

SERFF Tracking Number: GRTT-126822853 State: Arkansas  
Filing Company: Guarantee Trust Life Insurance Company State Tracking Number: 46841  
Company Tracking Number:  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.003B Small Group Only - PPO Basic  
Product Name: Pro Rig Medical/Dental  
Project Name/Number: /

## Filing at a Glance

Company: Guarantee Trust Life Insurance Company

Product Name: Pro Rig Medical/Dental SERFF Tr Num: GRTT-126822853 State: Arkansas  
TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 46841  
Closed

Sub-TOI: H16G.003B Small Group Only - PPO Co Tr Num: State Status: Approved-Closed  
Basic

Filing Type: Form

Author: Howard Moy

Date Submitted: 09/20/2010

Reviewer(s): Rosalind Minor

Disposition Date: 11/08/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Filed in Illinois on  
8/30/2010

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Association

Filing Status Changed: 11/08/2010

Explanation for Other Group Market Type:

State Status Changed: 11/08/2010

Deemer Date:

Created By: Howard Moy

Submitted By: Howard Moy

Corresponding Filing Tracking Number:

PPACA: Grandfathered Immed Mkt Reforms

Filing Description:

To Be Filed:

Medical Certificate AGC-2002-AR

Dental Certificate AGC-2002 DEN-AR

Articles of Incorporation/Bylaws for Pro Rig USA

Dear Sir or Madam:

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The captioned forms are submitted for your review and approval for issuance on a 1-case basis to Idaho residents who are members of Pro Rig USA. Pro Rig USA is an association of independent truckers based in Iowa to which our company has issued medical and dental coverage under group master policy MCP-2002 and master application GPA-2002.

Per your state's filing requirements for associations, we have included information for consideration of the association as an eligible group. Pro Rig USA is incorporated in Iowa. Their address is:

Pro Rig USA  
4212 R57 Hwy.  
Norwalk, IA 50211

The association does not have an office in Arkansas. Dues are \$10 per month for each member. The association is a resource for independent truckers for information such as loss control, safety, OSHA consultation, workers compensation, driver recruitment, human resource services, fuel discounts, tire discounts, driver benefits, insurance program discounts, and owner operator business assistance. Any trucking company with a fleet of from 1 to 500 trucks is eligible to join this association. Currently, there are no members in Arkansas. The association receives no compensation from the insurer.

Certificate AGC-2002-AR provides major medical coverage, not including dental, to the stated limits depending on the plan selected by the insured. Certificate AGC-2002 DEN-AR provides dental coverage up to the plan limits selected by the insured. Coverage under the medical and/or dental plans is optional to the individual. Coverage is also available to an individual's eligible dependents.

Both the major medical and dental coverage are issued based on First Health network providers. Enclosed with this filing is a list of the network providers in Idaho.

In addition, this filing is also made pursuant to compliance with the Patient Protection and Affordability Care Act (PPACA). A provision addressing this Act has been included with the forms.

Bracketed material in the forms represents variability. Variations will be used to reflect policyholder selection, state mandated benefits, elections of optional benefits and changes in coverage offerings. Variability will never be used to reduce benefit levels below statutory requirements.

## Company and Contact

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**Filing Contact Information**

Howard Moy, Senior Compliance Analyst hmoy@gtlic.com  
 1275 Milwaukee Ave. 847-904-5786 [Phone] 5786 [Ext]  
 Glenview, IL 60025 847-699-0093 [FAX]

**Filing Company Information**

Guarantee Trust Life Insurance Company CoCode: 64211 State of Domicile: Illinois  
 1275 Milwaukee Avenue Group Code: 687 Company Type: Mutual  
 1275 Milwaukee Avenue Group Name: State ID Number:  
 Glenview, IL 60025 FEIN Number: 36-1174500  
 (847) 460-4772 ext. [Phone]

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$250.00  
 Retaliatory? Yes  
 Fee Explanation: 2 certificates @\$50 = \$100  
 Articles of Incorporation, bylaws, brochure @\$50 = \$150  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Guarantee Trust Life Insurance Company	\$250.00	09/20/2010	39668943

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/08/2010	11/08/2010
Disapproved	Rosalind Minor	10/25/2010	10/25/2010

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Original article of incorporation	Howard Moy	10/25/2010	10/25/2010

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Your 10/29 Note	Note To Reviewer	Howard Moy	10/29/2010	10/29/2010
Association Group	Note To Filer	Rosalind Minor	10/29/2010	10/29/2010
Your 10/28 Note	Note To Reviewer	Howard Moy	10/29/2010	10/29/2010
Additional information on Association	Note To Filer	Rosalind Minor	10/28/2010	10/28/2010

*SERFF Tracking Number:*      *GRTT-126822853*                      *State:*                      *Arkansas*  
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*Project Name/Number:*      /

## **Disposition**

Disposition Date: 11/08/2010

Implementation Date:

Status: Approved-Closed

Comment:

Please disregard our disapproval of 10/25/10. After reopening the submission and reviewing additional information, we are approving the submission effective on this date.

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	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Articles of Incorporation/Bylaws	Approved-Closed	Yes
Supporting Document	Brochure	Approved-Closed	Yes
Supporting Document	2009 Financial	Approved-Closed	Yes
Supporting Document	Original article of incorporation	Approved-Closed	Yes
Form	Major medical certificate	Approved-Closed	Yes
Form	Dental certificate	Approved-Closed	Yes

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## Disposition

Disposition Date: 10/25/2010

Implementation Date:

Status: Disapproved

Comment:

Our association laws state that the association has been organized and maintained in good faith in active existence for at least two (2) years for purposes other than that of obtaining insurance. Since the Articles of Incorporation is effective 8/2/10 and has not been in existence for two years as required by ACA 23-86-106(2)(A)(III), this submission is being disapproved.

Thank you for your understanding in this matter.

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	PPACA Uniform Compliance Summary	Approved-Closed	Yes
<b>Supporting Document</b>	Articles of Incorporation/Bylaws	Approved-Closed	Yes
<b>Supporting Document</b>	Brochure	Approved-Closed	Yes
<b>Supporting Document</b>	2009 Financial	Approved-Closed	Yes
<b>Supporting Document</b>	Original article of incorporation	Approved-Closed	Yes
<b>Form</b>	Major medical certificate	Approved-Closed	Yes
<b>Form</b>	Dental certificate	Approved-Closed	Yes

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**Note To Reviewer**

**Created By:**

Howard Moy on 10/29/2010 12:19 PM

**Last Edited By:**

Howard Moy

**Submitted On:**

10/29/2010 12:20 PM

**Subject:**

Your 10/29 Note

**Comments:**

Dear Ms. Minor,

Pro Rig USA currently has about 850 members nation wide. However, there are none in Arkansas at the moment.

Please let me know if you need any more information.

Yours truly,  
Howard Moy

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**Note To Filer**

**Created By:**

Rosalind Minor on 10/29/2010 10:19 AM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

10/29/2010 10:19 AM

**Subject:**

Association Group

**Comments:**

Thank you for your response. I never thought to read the General Information tab again. Sorry.

One more question. How many members does the association have now?

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**Note To Reviewer**

**Created By:**

Howard Moy on 10/29/2010 08:35 AM

**Last Edited By:**

Howard Moy

**Submitted On:**

10/29/2010 08:36 AM

**Subject:**

Your 10/28 Note

**Comments:**

Dear Ms. Minor,

Thank you for your note. However, I believe that we had addressed each of the items on the list of questions for Association Requirements in the "General Information" tab of our filing. If you review the information there, you'll note that we had provided the information that is listed on this questionnaire within the information provided in this tab. Also, brochures, articles of incorporation, bylaws, etc had been attached to the Supporting Documents tab of our original filing.

Ms. Minor, I hope that this address your questions on this filing. If, however, you need any additional information, please do not hesitate to contact me.

Yours truly,  
Howard Moy

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**Note To Filer**

**Created By:**

Rosalind Minor on 10/28/2010 03:41 PM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

10/28/2010 03:41 PM

**Subject:**

Additional information on Association

**Comments:**

Thank you for the additional information on the association showing that the association has been in existence more than two years.

When I first reviewed the filing, I did not send you the attached questionnaire because it did not appear that the association was two years old. Please answer the questions and/or provide the additional information outlined on the questionnaire. I realize that some of this information is already included in this submission.

We appreciate your understanding and cooperation.

We have received your filing regarding the above named association/ discretionary group. To determine if this organization is a qualified group under our statutes, please provide the answers to the following questions:

1. Name and address of the group.
2. Is this group incorporated? If so, give state of incorporation.
3. Is there a current office in Arkansas?
4. Does the Arkansas part of the organization have any officers, committees, or chapters? If so, give details.
5. Are annual dues charged? If so, specify amount.
6. What are the specific activities of the organization?
7. What benefits are provided to the members in addition to insurance?  
PLEASE ATTACH BROCHURES ON THE BENEFITS.
8. What qualifies an individual for membership?
9. How are members recruited? If by mailing list, advise the source of this list.
10. Attach a copy of the organization by-laws.
11. Also, enclose a list of dues paying members residing in Arkansas with full addresses. If the organization considers this privileged information, we will treat it as such and once it has served our purpose, it will be destroyed.
12. Please attach a copy of the organization's most recent financial statement.
13. Does the organization receive any compensation of any kind from the insurer issuing contracts to its members?

Approval of the organization as a qualified group for insurance purposes will be determined upon receipt of your reply.

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**Amendment Letter**

Submitted Date: 10/25/2010

**Comments:**

Dear Ms. Minor,

Thank you for taking the time to speak with me this morning about this filing.

As we discussed, I am attaching documentation that shows that Pro Rig USA has actually been in existence since 2006. They underwent a name change to Pro Rig USA while still in Missouri. In August of this year, they reincorporated in Iowa using the same name.

As to the website, I checked with the association. Apparently, the website has been undergoing some updates and redevelopment. The association has advised that the website will be reactivated in the next few days. I can advise you when the website is back up.

Thanks again for your reconsideration of this filing.

Yours truly,  
Howard Moy

**Changed Items:**

**Supporting Document Schedule Item Changes:**

**User Added -Name: Original article of incorporation**

Comment:

Original Assoc Info .pdf

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## Form Schedule

### Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/08/2010	AGC-2002-AR	Certificate	Major medical certificate	Initial		46.500	AGC-2002 AR final 9-17-10.pdf
Approved-Closed 11/08/2010	AGC-2002-DEN-AR	Certificate	Dental certificate	Initial		43.000	AGC-2002 DEN-AR final 9-17-10.pdf

**GUARANTEE TRUST LIFE INSURANCE COMPANY**

1275 Milwaukee Avenue  
Glenview, Illinois 60025  
Telephone: 847 699-0600

**CERTIFICATE OF INSURANCE**

This is Your Certificate of Insurance (Certificate) while You are insured. It briefly explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a legal contract between the Policyholder and Us. The Policyholder is shown on the Schedule.

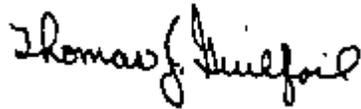
The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payment is governed by all the terms, conditions and limitations of the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

The Policy has been issued and delivered to the Policyholder in the state of Iowa. Except as otherwise stated in this Certificate, the Policy will be governed by the laws of the state where the Policy was issued. The Policy is held by the Policyholder. You may inspect it at any time during business hours at the office of the Policyholder.

This Certificate was issued on the basis that the information on Your enrollment form was correct and complete. If any information on the enrollment form was not correct, write to Us within 10 days of receipt of this Certificate. An error or omission in Your enrollment form may result in loss of coverage as of its Effective Date.

**Right to Examine:** If You are not satisfied with this Certificate, return it to Our home office within 10 days after the date You received it. This Certificate will then be canceled and any Premium paid will be refunded.

**READ YOUR CERTIFICATE CAREFULLY**



Secretary



President

**MAJOR MEDICAL COVERAGE**

**NON-PARTICIPATING**

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## GENERAL DEFINITIONS

*The terms listed below, if used, have the meaning stated.*

**Accident:** A sudden, unforeseeable, external event which results in an Injury.

**Actively at Work/Active Work** means the active expenditure of time and energy on a full-time basis of at least forty (40) hours per week in the service of and compensated for such service. An Insured is Actively at Work on each day of a regular paid vacation, or on a regular non-working day on which he or she is not disabled, provided he or she was Actively at Work on the last preceding regular working day. Actively at work requirements, if any, are determined by the Policyholder and are as shown in the Master Application.

**Ambulance:** A vehicle which is licensed solely as an ambulance by the local regulatory body to provide transportation to a Hospital or transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means or the Hospital cannot provide the needed care. Air Ambulance charges are payable only for transportation from the site of an Emergency Medical Condition to the nearest available Hospital that is equipped to treat the condition instead of local Ambulance service.

**Ambulatory Surgical Center:** A facility which meets licensing and other legal requirements and which:

- Is equipped and operated to provide medical care and treatment by a Doctor;
- Does not provide services or accommodations for overnight stays;
- Has a medical staff that is supervised full time by a Doctor;
- Has full-time services of a licensed registered nurse (R.N.) at all times when patients are in the facility;
- Has at least one operating room and one recovery room and is equipped to support any surgery performed;
- Has X-ray and laboratory diagnostic facilities;
- Maintains a medical record for each patient; and
- Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need confinement.

**Calendar Year:** The period of time beginning on January 1 and ending on December 31 of the same year. The first Calendar Year of the Certificate will begin on the date this Certificate becomes effective and end on the first December 31<sup>st</sup> after a covered Person's effective date of coverage.

**Class:** A category of persons based on job, salary or some other condition of employment or membership. Eligible Classes are shown on the Schedule.

**Company:** Guarantee Trust Life Insurance Company, a mutual company. Also hereinafter referred to as We, Us and Our.

**Complications of Pregnancy:** A condition which:

- When pregnancy is not terminated, requires medical treatment and the diagnosis is distinct from pregnancy but is adversely affected by or is caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; (i) and other similar medical and surgical conditions of comparable severity related to pregnancy; or
- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will **not** include:

- False labor;
- Occasional spotting;
- Doctor prescribed rest during the period of pregnancy;
- Morning Sickness;
- Preeclampsia; and
- Similar conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.

Delivery by cesarean section is considered a Complication of Pregnancy if the cesarean section is non-elective. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in

immediate danger of death, Sickness or Injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the child or mother.

**Covered Charge:** The Reasonable and Customary Charge incurred for a service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury. A Covered Charge is considered incurred on the date the treatment or service is rendered or the supply is furnished.

**Covered Person:** A person:

- Who is eligible for coverage as the Insured or as a Dependent;
- Who has been accepted for coverage or has been automatically added;
- Who has paid the required premium; and
- Whose coverage has become effective and has not terminated.

**Custodial Care:** Care that is primarily for the purpose of meeting non-medical personal needs, such as help with the activities of daily living and taking medications. Activities of daily living include, but are not limited to, bathing, dressing, eating, toileting, and transferring. Custodial Care can usually be provided by someone without professional medical skills or training.

**Dependent:** A person who is the Insured's:

- Legally married spouse, residing with the Insured.
- Child who is dependent upon the Insured for support and maintenance and is under the age of [25].
- Child who is dependent upon the Insured for support and maintenance, is 25 years of age or over and is attending school full time, as determined by the school the Dependent is attending, including colleges and vocational, technical, vocational-technical or trade schools or institutes.

The term child refers to the Insured's unmarried:

- Natural child;
- Stepchild or foster child; A stepchild is a Dependent on the date the Insured marries the child's parent.
- Adopted child, including a child placed with the Insured for the purpose of adoption, from the moment of placement as certified by the agency making the placement.
- Grandchild who is financially dependent upon the covered grandparent and who resides with that covered grandparent continuously from birth.
- Child for whom the Insured is required by court or administrative order to provide health coverage.

In the event both parents of a Dependent are insured persons, such child is considered as a Dependent of either parent. The child may not be considered a Dependent of both parents.

**Doctor:** A legally qualified person licensed in the healing arts and practicing within the scope of his or her license and is not a Family Member.

**Durable Medical Equipment:** A device which:

- Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
- Is used exclusively by the patient;
- Is routinely used in a Hospital but can be used effectively in a non-medical facility;
- Can be expected to make a meaningful contribution to the patient's Sickness or Injury; and
- Is prescribed by a Doctor and the device is Medically Necessary for rehabilitation.

Durable Medical Equipment does **not** include: (a) comfort and convenience items; (b) equipment that can be used by Family Members other than the patient; (c) health exercise equipment; and (d) equipment that may increase the value of the patient's residence. Such items that do not qualify as Durable Medical Equipment include, but are not limited to: modifications to the patient's residence, property or automobiles, such as ramps, elevators, spas, air conditioners and vehicle hand controls; or corrective shoes, exercise and sports equipment.

**Emergency Medical Condition:** The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average

knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

- Placing the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in significant jeopardy.
- Serious impairment to a bodily function.
- Serious dysfunction of any bodily organ or part.
- Inadequately controlled pain.
- With respect to a pregnant woman who is having contractions:
  - That there is inadequate time to effect a safe transfer to another hospital before delivery; or
  - That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

**Emergency Services:** Inpatient and outpatient health care services that are needed to evaluate or stabilize an Emergency Medical Condition.

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

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

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

**Family Member:** A person who is related to the Covered Person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member includes an individual who normally lives in the Covered Person's household.

**Hospital:** An institution licensed, accredited or certified by the State which:

- Provides 24-hour nursing service by licensed registered nurses (R.N.);
- Mainly provides diagnostic and therapeutic care under the supervision of Doctors while Hospital Confined; and
- Maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest; the aged; a nursing home; or an institution mainly rendering treatment or services for Mental or Nervous Disorders, Serious Mental Disorders, or substance abuse, except as specifically provided in the Policy.

**Hospital Confined/Hospital Confinement:** Confinement in a Hospital on an inpatient basis for at least 24 consecutive hours for which a room and board charge is made by reason of a Sickness or Injury for which benefits are payable.

**Hospice** means an agency which provides medical, health care services and medical social services for the palliative and supportive care and treatment of terminally ill individuals. The agency must:

- Provide 24 hour, 7 day a week service;
- Provide a program of service under direct supervision of a Doctor or licensed registered nurse (R.N.);
- Maintain full and complete records of all services provided to all Covered Persons; and
- Be established and operated in accordance with the applicable laws or regulations of the jurisdiction in which it is located.

**Hospice Care:** Services provided by a Hospice providing care to an individual for whom a certified medical prognosis has been made indicating a life expectancy of 6 months or less and who has elected to receive such care in lieu of other medical benefits provided herein.

**Injury:** Bodily injury due to an Accident which results solely, directly and independently of disease, bodily infirmity or any other causes.

All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single injury.

**Insured:** The Covered Person who is employed by the Policyholder or a member of the Policyholder's organization as defined on the Schedule of Benefits.

**Intensive Care Unit:** A specifically designed facility of the Hospital that provides the highest level of medical care; and which is restricted to those patients who are critically ill or injured.

Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be permanently equipped with special life-saving equipment for the care of the critically ill or injured; and under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit.

Intensive Care Unit does not mean any of these step-down units: progressive care; sub-acute intensive care; intermediate care units; private monitored rooms; observation units; or other facilities which do not meet the standards for intensive care.

**Late Applicant:** A member of an eligible Class who requests coverage more than 30 days after the date such person was first eligible to enroll. A person shall not be considered a Late Applicant if he:

- Was covered under another Policyholder's group health plan at the time of initial enrollment; and
- Stated at the time of initial enrollment that coverage under another Policyholder's group health plan was the reason for declining coverage; and
- Has lost coverage under another Policyholder's group health plan due to termination of employment, termination of the plan, death of a spouse or divorce; and
- Requests coverage within 30 days after termination of coverage; or
- Applies for coverage on a spouse or minor child within 30 days of a court order requiring coverage be provided under his plan.

**Medicaid:** The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965 as Then Constituted or Later Amended.

**Medicare:** The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.

**Medically Necessary:** A treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of Sickness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to Hospital Confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental/Investigational or for research purposes;

- Is provided solely for educational purposes or the convenience of the patient, the patient's family, Doctor, Hospital or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- Could have been omitted without adversely affecting the patient's condition or the quality of medical care;
- Involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA);
- Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- Can be safely provided to the patient on a more cost-effective basis such as out-patient, by a different medical professional, or pursuant to a more conservative form of treatment.

We reserve the right to determine whether a service, supply or drug is Medically Necessary.

**Mental or Nervous Disorder:** Nervous, emotional and mental disease, illness, syndrome or dysfunction classified in the most recent edition of the *International Classification of Diseases* as a Mental Disorder on the date the medical care or treatment is rendered to a Covered Person. Mental or Nervous Disorders include Serious Mental Disorders.

**Nurse:** A licensed registered nurse (R.N.) or licensed practical nurse (L.P.N.) who: (a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and (b) provides medical services which are within the scope of the nurse's license or certificate.

**Orthopedic Appliances:** Any supportive device or appliance used in treating Sickness or Injury.

**Physiotherapy:** Any form of the following administered by a Doctor:

- Physical or mechanical therapy;
- Diathermy;
- Ultra-sonic therapy;
- Heat treatment in any form; or
- Manipulation or massage.

**Policy Year:** The period of 12 months following the Policy's Effective Date or renewal.

**Policyholder:** The entity shown as the Policyholder on the Schedule.

**Pre-admission Testing:** Tests required prior to surgery; a Hospital bed and operating room have been reserved before the tests are made; the surgery is done within 7 days after the tests; and the patient is physically present for the tests.

**Pre-existing Condition:** A Sickness or Injury for which medical care, treatment, diagnosis or advice was received or recommended within the [6] months prior to the Covered Person's effective date of coverage under the Policy.

**Prescription Drugs:** Drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the U.S. Food and Drug Administration (FDA). The drugs must be dispensed by a licensed pharmacy provider for out of Hospital use. Coverage for a Prescription Drug will not be excluded for a particular indication on the ground that the drug has not been approved by the FDA for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies.

**Reasonable and Customary Charges, Fees or Expenses:** An amount equal to the lesser of:

- The actual amount charged by the provider;
- The negotiated rate, if any; or
- The reasonable charge as determined by the Payment System software as shown in the Schedule.

**Serious Mental Disorders:** Means the following terms as defined in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association:

- schizophrenia;
- schizoaffective disorder;
- major depressive disorder;
- bipolar disorder;
- paranoia and other psychotic disorders;
- obsessive-compulsive disorder; and
- panic disorder.

**Sickness:** Illness and disease.

**[Skilled Nursing Facility:** A place that:

- Is legally operated as a Skilled Nursing Facility;
- Primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Care under the supervision of a Doctor;
- Provides continuous 24 hour a day nursing service by or under the supervision of a licensed nurse; and
- Maintains a daily medical record on each patient.

Skilled Nursing Facility also means a place which may not meet the above rules, but is a nursing facility that is either approved for payment of Medicare benefits or could get such approval if so requested.

A Skilled Nursing Facility does not mean or include any home or facility, or part thereof, used primarily for rest, residential, retirement or Custodial Care.]

**Sound Natural Teeth:** Natural teeth, the major portion of the individual tooth which is present, regardless of fillings and caps; and is not carious, abscessed, or defective.

**We, Ours and Us:** The Guarantee Trust Life Insurance Company.

**Well-child Care:** Pediatric preventive services appropriate to the age of a child from birth to age seven as defined by current Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. The Recommendations may be obtained by contacting the American Academy of Pediatrics at 141 Northwest Point Boulevard, P.O. Box 927, Elk Grove Village, Illinois 60009-0927. Pediatric preventive services shall include, at a minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, vision and hearing screening, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels. "Development assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by and obtainable from the American Academy of Pediatrics.

**You, Your and Yours:** The Insured shown on the Schedule.

Male pronouns whenever used include female pronouns.  
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## CONDITIONS OF INSURANCE

### ELIGIBILITY

**Insured:** You are eligible for coverage if You are a member of an eligible Class and complete a valid enrollment form. Eligible Classes are shown in the Master Application.

**Dependent:** When a Dependent is a member of an eligible Class, such Dependent is eligible for coverage on the later of:

- The date You become eligible for insurance; or
- The date You acquire the Dependent.

A Dependent is deemed to be acquired as follows:

Spouse: On the date of the marriage to You.

Natural child: On the date of birth.

Adopted child: From the moment of placement with You for the purpose of adoption, as certified by the agency making the placement.

Stepchild: On the date of Your marriage to the child's parent.

## **EFFECTIVE DATE**

**Insured and Dependents, except Dependents Acquired After Effective Date:** Coverage is effective as stated on the Schedule.

**Late Applicant:** Coverage is effective the first day of the month following the date of Our receipt of the request for coverage.

## **Dependents Acquired After Effective Date**

**Newborn Children:** Your newborn child is automatically covered from the moment of birth until such child is 90 days old. Coverage for such child will be for Sickness and Injury, including congenital anomalies, prematurity and nursery care. However, You must notify Us in writing within 90 days of such birth and pay the required additional premium, if any, in order to have coverage for the newborn child continue beyond such 90 day period.

**Adopted Child:** Coverage for an adopted newborn that is placed with the adoptive Insured within 60 days of the adopted child's date of birth is effective from the moment of birth. Coverage for an adopted child placed with the adoptive Insured more than 60 days after the birth of the adopted child shall be from and after the date the child is placed. Coverage for such child will be for Sickness and Injury, including anomalies, prematurity and nursery care. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. However, You must notify Us in writing within 60 days of such adoption and pay the required additional premium, if any, in order to have coverage for the adopted child continue beyond such 60 day period.

"Placed" means physical placement of an adopted child in the care of the adoptive Insured, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive Insured signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage as to a child placed for adoption with the Insured continues in the same manner as it would with respect to a naturally born child of the Insured until the first to occur of the following events: date the child is removed permanently from that placement and the legal obligation terminates; or the date the Insured rescinds, in writing, the agreement or adoption or agreement assuming financial responsibility.

**Newborn Grandchildren:** Your newborn grandchild is automatically covered from the moment of birth if the child resides with You.

**Dependent Spouse:** A Dependent spouse is eligible for coverage on the date of marriage to You. Enrollment and premium must be received within 31 days of the marriage. Coverage is effective upon receipt of enrollment and premium by Us or Our authorized representative.

**Enrollment Under Court Orders:** If, pursuant to a court order, You are required to provide health coverage for a child and You are eligible for Dependent coverage, We shall:

- Permit You to enroll such child who is otherwise eligible for the coverage without regard to any enrollment season restrictions. Coverage for the child will take effect on the date specified in the court order or, if no date is specified, on the date the court order is issued; and
- Continue coverage of the child unless We are provided satisfactory written evidence that the:
- Court order is no longer in effect;
- Child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment; or
- Policyholder has eliminated family health coverage for all of its employees.

## **SPECIAL ENROLLMENT**

Special Enrollment Period for You and Your Dependents: Persons who are eligible for coverage under the Policy but not enrolled may enroll for coverage if all of the following conditions are met:

1. You were or Your Dependent was covered under a group health plan or had health insurance coverage at the time coverage under the Policy was previously offered;

2. You stated in writing at the time of initial eligibility that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if such statement was required at such time and You were provided with notice of the requirement and the consequences of such requirement at the time;
3. Coverage described in 1. above was:
  - a. terminated under a COBRA or state continuation provision and the coverage under such provision was exhausted; or
  - b. terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated; and
  - c. the eligible employee requested such enrollment not later than 30 calendar days after the date of exhaustion of coverage described in 3.a. above, or termination of coverage or employer contributions described in 3.b. above.

Special Enrollment Period for New Dependents Only. New dependents may enroll if they become dependents of the eligible employee through marriage, birth, adoption, placement for adoption or legal guardianship. The eligible employee, if not previously enrolled, may enroll when a new Dependent enrolls for coverage during the 30 day Special Enrollment Period. Other Dependents (such as siblings of a newborn child) are not entitled to special enrollment rights upon the birth or adoption of a child. Coverage for a new Dependent enrolling during the Special Enrollment Period will become effective:

1. In the case of marriage, not later than the first day of the month following Our receipt of the request for enrollment.
2. In the case of a Dependent child's birth, as of the date of such birth.
3. In the case of a Dependent child's adoption or placement for adoption, the date of such adoption or placement for adoption.

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## TERMINATION

**Covered Person:** Coverage with respect to a Covered Person will terminate at 12:01 a.m. standard time at Your residence on the earliest of:

- The date the Policy terminates;
- The date You are no longer eligible for coverage under the Policy.
- The date coverage is terminated by Us for all certificate holders in Your state;
- The date We receive Your written request to terminate coverage;
- The last day of the period for which the Premium is paid;
- The last date of the period for which Premium has been paid following the date a Dependent ceases to be a Dependent as defined;
- The date a Covered Person enters full time active military service. Upon written request within 30 days of entering the military, We will refund any unearned pro-rata Premium with respect to such person.

At least 45 days prior written notice will be given to You if We terminate Your coverage for any reason, except for nonpayment of Premium.

Termination of coverage is subject to the Extension of Benefits provision.

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## CONTINUATION FOR INCAPACITATED CHILDREN

Dependent children, who are covered under the terms of the Certificate, who reach the limiting age and are incapable of self-sustaining employment due to a handicapped condition may continue to be covered regardless of age. The Dependent must be chiefly dependent on You for support and maintenance.

We will inquire two (2) months prior to the attainment by a Dependent of the limiting age or at any reasonable time thereafter, whether such Dependent is in fact a disabled and dependent person. In the absence of proof submitted within 60 days of such inquiry that such Dependent is a disabled and dependent person, We may terminate coverage of such person at or after attainment of the limiting age. In the absence of such inquiry, coverage of any disabled and dependent person shall continue through the term of the coverage or any extension or renewal thereof.

Coverage for a handicapped child will end on the earliest of:

- The date the Dependent marries;
- The date the Dependent obtains self-sustaining employment;
- The date the Dependent ceases to be handicapped;
- The date the Dependent ceases to be chiefly dependent upon You;
- Sixty (60) days after a written request for proof of disability, if proof is not provided within such 60 days;
- The date You refuse to allow Us to examine the Dependent; or
- The date coverage would otherwise terminate.

## **CONTINUATION OF COVERAGE**

### In The Event of Dissolution of Marriage

If Your marriage is dissolved by a valid decree of dissolution and if Your spouse is a Covered Person on the date of the decree of dissolution, then the Dependent spouse's coverage will continue in force under the policy, subject to its provisions, if the Dependent spouse pays the first premium required for the continued coverage within 31 days after the entry of the decree of dissolution.

If the Dependent spouse continues coverage pursuant to this provision, We will issue him or her a new Certificate as evidence of coverage under the Policy.

### For a Dependent Child Reaching the Limiting Age

If a Dependent child no longer qualifies as a Dependent, then the Dependent child's coverage will continue in force under the Policy, subject to its provisions, if the Dependent child pays the first premium required for the continued coverage within 31 days after the date he or she no longer qualifies as a Dependent child.

If the Dependent child continues coverage pursuant to this provision, We will issue him or her a new Certificate as evidence of coverage under the Policy.

## **EXTENSION OF BENEFITS**

### In the event of Total Disability

If a Covered Person is Totally Disabled on the date the Policy terminates, We will extend that Covered Person's benefits for the Injury or Sickness which caused the Total Disability. Benefits will be paid as if coverage had remained in effect.

Total Disability/Totally Disabled means, with respect to You, the complete inability to perform all of the substantial and material duties of Your occupation and any other gainful occupation in which You earn substantially the same compensation earned prior to disability. With respect to a covered Dependent, Hospital Confinement.

Extension of benefits will end at the earlier of:

- the end of Total Disability;
- the end of a 12 month period following the date the Policy terminates;
- the date the Lifetime Aggregate Maximum Amount is reached.

At Our request a Doctor must certify in writing that the Covered Person continues to be Totally Disabled.

## **CONTINUATION OF COVERAGE**

The right to continue this coverage is available to a Covered Person who has been continuously insured under the Policy for at least 3 months and whose insurance under the Policy ceases upon termination of group membership. Premium for continued coverage must be paid within 31 days after notice of termination.

The continued coverage will cover the Covered Person and his insured Dependents.

### **Termination of Continued Coverage**

Continued coverage will terminate on the earlier of:

- The date 18 months after the date on which the group coverage would otherwise have terminated because of termination of group membership;
- If the Covered Person fails to make timely payment of premium, the end of the period for which premium payment was made; or
- The date the Policy is terminated and is not replaced by another group policy within 31 days.

If a group policy is replaced, Covered Persons covered under continued coverage shall remain under such coverage under the replaced policy until as provided in the Termination of Continued Coverage provision.

### **CONVERSION PRIVILEGE**

#### YOUR CONVERSION PRIVILEGE

The right to convert any hospital, surgical and major medical insurance provided under the Policy to conversion coverage is available to a Covered Person who has been continuously insured under the Policy for at least 3 months and whose insurance under the Policy ceases for any reason except:

1. Termination of the Policy with replacement by similar medical coverage within 31 days;
2. Termination of the class of Covered Persons with replacement by similar medical coverage within 31 days;
3. Non-payment of the required premium.

The conversion coverage will cover the Covered Person and his insured Dependents.

#### DEPENDENT'S CONVERSION PRIVILEGE

The right to convert any hospital, surgical and major medical insurance provided under the Policy to conversion coverage is also available to:

1. An insured spouse who ceases to be a Dependent due to:
  - a) Your death;
  - b) Annulment or dissolution of marriage; or
  - c) Ceasing to be a qualified Family Member.
2. An insured child who ceases to be a Covered Person and who is not covered under conversion coverage.

The conversion coverage will cover the spouse and the insured Dependent children whose insurance ceases.

#### CONVERSION

The right to convert is not available if issuance would result in over insurance according to Our standards. Our standards consider the following:

1. The benefits of the conversion coverage;
2. Similar benefits that the person is covered for under another policy or prepayment plan or program;
3. Similar benefits that the person is eligible for under arrangements for coverage of persons in a group. This is considered whether or not covered thereunder;
4. Similar benefits for which the person is eligible under any state or federal law.

The conversion coverage will provide coverage not less than that required by law.

Conversion coverage will be issued without proof of good health subject to the following:

1. Written application must be made to Us at Our Home Office within 31 days after insurance under the Policy ceases. Premium payment must also be made within the 31 day period.
2. The effective date of coverage will be the day following the date insurance under the Policy ceases.

The jurisdiction where delivery of the conversion coverage is to be made controls the form We issue. The laws of such jurisdiction may require a special plan be provided or be available. If that is the case, We will either provide the coverage or refer the person to the proper source for coverage.

## REPLACED PLAN

When this Certificate replaces the Policyholder's prior plan which terminated the day before the Policy's Effective Date, the following applies:

1. As to each Covered Person:
  - a. credit will be given under similar coverage of this Certificate for any of the following which was wholly or partially met under the Policyholder's prior plan:
    - Waiting Period;
    - Deductible (for the same year); and
    - Out-of-Pocket Maximum.The Covered Person must provide Us with proper documentation before credit will be applied.
  - b. Any benefits paid under the Policyholder's prior plan can be applied towards the Lifetime Aggregate Maximum Amount under this Certificate.
2. If the Covered Person is on Extension of Benefits under the Policyholder's prior plan, benefits under this Certificate will be paid secondary to those of the prior plan.

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## MEDICAL EXPENSE BENEFITS

We will pay benefits for Covered Charges incurred by the Covered Person due to Sickness or Injury. Covered Charges as shown on the Schedule are subject to:

- [Deductible;]
- [Insured Percent; ]
- [Copayment;]
- [Out-of-Pocket Maximum]
- [Coordination of Benefits;]
- [The Lifetime Aggregate Maximum Amount;] and
- [Definitions, limitations, exclusions and other provisions of the Policy.]

The [Deductible] [and] [Out-of-Pocket Maximum] are determined per [Calendar/Policy] Year.

**Copayment:** A fixed dollar amount which is paid by the Covered Person for certain Covered Charges. Copayments do not accumulate toward satisfaction of the Calendar Year Deductible. The Copayment is shown in the Schedule.

**Deductible:** A dollar amount of Covered Charges a Covered Person must pay each Calendar Year before We pay any benefits. The Deductible is shown in the Schedule.

A new Deductible will apply each Calendar Year.

**Family Deductible:** The Policy has a family deductible cap equal to two individual Deductibles, for each Calendar Year. Once You and Your covered Dependents meet the Family Deductible in a Calendar Year, We will pay benefits for Covered Charges incurred by any insured member of the covered family, subject to the Insured Percent, for the rest of that Calendar Year. The Family Deductible is shown in the Schedule.

**Insured Percent:** The percentage of Covered Charges We pay for each Injury or Sickness. The Insured Percent is shown in the Schedule.

**Lifetime Aggregate Maximum Amount:** The maximum amount of benefits We will pay while a Covered Person is covered under this Certificate. The Lifetime Aggregate Maximum Amount is inclusive of all benefit amounts received under this Certificate. The Lifetime Aggregate Maximum Amount is shown on the Schedule.

**Out-of-Pocket Maximum:** The amount of Covered Charges a Covered Person must pay during a Policy Year before his or her benefits are paid at 100%. The Out-of-Pocket Maximum includes Covered Charges applied to the Deductible and coinsurance amounts. The coinsurance amount is the amount of Covered Charges which are not covered because Covered Charges are paid at an Insured Percent which is less than 100%. The coinsurance amount is stated in the Schedule.

**Waiting Period:** The period of time after the Effective Date of a Covered Person's coverage during which no benefits are payable for Covered Charges. The Waiting Period is shown in the Schedule.

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## GENERAL EXCLUSIONS

We won't pay benefits for:

- Treatment, services or supplies which:
  - Are not Medically Necessary;
  - Are not prescribed by a Doctor as necessary to treat an Sickness or Injury;
  - Are determined to be Experimental/Investigational in nature by Us;
  - Are received without charge or legal obligation to pay;
  - Would not routinely be paid in the absence of insurance;
  - Are received from any Family Member.

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- Injury due to being legally intoxicated, as defined by the jurisdiction in which an Accident occurs, while operating a motor vehicle.
- Loss due to voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Doctor.
- Expenses incurred as a result of loss due to war, declared or undeclared, and/or armed aggression by the military forces of any country or combination of countries or any act incident to war.
- Expenses incurred as a result of committing or attempting to commit a felony or aggravated battery, unless the Injury or Sickness results from an act of domestic violence or a Mental or Nervous Disorder.
- Expenses incurred as a result of suicide or intentionally self-inflicted Injury while sane or insane.
- Injury or Sickness arising out of or in the course of any occupation or employment for wage or profit or for which the Covered Person is entitled to benefits under any Workers' Compensation or occupational disease law, whether benefits are claimed or not.
- Expenses incurred as a result of cosmetic surgery or treatment, except those expenses related to an Injury or expenses for functional repair or restoration of any body part when necessary to achieve normal body function.
- Expenses covered by automobile "no fault" contracts (group, group-type or individual); or any other automobile, homeowners, aircraft, boat owners or similar policy of insurance.
- Any service or supply not specifically listed as a Covered Charge.

GGEXXX200 ]

- Orthotics, unless specifically provided.
- Charges for palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
- Surgery and/or treatment for; acupuncture; massage therapy; allergy, including allergy testing; sexual dysfunction, organic or otherwise; hyperkinetic syndromes, learning disabilities and mental retardation which extends beyond traditional medical management or for inpatient confinement for environmental change; human growth hormones; respite care; nutritional supplements; nutritional counseling unless specifically provided; hair growth stimulants and products indicated only for cosmetic use; sexual reassignment surgery; smoking cessation, including deterrents; anorectic drugs used for the treatment of obesity; and weight reduction unless Medically Necessary for the treatment of morbid obesity.

GGEXXX300

- Routine examinations, routine immunizations, routine x-ray and laboratory services and well-baby care other than Hospital nursery expense of a Dependent newborn baby, and except as specifically stated.

GGEXXX400

- Temporomandibular Joint Dysfunction (TMJ).

GGEXXX500

- Expenses incurred as a result of dental treatment, except as specifically stated.
- Charges for dental implantology.
- Charges for oral surgery procedures, except as specifically stated.

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- Charges directly related to the care, filling, removal or replacement of teeth, the treatment of Injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates as specifically stated.

GGEXX600

- GlucoWatch products.
- Expenses for biologicals, vaccines, or immunizations agents.
- Allergy serums.

GGEXX700

- Routine eye care, eyeglasses, contact lenses, or charges for the fitting of eyeglasses, contact lenses, other than the initial purchase of glasses or contacts for aphakia, keratoconus or following cataract surgery or sclera shells intended for use in the treatment of Sickness or Injury.
- Charges for the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants and LASIX.
- Routine hearing checks, hearing aids, examinations for the prescription or fitting of hearing aids, or tinnitus masters, except as required for Dependent newborn infants.

GGEXX800

- Treatment in any Veteran's Administration or Hospital operated by one of the Uniformed Services for a service related condition.
- Expenses for medical care paid for or reimbursable by or through the government of a nation, state, province, county, municipality or other political subdivision, or instrumentality or agency of such government.

GGEXX900

- Procedures designed to reverse elective or Medically Necessary sterilizations.

GGEXX1000

- Expenses for methadone hydrochloride treatment for which no additional functional progress is expected to occur.
- Expenses for therapy services for which no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur and which are determined not to be Medically Necessary.

GGEXX1100

- Treatment of infertility and fertility enhancements, including in vitro fertilization, or any other artificial means of conception (except artificial insemination), except as specifically stated.

GGEXX1200

- Custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care.
- Personal hygiene and convenience items.
- Charges for personal comfort items including television and telephone.

GGEXX1300

- Abortions, except when the life of the mother would be endangered if the fetus were carried to term.

GGEXX1400

- Charges for third party examinations and treatments, such as those requested for employment, pre-marital examinations, purchase of insurance or school, camp, sports or travel.
- Charges for examination and all related services which are performed pursuant to state statute or regulation, unless the Injury or Sickness results from an act of domestic violence or medical condition.

GGEXX1500

- Health education, marriage counseling, holistic medicine or other programs with an objective to provide complete personal fulfillment.

GGEXX1600

- Travel expenses incurred for health care.

- Immunizations for foreign travel or employment.
- Failure to keep a scheduled visit, phone consultation, completion of claim forms or return to work or school forms.
- Purchase or rental of exercise equipment, whirlpools, saunas, spas, swimming pools, electric beds, water beds, lift chairs, home elevator, air conditioners, purifiers, filters, commodes, grab bars, shower seating, cervical pillows, massagers or heel lifts.
- Charges for vocational training, including work hardening programs.
- Charges by a provider or facility for Pre-certification or Continued Stay Review.

GGEXX1700

- Charges for room, board, and general nursing care for Hospital admissions mainly for physical therapy or for diagnostic studies.
- Outpatient Prescription Drugs except as specifically stated.
- Vision therapy.
- Charges for private duty nursing services, except as specifically stated.

GGEXX1800

- Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar persons or group.

GGBEXX1900

## PRE-EXISTING CONDITIONS LIMITATION

There is no coverage for Pre-existing Conditions unless the Covered Person has had 12 months of Continuous Coverage.

The Covered Person must provide us proof of prior Creditable Coverage.

This limitation will not apply if, during the period immediately preceding the Covered Person's Effective Date of coverage under this Policy, the Covered Person was covered under prior Creditable Coverage for 12 consecutive months. Prior Creditable Coverage of less than 12 months will be credited toward satisfying the Pre-existing Condition limitation. This waiver of Pre-existing Conditions will apply only if the Covered Person becomes eligible and applies for coverage within 63 days of termination of his or her prior coverage.

**Continuous Coverage:** The period of time that a Covered Person is continuously insured under this Policy and/or any prior Creditable Coverage with no greater than a 63 day lapse between the effective date of coverage under this Policy and the termination of prior Creditable Coverage.

The Pre-existing Condition Limitation does not apply to:

- A newborn Dependent child;
- A child adopted by the Insured or placed with the Insured for adoption, if the adoption or placement for adoption occurs while the Insured is covered under the Policy; or
- A Late Applicant after 18 months following the date he became covered.

**Creditable Coverage:** Means:

- 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 employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans.
- The federal Medicare program pursuant to Title XVIII of the Social Security Act.
- The Medicaid program pursuant to Title XIX of the Social Security Act.
- 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).

- A public health plan. For the purposes of this definition, a public health plan means any plan established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.
- A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. Sec. 2504(e)).
- Title XXI of the Social Security Act (State Children's Health Insurance Program).

Creditable Coverage includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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## COORDINATION OF BENEFITS

### APPLICABILITY

This coordination of benefits (COB) provision applies to This Plan when an insured person has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

1. Shall not be reduced when This Plan determines its benefits before another plan; but
2. May be reduced when another plan determines its benefits first.

### DEFINITIONS

**Plan** is any of these which provide benefits or services for, or because of, medical or dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage under 1 or 2 is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

**This Plan** is the part of the policy that provides benefits for health care expenses.

**Primary Plan/Secondary Plan:** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

Where there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

**Allowable Expense** means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the insured for whom claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary Plan because an insured person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions or precertification of admissions or services.

**Claim Determination Period** means a calendar year. However, it does not include any part of a year during which an insured person has no coverage under This Plan, or any part of a year before this COB provision or a similar provision takes effect.

## **ORDER OF BENEFIT DETERMINATION RULES**

### General

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

1. The other plan has rules coordinating its benefits with those of This Plan; and
2. Both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other plan.

### Rules

This Plan determines its order of benefits using the first of the following rules which applies:

1. **Non-Dependent/Dependent.** The benefits of the plan which covers the insured as an employee, member or subscriber are determined before those of the plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is (a) secondary to the plan covering the insured person as a dependent; and (b) primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.
2. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in Paragraph 3 below, when This Plan and another plan cover the same child as a dependent of different persons, called parents:
  - (a) The benefits of the plans of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
  - (b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. **Dependent Child/Separated or Divorced.** If two or more plans cover an insured person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - a. First, the plan of the parent with custody of the child;
  - b. Then, the plan of the spouse of the parent with custody;
  - c. Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. **Joint Custody.** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph 2.

5. **Active/Inactive Employee.** The benefits of a plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured 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 5 is ignored.
6. **Continuation Coverage.** If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:
  - (a) First, the benefits of a plan covering the insured person as an employee, member or subscriber (or as that person's dependent);
  - (b) Second, the benefits under the continuation coverage.
7. **Longer/Shorter Length of Coverage.** If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that insured person for the shorter term.

## **EFFECT ON THE BENEFITS OF THIS PLAN**

### **When this Section Applies**

This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

### **Reduction in This Plan's Benefits**

The benefits of This Plan will be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expense under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they are the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

## **RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

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

## **FACILITY OF PAYMENT**

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which 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 We should have paid under this COB provision, We may recover the excess from one or more of:

1. The persons We have paid or for whom We have paid;
2. Insurance companies; or
3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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## PRE-CERTIFICATION FOR HOSPITAL CONFINEMENT

Pre-certification is a review process to determine whether a service will be deemed Medically Necessary. Certification means a service was deemed Medically Necessary as a result of the Pre-Certification review process. Any functions done by Us for Pre-Certification may be done by an agency named by Us to do them. Hospital Confinement is subject to Pre-Certification. Failure to pre-certify may result in a reduction of benefits based on the Pre-certification Penalty stated in the Schedule

**How to Pre-Certify:** The Covered Person or the Covered Person's representative must call [name of entity performing pre-certification]. The call must be made prior to Hospital Confinement. In the case of an Emergency, the call must take place as soon as reasonably possible. If such prior notification is not given, We will reduce payment for such claims. The Pre-Certification Penalty Amount is shown in the Schedule.

**Continued Stay Review:** The [name of entity performing pre-certification] will contact the Covered Person's Doctor periodically for a review of the medical information to determine the need for continued Hospital Confinement. Additional days will be certified if the days are determined to be necessary. Covered Charges for which the Covered Person did not obtain pre-certification will be covered as stated in the Schedule of Benefits.

## PREFERRED PROVIDER BENEFIT

We encourage Covered Persons to use Preferred Providers by providing benefit incentives when Preferred Providers are used.

In the event of an Emergency, services rendered by any Hospital due to and within the first 24 hours after the onset of the Emergency Medical Condition are covered as if the service had been provided by a Preferred Hospital. After the first 24 hours, services rendered by a Non-Preferred Hospital to treat the Emergency Medical Condition will continue to be covered as if rendered by a Preferred Hospital only until the Covered Person can reasonably and safely be transferred to a Preferred Hospital.

In the event a Covered Person is traveling or is away from home, needs medical attention, and cannot use a Preferred Provider for the area, contact our customer service department. We will refer the Covered Person to a Preferred Provider that may be available in the area nearest to such person at the time. If there is no Preferred Provider available, benefits for Covered Charges maybe subject to the reduced Insured Percent.

A Covered Person is not required to seek treatment from a Preferred Provider. Each Covered Person is free to elect the services of a provider and benefits payable will be made in accordance with the terms and conditions of this benefit.

We do not make any representation or warranty as to the medical competence or ability of a Preferred Provider or to their respective staff or Doctors. We shall not have any liability or responsibility, either direct, indirect, vicarious or otherwise, for any actions or inactions, whether negligent or otherwise, of the Preferred Provider, their staff or Doctors.

**Out-of-Network:** Any Hospital or Doctor that is not a member of the Preferred Provider network arrangement that has contracted with us.

**Preferred Provider:** Any Hospital or Doctor that has contracted with Us to provide services, as described in this Policy, through a Preferred Provider network arrangement, to be reimbursed at discounted fees.

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## CLAIM PROVISIONS

**Notice of Claim:** Written Notice of Claim must be given to Us or Our authorized representative within 60 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

**Claim Forms:** Upon Our receipt of written Notice of Claim, We will furnish to the claimant such forms as are usually furnished by Us for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to Proof of Loss upon submitting, within the time fixed in this Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

**Proof of Loss:** Written Proof of Loss for Hospital Confinement must be given to Us or Our authorized representative within 90 days after release from the Hospital. Proof of any other covered loss must be given to Us or Our authorized representative not later than 90 days after the covered loss. If Proof of Loss is not given within 90 days, the claim will not be denied or reduced for that reason if that proof was given as soon as reasonably possible. In any case, the proof required must be given no later than one year from the time specified except in the absence of legal capacity.

**Time of Payment of Claims:** (a) Clean Claims shall be paid, denied, or settled within 30 calendar days after receipt by Us if submitted electronically and within 45 calendar days after receipt by Us if submitted by any other means.

(b) If the resolution of a claim requires additional information, then We shall, within 30 calendar days after receipt of the claim, give the provider, Policyholder, Insured, or patient, as appropriate, a full explanation of what additional information is needed. The person receiving a request for additional information shall submit all additional information requested by Us within 30 calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, We may deny a claim if a provider fails to timely submit additional information requested in this paragraph (b).

If We fail to pay, deny, or settle a Clean Claim in accordance with paragraph (a) of provision or take other required action within the time periods set forth in paragraph (b) of this provision, We shall be liable for the covered benefit and, in addition, shall pay to the Insured or health care provider, with proper assignment, interest at the rate of 12 percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due.

As used in this provision, a Clean Claim means a claim for payment of health care expenses that is submitted to Us on Our standard claim form with all required fields completed with correct and complete information in accordance with Our published filing requirements. A Clean Claim does not include a claim for payment of expenses incurred during a period of time for which premiums are not paid, except to the extent otherwise required by law.

**Payment of Claims:** Benefits will be payable to the Covered Person or the medical services provider if We have received a valid assignment by the Covered Person.

If any indemnity of this Policy shall be payable to the estate of the Covered Person or to a Covered Person who is a minor or otherwise not competent to give a valid release, We may pay such indemnity to his parent, guardian or other person actually supporting him. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Subject to any written direction of the Covered Person or of the legal or natural guardian of the Covered Person, if the Covered Person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by the Policy as a result of medical, surgical, dental, hospital or nursing service may, at Our option, and unless We are requested in writing not later than the time for filing Proofs of Loss, be paid directly to the Hospital or person rendering such services; but it is not requested that the services be rendered by a particular Hospital or person.

**Physical Examination:** We, at Our own expense, shall have the right and opportunity to examine the Covered Person as it may reasonably require while a claim is pending.

**Legal Actions:** A legal action may not be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

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## PREMIUM

**Payment of Premium/Due Date:** All premium, charges or fees (hereinafter "Premium") must be paid to Us at Our home office prior to the start of the term for which coverage is selected. In no event will coverage become effective prior to the date of enrollment and required premium are received at our home office or by Our authorized representative.

**Returned or Dishonored Payment:** If a check in payment for the Premium is dishonored for insufficient funds, a reasonable service charge may be charged to the Policyholder which will not exceed the maximum specified under state law. A dishonored check shall be considered a failure to pay Premium and coverage shall not take effect.

**Grace Period:** We allow a grace period of 31 days for the payment of premium after the first premium. Coverage is in force during the Grace Period. If at least 60 days prior to the premium due date We send written notice to You of Our intent not to renew this Certificate, then the Grace Period will not apply to any period after the date the non-renewal is to be effective. If You send written notice to Us that You are not renewing Your coverage, then the Grace Period will not apply after the date the non-renewal is to be effective.

Coverage terminates on the last day for which premium has been paid.

**Reinstatement:** If coverage terminates due to non-payment of premium, then a subsequent acceptance of premium by Us or by an agent, without requiring an application for reinstatement, will reinstate the insurance.

If We do require an application for reinstatement and accept premium, then We may issue a conditional premium receipt. If We approve the application, then insurance will be reinstated as of the date of Our approval. If We do not approve the application, then We will notify You in writing within 45 days after the date of the application.

If We do not notify You within 45 days, then coverage will be reinstated on the 45<sup>th</sup> day after the date of the conditional premium receipt.

The reinstated Certificate will cover only losses due to conditions that begin after the date of reinstatement. In all other respects, Your rights and Ours will be the same as before insurance terminated, unless there are new provisions added due to reinstatement. The premium We accept for reinstatement may be used for the period for which premiums had not been paid. We can apply the premium for as many as 60 days before the date of reinstatement.

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## GENERAL PROVISIONS

**Entire Contract; Changes:** The Policy, including the Certificate, if any, endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by one of Our executive officers and unless such approval is endorsed hereon or attached hereto. No agent has authority to change the Policy or waive any of its provisions.

Failure by Us to enforce any Policy provision shall not waive, modify or render such provision unenforceable at any other time; at any given time; or under any given set of circumstances, whether the circumstances are or are not the same.

**Incontestability:** All statements made in an application by You are, in the absence of fraud, representations and not warranties. No statement shall be used to contest this Certificate, the validity of coverage or reduce benefits, unless it is in writing, signed by You, and a copy of such statement is furnished to You.

After a Covered Person's coverage has been in force for 2 years under this Certificate, no statement of that Covered Person, except fraudulent misstatement, shall be used to void his insurance or to deny or reduce a claim for loss incurred after the 2 year period.

**Non-Participating:** This Certificate is non-participating. It does not share in Our profits or surplus earnings.

**Conformity With State Statutes:** If any provision of this Certificate is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

**Workers' Compensation:** This Certificate is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance.

**Clerical Error:** If a clerical error is made so that an otherwise eligible person's coverage does not become effective, coverage may be in effect if: (a) the Policyholder makes a written request for coverage on a form approved by Us ; and (b) any premium not paid because of the error is paid in full from the effective date of coverage. Company reserves the right to limit retroactive coverage to two months preceding the date the error was reported.

If a clerical error is made so that the coverage is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any Premium refund will be reduced by any payment made for claims. If claims paid exceed the Premium refund, the Policyholder shall reimburse Us for the overpayment.

**Information and Records:** We shall have the right to inspect, at reasonable times, any of the Policyholder's records for the Policy. The Policyholder shall provide Us with information necessary to administer coverage and set premium under the Policy. Information is required when an eligible person becomes covered, when changes in amounts of coverage occur, and when a Covered Person's coverage terminates.

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## **PATIENT PROTECTION AND AFFORDABLE CARE ACT**

Notwithstanding anything in the Policy or Certificate of Insurance to the contrary, it is hereby understood and agreed that the Policy and the Certificate of Insurance shall provide coverage as provided below:

The following provisions apply under the Policy and Certificate of Insurance beginning on or after September 23, 2010, to ensure compliance with Federal health care reform known as the Patient Protection and Affordable Care Act, including any amendments, regulations, rules or other guidance issued with respect to the act ('Act'):

1. Any lifetime maximum [dollar][day][visit][and][encounter] limit[s] referenced pertains only to those health care services and supplies that are not essential benefits or preventive benefits as defined in the Act.
2. Coverage cannot be rescinded except for fraud or intentional misrepresentation of a material fact.
3. If coverage includes Dependents, Dependent child coverage will continue until [the date the Dependent child turns age 26] [the end of the month the Dependent child turns age 26] [the end of the [Calendar Year][Plan Year] in which the Dependent child turns age 26] regardless of the marital status of such Dependent child. Coverage does not include the spouse or child of such Dependent child unless that child meets other coverage criteria established under state law. [Coverage will not continue for a Dependent child who is eligible to enroll under some other employer sponsored health plan.]
4. Any per [Calendar Year][Plan Year] [dollar][day][visit][and][encounter] limits are not applied to preventive benefits and may only be applied to essential benefits as allowed in the Act.
5. The preexisting condition exclusion does not apply to [Dependent children][Insured Persons] under age 19.
6. Coverage for preventive benefits, as defined in the Act, do not require payment of any Deductible, Copayment, or Coinsurance [if obtained from a Preferred Provider.] The following are covered preventive benefits:
  - a. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
  - b. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
  - c. with respect to Insured Persons who are infants, children, and adolescents, evidence-informed
  - d. preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
  - e. with respect to Insured Persons who are women, such additional preventive care and screenings not

described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.]

7. Except where an Insured Person's life or health would be seriously jeopardized, You must first exhaust Our internal grievance process before We will grant Your request for an external review. In no event shall Your rights to external review be any more restrictive than that set forth within the Uniform External Review Model Act established by the National Association of Insurance Commissioners (NAIC), by the Secretary of Health and Human Services (HHS) or within Your state external review act. [There will be no fee for filing an external review.] At all times, an Insured Person has the right to contact the Department of Insurance. [The Department has established a toll-free number exclusively for an Insured Person's grievance questions. This number is for an Insured Person's convenience to help assist with any inquiries he or she may have concerning a grievance/appeal. The address and toll-free number is:]

[Department of Insurance  
Address  
City, State, Zip  
800-XXX-XXXX]

[If the Insured Person has local telephone access, the local number to the Department of Insurance is  
(XXX) XXX XXXX.]

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## SCHEDULE

### POLICYHOLDER AND INSURED INFORMATION

<b>Policyholder:</b>	Truckers Association
<b>Sponsor Trucking Company:</b>	ABC Company
<b>Insured:</b>	John Public
<b>Certificate Number:</b>	12345
<b>Effective Date:</b>	11/1/2010
<b>Premium Due Dates:</b>	The first of each month for which coverage is provided.
<b>Premium:</b>	As shown in the Master Application
<b>Schedule Date:*</b>	
<b>Dependent Spouse:</b>	is <input checked="" type="checkbox"/> is not <input type="checkbox"/> insured under this Certificate as of the Schedule Date.
<b>Dependent Child(ren):</b>	is (are) <input checked="" type="checkbox"/> is (are) not <input type="checkbox"/> insured under this Certificate as of the Schedule Date.
<b>Waiting Period:</b>	30 Days from the date the member signs a lease with a sponsor trucking company.

This Schedule replaces and supersedes any Schedule attached to this Certificate with a date earlier than the Schedule Date shown above.

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### MEDICAL EXPENSE BENEFITS

<b>Lifetime Aggregate Maximum Amount</b> .....		\$1,000,000
	<b>Plan A</b>	<b>Plan B</b>
<b>Deductible, Per Calendar Year Per Covered Person</b>	\$750.00	\$1,500.00
<b>Family Deductible, Per Calendar Year</b> <i>No more than \$750.00 for Plan A or \$1,500.00 for Plan B for any one Covered Person will be applied to the Family Deductible</i>	\$1,500.00	\$3,000.00
<b>Out of Pocket Maximums</b>		
<b>Per Individual:</b>		
In-Network	\$3,000.00	\$5,000.00
Out-of-Network	\$3,500.00	\$7,000.00
<b>Per Family:</b>		
In-Network	\$6,000.00	\$10,000.00
Out-of-Network	\$7,000.00	\$14,000.00
<b>Insured Percent (except as specifically stated in Covered Charges)</b>		
<b>In-Network</b> .....		85%
<b>Out-of-Network</b> .....		70%
<b>Once the Out-of-Pocket Maximum is reached</b> .....		100%
<b>Out-of-Network Hospital Copayment:</b>		
Inpatient.....	\$200 per admission	
Outpatient .....	\$200 per admission	
<b>Prescription Drug Benefits</b>		
<b>Retail Program:</b>		
- Generic Coinsurance.....	50% Copayment	,up to a \$50 max
- Brand Coinsurance.....	50% Copayment	,up to a \$50 max
<b>Mail Order Program:</b>		
- Generic Coinsurance.....	50% Copayment	,up to a \$50 max
- Brand Coinsurance.....	50% Copayment	,up to a \$50 max
<b>Payment System Percentile</b> .....		90 <sup>th</sup>
<b>Pre-certification Penalty</b> .....	Failure to pre-certify when required will result in a benefit reduction of 50%.	

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**COVERED CHARGES**

Covered Charges are treatment, services or supplies incurred for:

**INPATIENT**

- Hospital room and board and general nursing care while Hospital Confined, up to the daily semi-private room rate.
- Hospital miscellaneous expense.
- Intensive Care Unit/Hospital expenses, not to exceed the Hospital rate for semi-private room.
- Doctor's fees for surgery and surgery when performed in a Hospital, including pre-operative and post-operative care.
- Anesthetist expense.
- Assistant surgeon's expense.
- Pathologist expense.
- Radiologist expense.
- Doctor's visits.
- Pre-Admission Testing expense.

**OUTPATIENT**

- Doctor's fees for surgery and surgery when performed in an out-patient department of a Hospital, Ambulatory Surgical Center or clinic. Includes pre-operative and post-operative care.
- Anesthetist expense.
- Assistant surgeon's expense.
- Doctor's visits.
- Diagnostic x-ray expense.
- Laboratory services expense.
- Radiation therapy and chemotherapy.
- Injections.
- Allergy testing including percutaneous, intracutaneous and patch tests.

**OTHER**

- Durable Medical Equipment.
- Voluntary second surgical opinions.
- Dental treatment for Injury to Sound Natural Teeth, other than Injury caused by chewing food or similar substances.
- Nurse expense for private duty nursing, when prescribed by the attending Doctor, limited to a maximum benefit of \$20,000.
- Casts, splints, trusses, Orthopedic Appliances and crutches.
- Rigid or semi-rigid supportive devices that restricts or eliminates motion of a weak or diseased body part. Benefits include purchase, fitting, necessary adjustment, repairs and replacement.
- Home Health Care expense.
- Sterilization expense.
- Abortion expense when the life of the mother would be endangered if the fetus was carried to term.
- Ambulance expense.
- Preventive care, to include examinations and immunizations. Annual examinations limited to \$120 per Calendar Year. Related laboratory tests limited to \$125 per Calendar Year. Adult immunizations limited to \$100 per Calendar Year.

- Prescription Drug expense.
  - a. Up to a 30 day supply of a drug per acute prescription or 31-60 day supply per maintenance prescription is subject to the copayment amount specified on the Schedule of Benefits.
  - b. Mail order drugs for a 90-day supply is subject to the copayment amount specified on the Schedule of Benefits.

If a brand name drug is used when a generic drug is available, the Covered Person is responsible for the difference between the generic drug cost and the brand name drug cost in addition to the brand name Copayment.

Eligible Prescription Drugs include federal legend drugs; compounded medication of which at least one ingredient is a prescription legend drug; legend and non-legend Meclizine; state restricted drugs; emergency allergic kits; injectable migraine medications; inhaler assisting devices; influenza treatments (retail only); topical Vitamin A derivatives up to age 35; Systemed Standard Self-Injectable medications; Specialty Pharmacy Drug list; non-insulin syringes with or without needles; prescription vitamins; hemophilia factors; substance abuse treatment medications; Synagis and RespiGam; and Interferon beta-1b (Betaseron) and Avonex.

- Hospice Care limited to 40 days of inpatient care per Calendar Year and 40 outpatient visits per Calendar Year.

- Organ and tissue transplant services including Hospital Confinement and all related post-surgical treatment and drugs. Transplant-related treatment is subject to the terms of the Policy.

Medical and Hospital expenses for the donor to donate the organ or tissue are covered.

Benefits for Organ and Tissue Transplants are paid at 50% for both in and out-of-network.

Prescription Drugs used in connection with organ and tissue transplant services are covered under the Prescription Drug benefit.

- Oral surgical procedures including extraction of impacted third molars when partially or totally covered by bone and extraction of teeth in preparation for radiation therapy; mandibular stable implant when not done to prepare the mouth for dentures; maxillary or mandibular frenectomy; Injury to the jaw or structures contiguous to the jaw; the correction of a non-dental physiological condition which has resulted in a severe functional impairment; treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth; and orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

- Infertility diagnosis, correction of a physical or medical problem associated with infertility and artificial insemination. Prescription Drugs for infertility, artificial insemination, in vitro or in vivo fertilization of an ovum, including Pergonal (Menotropins) are covered under the Prescription Drug benefit.

- Blood or blood plasma, other than the Covered Person's or that which has been donated specifically for the Covered Person.

- Physical, speech, and occupational therapy, limited to 30 visits per Calendar Year. Speech therapy is covered only when the therapy is Medically Necessary due to an Injury, surgery or organic pathological disorder such as a stroke.

- Radiation, respiratory infusion, and cardiac rehabilitation therapy.

- Initial purchase of prosthetic devices and supplies, including artificial limbs or eyes which replace an absent or malfunctioning body part or organ. Replacements thereof are covered if approved by Us. Repairs are covered when needed to restore proper function.

- Kidney dialysis treatment and equipment.

- Initial purchase of glasses or contacts for aphakia, keratoconus or following cataract surgery.

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- Skilled Nursing Care expense in a Hospital, payable at the skilled nursing care rate, if the level of care needed by the Covered Person has been reclassified from acute care to skilled nursing care and no designated skilled nursing care beds or swing beds are available in the Hospital or in another Hospital or health care facility within a 30 mile radius of the Hospital.

- Mammograms for female Covered Persons at the following intervals: One baseline mammogram age 35 through age 39; a mammogram every 2 years age 40 through age 49, or more frequently if recommended by a Doctor; a mammogram every year age 50 or older; and a mammogram for any woman desiring a

mammogram for medical cause.

- Diabetes equipment, supplies, and self-management training and education for the treatment of all types of diabetes mellitus. Coverage shall include coverage for the cost associated with all of the following
  - a. Blood glucose meter and glucose strips for home monitoring.
  - b. Payment for diabetes self-management training and education only under all of the following conditions:
    - (1) The physician managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge to participate in the management of the individual's condition.
    - (2) The diabetic self-management training and education program is certified by the Iowa department of public health. The department shall consult with the American diabetes association, Iowa affiliate, in developing the standards for certification of diabetes education programs as follows:
      - (a) Initial training shall cover up to 10 hours of initial outpatient diabetes self-management training within a continuous 12 month period for each individual that meets any of the following conditions:
        - i) A new onset of diabetes.
        - ii) Poor glycemic control as evidenced by a glycosylated hemoglobin of nine and five-tenths or more in the ninety days before attending the training.
        - iii) A change in treatment regimen from no diabetes medications to any diabetes medication, or from oral diabetes medication to insulin.
        - iv) High risk for complications based on poor glycemic control; documented acute episodes of severe hypoglycemia or acute severe hyperglycemia occurring in the past year during which the individual needed third-party assistance for either emergency room visits or hospitalization.
        - v) High risk based on documented complications of a lack of feeling in the foot or other foot complications such as foot ulcer or amputation, pre-proliferative or proliferative retinopathy or prior laser treatment of the eye, or kidney complications related to diabetes, such as macroalbuminuria or elevated creatinine.
      - (b) An individual who receives the initial training shall be eligible for a single follow-up training session of up to one hour each year.
- Well Child Care for a covered Dependent child at the following age intervals: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months or 2 years, 3 years, 4 years, 5 years, and 6 years.

**Note: If Prescription Drug Coverage is Provided**

- [Prescription contraceptive drugs or prescription contraceptive devices.]

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**GUARANTEE TRUST LIFE INSURANCE COMPANY**

1275 Milwaukee Avenue  
Glenview, Illinois 60025  
Telephone: 847 699-0600

**CERTIFICATE OF INSURANCE**

This is Your Certificate of Insurance (Certificate) while You are insured. It briefly explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a legal contract between the Policyholder and Us. The Policyholder is shown on the Schedule.

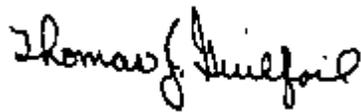
The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payment is governed by all the terms, conditions and limitations of the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

The Policy has been issued and delivered to the Policyholder in the state of Iowa. Except as otherwise stated in this Certificate, the Policy will be governed by the laws of the state where the Policy was issued. The Policy is held by the Policyholder. You may inspect it at any time during business hours at the office of the Policyholder.

This Certificate was issued on the basis that the information on Your enrollment form was correct and complete. If any information on the enrollment form was not correct, write to Us within ten (10) days of receipt of this Certificate. An error or omission in Your enrollment form may result in loss of coverage as of its Effective Date.

**Right to Examine:** If You are not satisfied with this Certificate, return it to Our home office within ten days after the date You received it. This Certificate will then be canceled and any Premium paid will be refunded.

**READ YOUR CERTIFICATE CAREFULLY**



Secretary



President

**DENTAL COVERAGE**

**NON-PARTICIPATING**

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## GENERAL DEFINITIONS

*The terms listed below, if used, have the meaning stated.*

**Accident:** A sudden, unforeseeable event which results in an Injury.

**Calendar Year:** The period of time beginning on January 1 and ending on December 31 of the same year. The first Calendar Year of the Certificate will begin on the date this Certificate becomes effective and end on the first December 31<sup>st</sup> after a covered Person's effective date of coverage.

**Class:** A category of persons based on student status, job, salary or some other condition of employment or membership. Eligible Classes are shown on the Schedule.

**Company:** Guarantee Trust Life Insurance Company, a mutual company. Also hereinafter referred to as We, Us and Our.

**Covered Person:** A person:

- Who is eligible for coverage as the Insured or as a Dependent;
- Who has been accepted for coverage or has been automatically added;
- Who has paid the required premium; and
- Whose coverage has become effective and has not terminated.

**Dependent:** A person who is the Insured's:

- Legally married spouse, residing with the Insured.
- Child who is dependent upon the Insured for support and maintenance and is under the age of [25].
- Child who is dependent upon the Insured for support and maintenance, is 25 years of age or over and is:
  - attending school full time, as determined by the school the Dependent is attending, including colleges and vocational, technical, vocational-technical or trade schools or institutes.

The term child refers to the Insured's unmarried:

- Natural child.
- Stepchild or foster child; A stepchild is a Dependent on the date the Insured marries the child's parent.
- Adopted child, including a child placed with the Insured for the purpose of adoption, from the moment of placement as certified by the agency making the placement.
- Grandchild who is financially dependent upon the covered grandparent and who resides with that covered grandparent continuously from birth.
- Child for whom the Insured is required by court or administrative order to provide health coverage.

In the event both parents of a Dependent are insured persons, such child is considered as a Dependent of either parent. The child may not be considered a Dependent of both parents.

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

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

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

**Family Member:** A person who is related to the Covered Person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member includes an individual who normally lives in the Covered Person's household.

**Hospital:** An institution licensed, accredited or certified by the State which:

- Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
- Provides 24-hour nursing service by licensed registered nurses (R.N.);
- Mainly provides diagnostic and therapeutic care under the supervision of Doctors while Hospital Confined; and
- Maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest; the aged; a nursing home; or an institution mainly rendering treatment or services for Mental or Nervous Disorders or substance abuse, except as specifically provided in the Policy.

**Hospital Confined/Hospital Confinement:** Confinement in a Hospital on an inpatient basis for at least 24 consecutive hours for which a room and board charge is made by reason of a Sickness or Injury for which benefits are payable.

**Injury:** Bodily injury due to an Accident which results solely, directly and independently of disease, bodily infirmity or any other causes.

All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single injury.

**Insured:** The Covered Person who is a member of the Policyholder's organization as defined on the Schedule of Benefits.

**Late Applicant:** A member of an eligible Class who requests coverage more than 30 days after the date such person was first eligible to enroll. A person shall not be considered a Late Applicant if he:

- Was covered under another Policyholder's group health plan at the time of initial enrollment; and
- Stated at the time of initial enrollment that coverage under another Policyholder's group health plan was the reason for declining coverage; and
- Has lost coverage under another Policyholder's group health plan due to termination of employment, termination of the plan, death of a spouse or divorce; and
- Requests coverage within 30 days after termination of coverage; or
- Applies for coverage on a spouse or minor child within 30 days of a court order requiring coverage be provided under his plan.

**Medicaid:** The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965 as Then Constituted or Later Amended.

**Medicare:** The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.

**Policy Year:** The period of 12 months following the Policy's Effective Date.

**Policyholder:** The entity shown as the Policyholder on the Schedule.

**Reasonable and Customary Charges, Fees or Expenses:** An amount equal to the lesser of:

- The actual amount charged by the provider;
- The negotiated rate, if any; or
- The reasonable charge as determined by the Payment System software as shown in the Schedule.

**Sickness:** Illness and disease.

**Sound Natural Teeth:** Natural teeth, the major portion of the individual tooth which is present, regardless of fillings and caps; and is not carious, abscessed, or defective.

**We, Ours and Us:** The Guarantee Trust Life Insurance Company.

**You, Your and Yours:** The Insured shown on the Schedule.

Male pronouns whenever used include female pronouns.

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## CONDITIONS OF INSURANCE

### ELIGIBILITY

**Insured:** You are eligible for coverage if You are a member of an eligible Class and complete a valid enrollment form. Eligible Classes are shown in the Master Application.

**Dependent:** When a Dependent is a member of an eligible Class, such Dependent is eligible for coverage on the later of:

- The date You become eligible for insurance; or
- The date You acquire the Dependent.

A Dependent is deemed to be acquired as follows:

Spouse: On the date of the marriage to You.

Natural child: On the date of birth.

Adopted child: From the moment of placement with You for the purpose of adoption, as certified by the agency making the placement.

Stepchild: On the date of Your marriage to the child's parent.

### EFFECTIVE DATE

**Insured and Dependents, except Dependents Acquired After Effective Date:** Coverage is effective as stated on the Schedule.

**Late Applicant:** Coverage is effective the first day of the month following the date of Our receipt of the request for coverage.

### Dependents Acquired After Effective Date

**Newborn Children:** Your newborn child is automatically covered from the moment of birth until such child is 90 days old. Coverage for such child will be for Sickness and Injury, including congenital anomalies, prematurity and nursery care. However, You must notify Us in writing within 90 days of such birth and pay the required additional premium, if any, in order to have coverage for the newborn child continue beyond such 90 day period.

**Adopted Child:** Coverage for an adopted newborn that is placed with the adoptive Insured within 60 days of the adopted child's date of birth is effective from the moment of birth. Coverage for an adopted child placed with the adoptive Insured more than 60 days after the birth of the adopted child shall be from and after the date the child is placed. Coverage for such child will be for Sickness and Injury, including anomalies, prematurity and nursery care. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. However, You must notify Us in writing within 60 days of such adoption and pay the required additional premium, if any, in order to have coverage for the adopted child continue beyond such 60 day period.

"Placed" means physical placement of an adopted child in the care of the adoptive Insured, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring

placement in a medical facility, it shall mean when the adoptive Insured signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage as to a child placed for adoption with the Insured continues in the same manner as it would with respect to a naturally born child of the Insured until the first to occur of the following events: date the child is removed permanently from that placement and the legal obligation terminates; or the date the Insured rescinds, in writing, the agreement or adoption or agreement assuming financial responsibility.

**Newborn Grandchildren:** Your newborn grandchild is automatically covered from the moment of birth if the child resides with You.

**Dependent Spouse:** A Dependent spouse is eligible for coverage on the date of marriage to You. Enrollment and premium must be received within 31 days of the marriage. Coverage is effective upon receipt of enrollment and premium by Us or Our authorized representative.

**Enrollment Under Court Orders:** If, pursuant to a court order, You are required to provide health coverage for a child and You are eligible for Dependent coverage, We shall:

- Permit You to enroll such child who is otherwise eligible for the coverage without regard to any enrollment season restrictions. Coverage for the child will take effect on the date specified in the court order or, if no date is specified, on the date the court order is issued; and
- Continue coverage of the child unless We are provided satisfactory written evidence that the:
- Court order is no longer in effect;
- Child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment; or
- Policyholder has eliminated family health coverage for all of its employees.]

#### **SPECIAL ENROLLMENT**

Special Enrollment Period for You and Your Dependents: Persons who are eligible for coverage under the Policy but not enrolled may enroll for coverage if all of the following conditions are met:

1. You were or Your Dependent was covered under a group health plan or had health insurance coverage at the time coverage under the Policy was previously offered;
2. You stated in writing at the time of initial eligibility that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if such statement was required at such time and You were provided with notice of the requirement and the consequences of such requirement at the time;
3. Coverage described in 1. above was:
  - a. terminated under a COBRA or state continuation provision and the coverage under such provision was exhausted; or
  - b. terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated; and
  - c. the eligible employee requested such enrollment not later than 30 calendar days after the date of exhaustion of coverage described in 3.a. above, or termination of coverage or employer contributions described in 3.b. above.

Special Enrollment Period for New Dependents Only. New dependents may enroll if they become dependents of the eligible employee through marriage, birth, adoption, placement for adoption or legal guardianship. The eligible employee, if not previously enrolled, may enroll when a new Dependent enrolls for coverage during the 30 day Special Enrollment Period. Other Dependents (such as siblings of a newborn child) are not entitled to special enrollment rights upon the birth or adoption of a child. Coverage for a new Dependent enrolling during the Special Enrollment Period will become effective:

1. In the case of marriage, not later than the first day of the month following Our receipt of the request for enrollment.
2. In the case of a Dependent child's birth, as of the date of such birth.
3. In the case of a Dependent child's adoption or placement for adoption, the date of such adoption or placement for adoption.

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## TERMINATION

**Covered Person:** Coverage with respect to a Covered Person will terminate at 12:01 a.m. standard time at Your residence on the earliest of:

- The date the Policy terminates;
- The date You are no longer eligible for coverage under the Policy.
- The date coverage is terminated by Us for all certificate holders in Your state;
- The date We receive Your written request to terminate coverage;
- The last day of the period for which the Premium is paid;
- The last date of the period for which Premium has been paid following the date a Dependent ceases to be a Dependent as defined;
- The date a Covered Person enters full time active military service. Upon written request within 30 days of entering the military, We will refund any unearned pro-rata Premium with respect to such person.

At least 45 days prior written notice will be given to You if We terminate Your coverage for any reason, except for nonpayment of Premium.

Termination of coverage is subject to the Extension of Benefits provision.  
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## CONTINUATION FOR INCAPACITATED CHILDREN

Dependent children, who are covered under the terms of the Certificate, who reach the limiting age and are incapable of self-sustaining employment due to a handicapped condition may continue to be covered regardless of age. The Dependent must be chiefly dependent on You for support and maintenance.

We will inquire two (2) months prior to the attainment by a Dependent of the limiting age or at any reasonable time thereafter, whether such Dependent is in fact a disabled and dependent person. In the absence of proof submitted within 60 days of such inquiry that such Dependent is a disabled and dependent person, We may terminate coverage of such person at or after attainment of the limiting age. In the absence of such inquiry, coverage of any disabled and dependent person shall continue through the term of the coverage or any extension or renewal thereof.

Coverage for a handicapped child will end on the earliest of:

- The date the Dependent marries;
- The date the Dependent obtains self-sustaining employment;
- The date the Dependent ceases to be handicapped;
- The date the Dependent ceases to be chiefly dependent upon You;
- Sixty (60) days after a written request for proof of disability, if proof is not provided within such 60 days;
- The date You refuse to allow Us to examine the Dependent; or
- The date coverage would otherwise terminate.

## CONTINUATION OF COVERAGE

### In The Event of Dissolution of Marriage

If Your marriage is dissolved by a valid decree of dissolution and if Your spouse is a Covered Person on the date of the decree of dissolution, then the Dependent spouse's coverage will continue in force under the policy, subject to its provisions, if the Dependent spouse pays the first premium required for the continued coverage within 31 days after the entry of the decree of dissolution.

If the Dependent spouse continues coverage pursuant to this provision, We will issue him or her a new Certificate as evidence of coverage under the Policy.

### For a Dependent Child Reaching the Limiting Age

If a Dependent child no longer qualifies as a Dependent, then the Dependent child's coverage will continue in force under the Policy, subject to its provisions, if the Dependent child pays the first premium required for the continued coverage within 31 days after the date he or she no longer qualifies as a Dependent child.

If the Dependent child continues coverage pursuant to this provision, We will issue him or her a new Certificate as evidence of coverage under the Policy.

### **CONTINUATION OF COVERAGE**

The right to continue this coverage is available to a Covered Person who has been continuously insured under the Policy for at least 3 months and whose insurance under the Policy ceases upon termination of group membership. Premium for continued coverage must be paid within 31 days after notice of termination.

The continued coverage will cover the Covered Person and his insured Dependents.

### **Termination of Continued Coverage**

Continued coverage will terminate on the earlier of:

- The date 18 months after the date on which the group coverage would otherwise have terminated because of termination of group membership;
- If the Covered Person fails to make timely payment of premium, the end of the period for which premium payment was made; or
- The date the Policy is terminated and is not replaced by another group policy within 31 days.

If a group policy is replaced, Covered Persons covered under continued coverage shall remain under such coverage under the replaced policy until as provided in the Termination of Continued Coverage provision.

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## **DENTAL BENEFIT PROVISION**

We will pay benefits for Dental Covered Charges incurred by a Covered Person. Benefits for Covered Dental Charges are subject to the:

1. Dental Deductible;
2. Dental Insured Percent;
3. Waiting Period, if any;
4. Calendar Year Maximum; and
5. Definitions, limitations and exclusions and other provisions of the Policy.

The Waiting Period, the Dental Deductible, Dental Insured Percent and Calendar Year Maximum are shown in the Schedule of Benefits.

Covered Dental Charges are payable only for:

1. Expense incurred after the Effective Date of a Covered Person's coverage; and
2. Expense incurred while the Policy is in force.

**ADA Code:** The code assigned by the American Dental Association to a particular dental procedure.

**Calendar Year:** The period of time beginning January 1<sup>st</sup> and ending on December 31<sup>st</sup> of the same year. The first Calendar Year of the Policy will begin on the date this Certificate becomes effective and end on the first December 31<sup>st</sup> after a Covered Person's effective date of coverage.

**Calendar Year Maximum:** The maximum amount payable by Us for all Covered Dental Charges in any Calendar Year. The Calendar Year Maximum will apply to each Covered Person.

**Dental Covered Charge:** The Reasonable and Customary Charge for Necessary Dental Treatment performed by a Dentist or a Dental Hygienist acting under the supervision and direction of a Dentist. A Dental Covered Charge is considered incurred on the date the treatment or service is rendered or the supply is furnished.

**Dental Deductible:** The amount of Covered Dental Charges a Covered Person must pay each Calendar Year before We pay any Benefits. The Calendar Year Dental Deductible applies separate to each Covered Person each Calendar Year.

**Dental Emergency:** An urgent, unplanned diagnostic visit to a Dentist for relief of an acute or unexpected dental condition.

**Dental Hygienist:** A person who is licensed to practice dental hygiene in the state where services are rendered and is acting under the supervision and direction of a Dentist and within the scope of that license.

**Dental Insured Percent:** The percentage of Dental Covered Charges We pay for each dental supply or service. The Dental Insured Percent is shown in the Schedule.

**Dentist:** A person who is licensed to practice dentistry in the state where services are rendered and is acting within the scope of that license. A Dentist shall also mean a licensed doctor performing dental services within the scope of that license.

**Necessary Dental Treatment:** Dental services or supplies which are consistent with currently accepted dental practice. Any operation, treatment, service or supply not a valid course of treatment recognized by the American Dental Association is not considered Necessary Dental Treatment.

**Policy Year Maximum:** The maximum amount payable by Us for all Covered Dental Charges in any Policy Year. The Policy Year Maximum will apply to each Covered Person.

**Waiting Period:** The period of time after the Effective Date of a Covered Person's coverage during which no benefits are payable for Necessary Dental Treatment, including related procedures, to which the period applies. The Waiting Period is shown in the Schedule.

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## DENTAL EXCLUSIONS

Benefits will not be paid for dental expenses arising from or in connection with:

- A service not furnished by a Dentist, except:
  - That performed by a Dental Hygienist under the supervision of a Dentist; and
  - X-rays ordered by a Dentist.
- Treatment, services or supplies which:
  - Are not Necessary Dental Treatment, except as provided herein;
  - Are Experimental/Investigational in nature.
- Treatment by any Family Member.
- Services or supplies for which there would be no charge in the absence of insurance.

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- War or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries.
- Care or treatment of a condition for which You are entitled or eligible for benefits under any Worker's Compensation Act or similar law.

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- Any portion of a charge for services in excess of the Scheduled Benefits.
- Procedures that are not included in the Schedule.

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- A service furnished to a Covered Person for:
  - Cosmetic purposes, unless needed as a result of Injury. Facing on crowns, or pontics, posterior to the second bicuspid shall always be considered cosmetic; or
  - Dental care of a congenital or developmental malformation (unless benefits for orthodontic services are specifically provided in the Schedule).

GDDEXXX400

- Replacement of bridges, full and partial dentures, crowns, inlays or onlays that can be repaired and restored to natural function.  
GDDEXXX500
- Implants; replacement of lost or stolen appliances; replacement of orthodontic retainers; athletic mouthguards; precision or semi-precision attachments; denture duplication; or sealants.  
GDDEXXX600
- Oral hygiene instructions; plaque control; acid etch; prescription for take-home fluoride; or diagnostic photographs.
- Overdentures and associated procedures.  
GDDEXXX700
- Services not completed by the end of the month in which insurance terminates.  
GDDEXXX800
- Expenses incurred as a result of suicide or intentionally self-inflicted Injury while sane  
GDEXXX900
- Treatment in any Veteran's Administration or Hospital operated by one of the Uniformed Services for a service related condition.
- Expenses for medical care paid for or reimbursable by or through the government of a nation, state, province, county, municipality or other political subdivision, or instrumentality or agency of such government.  
GDEXXX1000

## COORDINATION OF BENEFITS

### APPLICABILITY

This coordination of benefits (COB) provision applies to This Plan when an insured person has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

1. Shall not be reduced when This Plan determines its benefits before another plan; but
2. May be reduced when another plan determines its benefits first.

### DEFINITIONS

**Plan** is any of these which provide benefits or services for, or because of, medical or dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage under 1 or 2 is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

**This Plan** is the part of the policy that provides benefits for health care expenses.

**Primary Plan/Secondary Plan:** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

Where there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

**Allowable Expense** means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the insured for whom claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary Plan because an insured person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions or precertification of admissions or services.

**Claim Determination Period** means a calendar year. However, it does not include any part of a year during which an insured person has no coverage under This Plan, or any part of a year before this COB provision or a similar provision takes effect.

## **ORDER OF BENEFIT DETERMINATION RULES**

### General

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

1. The other plan has rules coordinating its benefits with those of This Plan; and
2. Both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other plan.

### Rules

This Plan determines its order of benefits using the first of the following rules which applies:

1. **Non-Dependent/Dependent.** The benefits of the plan which covers the insured as an employee, member or subscriber are determined before those of the plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is (a) secondary to the plan covering the insured person as a dependent; and (b) primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.
2. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in Paragraph 3 below, when This Plan and another plan cover the same child as a dependent of different persons, called parents:
  - (a) The benefits of the plans of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
  - (b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. **Dependent Child/Separated or Divorced.** If two or more plans cover an insured person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - a. First, the plan of the parent with custody of the child;
  - b. Then, the plan of the spouse of the parent with custody;
  - c. Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. **Joint Custody.** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph 2.
5. **Active/Inactive Employee.** The benefits of a plan which covers an insured person as an employee who is neither laid off nor retired are determined before those of a plan which covers that insured person as a laid off or retired employee. The same would hold true if an insured 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 5 is ignored.
6. **Continuation Coverage.** If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:
  - (a) First, the benefits of a plan covering the insured person as an employee, member or subscriber (or as that person's dependent);
  - (b) Second, the benefits under the continuation coverage.
7. **Longer/Shorter Length of Coverage.** If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that insured person for the shorter term.

#### **EFFECT ON THE BENEFITS OF THIS PLAN**

##### **When this Section Applies**

This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

##### **Reduction in This Plan's Benefits**

The benefits of This Plan will be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expense under This Plan is the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expense under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they are the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

#### **RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

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

#### **FACILITY OF PAYMENT**

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which 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 We should have paid under this COB provision, We may recover the excess from one or more of:

1. The persons We have paid or for whom We have paid;
2. Insurance companies; or
3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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## **CLAIM PROVISIONS**

**Notice of Claim:** Written Notice of Claim must be given to Us or Our authorized representative within 60 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

**Claim Forms:** Upon Our receipt of written Notice of Claim, We will furnish to the claimant such forms as are usually furnished by Us for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to Proof of Loss upon submitting, within the time fixed in this Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

**Proof of Loss:** Written Proof of Loss for Hospital Confinement must be given to Us or Our authorized representative within 90 days after release from the Hospital. Proof of any other covered loss must be given to Us or Our authorized representative not later than 90 days after the covered loss. If Proof of Loss is not given within 90 days, the claim will not be denied or reduced for that reason if that proof was given as soon as reasonably possible. In any case, the proof required must be given no later than one year from the time specified except in the absence of legal capacity.

**Time of Payment of Claims:** (a) Clean Claims shall be paid, denied, or settled within 30 calendar days after receipt by Us if submitted electronically and within 45 calendar days after receipt by Us if submitted by any other means.

(b) If the resolution of a claim requires additional information, then We shall, within 30 calendar days after receipt of the claim, give the provider, Policyholder, Insured, or patient, as appropriate, a full explanation of what additional information is needed. The person receiving a request for additional information shall submit all additional information requested by Us within 30 calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, We may deny a claim if a provider fails to timely submit additional information requested in this paragraph (b).

If We fail to pay, deny, or settle a Clean Claim in accordance with paragraph (a) of provision or take other required action within the time periods set forth in paragraph (b) of this provision, We shall be liable for the covered benefit and, in addition, shall pay to the Insured or health care provider, with proper assignment, interest at the rate of 12 percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due.

As used in this provision, a Clean Claim means a claim for payment of health care expenses that is submitted to Us on Our standard claim form with all required fields completed with correct and complete information in accordance with Our published filing requirements. A Clean Claim does not include a claim for payment of expenses incurred during a period of time for which premiums are not paid, except to the extent otherwise required by law.

**Payment of Claims:** Benefits will be payable to the Covered Person or the medical services provider if We have received a valid assignment by the Covered Person.

If any indemnity of this Policy shall be payable to the estate of the Covered Person or to a Covered Person who is a minor or otherwise not competent to give a valid release, We may pay such indemnity to his parent, guardian or other person actually supporting him. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Subject to any written direction of the Covered Person or of the legal or natural guardian of the Covered Person, if the Covered Person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by the Policy as a result of medical, surgical, dental, hospital or nursing service may, at Our option, and unless We are requested in writing not later than the time for filing Proofs of Loss, be paid directly to the Hospital or person rendering such services; but it is not requested that the services be rendered by a particular Hospital or person.

**Physical Examination:** We, at Our own expense, shall have the right and opportunity to examine the Covered Person as it may reasonably require while a claim is pending.

**Legal Actions:** A legal action may not be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

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## PREMIUM

**Payment of Premium/Due Date:** All premium, charges or fees (hereinafter "Premium") must be paid to Us at Our home office prior to the start of the term for which coverage is selected. In no event will coverage become effective prior to the date of enrollment and required premium are received at our home office or by Our authorized representative.

**Returned or Dishonored Payment:** If a check in payment for the Premium is dishonored for insufficient funds, a reasonable service charge may be charged to the Policyholder which will not exceed the maximum specified under state law. A dishonored check shall be considered a failure to pay Premium and coverage shall not take effect.

**Grace Period:** We allow a grace period of 31 days for the payment of premium after the first premium. Coverage is in force during the Grace Period. If at least 60 days prior to the premium due date We send written notice to You of Our intent not to renew this Certificate, then the Grace Period will not apply to any period after the date the non-renewal is to be effective. If You send written notice to Us that You are not renewing Your coverage, then the Grace Period will not apply after the date the non-renewal is to be effective.

Coverage terminates on the last day for which premium has been paid.

**Reinstatement:** If coverage terminates due to non-payment of premium, then a subsequent acceptance of premium by Us or by an agent, without requiring an application for reinstatement, will reinstate the insurance.

If We do require an application for reinstatement and accept premium, then We may issue a conditional premium receipt. If We approve the application, then insurance will be reinstated as of the date of Our approval. If We do not approve the application, then We will notify You in writing within 45 days after the date of the application.

If We do not notify You within 45 days, then coverage will be reinstated on the 45<sup>th</sup> day after the date of the conditional premium receipt.

The reinstated Certificate will cover only losses due to conditions that begin after the date of reinstatement. In all other respects, Your rights and Ours will be the same as before insurance terminated, unless there are new provisions added due to reinstatement. The premium We accept for reinstatement may be used for the period for which premiums had not been paid. We can apply the premium for as many as 60 days before the date of reinstatement.

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## GENERAL PROVISIONS

**Entire Contract; Changes:** The Policy, including the Certificate, if any, endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by one of Our executive officers and unless such approval is endorsed hereon or attached hereto. No agent has authority to change the Policy or waive any of its provisions.

Failure by Us to enforce any Policy provision shall not waive, modify or render such provision unenforceable at any other time; at any given time; or under any given set of circumstances, whether the circumstances are or are not the same.

**Incontestability:** The validity of the Certificate shall not be contested, except for nonpayment of premiums, after it has been in force for 2 years from its date of issue, and that no statement made by any person covered under the Certificate relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of 2 years during such person's lifetime nor unless it is contained in a written instrument signed by the person making such statement; except that, no such provision shall preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the Certificate or upon other provisions in the Certificate.

**Non-Participating:** This Certificate is non-participating. It does not share in Our profits or surplus earnings.

**Conformity With State Statutes:** If any provision of this Certificate is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

**Workers' Compensation:** This Certificate is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance.

**Clerical Error:** If a clerical error is made so that an otherwise eligible person's coverage does not become effective, coverage may be in effect if: (a) the Policyholder makes a written request for coverage on a form approved by Us ; and (b) any premium not paid because of the error is paid in full from the effective date of coverage. Company reserves the right to limit retroactive coverage to two months preceding the date the error was reported.

If a clerical error is made so that the coverage is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any Premium refund will be reduced by any payment made for claims. If claims paid exceed the Premium refund, the Policyholder shall reimburse Us for the overpayment.

**Information and Records:** We shall have the right to inspect, at reasonable times, any of the Policyholder's records for the Policy. The Policyholder shall provide Us with information necessary to administer coverage and set premium under the Policy. Information is required when an eligible person becomes covered, when changes in amounts of coverage occur, and when a Covered Person's coverage terminates.

GDGPXX110

## SCHEDULE

### POLICYHOLDER AND INSURED INFORMATION

<b>Policyholder:</b>	Trucking Association
<b>Sponsor Trucking Company:</b>	ABC Company
<b>Insured:</b>	John Public
<b>Certificate Number:</b>	12345
<b>Effective Date:</b>	11/1/2010
<b>Anniversary Date:</b>	November 1, 2011 and each six months thereafter
<b>Premium Due Dates:</b>	The first of each month for which coverage is provided.
<b>Premium:</b>	As shown in the Master Application
<b>Schedule Date:*</b>	
<b>Dependent Spouse:</b>	is <input checked="" type="checkbox"/> is not <input type="checkbox"/> insured under this Certificate as of the Schedule Date.
<b>Dependent Child(ren):</b>	is (are) <input checked="" type="checkbox"/> is (are) not <input type="checkbox"/> insured under this Certificate as of the Schedule Date.
<b>Waiting Period:</b>	30 Days from the date the member signs a lease with a sponsor trucking company.
<b>Eligible Classes:</b>	<p>Class 1: Members of the Trucking Association who are independent contractors of, and hold a current lease with, a sponsor trucking company which sponsors a designated benefit program offered by the Trucking Service Association.</p> <p>Class 2: Dependent spouses and children of Class 1.</p> <p>Members contracted to lease with [ABC Company]. Must work 40 or more hours per week on a regular basis to be eligible for coverage.</p> <p>Members on a personal leave of absence approved by [ABC Company] will still be considered eligible for coverage as long as the leave of absence is no longer than 90 days. Members will no longer be eligible for coverage after the 90 day leave.</p> <p>Members on a short term disability leave of absence approved by [ABC Company] will still be considered eligible for coverage as long as the leave of absence is no longer than 26 weeks. Members will no longer be eligible for coverage after the 26 weeks or upon expiration of the approved leave, whichever occurs earlier.</p> <p>Any member contracted to lease with [ABC Company] who has recorded zero hours driven in four consecutive weeks, except in the event of an approved leave of absence or approved short term disability leave of absence, will no longer be eligible for coverage at the end of the four weeks</p>

\* This Schedule replaces and supersedes any Schedule attached to this Certificate with a date earlier than the Schedule Date shown above.  
GDSOBXX100

**COVERED DENTAL CHARGES**

<b>Calendar Year Maximum, Per Covered Person</b> .....	[\$1,000-\$10,000]
<b>Per Family</b> .....	[\$2,000-\$20,000]
<b>Calendar Year Dental Deductible, Per Covered Person</b> .....	[\$50-\$500]
<b>Calendar Year Orthodontia Deductible, Per Covered Person</b> .....	[\$50-\$1,000]
<b>Payment System Percentile</b> .....	[70-90 <sup>th</sup> ]
<b><u>PREVENTIVE SERVICES</u></b>	
<b>Insured Percent</b> .....	[75-100%]
Deductible does not apply to Preventive Services	
<b><u>Preventive Service</u></b>	
Periodic Oral Exam: Limited to 1 procedure per 6 month period.	
Emergency Oral Exam. Limited to 1 visit per 6 month period.	
Full Mouth X-ray: Limited to 1 procedure every 3 Calendar Years.	
Bitewings: Limited to 1 procedure per 6 month period.	
Prophylaxis: Limited to 1 procedure per 6 month period.	
Space Maintainers – Child: Limited to 1 procedure per Calendar Year	
Sealants – Child: Limited to children age 14 and under.	
<b><u>BASIC SERVICES</u></b>	
<b>Insured Percent</b> .....	[50-80%]
<b><u>Basic Services</u></b>	
Simple Restorative Fillings	
Oral Surgery limited to simple extractions	
Endodontics	
General Anesthesia	
Periodontics including consultations	
Repair of crowns, bridges and dentures	
<b><u>MAJOR SERVICES</u></b>	
<b>Insured Percent</b> .....	50%
<b>Waiting Period</b> .....	[1-2] Year(s)
<b><u>Major Services</u></b>	
Crowns	
Inlays and Onlays	
Pontics	
Bridges	
Dentures, including relining	

## Plan A

<b>ORTHODONTIA SERVICES</b>	
Insured Percent.....	50%
Lifetime Maximum Benefit per Covered Person.....	[\$1,000-\$5,000]
Limited to Dependent Children age 18 and under	
Waiting Period.....	[1-2] Year(s)
<b>Orthodontia Services</b>	
Active appliances to correct the position of maloccluded or malpositioned teeth.	
Payment of the initial fee at the time the appliance is first inserted is either:	
<ul style="list-style-type: none"> <li>• 30% of the total fee when services are billed in a global fee; or</li> <li>• 30% of the lesser of the total fee or the actual charge billed when services are billed separately.</li> </ul>	
Payments of remaining fees are made at the end of each quarter of treatment provided coverage under the Policy is still in effect.	
Benefits are not payable if coverage under the Policy terminates or if the Covered Person reaches the limiting age, if any.	

## Plan B

<b>ORTHODONTIA SERVICES</b>	
Insured Percent.....	50%
Lifetime Maximum Benefit per Covered Person.....	[\$2,000-\$4,000]
Limited to Dependent Children age 19 and under	
Waiting Period.....	[1-2] Year(s)
<b>Orthodontia Services</b>	
Active appliances to correct the position of maloccluded or malpositioned teeth.	
Payment of the initial fee at the time the appliance is first inserted is either:	
<ul style="list-style-type: none"> <li>• 30% of the total fee when services are billed in a global fee; or</li> <li>• 30% of the lesser of the total fee or the actual charge billed when services are billed separately.</li> </ul>	
Payments of remaining fees are made at the end of each quarter of treatment provided coverage under the Policy is still in effect.	
Benefits are not payable if coverage under the Policy terminates or if the Covered Person reaches the limiting age, if any.	

## Plan C

<b>ORTHODONTIA SERVICES</b>	
Insured Percent.....	50%
Lifetime Maximum Benefit per Covered Person.....	[\$2,500-\$5,000]
Waiting Period.....	[1-2] Year(s)
<b>Orthodontia Services</b>	
Active appliances to correct the position of maloccluded or malpositioned teeth.	
Payment of the initial fee at the time the appliance is first inserted is either:	
<ul style="list-style-type: none"> <li>• 30% of the total fee when services are billed in a global fee; or</li> <li>• 30% of the lesser of the total fee or the actual charge billed when services are billed separately.</li> </ul>	
Payments of remaining fees are made at the end of each quarter of treatment provided coverage under the Policy is still in effect.	
Benefits are not payable if coverage under the Policy terminates or if the Covered Person reaches the limiting age, if any.	

GDSOBXX200

SERFF Tracking Number: GRTT-126822853 State: Arkansas  
 Filing Company: Guarantee Trust Life Insurance Company State Tracking Number: 46841  
 Company Tracking Number:  
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.003B Small Group Only - PPO Basic  
 Product Name: Pro Rig Medical/Dental  
 Project Name/Number: /

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Flesch Certification	Approved-Closed	11/08/2010
<b>Bypass Reason:</b> See Forms Schedule tab		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application	Approved-Closed	11/08/2010
<b>Bypass Reason:</b> n/a		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> PPACA Uniform Compliance Summary	Approved-Closed	11/08/2010
<b>Comments:</b>		
<b>Attachment:</b> PPACA Compliance Summary.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Articles of Incorporation/Bylaws	Approved-Closed	11/08/2010
<b>Comments:</b>		
<b>Attachments:</b> Pro-Rig Articles of Incorporation.pdf Pro-Rig By-Laws.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Brochure	Approved-Closed	11/08/2010
<b>Comments:</b>		

SERFF Tracking Number: GRTT-126822853 State: Arkansas  
Filing Company: Guarantee Trust Life Insurance Company State Tracking Number: 46841  
Company Tracking Number:  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.003B Small Group Only - PPO Basic  
Product Name: Pro Rig Medical/Dental  
Project Name/Number: /

**Attachment:**

Association Brochure.pdf

	<b>Item Status:</b>	<b>Status</b>
<b>Satisfied - Item:</b> Original article of incorporation	Approved-Closed	<b>Date:</b> 11/08/2010
<b>Comments:</b>		
<b>Attachment:</b>		
Original Assoc Info .pdf		

## PPACA Uniform Compliance Summary

**Please select the appropriate check box below to indicate which product is amended by this filing.**

**INDIVIDUAL HEALTH BENEFIT PLANS** (Complete [SECTION A](#) only)

**SMALL / LARGE GROUP HEALTH BENEFIT PLANS** (Complete [SECTION B](#) only)

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as “major medical” in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. *(If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)*

**\*For all filings, include the Type of Insurance (TOI) in the first column.**

Check box if this is a paper filing.

### COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
				<input type="checkbox"/> Yes <input type="checkbox"/> No

## PPACA Uniform Compliance Summary

### SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<b>Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19</b>	<i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Eliminate Annual Dollar Limits on Essential Benefits</b> Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Eliminate Lifetime Dollar Limits on Essential Benefits</b>	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Prohibit Rescissions</b> – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			

## PPACA Uniform Compliance Summary

### SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p><b>Preventive Services</b> – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	<p><b>Extends Dependent Coverage for Children Until age 26</b> – If a policy offers dependent coverage, it must include dependent coverage until age 26.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	<p><b>Appeals Process</b> – Requires establishment of an internal claims appeal process and external review process.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	<p><b>Emergency Services</b> – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.

## PPACA Uniform Compliance Summary

### SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p><b>Access to Pediatricians</b> – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>no</b>, please explain.</p>
	<p><b>Access to OB/GYNs</b> – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>no</b>, please explain.</p>

## PPACA Uniform Compliance Summary

### SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<b>Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19</b>	<i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Eliminate Annual Dollar Limits on Essential Benefits –</b> Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Eliminate Lifetime Dollar Limits on Essential Benefits</b>	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Prohibit Rescissions –</b> Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.
	Explanation:			
	Page Number:			

## PPACA Uniform Compliance Summary

### SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<b>Preventive Services</b> – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Extends Dependent Coverage for Children Until age 26</b> – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◇	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <sup>◇</sup> <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Appeals Process</b> – Requires establishment of an internal claims appeal process and external review process.	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			

◇ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

## PPACA Uniform Compliance Summary

### SECTION B – Group Health Benefit Plans (Small and Large)

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# IOWA

No: W00685632  
Date: 08/02/2010

## SECRETARY OF STATE

504RDN-402262  
PRO RIG USA

### ACKNOWLEDGEMENT OF DOCUMENT FILED

The Secretary of State acknowledges receipt of the following document:

Articles of Incorporation

The document was filed on Aug 2 2010 11:04AM, to be effective as of Aug 2 2010 11:04AM.

The amount of \$20.00 was received in full payment of the filing fee.



*Michael A. Mauro*  
MICHAEL A. MAURO SECRETARY OF STATE



402262

**Non-Profit Articles of Incorporation  
For  
Pro Rig USA**

To: State of Iowa  
Secretary of State  
321 E. 12th St.  
Des Moines, IA 50319

10 AUG -2 AM 11:04

SECRETARY OF STATE  
IOWA  
508349

**Pursuant to the provisions of the state of Iowa non-profit Corporation Act, the undersigned adopts the following Articles of Incorporation:**

Article 1: The name of the corporation is: **Pro Rig USA**

Article 2: The name and address of the initial registered agent and registered office are:

**C T Corporation System  
500 East Court Avenue  
Des Moines, Iowa 50309**

10 JUL 21 AM 9:46

SECRETARY OF STATE  
IOWA

Article 3: The names and addresses of each Incorporator being as follows:

**Karen Boeker, 13 Bordeaux Place, Lake St. Louis, MO 63367**

Article 4: The Association will have members.

Article 5: In the event of dissolution of the Association any funds remaining shall be distributed to one or more regularly organized and qualified charitable, educational, scientific, or philanthropic organizations to be selected by the Board of Directors.

Article 6: The undersigned incorporator hereby declares, under penalties of perjury, that the statements made in the foregoing Articles of Incorporation are true.

July 15, 2010  
Date

FILED  
IOWA  
SECRETARY OF STATE

8/2/10  
11:04 AM

W685632



Karen Boeker  
Signature

Printed Name: Karen Boeker

**BY-LAWS**  
**OF**  
**“PRO RIG USA“**

ARTICLE I  
PURPOSES

The purpose or purposes of “Pro Rig USA” (the “Association”) shall be: To provide discounted benefits, services, programs and resources that will promote and enhance the safety, safety practices, risk management, loss control services and profitability of the transportation industry, specifically for motor carrier companies. To exercise all the powers not limited to the corporation by the laws of Iowa.

ARTICLE II  
OFFICES

The Association shall have and continuously maintain in this state a registered office and a registered agent, and the registered office of the association shall be identical with that of its registered agent. The Association may have other offices within or without the State of Iowa as the Board of Directors may from time to time determine.

ARTICLE III  
MEMBERS

Section 1.     Classes of Members. The Association shall have two (2) classes of members and a person may become a member of the Association for one or more periods of one calendar year, subject to the requirements of these By-Laws and any rules and regulations established by the Board of Directors not inconsistent with these By-Laws. The designation of such classes and qualifications of the members of such classes shall be as follows:

- a) Regular Full Members: Motor Carrier Companies are entitled to participate in all benefit programs offered by the Association:
  - i) Paying dues set by no less than a two-thirds (2/3) majority vote of the Board of Directors; and,
  - ii) Meeting the policy and requirements established by no less than a two-thirds (2/3) majority vote of the Board of Directors
  
- b) Associate Members: Persons admitted to membership by two-thirds (2/3) majority vote of the Board of Directors annually are entitled to participate in some, but not all, benefit programs offered by the Association, as determined by the Board of Directors.

Section 2. Voting Rights. Regular Full Member shall be entitled to one vote on each matter submitted to a vote of the members. Associate Members do not have a right to vote.

Voting may be in person or by proxy; provided that no proxy may be used for voting purposes unless the original of the proxy is filed with the Secretary of the Association at least seven (7) days before the meeting at which it is to be used.

Section 3. Termination of Membership. Any member who shall be in default in the payment of dues for the period fixed in Article XI of the By-Laws is automatically ineligible for membership and loses all privileges and rights of the Association, subject to the discretion of the Board of Directors to extend such time period for the payment of dues.

Section 4. Resignation. Any member may resign by filing a written resignation with the Secretary, but such resignation shall not entitle such member to any refund of dues and the member shall immediately lose all privileges and rights of the Association.

Section 5. Reinstatement. Upon written reapplication a former member may be reinstated to membership in the Association.

Section 6. Transfer of Membership. Membership in the Association is not transferable or assignable.

#### ARTICLE IV MEETINGS OF MEMBERS

Section 1. Annual Meeting. An annual meeting of the members of the Association shall be held for the purpose of electing Directors and the transaction of any other business as may come before the meeting. The date of the annual meeting shall be determined by the Board of Directors.

Section 2. Special Meeting. Special meetings of the members, for any purpose or purposes, unless otherwise prescribed by law, may be called by the President and shall be called by the Secretary at the direction of a majority of the Board of Directors, or at the request in writing of members representing at least one hundred (100) votes entitled to be cast at such meeting.

Section 3. Place of Meeting. The Board of Directors may designate any place, within or without the State of Missouri as the place of meeting for any annual meeting. The President or

the Board of Directors may designate any place within or without the State of Missouri as the place of the meeting for any special meeting. If no designation is made, the place of meeting shall be the registered office of the Association.

Section 4. Notice of Meetings. Written or printed notice stating the place, day and hour of any regular or special meeting of the Association members shall be delivered, either personally, by mail or through the internet, to each member, not less than seven (7) or more than forty (40) days before the date of such meeting, by or at the direction of the President, or Secretary, or the Board of Directors or person calling the meeting. In the case of special meetings, the purpose for which the meeting is called shall be stated in the notice. If mailed, the notice of meeting shall be deemed delivered when deposited in the United States mail addressed to the member at this address as it appears on the records of the Association, with postage thereon paid. Notice of meetings may be included in any publication that is distributed to the member.

Section 5. Quorum. There shall be no minimum number of members necessary to be present at any regular meeting or special meeting, in order to constitute a quorum. Those members present shall therefore constitute a quorum.

Section 6. Manner of Acting. The act of a majority of the members present at any regular or special meeting shall constitute the act of the members.

Section 7. Informal Action by Members. Upon approval by the directors, any action required to be taken at a meeting of the members of the Association or any other action which may be taken at a meeting, may be taken without a meeting if consents in writing, setting forth the action so taken, shall be signed by a majority of the members with respect to the subject matter thereof.

Section 8. Parliamentary Procedures. Parliamentary Procedure for all meetings of members, directors, and committees shall be conducted in accordance with the latest revised edition of Robert's Rules of Order, unless otherwise inconsistent with these By-Laws.

Section 9. Voting. At all meetings of the members, each member of records shall be entitled to one (1) vote. A vote may be cast either orally or in writing in person or by proxy. A "member of record" is a person who is a member in good standing of the Association as of the close of business on a date, selected by the Board of Directors, not less than forty (40) days nor more than fifty (50) days before the date of the meeting (the "record date"). When a quorum is present at any meeting, the vote of the holders of a majority of members present shall decide any questions brought before such meeting, unless the questions are ones upon which, by express provision of law

or of the Association's Articles of Incorporation, a different vote is required, in which case such express provision shall govern and control the decision of such question.

Section 10. Matters Reserved to Membership Vote. The following matters shall be authorized only upon a vote "thereon" by the members at a meeting called to consider such matter:

1. An amendment to the Association's Articles of Incorporation;
2. The election of the Board of Directors; and
3. Any other matter which the Board of Directors, in their sole discretion, by resolution shall commit to a vote of the members.

## ARTICLE V BOARD OF DIRECTORS

Section 1. General Powers. The affairs of the Association shall be managed by its Board of Directors.

Section 2. Number, Tenure and Qualifications. The number of directors shall be no fewer than three (3) and no more than twenty-five (25) and may be changed from time to time by resolution of the Board of Directors. The Board of Directors shall appoint a committee to nominate successor directors. The directors shall be elected at an annual meeting of the members, except as provided in Section 8 of this Article, and each director elected shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. Directors shall be residents of the United States of America and be members of the association.

Section 3. Regular Meetings. A regular annual meeting of the Board of Directors shall be held each year immediately after the annual meeting of the members of the Association for the purpose of electing officers and for the transaction of such other business as may come before the meeting. The regular annual meeting of directors shall be held without other notice than these By-Laws. The Board of Directors may provide by resolution the time and place, within or without the State of Missouri for the holding of additional regular meetings of the Board of Directors.

Section 4. Special Meetings. Special meetings of the Board of Directors may be called by or at the request of the President or any two (2) directors. All special meetings shall be held at

the registered office of the Association unless otherwise agreed upon by a majority of the Board of Directors in attendance at the meeting.

Section 5. Notice. Notice of any special meeting of the Board of Directors and the business to be transacted shall be given at least five (5) days previously thereto by written notice delivered personally, by mail or through the internet to each director at his address shown on the records of the Association. If notice be given by mail, such notice shall be deemed to be delivered when deposited in the United States mail addressed to the director. Any director may waive notice transaction of any business because the meeting is not lawfully called or convened. The purpose of any special meeting of the Board of Directors shall be specified in the notice of such meeting.

Section 6. Quorum. A majority of the Board of Directors shall constitute a quorum for the transaction of business at any meeting of the Board of Directors provided that if less than a majority of the directors are present at said meeting, a majority of the directors present may adjourn the meeting from time to time without further notice.

Section 7. Manner of Acting. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, except where otherwise provided by law or these By-Laws.

Section 8. Vacancies. Vacancies created by the death, resignation, or removal of a director may be filled by a majority vote of the directors then in office though less than a quorum, and each director so chosen shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. A director may be removed at any time, with or without cause, by a vote of a majority of the remaining directors. If there are not directors in office, then an election of directors may be held in the manner provided by law. Newly created directorships shall be filled by election at an annual meeting or special meeting called for that purpose.

Section 9. Compensation. Directors as such shall not receive any stated salaries for their services, but by resolution of the Board of Directors, a fixed sum and expenses of attendance, if any, may be allowed for attendance at each meeting of the Board of Directors. Nothing herein contained shall be construed to preclude any director from serving the Association in any other capacity and receiving compensation therefor upon approval by the Board.

Section 10. Telephonic Participation in Meeting. The members of the Board of Directors, or of any committee designated by the Board of Directors, may participate in a meeting of the Board of Directors or committee by means of conference telephone or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in a meeting in this manner shall constitute presence in person at the meeting.

Section 11. Action by Written Consent. Any action which is required to be or may be taken at a meeting of the directors, or of any committee of the directors, may be taken without a meeting if consents in writing, setting forth the action so taken are signed by all of the members of the Board of Directors or of the committee as the case may be. The consents shall have the same force and effect as a unanimous vote at a meeting duly held. The Secretary shall file the consents with the minutes of the meetings of the Board of Directors or of the committee as the case may be.

## ARTICLE VI OFFICERS

Section 1. Officers. The Officers of the Association shall be a President, one or more Vice Presidents (the number thereof to be determined by the Board of Directors), a Treasurer, a Secretary or combination thereof, and such other officers as may be elected in accordance with the provisions of this article. The Board of Directors may elect or appoint other officers, including one or more Assistant Secretaries and one or more Assistant Treasurers, as it shall deem desirable, such officers to have the authority and perform the duties prescribed, from time to time, by the Board of Directors. Any two or more offices may be held by the same person, except the offices of President and Secretary.

Section 2. Election and Term of Office. The Officers of the Association shall be elected annually by the Board of Directors at the regular annual meeting of the Board of Directors. If the election of Officers shall not be held at such meeting, such election shall be held as soon thereafter as convenient. Vacancies may be filled or new officers created and filled at any meeting of the Board of Directors. Each Officer shall hold office until his successor shall have been duly elected and shall have qualified.

Section 3. Removal. Any Officer or Agent elected or appointed by the Board of Directors may be removed by the Board of Directors whenever in its judgment the best interests of the Association would be served thereby.

Section 4. Vacancies. A vacancy in any office because of death, resignation, removal, disqualification or otherwise, may be filled by the Board of Directors for the unexpired portion of the term.

Section 5. President. The President of the Association shall be the principal executive officer of the Association. He shall supervise and conduct the affairs of the Association in such manner as will best accomplish the purposes set forth in the Articles of Incorporation of the

Association. He shall preside at all meetings of the Association members and the Board of Directors. He shall countersign all checks together with the Treasurer.

Section 6.     Vice President. In the absence of the President, or in the event of his inability or refusal to act, the Vice President shall perform the duties of the President, and when so acting, shall have all the powers of and be subject to all the restrictions upon the President. The Vice President shall perform such other duties as from time to time may be assigned to him by the President or by the Board of Directors.

Section 7.     Treasurer. The Treasurer or Assistant Treasurer shall have charge and custody of and be responsible for all funds and securities of the Association; receive and give receipts for monies received by the Association from any source whatsoever, and deposit all such monies in the name of the Association in such banks, trust companies or other depositories as shall be selected in accordance with the provisions of Article VIII of these By-Laws.

Section 8.     Secretary. The Secretary or Assistant Secretary of the Association shall keep the minutes of the meetings of the members and of the Board of Directors in one or more books provided for that purpose; see that all notices are duly given in accordance with the provisions of these By-Laws or as required by law; be custodian of the corporate records of the Association; see that the seal of the Association, if any, is affixed to all documents, the execution of which on behalf of the Association under its seal, if any, is duly authorized in accordance with the provisions of these By-Laws; keep a register of the post office address of each member which shall be furnished to the Secretary or Assistant Secretary by such member; and in general perform all duties incident to the office of Secretary and such other duties as from time to time may be assigned to the Secretary or Assistant Secretary by the President or by the Board of Directors.

## ARTICLE VII COMMITTEES

Section 1.     Committees of Directors. The Board of Directors, by resolution adopted by the majority of the directors in office, may designate one or more committees, each of which shall consist of two (2) or more directors, which committees, to the extent provided in said resolution, shall have and exercise the authority of the Board of Directors in the management of the Association; but the designation of such committees and the delegation thereto of authority shall not operate to relieve the Board of Directors, or any individual director, of any responsibility imposed upon it or him by law. The President shall be an ex-officio member of all committees of directors.

Section 2. Other Committees. Other committees not having and exercising the authority of the Board of Directors in the management of the Association may be designated by a resolution adopted by a majority of the directors present at a meeting at which a quorum is present. Except as otherwise provided in such resolution, members of each such committee shall be members of the Association, and the President of the Association shall appoint the members thereof. Any member thereof may be removed by the person or persons authorized to appoint such member whenever in their judgment the best interests of the Association will be served by such removal. One member of each committee shall be a director.

Section 3 Vacancies. Vacancies in the membership of any committee may be filled by appointments made in the same manner as provided in the case of original appointments.

Section 4. Quorum. Unless provided in the resolution of the Board of Directors designating a committee, a majority of the whole committee shall constitute a quorum and the act of a majority of the members present at a meeting at which a quorum is present shall be the act of the committee.

Section 5. Rules. Each committee may adopt rules for its own government not inconsistent with these By-Laws or with rules adopted by the Board of Directors.

## ARTICLE VIII CONTRACTS, CHECKS, DEPOSITS, AND FUNDS

Section 1. Contracts. The Board of Directors may authorize the officers or agents of the Association to enter into contracts or to execute and deliver documents in the name of and on behalf of the Association. Such authority shall be confined to specific instances. Such contracts may be for any purpose deemed by the Board of Directors to be appropriate, including the contracting with a third party for any or all administrative and other services and functions necessary for the Association to achieve its purpose.

Section 2. Checks, Drafts, Etc. All checks, drafts, or other orders for payment of money, notes or other evidences of indebtedness issued in the name of the Association shall be signed by such officer or officers, agent or agents of the Association and in such manner as shall from time to time be determined by the resolution of the Board of Directors. In the absence of such determination by the Board of Directors, such instruments shall be signed by the Treasurer or an Assistant Treasurer and countersigned by the President or Vice President of the Association.

Section 3.     Deposits. All funds coming into possession of the Association shall be deposited from time to time to the credit of the Association in such banks, trust companies, or other depositories as the Board of Directors may select.

Section 4.     Gifts. The Board of Directors may accept on behalf of the Association any contributions, gifts, bequests, or device for the general purpose or for any special purpose of the Association.

Section 5.     Loans. The Association may, upon authorization of the Board of Directors, from time to time accept or negotiate loans of financial assistance to be repaid at such time as the Association is reasonably able to repay.

ARTICLE IX  
CERTIFICATES OF MEMBERSHIP

Section 1.     Certificates of Membership. The Board of Directors may provide for the issuance of certificates evidencing membership in the Association which shall be in such form as may be determined by the Board. Such certificates shall be signed by the President or Vice President and shall be sealed with the seal of the Association, if any. The name and address of each member and the date of issuance of the certificate shall be entered on the records of the Association. If any certificate shall become lost, mutilated or destroyed, a new certificate may be issued therefor upon such terms and conditions as the Board of Directors may determine.

Section 2.     Issuance of Certificates. When a member has applied for and is eligible for membership and has paid any initiation fee and dues that may then be required, a certificate of membership shall be issued and delivered to him by the Secretary, if the Board of Directors shall have provided for the issuance of certificates of membership under the provisions of Section 1 of this article.

ARTICLE X  
BOOKS AND RECORDS

The Association shall keep correct and complete books and records of accounts and shall also keep minutes of the proceedings of its members, Board of Directors and committees having any of the authority of the Board of Directors, and shall keep at the registered or principal office a record giving the names and addresses of the members entitled to vote. All books and records of the Association may be inspected by any member, or his agent or attorney for any purpose at any reasonable time.

ARTICLE XI  
DUES AND INITIATION FEE

Section 1.     Annual Dues. The Board of Directors may determine from time to time the amount of annual dues payable to the Association by members of each class.

Section 2.     Payment of Dues. Dues shall be payable in advance.

Section 3.     Default and Termination of Membership. When any member of any class shall be in default in the payment of dues for a period of one month from the beginning of the period from which such dues became payable, such member shall be automatically dropped from membership unless the Board of Directors, in its discretion, extends the time for payment of dues.

Section 4.     Initiation Fee. Each member may be required to pay, in addition to applicable dues, the amount of any initiation fee designated by the Board of Directors as a prerequisite to membership. The Board of Directors may provide that the initiation fee is waived for members who are part of a group where the sponsor pays a stated initiation fee on behalf of all group members.

ARTICLE XII  
FISCAL YEAR

The fiscal year of the Association shall begin the first day of January and end on the last day of December in each year.

ARTICLE XIII  
SEAL

The Board of Directors may provide a corporate seal which shall be in the form of a circle and shall have inscribed thereon the name of the corporation and the words "Corporate Seal".

ARTICLE XIV  
WAIVER OF NOTICE

Whenever any notice is required to be given under the provisions of the General Not-For-Profit Corporation Law of Missouri under the provisions of the Articles of Incorporation or the By-Laws of the Association, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

ARTICLE XV  
AMENDMENT OF BY-LAWS

These By-Laws may be altered, amended or repealed and new By-Laws may be adopted by a two-thirds (2/3) majority of the directors present at any regular meeting or any special meeting, provided that at least seven (7) days' written notice is given of intention to alter, amend or repeal or to adopt new By-Laws at such meeting.

ARTICLE XVI  
INDEMNIFICATION

The Association shall provide for indemnification by the Association of any and all of its directors of officers or former directors or officers against expenses actually and necessarily incurred by them in connection with the defense of any action, suit, or proceeding, in which they or any of them are made parties, or a party, by reason of having been directors or officers of the Association, except in relation to matters as to which such director or officer or former director or officer shall be adjudged in such action, suit, or proceeding to be liable for gross negligence or misconduct in the performance of duty and to such matters as shall be settled by agreement predicated on the existence of such liability for gross negligence or misconduct.

ARTICLE XVII  
DISSOLUTION

The Association shall use its funds only to accomplish the objectives and purposes specified in these By-Laws, and no part of said funds shall inure, or be distributed, to the members of the Association. On dissolution of the Association any funds remaining shall be distributed to one or more regularly organized and qualified charitable, educational, scientific, or philanthropic organizations to be selected by the Board of Directors.

*Share* insurance company profit without sharing risk with others and without burdensome costs or collateral.

*Share* in the purchasing power of a larger group while maintaining individual identity.

*Share* ideas with peers in your segment of the transportation industry.

*Share* the benefits of recognized industry leaders in recruiting, retention, legal, safety and claims without bearing the total cost of each.

**Control  
Your Risk...  
Share The  
Reward**

**PRO-RIG** USA  
"Bettering the Business of Trucking"

P.O. Box 1230  
Cedar Rapids, Iowa 52406-1230

Tel (866) 548-0720  
www.prorigusa.com

**TRUE NORTH**  
Insurance and Financial Strategies

Offered exclusively through TrueNorth, a recognized leader in transportation insurance. TrueNorth has partnered with an A+ domestic insurance carrier to provide preferred rates, superior claims handling, and Midwestern values to high quality trucking risks right here in the heartland.

**Control  
Your Risk...  
Share The  
Reward**

**PRO-RIG** USA  
"Bettering the Business of Trucking"



**PRO-RIG USA is a non-profit association dedicated to bettering the business of trucking through:**

- Improving operating results
- Reducing total cost of risk
- Forming long-term partnerships
- Enhancing safety and claims handling
- Gaining purchasing power
- Lowering driver turnover & increasing retention

**If your trucks operate in America's heartland 80% of the time, you may qualify for this program.**



**ASSOCIATION BENEFITS:**

**MOTOR CARRIER ADVANTAGES:**

- Enhanced safety and claims service
- Profit sharing dividend
- Recruiting/retention specialist
- Asset and profit protection
- Fuel discount card
- Legal and compliance
- Business tax services

**DRIVER ADVANTAGES:**

- 24/7 nurse line
- Emergency medical info card
- Retail discount pharmacy program
- GlobalFit
- Med script discount pharmacy service
- Lens Crafters vision club
- Vitamin and nutritional supplement discounts
- Payroll processing service
- Quest hotel discounts
- Travel assistance plan
- Savers Club book
- UBR child ID card
- Newsletters



# STATE OF MISSOURI



Robin Carnahan  
Secretary of State

CERTIFICATE OF AMENDMENT  
OF A  
MISSOURI NONPROFIT CORPORATION

WHEREAS,

*Pro Rig USA*  
*N00615426*

Formerly,

*Internet Technology Association of America*

a corporation organized under The Missouri Nonprofit Corporation Law has delivered to me its Articles of Amendment of its Articles of Incorporation and has in all respects complied with the requirements of law governing the Amendment of Articles of Incorporation under The Missouri Nonprofit Corporation Law, and that the Articles of Incorporation of said corporation are amended in accordance therewith.

IN TESTIMONY WHEREOF, I hereunto  
set my hand and cause to be affixed the  
GREAT SEAL of the State of Missouri.  
Done at the City of Jefferson, this  
16th day of October, 2006.

  
Secretary of State





**State of Missouri**  
 Robin Carnahan, Secretary of State

Corporations Division  
 P.O. Box 778 / 600 W. Main Street, Rm 322  
 Jefferson City, MO 65102

File Number: 200629021113  
 N00615426  
 Date Filed: 10/16/2006  
 Robin Carnahan  
 Secretary of State

**Articles of Amendment  
 for a Nonprofit Corporation**  
*(Submit with filing fee of \$10.00)*

The undersigned corporation, for the purpose of amending its articles of incorporation, hereby executes the following articles of amendment:

- (1) The name of corporation is: Internet Technology Association of America
- (2) The amendment was adopted on September 27, 2006 and changed article(s) 1 and 8 to state as follows:  
month/day/year

Article number One (1) is amended to read as follows:  
 The name of the corporation is: Pro Rig USA

Article number Eight (8) is amended to read as follows:  
 See Attached.

- (3) If approval of members was not required, and the amendment(s) was approved by a sufficient vote of the board of directors or incorporators, check here and skip to number (5): ✓

- (4) If approval by members was required, check here and provide the following information: \_\_\_\_\_

- A. Number of memberships outstanding: \_\_\_\_\_  
 B. Complete either C or D:  
 C. Number of votes for and against the amendments(s) by class was:

Class:	Number entitled to vote:	Number voting for:	Number voting against:
_____	_____	_____	_____
_____	_____	_____	_____

*Please see next page*

State of Missouri  
 Amend/Restate - NonProfit 3 Page(s)

Name and address to return filed document:

Name: Ryan C. Johnston  
 Address: 76476 Chesterfield Airport Rd.  
 City, State, and Zip Code: Chesterfield, MO 63017



T0629001104

Corp. 53A (01/05)  
 P. T0627562062

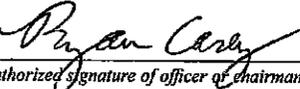
D. Number of undisputed votes cast for the amendment(s) was sufficient for approval, and was:

Class:	Number Voting undisputed:
_____	_____
_____	_____
_____	_____

The number of votes cast in favor of the amendment(s) by each class was sufficient for approval by that class.

(5) If approval of the amendment(s) by some person(s) other than the members, the board or the incorporators was required pursuant to section 355.606, check here to indicate that approval was obtained: \_\_\_\_\_

In Affirmation thereof, the facts stated above are true and correct:  
(The undersigned understands that false statements made in this filing are subject to the penalties provided under Section 575.040, RSMo)

	Ryan Casey	Vice-President	9/27/06
<i>Authorized signature of officer or chairman of the board</i>	<i>Printed Name</i>	<i>Title</i>	<i>Date</i>

The purpose or purposes for which the corporation is being formed are:

To provide discounted benefits, services and resources that will enhance the safety and profitability of the transportation industry, specifically those persons who own and operate their own trucks.

To exercise all the powers conferred upon corporations formed under the Missouri Not-For-Profit Corporation Act.

# STATE OF MISSOURI



**Matt Blunt**  
**Secretary of State**

**CERTIFICATE OF INCORPORATION  
MISSOURI NONPROFIT**

WHEREAS, duplicate originals of Articles of Incorporation of

*Internet Technology Association of America*  
*N00615426*

have been received and filed in the Office of the Secretary of State, which Articles, in all respects, comply with the requirements of Missouri Nonprofit Corporation Law;

NOW, THEREFORE, I, MATT BLUNT, Secretary of State of the State of Missouri, do by virtue of the authority vested in me by law, do hereby certify and declare this entity a body corporate, duly organized this date and that it is entitled to all rights and privileges granted corporations organized under the Missouri Nonprofit Corporation Law.

IN TESTIMONY WHEREOF, I have set  
my hand and imprinted the GREAT SEAL  
of the State of Missouri, on this, the 4th day  
of October, 2004.

  
\_\_\_\_\_  
Secretary of State





**State of Missouri**  
**Matt Blunt, Secretary of State**

Corporations Division  
 P.O. Box 778 / 600 W. Main Street, Rm 322  
 Jefferson City, MO 65102

**Articles of Incorporation of a Nonprofit Corporation**  
*(To be submitted with a filing fee of \$25)*

The undersigned natural person(s) of the age of eighteen years or more for the purpose of forming a corporation under the Missouri Nonprofit Corporation Act adopt the following Articles of Incorporation:

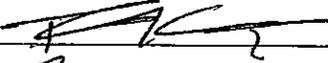
- (1) The name of the corporation is Internet Technology Association of America
- (2) This corporation is a mutual (Public or Mutual) Benefit Corporation.
- (3) The period of duration of the corporation is perpetual  
("Perpetual" unless stated otherwise)
- (4) The name and street address of the Registered Agent and Registered Office in Missouri is:  
Karen Boeker 16476 Chesterfield Airport Rd. 2<sup>nd</sup> Flr. Chesterfield, Mo 63017  
Name Address City/State/Zip
- (5) The name(s) and address(es) of each incorporator:  
Tina Kompon 1014 Timberfield Drive Ballwin, Mo 63021  
Ryan Casey 1880 Newburgport Rd. Chesterfield, Mo 63005
- (6) Does the corporation have members? YES  NO
- (7) The assets of the corporation will be distributed on dissolution as follows:  
Assets would be distributed to another mutual benefit corporation
- (8) The corporation is formed for the following purpose(s): To promote the common interests of Internet users, and to help Internet users take advantage of the mass purchasing power and other benefit enhancements of other organizations.
- (9) The effective date of this document is the date it is filed by the Secretary of State of Missouri, unless you indicate a future date, as follows: —  
(Date may not be more than 90 days after the filing date in this Office)

Please see next page

Name and address to return filed document: Name: <u>Rachel DiFulvio</u> Address: <u>1819 Clarkson Rd. Suite 301</u> City, State, and Zip Code: <u>Chesterfield, Mo 63017</u>	State of Missouri Creation - NonProfit 2 Page(s)  T0427916511
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In Affirmation thereof, the facts stated above are true and correct:  
(The undersigned understands that false statements made in this filing are subject to the penalties provided under Section 575.040, RSMo)

Signed by Incorporator(s):

  
\_\_\_\_\_  
*Myron Cady*  
\_\_\_\_\_  
\_\_\_\_\_