from an abortion;]

[Sex change procedures;]

- [Experimental health care services unless such services are:
- a. prescribed or recommended as Appropriate Treatment by the Covered Person's Doctor; and
  - b. approved, on a basis other than limited or experimental, by the American Medical Association or the appropriate medical specialty society for such treatment;]

[Diagnosis and treatment of infertility in connection with the reversal of elective sterilizations;]

[Diagnosis and treatment of infertility in connection with: in vitro fertilization, gameteintrafallopian tube transfers or zygote intrafallopian tube transfers; cloning; or medical or surgical services deemed to be experimental;]

[Treatment of exogenous obesity, gastric bypass surgery or weight control;]

[Air ambulance service;]

[Confinement, or services or treatment received on Friday and/or Saturday in the case of a non-emergency Hospital admission, unless a surgical procedure is performed within 24 hours of admission;]

[For the diagnosis of, or any symptom or medical problem, which initiated any investigation leading to a diagnosis of a covered condition, when the condition commenced prior to the Effective Date;]

[For a Loss caused or contributed to by the use of voluntarily self-administered drugs, poisonous or chemical substance other than as prescribed and administered by or in accordance with a Doctor;]

[Non-therapeutic release of radiation;]

[For a Loss caused by or contributed to by participation in a hazardous activity, including but not limited to skydiving, land or water racing, bungee jumping, scuba diving, amateur or interscholastic athletics, sports competition or events, hang gliding, ballooning, parasailing, mountain climbing or hunting;] [or]

[For congenital defects or conditions].

[Medical or healthcare treatment, services, or supplies which:

- Are not Medically Necessary; or
- Are not prescribed by a licensed Doctor as necessary to treat sickness, illness or injuries including Mental Illness; or
- Are experimental or investigational in nature, except as required by law; or
- Are received without charge or legal obligation to pay; or
- Are rendered or supplied to the Named Insured outside the United States, its possessions or the countries of Canada and Mexico.]

### **[PRE-EXISTING CONDITION LIMITATION**

There is no coverage for a pre-existing condition for a continuous period of [12] 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 31 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 31-day period beginning on the date of birth, adoption or placement for adoption, is covered under creditable coverage;
- pregnancy; and
- an individual, and any dependent of such individual, who is eligible for a federal tax credit under the federal Trade Adjustment Assistance Reform Act of 2002 and who has three months or more of creditable coverage.

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 was: (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.]

Credit for Prior Coverage: A Covered Person whose coverage under prior Creditable Coverage ended no more than [63] days before the Covered Person's effective date under the policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than [63] days, we will credit only the days of such coverage after the break.

Creditable Coverage means coverage under any of the following:

- a.) any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
- b.) the federal Medicare Program pursuant to Title XVIII of the Social Security Act;
- c.) the Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;
- d.) Chapter 55 of Title 10, United States Code, the Civilian Health and Medical Program of the Uniformed Services;
- e.) a medical care program of the Indian Health Service or a tribal organization;
- f.) a state health benefit risk pool;
- g.) a health plan offered under chapter 89 of Title 4, United States Code, Federal Employees Health Benefits Program;
- h.) a public health plan as defined by federal regulations; or
- i.) a health benefit plan under section 5(e) of the Peace Corps Act.

## **PREMIUMS**

Premiums are shown on the Schedule of Benefits. The premium must be remitted to us on or before the premium due date [and not more than [31] days after the effective date of the eligible person's coverage]. A person's coverage will not be affected by the Policyholder's failure, due to clerical error, to remit premiums to us on time.

Rates are provided on a group basis. Premiums may be changed on any premium due date, on or after the first anniversary, with [60] days advance notice in writing to the Policyholder.

Grace Period: There is a [31] day grace period after each premium due date after the first premium. If a subsequent premium is not paid on time, coverage will stay in force during the grace period. Coverage will end at the end of the grace period, if the premium is not paid by then. If this happens, the premium for the grace period will still be owed to us.

## CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within 31 days after a covered loss begins, or as soon as reasonably possible. Notice should include information that identifies the claimant and the policy.

Claim Forms: When we receive notice of claim, we will send forms for filing proof of loss to the claimant. If these forms are not sent within [15] days, the claimant will meet the proof of loss requirements if we are given, within 90 days, written proof of the nature and extent of the loss.

Proof of Loss: Written proof of loss must be given to us within 90 days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to us within 1 year after it is due, unless the Insured is legally incapable of doing so.

Time of Payment of Claim: Benefits for loss covered by the policy will be paid as soon as we receive proper written proof of such loss.

Payment of Claims — Accidental Death Benefit: Benefits paid on account of an Insured's death will be paid to the beneficiary he has chosen. This choice must be in writing and filed with us, or filed with the Policyholder if we have agreed in advance. The Insured will automatically be the beneficiary for any covered dependents.

If the insured has not chosen a beneficiary, or if there is no beneficiary alive when he dies, we will pay this benefit:

- a.) to his spouse, if living;
- b.) if not, in equal shares to his living children;
- c.) if there are none, in equal shares to his living parents;
- d.) if there are none, in equal shares to his living brothers and sisters;
- e.) if there are none, to his estate.

Instead of a lump sum payment, the Insured (while he is living) or his beneficiary (after the insured's death) may choose installment payments from one of the settlement options we are then offering, if any.

Payment of Claims — Other Benefits: All benefits will be paid to the Insured, unless an Assignment of Benefits has been requested by the Insured. Any other benefits due and unpaid at the Insured's death will be paid to the Insured's estate. Any payment made by us in good faith pursuant to this provision will fully release us to the extent of such payment.

Selection or Change of Beneficiary Assignment: The Insured has the right to select or change a beneficiary. He does not need the consent of the beneficiary to make such change, to assign his rights or benefits, or to change his coverage. We will not be bound by an assignment, or by a selection or change of beneficiary, until we receive a signed copy of it. We are not responsible for its validity or sufficiency.

Physical Examination and Autopsy: At our expense, we may: have a person claiming benefits examined as often as reasonably necessary while the claim is pending; and to make an autopsy in the case of death where it is not forbidden by law.

Legal Action: No legal action may be brought to recover on the policy before 60 days after written proof of loss has been furnished as required by the policy. No such action may be brought after [3] years from the time written proof of loss is required to be furnished.

Misstatement of Age: If the age of the Covered Person is misstated, all amounts payable under the policy shall be such as the premium paid would have purchased at the correct age.

[Coordination of Benefits: This provision will be used to determine a Covered Person's benefits under the policy if a Covered Person has health care coverage under more than one plan.

**Explanation.** This coordination of benefits (COB) provision applies when a person has health care coverage under more than one plan "Plan" is defined below. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

### **Definitions**

The following definitions apply to this provision:

- A. A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
- (1) "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of \$200 per day; medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
  - (2) "Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of \$200 or less per day; school accident type coverage, benefits for non medical components of group long term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law. Each contract for coverage under (1) or (2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.
- B. The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person. When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.
- C. "Allowable expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:
- (1) If a Covered Person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital. and the private room, (unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms) is not an allowable expense.
  - (2) If a Covered Person is covered by 2 or more plans that compute their benefit payments on the basis of Usual and Customary fees, any amount in excess of the highest of the Usual and Customary fees for a specific benefit is not an allowable expense.
  - (3) If a Covered Person is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
  - (4) If a Covered Person is covered by one plan that calculates its benefits or services on the basis of Usual and Customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements shall be the allowable expense for all plans.

- (5) The amount a benefit is reduced by the primary plan because a Covered Person does not comply with the plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
- D. "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.
- E. "Closed panel plan" is a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

#### **Order of Benefit Determination Rules**

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- A. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- B. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- C. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- D. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
- (1) Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent [(e.g. a retired employee)]; then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
- (2) Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one plan is:
- (a) The primary plan is the plan of the parent whose birthday is earlier in the year if:
- The parents are married;
  - The parents are not separated (whether or not they ever have been married); or
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If both parents have the same birthday, the plan that covered either of the parents longer is primary.
- (b) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.
- (c) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
- The plan of the custodial parent;
  - The plan of the spouse of the custodial parent;
  - The plan of the noncustodial parent; and then
  - The plan of the spouse of the noncustodial parent.

- (3) [Active or inactive employee. The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled B{1}.]
- (4) Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (5) Longer or shorter length of coverage. The plan that covered the person as an employee, member, subscriber or retiree longer is primary.
- (6) If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

#### **Effect on the Benefits of this Plan**

- A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:
  - (1) Determine its obligation to pay or provide benefits under its contract;
  - (2) Determine whether a benefit reserve has been recorded for the covered person; and
  - (3) Determine whether there are any unpaid allowable expenses during that claims determination period. If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to 100% of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.
- B. If a Covered Person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

#### **Right to Receive and Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Us any facts it needs to apply those rules and determine benefits payable.

#### **Facility of Payment**

A payment made under another plan may include an amount that should have been paid under this plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

## **Right of Recovery**

If the amount of the payments made by Us is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.]

## **GENERAL PROVISIONS**

Not in Lieu of Workers' Compensation: The policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

Termination of Policy: The Policyholder may terminate the policy at any time on or after the first anniversary of the policy's effective date, by sending us written notice. This policy will be terminated on the date we receive the written notice or later if so specified. We may not terminate this policy, other than due to one of the following: a) fraud or misrepresentation; or b) non-payment of premiums or failure to pay premiums according to the terms of the policy; or c) violation of any applicable participation or contribution rules; or d) we terminate all similar group health policies in the State.

Termination will be without prejudice to a claim for benefits for covered charges that were incurred while this policy was in force.

Subrogation: If we paid benefits to a Covered Person for Injuries received in a covered Accident, and in our opinion a third party may be liable, we will be subrogated to the extent of such payment and to all rights of the Covered Person regarding recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered person agrees to sign papers and do whatever is necessary to transfer his rights to us. We will exercise such rights on his behalf. The Covered Person further agrees to furnish us with all relevant information and documents.

Incontestability: The validity of the policy shall not be contested except for nonpayment of premiums after it has been in force for 2 years from its date of issue. All statements made by a Covered Person will, in the absence of fraud, be deemed representations and not warranties. No such statement will be used in defense of any claim or in a contest unless the Covered Person has been given a copy. Any misstatement or omission of information made on the Covered Person's application form or on any other materials on which We relied to issue, change or increase coverage will be considered a misrepresentation and may be the basis for later rescission of coverage. After coverage for a Covered Person has been in force for 2 years during the Covered Person's lifetime, We do not have the right to contest coverage, except for fraud or non-payment of premium.

Representations: In the absence of fraud, any statements made by the Policyholder or Covered Person are deemed representations and not warranties.

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.



# Starr Indemnity & Liability Company

Dallas, Texas

Administrative Office: [90 Park Avenue, 7<sup>th</sup> Floor, New York, NY 10016]

## SUPPLEMENTAL ACCIDENT EXPENSE BENEFIT RIDER

### LIMITED BENEFIT, PLEASE READ CAREFULLY

<b>POLICYHOLDER:</b>	[Policyholder Name]
<b>GROUP POLICY NUMBER:</b>	[1234567890]
<b>GROUP POLICY EFFECTIVE DATE:</b>	[MM/DD/YY]
<b>GROUP POLICY ISSUE DATE:</b>	[MM/DD/YY]
<b>GROUP POLICY ANNIVERSARY DATE:</b>	[MM/DD/YY]
<b>PARTICIPATING GROUP:</b>	[Participating Group Name]
<b>PARTICIPATING GROUP NUMBER:</b>	[A1234567890]
<b>STATE OF ISSUE:</b>	[State]
<b>EFFECTIVE DATE OF THIS RIDER:</b>	[MM/DD/YY]

This Supplemental Accident Benefit Rider is a part of the Policy and Certificate to which it is attached. It is issued in consideration of the application and the continued payment of the required premium.

### SCHEDULE OF BENEFITS

Maximum Benefit per Covered Accident      [\$100 - \$5,000]

### SUPPLEMENTAL ACCIDENT BENEFIT

We will pay expenses incurred by a Covered Person per Covered Accident up to the maximum shown in the Schedule of Benefits on this page for Appropriate Treatment of an injury sustained in a Covered Accident received within [180-365] days of the Covered Accident. We will pay this Supplemental Accident Benefit in addition to any benefits payable under the Policy.

Benefits are subject to all terms and conditions of the Policy. This Rider does not waive, alter or extend any provisions or limitations of the Policy except to the extent shown above.

This Rider takes effect and ends concurrently with the Policy and Certificate to which it is attached.

“Covered Accident” means an Accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury covered by the Policy for which benefits are payable.

“Appropriate Treatment” means particularly adapted proper and suitable administration or application of remedies to a Covered Person for an injury sustained in a Covered Accident.



# Starr Indemnity & Liability Company

Dallas, Texas

Administrative Office: [90 Park Avenue, 7<sup>th</sup> Floor, New York, NY 10016]

## VISION BENEFIT RIDER

### LIMITED BENEFIT, PLEASE READ CAREFULLY

<b>POLICYHOLDER:</b>	[Policyholder Name]
<b>GROUP POLICY NUMBER:</b>	[1234657890]
<b>GROUP POLICY EFFECTIVE DATE:</b>	[MM/DD/YY]
<b>GROUP POLICY ISSUE DATE:</b>	[MM/DD/YY]
<b>GROUP POLICY ANNIVERSARY DATE:</b>	[MM/DD/YY]
<b>PARTICIPATING GROUP:</b>	[Participating Group Name]
<b>PARTICIPATING GROUP NUMBER:</b>	[A1234567890]
<b>STATE OF ISSUE:</b>	[State]
<b>EFFECTIVE DATE OF THIS RIDER:</b>	[MM/DD/YY]

This Vision Benefit Rider is a part of the Policy and Certificate to which it is attached. It is issued in consideration of the application and the continued payment of the required premium.

### SCHEDULE OF BENEFITS

[Vision Examination One examination every [12-36] months	[\$25-\$100]
Eyeglass Frames One frame every [12-36] months	[\$25-\$100]
Eyeglass Lenses per pair Single Vision One pair every [12-36] months	[\$25-\$100]
Multi-focal One pair every [12-36] months	[\$25-\$100]
Contact Lenses per pair One pair every [12-36] months	[\$25-\$100]

## VISION BENEFITS

We will pay the Covered Expenses listed below for vision care, treatment and material rendered to a Covered Person by a Physician up to the amounts and limitations shown in the Schedule of Benefits on Page 1 of this Vision Benefits Rider for:

1. eye examination and refractive services;
2. contact lens fitting and prescription services; and
3. post-refractive services.

We will pay the Vision Benefit in addition to any benefits payable under the Policy.

An eye examination and refractive services shall include, but not be limited to, the following:

1. case history;
2. visual acuity (near and distance);
3. external examination (including pupils, modifies, color vision test when indicated);
4. tonometry;
5. refraction (subjective, objective);
6. binocular vision testing when indicated;
7. slit lamp examination of the anterior segment including crystalline lens);
8. assessment; and
9. plans.

A contact lens fitting and prescription services shall include, but not be limited to, the following:

1. keratometry;
2. proper fitting of appropriate contact lenses including the application of trial contact lenses to the corneas;
3. post-dispensing contact lens follow up care including the correction of any ill-fitting or unsuitable lenses for a period of [90] days.

Post-refractive services consist of:

1. ordering lenses and frames (facial measurements, lenticular formula and other specifications);
2. cost of the materials;
3. verification of the completed prescription;
4. adjustment of the completed glasses; and
5. subsequent servicing (refitting, realigning, readjusting, tightening) for a period not to exceed [90] days.

## **VISION BENEFITS LIMITATIONS**

Benefits for vision care will be limited in the following manner:

1. Benefits for an eye examination and refraction [or contact lens fitting and prescription] is limited to once every [12-36] months;
2. [Benefits for a contact lens fitting and prescription is limited to once every [12-36] months;]
3. Benefits for an eyeglass frames is limited to once every [12-36] months;
4. Benefits for an eyeglass lenses is limited to once every [12-36] months;
5. Benefits for an contact lenses is limited to once every [12-36] months; and
6. Benefits for frames, lenses and/or contact lenses will be made only if prescribed by a Physician.

## **VISION BENEFITS EXCLUSIONS**

In addition to the exclusions of the Policy, benefits are not payable under this Rider for:

1. Examinations or material which are not listed as a covered service or supply;
2. Nonprescription lenses and/or frames;
3. Safety glasses and safety goggles;
4. replacement of lenses or frames broken, stolen, or lost before the state intervals in the *Schedule of Benefits*;
5. Medical or surgical treatment of the eye;
6. Drugs or any other medications;
7. Orthoptics or vision training; or
8. Eye examinations or materials necessitated by the Covered Person's employment or furnished as a condition of employment.

Benefits are subject to all terms and conditions of the Policy. This Rider does not waive, alter or extend any provisions or limitations of the Policy except to the extent shown above.

This Rider takes effect and ends concurrently with the Policy and Certificate to which it is attached.



# Starr Indemnity & Liability Company

Dallas, Texas

Administrative Office: [90 Park Avenue, 7<sup>th</sup> Floor, New York, New York 10016]

## GROUP APPLICATION

**GROUP POLICY NUMBER:** [XXX123456789]  
**GROUP POLICY EFFECTIVE DATE:** [January 1, 2010]  
**GROUP POLICY ISSUE DATE:** [January 1, 2011]  
**GROUP POLICY ANNIVERSARY DATE:** [January 1]  
**STATE OF ISSUE:** [State]

Application is made to Us by the Policyholder as listed below.

We hereby agree that the Policy is approved and its terms are accepted.

This Application is completed in duplicate, one copy to be attached to your Policy and the other returned to Us. It is agreed that this Application takes the place of any previous application for your Policy.

Signed at [Any Town, State] the [1<sup>st</sup>] day of [January].

**POLICYHOLDER:** [The ABC Association]

By: \_\_\_\_\_ [Agent: John Doe \_\_\_\_\_]  
Title: \_\_\_\_\_ [\_\_\_\_\_]

[Certain state insurance departments require that we advise you of the following statements:]

**Fraud Warning:** 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, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

## STATE-SPECIFIC REQUIRED FRAUD WARNINGS

**Arkansas and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits 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.

**California Residents:** Any person who knowingly presents a false or fraudulent claim of payment of a loss is guilty of a crime and may be subject to civil fines and confinement in state prison.

**District of Columbia Residents:** 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 and Pennsylvania 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 commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

**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 may include imprisonment, fines or a denial of insurance benefits.

**New Mexico Residents:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

**North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

**Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon Residents:** Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form 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 have violated state law.

**Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

**Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 commits a fraudulent act, which may be a crime and subjects such person to criminal and civil penalties.

**Washington 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.]



# Starr Indemnity & Liability Company

Dallas, Texas

Administrative Office: [90 Park Avenue, 7<sup>th</sup> Floor, New York, NY 10016]

## ENROLLMENT FORM

<b>TO BE COMPLETED BY MEMBER</b>					
Sponsor Member:			Group #:		
New Enrollment					
<input type="checkbox"/> Change      Date of Qualifying Event:					
Please indicate the nature of change/qualifying event:					
<input type="checkbox"/> Beneficiary Change					
<input type="checkbox"/> Annual Enrollment Change					
<input type="checkbox"/> Termination		Date of Termination:		Term Reason:	
NAME (Last)                      (First)                      (Middle Initial)			Social Security Number:		
Home Address (Street):		City	State	Zip	
Telephone Number:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date:	
Marital Status (check one): <input type="checkbox"/> Married    Date: <input type="checkbox"/> Single <input type="checkbox"/> Divorced				<input type="checkbox"/> Legally Separated	
<b>CHECK THE BOXES BELOW FOR COVERAGE ELECTED</b>					
MEDICAL Level of Coverage:	<input type="checkbox"/> Medical Expense <input type="checkbox"/> Supplemental/Additional <input type="checkbox"/> Medical Expense In Network Only <input type="checkbox"/> Outpatient Prescription Drug Coverage <input type="checkbox"/> Vision Coverage <input type="checkbox"/> Supplemental Accident Coverage <input type="checkbox"/> Critical Illness Coverage			<input type="checkbox"/> Decline Medical Coverage Due to other coverage? Yes / No	
	<input type="checkbox"/> Member Only <input type="checkbox"/> Member/Spouse <input type="checkbox"/> MemberPlus One <input type="checkbox"/> Member/Child(ren) <input type="checkbox"/> Member/Family <input type="checkbox"/> Child(ren) Only				
Covered Dependents Full Name	Social Security #	Sex	Birth Date	Student's College, City, State, # Hours	
Spouse					
Dep					
Dep					
Do you or your dependents have other medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, complete this section.					
Insured:      Date of Birth:		Effective Date of Coverage:			
Name of Health Carrier:		Group/Policy #:			
Covered Dependents:					
Do you or your dependents have Medicare Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No      Name of Covered Person					
<input type="checkbox"/> Medicare A <input type="checkbox"/> Medicare B    Medicare # (attach copy of card)			Effective Date		
ACCIDENTAL DEATH INSURANCE Amount Requested:	<input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent				
	\$	\$	\$		



[Certain state insurance departments require that we advise you of the following statements:]

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**California Residents:** Any person who knowingly presents a false or fraudulent claim of payment of a loss is guilty of a crime and may be subject to civil fines and confinement in state prison.

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**Kentucky and Pennsylvania 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 commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

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**New Mexico Residents:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

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**Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon Residents:** Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form 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 have violated state law.

**Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

**Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 commits a fraudulent act, which may be a crime and subjects such person to criminal and civil penalties.

**Washington 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.]



# Starr Indemnity & Liability Company

Dallas, Texas

Administrative Office: [90 Park Avenue, 7<sup>th</sup> Floor, New York, NY 10016]

## ARKANSAS ENDORSEMENT

This Endorsement is attached to and made a part of Group Policy Number [12345] issued to [The ABC Association] (the Policyholder).

Effective [12/01/09 at 12:01 A.M.], the [Policy][ and][ Certificate] [is][are] hereby amended as follows:

1. The "Schedule of Benefits is amended by the deletion of the following:

### Mental Health Benefit

Mental Health Inpatient Maximum Benefit	60 days per Coverage Year per Certificate of Insurance
Mental Health Outpatient Maximum Benefit Coinsurance - paid by Insurance Company	75% for the first 40 Outpatient visits and 60% for any further visits per Coverage Year per Certificate of Insurance

- [2. The "Newborn Child Coverage" provision in the "Eligibility" provision in the "INDIVIDUAL INSURING PROVISIONS" section is deleted in its entirety. The following is substituted in its place:

Newborn Child Coverage: A child of the Insured born while the Policy is in force is covered for Injury and Sickness (including necessary care and treatment of congenital defects, birth abnormality and premature birth, and tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed, as well as any testing of newborn infants mandated by law), as well as routine newborn care and pediatric charges for the first 31 days. The child is covered from the moment of birth. However, You must notify Us in writing within 90 days of such birth or before the next premium due date, whichever is later, in order to have coverage for the newborn child continue.]

- [[3]. The "Adopted Child Coverage" provision in the "Eligibility" provision in the "INDIVIDUAL INSURING PROVISIONS" section is deleted in its entirety. The following is substituted in its place:

Adopted Child Coverage: A minor child who comes under the charge, care and control of the Insured while the policy is in force is covered for injury or Sickness, provided the Insured files a petition to adopt. The coverage of such child will be the same as provided for other members of the Insured's family. Such child shall be covered from the date of placement in the Insured's home if the insured applies for coverage and pays any required premium within 31 days after the date of placement. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 60 days after the child's birth. Such child's coverage will not be subject to any pre-existing conditions limitation provided by this policy. Coverage for such minor child will continue unless the petition for adoption is dismissed or denied.]

[[4]. The "Dependents" provision in the "Termination" provision in the "INDIVIDUAL INSURING PROVISIONS" section is deleted in its entirety. The following is substituted in its place:

[Dependents – Coverage for dependents will end on the earliest of:

- a.) the Insured's termination date; or
- b.) the date the dependent is no longer eligible [unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid].

Coverage will continue for any child who reaches the age limit and is both:

- a.) totally incapable of self-sustaining employment due to physical or mental handicap; and
- b.) chiefly dependent on the Insured for support and maintenance.

The Insured may give us notice of the child's incapacity and dependency.

In no case will coverage end later than the Insured's.]

[[5]. The "Per Coverage Year Medical Expense Benefit – Inpatient [and Outpatient]" provision in the "DESCRIPTION OF BENEFITS" section is amended by the addition of the following:

Covered expenses include:

Administration of general anesthesia and hospital [or ambulatory surgical center] charges for dental care if the provider treating the Covered Person certifies that because of the Covered Person's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the Covered Person is: a child under the age of seven who is determined by two licensed dentists to require without delay necessary dental treatment in a hospital [or ambulatory surgical center] for a significantly complex dental condition; a person with a diagnosed serious mental or physical condition; or a person with a significant behavioral problem as determined by the Covered Person's Doctor.

Medical and surgical benefits for: a hospital stay in connection with a mastectomy for not less than 48 hours unless the decision to discharge the Covered Person before the expiration of the minimum length of stay is made by the Doctor in consultation with the Covered Person; surgery and 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 coverage for physical complications at all stages of a mastectomy, including lymphedemas.

[Children's preventive health care services for Doctor-delivered or Doctor-supervised services for eligible dependents from birth through age 18 years of age, with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards. Periodic preventive care visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Children's preventive health care services that are rendered during a periodic review shall only be covered to the extent that those services are provided by or under the supervision of a single Doctor during the course of one visit. Periodic review will include 20 visits at approximately the following age intervals: birth; 2 weeks; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 2 years; 3 years; 4 years; 5 years; 6 years; 8 years; 10 years; 12 years; 14 years; 16 years; and 18 years.]

Amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas for the treatment of a Covered Person inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism if: the medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism; the products are administered under the direction of a Doctor; and the cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the income tax credit of two thousand four hundred dollars (\$2,400) per year per person.

Care and treatment of loss or impairment of speech or hearing including those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification. This coverage does not apply to hearing instruments or devices.]

- [[6]. The “Per Occurrence Medical Expense Benefit – Inpatient [and Outpatient]” provision in the “DESCRIPTION OF BENEFITS” section is amended by the addition of the following:

Covered expenses include:

Administration of general anesthesia and hospital [or ambulatory surgical center] charges for dental care if the provider treating the Covered Person certifies that because of the Covered Person’s age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the Covered Person is: a child under the age of seven who is determined by two licensed dentists to require without delay necessary dental treatment in a hospital [or ambulatory surgical center] for a significantly complex dental condition; a person with a diagnosed serious mental or physical condition; or a person with a significant behavioral problem as determined by the Covered Person’s Doctor.

Medical and surgical benefits for: a hospital stay in connection with a mastectomy for not less than 48 hours unless the decision to discharge the Covered Person before the expiration of the minimum length of stay is made by the Doctor in consultation with the Covered Person; surgery and 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 coverage for physical complications at all stages of a mastectomy, including lymphedemas.

[Children’s preventive health care services for Doctor-delivered or Doctor-supervised services for eligible dependents from birth through age 18 years of age, with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards. Periodic preventive care visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Children’s preventive health care services that are rendered during a periodic review shall only be covered to the extent that those services are provided by or under the supervision of a single Doctor during the course of one visit. Periodic review will include 20 visits at approximately the following age intervals: birth; 2 weeks; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 2 years; 3 years; 4 years; 5 years; 6 years; 8 years; 10 years; 12 years; 14 years; 16 years; and 18 years.]

Amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas for the treatment of a Covered Person inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism if: the medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism; the products are administered under the direction of a Doctor; and the cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the income tax credit of two thousand four hundred dollars (\$2,400) per year per person.

Care and treatment of loss or impairment of speech or hearing including those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification. This coverage does not apply to hearing instruments or devices.]

- [[7]. The “Per Hospital Confinement Medical Expense Benefit – Inpatient” provision in the “DESCRIPTION OF BENEFITS” section is amended by the addition of the following:

Covered expenses include:

Administration of general anesthesia and hospital charges for dental care if the provider treating the Covered Person certifies that because of the Covered Person’s age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the Covered Person is: a child under the age of seven who is determined by two licensed dentists to require without delay necessary dental treatment in a hospital for a significantly complex dental condition; a person with a diagnosed serious mental or physical condition; or a person with a significant behavioral problem as determined by the Covered Person’s Doctor.

Medical and surgical benefits for: a hospital stay in connection with a mastectomy for not less than 48 hours unless the decision to discharge the Covered Person before the expiration of the minimum length of stay is made by the Doctor in consultation with the Covered Person; surgery and 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 coverage for physical complications at all stages of a mastectomy, including lymphedemas.]

- [[8]. The “Per Coverage Year Medical Expense Benefit In Network Only Option– Accident and Sickness – Hospital and Surgical Benefits – Network Provider: [ABC] Network” provision in the “DESCRIPTION OF BENEFITS” section is amended by the addition of the following:

Covered expenses include:

Administration of general anesthesia and hospital or ambulatory surgical center charges for dental care if the provider treating the Covered Person certifies that because of the Covered Person’s age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the Covered Person is: a child under the age of seven who is determined by two licensed dentists to require without delay necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; a person with a diagnosed serious mental or physical condition; or a person with a significant behavioral problem as determined by the Covered Person’s Doctor.

Medical and surgical benefits for: a hospital stay in connection with a mastectomy for not less than 48 hours unless the decision to discharge the Covered Person before the expiration of the minimum length of stay is made by the Doctor in consultation with the Covered Person; surgery and 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 coverage for physical complications at all stages of a mastectomy, including lymphedemas.]

[Children’s preventive health care services for Doctor-delivered or Doctor-supervised services for eligible dependents from birth through age 18 years of age, with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards. Periodic preventive care visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Children’s preventive health care services that are rendered during a periodic review shall only be covered to the extent that those services are provided by or under the supervision of a single Doctor during the course of one visit. Periodic review will include 20 visits at approximately the following age intervals: birth; 2 weeks; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 2 years; 3 years; 4 years; 5 years; 6 years; 8 years; 10 years; 12 years; 14 years; 16 years; and 18 years.]

Amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas for the treatment of a Covered Person inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism if: the medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism; the products are administered under the direction of a Doctor; and the cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the income tax credit of two thousand four hundred dollars (\$2,400) per year per person.

Care and treatment of loss or impairment of speech or hearing including those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification. This coverage does not apply to hearing instruments or devices.]

- [9]. The "Mental Health Benefits" provision in the "DESCRIPTION OF BENEFITS" section is deleted in its entirety. The following is substituted in its place:

### **MENTAL HEALTH BENEFITS**

#### **Inpatient Benefits**

For Covered Persons confined as an Inpatient to a licensed mental health facility due to Mental Illness we will pay benefits the same as any other Sickness.

#### **Outpatient Benefits**

For Covered Persons seeking treatment for Mental Illness on an Outpatient basis at a licensed mental health facility, we will pay benefits the same as any other Sickness.

***Mental Illness*** means any psychiatric disease identified in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual.

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.

- [[10]. The Certificate is amended by the addition of the following "CONTINUATION OF COVERAGE PRIVILEGE" section:

### **CONTINUATION OF COVERAGE PRIVILEGE**

Coverage for Hospital, surgical and/or Medical Expenses incurred as a result of Injury or Sickness may be continued, under certain circumstances.

#### **Eligibility:**

**Insured:** An Insured may elect to continue coverage for himself [and his covered dependents].

Coverage may be continued for 13 months if one of the following events occurs:

- a.) the Insured's employment is terminated for any reason other than gross misconduct; or
- b.) a reduction in an Insured's hours results in the loss of such coverage.

**Disabled Insured:** Insureds who are determined to be disabled under the Social Security Act within 60 days of the date they become eligible for continuation under this Part, may continue coverage for themselves [and their covered dependents] for up to 29 months.

**[Dependents:** A covered dependent may elect to continue coverage for a period of 36 months if one of the following events occurs:

- a.) the death of the Insured;
- b.) the divorce or legal separation of the insured and dependent spouse;
- c.) the Insured becomes entitled to Medicare benefits;
- d.) a dependent child is no longer a dependent child for the purposes of the plan.]

Evidence of Insurability is not required for this continuation of coverage. If a Covered Person exercises this option, it will be lieu of any continuation rights granted under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

#### **Coverage:**

If a Covered person exercises this option, coverage will be identical in scope to the coverage provided in the policy.

#### **Premiums:**

The Covered Person will pay premiums directly to the Policyholder with the option of paying in monthly installments. The premiums will not exceed 102 percent of the applicable premium for such period.

**Notice Requirements:**

The Policyholder must notify us in writing within 31 days after the date:

- a.) the Insured dies; or
- b.) the Insured's employment is terminated, the Insured's hours are reduced; or
- c.) the Insured becomes entitled to Medicare benefits.

[Each covered dependent who wishes to continue coverage must notify us in writing within 60 days after the date:

- a.) of divorce or legal separation from the Insured, or
- b.) a dependent child is no longer a dependent child for the purposes of the plan.]

Upon our receipt of any such notice, we must give written notice of the right to continue coverage to any insured or his covered dependents within 14 days.

Each Insured [or covered dependent] who wish to continue coverage must notify us in writing within [60] days after the date he receives notice of his right to continue coverage.

**Termination:**

A Covered Person who exercises this option will not have his coverage interrupted or canceled or otherwise terminated until the date on which:

- a.) he fails to make premium payment in the time required to make that payment; or
- b.) he becomes eligible for substantially similar coverage under another group health plan, hospital or medical service subscriber contract, medical practice or other prepayment plan, or any other plan or program (including Medicare); or
- c.) the required period for continued coverage ends; or
- d.) the policy terminates; or
- e.) The Insured provides the Policyholder or us with written notice that he wants his coverage terminated.]

[[11.] The Certificate is amended by the addition of the following "CONVERSION PRIVILEGE" section:

**CONVERSION PRIVILEGE**

A Conversion Privilege will be given if:

- a.) coverage under the policy ends for any reason other than non-payment of premium; and
- b.) the Covered Person is not eligible for or covered by:
  - a. Medicare;
  - b. similar coverage that replaced the terminating coverage within 31 days after the policy ends; or
  - c. full coverage under any other group accident and health policy or contract. This coverage must provide benefits for all preexisting conditions to be considered full coverage.

To convert from coverage under the policy to conversion coverage, written application and first premium payment must be made no more than 31 days after coverage under the policy has ended. Medical evidence of insurability is not required. Questions concerning other coverage under which the person is eligible or is covered may be asked.

The conversion coverage will provide benefits:

- a.) that are of the same type as the benefits provided by the policy for Hospital, surgical or medical expenses; and
- b.) that meet the minimum requirements for a conversion policy in the state where the person resides on the date of conversion. Benefit amounts may be less than those provided by the policy, to the extent permitted by law.

Upon request we will provide full details of the conversion coverage. At our option, we may provide group insurance coverage that meets the above requirements instead of an individual conversion policy.]

[[12.]The “CONVERSION PRIVILEGE” section is deleted in its entirety. The following is substituted in its place:

### CONVERSION PRIVILEGE

A Conversion Privilege will be given if:

- c.) coverage under the policy ends for any reason other than non-payment of premium; and
- d.) the Covered Person is not eligible for or covered by:
  - a. Medicare;
  - b. similar coverage that replaced the terminating coverage within 31 days after the policy ends; or
  - c. full coverage under any other group accident and health policy or contract. This coverage must provide benefits for all preexisting conditions to be considered full coverage.

To convert from coverage under the policy to conversion coverage, written application and first premium payment must be made no more than 31 days after coverage under the policy has ended. Medical evidence of insurability is not required. Questions concerning other coverage under which the person is eligible or is covered may be asked.

The conversion coverage will provide benefits:

- c.) that are of the same type as the benefits provided by the policy for Hospital, surgical or medical expenses; and
- d.) that meet the minimum requirements for a conversion policy in the state where the person resides on the date of conversion. Benefit amounts may be less than those provided by the policy, to the extent permitted by law.

Upon request we will provide full details of the conversion coverage. At our option, we may provide group insurance coverage that meets the above requirements instead of an individual conversion policy.]

[[13.] The “LIMITATIONS AND EXCLUSIONS” section is amended by the deletion of the following:

Acts of terrorism, unless committed by individuals or groups will not be excluded from coverage unless the Covered Person who suffered the loss committed the act of terrorism;]

[14]. The “Time of Payment of Claim” provision in the “CLAIM PROVISIONS” section is deleted in its entirety. The following is substituted in its place:

Benefits for loss covered by the policy will be paid immediately upon our receipt of proper written proof of such loss. In no event will benefits due be paid not more than 30 days after We receive written proof of loss electronically or 45 days if the claim is submitted by other means.

In all other respects, the [Policy] [and] [Certificate] remain(s) the same.

Signed for the STARR INDEMNITY & LIABILITY COMPANY:

[Honora M. Keane], General Counsel

[Charles H. Dangelo], President



# Starr Indemnity & Liability Company

Dallas, Texas

Administrative Office: [90 Park Avenue, 7<sup>th</sup> Floor, New York, NY 10016]

## Arkansas Mandatory Offer of Coverage

I hereby \_\_\_\_\_ elect \_\_\_\_\_ decline the offer that coverage be provided for the treatment of alcohol or drug dependency the same as any other Sickness, pursuant to Section 23-79-139, subject to the following:

For each twenty-four-month period, a maximum benefit of \$6,000 will be provided for the necessary care and treatment of alcohol or drug dependency. A maximum lifetime benefit of \$12,000 will be provided for each Covered Person.

No more than one-half ( 1/2 ) of the policy's or contract's maximum benefits for alcohol or drug dependency for a twenty-four-month period shall be paid for the necessary care and treatment of alcohol or drug dependency in any thirty-consecutive-day period; and

The policy or contract shall provide a minimum benefit of twelve thousand dollars (\$12,000) for the necessary care and treatment of alcohol or drug dependency for the life of the recipient of benefits.

Dated at: \_\_\_\_\_  
(City, State)

By: \_\_\_\_\_  
(Authorized Signature/Title)

On: \_\_\_\_\_  
Date (mm/dd/yyyy)

By: \_\_\_\_\_  
(Printed Agent/Broker Name)

\_\_\_\_\_  
(Signature of Agent/Broker)

SERFF Tracking Number: CMPL-126439621 State: Arkansas  
 Filing Company: Starr Indemnity & Liability Company State Tracking Number: 44468  
 Company Tracking Number: STARR ILC GH IND NCE  
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only  
 Expense  
 Product Name: STARR ILC GH IND NCE  
 Project Name/Number: STARR ILC GH IND NCE /STARR ILC GH IND NCE

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	01/21/2010
<b>Comments:</b>		
<b>Attachment:</b> AR READABILITY CERTIFICATION SIGNED 1.04.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	01/21/2010
<b>Comments:</b> acknowledged and included on the form schedule for your review and approval		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Authorization	Approved-Closed	01/21/2010
<b>Comments:</b>		
<b>Attachment:</b> Signed Auth 10.27.09.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> ByLaws	Approved-Closed	01/21/2010
<b>Comments:</b>		
<b>Attachment:</b> NCE CONSTITUTION & BYLAWS 7.20.09.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> COC	Approved-Closed	01/21/2010
<b>Comments:</b>		



# READABILITY CERTIFICATION

## Starr Indemnity & Liability Company

NAIC: 38318

FEIN Number: 75-1670124

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>
AH-70001CN-AR	Certificate of Insurance	43.9
AH-70017	Supplemental Accident Expense Benefit Rider	40.2
AH-70018	Vision Benefit Rider	40
AH-70003N	Group Application	
AH-70007MN	Enrollment Form	
AH-70010N-AR	Arkansas Endorsement	41.5
AH-70010N-ARO	Arkansas Offer	40.1

  
\_\_\_\_\_  
(Signature)

General Counsel  
\_\_\_\_\_  
(Title)

January 4, 2010  
\_\_\_\_\_  
(Date)



## Starr Indemnity & Liability Company

October 27, 2009

NAIC Company Code: 38318  
NAIC Group Code: 0000  
FEIN: 75-1670124

TOI: H15G Group Health  
Sub TOI: H15G.002 Large Group Only

Forms: AH-70001N et al

To: All Departments of Insurance

Starr Indemnity & Liability Company hereby authorizes Compliance Research Services, LLC to represent us in the submission of the above-referenced forms and to negotiate with insurance departments for their approval.

Representatives of Compliance Research Services LLC include:  
J. David Simon, CRS President  
Nancy L. French, Product Manager

Sincerely,

A handwritten signature in cursive script that reads "Honora M. Keane". The signature is written in black ink and is positioned above the printed name and title.

Honora M. Keane  
General Counsel

**AMENDED CONSTITUTION AND BY-LAWS**  
**OF**  
**THE N.C.E**

ARTICLE I  
NAME & OFFICE

**Section 1 – Name**

The name of the Association shall be **The N.C.E. also known as The NATIONAL CONGRESS OF EMPLOYERS.**

**Section 2 – Office**

The principal offices of the association shall be located at 1001, Pennsylvania Avenue, Washington D.C. and additional Chapter offices in New York and any other location the Board deems appropriate.

ARTICLE II  
SEAL

**Section 1 – Seal**

The association shall have a common seal consisting of a design to be determined by vote of the Board of Directors. The Seal shall contain the name of the Organization in a semi-circular fashion and the year of formal organization, 1996 surrounding or overwritten on an acceptable symbol embodying the purpose of the Organization.

ARTICLE III  
PURPOSE

**Section 1 – Mission:**

The mission of the Association is to impact public policy at the state and federal level and be a key business resource for small, independent business in America. To render public services as non-partisan, non-profit, and non-stock organization. To develop acquaintance and fellowship, undertake projects, and act upon matters of common interest and welfare to the members of the association; To instill, foster, encourage, and promote among members of the association the importance of adhering to the highest ethical standards of their respective professions; To establish facilities and provide forum for the interchange of ideas, opinions, technical know-how, and experiences among members of the association and other national and international organizations.

**Section 2 - Core Values**

We Believe Deeply That:

- Small, independent business is essential to America.
- Free enterprise is essential to the start-up and expansion of small business.
- Small business is threatened by government intervention.
- An informed, educated, concerned and involved public is the ultimate safeguard for small independent business.
- Members determine the public policy positions of the organization.
- Our Members, collectively and individually, determine the success of N.C.E's endeavors, and each person has a valued contribution to make.
- Honesty, integrity and respect for human and spiritual values are important in all aspects of life, and are essential to a sustaining a successful work environment.

ARTICLE IV  
MEMBERSHIP

**Section 1 – Qualifications**

The N.C.E. is a private, not for profit, fraternal organization which neither seeks nor accepts public or corporate funding in any form. Membership is reserved for those individuals that embody the purposes and ideals of the N.C.E. as defined by the Board of Directors. The Board and its Membership Committee reserves the right to deny membership to any applicant for any reason. Notwithstanding the foregoing, the Board shall not deny membership on the basis of race, religion or gender.

**Section 2 - Classification of Members**

Membership into this organization shall be classified as follows:

1. CHARTER MEMBERS – These shall include the names of founding members; Hon. George F. Sabatella, Hon. Robert DiCarlo, Christopher G. Sabatella, Mathew D. Saronson and Andrea Ceretti, Michael DiFilippo
  
2. ACTIVE MEMBERS – These shall include individuals operating sole proprietorships “Freelancers” and other like situated individuals duly enrolled and in good standing, having been approved for full membership by the Board of Directors or their duly authorized delegated Membership Committee.
  
2. ASSOCIATE MEMBERS – These shall include individuals that are members of the association but do not enjoy voting rights, cannot head committee chairmanships not have access to the other emollients of Full Membership in good standing. .

4. SUPPORTING MEMBERS – These shall include individuals who are conferred membership as such by the Board of Directors.

## **Section 2 – Rights and Privileges**

1. CHARTER MEMBER – They shall be entitled to all the privileges and services offered by the association, and shall serve as permanent members of the Board of Directors.
2. ACTIVE MEMBER – They shall be entitled to all the privileges and services offered by the association. Each member may vote and be voted upon, for office in the Organization
3. AFFILIATE MEMBER – This Affiliate Members shall enjoy the same rights as Active Members. They shall be free to participate in the political, educational and charitable activities of the Organization. However, Association members are not entitled to hold office nor vote nor be voted upon.
4. HONORARY MEMBER – They shall be entitled to all privileges and services offered by the Association. However, they may neither vote nor be voted upon.
5. OTHER PRIVILEGES - Other membership privileges include participation in various activities, programs and publications of the Association as may be designated from time to time by the Board of Directors.

### **Section 3 – Fees and Dues**

1. The Board of Directors may at any meeting of the Board adjust the membership dues applicable to the classes of members enumerated in these Bylaws, without amending the Bylaws. Provided, however, that any dues increase which exceeds the cumulative increase of the Composite Consumer Price Index since the last dues increase must be confirmed by a majority of the Board of Directors. Dues shall be payable in advance of the month due.
2. The Board of Directors shall determine the charges for all other fees Associated with meetings or any other products provided by the Association.
3. Monthly membership dues will include fees for general membership meetings and publications.

### **Section 4 – Admission and Effectiveness of Membership**

1. Applications for membership shall be made in writing. Applications shall be processed by the membership committee. The applicant will be advised of action taken in their application.
3. Effectiveness of membership shall start from the payment of entrance fees and membership dues of the applicant and after submission of other requirements that may be imposed by the membership committee and/or Board of Directors.
3. Fees shall be paid within thirty (30) days after official approval of application for membership.

### **Section 6 – Members in Good Standing**

In order to be a member in good standing, a member shall have paid all dues and assessments within (30) days after the same shall have become due and payable.

### **Section 7 – Liability of Members**

Members who have not fully paid their annual dues and other obligations to the association shall be liable for any indebtedness of the association to the extent of their unpaid accounts.

### **Section 8 – Termination of Membership**

Any member may be separated from membership for any of the following causes:

1. Any member who shall have defaulted in the payment of dues and assessments for two (2) successive month shall be automatically suspended after due notices had been given and will forfeit all rights and privileges in the association; provided, however, that any member so suspended may be reinstated to full standing upon payment of all dues in arrears and upon the approval of the majority of the Board of Directors;
2. Any other cause or causes detrimental to the association upon which, after due notice, investigation and hearing, the Board of Directors vote in favor of termination.

## **ARTICLE V MEETINGS**

### **Section 1 – Annual Meetings**

The annual general membership meeting, for the purpose of election of the Board of Directors, shall be held on the third Friday of December of each year at the

principal office of the association or at any place in State of New York or District of Columbia to be decided on by the Board of Directors.

The order of business shall be as follows:

- Reading of the Minutes of the last Annual General Membership Meeting and approval thereof;
- Report of the Treasurer;
- Report of the President;
- General Annual Elections of the Board of Directors;
- Unfinished business;
- New and other business;
- Report of the election committee and announcement of the results of the election.

### **Section 2 – Special Meetings**

Special meetings of the association may be called anytime by the Executive Director or by a majority of the Board of Directors whenever either shall deem it necessary.

### **Section 3 – Notice of Meetings**

The notice of the annual meetings or special meetings must be advised to all members in writing at least one week before the meeting.

### **Section 4 – Quorum**

A simple majority (50% + 1) of the Active members in good standing, including proxies, shall constitute a quorum for the election of the Directors or for the transaction of any other business except in those cases where the By-Laws require the affirmative vote of a greater proportion.

ARTICLE VI  
VOTING RULES AND REGULATIONS

**Section 1 – Election Committee**

An election committee shall be appointed by the Board of Directors to conduct elections. It shall be formed not later than ninety (90) days before the election from among members who do not intend to run for office. No member of the election committee can be voted upon. The members of the committee shall select their chairperson. The administrative officer shall be an ex-officio member. The committees empowered to formulate rules and regulations concerning the manner of elections and questions of eligibility, breaking of all ties, and such other matters relative to the elections. The committee shall automatically be dissolved after it has canvassed the election returns and proclaimed the winning candidates. The rules to be set by the committee on elections shall be disseminated to the membership at least three (3) days prior to the election.

**Section 2– Manner of Nomination**

A certified list of official representatives of members in good standing shall be sent out together with nomination forms to all members in good standing of the association not later than sixty (60) days prior to the election.

Any voting member may nominate a maximum of nine (9) names from those enumerated in the certified list. Nominations shall be received by the Election Committee not later than thirty (30) days prior to the election after which date the nominations shall be deemed closed.

The Election Committee will inform all nominees of their nomination and acceptance therefore shall be received from them in writing.

The final list of candidates, arranged alphabetically, will be circulated to all voting members not later than 15 days before the election. The list shall not indicate the number of nominations received by each candidate.

In the event that the number of candidates equal or would be less than the number of elective positions, the nomination shall be declared re-opened by the Election Committee on the floor during election day.

#### **Section 4 – Voting of Members**

Founding and Active members of good standing (Voting Members) may vote at all meetings. Each Voting Member is entitled to one vote that may be cast in person either in person or with approval of the Board of Directors via telephonic participation. In voting for members of the Board of Directors, each Voting Member shall vote a maximum of nine (9) different candidates. If any voting member cannot attend the election, he may submit a written proxy to the committee on election before the election, which shall be used for quorum purposes only.

#### **Section 5 – Certification**

Prior to the elections, the Committee on Elections shall certify that all the candidates are qualified and have been nominated in accordance with the Constitution and By-Laws of The N.C.E..

#### **Section 6 – Election of Directors**

The election of Directors shall be by secret ballot. Action on all other matters shall be by ‘aye’ or ‘nay’ vote or by other means as the majority present may decide.

#### **Section 7 – Manner in Deciding a Tie**

Should there be a tie in the election for Director, the same shall be decided by drawing lots.

### **Section 8 – Campaign**

Any candidate for election may campaign for his candidacy by sending personalized letters only to members of the association. Any other form of campaigning is disallowed and considered a violation of election rules. However, on the election floor, candidates may distribute personal business cards.

### **Section 9 – Violation of Rules**

Any willful violation of election rules by any member of the association shall disqualify them from running for office and/or voting during the election and will subject them to disciplinary action.

## ARTICLE VII BOARD OF DIRECTORS

### **Section 1 – Number and Term of Office**

The management of the affairs of the association shall be vested in the Board of Directors consisting of no fewer than four (4) and no greater than nine (9) members who shall be elected bi-annually by the voting members of the association.

### **Section 2 – Quorum**

The Directors shall act only as a Board. No individual Director shall have the power to act in behalf of the Board. An attendance of a quorum of Directors is necessary at all meetings for the transaction of any business and every decision of majority of those present shall be valid as an Association act. A Quorum shall consist of a simple majority of Directors (50% +1)

### **Section 3 – Regular Meetings**

The Board of Directors shall hold regular meetings every second Wednesday of the month at the office of the association or at any date and place to be designated by the Board.

#### **Section 4 – Special Meetings**

Special meetings of the Board of Directors may be called by the Executive Director or at the written request of the majority of the directors. Notice of special meeting shall be given at least twenty-four (24) hours before the date of the meeting. Notice of such meeting shall be deemed waived if all members of the Board are present.

#### **Section 5 – Powers**

The Board of Directors shall exercise the following powers and such other powers as may be provided for by the laws of the State of New York:

1. To promulgate such rules and regulations not inconsistent with these By-Laws;
2. To manage the affairs of the association within the context of the By-Laws and Articles of Incorporation;
3. To purchase or acquire or sell or dispose of assets for the association on such terms and conditions as it shall be deemed proper;
4. To employ and fix the compensation of the administrative officer, employees, and other officers of the association;
5. To act on all matters as may be designated by the association as a whole.
6. To alter, merge or subdivide the association as the Board sees fit and to best serve the interests of the membership.
7. To perform any and all tasks necessary to further the interests of the Association, limited only by these by-laws and the laws of the State of New York.
7. To enter into contracts, form or execute trusts, subsidiary organizations,
8. to enter into partnership agreements or strategic alliances with like intended associations or groups.
9. Approves an annual budget and financial audit
10. Approves the time and place for the annual meetings of the members

and the Board of Directors and all business meetings of the Board.

11. Hire staff as it deems necessary
12. Approves all committees and organizational appointments
13. Fills vacancies on the Board of Directors
14. Serves as the primary strategic planning unit for the corporation.
15. Establishes organizational policies and develops strategies and allocates resources to implement same.

### **Section 6 – Resignation**

Any Director or officer may resign his office in writing. Such resignation should take effect upon approval and clearance by the Board.

### **Section 7 – Vacancy**

In the event of any vacancy in the Board of Directors by reason of resignation, termination, death, inability to discharge responsibilities, or for any other reason acceptable to the Board, said vacancy shall, with the approval of the remaining Board of Directors be filled by the surviving spouse of the Director, for the remainder of that Director's Term of Office. Subsequent vacancies shall likewise be filled in the same manner from candidates ranked in the descending order of number of votes received.

If the vacancy is in the ranks of principal officers of the Board, it shall be filled by election from among the members of the Board during the next regular or special meeting held for the purpose.

## **ARTICLE VIII**

### **OFFICERS**

#### **Section 1 – Principal Officers**

Within the next fifteen (15) days after the election, as provided for in Article V, Section 1, the members of the Board of the Directors shall elect from among themselves the Executive Director, President, Secretary and Treasurer.

### **Section 2 - Subordinate Officers**

The Boards, in its discretion, may create those new, subordinate offices they deem necessary. The subordinate officers shall be members of the association, shall be appointed by the Board of Directors. The subordinate officers may be employed by the Board of Directors who shall determine the compensation of all subordinate officers.

### **Section 3 – Compensation of Officers**

The President, Executive Director, Secretary, Treasurer, and members of the Board of Directors shall receive no compensation. Salaries and compensation of other officers shall be fixed by the Board of Directors, provided that no member of the association shall be appointed or elected to any position carrying with it compensation.

## ARTICLE IX

### DUTIES OF OFFICERS

#### **Section 1 – Powers and Duties of the Executive Director**

The Executive Director shall be the Chief Executive Officer of the association and, as such, shall exercise all the powers and discharge all such duties regularly or continually inherent in his office under the law, and such others as may be required by resolutions of the Board of Directors and of the association.

#### **Section 2 – Powers and Duties of the President**

The President shall act as Deputy Executive Officer and shall exercise and discharge all the powers and the duties of the President in case of the disability or

absence of the latter. The President shall have direction of the following standing committees:

1. Membership Committee
2. Political Action Committee
3. Member Benefit Committee
4. Education Committee
5. Legal Committee
6. Charitable Works Committee
7. Other committees and functions as may be assigned to him.

Each committee shall be headed by a Chairperson.

#### **Section 5 – Powers and Duties of the Secretary**

The Secretary, who must be a member of the N.C.E., shall be the custodian of all corporate records and other minutes of all meetings of the association and of the Board of Directors. He shall issue notices of meetings and prepare the Order of Business thereof. He shall keep in safe custody the seal of the association and when authorized by the Board of Directors shall affix such seal to any instrument requiring the same. The seal so affixed shall be attested by him. He shall perform such other duties as may be delegated to him by the Executive Director or the Board of Directors or as may be required of him.

#### **Section 6 – Powers and Duties of the Treasurer**

The Treasurer shall be the finance officer of the association and as such shall be the custodian of all funds and properties of the association. He shall have charge of all the books of accounts of the association. He shall be responsible for all the collection of all the fees and dues from members. He shall make such disbursements as may be authorized by the Board. He shall make an annual financial report to the association and such other reports as the Board of Directors may require.

### ARTICLE X

## COMMITTEES

### **Section 1 – Standing Committees**

There shall be three major standing committees governed by a fourth, governed by the Executive Committee, namely:

1. Membership Committee
2. Political Action Committee
3. Member Benefit Committee

All standing committees shall submit their master programs for the fiscal year to the Board not later than the second regular Board meeting.

### **Section 2 – Executive Committee**

It shall be composed of the Executive Director, the President, the Secretary, the Treasurer, and the Chairman of each of the three Standing Committees.

The committee shall be responsible for the preparation of the annual budget for submission to the Board of Directors not later than the second regular meeting of the Board. It shall also formulate policies and procedures in furtherance of the objectives of the association for submission to the Board, and direct the governance and running of the standing committees. It shall also perform such other duties as may be delegated by the Board of Directors.

## ARTICLE XI

### GENERAL PROVISIONS

#### **Section 1 – Fiscal Year**

The fiscal year shall begin on January 1 and end on December 31 of the same year.

#### **Section 2 – Budget**

The Board of Directors shall approve the annual budget of the association within fifteen (15) days after receipt of the recommended budget from the Executive Committee. The approved budget shall be the appropriated measure of the association. No expenditures in excess of the budget shall be authorized without the prior approval of the Board of Directors.

### **Section 3 – Signatories**

All disbursements of funds of the association shall be made by checks. Checks shall be signed by the Executive Director and countersigned by the President. The Board of Directors may authorized any officer or officers to sign in place of the duly authorized signatories.

## ARTICLE XII AMENDMENTS

### **Section 1 – Amendments**

A two-third majority of the members of the Board of Directors may amend or repeal these By-Laws or adopt new By-Laws.

## ARTICLE XIII TRANSITORY PROVISIONS

### **Section 1 – Regular Members**

All Charter, Active and Honorary members of the association in good standing as of the approval of these amended By-Laws are ipso facto members of the association.

## ARTICLE XIV ASSOCIATION RELATIONSHIPS

### **Section 1- Affiliation With Other Professional Organizations**

All members shall be encouraged to maintain active membership in local, national, and international organizations. The Association shall maintain an affiliation with its sister Associations the National Congress of Employees. The

Association may seek affiliation with like intended organizations as determined by the Board of Directors.

ARTICLE XV  
LIQUIDATION

**Section 1 – Dissolution**

In the event of the liquidation and dissolution of the N.C.E., any properties, funds or monies, securities or other assets remaining in the treasury of, or to the account of, or otherwise belonging to, the N.C.E. shall be disposed of as follows:

- (a) All liabilities and obligations of the N.C.E. shall be paid and discharged, or adequate provision shall be made therefore:
  
- (b) Assets held by the N.C.E. subject to legally valid requirements for their return, transfer, or conveyance, upon dissolution and liquidation, shall be returned, transferred, or conveyed in accordance with such requirements: and
  
- (c) All remaining assets held by the N.C.E. shall be transferred or conveyed, without obligation, to another not for profit organization or foundation selected by the Board of Directors in office at the point dissolution is decided upon.

**Certificate of Compliance with  
Arkansas Rule and Regulation 19**

Insurer: **Starr Indemnity & Liability Company**

Form Number(s):	AH-70001CN-AR	Certificate of Insurance
	AH-70017	Supplemental Accident Expense Benefit Rider
	AH-70018	Vision Benefit Rider
	AH-70003N	Group Application
	AH-70007MN	Enrollment Form
	AH-70010N-AR	Arkansas Endorsement
	AH-70010N-ARO	Arkansas Offer

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



Signature of Company Officer

Honora M. Keane

Name

General Counsel

Title

1-4-2010

Date

SERFF Tracking Number: CMPL-126439621 State: Arkansas  
 Filing Company: Starr Indemnity & Liability Company State Tracking Number: 44468  
 Company Tracking Number: STARR ILC GH IND NCE  
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only  
 Expense  
 Product Name: STARR ILC GH IND NCE  
 Project Name/Number: STARR ILC GH IND NCE /STARR ILC GH IND NCE

## Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/04/2010	Form	Arkansas Endorsement	01/19/2010	AH-70010N-AR END NCE 12.23.pdf (Superseded)



# Starr Indemnity & Liability Company

Dallas, Texas

Administrative Office: [90 Park Avenue, 7<sup>th</sup> Floor, New York, NY 10016]

## ARKANSAS ENDORSEMENT

This Endorsement is attached to and made a part of Group Policy Number [12345] issued to [The ABC Association] (the Policyholder).

Effective [12/01/09 at 12:01 A.M.], the [Policy][ and][ Certificate] [is][are] hereby amended as follows:

- [1. The "Newborn Child Coverage" provision in the "Eligibility" provision in the "INDIVIDUAL INSURING PROVISIONS" section is deleted in its entirety. The following is substituted in its place:

Newborn Child Coverage: A child of the Insured born while the Policy is in force is covered for Injury and Sickness (including necessary care and treatment of congenital defects, birth abnormality and premature birth, and tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed, as well as any testing of newborn infants mandated by law), as well as routine newborn care and pediatric charges for the first 31 days. The child is covered from the moment of birth. However, You must notify Us in writing within 90 days of such birth or before the next premium due date, whichever is later, in order to have coverage for the newborn child continue.]

- [[2]. The "Adopted Child Coverage" provision in the "Eligibility" provision in the "INDIVIDUAL INSURING PROVISIONS" section is deleted in its entirety. The following is substituted in its place:

Adopted Child Coverage: A minor child who comes under the charge, care and control of the Insured while the policy is in force is covered for injury or Sickness, provided the Insured files a petition to adopt. The coverage of such child will be the same as provided for other members of the Insured's family. Such child shall be covered from the date of placement in the Insured's home if the insured applies for coverage and pays any required premium within 31 days after the date of placement. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 60 days after the child's birth. Such child's coverage will not be subject to any pre-existing conditions limitation provided by this policy. Coverage for such minor child will continue unless the petition for adoption is dismissed or denied.]

- [[3]. The "Dependents" provision in the "Termination" provision in the "INDIVIDUAL INSURING PROVISIONS" section is deleted in its entirety. The following is substituted in its place:

[Dependents – Coverage for dependents will end on the earliest of:

- a.) the Insured's termination date; or
- b.) the date the dependent is no longer eligible [unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid].

Coverage will continue for any child who reaches the age limit and is both:

- a.) totally incapable of self-sustaining employment due to physical or mental handicap; and
- b.) chiefly dependent on the Insured for support and maintenance.

The Insured may give us notice of the child's incapacity and dependency.

In no case will coverage end later than the Insured's.]

- [[4]. The “Per Coverage Year Medical Expense Benefit – Inpatient [and Outpatient]” provision in the “DESCRIPTION OF BENEFITS” section is amended by the addition of the following:

Covered expenses include:

Administration of general anesthesia and hospital [or ambulatory surgical center] charges for dental care if the provider treating the Covered Person certifies that because of the Covered Person’s age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the Covered Person is: a child under the age of seven who is determined by two licensed dentists to require without delay necessary dental treatment in a hospital [or ambulatory surgical center] for a significantly complex dental condition; a person with a diagnosed serious mental or physical condition; or a person with a significant behavioral problem as determined by the Covered Person’s Doctor.

Medical and surgical benefits for: a hospital stay in connection with a mastectomy for not less than 48 hours unless the decision to discharge the Covered Person before the expiration of the minimum length of stay is made by the Doctor in consultation with the Covered Person; surgery and 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 coverage for physical complications at all stages of a mastectomy, including lymphedemas.

[Children’s preventive health care services for Doctor-delivered or Doctor-supervised services for eligible dependents from birth through age 18 years of age, with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards. Periodic preventive care visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Children’s preventive health care services that are rendered during a periodic review shall only be covered to the extent that those services are provided by or under the supervision of a single Doctor during the course of one visit. Periodic review will include 20 visits at approximately the following age intervals: birth; 2 weeks; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 2 years; 3 years; 4 years; 5 years; 6 years; 8 years; 10 years; 12 years; 14 years; 16 years; and 18 years.]

Amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas for the treatment of a Covered Person inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism if: the medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism; the products are administered under the direction of a Doctor; and the cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the income tax credit of two thousand four hundred dollars (\$2,400) per year per person.

Care and treatment of loss or impairment of speech or hearing including those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification. This coverage does not apply to hearing instruments or devices.]

- [[5]. The “Per Occurrence Medical Expense Benefit – Inpatient [and Outpatient]” provision in the “DESCRIPTION OF BENEFITS” section is amended by the addition of the following:

Covered expenses include:

Administration of general anesthesia and hospital [or ambulatory surgical center] charges for dental care if the provider treating the Covered Person certifies that because of the Covered Person’s age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the Covered Person is: a child under the age of seven who is determined by two licensed dentists to require without delay necessary dental treatment in a hospital [or ambulatory surgical center] for a significantly complex dental condition; a person with a diagnosed serious mental or physical condition; or a person with a significant behavioral problem as determined by the Covered Person’s Doctor.

Medical and surgical benefits for: a hospital stay in connection with a mastectomy for not less than 48 hours unless the decision to discharge the Covered Person before the expiration of the minimum length of stay is made by the Doctor in consultation with the Covered Person; surgery and 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 coverage for physical complications at all stages of a mastectomy, including lymphedemas.

[Children's preventive health care services for Doctor-delivered or Doctor-supervised services for eligible dependents from birth through age 18 years of age, with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards. Periodic preventive care visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Children's preventive health care services that are rendered during a periodic review shall only be covered to the extent that those services are provided by or under the supervision of a single Doctor during the course of one visit. Periodic review will include 20 visits at approximately the following age intervals: birth; 2 weeks; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 2 years; 3 years; 4 years; 5 years; 6 years; 8 years; 10 years; 12 years; 14 years; 16 years; and 18 years.]

Amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas for the treatment of a Covered Person inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism if: the medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism; the products are administered under the direction of a Doctor; and the cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the income tax credit of two thousand four hundred dollars (\$2,400) per year per person.

Care and treatment of loss or impairment of speech or hearing including those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification. This coverage does not apply to hearing instruments or devices.]

- [[6]. The "Per Hospital Confinement Medical Expense Benefit – Inpatient" provision in the "DESCRIPTION OF BENEFITS" section is amended by the addition of the following:

Covered expenses include:

Administration of general anesthesia and hospital charges for dental care if the provider treating the Covered Person certifies that because of the Covered Person's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the Covered Person is: a child under the age of seven who is determined by two licensed dentists to require without delay necessary dental treatment in a hospital for a significantly complex dental condition; a person with a diagnosed serious mental or physical condition; or a person with a significant behavioral problem as determined by the Covered Person's Doctor.

Medical and surgical benefits for: a hospital stay in connection with a mastectomy for not less than 48 hours unless the decision to discharge the Covered Person before the expiration of the minimum length of stay is made by the Doctor in consultation with the Covered Person; surgery and 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 coverage for physical complications at all stages of a mastectomy, including lymphedemas.]

- [[7]. The "Per Coverage Year Medical Expense Benefit In Network Only Option– Accident and Sickness – Hospital and Surgical Benefits – Network Provider: [ABC] Network" provision in the "DESCRIPTION OF BENEFITS" section is amended by the addition of the following:

Covered expenses include:

Administration of general anesthesia and hospital or ambulatory surgical center charges for dental care if the provider treating the Covered Person certifies that because of the Covered Person's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively

perform the procedures and the Covered Person is: a child under the age of seven who is determined by two licensed dentists to require without delay necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; a person with a diagnosed serious mental or physical condition; or a person with a significant behavioral problem as determined by the Covered Person's Doctor.

Medical and surgical benefits for: a hospital stay in connection with a mastectomy for not less than 48 hours unless the decision to discharge the Covered Person before the expiration of the minimum length of stay is made by the Doctor in consultation with the Covered Person; surgery and 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 coverage for physical complications at all stages of a mastectomy, including lymphedemas.

[Children's preventive health care services for Doctor-delivered or Doctor-supervised services for eligible dependents from birth through age 18 years of age, with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards. Periodic preventive care visits means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Children's preventive health care services that are rendered during a periodic review shall only be covered to the extent that those services are provided by or under the supervision of a single Doctor during the course of one visit. Periodic review will include 20 visits at approximately the following age intervals: birth; 2 weeks; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 2 years; 3 years; 4 years; 5 years; 6 years; 8 years; 10 years; 12 years; 14 years; 16 years; and 18 years.]

Amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas for the treatment of a Covered Person inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism if: the medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism; the products are administered under the direction of a Doctor; and the cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the income tax credit of two thousand four hundred dollars (\$2,400) per year per person.

Care and treatment of loss or impairment of speech or hearing including those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification. This coverage does not apply to hearing instruments or devices.]

- [8]. The "Mental Health Benefits" provision in the "DESCRIPTION OF BENEFITS" section is deleted in its entirety. The following is substituted in its place:

## **MENTAL HEALTH BENEFITS**

### **Inpatient Benefits**

For Covered Persons confined as an Inpatient to a licensed mental health facility due to Mental Illness we will pay benefits the same as any other Sickness.

### **Outpatient Benefits**

For Covered Persons seeking treatment for Mental Illness on an Outpatient basis at a licensed mental health facility, we will pay benefits the same as any other Sickness.

***Mental Illness*** means any psychiatric disease identified in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual.

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.

[[9]. The Certificate is amended by the addition of the following "CONTINUATION OF COVERAGE PRIVILEGE" section:

### **CONTINUATION OF COVERAGE PRIVILEGE**

Coverage for Hospital, surgical and/or Medical Expenses incurred as a result of Injury or Sickness may be continued, under certain circumstances.

#### **Eligibility:**

Insured: An Insured may elect to continue coverage for himself [and his covered dependents].

Coverage may be continued for 13 months if one of the following events occurs:

- a.) the Insured's employment is terminated for any reason other than gross misconduct; or
- b.) a reduction in an Insured's hours results in the loss of such coverage.

Disabled Insured: Insureds who are determined to be disabled under the Social Security Act within 60 days of the date they become eligible for continuation under this Part, may continue coverage for themselves [and their covered dependents] for up to 29 months.

[Dependents: A covered dependent may elect to continue coverage for a period of 36 months if one of the following events occurs:

- a.) the death of the Insured;
- b.) the divorce or legal separation of the insured and dependent spouse;
- c.) the Insured becomes entitled to Medicare benefits;
- d.) a dependent child is no longer a dependent child for the purposes of the plan.]

Evidence of Insurability is not required for this continuation of coverage. If a Covered Person exercises this option, it will be lieu of any continuation rights granted under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

#### **Coverage:**

If a Covered person exercises this option, coverage will be identical in scope to the coverage provided in the policy.

#### **Premiums:**

The Covered Person will pay premiums directly to the Policyholder with the option of paying in monthly installments. The premiums will not exceed 102 percent of the applicable premium for such period.

#### **Notice Requirements:**

The Policyholder must notify us in writing within 31 days after the date:

- a.) the Insured dies; or
- b.) the Insured's employment is terminated, the Insured's hours are reduced; or
- c.) the Insured becomes entitled to Medicare benefits.

[Each covered dependent who wishes to continue coverage must notify us in writing within 60 days after the date:

- a.) of divorce or legal separation from the Insured, or
- b.) a dependent child is no longer a dependent child for the purposes of the plan.]

Upon our receipt of any such notice, we must give written notice of the right to continue coverage to any insured or his covered dependents within 14 days.

Each Insured [or covered dependent] who wish to continue coverage must notify us in writing within [60] days after the date he receives notice of his right to continue coverage.

**Termination:**

A Covered Person who exercises this option will not have his coverage interrupted or canceled or otherwise terminated until the date on which:

- a.) he fails to make premium payment in the time required to make that payment; or
- b.) he becomes eligible for substantially similar coverage under another group health plan, hospital or medical service subscriber contract, medical practice or other prepayment plan, or any other plan or program (including Medicare); or
- c.) the required period for continued coverage ends; or
- d.) the policy terminates; or
- e.) The Insured provides the Policyholder or us with written notice that he wants his coverage terminated.]

[[10.]The Certificate is amended by the addition of the following "CONVERSION PRIVILEGE" section:

**CONVERSION PRIVILEGE**

A Conversion Privilege will be given if:

- a.) coverage under the policy ends for any reason other than non-payment of premium; and
- b.) the Covered Person is not eligible for or covered by:
  - a. Medicare;
  - b. similar coverage that replaced the terminating coverage within 31 days after the policy ends; or
  - c. full coverage under any other group accident and health policy or contract. This coverage must provide benefits for all preexisting conditions to be considered full coverage.

To convert from coverage under the policy to conversion coverage, written application and first premium payment must be made no more than 31 days after coverage under the policy has ended. Medical evidence of insurability is not required. Questions concerning other coverage under which the person is eligible or is covered may be asked.

The conversion coverage will provide benefits:

- a.) that are of the same type as the benefits provided by the policy for Hospital, surgical or medical expenses; and
- b.) that meet the minimum requirements for a conversion policy in the state where the person resides on the date of conversion. Benefit amounts may be less than those provided by the policy, to the extent permitted by law.

Upon request we will provide full details of the conversion coverage. At our option, we may provide group insurance coverage that meets the above requirements instead of an individual conversion policy.]

[[11.]The "CONVERSION PRIVILEGE" section is deleted in its entirety. The following is substituted in its place:

**CONVERSION PRIVILEGE**

A Conversion Privilege will be given if:

- c.) coverage under the policy ends for any reason other than non-payment of premium; and
- d.) the Covered Person is not eligible for or covered by:
  - a. Medicare;
  - b. similar coverage that replaced the terminating coverage within 31 days after the policy ends; or
  - c. full coverage under any other group accident and health policy or contract. This coverage must provide benefits for all preexisting conditions to be considered full coverage.

To convert from coverage under the policy to conversion coverage, written application and first premium payment must be made no more than 31 days after coverage under the policy has ended. Medical evidence of insurability is not required. Questions concerning other coverage under which the person is eligible or is covered may be asked.

The conversion coverage will provide benefits:

- c.) that are of the same type as the benefits provided by the policy for Hospital, surgical or medical expenses; and
- d.) that meet the minimum requirements for a conversion policy in the state where the person resides on the date of conversion. Benefit amounts may be less than those provided by the policy, to the extent permitted by law.

Upon request we will provide full details of the conversion coverage. At our option, we may provide group insurance coverage that meets the above requirements instead of an individual conversion policy.]

[12]. The "Time of Payment of Claim" provision in the "CLAIM PROVISIONS" section is deleted in its entirety. The following is substituted in its place:

Benefits for loss covered by the policy will be paid immediately upon our receipt of proper written proof of such loss. In no event will benefits due be paid not more than 30 days after We receive written proof of loss electronically or 45 days if the claim is submitted by other means.

In all other respects, the [Policy] [and] [Certificate] remain(s) the same.

Signed for the STARR INDEMNITY & LIABILITY COMPANY:

[Honora M. Keane], General Counsel

[Charles H. Dangelo], President