

SERFF Tracking Number: ICCI-126879896 State: Arkansas
Filing Company: Madison National Life Insurance Company, Inc. State Tracking Number: 47214
Company Tracking Number: MNL MMFI POL D610
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: Group Fixed Indemnity MNL MMFI POL D610
Project Name/Number: Group Fixed Indemnity Policy/MNL MMFI POL D610

Filing at a Glance

Company: Madison National Life Insurance Company, Inc.

Product Name: Group Fixed Indemnity MNL SERFF Tr Num: ICCI-126879896 State: Arkansas
MMFI POL D610

TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed-Approved- State Tr Num: 47214
Closed

Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: MNL MMFI POL D610 State Status: Approved-Closed

Filing Type: Form

Author: Brenda Dawson

Reviewer(s): Rosalind Minor

Date Submitted: 11/04/2010

Disposition Date: 11/15/2010

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Group Fixed Indemnity Policy

Project Number: MNL MMFI POL D610

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 11/15/2010

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Association

Explanation for Other Group Market Type:

State Status Changed: 11/15/2010

Created By: Brenda Dawson

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Brenda Dawson

Filing Description:

Enclosed for review and approval for use in your state are the forms attached to the Form Schedule tab. These forms are new and are not intended to replace any forms previously approved by your Department.

Insurance Compliance Consultants, Inc., is making this filing on behalf of Madison National Life Insurance Company, Inc. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc., at the address shown above.

Group Fixed Indemnity Health Insurance Policy form MNL MMFI POL D610 will be issued to an association group

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located outside of your state.

Group Policyholder Application MNL MMFI GAPP 610, will be completed by the Association to apply for the Policy.

Form MNL MMFI CERT D610 is the Group Certificate evidencing coverage under the Group Policy. Amendatory Endorsement MNL FI AEAR 610 will be attached to all Certificate issued to Arkansas residents.

Amendatory Endorsement MNL HI/FI AE 1010 may or may not be included with the coverage depending upon the group and or the marketing program being offered.

Group Limited Benefit Fixed Indemnity Health Insurance Application form MNL MMFI APP 610 will be completed by the individual applying for coverage under the Group Policy.

This is individual fixed indemnity coverage under a group Association Policy. As such, covered benefits are paid subject to the terms, limitations and exclusions of the Policy, regardless of the amount billed by the health care provider.

The Policy documents were prepared on a personal computer and will ultimately be printed from another data processing system that may cause some print style and/or page spacing changes. However, there will not be any changes to the actual text of the contract other than listed or bracketed variables, or to the general print size.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions.

Company and Contact

Filing Contact Information

Brenda Dawson, Authorized Representative Brendadawson@inscompliance.com
3925 East State Street, Suite 200 815-316-6714 [Phone]
Rockford, IL 61108 815-986-2355 [FAX]

Filing Company Information

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

Madison National Life Insurance Company, Inc. CoCode: 65781 State of Domicile: Wisconsin
P. O. Box 5008 Group Code: Company Type:
Madison, WI 53705 Group Name: State ID Number:
(800) 356-9601 ext. [Phone] FEIN Number: 39-0990296

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Filing Fees

Fee Required? Yes
Fee Amount: \$300.00
Retaliatory? No
Fee Explanation: \$50 per form
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Madison National Life Insurance Company, Inc.	\$300.00	11/04/2010	41539436

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/15/2010	11/15/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	11/15/2010	11/15/2010	Brenda Dawson	11/15/2010	11/15/2010

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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	MNL Authorization Letter	Approved-Closed	Yes
Supporting Document	Prior approval letter for CA Association	Approved-Closed	Yes
Supporting Document	CA Association name change effective 1/17/07	Approved-Closed	Yes
Form	Group Fixed Indemnity Policy	Approved-Closed	Yes
Form	Group Certificate	Approved-Closed	Yes
Form	Group Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 11/15/2010

Submitted Date 11/15/2010

Respond By Date

Dear Brenda Dawson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Fixed Indemnity Policy, MNL MMFI POL D610 (Form)
- Group Certificate, MNL MMFI CERT D610 (Form)

Comment:

You state under your General Instructions tab that the policyholder will be an out-of-state association group.

The information on the association group must comply with ACA 23-85-106(2)(A)(i)(ii)(iii) and (C)(i)(ii)(iii)(a)(b). Also refer to (D) and (E).

I am attaching a questionnaire requesting further information on the association group.

If the association has been pre-approved by our Department, please give me the name of the association and approximate of approval.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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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Response Letter

Response Letter Status Submitted to State
Response Letter Date 11/15/2010
Submitted Date 11/15/2010

Dear Rosalind Minor,

Comments:

Thank you for your letter.

Response 1

Comments: Please find attached the prior approval letter from the Department approving the use of the Communicating for Agriculture and the Self-Employed Association (CA). Also attached the name change of this Association to Communicating for America (CA).

Related Objection 1

Applies To:

- Group Fixed Indemnity Policy, MNL MMFI POL D610 (Form)
- Group Certificate, MNL MMFI CERT D610 (Form)

Comment:

You state under your General Instructions tab that the policyholder will be an out-of-state association group.

The information on the association group must comply with ACA 23-85-106(2)(A)(i)(ii)(iii) and (C)(i)(ii)(iii)(a)(b). Also refer to (D) and (E).

I am attaching a questionnaire requesting further information on the association group.

If the association has been pre-approved by our Department, please give me the name of the association and approximate of approval.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Prior approval letter for CA Association

Comment:

Satisfied -Name: CA Association name change effective 1/17/07

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Form Schedule

Lead Form Number: MNL MMFI POL D610

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/15/2010	MNL MMFI POL D610	Policy/Cont ract/Fraternal Certificate	Group Fixed Indemnity Policy	Initial		0.000	MNL MMFI POL D610.pdf
Approved-Closed 11/15/2010	MNL MMFI CERT D610	Certificate	Group Certificate	Initial		0.000	MNL MMFI CERT D610 clean copy 10-22-10.pdf
Approved-Closed 11/15/2010	MNL MMFI GAPP 610	Application/ Enrollment Form	Group Application	Initial		0.000	MNL MMFI GAPP 610 _Group Application_.pdf
Approved-Closed 11/15/2010	MNL MMFI APP 610	Application/ Enrollment Form	Application	Initial		0.000	MNL MMFI App Mini-Med 6-4-10.pdf
Approved-Closed 11/15/2010	MNL HI/FI AE 1010	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Amendatory Endorsement	Initial		0.000	MNL HI-FI AE 1010.pdf
Approved-Closed 11/15/2010	MNL FI AEAR 610	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Amendatory Endorsement	Initial			AR MNL FI AEAR 610.pdf

MADISON NATIONAL LIFE INSURANCE COMPANY, INC
[P.O. Box 5008, Madison, WI 53705]

(Herein called We, Our, Us or the Company)

POLICYHOLDER: [ABC Association]
POLICY NUMBER: [XX-XXXXX]
EFFECTIVE DATE: [June 1, 2010]
STATE OF DELIVERY: [District of Columbia]

In consideration of the Master Group Policy Application made by the Policyholder, and in consideration of the payment of any applicable premium due, We agree to pay the group insurance benefits herein with respect to each Covered Person, in accordance with and subject to the terms, conditions and limitations of the Policy. Benefits are payable in United States dollars only.

The Policy becomes effective at 12:01 a.m. Standard Time at the Policyholder's address on the Effective Date shown above, and will remain in force until it is terminated by [sixty (60)] days written notice to the Policyholder or Us. The Policy renews monthly following the Effective Date shown above.

This Policy is governed by the laws of the jurisdiction of the State of delivery.

This face page and all endorsements, Riders, Schedule of Benefits, Certificates, applications and any addendums, form the Master Policy. These pages are all part of this Policy as if fully recited over the signature shown below.

Executed for Madison National Life Insurance Company, Inc., as of the Effective Date.

GROUP FIXED INDEMNITY HEALTH INSURANCE BENEFITS

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President



Adam C. Vandervoort
Secretary

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

CERTIFICATE OF INSURANCE

Madison National Life Insurance Company, Inc., herein called The Company, hereby certifies that it has issued and delivered to the Policyholder a group Policy, described on the Schedule of Benefits page. The group Policy covers certain Covered Persons as described in the Policy.

This Certificate describes the Benefits and provisions of the Policy. This Certificate becomes effective only if: (1) the Eligible Person is eligible for insurance; (2) We have received the Eligible Person's application/enrollment form; (3) the required premium has been paid; and (4) the Eligible Person becomes insured in accordance with all of the provisions of the Policy.

No agent may change the Policy or waive its provisions.

[10-30] Day Right To Return

Carefully read this Certificate including all provisions, Benefits and limitations as soon as You receive it. It is important that You understand and are satisfied with the coverage provided under the Policy. If You are not satisfied with this Certificate, return it to The Company at its home office within [10-30] days after You receive it. All premiums will be refunded and coverage will be considered to be void from the beginning.

Group Fixed Indemnity Health Insurance

LIMITED BENEFIT, PLEASE READ CAREFULLY

**THIS FACE PAGE SUPERSEDES AND REPLACES ANY AND ALL
PREVIOUSLY ISSUED TO THE ELIGIBLE PERSON**

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President



Adam C. Vandervoort
Secretary

Table of Contents

Schedule of Benefits

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Section 6.....PREMIUMS

Section 7.....GENERAL PROVISIONS

Schedule of Benefits
Fixed Indemnity Benefits Per Covered Person

Name of Eligible Person (Certificateholder): [John Doe]	[Covered Dependents: [Mary Doe, Spouse] [James Doe, Child]
Eligible Person's Coverage Effective Date: [June 1, 2010]	[Dependent's Coverage Effective Date: [June 1, 2010]]
[Certificate Number: [123456]]	[Plan Chosen: [1, 2, 3]]
Policyholder: [ABC Association]	Group Policy Number: [GP001]
[Outpatient Doctor Office Visit Indemnity Benefit: [Visits for [Preventive Care,] [Mental Illness Disorders,] [Substance Abuse] [and] [Pregnancy] are not covered under this Benefit.]	[Included] [Not Included] [\$40 -\$200] per visit [Maximum Benefit of [\$40 -\$1,600] per Calendar Year] [Maximum Benefit of [1-8] visits per Calendar Year]]
[Outpatient Diagnostic [Lab] Testing and X-Ray [and Venipuncture] Indemnity Benefit:	[Included] [Not Included] [\$40 -\$400] per procedure [Limited to [one] procedure per day] [Maximum Benefit of [\$40 -\$2,000] per Calendar Year] [Maximum Benefit of [1-5] procedures per Calendar Year for all Lab and X-Ray [and Venipuncture] procedures combined.]]
[Outpatient Diagnostic Advanced Study/Studies Indemnity Benefit:	[Included] [Not Included] [\$50 -\$2,000] per Advanced Study [Maximum Benefit of [\$50 -\$10,000] per Calendar Year] [Maximum Benefit of [1-5] Advanced Studies per Calendar Year.]]
[Outpatient Venipuncture Surgical Indemnity Benefit:	[Included] [Not Included] [\$40 -\$300] per procedure [Maximum Benefit of [\$40 -\$1,500] per Calendar Year] [Maximum Benefit of [1-5] procedures per Calendar Year.]]
[[Outpatient Minor Surgical Indemnity Benefit] [and Outpatient Venipuncture Surgical Indemnity Benefit]:	[Included] [Not Included] [\$25 -\$300] per procedure [Maximum Benefit of [\$25 -\$1,500] per Calendar Year] [Maximum Benefit of [1-5] procedures per Calendar Year [for all Outpatient Minor Surgical Procedures [and Outpatient Venipuncture procedures combined.]]
[Preventive Care Indemnity Benefit:	[Included] [Not Included] [\$40 -\$300] per visit [Limited to [1] visit per day] [Maximum Benefit of [\$40 -\$900] per Calendar Year] [Maximum Benefit of [1-3] [visits] per Calendar Year.]] [\$40 -\$300] per test [Limited to [1] test per day] [Maximum Benefit of [\$40 -\$900] per Calendar Year] [Maximum Benefit of [1-3] [tests] per Calendar Year.]] [Maximum Benefit of [\$40-900] per Calendar Year for all visits and tests combined]]
[Infant Wellness Indemnity Benefit: <i>[Includes pre-natal care]</i>	[Included] [Not Included] [\$40 -\$100] per visit [Maximum Benefit of [\$40 -\$800] per Calendar Year] [Maximum Benefit of [1-8] visits per Calendar Year.]]

<p>[[Urgent Care Facility] [or] [Hospital Emergency Room] Visit Indemnity Benefit:</p>	<p>[Included] [Not Included]</p> <p>[\$50 -\$200] per visit [Maximum Benefit of [\$50 -\$600] per Calendar Year] [Maximum Benefit of [1-3] [visits] per Calendar Year] [for all visits to an Urgent Care Facility and a Hospital Emergency Room combined per Calendar Year.]]</p>
<p>[Ambulance Indemnity Benefit: [Air], [Ground], [Water]</p>	<p>[Included] [Not Included]</p> <p>[\$50 -\$500] [per conveyance] [per [air] [ground] [water] occurrence] [Maximum Benefit of [\$50 -\$1,500] per Calendar Year] [Maximum Benefit of [1-3] [conveyances] per Calendar Year.]]</p>
<p>[First Day Hospital Confinement Indemnity Benefit:</p>	<p>[Included] [Not Included]</p> <p>[\$200 - \$2,000] payable only once in a single sum for any period of Inpatient confinement. [Maximum Benefit of [\$200 - \$6,000] per Calendar Year] [Maximum Benefit of [1-3] [Confinement(s)] per Calendar Year.]]</p>
<p>[Daily Hospital Confinement Indemnity Benefit: <i>[Does not include Mental Health or Substance Abuse.]</i></p>	<p>[Included] [Not Included]</p> <p>[\$100 - \$2,000] per day [Maximum Benefit of Inpatient days per [confinement] [Calendar Year]: [1-30]] [Maximum Benefit of [1-3] confinement(s) per Calendar Year] [Maximum Benefit of [\$100-\$180,000] per [confinement] [Calendar Year]]</p>
<p>[[Intensive Care Unit] [or] [Cardiac Care Unit], [Burn Unit] [or] [Other Specialized Care Unit][Indemnity Benefit: <i>[Paid in addition to the Daily Hospital Confinement Indemnity Benefit]. [Benefit is not included unless Daily Hospital Confinement [and Skilled Nursing Confinement] Indemnity Benefit is included.]</i></p>	<p>[Included] [Not Included]</p> <p>[\$100 - \$2,000] per day [Maximum Benefit of Inpatient days per [confinement] [Calendar Year]: [1-30]] [Maximum Benefit of [1-3] confinement(s) per Calendar Year] [Maximum Benefit of [\$100-\$180,000] per [confinement] [Calendar Year]]</p>
<p>[[Skilled Nursing Facility Indemnity Benefit] [or] [Hospice Indemnity Benefit]: <i>[Skilled Nursing Facility [or] Hospice must follow Hospital confinement of at least [3] days].</i></p>	<p>[Included] [Not Included]</p> <p>[[[\$100 - \$2,000] per day [Maximum Benefit of [10-30] Inpatient days of confinement per Calendar Year in a Skilled Nursing Facility.] [Maximum Benefit of [10-30] Inpatient [and Outpatient] days per Calendar Year in Hospice] [Maximum Benefit combined for Skilled Nursing Facility and Hospice [10-30] days per Calendar Year] [Maximum Benefit of [\$100-\$60,000] per [confinement] [Calendar Year]]]</p>
<p>[[Miscellaneous Hospital Services Indemnity Benefit:] <i>Covers miscellaneous Hospital services such as Lab work, Blood tests, X-rays, Diagnostic Studies, Medication, Crutches, Bandages and other services supplied while confined. [Paid in addition to Daily Hospital Confinement [and Skilled Nursing Facility] [and Anesthesia] Indemnity Benefit.] [Benefit is not included unless Daily Hospital Confinement Indemnity Benefit is included.]</i></p>	<p>[Included] [Not Included]</p> <p>[\$100 - \$300] per day [Maximum Benefit of days per [confinement] [Calendar Year]: [1-30]] [Maximum Benefit of [1-3] confinement(s) per Calendar Year] [Maximum Benefit of [\$100-\$27,000] per [confinement] [Calendar Year]]</p>

<p>[[Inpatient] [and] [Outpatient] Surgical Indemnity Benefit:] <i>[Does not include [Venipuncture or] Minor Surgical Procedures.]</i></p>	<p>[Included] [Not Included]</p> <p>[Benefit is based on the Payment Factor shown in the Schedule of Surgical Indemnity Benefits in Section 3, times the Surgical Procedure Units [1-10]]</p> <p>[Benefit is [50%] [80%] [100%] of the [2010] Medicare National Fee Schedule]</p> <p>[[\$500 - \$10,000] per Inpatient surgical procedure] [[\$250 - \$5,000] per Outpatient Surgical Procedure] [Maximum [combined] Benefit of Inpatient [and] [Outpatient] surgeries per Calendar Year [1-3]] [Maximum Benefit of [\$250-\$50,000] per Calendar Year]]</p>
<p>[[Outpatient Surgical Indemnity Benefit:] <i>[Does not include [Venipuncture or] Minor Surgical Procedures.]</i></p>	<p>[Included] [Not Included]</p> <p>[Benefit is based on the Payment Factor shown in the Schedule of Surgical Indemnity Benefits in Section 3, times the Surgical Procedure Units [1-10]]</p> <p>[Benefit is [50%] [80%] [100%] of the [2010] Medicare National Fee Schedule]</p> <p>[[\$50 - \$2,000] per Outpatient surgical procedure]</p> <p>[Maximum Benefit of Outpatient surgeries per Calendar Year [1-3]] [Maximum Benefit of [\$50-\$6,000] per Calendar Year]]</p>
<p>[Pregnancy Indemnity Benefit:]</p>	<p>[Included] [Not Included]</p> <p>[Waiting Period [9-12] months] [[\$500-\$2,000] per Pregnancy] [No other Benefits are payable] [Covered the same as any other Covered Illness]]</p>
<p>[Anesthesia Indemnity Benefit:]</p>	<p>[Included] [Not Included]</p> <p>[Benefit is equal to [20%-30%] of the Benefit paid under the [Inpatient] [and] [Outpatient] Surgical Indemnity Benefit [or] Outpatient Surgical Indemnity Benefit [or] [the Outpatient Minor [and Venipuncture] Surgical Indemnity Benefit] [[\$50 - \$1,000] per surgery] [Maximum Benefit of [1-3] Inpatient and [1-3] Outpatient [combined] surgeries per Calendar Year.] [Maximum Benefit of [\$50-\$30,000] per Calendar Year]]</p>
<p>[Durable Medical Equipment Indemnity Benefit:] <i>[Covers miscellaneous items such as Canes, Crutches, Walkers, Wheelchairs, Respiratory equipment, Splints, Nebulizers, Neck Braces, Slings.]</i></p>	<p>[Included] [Not Included]</p> <p>[\$50-\$100] per item [Maximum Benefit of [[1-2] items of Durable Medical Equipment] [\$100-\$1,000] per Calendar Year]]</p>
<p>[Inpatient Mental Illness Disorders Indemnity Benefit:] <i>[Other Inpatient Benefits are not payable.]</i></p>	<p>[Included] [Not Included]</p> <p>[\$40- \$100] per day [Maximum Benefit of [\$400-\$3,000] per [confinement] [Calendar Year]] [Maximum Benefit of [10-30] days per [confinement] [Calendar Year]]]</p>

<p>[Outpatient Mental Illness Disorders Indemnity Benefit: <i>[Other Outpatient Benefits are not payable].</i></p>	<p>[Included] [Not Included]</p> <p>[\$40-\$100] per visit [Maximum Benefit of [\$400-\$2,000] per Calendar Year] [Maximum Benefit of [10-20] visits per Calendar Year]</p>
<p>[Inpatient Substance Abuse Indemnity Benefit: <i>Other Inpatient benefits are not payable.</i></p>	<p>[Included] [Not Included]</p> <p>[\$40- \$100] per day [Maximum Benefit of [\$400-\$3,000] per [confinement] [Calendar Year]] [Maximum Benefit of [10-30] days per [confinement] [Calendar Year]]</p>
<p>[Outpatient Substance Abuse Indemnity Benefit: <i>Other Outpatient benefits are not payable.</i></p>	<p>[Included] [Not Included]</p> <p>[\$40-\$100] per visit [Maximum Benefit of [\$400-\$2,000] per Calendar Year] [Maximum Benefit of [10-20] visits per Calendar Year]</p>
<p>[Outpatient Physical Therapy Indemnity Benefit]:</p>	<p>[Included] [Not Included]</p> <p>[\$20-\$50] per visit [Maximum Benefit of [\$20-\$500] per Calendar Year] [Maximum Benefit of [1-10] visits per Calendar Year]</p>
<p>[Outpatient Prescription Medication Indemnity Benefit:</p>	<p>[Included] [Not Included]</p> <p>[Maximum Benefit for Generic Medication: \$[10-50] [per each Generic Medication purchased] [Maximum Benefit of [1-3] [\$10-\$150] Generic Prescription(s) per Coverage Month] [Maximum Benefit of [1-6] [\$10-\$300 for all] Generic Prescription(s) per Calendar Year]</p> <p>[Maximum Benefit for [Formulary Brand] [or] [Non-Formulary Brand] Drugs: \$[10-100] per each Brand Drug purchased] [Maximum Benefit of [1-3] [\$10-\$300] Brand Prescription(s) per Coverage Month] [Maximum Benefit of [1-6] [\$10-\$600 for all] Brand Prescription(s) per Calendar Year] [Maximum Benefit of [\$1,000-\$5,000] per [Coverage Month] [Calendar Year] for all Outpatient Prescription Medication combined]]</p>
<p>[Accident Indemnity Benefit:</p>	<p>[Included] [Not Included]</p> <p>[\$200 - \$2,000] [per Accidental Bodily Injury] [Maximum Benefit of [\$200 -\$6,000] per Calendar Year] [1-3] [Accidental Bodily Injuries] per Calendar Year.]</p>

Section 1

Definitions

Accidental Bodily Injury/Injury: A sudden, unexpected and unintended bodily injury resulting directly from an accident which is independent of any Injury and which takes place while the Covered Person's coverage is in force.

Advanced Study/Studies: Those procedures in the CPT Code [90000] Series excluding Preventive Care and limited to: [Angiogram; Arteriogram; Computed Tomography Scan (CT); Electroencephalogram (EEG); Magnetic Resonance Imaging (MRI); Myelogram; Positron Emission Tomography Scan (PET); and Thallium Stress Test.]

Ambulatory Surgical Center: Any public or private establishment with:

1. An organized medical staff of Doctors;
2. Permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
3. Continuous Doctors' services whenever a patient is in the facility; and
4. Which does not provide services or accommodations for patients to stay overnight.

Benefit: The dollar amount payable by Us to an Eligible Person or assignee of an Eligible Person under the Policy.

Calendar Year: The period of time beginning January 1st and ending on December 31st of the same year. The first Calendar Year of the Certificate will begin on the date Your coverage becomes effective and end on the first December 31st after a Covered Person's Effective Date of coverage.

Calendar Year Maximum Benefit: The maximum Benefit payable for specific Covered Benefits as shown on the Schedule of Benefits.

Certificate: The Certificate of Insurance given to the Eligible Person. It describes the Benefits and provisions of the Policy for the Eligible Person and Dependents, if any.

Child:

1. An Eligible Person's natural Child;
2. An Eligible Person's lawfully adopted Child;
3. A Child placed for adoption with an Eligible Person;
4. An Eligible Person's stepchild;
5. An Eligible Person's foster Child;
6. A Child for whom the Eligible Person has been appointed legal guardian by a court of competent jurisdiction and who resides with and who is dependent upon the Eligible Person in a regular parent-child relationship; or
7. A Child of the Eligible Person for whom the Eligible Person is obligated to provide medical child support pursuant to a Qualified Medical Support Order.

Complications of Pregnancy: 1) Conditions (when Pregnancy is not terminated) whose diagnoses are distinct from Pregnancy but are adversely affected by or caused by Pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion hyperemesis gravidarum, preeclampsia, and similar medical and surgical conditions of comparable severity; and (2) non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of Pregnancy which occurs during a period of gestation in which a viable birth is not possible.

"Complications of Pregnancy" does not include false labor, occasional spotting, Doctor-prescribed rest during the period of pregnancy, morning sickness, elective cesarean section, and similar conditions associated with the management of a difficult Pregnancy but not constituting a nosologically distinct Complication of Pregnancy.

Copayment: The fixed dollar amount shown in the Schedule of Benefits that is payable by a Covered Person in connection with a specific Covered Benefit.

Coverage Effective Date: The date, starting at 12:01 A.M. at the Eligible Person's residence, that coverage for a Covered Person takes effect under the Policy.

Coverage Month: One month immediately following the Coverage Effective Date and every consecutive one month period thereafter while this coverage is in force.

Covered Benefits: Those services or supplies that:

1. Are Medically Necessary;
2. Are received while the Covered Person is insured under the Policy; and
3. Are not excluded under Section 4 – Exclusions and Limitations.

Covered Person: A person who has satisfied all of the following requirements:

1. He or she is eligible for coverage under the Policy, either as an Eligible Person or as a Dependent;
2. He or she has been accepted for coverage under the Policy or has been automatically added;
3. Premium has been paid for him or her; and
4. His or her coverage has become effective and has not terminated.

Covered Persons are shown on the [Identification Card] [and] Schedule of Benefits.

CPT: The Doctor's Current Procedural Terminology published by the American Medical Association, version in effect on the date the service is provided.

Custodial Care: Services (including room and board) or supplies which:

1. Are primarily to help the Covered Person perform the activities of daily living;
2. Can safely be provided by non-skilled persons; and
3. Are not Medically Necessary to reduce the disability.

Dependent: An Eligible Person's:

1. Spouse;
- [2. Unmarried Child who is primarily dependent upon the Eligible Person for support and maintenance and is:
 - a. Less than [19] years of age; or
 - b. Between [19] and [26] years of age;] [provided however, that the Child is dependent upon the Eligible Person for support and maintenance];
- [2. Child who is less than [26] years of age.]

Dependent does not include anyone who:

1. Lives outside the United States;
2. Is in the armed forces of any country; or
3. Has coverage under the Policy as an Eligible Person or as a Dependent of another person.

Doctor: A person who is:

1. Licensed as a provider of medical services by the state in which he or she practices;
2. Acting within the scope of his or her license; and
3. Not one of the following:
 - a. A person who ordinarily resides in Your household.
 - b. A member of Your Immediate Family.

Durable Medical Equipment: Equipment that is customarily used to serve a medical purpose and not generally useful to a person in the absence of an Illness or Injury.

Eligible Person: The primary insured named as the Member on the Schedule of Benefits whose coverage has become effective and has not terminated.

Emergency: The sudden onset of a medical condition manifested by symptoms of such severity that the failure to immediately provide Medically Necessary treatment could reasonably be expected to result in:

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

Emergency Room: A facility located on the premises of, or physically a part of, a Hospital that provides initial treatment to patients with a broad spectrum of Illnesses and Injuries that require immediate attention and is especially equipped and staffed for Emergency Care.

[Evidence of Insurability: A medical statement that is to be completed to the best of the individual's ability. Evidence of good health is a series of questions regarding the applicant's and/or Dependent's current and previous medical conditions and any treatment they may have received.]

Experimental/Investigational: One or more of the following applies:

1. The medical treatment, surgical procedure, service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include, but are not limited to Phase I, II and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the medical treatment, surgical procedure, service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings. The Company will determine if this item applies based on:
 - a. published reports in authoritative medical literature; and
 - b. regulations, reports, publications and evaluations issued by government agencies or professional organizations such as the National Cancer Institute, the Agency for Health Care Policy and Research, the National Institute of Health and the FDA.
3. The provider's institutional review board acknowledges that the use of the medical treatment, surgical procedures, services or supply is Experimental or Investigational and subject to that board's approval.
4. Research protocols indicate that the medical treatment, surgical procedure, service or supply is Experimental or Investigational. This item applies for protocols used by the Covered Person's provider as well as for protocols used by other providers studying substantially the same medical treatment, surgical procedure, service or supply.

[Hospice Care Services: Home care services provided by professional nurses or home health aides under active management of a Hospice agency licensed and operated pursuant to law and providing a hospice care program of palliative, supportive and interdisciplinary team services. Hospice Care Services does not include services provided by volunteers.]

Hospital: An institution that:

1. Operates pursuant to law;
2. Has 24 hour nursing services by registered nurses;
3. Has a staff of one or more Doctors;
4. Provides Inpatient therapeutic and diagnostic services for Illness or Injury;
5. Provides facilities for major surgery or has a formal arrangement with another institution for surgical facilities; and
6. Is approved by the Joint Commission on the Accreditation of Health Care Facilities as a Hospital (JCAHO); the American Hospital Association (AHA); the American Osteopathic Healthcare Association (AOHA); the American Osteopathic Association accreditation (AOA); or the Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation.

Hospital does not include any of the following:

1. A rest or nursing home, home for the aged or convalescent home;
2. A Skilled Nursing Facility; an extended care facility; or
3. A hospice, a place for Custodial Care, or a birthing center.

Illness: A sickness or disease or Complications of Pregnancy [or Pregnancy] which requires treatment by a Doctor.

Immediate Family: The Eligible Person's Spouse, or the parent, brother, sister, Child or grandparent of the Eligible Person or the Eligible Person's Spouse; or any person related to the Eligible Person by blood, marriage or legal adoption; or any person who is a resident in the Eligible Person's household.

[Infant Wellness: Includes the following:

1. Routine health examinations and immunizations for covered Dependent Child under age [1]; and
2. Routine prenatal and well-child care.]

Inpatient and Outpatient: The terms "Inpatient" and "Outpatient" refer either to the setting in which medical care is given or to a Covered Person who is receiving care in that setting.

When the terms describe the setting in which medical care is given:

1. "Inpatient" means therapeutic services which are available on a 24-hour basis to a Covered Person while confined in a Hospital or other treatment facility, as a registered bed patient;
2. "Outpatient" means therapeutic services are furnished to a Covered Person while not confined.

When the terms refers to a Covered Person who is receiving medical care:

1. "Inpatient" means a Covered Person who is confined in a Hospital as a registered bed patient for a period of 23 consecutive hours or longer upon the advice of a Doctor for the purpose of other than Custodial Care;
2. "Outpatient" means a Covered Person who is not so confined.

[Intensive Care Unit] or [Cardiac Care Unit], [Burn Unit] or [Other Specialized Care Unit] of a Hospital: A Cardiac Care Unit or other unit or area of a Hospital which:

1. Is reserved for the seriously ill or injured requiring close observation;
2. Is permanently equipped to provide specialized care by trained qualified personnel and special equipment and supplies on a standby basis;
3. Meets the required standards of the Joint Commission on Accreditation of Hospitals for special care units.

If a Hospital has more than one level of intensive care, care provided in an:

1. Intermediate Intensive Care Unit;
2. Step-down unit;
3. Similar transitional care unit; or
4. Will be covered as though it were provided in an Intensive Care Unit.

Lab Test: A test that is done in the laboratory where the appropriate equipment, supplies and certified expertise are available including those procedures in the CPT Code Range [70000]; but excluding Preventive Care and those procedures in the CPT Code Range [36400-36416] (Venipuncture).

Medically Necessary: Treatment, services or supplies provided for an Illness or Injury which:

1. Have been established as safe and effective;
2. Are furnished in accordance with generally accepted professional standards to treat an Illness or Injury;
3. Are determined to be:
 - a. Rendered for the treatment or diagnosis of an Illness or Injury;
 - b. Appropriate for the symptoms, consistent with the diagnosis;

- c. Are otherwise in accordance with generally accepted medical practice and professionally recognized standards;
 - d. Not mainly for the convenience of the Covered Person, his or her Doctor or other providers;
 - e. Not in excess (in scope, duration or intensity) of that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment;
 - f. Not Experimental or Investigational;
 - g. Services and supplies that are necessary for the therapeutic treatment of an Illness or Injury; and
4. When applied to confinement in a Hospital, the Covered Person:
- a. Must be confined as an Inpatient due to the nature of treatment, services or supplies rendered or due to his or her condition; and
 - b. Cannot receive safe and adequate care through Outpatient treatment.

Treatment, services or supplies are not automatically deemed Medically Necessary based solely on the fact that they were prescribed, ordered or recommended by a Doctor or any other provider.

Medicare: The Health Insurance for the Aged Act. Title XVIII of the Social Security Amendments of 1965, as amended.

[Medicare National Fee Schedule – The schedule used by the federal government to calculate Medicare allowances. Benefits for surgical procedures are payable based on the Medicare National Fee Schedule.]

Mental Illness Disorder: Any nervous, emotional and/ or mental disease, Illness, syndrome, or dysfunction, other than a behavior or conduct disorders, classified in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* including, but not limited to neurosis, psychoneurosis, psychopathy, psychosis, and eating or panic disorder except for mental retardation. It also includes any nervous, emotional or nervous disorder that may be a manifestation of an organic condition, disease, Illness, or syndrome, including organic mental syndrome associated with psychoactive substances (e.g., alcohol, cocaine, opiate, and others).

Outpatient Minor Surgical Procedure: Surgery as follows on an Outpatient basis: Those procedures in the following CPT Code ranges: incision and drainage [(10040-11010)], small lesions [(11055-11311)], excision of benign lesions [(11400-11442)], nails [(11719-11755)], surgical injections (20500-20612)], application of casts and strapping [(29035-29750)], catheterizations (36400-36680)], lesions of the mouth [(40800-40840) & [41000-41116)], gum lesions [(41800-42107)], nerve blocks [(64402-64553)] lesions of the eye [(67700-67850)] and lesions of the ear [(69400-69424)].

Physical Therapy: The treatment of an Illness or Accidental Bodily Injury of a Covered Person by physical and mechanical means, such as massage, regulated exercise, water, light, heat, and electricity.

Policy: The contract providing the Benefits described herein issued to the Policyholder.

Policyholder: The entity, in whose name the Policy is issued, as specified in the Schedule of Benefits.

[Pregnancy: The period following the receipt by a Covered Person of a diagnosis of Pregnancy until the discharge of the Covered Person from the Hospital or other facility following the delivery of the newborn Child.]

Prescription Medication: Any medical substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound which can only be dispensed pursuant to a prescription and which is required to bear the following statement on the label: "Caution: Federal law prohibits dispensing without a prescription."

Preventive Care: Includes, but is not limited to, the following:

1. Periodic health evaluations, including tests and diagnostic procedures ordered in connection with a routine examination, such as annual physicals.
2. Routine prenatal and well-child care.
3. Child and adult immunizations.
4. Cancer screening services.
5. Vision Screening Services.

However, Preventive Care does not include any service intended to treat an illness or injury.

Pre-Existing Condition: A disease, Accidental Bodily Injury, Illness or physical condition for which a Covered Person:

1. had treatment;
2. incurred charge;
3. took medication; or
4. received a diagnosis or advice from a Doctor;

during the [12] month period immediately preceding the Covered Person(s) Coverage Effective Date.

Skilled Nursing Facility: A free-standing facility or part of a Hospital that is certified by Medicare to accept patients in need of rehabilitative and skilled care.

Spouse: The Eligible Person's lawful Spouse, common law Spouse, [domestic partner] [or] [domestic same sex partner] [under age [64 ½]].

Substance Abuse: The pathological use or abuse of alcohol or other drugs or substances in a manner and to a degree that produces impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

Surgery/Surgical: A medical procedure or operation involving an incision with instruments, performed to repair damage, arrest disease in a living body or find out if disease is present.

Urgent Care Facility: A free-standing facility, by whatever actual name it may be called, which is engaged primarily in providing minor Emergency and episodic, medical care. A Doctor, a registered nurse and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include X-ray and laboratory equipment and a life support system. It must be licensed as an Urgent Care Facility, if required by law.

Venipuncture: The puncture of a vein with a needle for the purpose of obtaining a blood specimen limited to those procedures in the CPT Code Range [36400-36416].

We, Our, Us, The Company: Madison National Life Insurance Company, Inc., a Wisconsin Insurance Company.

X-ray: A type of irradiation used for imaging purposes with the image captured on photographic film including those procedures in the CPT Code Range [80000] and those procedures in the CPT Code Range [90000] other than Advanced Studies; but excluding Preventive Care.

You, Your: An Eligible Person who is covered under the Policy.

Section 2

Eligibility and Effective Dates

All persons who:

1. Are members in good standing of the Association to which the Policy is issued; and
2. Are under age [64 ½] years;

are eligible to be insured as Eligible Persons under the Policy. [Evidence of Insurability acceptable to The Company may be required.]

Insurance for Eligible Persons will take effect at 12:01 A.M., local time at the Eligible Person's resident address on the Coverage Effective Date shown in the Schedule of Benefits if:

1. An application/enrollment form is completed and received by The Company on or before said Coverage Effective Date;
2. The underwriting rules of The Company are met; and
3. The first premium is received by The Company on or before the Coverage Effective Date.

A Dependent is eligible for coverage under the Policy upon meeting the definition of Dependent [and meeting [all] of the following requirements:]

1. [The Dependent is insurable pursuant to Our then current underwriting guidelines; and]
2. [The Eligible Person must be insured in order for his or her Dependents to be eligible for coverage.]

Insurance for Dependents will take effect on the date on which We approve the Eligible Person's written request for Dependent coverage and the applicable premium is paid.

Dependents Acquired After the Eligible Person's Coverage Effective Date

A newborn Child of an Eligible Person will become insured automatically on the day he or she is born as long as the Eligible Person's coverage is in force on that date. Coverage of the newborn Child includes prematurity, congenital defects and birth abnormalities. Coverage for the newborn Child will not continue past the 31-day period following birth unless:

1. The Company is notified by the end of that 31-day period of the Eligible Person's intent to add the newborn Child; and
2. Any applicable additional premium is paid.

An adopted Child or a Child placed for adoption who has not attained 18 years of age, will become insured automatically as of the date of adoption or placement for adoption. Placement for adoption means the assumption and retention by a person of the legal obligation for total or partial support of a Child in anticipation of the Child's adoption. Coverage for an adopted Child or Child placed for adoption will not continue past the 31-day period following adoption or placement for adoption unless:

1. The Company is notified by the end of the 31-day period the Eligible Persons intent to add the Child; and
2. Any applicable additional premium is paid.

A Dependent Spouse [or Domestic Partner] acquired after the Coverage Effective Date is eligible for coverage on the date of marriage to the Eligible Person [or the effective date of the Domestic Partnership]. Coverage begins on the first of the month next following Our receipt of the enrollment form or completion of the enrollment process and premium after the date of marriage [entering into the Domestic Partnership].

A Dependent Child acquired after the Coverage Effective Date is eligible for coverage on the date of marriage of the Eligible Person and Dependent Spouse [or the effective date of the Domestic Partnership]. Coverage begins on the first day of the month next following Our receipt of the enrollment form or completion of the enrollment process and premium after the date of marriage [or Domestic Partnership].

Section 3

Benefit Provisions

All Covered Benefits must be as a result of a non-occupational Illness or Injury while covered under the Policy. All Covered Benefits must be Medically Necessary due to Injury or Illness, [except Benefits under [Preventive Care Indemnity Benefit] [and Infant Wellness Indemnity Benefit] if such Benefits are included on the Schedule of Benefits].

[The following Benefits may be subject to specific Benefit maximums or limitations, as specified in the Schedule of Benefits. It is important that the Covered Person reviews the Schedule of Benefits for the Benefit's maximums or limitations.]

[Outpatient Doctor Office Visit Indemnity Benefit

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Outpatient Doctor Office Visit Indemnity Benefit, as shown in the Schedule of Benefits, when a Covered Person has a Doctor Office visit, [not to exceed the maximum [Benefit and maximum] number of office visits per Calendar Year, as shown in the Schedule of Benefits]. [Visits for [Preventive Care,] [Mental Illness Disorders,] [Substance Abuse] [and] [Pregnancy] are not covered under this Benefit.]]

[Outpatient Diagnostic [Lab] Testing, X-Ray and [Venipuncture] Indemnity Benefit

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Outpatient Diagnostic [Lab] Testing, X-Ray and [Venipuncture] Indemnity Benefit, as shown in the Schedule of Benefits, when a Covered Person has diagnostic X-ray or laboratory tests [or Venipuncture] ordered by a Doctor to treat a covered Illness or Injury. [This Benefit is limited to one procedure per day, [not to exceed the maximum [Benefit and maximum] number of procedures per Calendar Year, as shown in the Schedule of Benefits.] Coverage is limited to procedures performed because of a Covered Person's Illness or Injury.

This Benefit will not be paid if a Covered Person is confined in a Hospital.]

[Outpatient Diagnostic Advanced Study/Studies Indemnity Benefit

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Advanced Studies Benefit as shown in the Schedule of Benefits, when a Covered Person has an Outpatient Advanced Study. [Benefits will not exceed the maximum [Benefit and maximum] number of Advanced Studies per Calendar Year, as shown in the Schedule of Benefits.] Preventive Care Advanced Studies are not covered under this Benefit.

Benefits will be paid only if:

1. A Covered Person is not confined in a Hospital; and
2. Advanced Studies are ordered or performed by a Doctor.]

[Outpatient Venipuncture Surgical Indemnity Benefit

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Outpatient Venipuncture Benefit as specified in the Schedule of Benefits, when a Covered Person has Outpatient Venipuncture. [Benefits will not exceed the

maximum [Benefit and maximum] number of procedures per Calendar Year, as shown on the Schedule of Benefits.]

[If two or more Surgical procedures are done at the same time and in the same Surgical session, the total Benefit will not exceed the Benefit shown in the Schedule of Benefits.]]

[[Outpatient Minor] and [Outpatient Venipuncture] Surgical Indemnity Benefit

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the [Outpatient Minor] and [Outpatient Venipuncture Benefit] as specified in the Schedule of Benefits, when a Covered Person has [Outpatient Minor Surgery] [or] [Outpatient Venipuncture] performed. [Benefits will not exceed the maximum [Benefit and maximum] number of procedures per Calendar Year, as shown on the Schedule of Benefits.]

If two or more Surgical procedures are done at the same time and in the same Surgical session, the total Benefit will not exceed the Benefit shown in the Schedule of Benefits.]

[Dentistry or oral surgery is not covered under this Benefit except for:

1. Excision of impacted third molars;
2. Closed or open reduction of fractures or dislocation of the jaw.]]

[Preventive Care Indemnity Benefit:

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Preventive Care Benefit shown in the Schedule of Benefits, for a Covered Person for the following Preventive Care services provided by a Doctor:

1. Well baby and Child care visits (for Covered Persons ages [18] and under):
 - a. Routine examinations and medical history, including development assessment and anticipatory guidance;
 - b. Routine immunizations;
 - c. One hearing screening from birth to age one; and
 - d. One vision screening per Calendar Year.
2. Well adult care visits (for Covered Persons ages [19] and over):
 - a. One routine physical examination per Calendar Year;
 - b. Routine gynecological care, including cytologic screening;
 - c. Routine Immunizations; and
 - d. One vision screening per Calendar Year.
3. The following tests are covered when ordered in connection with a routine examination: [Blood test for triglycerides,] [Bone marrow testing,] [Breast ultrasound,] [CA 15-3 (blood test for breast cancer),] [CA 125 (blood test for ovarian cancer),] [CEA (blood test for colon cancer),] [Chest X-ray,] [Colonoscopy or virtual colonoscopy,] [Fasting blood glucose test,] [Flexible sigmoidoscopy,] [Hemocult stool analysis,] [Mammography,] [PSA (blood test for prostate cancer),] [Pap smear or Thin Prep Pap Test,] [Serum Protein Electrophoresis (blood test for myeloma),] [Stress test on a bicycle or treadmill].

[This Benefit will not exceed the maximum [Benefit and maximum] number of [visits] [and] [tests] per Covered Person per Calendar Year, as shown in the Schedule of Benefits.] [Only one [visit] [and] one [test] per day is a Covered Benefit under the Policy.]

[One visit includes a well baby and Child care visit or a well adult visit and all tests performed on the same day.]

[Visits and tests that are Covered Benefits under this Preventive Care Indemnity Benefit are not payable under any other Benefit in the Policy.]]

[Infant Wellness Indemnity Benefit:

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Infant Wellness Indemnity Benefit amount shown in the Schedule of Benefits, for routine health examinations and immunizations for a covered Dependent Child under age [1] [limited to one Doctor visit per day] [not to exceed the maximum [Benefit and maximum] number of visits per Calendar Year, as shown on the Schedule of Benefits].

[Services that are Covered Benefits under this Infant Wellness Indemnity Benefit are not payable under any other Benefit in the Policy.]

[[Urgent Care Facility] [or] [Hospital Emergency Room Visit] Indemnity Benefit:

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the [Urgent Care Facility] [or] [Hospital Emergency Room] Benefit shown in the Schedule of Benefits, when a Covered Person has an [Urgent Care Facility] [or] an Emergency Room Visit while covered under the Policy. Services must be Medically Necessary, provided on an Emergency basis and the Illness or Injury must not result in an Inpatient confinement.

[This Benefit will not exceed the maximum [Benefit and maximum] number of visits per Covered Person per Calendar Year, as shown in the Schedule of Benefits.]

The [Urgent Care Facility Visit] [or] [Hospital Emergency Room Visit] must occur within [72] hours from the time the Injury or Illness was first manifested.]]

[Ambulance Indemnity Benefit

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Ambulance Indemnity Benefit shown in the Schedule of Benefits, when a Covered Person has a conveyance in an Ambulance that is Medically Necessary and is provided on an Emergency basis while covered under the Policy.

[This Benefit will not exceed the maximum [Benefit and maximum] number of conveyances per Covered Person per Calendar Year, as shown in the Schedule of Benefits.]]

[First Day Hospital Confinement Indemnity Benefit

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the first day Benefit shown in the Schedule of Benefits, when a Covered Person is admitted to a Hospital as an Inpatient.

The Hospital Confinement Benefit - will be paid only if:

1. The Covered Person is confined in a Hospital as an Inpatient;
2. The confinement is Medically Necessary;
3. A charge is made for room and board; and
4. The Hospital confinement is recommended and approved by a Doctor; and
5. The Covered Person is not admitted as a newborn Child.

[This Benefit will not exceed the maximum [Benefit and maximum] number of confinements per Covered Person per Calendar Year, as shown in the Schedule of Benefits.]

We will pay the Benefit specified in the Schedule of Benefits for each first day Hospital Confinement. However, the Benefit provided is only payable once for the first day and only once per Confinement. If a Covered Person is later confined to a Hospital because of the same or related Illness or Injury, We will not pay this Benefit again.]

[Daily Hospital Confinement Indemnity Benefit

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Daily Hospital Confinement Indemnity Benefit shown in the Schedule of Benefits, when a Covered Person is confined in a Hospital as an Inpatient.

We will pay the Daily Hospital Confinement Benefit specified in the Schedule of Benefits for each day of such Hospital confinement. [This Benefit will not exceed the maximum [Benefit and maximum] number of days per confinement [and maximum number of confinements] per Covered Person per Calendar Year, as shown in the Schedule of Benefits.]

Daily Hospital Daily Indemnity Benefits will be paid only if:

1. A Covered Person is confined in a Hospital as an Inpatient;
2. The confinement is Medically Necessary; and
3. The entire duration of such Hospital confinement is recommended and approved by a Doctor.]

[[Intensive Care Unit] [or] [Cardiac Care Unit] [or] [Burn Unit] [or] [Other Specialized Care Unit] Daily Indemnity Benefit

(Applicable only if this Benefit and the Daily Hospital Confinement [and] [Skilled Nursing Facility Confinement] Indemnity Benefit are included on the Schedule of Benefits.)

The Company will pay the [Intensive Care Unit] [or] [Cardiac Care Unit Daily] [or] [Other Specialized Care Unit] Benefit shown in the Schedule of Benefits, when a Covered Person is confined in an [Intensive Care Unit] [or] [Cardiac Care Unit] [or] [Other Specialized Care Unit], while covered under the Policy.

We will pay the daily Benefit specified in the Schedule of Benefits for each day of such [Intensive Care Unit] [or] [Cardiac Care Unit] [or] [Burn Unit] [or] [Specialized Care Unit] confinement. [This Benefit will not exceed the maximum [Benefit and maximum] number of days per confinement [and the maximum number of confinements] per Covered Person per Calendar Year, as shown in the Schedule of Benefits.]

[Intensive Care Unit] [or] [Cardiac Care Unit] [or] [Burn Unit] [or] [Specialized Care Unit] Indemnity Benefits will be paid only if:

1. A Covered Person is confined in a [Intensive Care Unit] or [Cardiac Care Unit] [or Burn Unit] [or Specialized Care Unit] as an Inpatient;
2. The confinement is Medically Necessary;
3. A charge is made for room and board; and
4. The entire duration of such Hospital or Skilled Nursing Facility confinement is recommended and approved by a Doctor.

[This Benefit is paid in addition to the Daily Hospital Confinement Indemnity Benefit.]

[[Skilled Nursing Facility] [or] [Hospice] Indemnity Benefit

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the [Skilled Nursing Facility Confinement] [or] [Hospice] Daily Indemnity Benefit shown in the Schedule of Benefits, when a Covered Person is confined in a [Skilled Nursing Facility Confinement] [or] [Hospice] as an Inpatient [or Outpatient Hospice Care Services].

We will pay the daily Benefit specified in the Schedule of Benefits for each day of such [Skilled Nursing Facility Confinement] [or] [Hospice] confinement [or Outpatient Hospice Care Services]. [This Benefit will not exceed the maximum [Benefit and maximum] number of days [and maximum number of confinements] per Covered Person per Calendar Year, as shown in the Schedule of Benefits.]

[Skilled Nursing Facility Confinement] [or] [Hospice] Daily Indemnity Benefits will be paid only if:

1. A Covered Person is confined in a [Skilled Nursing Facility] [or] [Hospice] as an Inpatient [or receiving Hospice Care Services on an Outpatient basis];
2. The confinement [or Hospice Care Services] is Medically Necessary; and
3. The entire duration of such [Skilled Nursing Facility Confinement] [or] [Hospice] confinement [or Outpatient Hospice Care Services] is recommended and approved by a Doctor.

[Benefits are payable for [Skilled Nursing Facility] [or] [Hospice] only if it follows a covered Inpatient Hospital Confinement of at least [3] consecutive days.]

[Miscellaneous Hospital Services Indemnity Benefit

(Applicable only if this Benefit and the Daily Hospital Confinement [and] [Skilled Nursing Facility Confinement] Daily Indemnity Benefit are included on the Schedule of Benefits.)

The Company will pay the Miscellaneous Hospital Services Benefit shown in the Schedule of Benefits, when a Covered Person has miscellaneous Hospital Services such as Lab work, blood tests, X-rays, diagnostic studies, medication, crutches, bandages and other services supplied while confined.

Covered Benefits begin on day [1] of a Hospital confinement for a maximum Benefit of [10] days. [This Benefit is payable in addition to the [Daily Hospital Confinement Indemnity Benefit] [and] [Skilled Nursing Facility Confinement Indemnity Benefit] [and] [Anesthesia] Indemnity Benefit.]

[This Benefit will not exceed the maximum [Benefit and maximum] number of days of confinement per Covered Person per Calendar Year, as shown in the Schedule of Benefits.]

[Pregnancy Indemnity Benefit

(Applicable only if this Benefit is included on the Schedule of Benefits.)

[Subject to the Pregnancy Waiting Period as shown in the Schedule of Benefits], The Company will pay the Pregnancy Indemnity Benefit shown in the Schedule of Benefits following the delivery of a newborn Child by an Eligible Person or the Eligible Person's covered Dependent Spouse.

This Benefit is paid only once per Pregnancy. [Benefits for the Pregnancy are not payable under any other Benefit of the Policy.] [This Benefit will not exceed the maximum Benefit per Pregnancy, as shown in the Schedule of Benefits.]

[[Subject to the Pregnancy Waiting Period,] Pregnancy is paid the same as any other Covered Illness.]]

[Anesthesia Indemnity Benefit

(Applicable only if this Benefit and the [Inpatient] [Outpatient] and [Outpatient Minor] and [Venipuncture] Surgical Indemnity Benefit are included on the Schedule of Benefits.)

The Company will pay the Benefit shown in the Schedule of Benefits, for anesthesia when Surgery is performed and Benefits are paid under the [Inpatient], [Outpatient] [and] [Outpatient Minor] [and] [Outpatient Venipuncture] Surgical Indemnity Benefit. [The Anesthesia Indemnity Benefit will equal [20%-30%] of the amount paid under the [Inpatient], [Outpatient], [Outpatient Minor] [and] [Outpatient Venipuncture] Surgical Indemnity Benefit.] [This Benefit will not exceed the maximum [Benefit and maximum] number of [Inpatient] [and] [Outpatient] Surgeries per Calendar Year, as shown in the Schedule of Benefits.]

[Durable Medical Equipment Indemnity Benefit

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Benefit shown in the Schedule of Benefits, when a Covered Person purchases Durable Medical Equipment if ordered by a Doctor. Examples of covered Durable

Medical Equipment items include: canes, crutches, walkers, wheelchairs, respiratory equipment, splints, nebulizers, neck braces, and slings.

This Benefit does not include rental of Durable Medical Equipment.

[This Benefit will not exceed the maximum number of Durable Medical Equipment items purchased per Calendar Year, as shown in the Schedule of Benefits.]]

[Inpatient Mental Illness Disorders Indemnity Benefit

(Applicable only if this Benefit is included in the Schedule of Benefits.)

The Company will pay the Inpatient Mental Illness Disorders Benefit shown in the Schedule of Benefits when a Covered Person is confined as an Inpatient in a Hospital or licensed institution that provides treatment for Mental Illness Disorders.

[This Benefit will not exceed the maximum [Benefit and maximum] number of days of confinement [and maximum number of confinements] per Covered Person per Calendar Year, as shown in the Schedule of Benefits.]]

[Outpatient Mental Illness Disorders Indemnity Benefit

(Applicable only if this Benefit is included in the Schedule of Benefits.)

The Company will pay the Outpatient Mental Illness Disorders Indemnity Benefit, shown in the Schedule of Benefits, when a Covered Person receives Outpatient treatment for a Mental Illness Disorder.

[This Benefit will not exceed the maximum [Benefit and maximum] number of visits per Covered Person per Calendar Year, as shown in the Schedule of Benefits.]

We will not pay any Benefit for treatment received in a facility that is not a licensed facility offering treatment for Mental Illness Disorders.]

[Inpatient Substance Abuse Indemnity Benefit

(Applicable only if this Benefit is included in the Schedule of Benefits.)

The Company will pay the Inpatient Substance Abuse Indemnity Benefit, shown in the Schedule of Benefits when a Covered Person receives services as an Inpatient provided in facilities which are accredited by the joint commission on accreditation of Hospitals as alcoholism, Substance Abuse or chemical dependence treatment programs, for the treatment of Substance Abuse.

This Benefit includes Inpatient detoxification services as a consequence of Substance Abuse.

[This Benefit will not exceed the maximum [Benefit and maximum] number of days of confinement [and maximum number of confinements] per Covered Person per Calendar Year, as shown in the Schedule of Benefits.]]

[Outpatient Substance Abuse Indemnity Benefit

(Applicable only if this Benefit is included in the Schedule of Benefits.)

The Company will pay the Outpatient Substance Abuse Disorders Benefit shown in the Schedule of Benefits when a Covered Person receives Outpatient treatment for Substance Abuse.

We will not pay this Benefit for treatment received in a facility that is not a licensed facility offering treatment of Substance Abuse.

[This Benefit will not exceed the maximum [Benefit and maximum] number of visits per Covered Person per Calendar Year, as shown in the Schedule of Benefits.]]

[Outpatient Physical Therapy Indemnity Benefit

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Physical Therapy Indemnity Benefit when a Covered Person has Physical Therapy ordered by a Doctor.

[This Benefit will not exceed the maximum [Benefit and maximum] number of visits per Covered Person per Calendar Year, as shown in the Schedule of Benefits.]

This Benefit does not include Occupational Therapy or Speech Therapy.]

[Outpatient Prescription Medication Indemnity Benefit]

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Indemnity Benefit specified in the Schedule of Benefits for Prescription Medication.

[Outpatient Prescription Medications are separated into [one] [two] [three] categories:

[Generic Medication: Prescription Medications that are chemically and therapeutically equivalent to Brand name Prescription Medications in the same class but are not protected by a patent. The FDA approves Generic Prescription Medication as bioequivalent- meaning they perform in Your body the same as a Formulary Brand and/or Non-Formulary Brand Prescription Medication. These Prescription Medications are generally less costly than their Brand-name counterparts.]

[Formulary Brand Drugs: Brand-name Prescription Medications that have been determined to be superior or equal to Non-Formulary Brand Prescription Medication, but are more cost effective]

[Non-Formulary Brand Drugs: Brand-name Prescription Medications that have a more cost-effective therapeutic alternative.]

[Refer to Your Schedule of Benefits for the Benefit level of each category.]

Excluded Drugs

The following Outpatient Prescription Medications will not be covered under this Benefit:

1. Over-the-Counter medications, supplies or products; or
2. Medications or other agents to increase or enhance fertility or the likelihood of conception; or
3. Medications for the treatment of erectile dysfunction or to assist in or enhance sexual performance; or
4. Vitamins and or nutritional supplements; *provided however*, pre-natal vitamins will be covered;
5. Medications to eliminate or reduce a dependency or an addiction to tobacco including, but no limited to, the cessation or termination of cigarette, cigar, or tobacco smoking or the use of smokeless tobacco, including nicotine products, gums and transdermal patches;
6. Medications for the treatment of hair loss or for the purpose of regrowing lost hair, such as Rogaine, Minoxidil;
7. Immunization agents, biological sera, blood or blood plasma;
8. Experimental or Investigational Medication;
9. Medications covered under Workers' Compensation;
10. Medications for the treatment or obesity or diet control;
11. Medications taken, prescribed or administered while an Inpatient at a Hospital, Rest Home, Sanitarium, Skilled Nursing Facility, Convalescent Hospital, Nursing Home or similar institution which operates a facility for dispensing Drugs;
12. Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use;
13. Homeopathic medications; or
14. Any medication purchased outside the United States of America.

[This Benefit will not exceed the maximum [Benefit and maximum] number of Prescription Medications per Covered Person per Calendar Year, as shown in the Schedule of Benefits.]]

[Accident Indemnity Benefit

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Accident Indemnity Benefit shown in the Schedule of Benefits when a Covered Person has an Accidental Bodily Injury and Benefits are payable under the Policy as a result of such Accidental Bodily Injury under any other Benefit.

[This Benefit will not exceed the maximum [Benefit and maximum] number of Accidental Bodily Injuries per Covered Person per Calendar Year, as shown in the Schedule of Benefits.]]

[[Inpatient] [or] [Outpatient] Surgical Indemnity Benefit

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Surgical Indemnity Benefit shown in the Schedule of Benefits, when a Covered Person has [Inpatient] [or], [Outpatient] Surgery.

If two or more Surgical procedures are done at the same time and in the same Surgical session, the total Covered Benefit will not exceed the Benefit shown in the Schedule of Benefits.

[This Benefit will not exceed the maximum [Benefit and maximum] number of [Inpatient and Outpatient] Surgeries per Calendar Year, as shown in the Schedule of Benefits.]

No Benefit will be paid for dentistry or oral surgery except:

1. Excision of impacted third molars;
2. Closed or open reduction of fractures or dislocation of the jaw.]

[[Outpatient] Surgical Indemnity Benefit

(Applicable only if this Benefit is included on the Schedule of Benefits.)

The Company will pay the Surgical Indemnity Benefit shown in the Schedule of Benefits, when a Covered Person has [Outpatient] Surgery.

If two or more Surgical procedures are done at the same time and in the same Surgical session, the total Covered Benefit will not exceed the Benefit shown in the Schedule of Benefits.

[This Benefit will not exceed the maximum [Benefit and maximum] number of [Outpatient] Surgeries per Calendar Year, as shown in the Schedule of Benefits.]

No Benefit will be paid for dentistry or oral surgery except:

1. Excision of impacted third molars;
2. Closed or open reduction of fractures or dislocation of the jaw.]

**[SCHEDULE OF SURGICAL [INPATIENT] [AND] [OUTPATIENT] INDEMNITY BENEFITS
SCHEDULE OF SURGICAL INDEMNITY BENEFITS**

[Benefit is based on the Payment Factor shown below times the Surgical Procedure Units, as shown in the
Schedule of Benefits]

Procedure	Payment Factor
[1. ABDOMINAL SURGERY	
[Abdomen, paracentesis	[10-20]]
[Herniotomy, single, inguinal, femoral or umbilical	[45-90]]
[Herniotomy, hiatus or diaphragmatic	[120-240]]
[Herniotomy, ventral or incisional	[65-130]]
[Esophageal diverticulum	[90-180]]
[Gastrotomy or gastrostomy	[100-200]]
[Gastrectomy, total	[150-300]]
[Gastro-enterostomy	[135-270]]
[Peptic ulcer, perforated, closure	[75-150]]
[Peptic ulcer, subtotal gastrectomy	[125-250]]
[Pyloric stenosis (Ramstedt's in infant)	[55-110]]
[Intestines anastomosis	[80-160]]
[Intestines (small) resection	[95-190]]
[Laparotomy	[80-160]]
[Colon, resection	[140-280]]
[Colonoscopy	[40-80]]
[Colostomy	[95-190]]
[Appendectomy	[60-120]]
[Diverticulum intestinal (Meckel's)	[70-140]]
[Common duct with or without Cholecystectomy	[105-210]]
[Appendiceal, abscess, drainage	[60-120]]
[Subdiaphragmatic abscess	[70-140]]
[Cholecystectomy	[75-150]]
[Cholecystoduodenostomy	[110-220]]
[Pancreas Drainage	[95-190]]
[Splenectomy	[85-170]]
[2. OPHTHALMOLOGY	
[Foreign body removal within anterior or posterior chamber	[90-180]]
[Cornea, paracentesis	[15-30]]
[Conjunctival suture	[30-60]]
[Conjunctival flap for corneal ulcer, etc.	[60-120]]
[Chalazion (excision) Simple	[10-20]]
[Chalazion (excision) Multiple	[15-30]]
[Lacrimal sac, plastic	[50-100]]
[Entropion or ectropion or ectropion, Zeigler's puncture	[50-100]]
[Entropion or ectropion, plastic operation	[30-60]]
[Entropion or ectropion, plastic operation graphs of flaps	[45-90]]
[Symblepharon, release	[25-50]]
[Pterygium	[40-80]]
[Corneal ulcer cauterization	[35-70]]
[Tarsorrhaphy, orbicularis paralysis	[55-110]]
[Ptosis (single)	[55-110]]
[Strabismus, one or more muscles	[55-110]]
[Cataract, needling	[40-80]]
[Cataract, removal	[95-190]]

[Iridectomy	[75-150]]
[Removal foreign body of cornea	[5-10]]
[Glaucoma, filtration operation	[75-150]]
[Enucleation or evisceration	[65-130]]
[Enucleation with implant	[65-130]]
[Tumor, exenteration of orbit	[120-240]]
[Dacryosystorhinostomy	[70-140]]
[Detached retina	[120-240]]

[3. ORTHOPEDIC

[Spinal fusion	[145-290]]
[Cartilage of condyle of femur removal	[110-220]]
[Bone plate removal	[40-80]]
[Talipes metatarsus vargus, calcaneus valgus, eqinovarus	[5-10]]
[Semilunar cartilage removal from joint	[70-140]]
[Tenotomy simple open	[75-150]]
[Tenotomy simple Closed	[45-90]]
[Claw foot, except bone surgery (see foot stabilization)	[45-90]]
[Coccyx, excision	[55-110]]
[Arthrotomy, any major joint	[80-160]]
[Hallux valgus radical operation	[70-140]]
[Exostosectomy	[45-90]]
[Osteomyelitis, sequestrum removal	[85-170]]
[Foot stabilization	[25-50]]
[Hammer toe, operation	[45-90]]
[Arthrodisis of knee, hip, shoulder, or elbow	[135-270]]
[Torticollis, operation	[65-130]]
[Arthorplasty, any major joint	[140-280]]
[Hip joint, resection	[130-260]]
[Any major joint resection	[100-200]]
[Any joint resection of fingers or toes	[40-80]]

[4. AMPUTATIONS

[Upper Arm	[85-170]]
[Forearm	[90-180]]
[Hand	[75-150]]
[Finger, single	[80-160]]
[Hip	[150-300]]
[Thigh	[100-200]]
[Knee	[90-180]]
[Leg	[95-190]]
[Toe	[55-110]]
[Foot	[70-140]]
[Scapulothoracic amputation	[145-290]]

5. [DISLOCATIONS

[Carpal bone, one	[50-100]]
[Clavicle	[65-130]]
[Elbow	[35-70]]
[Finger, one	[25-50]]
[Hip	[105-110]]
[Knee	[85-170]]
[Mandible	[80-160]]
[Metacarpal bone, one	[65-130]]
[Metatarsal bone, one	[45-90]]

[Patella	[95-190]]
[Shoulder	[40-80]]
[Tarsal bone, one	[35-70]]
[Thumb	[55-110]]
[Toe, one	[30-60]]
[Vertebra, one or more	[75-150]]

[6. SIMPLE FRACTURES

[Lower jaw	[70-140]]
[Carpal bone, one	[40-80]]
[Clavicle	[30-60]]
[Coccyx	[15-30]]
[Femur	[135-270]]
[Tibia or fibula or both	[60-120]]
[Pott's or Cotton's fracture	[45-90]]
[Finger, one simple	[50-100]]
[Finger, Extension with traction	[25-50]]
[Humerus	[85-170]]
[Metacarpal bone, one	[50-100]]
[Metatarsal bone, one	[35-70]]
[Patella, closed	[25-50]]
[Nasal bone or bones, reduced	[15-30]]
[Pelvis	[115-230]]
[Radius of ulna, or bone	[65-130]]
[Rib, one or more	[10-20]]
[Sacrum	[35-70]]
[Skull	[75-150]]
[Sternum	[75-150]]
[Tarsal bone, one (exclude os calcis and astragalus)	[30-60]]
[Toe, one	[25-50]]
[Vertebra, one or more	[135-270]]
[Oscalsis or astragalus, or both	[60-120]]

[7. COMPOUND FRACTURES

Simple

[Two-three] times

Fracture Payment
Factor, not to Exceed
[\$150-300]]

[8. SKULL

[Simple fracture (non-operable) with brain Injury	[5-10]]
[Depressed	[75-150]]
[Compound	[115-230]]
[Brain Tumors	[150-300]]

9. [INFECTIONS AND TRAUMATA

[Abscess incision and drainage	[5-10]]
[Carbuncle	[5-10]]
[Ulcer, surface, excision	[85-170]]
[Tendon, repair, one	[85-170]]
[Tendon, repair, each additional	[85-170]]
[Septic finger, hand (tendon sheath involvement)	[60-120]]
[Lacerations, extensive	[25-50]]
[Lacerations, minor	[10-20]]

10. [CYSTS

[Removal of ganglion cyst	[35-70]]
[Pilonidal cyst or sinus	[20-40]]
[Thyroglossal cyst, removal	[50-100]]
[Branchial cyst, removal	[30-60]]]

11. [TUMORS

[Tumors, benign external removal	[20-40]]
[Tumors, benign removal	[40-80]]
[Parotid tumor, removal	[100-200]]
[Epithelioma of face, surgical removal	[50-100]]
[Cancer of tongue (resection or removal)	[85-170]]
[Cancer of lip (local operation)	[65-130]]
[Cancer of lip same with neck dissection	[150-300]]]

[12. [BIOPSY

[Biopsy, superficial	[5-10]]
[Biopsy, bone, or bone marrow	[30-60]]]

13. [GLANDS

[Glands, superficial, removal	[20-40]]
[Dissection glands	[125-150]]
[Radical axilla or groin	[70-140]]]

14. [THYROID

[Thyroidectomy	[75-150]]
[Thyroidectomy, two-stage, subtotal (with or without ligation) complete procedure	[100-200]]
[Parathyroidectomy	[110-220]]]

15. [OBSTETRICS

[Pregnancy, delivery (does not include prenatal and postnatal care)	[90-180]]
[Miscarriage (curretage)	[25-50]]
[Caesarean section, vaginal, abdominal	[105-110]]
[Pregnancy, ectopic	[80-160]]]

16. [PROCTOLOGY

[Hemorrhoids, injections, each	[10-20]]
[Hemorrhoids, external, single, thrombosis, incision	[10-20]]
[Complete Hemorrhoidectomy	[30-60]]
[Fistulectomy, single, excision of tract	[45-90]]
[Fissurectomy, office, Hospital	[25-50]]
[Abscess, ischio-rectal or peri-rectal drainage	[35-70]]
[Carcinoma of rectum resection	[85-170]]
[Propapsed rectum, repair or injection	[45-90]]]

[17. UROLOGY

[Circumcision, infant not requiring anesthesia	[15-30]]
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[Circumcision, other	[15-30]]
[Ureterotomy	[105-210]]
[Prostatic abscess	[55-110]]
[Prostatectomy, perineal	[115-230]]
[Prostatectomy, Radical	[150-300]]
[Prostatectomy suprapubic including vasectomy	[100-200]]
[Prostatectomy, transurethral	[60-120]]
[Punch operation with suprapubic drainage	[10-20]]
[Perineoplasty with urethral repair	[30-60]]
[Hydrocele, radical operation	[40-80]]
[Litholapaxy	[40-80]]
[Epididymectomy	[45-90]]
[Vasectomy (when no preliminary to prostatectomy)	[25-50]]

18. [GYNECOLOGY

[Bartholin's gland, incision	[10-20]]
[Bartholin's gland, excision	[25-50]]
[Fistula recto-vaginal	[90-180]]
[Fistula vesico-vaginal	[90-180]]
[Cul-de-sac, drainage	[20-40]]
[Cauterization, electric	[15-40]]
[Dilation and curettage with or without cauterization	[25-50]]
[Uterine polyp removal with dilation and curettage	[30-60]]
[Cervical polyp removal	[5-10]]
[Trachelorrhaphy	[30-60]]
[Cervix amputation	[35-70]]
[Oophorectomy or resection of ovaries	[50-100]]
[Hysterectomy (subtotal)	[125-150]]
[Hysterectomy (total)	[100-200]]
[Myomectomy	[95-190]]
[Uterine flexions, etc., correction (plus surgery of tubes and ovaries)	[45-90]]
[Uterine flexions, with vaginal plastic work	[90-180]]
[Salpingectomy	[45-90]]
[Tubal ligation (independent procedure)	[30-60]]
[Salpingo-oophorectomy	[75-150]]
[Cystocele	[45-90]]
[Rectocele	[55-110]]
[Vulvectomy	[115-130]]
[Vulvectomy with groin dissection	[150-300]]

[19. PRELIMINARY ENDOSCOPY

[Bronchoscopy, diagnostic, preceding surgery	[20-40]]
[Bronchoscopy, Operative	[35-70]]
[Cystoscopy, observation	[10-20]]
[Cystoscopy Ureteral catheterization	[15-30]]
[Cystoscopy Operative	[30-60]]
[Gastroscopy	[15-30]]
[Gastroscopy Operative	[25-50]]
[Laryngoscopy, diagnostic (by Laryngoscopy)	[10-20]]
[Laryngoscopy, Operative	[30-60]]
[Sigmoidoscopy and biopsy	[10-20]]
[Esophagoscopy	[15-30]]
[Vesiculectomy	[75-150]]
[Variocoelectomy	[40-80]]
[Orchidectomy, simple	[40-80]]

[Orchidectomy, bilateral, with gland dissection	[65-130]]
[Cystotomy or cystostomy	[85-170]]
[Cystostomy with fulguration	[50-100]]
[Cystectomy	[150-300]]
[Ureter transplantation, single	[105-210]]
[Bladder tumor, diverticula, etc, (resection) open operation	[55-110]]
[Urethra-lithotomy	[65-130]]
[Nephrotomy	[105-210]]
[Nephrostomy	[50-100]]
[Nephrectomy	[145-290]]
[Nephropexy	[125-250]]
[Plastic on pelvis and ureter	[105-110]]
[Heminephrectomy	[150-300]]
[Excision and suture of urinary Fistula-suprapubic	[95-190]]
[Vaginal	[10-20]]
[Penis amputation	[70-140]]
[Penis amputation with groin dissection	[135-270]]
[Plastic hypospadias or epispadias	[90-180]]
[Meatotomy	[10-20]]
[Caruncle excision, fulguration	[20-40]]

[20. THORACIC SURGERY

[Pneumolysis	[145-290]]
[Pleura, paracentesis	[10-20]]
[Empyema, closed drainage	[30-60]]
[Empyema, rib section	[60-120]]
[Phrenic nerve crushing	[50-100]]
[Thoracoplasty (First state or partial), complete	[150-300]]
[Lobectomy	[140-280]]
[Induction of artificial pneumothorax	[10-20]]

21. [OTOLOGY (Science of the Ear)

[Aural polyp	[10-20]]
[Paracentesis, tympani	[10-20]]
[Mastoidectomy, acute single, bilateral	[100-200]]
[Mastoidectomy, radical single	[105-210]]
[Myringotomy	[10-20]]
[Fenestration for otosclerosis	[80-160]]

22. [NOSE AND THROAT

[Nasal polyps, removal	[10-20]]
[Antrum, Caldwell-Luc	[45-90]]
[Ethmoidectomy	[65-130]]
[Frontal sinus, radical	[85-170]]
[Turbinectomy	[30-60]]
[Submucous resection	[50-100]]
[Palatorrhaphy	[90-180]]
[Tonsillectomy and adenoidectomy under age 12	[30-60]]
[Tonsillectomy and adenoidectomy age 12 and over	[35-75]]
[Laryngectomy	[150-300]]
[Tracheotomy	[10-20]]
[Malignant disease accessory sinuses, radical operation, one sinus	[110-220]]
[Malignant disease, tonsil and pharynx, radical operation	[70-140]]
[Antrum puncture and irrigation	[5-10]]
[Antrum window	[25-50]]

[23. BREASTS

[Breast abscess	[25-50]]
[Breast cyst or abscess, aspiration	[5-10]]
[Breast tumor or benign, removal	[40-80]]
[Breast, radical removal, including auxiliary dissection	[110-220]]
[Breast, simple removal	[65-130]]]

24. [OPERABLE BRAIN INJURIES

[Extradural hematoma, subdural hematoma	[120-240]]
[Exploratory trephination, one and two sides	[80-160]]
[Arterio-venous fistula, intracranial	[150-300]]

Section 4

Exclusions and Limitations

The Policy does not provide any Benefits when a Covered Person has any of the following:

1. A Pre-existing Condition(s); or
2. Preventive Care which is not Medically Necessary for the treatment of Illness or Injury, [except as specified in the Preventive Care Indemnity Benefit, if shown as Included in the Schedule of Benefits]; or
3. Any treatment, service or supply which is not due to an Illness or Injury; or
4. Any treatment, service or supply which is not recommended by a Doctor; or
5. Any treatment, service or supply which is not Medically Necessary; or
6. Treatment, services or supplies for which no charge is made or for which the Covered Person is not required to pay; or
7. Any treatment, service or supply provided by a government owned or operated facility or by government employed health care providers; or
8. A weekend Hospital Confinement occurring between noon on any Friday and noon the following Sunday for non-emergency procedures, unless Medically Necessary or unless surgery is scheduled for the next day; or
9. An Illness or Injury which arises out of or in the course of any employment for wage or profit or an Illness or Injury for which the Covered Person has or had a right to recovery under any Workers' Compensation or Occupational Disease Law; or
10. Physical or psychological examinations required by any third party, such as by a court or for employment, licensing, insurance; or
11. An Illness or Injury incurred while on active duty with the military of any country or international organization; or
12. An Illness or Injury resulting from war or any act of war (declared or undeclared) or the participation in a riot or insurrection; or
13. An Illness or Injury incurred (a) during the commission or attempted commission of a crime or felony or while engaged in an illegal act; or (b) while imprisoned; or
14. An Illness or Injury incurred due to, or contracted as a consequence of a Covered Person (a) being intoxicated; or (b) being under the influence of any illegal narcotic, barbiturate, hallucinatory or other drug, unless administered by a Doctor and taken in accordance with the prescribed dosage. A Covered Person is conclusively determined to be intoxicated by drug or alcohol if a chemical test administered in the jurisdiction where the loss or cause of loss occurred is at or above the legal limit set by that jurisdiction; or
15. An Illness or Injury for which treatment, services or supplies were received or purchased outside the United States unless the charges are incurred while traveling on business or for pleasure, for a period not to exceed [90] days, and the charges are incurred for an Emergency,

- provided the treatment, services or supplies used in connection with the Emergency are approved for use in the United States; or
16. Treatment, services or supplies to improve the appearance or self-perception of a Covered Person, which does not restore a bodily function including, without limitation, cosmetic or plastic surgery, hair loss or skin wrinkling, or the complications of any such treatment; or
 17. Treatment, services or supplies for (a) breast augmentation; (b) the removal of breast implants unless Medically Necessary and related to surgery performed as reconstructive surgery due to a Sickness; and (c) breast reduction surgery unless Medically Necessary due to a Sickness; or
 18. Surgery to correct refractive errors, such as radial keratotomy or radial keratectomy; or
 19. Routine eye exams, glasses, visual therapy, or contact lenses; or
 20. Routine hearing exams to assess the need for, or change to, hearing aids; and the purchase, fittings or adjustments of hearing aids; or
 21. Penile implants and fertility and sterility studies; or
 22. Treatment, services or supplies: (a) to restore or enhance fertility; or (b) to reverse sterilization; or
 23. Impregnation techniques such as: (a) artificial insemination; or (b) in vitro fertilization; including but not limited to: artificial insemination, in vitro zygote and intra-fallopian transfers, gamete intra-fallopian transfer, and genetic counseling; or
 24. Voluntary abortion; except if the life of the mother would be in danger if the fetus were carried to term; or
 25. Mental Illness Disorders except as specified in the Inpatient or Outpatient Mental Illness Disorder Indemnity Benefits, if such Benefits are shown as Included in the Schedule of Benefits; or
 26. Substance Abuse except as specified in the Inpatient or Outpatient Substance Abuse Indemnity Benefits, if such Benefits are shown as Included in the Schedule of Benefits.
 27. Treatment, services or supplies to eliminate or reduce a dependency on or an addiction to tobacco, including but not limited to: nicotine withdrawal programs; nicotine products, such as transdermal patches and gums; hypnotism; and goal oriented behavioral modification; or
 28. Marriage or family counseling, recreational therapy, equine therapy, educational therapy, social therapy, or sex therapy; or
 29. Sexual reassignments or sexual dysfunctions or inadequacies; or
 30. Meridian therapy (acupuncture); or
 31. Treatment, services or supplies related to paring or removal of corns, calluses, bunions or toenails (other than partial or complete removal of nail roots); or
 32. Treatment, services or supplies related to the feet by means of posting or strapping, or range of motion studies; or
 33. Orthotics; or
 34. Treatment, services or supplies for obesity or weight reduction, including wiring of the teeth and all forms of intestinal bypass surgery and complications resulting from such surgery; or
 35. Treatment, services or supplies received from a Doctor or other provider if such person is: (a) a person who ordinarily resides in Your household, (b) a member of Your Immediate Family; or
 36. Custodial Care, regardless of who prescribes or renders such care; or
 37. An Illness or Injury for which treatment, services or supplies were received as a result of participation in hazardous avocations including: mountain or rock climbing, sky diving, hang gliding, motor vehicle racing, scuba diving, rodeo or private aviation, treatment therefor or complications thereof; or
 38. Telephone consultations, missed appointment fees and fees for completing claim forms; or
 39. Treatment, services or supplies for complications of conditions that are not covered under the Policy; or
 40. Prescription Medications, [except as specified in the Outpatient Prescription Medication Indemnity Benefit, if shown as Included in the Schedule of Benefits]; or
 41. Treatment, services or supplies related to: (a) the teeth; and (b) the gums other than tumors; and (c) any other associated structures; (d) the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids; and (e) dental implants, regardless of the cause; or

42. Treatment, services or supplies as the result of prognathism, retrognathism, micrognathism, or any treatment, services or supplies to reposition the maxilla (upper jaw) mandible (lower jaw), or both maxilla and mandible; or
43. Treatment, services or supplies provided for temporomandibular joint (TMJ) dysfunction; or
44. Speech and occupational therapy; or
45. [Hospice Care]; or
46. Home Health Care; or
47. Experimental or Investigational procedures, drugs or treatment methods; or
48. Experimental or Investigational organ transplant procedures; or
49. Pregnancy and related services; [except as specified in the Pregnancy Indemnity Benefit, if such Benefit is shown as Included in the Schedule of Benefits]; or
50. Intentional self-inflicted Illness or Injury while sane; except that this exclusion will not apply to any self-inflicted Illness or Injury that is the result of a medical condition; or
51. Venipuncture [except as specified in the [Inpatient] [Outpatient] [Minor Outpatient] [Venipuncture Indemnity Benefit] if such Benefit is shown as Included in the Schedule of Benefits]; or
52. Physical therapy; except as specified in the Physical Therapy Indemnity Benefit if such Benefit is shown as Included in the Schedule of Benefits.

[Limitations and Exclusions for Pre-Existing Conditions

Benefits shall not be payable for a Pre-Existing Condition as defined herein. This provision will cease to apply to any Covered Benefits incurred in connection with a Pre-Existing Condition after the Covered Person has been continuously covered under the Policy for [1-12] consecutive months.

This provision does not apply to a newborn or newly adopted Child or Child placed for adoption under the age of 18 if such Child is enrolled for coverage within 31 days from the date of birth or the date of adoption or placement for adoption.]

Section 5

Termination of Insurance

Termination of an Eligible Person's Coverage

Coverage for an Eligible Person shall automatically terminate on the earliest of the following dates:

1. The date of termination of the Policy; or
2. The last day of the month in which You are no longer a member of the Policyholder; or
3. [The last day of the month following the date You attain age [65]; or]
4. [The last day of the month You become eligible for Medicare; or]
5. The date You fail to pay the required premium; or
6. The premium due date coinciding with or next following the date after We receive Your written request to terminate Your coverage under the Policy; or
7. The date You enter the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less or as provided under the Statement of Uniform Services Employment and Reemployment Rights Act of 1994 provision; or
8. The date of Your death.

Termination of a Dependent's Coverage

Coverage for Your Dependents shall terminate on the earliest of the following dates:

1. The date of termination of the Policy; or
2. The date You fail to pay the required premium; or
3. The premium due date coinciding with or next following the date after We receive Your written request to terminate Your Dependent's coverage; or

4. The date the Dependent enters the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less or as provided under the Uniform Services Employment and Reemployment Rights Act of 1994; or
5. [With respect to Your covered Dependent Spouse, the last day of the month following the date Your Spouse attains age [65]; or]
6. [With respect to Your covered Dependent Spouse, the last day of the month Your Spouse becomes eligible for Medicare; or]
7. With respect to Your covered Dependent Spouse, the premium due date coinciding with or next following the date on which the Eligible Person is divorced or legally separated from such Spouse; or
8. [The date Your coverage under the Policy is terminated; or]
9. With respect to Your covered Dependent Child, the premium due date coinciding with or next following [the earliest of:]
 - [The date of the covered Dependent Child's marriage;]
 - The date the Covered Dependent Child attains [age 26] [age [19] [or between age [19] and age [26] if the unmarried Child is no longer dependent upon You for support and maintenance].

If a covered unmarried Dependent Child's coverage terminates upon attaining any limiting and such Dependent Child is incapable of earning his or her own living and is chiefly Dependent upon the Covered Person for support and maintenance, because of Mental or Physical Incapacity, as defined below, coverage for the Dependent Child may be continued during the continuance of such incapacity, providing that:

- a. Medical proof, in writing, of such incapacity must be given to Us within 31 days after the date on which the Dependent Child attains a limiting age;
- b. We shall have the right any time during the continuance of insurance under this provision to require due proof of the continuance of the incapacity and to have the Dependent Child examined by Doctors designated by Us at any time during the first 2 years of such continuance and not more than once each year thereafter;
- c. You continue paying the required premium for the Dependent; and
- d. The continuance described herein shall cease in the event of the occurrence of any of the circumstances described in the Termination of Dependent's Coverage above.

For the purposes of the provision, Mental or Physical Incapacity means a mental or physical impairment that results in anatomical, physiological or psychological abnormalities which are demonstrated by medically acceptable clinical, laboratory or diagnostic techniques and which are expected to last for a continuous period of time not less than 12 months in duration.

Section 6

Premiums

All premiums are payable on or before the date they are due. Premiums are payable by a mode of payment that has been selected by the Eligible Person.

The premium rates may be changed by The Company. If the rates are changed, The Company will give at least 31 days advance written notice. If an increase takes place on other than a premium due date, they will be due on the date of the increase to the next premium due date. If such premium is not paid when due, the coverage will automatically be discontinued as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

If a change in Benefits increases The Company's liability, premium rates may be changed on the date that the liability is increased.

The Company will promptly refund any unearned premium upon notification of the death of any Covered Person under this Policy. The refund of premiums will be made directly to:

1. The decedent's Spouse at the time of the decedent's death;
2. The Eligible Person, if the decedent was a covered Dependent Child; or
3. The decedent's estate, if neither (a) or (b) applies.

Grace Period

A grace period of 31 days is allowed for payment of each premium (except the first) during which coverage under the Policy shall remain in force. Coverage may terminate prior to the end of the grace period by giving Us at least 31 days advance written notice of cancellation. Failure to pay a premium within the grace period will cause coverage under the Policy to lapse as of the date for which the last premium payment has been made.

Section 7

General Provisions

Entire Contract

The entire contract is made up of: (a) the Policy; (b) the Policyholder application; and (c) any individual Eligible Person applications. No agent, Covered Person, or other individual, except Our President, Vice President, Secretary or Assistant Secretary can: (a) approve a change to the Policy; or (b) extend the time for payment of any premium. No change will be valid unless it is made: (a) by an Endorsement or Rider to the Policy; or (b) by an Amendment signed by Our President, Vice President, Secretary or Assistant Secretary. Any change made will be binding on each Covered Person and on any other individual(s) referred to in the Policy.

Contestability

In the absence of fraud, statements made by any Covered Person or the Policyholder are representations and not warranties. After a Covered Person has been covered under the Policy for 2 consecutive years, only fraudulent misstatements in the application may be used to void a Covered Person's coverage under the Policy or deny any claim for loss incurred or disability starting after the 2-year period. If a Covered Person's age was misstated, We will provide the amount of insurance for the correct age and an equitable premium adjustment will be made so that We will receive the correct premium for the true age.

Notice of Claim

Written notice of claim must be given to Us: (a) within 20 days after the date on which the claim was incurred; or (b) as soon as reasonably possible thereafter. Notice can be sent to Our authorized administrator or Our Home Office. The notice should include the Covered Person's name and policy number.

Assignments

An Eligible Person may authorize Us or Our authorized administrator to pay Benefits directly to a Doctor or other health care provider from whom he or she receives services.

Proof of Loss

Written proof of loss must be given to Us or Our authorized Administrator within 90 days of the date on which the claim was incurred. If it was not possible for proof to be given within the 90 days, We will not deny the Benefit provided proof is given as soon as reasonably possible. The date on which the claim was incurred is the date on which the services or supplies were provided. Notwithstanding the foregoing, proof must be sent no later than one year from the date on which the claim was incurred unless the Eligible Person is legally incapacitated.

Time of Payment of Claims

Benefits will be paid subject to written proof of loss. Any balance unpaid at the end of liability will be paid on receipt of written proof of loss. Benefits paid under the Policy will be paid within 30 days following the date on which Our authorized Administrator receives written proof of loss. Claims payable under the Policy are overdue if not paid within 30 days after We, or Our authorized

administrator, receive proof of loss and necessary medical information or other information required by Us essential to administer the provisions of the Policy. If such information is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within 30 days. Any part or all of the remainder of the claim that is later supported by such proof is overdue if not paid within 30 days.

Payment of Claims

Benefits will be payable to the Eligible Person [unless they are assigned to a Doctor or other health care provider.] Any notice of assignment of Benefits must be in writing and mailed to Us or Our authorized administrator. Notice of the assignment of Benefits received from a Doctor or other health care provider will be sufficient to cause Benefits to be paid to such Doctor, Hospital or other health care provider. You may revoke an assignment of Benefits at any time by providing written notice of such revocation to Us or Our authorized administrator. Any such written revocation of an assignment of Benefits shall be valid as to both You and the Doctor, Hospital or other health care provider.

Recovery of Overpayments

We reserve the right to deduct from any Benefits properly payable under this Policy the amount of any payment that has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss;
3. Pursuant to fraud or intentional misrepresentation made to obtain coverage under the Policy in the event that a loss related to the fraud or intentional misrepresentation is incurred within 2 years after the date such coverage commences;
4. With respect to an ineligible person; or
5. Pursuant to a claim for which Benefits are recoverable under any Policy or act of law providing coverage for occupational Injury or disease to the extent that such Benefits are recovered.

Such deduction may be against any claim for Benefits under the Policy made by a Covered Person if claim payments under this reservation of rights were made with respect to such Covered Person.

Conformity with Federal and State Laws

Any provision of the Policy which is in conflict with federal laws or any applicable state law, is hereby amended to meet the minimum requirements of the law.

Legal Actions

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Clerical Errors

Clerical error pertaining to the coverage of any Covered Person shall not terminate coverage otherwise validly in force nor continue coverage otherwise validly terminated. If a clerical error occurs, We or Our authorized administrator, reserves the right to make any corresponding premium adjustment which will be computed on the basis of the premium rates then in effect.

[Rescission of Coverage

We or Our authorized administrator, reserve the right to rescind insurance coverage on any Covered Person due to a Covered Person's intentional misrepresentation or fraud in the application for coverage. In the event of rescission, premiums will be refunded less any amounts paid for claims on behalf of such Covered Person.]

Waiver of Rights

If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date; nor will it affect Our right to enforce any other provision of the Policy. Any waiver of rights must be in writing and signed by Our President, Vice President Secretary or Assistant Secretary or an individual authorized by them to agree to such waiver.

Required Information

The Eligible Person agrees to provide to Us any information or data that We reasonably request for the proper administration of the Policy including; but not limited to, information pertaining to medical history, medical records, the names of all health care providers from whom Covered Persons have received treatment or services, marriage license, documentation of adoption or placement for adoption, documentation of legal custody of a Dependent, student status information, and treating provider statements.

Effective Date

No insurance under the Policy shall become effective until notice in writing is given by Us or Our authorized administrator. Issuance of a Certificate with a Schedule of Benefits will be deemed proper notification, provided premium due has been paid in accordance with the terms of the Policy.

[Subrogation/Right Of Reimbursement

As a condition to receiving Benefits under the Policy, Covered Person(s) agree to transfer to Us their right to recover damages to the extent of Benefits paid by Us when an Illness or Injury occurs through the act or omission of another person. If a Covered Person received payment from another person or entity on account of, due to, or arising out of an Illness or Injury, the Covered Person agrees to reimburse Us to the full extent of the amount paid by Us. If a repayment agreement is required to be signed, all rights of recovery are transferred to Us regardless of whether it is actually signed. It is only necessary that the Illness or Injury occur through the act or omission of another person or entity. Our rights of full recovery may be from any other person or entity, any liability or other insurance covering such other person or entity, the Covered Person's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault, workers compensation or school insurance Coverages which are paid or payable. We may enforce Our reimbursement rights by requiring the Covered Person to assert a claim to any of the foregoing Coverages to which the Covered Person may be entitled. Covered Person(s) shall provide all requested accident and insurance information to Us. We shall not be required to pay any portion of Covered Person's attorneys' fees or other costs associated with a claim/lawsuit.]

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

APPLICATION FOR GROUP INSURANCE

GROUP POLICY NUMBER [XX-XXXX]

Application is hereby made to Madison National Life Insurance Company, Inc., for Group Insurance Benefits in the Policy form attached to and made a part hereof; and if this application is accepted by Madison National Life Insurance Company, Inc., the Policy shall be issued to:

Name of Applicant: [ABC Association]

State of Delivery: [State]

To be effective 12:01 A.M. on the 1st day of [June 1, 2010].

Applicant's Signature: [Jane Doe]

Title: [President]

Date: [June 1, 2010]

MADISON NATIONAL LIFE INSURANCE COMPANY, INC., [Plan Name] LIMITED BENEFIT FIXED INDEMNITY HEALTH INSURANCE APPLICATION

Applicant's Name				I hereby request coverage under the policy issued to the group policyholder by the insurer and understand that if the coverage applied for becomes effective, I agree to all terms of the group policy.					
Date Of Birth	Age	Sex	Social Security Number	I understand that the broker who solicited this application was acting as an independent contractor and not as an agent of the Insurance Company. I further acknowledge that the person who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied, was retained by me as my agent, and that such person has no right to bind or approve coverage or alter any of the terms or conditions of the policy.					
Occupation			Telephone						
Street Address									
City			State	Zip	I understand that I am applying as an individual for membership to the [Association] and am simultaneously applying for insurance to which I am now or may become eligible for under the provisions of the Group Master Policy issued to [Association] by Madison National Life Insurance Company, Inc. I understand that my application is subject to acceptance by Madison National Life Insurance Company, Inc., or its authorized administrator. I understand that this coverage is not an employer health plan and I certify that (a) premiums are being paid by me as a personal expense and, neither my employer nor the employer of my dependents is now or in the future will be paying any part of the premium either directly or through wage adjustments or otherwise and (b) to the best of my knowledge and belief my employer has not and will not maintain, endorse or represent this health plan as an employer health insurance plan for any purpose, including a tax deduction, individuals not meeting this certification above are not eligible for this plan. I further understand that acceptance of the check submitted with this application does not constitute approval or guarantee of coverage.				
Billing Address (if different)									
City			State	Zip	I understand that this coverage is a limited benefit health insurance plan [and that no benefits will be paid for a pre-existing condition (as defined) until coverage has been in effect under the policy for [1-12] months.]				
Email Address									
COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE/[DOMESTIC PARTNER] AND/OR CHILDREN:									
Spouse's/[Domestic Partner's] Name									
Date Of Birth			Age	Sex	Signature of Applicant: _____ Date: _____				
Occupation			Social Security Number						
Child's Name									
Date Of Birth			Age	Social Security Number		[Fraud Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.]			
Child's Name									
Date Of Birth			Age	Social Security Number		[Arkansas Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]			
Child's Name									
Date Of Birth			Age	Social Security Number		[District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.]			
Child's Name									
Date Of Birth			Age	Social Security Number		[Kentucky, Ohio and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]			
Child's Name									
Date Of Birth			Age	Social Security Number		[Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]			
Child's Name									
Date Of Birth			Age	Social Security Number		[Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.]			
Child's Name									
Coverage Effective Date									
[Month: _____ Day: <input type="checkbox"/> 1 st <input type="checkbox"/> 8 th <input type="checkbox"/> 15 th <input type="checkbox"/> 22 nd				Choose Plan <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan Name]]					
<input type="checkbox"/> Any Date: _____]									
[Indicate Coverage Type									
<input type="checkbox"/> Applicant Only <input type="checkbox"/> Applicant + Child(ren) <input type="checkbox"/> Applicant + Spouse/[Domestic Partner] <input type="checkbox"/> Family (Applicant, Spouse & Child(ren))									

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
[P.O. Box 5008, Madison, WI 53705]

AMENDATORY ENDORSEMENT
(Applies to Eligible Person [and Eligible Person's Covered Dependent Spouse] only)

Notwithstanding anything in the Policy and Certificate of Insurance to the contrary, it is hereby understood and agreed that the Policy and any Certificate of Insurance to which this amendatory endorsement is attached are amended as follows:

A. **Section 3 – BENEFITS**, the following change is hereby made:

The first sentence in the first paragraph pertaining to all Covered Benefits being the result of non-occupational Illness or Injury is deleted and replaced with the following:

All Covered Benefits must be as a result of a non-occupational Illness or Injury while covered under the Policy; except that Covered Benefits may be a result of an occupational Illness or Injury of an Eligible Person [and the Eligible Person's Covered Dependent Spouse], while covered under the Policy, who is a sole proprietor, partner, or owner eligible under state law to legally elect to not be covered under Workers' Compensation and who is not insured under any Workers' Compensation Law or Occupational Disease Law. Coverage for occupational Injury or Illness of a sole proprietor, partner or owner is not intended to take the place of Workers' Compensation Insurance.

B. **Section 4 – EXCLUSIONS and LIMITATIONS**, the following change is hereby made:

Item 9 pertaining to an employment related Illness or Injury is deleted and replaced with the following:

9. An Illness or Injury which arises out of or in the course of any employment for wage or profit or an Illness or Injury for which the Eligible Person [or the Eligible Person's Covered Dependent Spouse] has or had a right to recovery under any Workers' Compensation or Occupational Disease Law. This exclusion does not apply to an employment related Injury or Illness of an Eligible Person [and the Eligible Person's Covered Dependent Spouse] who is a sole proprietor, partner, or owner eligible under state law to legally elect to not be covered under Workers' Compensation and who is not insured under, and who does not have or had a right to recovery for such employment related Injury or Illness under any Workers' Compensation Law or Occupational Disease Law;

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of its Effective Date.

Nothing in this Amendatory Endorsement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, provisions or limitations of the Policy, other than as stated above.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President



Adam C. Vandervoort
Secretary

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

[P.O. Box 5008, Madison, WI 53705]

ARKANSAS AMENDATORY ENDORSEMENT

Notwithstanding anything in the Policy and Certificate of Insurance to the contrary, it is hereby understood and agreed that the Policy and any Certificate of Insurance to which this amendatory endorsement is attached are amended for residents of Arkansas as follows:

A. **Section 1 - Definitions**, the following change is hereby made:

1. The definition of Illness is deleted and replaced with the following:

Illness:

1. A disorder or disease of the mind or body;
2. A pregnancy; or
3. TMJ.

B. **Section 2 – Eligibility and Effective Dates, Dependents Acquired After the Eligible Person’s Coverage Effective Date**, the following changes are hereby made:

1. The paragraph pertaining to A newborn Child is deleted and replaced with the following:

A newborn Child of an Eligible Person will become insured automatically from the moment of birth and coverage will remain in force for 90 days. Coverage for newborns shall be the same as for all other Dependents. 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 days.

2. The paragraph pertaining to An adopted Child or a Child placed for adoption is deleted and replaced with the following:

An adopted Child or a minor under Your charge, care and control for whom You have filed a petition to adopt, is effective upon the earlier of the date of placement for the purpose of adoption, or the date of the entry of an order granting the adoptive parent custody of the Child for purposes of adoption. Coverage for such Child will be the same as for all other Dependents. 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 placement for adoption or entry of an order and pay the required additional premium, if any, in order to have coverage for the adopted Child continue beyond such 60 day period.

C. **Section 3 – Benefit Provisions**, the following State Mandated Benefits are hereby added:

We will pay the following Arkansas state mandates as applicable to the specific Covered Benefits in this Section 3. The state mandates are subject to the terms, conditions, limitations and exclusions of the Policy. The specific Benefit must be shown as applicable on the Schedule of Benefits in order for the state mandates listed below to be Covered Benefits. The state mandates will be paid up to the maximum amount shown for the specific Policy Benefit or Benefits in the Schedule of Benefits. Benefits payable for state mandates will not exceed the Calendar Year Maximum Benefit for the number of days shown on the Schedule of Benefits.

1. Payment of anesthesia and Hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a Hospital or ambulatory surgical facility are Covered Benefits if: (1) the provider treating the Covered Person certifies that because of the Covered Person’s age or condition or problem, Hospitalization or general anesthesia is required in order to safely and effectively perform the procedures; and (2) the Covered Person is: (a) a Child under 7 years of age who is determined by two dentists to have a significantly complex dental condition; (b) a Covered Person diagnosed with a serious mental or physical condition; or (c) a Covered Person with a significant behavioral problem as determined by his or her Doctor. Such treatment does not apply to TMJ.

- D. **Section 4 – Exclusions and Limitations**, item 43 pertaining to TMJ is deleted in its entirety.
- E. **Section 5 – Termination of Insurance, Termination of a Dependent’s Coverage**, item 9. a., pertaining to medical proof is deleted and replaced with the following:
- a. Medical proof, in writing, of such incapacity must be given to Us after the date on which the Dependent Child attains a limiting age.
- F. **Section 7 – General Provisions**, the following changes are hereby made:
1. **Time of Payment of Claims, Clean Claim** is added:

We will pay, deny or settle all benefits due for Clean Claims within 30 calendar days after receipt of proof of loss submitted electronically or within 45 days by any other method.

If the resolution of a claim requires additional information, We will, within 30 calendar days after receipt of the claim, give the Covered Person a full explanation of what additional information is needed. If the Covered Person and the provider have provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled within 30 calendar days after receipt.

If We fail to pay, settle or deny a clean claim or take other required actions within 30 or 45 calendar days (excluding the time waiting for additional information), We will pay interest at the rate of 12% annually on the amount ultimately allowed on the claim, accruing from the date payment was due.

For the purpose of this provision, the following definition has been added:

Clean Claim means a claim that is submitted on a HCFA 1500 or on a UB92, in a format required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or on the Plan's standard claim form with all required fields completed in accordance with the Plan's published claim filing requirements. A Clean Claim does not include a claim (1) for payment of expenses incurred during a period of time for which premiums are delinquent, or (2) for which the Plan needs additional information in order to resolve one or more outstanding issues.

2. **Recovery of Overpayments**, the following is added:

Except in cases of fraud committed by a health care provider, We may exercise recoupment from a provider only during the 18 month period after the date We paid the claim submitted by the health care provider. If We exercise recoupment, We shall give the health care provider a written or electronic statement specifying the basis for the recoupment. The statement will provide the following information: (a) the amount of the recoupment; (b) the Covered Person’s name to whom the recoupment applies; (c) the patient identification number; (d) the date of date of service; (e) the service or services on which the recoupment is based; (f) the pending claims being recouped or future claims that will be recouped; and (g) the specific reasons for the recoupment.

For the purpose of this provision, the following definitions are added:

Recoupment means any action or attempt by a health care insurer to recover or collect payments already made to the health care provider with respect to a claim: (a) by reducing other payments currently owed to the health care provider; (b) by withholding or setting off the amount against current or future payments to the health care provider; (c) by demanding payment back from a health care provider for a claim already paid; or (d) by any other manner that reduces or affects the future claim payments to the health care provider.

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of its Effective Date.

Nothing in this Amendatory Endorsement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, provisions or limitations of the Policy, other than as stated above.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.



Larry R. Graber
President



Adam C. Vandervoort
Secretary

SERFF Tracking Number: ICCI-126879896 State: Arkansas
 Filing Company: Madison National Life Insurance Company, Inc. State Tracking Number: 47214
 Company Tracking Number: MNL MMFI POL D610
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: Group Fixed Indemnity MNL MMFI POL D610
 Project Name/Number: Group Fixed Indemnity Policy/MNL MMFI POL D610

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	11/15/2010
Comments:		
Attachment: Cert of Comp. with Rule 19 MNL MMFI D610.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	11/15/2010
Comments: See Form schedule tab for application		

	Item Status:	Status Date:
Satisfied - Item: MNL Authorization Letter	Approved-Closed	11/15/2010
Comments:		
Attachment: ICC Authorization letter Madison Nat 2010.pdf		

	Item Status:	Status Date:
Satisfied - Item: Prior approval letter for CA Association	Approved-Closed	11/15/2010
Comments:		
Attachment: AR Prior approval of CA association 6-30-05.pdf		

	Item Status:	Status Date:
Satisfied - Item: CA Association name change effective 1/17/07	Approved-Closed	11/15/2010

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

Insurer: Madison National Life Insurance Company, Inc.

Form Number(s): MNL MMFI POL D610, MNL MMFI GAPP 610, MNL MMFI CERT D610,
MNL FI AEAR 610, MNL HI/FI AE 1010, MNL MMFI APP 610

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



Signature of Company Officer

Larry R. Graber
Name

President
Title

November 4, 2010
Date



Madison National Life

January 1, 2010

Mr. Brian Camling
President
Insurance Compliance Consultants, Inc.
3925 East State Street, Suite 200
Rockford, IL 61108

Dear Mr. Camling:

Please accept this letter as written confirmation that Insurance Compliance Consultants, Inc., has authority to file the attached form(s) or a state specific variation of it, and to act on behalf of Madison National Life Insurance Company, Inc. regarding such filings, in all jurisdictions where this form(s) or a state specific variation of it is being filed. Madison National may withdraw this authorization at any time, by giving notice to Insurance Compliance Consultants.

Sincerely,

A handwritten signature in cursive script, reading "Larry R. Graber". The signature is written in black ink and is positioned above the printed name.

Larry Graber



INSURANCE
COMPLIANCE
CONSULTANTS, INC.

May 17, 2005

519 Colman Center Drive
Rockford, Illinois 61108

Phone: (815) 316-6714
FAX: (815) 316-6720

Honorable Mike Pickens
Insurance Commissioner
State of Arkansas
Arkansas Department of Insurance
1200 W. Third St.
Little Rock, AR 72201-1904

RECEIVED

MAY 18 2005

LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

RE: MADISON NATIONAL LIFE INSURANCE COMPANY, INC. - NAIC# 65781
FEIN# 39-0990296

Group Major Medical Expense Policy - MNL MMP 0205
Master Application - MNL MAPP 0205
Group Major Medical Expense Cover Page and Certificate - MNL MMC 0205
Group Major Medical Expense Schedule of Benefits - MNL MMC PPO SB 0205
Group Major Medical Expense Schedule of Benefits - MNL MMC IND SB 0205
Group Major Medical Expense Schedule of Benefits - MNL MMC SD SB 0205
Group Major Medical Expense Schedule of Benefits - MNL MMC DD SB 0205
Amendatory Endorsement Rider - MNL AEAR 0205

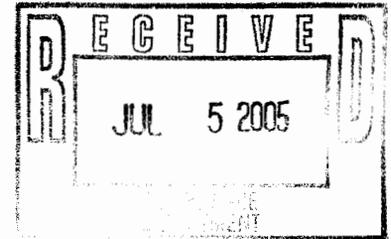
Optional Riders:

Prescription Medication Rider - MNL PMR 0205 AR
Dental Rider - MNL DEN 0205
Vision Rider - MNL VIS 0205
Life Rider - MNL LIF 0205
Supplemental Accident Rider - MNL SUPA 0205
24-Hour Occupational Coverage Rider - MNL OCC 0205
Maternity Benefit Rider - MNL MBR 0205 AR
Weekly Disability Income Rider - MNL WDI 0205
Wellness Benefit Rider - MNL WELL 0205 AR
Alcoholism and Drug Dependency Benefit Rider - MNL-AEALCAR 0205
Treatment of the Bones and Joints of the Face, Neck and Head - MNL AETMJAR 0205
Mammography Screening Benefit Rider - MNL AEMAMAR 0205
Mental Illness Benefit Rider - MNL AEMJAR 0205
Woman's Health and Cancer Rights Act - MNL-WHCRA SUP 0205
Employee Application - MNL EEAPP 0205
Employer Application - MNL ERAPP 0205

APPROVED

JUN 30 2005

LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT



Dear Commissioner Pickens:

We are hereby submitting the above referenced forms for approval in your state. These forms are new and are not intended to replace any forms previously approved in your state.

Insurance Compliance Consultants, Inc., is making this filing on behalf of Madison National Life Insurance Company, Inc., a Wisconsin domiciled company. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc., at the address shown above.

Master Application form MNL MAPP 0205 will be used to apply for Master Policy MNL MMP 0205. Master policy form MNL MMP 0205 will be issued to the Communicating for Agriculture and the Self-Employed, Inc., (CA) Association at the Washington, D.C., location for CA.

Form MNL MMC 0205 is the Group Major Medical Expense Certificate of Insurance evidencing coverage under the Group Master Policy. Amendatory Endorsement Rider MNL AEAR 0205 will be attached to all certificates issued in Arkansas.

State of Minnesota

SECRETARY OF STATE

Certificate of Name Change

I, Mark Ritchie, Secretary of State of Minnesota, do certify that the corporation listed below filed an amendment of its articles of incorporation, or, in the case of a non-Minnesota corporation, a certificate of name change, changing its name with this office on the date listed below, and that the corporation has complied with the relevant laws of Minnesota with respect to that filing.

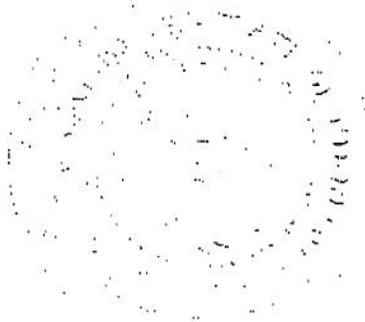
Old Name: COMMUNICATING FOR AGRICULTURE AND THE SELF
EMPLOYED, INC.

New Name: Communicating for America, Inc.

State of Incorporation: MN

Date Amendment filed: 12/26/2006

This certificate has been issued on 01/17/07.



Mark Ritchie
Secretary of State.