

SERFF Tracking Number: INCS-126444889 State: Arkansas  
Filing Company: Pan-American Life Insurance Company State Tracking Number: 44718  
Company Tracking Number: PAL-STMIP-2008-AR  
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.004 Short Term  
Product Name: PALIC STM Ind  
Project Name/Number: PALIC STM IND/PAL-STMIP-2008-AR

## Filing at a Glance

Company: Pan-American Life Insurance Company

Product Name: PALIC STM Ind

SERFF Tr Num: INCS-126444889 State: Arkansas

TOI: H16I Individual Health - Major Medical

SERFF Status: Closed-Approved-  
Closed State Tr Num: 44718

Sub-TOI: H16I.004 Short Term

Co Tr Num: PAL-STMIP-2008-AR State Status: Approved-Closed

Filing Type: Form/Rate

Author: Renee Weaver

Reviewer(s): Rosalind Minor

Date Submitted: 01/29/2010

Disposition Date: 02/05/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: PALIC STM IND

Status of Filing in Domicile: Authorized

Project Number: PAL-STMIP-2008-AR

Date Approved in Domicile: 08/24/2008

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 02/05/2010

Explanation for Other Group Market Type:

State Status Changed: 02/05/2010

Deemer Date:

Created By: Renee Weaver

Submitted By: Renee Weaver

Corresponding Filing Tracking Number:

Filing Description:

Submission for: Pan-American Insurance Company

NAIC#: 67539 FEIN#: 72-0281240

RE: Individual Short Term Medical Product Filing

Forms:

Policy: PAL-STMIP-2008-AR

Optional Accidental Injury Benefit Rider: PAL-STMIAR-2008-ACC

Application: PAL-STMIA-2008

Outline of Coverage PAL-STMIO-2008-AR

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Innovative Compliance Solutions has been retained by Pan American Life Insurance Company to file the above mentioned filing in your state. Please address any future correspondence and/or approvals to my attention.

Enclosed for your consideration is Pan-American Life Insurance Company's Individual Short Term Medical Insurance product. These forms are new and will not replace any forms that have been previously approved in your state.

The Individual Short Term Medical Insurance Policy provides the insureds and their dependents with medical coverage for a short term limited duration. The coverage period is 12-months or less and the policy is non-renewable. As you know, the Health Insurance Portability and Accountability Act (HIPAA) specifically exempts short-term medical contracts from compliance with any HIPAA requirements.

To provide flexibility, all variable text is indicated by brackets. Variable text will never exclude or limit provisions required by your state. Generally, any provision in brackets may be included or may be removed in accordance with the plan options offered. Letters and numbers (excluding form numbers) may be varied. Colons, semicolons, semicolons followed by the word "or" and semicolons followed by the words "and/or" may be omitted. If omitted, a period will be substituted, if necessary. Articles such as "a" and "an" may be substituted as grammatically necessary.

A detailed explanation of the variable text has been provided.

Please note the following information:

1. The forms contained in this filing are to be used on an insert form basis. In lieu of filing modifications via amendments, the insert form(s) impacted by the modification will be submitted for review and approval. Please refer to the "Forms Listing" document for all of the forms to be used in conjunction with this new policy/certificate series.
2. The company's state of domicile is Louisiana and does not require prior filing or approval.
3. Sale of the product will be through properly licensed agents and brokers.
4. Forms are being submitted in final printed format. Printing is subject to changes in ink, paper stock, page numbers, margins, position and format. Printing standards will never be less than that required by your state. We would like to reserve the option of using the form in its submitted format electronically.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

Should you have any questions, or need additional information, please contact me by email at [rweaver@innovative-compliance.com](mailto:rweaver@innovative-compliance.com) or by telephone at 763-323-8643. My fax number is 763-712-8001.

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Sincerely,

Renee Weaver  
Compliance Consultant

## Company and Contact

### Filing Contact Information

Renee Weaver, Consultant rweaver@innovative-compliance.com  
PO Box 773 763-323-8643 [Phone]  
Anoka, MN 55303 763-712-8001 [FAX]

### Filing Company Information

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

Pan-American Life Insurance Company CoCode: 67539 State of Domicile: Louisiana  
601 Poydras St Group Code: Company Type:  
New Orleans, LA 70130 Group Name: State ID Number:  
(877) 569-3075 ext. [Phone] FEIN Number: 72-0281240

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$100.00  
Retaliatory? Yes  
Fee Explanation: \$100 PER FILING  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pan-American Life Insurance Company	\$100.00	01/29/2010	33877121

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/05/2010	02/05/2010

### 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	02/03/2010	02/03/2010	Renee Weaver	02/03/2010	02/03/2010

*SERFF Tracking Number:* INCS-126444889      *State:* Arkansas  
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## **Disposition**

Disposition Date: 02/05/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	AUTHORIZATION LETTER	Approved-Closed	Yes
Supporting Document	POLICY FORMS LIST	Approved-Closed	Yes
Supporting Document	EXPLANATION OF VARIABLES	Approved-Closed	Yes
Form ( <i>revised</i> )	POLICY	Approved-Closed	Yes
Form	POLICY	Replaced	Yes
Form	OPTIONAL ACCIDENTAL INJURY RIDER	Approved-Closed	Yes
Form	APPLICATION	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 02/03/2010  
Submitted Date 02/03/2010

Respond By Date

Dear Renee Weaver,

This will acknowledge receipt of the captioned filing.

Objection 1

- POLICY, PAL-STMIP-2008-AR (Form)

Comment:

With respect to the Arbitration provision in the policy, this is a reminder that Arkansas does not allow Binding Arbitration. Please refer to ACA 23-79-203.

Objection 2

- POLICY, PAL-STMIP-2008-AR (Form)

Comment:

Please verify that the coverage for newborn infants, ACA 23-79-129 and children for whom a petition for adoption has been filed will be covered without any underwriting as long as the newborn sends notice for the newborn within 90 days or the next premium due date whichever is later (See Bulletin 3-75 (Revised)). Also, for the adopted child will be covered without any underwriting unless the coverage ceases upon the dismissal or denial of the petition to adopt.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 02/03/2010  
Submitted Date 02/03/2010

Dear Rosalind Minor,

**Comments:**

SERFF Tracking Number: INCS-126444889 State: Arkansas  
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Thank you for your quick review, I appreciate it. I've addressed your concerns below.

**Response 1**

Comments: The arbitration provision has been deleted from the General Provisions section.

**Related Objection 1**

Applies To:

- POLICY, PAL-STMIP-2008-AR (Form)

Comment:

With respect to the Arbitration provision in the policy, this is a reminder that Arkansas does not allow Binding Arbitration. Please refer to ACA 23-79-203.

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
POLICY	PAL-STMIP-2008-AR		Policy/Contract/Fraternal Certificate	Initial		45.100	AR STM Individual Policy PAL-STMIP-2008 2-10.pdf

**Previous Version**

POLICY	PAL-STMIP-2008-AR		Policy/Contract/Fraternal Certificate	Initial		45.100	AR STM Individual Policy PAL-STMIP-2008.pdf
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No Rate/Rule Schedule items changed.

## Response 2

Comments: Coverage for newborns and newly adopted children are without underwriting during the first 90 or 60 days, respectively. The only underwriting that is done is a yes/no health question application. They are not required to fill out an application unless then do not continue coverage beyond this required period. The provision states the following: "To add the child after the initial period has expired, see the provision titled Adding Persons After The Effective Date."

Also note that I added the following language "or the next premium due date whichever is later" to the written notice requirement for newborns.

### Related Objection 1

Applies To:

- POLICY, PAL-STMIP-2008-AR (Form)

Comment:

Please verify that the coverage for newborn infants, ACA 23-79-129 and children for whom a petition for adoption has been filed will be covered without any underwriting as long as the newborn sends notice for the newborn within 90 days or the next premium due date whichever is later (See Bulletin 3-75 (Revised)). Also, for the adopted child will be covered without any underwriting unless the coverage ceases upon the dismissal or denial of the petition to adopt.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
POLICY	PAL-STMIP-2008-AR		Policy/Contract/Fraternal Certificate	Initial		45.100	AR STM Individual Policy PAL-STMIP-2008 2-

*SERFF Tracking Number:* INCS-126444889      *State:* Arkansas  
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*Product Name:* PALIC STM Ind  
*Project Name/Number:* PALIC STM IND/PAL-STMIP-2008-AR

10.pdf

**Previous Version**

<i>POLICY</i>	<i>PAL- STMIP- 2008-AR</i>	<i>Policy/Contract/Fraternal Initial Certificate</i>	<i>45.100</i>	<i>AR STM Individual Policy PAL- STMIP- 2008.pdf</i>
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No Rate/Rule Schedule items changed.

I trust that these comments/revisions will allow the Department to complete its review of this filing. Please contact me if you have any other questions.

Thank you.

Sincerely,  
Renee Weaver

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## Form Schedule

### Lead Form Number: PAL-STMIP-2008-AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/05/2010	PAL-STMIP-2008-AR	Policy/Contract	POLICY Fraternal Certificate	Initial		45.100	AR STM Individual Policy PAL-STMIP-2008-2-10.pdf
Approved-Closed 02/05/2010	PAL-STMIAR-2008-ACC	Policy/Contract	OPTIONAL ACCIDENTAL INJURY RIDER Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		45.100	STM Individual Amendment PAL-STMIAR-2008-ACC.pdf
Approved-Closed 02/05/2010	PAL-STMIA-2008	Application/Enrollment Form	APPLICATION	Initial		45.100	PAL-STMIA-2008 Individual Application.pdf

# PAN-AMERICAN LIFE INSURANCE COMPANY

[601 Poydras Street  
New Orleans, Louisiana 70130  
TOLL FREE: 1-877-569-3075]

## INDIVIDUAL SHORT TERM MEDICAL EXPENSE INSURANCE POLICY

**Policy Number:**[G-123456 or see attached]

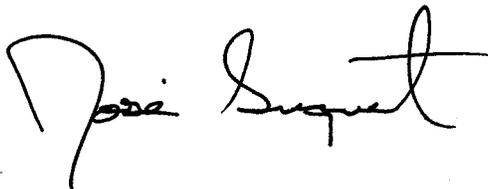
**Policy Effective Date:** [December 1, 2009 or see attached]

**Governing Jurisdiction:** This Policy is delivered in Arkansas and is subject to the laws of that jurisdiction.

### 10-DAY RIGHT TO RETURN THE POLICY

If for any reason you are not satisfied with this Policy, you may return it to us within 10-days after you receive it. We will refund any premium paid and coverage issued under the Policy will be deemed void, just as though coverage had not been issued.

PAN-AMERICAN LIFE INSURANCE COMPANY



[  
[President and Chief Executive Officer]

### THE COVERAGE IS NON-RENEWABLE SHORT TERM INSURANCE.

**Policyholder Service Office of Company:** Pan-American Life Insurance Company

**Address:** [601 Poydras Street, New Orleans, LA 70130]

**Telephone:** [1-800-XXX-XXXX]

If we at Pan-American Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

**Arkansas Insurance Department - Consumer Services Division**

**[1200 West Third Street, Little Rock, Arkansas 72201-1904**

**Telephone: (501) 371-2640] or Toll-Free: [800-852-5494]**

## **TABLE OF CONTENTS**

The following provisions appear within this Policy in the following order:

**Schedule**

**Definitions**

**Eligibility**

**Effective Dates**

**Termination of Insurance**

**Short Term Medical Expense Benefits**

**Exclusions and Limitations**

**Premium Provisions**

**Claim Provisions**

**General Provisions**

## [SCHEDULE

### **PRE-ADMISSION CERTIFICATION NOTICE**

This plan requires a Pre-Admission Certification by a Professional Review Organization prior to in-patient Hospitalization or surgery.

A Covered Person must call the Professional Review Organization:

1. For elective or non-emergency Hospitalization or surgery, at least 10-days prior to the date of proposed Hospitalization;
2. Within 48-hours of an emergency admission; or
3. Within 48-hours of delivery for complicated childbirth.

Non-compliance with the Pre-Admission Certification procedure will result in a **reduction in benefits of 50%**, unless the Covered Person is incapacitated and unable to contact us. In such cases, the Covered Person must contact us as soon as possible. You have been provided with information and procedures necessary for Pre-Admission Certification. You may obtain more information regarding Pre-Certification and its procedures from the Company.

### **SECTION I**

**The Deductible, Coinsurance Percentage, Coinsurance Limit and Lifetime Maximum Amount for Covered Expenses apply to each Covered Person, unless otherwise stated for a specific benefit, including any maximum benefits for each Covered Person, in SECTION II.**

#### **THE FOLLOWING SHALL APPLY TO EACH COVERED PERSON**

**DEDUCTIBLE:** [500-\$10,000 per Coverage Period, as elected and shown in the attached Policy Schedule]

[When 3 insured individuals in a family satisfy their Deductibles, the Deductibles for any remaining insured individual in the insured family are deemed satisfied for the remainder of the Coverage Period.]

**[DEDUCTIBLE Per Cause:** [500-\$10,000 per person, per cause, as elected and shown in the attached Certificate Schedule]

If You elect the per cause Deductible, You must satisfy Your elected Deductible Amount for **each** incident or subsequent incidents for the same Sickness or Injury before any other Covered Expenses will be paid for such incident.]

#### **COINSURANCE:**

Coinsurance Percentage: [50% - 80% as elected and shown in the attached Policy Schedule], up to the Coinsurance Limit

Coinsurance Limit: [100% for deductibles \$2,500 or higher]  
[\$5,000 - \$10,000 as elected and shown in the attached Policy Schedule]

Thereafter: [100%]

**LIFETIME MAXIMUM AMOUNT:** [\$100,000 - \$2,000,000 per Covered Person]

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### **SECTION II**

#### **MAXIMUM BENEFITS FOR EACH COVERED PERSON:**

#### **HOSPITAL COVERED EXPENSES:**

##### **In Hospital Regular Care:**

The Average Semi-Private Room Rate [not to exceed [\$1,000] per day including all Inpatient Miscellaneous Medical Expense Services]

##### **In Hospital Intensive or Critical Care:**

[[3 times the Average Semi-Private Room Rate] [not to exceed [\$2,000] per day including all Inpatient Miscellaneous Medical Expense Services]

**[Emergency Room Treatment:** Up to [\$500] per day including the emergency room Doctor charge, 24 hour observation and all miscellaneous medical expenses received during the emergency room visit]

**[In Hospital Doctor Visits:** Up to [\$500] per in-hospital confinement.]

**OTHER COVERED EXPENSES:**

**Doctor Office Visits:** [Up to [\$50] per visit not to exceed [2] visits per Coverage Period up to a maximum payment of [\$100] per person. The balance of the office visit expense will be payable subject to the Deductible and Coinsurance, up to a maximum benefit of [\$1,000] per Covered Person for each Coverage Period.]

**[Outpatient Hospital Surgery or Ambulatory Surgical Center:** [Up to \$1,000] per day including all Miscellaneous Medical Expenses]

**Surgeon Services** [up to \$2,500 per surgery]

**Anesthetics Coinsurance Percentage:** [up to 20%] of the surgeon's benefit

**Assistant Surgeon Coinsurance Percentage:** [up to 20%] of the surgeon's benefit

**Surgeon's Assistant Coinsurance Percentage:** [up to 15%] of the surgeon's benefit

[The Surgeon, Anesthetics, Assistance Surgeon and Surgeon's Assistants benefits are limited to [\$2,500] per surgery, for all Covered Expenses combined, not to exceed [\$5,000] per Coverage Period]

**Ambulance, Ground or Air** [Up to \$250] per incident

**[Acquired Immune Deficiency Syndrome (AIDS)** [up to \$10,000] per Coverage Period]

**[Knee Injury or Disorder** [up to 2,500] per Coverage Period for both left and right knees]

**[Gallbladder Surgery:** [up to 2,500] per Coverage Period]

**Mammography Benefit**  
Maximum Amount: [\$50] for each screening mammography, which includes payment of both the professional and technical components.\*

\*In cases of Hospital outpatient screening mammography, and comparable situations, where professional services are billed separate from technical services, the professional component will not be less than 40% of the total fee.

**[Outpatient Miscellaneous Medical Covered Expenses:**

[Up to \$1,000] per Coverage Period for all Covered Expenses combined. Does not include Inpatient Hospital or outpatient Hospital surgery]

**MONTHLY PREMIUM RATES**

The monthly premium rates as of the Policy Effective Date for the coverage provided by this Policy are on file with The Company.

## DEFINITIONS

This section provides the meaning of special terms used in this Policy. Whenever the following terms appear capitalized in this Policy, these definitions apply.

**Ambulatory Surgical Center** means a licensed health care facility whose main purpose is the diagnosis or treatment of patients by surgery. It must (1) admit and discharge the patient within the same working day; (2) be supervised by a Doctor; (3) require a licensed anesthesiologist or licensed Certified Registered Nurse Anesthetist to administer anesthesia and remain during the surgery; (4) provide a post-anesthesia recovery room; and (5) have a written agreement with at least one Hospital for immediate acceptance of patients who develop complications.

“Ambulatory surgical center” does not include: (1) a facility whose main purpose is performing terminations of pregnancy; (2) an office maintained by a Doctor for the practice of medicine; or (3) an office maintained for the practice of dentistry.

**Coinsurance Percentage** is the applicable percentage specified in the Schedule that We will use in computing the amount payable for a benefit.

**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, HELLP syndrome, uterine rupture, amniotic fluid embolism, chorioamnionitis, fatty liver in pregnancy, septic abortion, placenta accrete, gestational hypertension, puerperal sepsis, peripartum cardiomyopathy, cholestasis in pregnancy, thrombocytopenia in pregnancy, placenta previa, placental abruption, acute cholecystitis and pancreatitis in pregnancy, post hemorrhage, septic pelvic thrombophlebitis, retained placenta, venous air embolus associated with pregnancy, miscarriage, or an emergency Cesarean section required because of: (a) fetal or maternal distress during labor, (b) severe pre-eclampsia, (c) arrest of descent or dilatation, (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a Cesarean section delivery is not considered to be an emergency Cesarean section if it is merely for the convenience of the patient and/or Doctor solely due to a previous Cesarean section.

(2) Treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: hyperthyroidism, hepatitis B or C; HIV; Human papilloma virus; abnormal PAP; syphilis; Chlamydia; herpes; urinary tract infections; thromboembolism; appendicitis; hypothyroidism; pulmonary embolism; sickle cell disease; tuberculosis; migraine headaches; depression; acute myocarditis; asthma; maternal cytomegalovirus; urolithiasis; DVT prophylaxis; ovarian dermoid tumors; biliary atresia and/or cirrhosis; first trimester adnexal mass; hydatidiform mole; or ectopic pregnancy.

“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.

**Confined/Confinement** means the time in which a Covered Person is a Registered Bed Patient in a Hospital, on the order of a Doctor, for Medically Necessary medical treatment.

**Covered Dependent** means Eligible Dependents who have become Covered Person(s) under this Policy.

**Covered Expenses** means Expenses for treatments, services and supplies which a Doctor recommends (1) as Medically Necessary to treat a Sickness or Injury; (2) which are Usual, Reasonable and Customary; and (3) which do not exceed any amount payable under the terms of the Policy.

**Coverage Period** means the maximum length of time coverage is in force under this Policy.

**Covered Person(s)** means You and Your Covered Dependents.

**Deductible** means the amount of Covered Expenses that each Covered Person must pay before benefits will be payable. [The Deductible is shown in the Schedule.]

**Doctor** means a licensed practitioner of the healing arts who is practicing and treating within the scope and limitations of that license. “Doctor” does not include You, a Covered Dependent, Immediate Family, or a Covered Person’s employer.

**[Domestic Partner]** means a person of the [opposite sex] [same sex] [opposite or same sex] with whom the Covered Person has established a Domestic Partnership. In no event, will a person's legal spouse be considered a Domestic Partner.]

**[Domestic Partnership]** means a relationship between the Covered Person and one other person of the [opposite sex] [same sex] [opposite or same sex]. The following requirements apply to both persons:

1. [They share the same permanent residence and the common necessities of life;
2. They are not related by blood or a degree of closeness which would prohibit marriage in the law of state in which they reside;
3. Each is at least 18 years of age;
4. Each is mentally competent to consent to contract;
5. Neither is currently married to, or Domestic Partner of, another person under either a statutory or common law;
6. They are financially interdependent and have furnished at least two of the following documents evidencing such financial interdependence:
  - a. have a single dedicated relationship of at least 6 months duration;
  - b. joint ownership of residence;
  - c. at least two of the following:
    - i. joint ownership of an automobile;
    - ii. joint checking, bank or investment account;
    - iii. joint credit account;
    - iv. lease for a residence identifying both partners as tenants;
    - v. a will and/or life insurance policies which designates the other as primary beneficiary.
7. The Covered Person and Domestic Partner must jointly sign an affidavit of Domestic Partnership.]

**Effective Date** means the date coverage under the Policy begins for a Covered Person. The Effective Date is shown on the face page of the Policy.

**Evidence of Insurability** means an Eligible Person will satisfy the insurability requirement on the day The Company agrees in writing to accept the person as insured for that amount. To determine a person's acceptability for coverage, The Company will require evidence of good health and may require it to be provided at the Insured Person's expense.

**Expenses** means the amounts billed for treatments, services and supplies rendered to a Covered Person. An expense shall be considered to have been incurred on the date the treatment, service or supply was provided.

**Experimental or Investigational:** means a treatment, drug, device, procedure, supply or service and related services (or any portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any one of the following exists: (1) It cannot be legally marketed without the approval of the United States Food and Drug Administration (FDA) and such approval has not been granted at the time of its proposed use. (2) It is not yet recognized as acceptable medical practice throughout the United States to treat that Illness or Injury. (3) It is the subject of either: (a) a written investigational or research protocol; or (b) a written informed consent or protocol used by the treating facility in which reference is made to it being experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or (c) an ongoing phase I, or phase II clinical trial or as the experimental or research arm of a phase III clinical trial, as the phases are defined in regulations and other official actions and publications issued by the FDA and the Department of Health and Human Services (HHS); or (d) an ongoing review by an Institutional Review Board (IRB); or (4) It does not have either: (a) the positive endorsement of national medical bodies or panels, such as the American Cancer Society; or (b) multiple published peer review medical literature articles, such as the Journal of the American Medical Association (J.A.M.A.), concerning Health Care Service and reflecting its recognition and reproducibility by non-affiliated sources the Claims Administrator determines to be authoritative. (5) It is regarded within a Doctor's profession as appropriate only when provided in a clinical research setting.

We may also determine whether a treatment, drug, device, procedure, supply or service is experimental or investigational by using the following evaluations: (1) Reports in peer review medical literature. (2) Scientific evaluations published by organizations that conduct health care research such as the Agency for Health Care Policy and Research, the National Institutes of Health, the American Medical Association, and the American College of Physicians. (3) Opinions of independent medical consultants. (4) Listings in drug correspondence, including the American Medical Association's Drug Evaluations, the American Hospital Formulary Service Drug Information, and the United States Pharmacopoeia Drug Information. (5) Use of a written informed consent addressing the experimental or investigational nature of the service or supply. This applies whether consent is used by the Covered Person's Doctor or by any other Doctor studying the same or similar service or supply. (6) Any requirement that the use of the service or supply be subject to Institutional Review Board ("IRB") approval. (7) Written protocols used by the health care provider.

**Policy** means the contract issued to You providing the benefits described herein.

**Hospital** means an institution which is legally constituted and operated in accordance with the laws pertaining to Hospitals in the jurisdiction where it is located, which meets all of the following requirements:

1. It is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patient's expense;
2. It provides 24-hour-a-day nursing service by a Nurse;
3. It is under the supervision of a staff of duly-licensed Doctors;
1. It provides organized facilities for diagnosis and for major operative surgery either on its premises or in facilities available on a prearranged basis; and

“Hospital” does not mean primarily a clinic, nursing home, rest or convalescent home, extended care facility, Hospice or similar establishment nor, other than incidentally, a place providing care for persons with mental illness or nervous disorders; the aged; or those suffering from alcoholism or drug addiction.

Confinement in a special unit of a Hospital used primarily as a nursing, rest, or convalescent home shall be deemed to be Confinement in an institution other than a Hospital.

**Immediate Family** means: (1) the parent, spouse, brother, sister or children of a Covered Person; (2) a resident in a Covered Person's household; or (3) any person related to a Covered Person by blood, marriage or legal adoption.

**Injury** means bodily harm caused by an accident, directly and independently of Sickness or bodily infirmity, resulting in unforeseen trauma requiring immediate medical attention. The Injury must occur after the Covered Person's Effective Date of coverage and while such person's coverage is in force. All injuries to the same Covered Person sustained in one accident, including all related conditions and recurring symptoms of the Injuries, will be considered one injury. Bodily damage caused by chewing is not considered an Injury.

**Intensive Care Unit** means a section, ward or wing within a Hospital which is separated from other Hospital facilities and: (1) is operated exclusively for the purpose of providing professional care and treatment for critically ill patients; (2) has special supplies and equipment necessary for such care and treatment which are available on a standby basis for immediate use; (3) provides room and board, and constant observation by a Nurse or other specially-trained Hospital personnel; and (4) is not maintained for the purpose of providing normal postoperative recovery treatment or service.

**Lifetime Maximum Amount** means the total aggregate amount of benefits payable under the Policy for all Covered Expenses which are incurred for Sickness or Injury by each Covered Person during such person's lifetime.

**Medically Necessary** means a Confinement, service, supply, or treatment that meets each of these requirements:

1. It is ordered by a Doctor for the diagnosis or the treatment of a Sickness or Injury;
2. For services, supplies, or treatment, the prevailing opinion within the appropriate specialty of the United States medical profession is that such service, supply, or treatment is safe and effective for its intended use, and that omission would adversely affect the Covered Person's medical condition. For Confinement in a Hospital, the prevailing opinion within the appropriate specialty of the United States medical profession is that inpatient acute care Confinement is necessary and any lesser level of care would adversely affect the Covered Person's medical condition; and
3. It is furnished by a provider with appropriate licensing, training, experience, staff and facilities to offer that particular service or supply.

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

**Nurse** means a licensed registered graduate professional Nurse (R.N.) or a licensed practical Nurse (L.P.N.) who is under the direction of a Doctor. Nurse does not include the Immediate Family of a Covered Person.

**Prescription Or Legend Drugs** means (1) a Legend Drug; (2) injectable insulin prescribed by a Doctor; (3) a compounded drug of which at least one part is a Legend Drug; or (4) any other drug that, under state law, may only be dispensed upon the written prescription of a Doctor. “Prescription or Legend Drugs” does not include oral contraceptives for prevention of pregnancy.

**Registered Bed-Patient** means an individual who, while Confined to a Hospital, is assigned to a bed in any department of the Hospital, and for whom a charge for room and board is made by the Hospital.

**Rehabilitative** means treatment for purposes of restraining bodily function which has been lost due to a Covered Sickness/Injury. Care ceases to be rehabilitative when the patient can perform the activities which are normal for someone of the same age and gender or the patient has reached maximum therapeutic benefit and further treatment cannot restore bodily function beyond the level the patient currently possess.

**Sickness** means an illness, disease, or infection which begins while coverage is in force under this Policy for the Covered Person. All related conditions and recurring symptoms of sickness to the same person will be considered one sickness. Sickness includes Complications of Pregnancy, provided conception occurred after the Covered Person's Effective Date of coverage.

**Usual, Reasonable and Customary** means:

1. With respect to fees or charges, fees for medical services or supplies which are:
  - a. Usually charged by the provider for the service or supply given; and
  - b. The average charged for the service or supply in the locality in which the service or supply is received; whichever is less, or
2. With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

In reaching a determination as to what amount should be considered as Usual, Reasonable and Customary for services and supplies, We may use and subscribe to a standard industry reference source that collects data and makes it available to its member companies. The data base used reflects the amounts charged by providers for health care services based on geographic zip code areas generating a statistically credible charge distribution. The data is reflective of reported provider charges from the lowest to the highest for each service or supply. The data is also adjusted periodically to reflect negotiated fee schedules with providers not included in the data base.]

**We, Us, Our, The Company** means Pan-American Life Insurance Company.

**You or Your** (also, Policyholder) means an Eligible Person who is properly enrolled for coverage under the Policy. You are the person (who is not a Dependent) on whose behalf the Policy is issued.

## ELIGIBILITY

### YOU

You will be eligible for insurance provided:

1. [You are at least 1 but under 65 years of age;
2. You are not covered as a dependent under the Policy;
3. You are not pregnant at the time of application;
4. You have lived in the U.S. for 12 consecutive months;
5. You are not an active member of the armed forces;
6. You submit a written application for insurance, provide Evidence of Insurability, if evidence is required, and meet our enrollment and underwriting requirements; and
7. You pay all required premiums when due.]

### ELIGIBLE DEPENDENTS

**Spouse** - You will be eligible to apply for insurance for Your lawful spouse who:

1. [Is under age 65 at the time of application;
2. Is not pregnant at the time of application;
3. Is not an active member of the armed forces;
4. Has lived in the U.S. for 12 consecutive months; and
5. Has provided a written application for insurance and Evidence of Insurability, if evidence is required, have been approved, and meets our enrollment and underwriting requirements.]

[All references to Your spouse shall include a Domestic Partner.]

**Dependent Children** - You will be eligible to apply for insurance for your dependent children who:

1. Are unmarried children primarily dependent upon You for support and maintenance; and
2. a. Are less than [19 years] or age; or  
b. Are at least [19 years] of age but less than [25 years] and enrolled and attending as a full-time student at an accredited college, university, vocational or technical school.
3. [Are not pregnant at the time of application;
4. Are not active members of the armed forces; and
5. Have provided a written application for insurance and Evidence of Insurability, if evidence is required, have been approved, and meet our enrollment and underwriting requirements.]

“Children” means natural children, stepchildren, legally-adopted children, children placed with You for the purpose of adoption, and children subject to Your legal guardianship.

If You and Your spouse are both Covered Persons, only one parent will be eligible for insurance on any Covered Dependent children You may have.

### ENROLLMENT REQUIREMENTS

You and your Eligible Dependents who desire coverage must complete and submit an application for the plan and complete or provide any other documents (including evidence of insurability) as we deem necessary. You must submit the required premium with Your application form. Any misrepresentation or omission of information in Your application or any documents submitted to Us may result in rescission of all coverage for all Covered Persons.

### UNDERWRITING REQUIREMENTS

You and your Eligible Dependents are subject to our underwriting requirements. We reserve the right to decline or rate any person at Our discretion.

### ADDITIONAL CONDITIONS

Insurance will not be effective unless all eligibility requirements are met and You receive written acceptance from Us. Insurance on a Covered Person will not be effective unless premium is paid and accepted by Us for such insurance. Issuance of a Certificate is not a waiver of any of the above conditions.

## **EFFECTIVE DATES**

### **YOU AND ELIGIBLE DEPENDENTS**

Coverage is effective [as of the Effective Date] for You and any Eligible Dependents who were included in Your initial application, provided that You meet Our eligibility, underwriting and enrollment requirements. Coverage will not become effective for any person whose medical history changes prior to the Effective Date, such that the person's answer would be "Yes" to any of the medical history questions in the Application. If Your medical history changes prior to the Effective Date, coverage is automatically declined for all persons included in Your Application.

### **ADDING PERSONS AFTER THE EFFECTIVE DATE**

You may wish to apply for coverage for a previously uncovered spouse or dependent child. To do so, the following requirements must be met:

1. You must complete and submit to Us for approval an application form for such person;
2. Such person must meet Our definition of an Eligible Dependent; and
3. You must pay any additional premium, if approved for coverage.

### **NEWLY-ACQUIRED DEPENDENT CHILDREN**

Coverage for Your child or children born after the Effective Date will be effective from the moment of birth and will remain in force for 90-days. We must receive this notice within 90-days after the child's date of birth or the next premium due date whichever is later.. Coverage for a child whom a petition for adoption has been filed, will become effective the the date the petition is filed, if coverage is applied for within 60 days of such filing. Coverage for an adopted newborn child is from the moment of birth, if coverage is applied for within the 60-days after birth. Coverage ceases upon the dismissal or denial of a petition for adoption. Any required additional premium must accompany Your notice. A claim form or Hospital bill does not constitute written notice. To add the child after the initial period has expired, see the provision titled Adding Persons After The Effective Date.

Coverage for Your child or children will be for Injury or Sickness, including care or treatment of congenital defects, birth abnormalities, and premature birth and tests for hypothyroidism, phenylketonuria, galactosemia, and sickle-cell anemia for a non-Caucasian newborn child. Coverage is not provided for normal newborn care, except as specifically provided.

### **WHEN CHANGES IN COVERAGE OCCUR**

1. Any change in benefits which occurs automatically under the Certificate provisions or Schedule will become effective on the date that the status of the Covered Person changed.
2. If any decrease in benefits or coverage is requested, such decrease shall become effective as of the [first premium due date coinciding with or next following the] date of the approval of such decrease.
3. If any increase in benefits or coverage is requested, such increase shall become effective as of the [first day of the month coinciding with or next following the] date of the approval of such increase.
4. If any requested change increases benefits or coverage, the Effective Date of the increase will be delayed for You or a Covered Dependent who is Confined for medical treatment in an institution. The delay will end and the increase shall become effective on the day following final medical discharge from such Confinement.]

## **TERMINATION OF INSURANCE**

### **TERMINATION OF YOUR INSURANCE**

Your insurance will automatically terminate on the earliest of the following dates:

1. The due date of a premium payment that is not paid when due, if such payment has not been made within 31-days following such premium due date;
2. The date that we determine fraudulent statements or a material misrepresentation has been made by the You or with Your knowledge in filing a claim for benefits;
3. The date that You enter full-time active duty in the armed forces of any country or international organization;
4. The date You become eligible for Medicare; or
5. The earlier of: (1) the Expiration Date of Your coverage; or (2) 12-months from the Effective Date of Your insurance, whichever occurs first.

### **TERMINATION OF A COVERED DEPENDENT'S INSURANCE**

A Covered Dependent's insurance will automatically terminate on the earliest of the following dates:

1. The due date of a premium payment that is not paid when due, if such premium payment has not been made within 31-days following such premium due date;
2. The date that we determine fraud or material misrepresentation has been made by You or a Covered Dependent or with Your or a Covered Dependent's knowledge in filing a claim for benefits;
3. The date that Your insurance terminates. However, if termination is due to Your death, a Covered Dependent may elect to continue coverage beyond the original Expiration Date by making written request for such coverage and by continuing payments toward the cost of that insurance. When such an election is made, Your Covered Dependent spouse will be considered the primary insured;
4. The date You or a Covered Dependent becomes eligible for Medicare;
5. The date the Covered Dependent ceases to be eligible. However if, upon attaining any limiting age, a Covered Dependent has a handicapped condition rendering such person incapable of earning his own living and is chiefly dependent upon You or other care providers for lifetime care and supervision because of a handicapped condition that occurred before attainment of the limiting age, benefits with respect to such person may be continued on a premium-paying basis during the continuance of such incapacity up to the end of the Coverage Period, provided that we receive written proof of such incapacity after the date on which the Covered Dependent attains the limiting age. During continuance of insurance, We have the right to require due proof of the continuance of the incapacity and to have such dependent examined by Doctors designated by us at any time during the term of coverage. The continuance of insurance as described will cease in the event of the termination of Your insurance; or
6. The earlier of: (i) the Expiration Date shown in the Schedule; or (ii) 12-months from the Effective Date of Your insurance, whichever occurs first.

### **TERMINATION OF THE POLICY**

The Policy will terminate on the earliest of the following dates:

1. The date there are no insured persons under the Policy; or
2. [The first day of any policy month] The Company gives written notice to You at least [30 days] in advance.

## SHORT TERM MEDICAL EXPENSE BENEFITS

### HOSPITAL PRECERTIFICATION

Hospital admissions and lengths of stay are subject to certification by the pre-certification service, as stated below:

1. You must notify the pre-certification service on behalf of a Covered Person:
  - a. Ten (10) days prior to non-emergency admission of the Covered Person to a Hospital;
  - b. Within 48-hours or on the first business day following an emergency admission of the Covered Person to a Hospital, or as soon thereafter as is reasonably possible; or
  - c. Within 48-hours of delivery for complicated birth.
2. The pre-certification service, after reviewing the applicable information, will certify:
  - a. If the Hospital admission is Medically Necessary;
  - b. The appropriate length of stay; and
  - c. Appropriate extensions beyond the initially-certified length of stay.
3. Reduction of Benefits - If Covered Expenses for the Hospital admission, length of stay, or extensions of stay are not certified by the Professional Review Organization, we will only pay 50% of the benefits which would otherwise have been payable for Covered Expenses, unless the Covered Person is incapacitated and unable to contact us. In such cases, the Covered Person must contact us as soon as possible. No benefits will be payable in the event such Hospital admission, length of stay or extension of stay is not Medically Necessary or Experimental or Investigational.
4. Not a Guarantee of Benefits – Pre-certification does not guarantee that benefits will be paid. Payment of benefits will be determined by Us in accordance with and subject to all terms, conditions, limitations and exclusions of the Policy.

### DESCRIPTION OF BENEFITS

#### WHAT IS COVERED

Subject to the Hospital Precertification provision, if You or a Covered Dependent incurs Covered Expenses for medical treatment, supplies or services as a result of a Sickness or Injury which occurs while coverage is in force, and after satisfaction of the Deductible, We will pay the Coinsurance Percentage for Covered Expenses incurred in excess of the Deductible up to the Maximum Benefit amounts as shown in the Schedule. We will pay this amount for all Covered Expenses unless otherwise noted for a specific benefit or specified as limited or excluded in the Limitations and Exclusions provision.

After Covered Expenses for which benefits are payable at the Coinsurance Percentage have equaled the Coinsurance Limit for a Covered Person, we will pay Covered Expenses in excess of the Coinsurance Limit at the amount shown in the Schedule for each such person while coverage is in force, but not to exceed the Lifetime Maximum Amount payable for each Covered Person.

The Deductible, Coinsurance Percentage, Coinsurance Limit and Lifetime Maximum Amount are shown in the Schedule.

#### COVERED EXPENSES

Covered Expenses means the Usual, Reasonable and Customary charges for the following Medically Necessary services, supplies, or treatment prescribed or provided by a Doctor for a covered Injury or Sickness while coverage is in force for a Covered Person. **[Covered Expenses do not include Expenses which are in excess of the Maximum Amounts shown in the Schedule. Expenses in excess of the Maximum Amounts shown in the Schedule do not apply to the Deductible or the Coinsurance Limit. ]**

#### A. HOSPITAL COVERED EXPENSES

**Hospital Room, Board and General Nursing Care** while Confined in a Hospital, not to exceed the Maximum Benefit amount shown in the Schedule. For confinement in a private room, the Covered Expense is limited to the Hospital's average daily charge for a semi-private room not to exceed the Maximum Benefit amount shown in the Schedule.

**Intensive or Specialized Care Unit** provided four or more hours of nursing care is being provided each day, not to exceed the Maximum Benefit amount shown in the Schedule.

**Emergency Room Treatment** for services, supplies and treatment [, not to exceed the Maximum Benefit amount shown in the Schedule].

**Inpatient Miscellaneous Medical Expense Services** for services and supplies provided on an inpatient basis in a Hospital [, not to exceed the In Hospital Maximum Benefit amount shown in the Schedule]. Miscellaneous charges do not include

charges for a telephone, radio, television, extra beds or cots, meals for guests, take home items, or other items of convenience.

**Inpatient Doctor Visits** for treatment provided by a Doctor during a Hospital confinement [, not to exceed the Maximum Benefit amount shown in the Schedule].

**B. COVERED EXPENSES FOR TREATMENT , SERVICES, OR SUPPLIES**

**Doctor Office Visits** for treatment provided by a Doctor in a Doctor's office [, not to exceed the Maximum Benefit amount shown in the Schedule]. This benefit is not payable for treatment provided by a member of your Immediate Family.

**Ambulatory Surgical Center or Outpatient Hospital Surgery** for treatment or services in a state-approved freestanding Ambulatory Surgical Center that is not part of a Hospital, or a Hospital Outpatient Surgery Facility [, not to exceed the Maximum Benefit amount shown in the Schedule].

**Surgeon Services** for Covered Expenses incurred from a Doctor performing surgery in either an inpatient or outpatient setting [, not to exceed the Maximum Benefit amount shown in the Schedule].

**Services** of a Doctor administering anesthetics [, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule].

**Assistant Surgeon** services for a Doctor assisting in the performance of a surgery [, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule].

**Surgeon's Assistant** services for an assistant to the Doctor performing the surgery [, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule].

**Complications of Pregnancy.** Treatment for Complications of Pregnancy on the same basis as any other Sickness.

**Cosmetic or Reconstructive Surgery (except Breast Reconstructive Surgery)** for cosmetic or reconstructive surgery and complications of cosmetic procedures. Benefits are payable, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule, when services and treatment are:

1. Incidental to or follows a covered Injury or Sickness occurring while this coverage is in force; or
2. Performed due to a congenital defect or birth anomaly of a Covered Person born while this coverage is in force.

**Breast Reconstructive Surgery** for a female Covered Person who undergoes a covered mastectomy surgery while such person's coverage under this Certificate is in force. Benefits payable, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule, include:

1. Reconstructive surgery of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast for the purpose of obtaining a symmetrical appearance; and
3. Prostheses and for treatment for physical complications related to the mastectomy.

**Ambulance Services** for local licensed ground ambulance service, or air ambulance service within the 48 contiguous states, to the nearest Hospital qualified to treat the covered Injury or Sickness, not to exceed the Maximum Benefit amount shown in the Schedule. Such service must be Medically Necessary due to a sudden and unexpected Injury or Sickness that involves a life-threatening element.

**Prescription or Legend Drugs** when prescribed on an inpatient basis for a covered Injury or Sickness.

**Dental Treatment** for treatment or care required as a result of a covered Injury to a tooth that is natural, free of disease, and vital where the major portion of the tooth is present regardless of fillings or caps.

[**AIDS** for the treatment of Acquired Immune Deficiency Syndrome (AIDS) or any complication or condition caused by, resulting from or related to AIDS or HIV, not to exceed the Maximum Benefit amount shown in the Schedule.]

[**Knee Injury or Disorder** The knee consists of the bones, muscles, cartilage, ligaments, membranes and menisci of the anterior aspect of the leg at the articulation of the femur and tibia. Coverage does not include charges incurred to diagnose or treat an injury or disorder of the knee including surgery in excess of the maximum benefit amount shown in the Schedule.]

**[Gallbladder Surgery** includes cholecystectomy and any type of surgical procedure to diagnose or treat a disorder of the gallbladder, including any condition related to or caused by a gallstone(s) in the bile duct. Surgery includes the pre-operative and post-operative visits, testing, the services of the surgeon, assistance surgeon, anesthesiologist, radiologist, pathologist, the Hospital or outpatient facility charges, and any other charges related to the surgery or complications there from, not to exceed the maximum benefit shown in the Schedule.]

### C. OUTPATIENT MISCELLANEOUS MEDICAL EXPENSE SERVICES

[Outpatient Miscellaneous Medical Expenses as listed below are payable up to the Maximum Benefit amount shown in the Schedule for all services combined.]

[  
**Blood or Blood Plasma** and their administration, if not replaced.

**Artificial limbs or eyes.**

**Casts, non-dental splints, trusses, crutches, or non-orthodontic braces.**

**Equipment Rental** for a wheelchair, hospital-type bed or similar durable medical equipment. At our option, benefits may be available for purchase of such equipment, payable in monthly installments, while Your coverage remains in force under the Policy.

**Oxygen** for oxygen and rental of equipment for the administration of oxygen, not to exceed the purchase price of such equipment.

**Diagnostic Testing Services** for diagnostic tests including related professional fees, incurred on an outpatient basis. Diagnostic tests include x-rays, laboratory tests, electrocardiograms (EKGs), electroencephalograms (EEGs), nuclear medicine imaging, radioimmune assay, ultrasound/echography, computerized tomography (CT), magnetic resonance imaging (MRI), cholecystography, cytourethroscopy, endoscopy, duodenoscopy, hysterosalpingography, laparoscopy, myelography, pyelography, pancreatography, vasography, or venography.

**Therapy Services** for treatment provided by a physical therapist, inhalation therapist (respiratory), and speech therapist for diagnosis and Rehabilitative treatment. This benefit is not payable for treatment provided by a member of your Immediate Family.

**Radiation Therapy and Chemotherapy Services** for therapeutic treatment of covered benign and malignant conditions, including charges for x-rays, radium, radioactive isotopes and chemotherapy drugs and supplies used in treatment.

**Pap Smear** for: one annual cervical cytological screening for a female Covered Person. This benefit is not subject to satisfaction of the Deductible.

**Prostate Cancer Screening** for the early detection of prostate cancer in men forty (40) years of age and older according to the National Comprehensive Cancer Network guidelines and performed by a qualified medical professional. If a medical practitioner recommends that an insured, undergo a prostate specific antigen blood test, coverage may not be denied on the ground that the insured has already had a digital rectal examination and the examination result was negative. These charges are not subject to the Deductible.

**Mammography** for: 1) one baseline mammogram; 2) an annual screening mammogram; 3) a mammogram as recommended by the Doctor for a women who has had a prior history of breast cancer or who's mother or sister has had a history of breast cancer; 4) a diagnostic mammography at any age when prescribed by the woman's Doctor; not to exceed the Maximum Benefit Amount shown in the Schedule..

Benefits for Screening Mammography will not prejudice coverage for Diagnostic Mammography as recommended by a woman's Doctor. For purposes of this benefit, the following Definitions apply:

“Screening mammography” means a radiologic procedure provided to a woman who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer. The procedure entails two views of each breast and includes a Doctor's interpretation of results of the procedure.

“Diagnostic mammography” means a problem-solving radiologic procedure of higher intensity than Screening Mammography provided to women who are suspected to have breast pathology. Patient are usually referred for analysis of palpable abnormalities or for further evaluation of mammographically detected abnormalities. All images are immediately

reviewed by the Doctor interpreting the study, and additional views are obtained as needed. Physical exam of the breast by the interpreting Doctor to correlate the radiologic findings is often performed as part of the study.

**Routine Child Health Care** coverage from the moment of birth through the age of eighteen (18) years for Doctor-delivered or Doctor-supervised preventive health care services at the approximate age intervals of: birth; 2 weeks; 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months; 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years, and 18 years. Services, performed in accordance with prevailing medical standards must be provided by a single physician during the course of one visit and are limited to; medical history, physical examination, developmental assessment, anticipatory guidance, laboratory tests, and appropriate immunizations. All services, with the exception of immunization will be subject to any copayment, coinsurance, deductible or dollar limit appearing within the Policy.

**[Applicable only to a Covered Person with a Coverage Period greater than six (6) months:]**

**Diabetes Self-Management Training and Treatment** when prescribed by a Doctor as being Medically Necessary, and upon certification by an appropriately licensed health care professional of satisfactory completion, coverage will be provided for one lifetime Diabetes Self-management Training program plus additional diabetes self-management training when prescribed by the attending Doctor as being Medically Necessary due to a significant change in the Covered Person's symptoms or condition. This will also include medical coverage for Medically Necessary equipment, supplies, and services for the treatment of Type I, Type II, and gestational diabetes, when prescribed by a Doctor.

Diabetes Self-Management Training means instruction in an inpatient or outpatient setting, including medical nutrition therapy, relating to diet, caloric intake and diabetes management but excluding programs which the primary purpose is weight reduction, when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program developed by the American Diabetes Association.

**Loss or Impairment of Speech or Hearing** for the Medically Necessary diagnosis and treatment of loss or impairment of speech or hearing. Covered Expenses for such treatment will be paid as they would for any other Sickness. No benefits will be paid for hearing instruments or devices. Loss or impairment of speech or hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the State Board of Examiners in Speech Pathology and Audiology that fall within the scope of his area of certification.

**Hospital Newborn Coverage** for routine nursery care and pediatric charges for up to five (5) full days in a Hospital nursery or until discharge of the mother of the newborn from the Hospital following the birth of the child, whichever is the later; and any testing of a newborn child hereafter mandated by law.

**Colorectal Cancer Exams and Lab Tests** for the following colorectal cancer examinations and laboratory tests: (1) an annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five years; (2) a double-contrast barium enema every five years; (3) a colonoscopy every ten years; and (4) any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health, subject to the guidelines for the management or subsequent need for follow-up colonoscopy.

These benefits will be covered for a Covered Person who is: (1) fifty years of age or older; (2) less than fifty years of age and a high risk for colorectal cancer according to the current American Cancer Society colorectal cancer screening guidelines; and (3) experiencing the following symptoms of colorectal cancer as determined by a Doctor: (a) bleeding from the rectum or blood in the stool; or (b) a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five days.

**Medically Necessary Foods** and low protein modified food products for the treatment of a Covered Person afflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism if:

- a. The medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism;
- b. The products are administered under the direction of a Doctor;
- c. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the income tax credit of [two thousand four hundred dollars (\$2,400)] per year per person allowed under Arkansas law.

This includes coverage for amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas prescribed under the direction of a Doctor for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism.

**In Vitro Fertilization** services performed at a medical facility certified by the Department of Health, or a facility certified as conforming to the American College of Obstetricians and Gynecologists Guidelines for In Vitro Fertilization, or which meets the American Fertility Society standards.

**[Hearing Aids** for coverage for a hearing aid or hearing instrument sold by a professional licensed by the state to dispense a hearing aid or hearing instrument, not to exceed one thousand four hundred dollars (\$1,400) per beginning on the first day of coverage. These charges are not subject to the Deductibles or any copayment requirements.]

**[Musculoskeletal Disorders of Bone or Joint in Face, Neck or Head** will include the Medically Necessary diagnosis and treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head. This includes temporomandibular joint disorder and craniomandibular disorder. Treatment includes both surgical and nonsurgical procedures. Benefits are provided for these conditions whether they are the result of accident, trauma, congenital defect, developmental defect or pathology.]

#### **ALLOCATION AND APPORTIONMENT OF BENEFITS**

We reserve the right to allocate the Deductible to any Covered Expenses and to apportion the payment of benefits between You and any person designated by You. Such allocation and apportionment shall be conclusive and shall be binding upon You and all assignees.

#### **EXTENSION OF BENEFITS**

If a Covered Person is Hospital confined on the date insurance ends, other than for failure to pay the required premium, benefits will be continued only for the condition causing the Hospital confinement until the earlier of:

1. the date Hospital confinement ends;
2. the date when treatment for the Hospital confinement is no longer required;
3. the expiration of a 90 day period after the insurance ceases;
4. the date the Covered Person becomes eligible for any other group insurance plan providing coverage for the same conditions causing the Hospital Confinement; or
5. the date the Maximum Lifetime Benefit under the Policy has been reached.

Benefits payable due to the Extension of Benefits provision after the Expiration Date or when a Covered Person's coverage ends, are subject to a new Deductible and satisfaction of the Coinsurance Limit.

## EXCLUSIONS AND LIMITATIONS

We will not pay for loss or expense caused by or resulting from any of the following:

1. Expenses for the treatment of Preexisting Conditions, as defined in the Preexisting Conditions Limitation provision.
2. Expenses incurred prior to the Effective Date of a Covered Person's coverage or incurred after the Expiration Date, regardless of when the condition originated, except in accordance with the Extension of Benefits provision.
3. Expenses to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the Policy.
4. Expenses incurred for Experimental or Investigational services or treatment or unproven services or treatment.
5. Amounts in excess of the Usual, Reasonable and Customary charges made for covered services or supplies.
6. Expenses You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed.
7. Expenses that do not meet the definition of or are not specifically identified under the Policy as Covered Expenses.
8. [Expenses for purposes determined by Us to be educational. ]
9. [Expenses to the extent that they are paid or payable under another group insurance or medical prepayment plan.]
10. [Charges that are eligible for payment by Medicare or any other government program except Medicaid. ]
11. [Expenses for care in government institutions unless You or Your Covered Dependent are obligated to pay for such care. ]
12. [Expenses for which benefits are paid or payable under workers' compensation or similar laws. ]
13. [Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited). ]
14. [Expenses incurred by a Covered Person while on active duty in the armed forces. Upon written notice to us of entry into such active duty, the unused premium will be returned to you on a pro-rated basis. ]
15. [Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection. ]
16. [Expenses incurred while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony or assault. ]
17. [Expenses for the treatment of normal pregnancy or childbirth, except for Complications of Pregnancy. ]
18. [Expenses for voluntary termination of normal pregnancy or elective cesarean section. ]
19. [Expenses incurred for any drug, including birth control pills, implants, injections, supply, treatment device or procedure that prevents conception or childbirth. ]
20. [Expenses for the diagnosis and treatment of infertility, including but not limited to any attempt to induce fertilization by any method, artificial insemination or similar procedures, whether the Covered Person is a donor, recipient or surrogate. ]
21. [Expenses for sterilization or reversal of sterilization. ]
22. [Charges for a Covered Dependent who is a newborn child not yet discharged from the Hospital, except as specifically covered under the Policy. This does not apply to charges that are Medically Necessary to treat premature birth, congenital Injury or Sickness, or Sickness or Injury sustained during or after birth. ]
23. [Expenses related to sex transformation or penile implants or sex dysfunction or inadequacies. ]
24. [Expenses for physical exams or other services not needed for medical treatment, except as specifically covered.]
25. [Expenses for prophylactic treatment, including surgery or diagnostic testing, except as specifically covered. ]
26. [Expenses for the treatment of mental illness or nervous disorders, including, but not limited to, neurosis, psychoneurosis, psychopathy, psychosis, attention deficit disorder, autism, hyperactivity, or mental or emotional disease or disorder of any kind; unless it is specifically covered. ]
27. [Expenses for the treatment of alcoholism or alcohol abuse, chemical dependency, substance abuse or drug addiction; unless it is specifically covered. ]
28. [Expenses incurred for loss sustained or contracted in consequence of the Covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of a Doctor. Intoxication shall be established conclusively by a blood alcohol level of .10 or the legal limit in the state where the incident occurred, whichever is less. ]
29. [Expenses incurred for a loss that arises out of or in the course of employment. ]
30. [Expenses incurred in connection with programs, treatment, or procedures for tobacco use cessation. ]
31. [Expenses resulting from suicide or attempted suicide or intentionally self-inflicted Injury, while sane or insane. ]
32. [Expenses for dental treatment or care or orthodontia or other treatment involving the teeth or supporting structures, except as specifically covered. ]
33. [Expenses of radial keratotomy or correction of refractive error, eye refractions, vision therapy, routine vision exams to assess the initial need for, or changes to prescription eyeglasses or contact lenses, the purchase, fitting or adjustment of eyeglasses or contact lenses, or treatment of cataracts. ]
34. [Expenses for routine hearing exams to assess the need for or change to hearing aids, or the purchase, fittings or adjustments of hearing aids, except as specifically covered under the Policy. ]
35. [Expenses for cosmetic or reconstructive procedures, services or supplies; except as specifically covered. ]
36. [Expenses for breast reduction or augmentation or complications arising from these procedures; except as specifically covered. ]
37. Outpatient Prescription or Legend Drugs, medications, vitamins, and mineral or food supplements, including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.

38. [Expenses incurred in connection with any drug or other item used to treat hair loss. ]
39. [Expenses incurred in the treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions, spurs, or the removal of corns, calluses or toenails, unless specifically for the treatment of a metabolic or peripheral vascular disease or for the prompt repair of an Injury sustained while coverage is in force for the Covered Person. ]
40. [Expenses incurred in the treatment of acne, or varicose veins. ]
41. [Expenses of weight loss programs or diets. ]
42. [Transportation Expenses, except as specifically covered. ]
43. [Expenses for rest or recuperation cures or care in an extended care facility, convalescent nursing home, a facility providing rehabilitative treatment, Skilled Nursing Facility, or home for the aged, whether or not part of a Hospital.]
44. [Expenses for services or supplies for personal comfort or convenience, including homemaker services or supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to bathing, dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops. ]
45. [Expenses for services or supplies furnished or provided by a member of your Immediate Family. ]
46. [Expenses for diagnosis or treatment of a sleeping disorder. ]
47. [Expenses incurred in the treatment of Injury or Sickness resulting from participation in skydiving, scuba diving, hang or ultra light gliding, riding an all terrain vehicle such as a dirt bike, snowmobile or go-cart, racing with a motorcycle, boat or any form of aircraft, any participation in sports for pay or profit, or participation in rodeo contests. ]
48. [Expenses for the purchase of a noninvasive osteogenesis stimulator (bone stimulator). ]
49. [Expenses for services or supplies of a common household use, such as exercise cycles, air or water purifiers, air conditioners, allergenic mattresses, and blood pressure kits. ]
50. [Expenses during the first 6-months after the Effective Date of coverage for a Covered Person for: [(a) total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma; (b) tonsillectomy; (c) adenoidectomy; (d) repair of deviated nasal septum or any type of surgery involving the sinus; (e) myringotomy; (f) tympanotomy; (g) herniorrhaphy; or (h) cholecystectomy;] (subject to all other coverage provisions, including but not limited to, the Pre-existing Conditions exclusion). ]
51. [Expenses for participating in interscholastic, intercollegiate or organized competitive sports, unless it is specifically covered. ]
52. [Medical care, treatment, service or supplies received outside of the United States, Canada or its possessions. ]
53. [Expenses for private duty nursing services. ]
54. [Expenses for the repair or maintenance of a wheelchair, hospital-type bed or similar durable mechanical equipment. ]
55. [Expenses for orthotics, special shoes, spine and arch supports, heel wedges, sneakers or similar devices unless they are a permanent part of an orthopedic leg brace. ]
56. [Expenses incurred in connection with the voluntary taking of a poison or inhaling gas. ]
57. [Expenses incurred in connection with obesity treatment or weight reduction including all forms of intestinal and gastric bypass surgery, including the reversal of such surgery even if the Covered Person has other health conditions that might be helped by a reduction of obesity or weight. ]
58. [Expenses for marital counseling or social counseling. ]
59. [Expenses for acupuncture. ]
60. [Expenses for a service or supply whose primary purpose is to provide a Covered Person with (1) training in the requirements of daily living; (2) instruction in scholastic skills such as reading and writing; (3) preparation for an occupation; (4) treatment of learning disabilities, developmental delays or dyslexia; or (5) development beyond a point where function has been demonstrably restored. ]
61. [Expenses for replacement of artificial limbs or eyes. ]
62. [Expenses for removal of breast implants. ]

**PRE-EXISTING CONDITIONS LIMITATION:** We will not provide benefits for any loss caused by, or resulting from, a Pre-existing Condition. "Preexisting Conditions" means any medical condition or Sickness for which:

1. Medical advice, care, diagnosis, treatment, Consultation, or medication was recommended by or received from a Doctor within the [5-years] immediately prior to a Covered Person's Effective Date of coverage; or
2. Symptoms existed within the [5-years] immediately prior to the Covered Persons Effective Date of coverage which would cause a reasonable person to seek diagnosis, care or treatment.

"Consultation" means evaluation, diagnosis, or medical advice was given with or without the necessity of a personal examination or visit.

## PREMIUM PROVISIONS

**Premium Payment:** Premiums are payable at the Home Office of The Company or if We direct, to Our authorized administrator, on or before each premium due date.

**Premium Due Date:** The first premium will be due on the Policy effective date and on the same day of each subsequent month unless You and The Company agree on some other method of premium payment.

If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period.

**Changes in Premium Rates:** The monthly premium rates may be changed by Us from time to time if We give You at least [thirty-one (31) days] advance written notice. The premium rates may also be changed at any time the terms of the Policy are changed.

**Incorrect Premium Payment:** Premiums paid in error for a person who is not eligible to be insured, or for a person after his insurance has ceased, will be refunded without interest when requested by You. These premiums will not be refunded for any period before the last anniversary date.

**Grace Period:** If, before any premium due date except the first, You have not given written notice to The Company that the Policy is to be terminated, a Grace Period of thirty-one (31) days will be given in which to pay the premium then due. The Policy will stay in effect during that time. If any premium is not paid by the end of the Grace Period, the Policy will automatically terminate at the end of the Grace Period; except that if You have given written notice in advance of an earlier date of termination, the Policy will terminate as of the earlier date.

## CLAIM PROVISIONS

**Notice of Claim:** Written notice of claim must be given to The Company within thirty-one (31) days after a covered loss occurs or begins. If this notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible. The notice must be sent to The Company at its Home Office and should include the Your name, address, city, state, zip, and policy number.

**Claim Forms:** The Company will send the claim forms to You upon receipt of notice of claim. If You do not receive these forms within fifteen (15) days, the proof of loss requirement may be met by giving The Company a written statement of the nature and extent of the loss within the time limit stated below.

**Proof of Loss:** The Company requires written proof of loss within ninety (90) days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one (1) year from such time unless the claimant was legally incapacitated.

**Time of Payment of Claims:** We will make payment promptly upon receipt of due written proof of loss.

**Payment of Claims:** Payment will be made directly to You or the provider of the service, as directed by You in writing at the time of submitting proof of loss.

If any benefit under the Policy becomes payable to:

1. A Covered Person's estate;
2. A minor, or
3. Any person who, in the opinion of The Company, is not competent to give a valid release; then The Company, at its option, may make payment to any one or more the following:
  - a. A person who has assumed the care and support of the Covered Person or beneficiary;
  - b. A person who has incurred funeral or other expenses as a result of the Covered Person's last illness or death;
  - c. The personal representative of the Covered Person's estate;
  - d. Any person related to the Covered Person by blood or marriage.

No payments made to anyone named above may exceed \$250, or the maximum allowed by state law. Any payment made in good faith under this section will fully discharge The Company to the extent of the payment.

**Appeal of Claim Denial:** If a claim is denied, You will receive written notice giving the reason for the denial. If You wish to appeal the denial of the claim, such appeal must be submitted to us in writing within sixty (60) days from the date of notice. You must clearly state the reason You believe the claim decision is incorrect.

## GENERAL PROVISIONS

**Execution of Policy:** The Policy is executed at the Home Office of Pan-American Life Insurance Company in New Orleans, Louisiana.

**Consideration:** The Policy is issued to the Covered Person in consideration of the application and payment of premiums.

**Incontestability:** We will not contest the Policy after three (3) years from the date of onset of issue except for failure to pay premium. No statement made by an Covered Person will be used to deny a claim after the person's coverage has been in force for a period of three (3) years during the Covered Person's life; then only if the statement is made in writing and signed by the Covered Person.

**Statements Not Warranties:** All statements made by the Covered Person will, be deemed representations and not warranties. No statement made by the Covered Person to obtain insurance will be used to avoid or reduce the insurance unless:

1. It is made in writing;
2. It is signed by the Covered Person; and
3. A copy is sent to the Covered Person or the Covered Person's Beneficiary.

**Entire Contract:** The entire contract will be made up of the Policy, Certificates, the individual Covered Person's applications, Amendments and Riders will constitute the entire Policy between parties.

**Policy Changes:** Insurance provided by the Policy may be amended, changed or canceled without the consent of any Covered Person and without prior notice to him. Changes may be made in the Policy only by amendment signed by The Company acting through one (1) of its officers. No agent may change or waive any terms of the Policy.

**Clerical Error:** Clerical error will not void insurance otherwise validly in force nor will it keep in force insurance which otherwise would cease.

**Conformity With Statutes:** Any provision of this Policy that is in conflict with the statutes of the jurisdiction in which the Policy is issued is hereby amended to conform to the minimum requirements of such statutes.

**Assignment and Claims of Creditors:** Benefits are not assignable except that You may direct us to pay benefits to the person or institution on whose charges any claim is based. Any such payment that we make will fully discharge Us to the extent of the payment.

**Contract/Changes:** The effective time for any dates used shall be 12:01 A.M. Standard Time at the address of the Covered Person.

**Medical Records:** The Company shall have access to medical and treatment records of the Covered Persons to determine benefits, process claims, utilization review, quality assurance, or for any other purpose reasonably related to the Policy benefits. Each Covered Person shall complete and submit to the Company such additional consents, releases and other documents as may be requested by the Company in order to determine or provide benefits under the Policy. The Company reserves the right to reject or suspend a claim based on lack of supporting medical information or records.

**Physical Exam and Autopsy:** We may require, at Our expense, medical examinations of any person for whom claim is made when and as often as it may reasonably require during the pendency of a claim. We may also make an autopsy, if not forbidden by law.

**Pronouns:** Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine also, unless the context clearly indicates to the contrary.

**Rescission:** A misrepresentation or omission in the application form or other documents provided to Us may be the basis for later rescission of all coverage of all Covered Persons. Rescission voids all coverage as of the Effective Date and means that no benefits will be paid to any person for any claim submitted, whether or not such claim relates to the condition about which information was misrepresented or omitted. We will refund to You premiums paid after deduction for any claims We paid.

**Waiver of Rights:** The Company's failure to enforce any provision of the Policy does not affect Our right to enforce any provision at a later date, and does not affect the Company's right to enforce any other provision of the Policy.

**Workers' Compensation:** This Policy is not a substitute for Workers' Compensation insurance and does not affect any requirement for Workers' Compensation coverage.

**[Subrogation:** As a condition to receiving benefits under the Policy, Covered Persons receiving medical benefits agree to transfer in full to Us their rights to recover damages for these benefits when the Injury or Sickness occurs through the act or omission of another person. 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 Injury or Sickness occurs through the act of a third party. Our subrogation rights of full recovery may be from any person or business entity, in accordance with the laws of the jurisdiction wherein the Injury or Sickness occurred. We may enforce Our right of subrogation by requiring the Covered Person to assert a claim to any of the coverages to which he/she may be entitled. We will not pay fees or expenses associated with a claim/lawsuit without express written authorization.

If We are precluded by law from exercising Our Subrogation Right, We may exercise Our Right of Reimbursement.]

**[Right of Reimbursement:** As a condition to receiving benefits under the Policy, Covered Persons receiving medical care benefits agree to reimburse Us in full any such benefits when they are recovered from another person or business entity. If a repayment agreement is required to be signed, We shall be entitled to full reimbursement regardless of whether it is actually signed. Our right of reimbursement may be from funds received from any person or business entity, in accordance with the laws of the jurisdiction wherein the Injury or Sickness occurred. We may enforce Our right of reimbursement by requiring the Covered Person to assert a claim to any of the coverages to which he/she may be entitled. We will not pay fees or expenses associated with any claim/lawsuit without express written consent.]

**[Third Party Clause:** Medical care benefits are not payable to or for a Covered Person under the Policy when the Injury or Sickness to the Covered Person occurs through the act or omission of another person. However, We may elect to advance payment for medical expenses incurred for an Injury or Sickness caused by a third party. The Covered Person or guardian must sign an agreement to repay Us in full any sums advanced for such medical expenses from any judgment or settlement received. We have the right to recover in full the medical expenses advanced regardless of whether that person actually signs any required repayment agreement. It is only necessary that the Injury or Sickness occurs through the act of a third party. Our right of recovery in full may be from any person or business entity, in accordance with the laws of the jurisdiction wherein the Injury or Sickness occurred. We may enforce this provision by requiring the Covered Person to assert a claim to any of the coverages to which he may be entitled. We will not pay fees or expenses associated with the claim/lawsuit without express written authorization.]

**Legal Proceedings:** No proceedings to obtain benefits may be brought against us until 60-days after we have received proper written proof of loss and any other documentation necessary to establish the benefits due. No proceedings may be brought more than 3-years after proof is required to be filed.

**Misstatement of Age:** If a Covered Person's age has been misstated, premiums will be subject to an equitable adjustment. If the amount of the benefit depends upon age, then the benefit will be that which would have been payable, based upon the person's correct age.

**Reinstatement:** If any renewal premium is not paid within the time granted the Covered Person for payment, a subsequent acceptance of premium by the Company without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the Company requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the Company or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the Company has previously notified the Covered Person in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects, the Covered Person and the Company shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

**Refund of unearned premiums upon death of insured.** Upon the death of the Covered Person, the proceeds payable to the insured or his or her estate under the Policy shall include premiums paid for any period beyond the end of the Policy month in which the death occurred. The unearned premiums shall be paid in lump sum on a date no later than thirty (30) days after the proof of the Covered Person's death has been furnished to the Company.

[

## POLICY SCHEDULE OF INSURANCE

Policy Number: G-123456  
Policyholder Name: John Doe  
Effective Date: December 1, 2008  
Supplement Accidental Injury Rider: December 1, 2008

Dependent Coverage:  Yes  No  
Coverage Period: 6 months

Deductible: \$500  
Coinsurance: 80% up to \$5,000 and 100% thereafter  
Lifetime Maximum: \$500,000

]

**PAN-AMERICAN LIFE INSURANCE COMPANY**  
**[601 Poydras Street**  
**New Orleans, Louisiana 70130]**

**OPTIONAL SUPPLEMENTAL ACCIDENTAL INJURY BENEFIT**  
**AMENDATORY RIDER**

This amendatory rider becomes a part of the Policy to which it is attached.

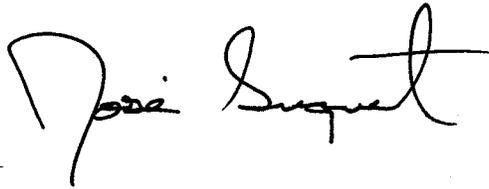
**These Benefits will only be effective if the required premium for these benefits has been paid. [The Effective Date is shown in the Schedule.]**

Supplemental Accident Benefit..... [100% of the first [\$300] of inpatient or outpatient Covered Expenses incurred due to an Accidental Injury, payable per accident. Any Covered Expense incurred beyond [\$300] will be subject to the applicable Deductible and coinsurance amounts. ]

The Company will pay for expenses incurred due to an Accidental Injury, up to the maximum amount shown above. The Covered Expenses must be within [90 days] of the accident and the Covered Person must receive the first medical treatment within [72 hours] of the accident.

Accidental Injury means accidental bodily Injury sustained by a Covered Person, on or after the Effective Date of coverage, caused by an outside agent or force, that happens solely, directly, and independently of all other causes.

**PAN-AMERICAN LIFE INSURANCE COMPANY**



[  
[President and Chief Executive Officer]

PAN-AMERICAN LIFE INSURANCE COMPANY – [SHORT TERM MEDICAL] INSURANCE APPLICATION

[COMPLETE THE FOLLOWING INFORMATION ABOUT YOURSELF:

Applicant: Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_
Social Security Number \_\_\_\_\_ Telephone \_\_\_\_\_
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Billing Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ ]
E-mail address \_\_\_\_\_

[COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE AND/OR CHILDREN:

Spouse: Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_
Social Security Number \_\_\_\_\_
Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_ Social Security Number \_\_\_\_\_
Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_ Social Security Number \_\_\_\_\_
Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_ Social Security Number \_\_\_\_\_ ]

COMPLETE THE FOLLOWING PLAN CHOICES:

A. [Coverage Effective Date:  Day after US Post Office Date Stamp  Later Effective Date: \_\_\_\_\_ ]
B. Coverage Length: [ 30 days  60 Days  90 Days  120 Days  150 Days  180 Days  # \_\_\_\_ Days (Minimum of 31 days)
 Up to 6 Months (Monthly Payments)  Up to 12 Months (Monthly Payments)]
C. Coinsurance:  80/20 of \$5,000  50/50 of \$5,000  80/20 of \$10,000  50/50 of \$10,000]
D. Deductible: [\$500  \$750  \$1,000  \$2,500  \$5,000  \$10,000]
E. Payment Method: [ Check or Money Order  Credit Card  Monthly Automatic Bank Withdrawal ]

ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:

Answer the following questions completely and accurately.

- 1. [Have/Are you, your spouse, or any person to be insured:.....  Yes  No
\* been denied insurance due to any health reasons that are still present?
\* over 300 pounds if male, or over 250 pounds if female?
\* now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?
2. [For any of the following conditions within the last 5 years, have you or any person to be insured received any abnormal test results or medical or surgical treatment, or consulted a health care professional, or taken medication for:.....  Yes  No
\* heart disorder including but not limited to heart attack or chest pain?
\* Emphysema?
\* Chrohn's disease, ulceractive colitis or hepatitis?
\* Acquired Immune Deficiency Disorder (AIDS) or tested positive for HIV?
\* Stroke?
\* Kidney disorder, excluding kidney stones?
\* Diabetes?
\* Cancer or tumor?
\* Alcoholism, chemical dependency, drug or alcohol abuse? ]

NOTE: IF "YES" IS ANSWERED ON QUESTIONS 1 AND 2 COVERAGE CANNOT BE ISSUED.

I agree that coverage will not become effective for any person whose medical history changes prior to coverage approval, such that the person's answer would be "yes" to any of the Medical History questions in this application. If such person is the Applicant, coverage is automatically declined for all persons included in this application. I hereby request coverage under the policy issued by the insurer and understand that if the coverage applied for becomes effective, I agree to all terms of the policy. I understand that health insurance benefits are excluded for pre-existing conditions. 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. I have read this application and have verified that all of the information provided in it is complete, true and correct, and is all within my personal knowledge. I agree to immediately notify the insurer of any changes in any of the information contained in this form which may occur prior to the approval of coverage. All information provided will be held in strictest confidence. Your personal health information is protected at all times and may only be released with your express written authorization to do so.

I certify that I have read the applicable Fraud Notice.

I understand that this coverage will not pay benefits for a disease or physical condition that I now have or have had in the past.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Spouse: \_\_\_\_\_ Date: \_\_\_\_\_

Underwritten by: PAN-AMERICAN LIFE INSURANCE COMPANY, NEW ORLEANS, LA

**IMPORTANT FRAUD NOTICE [Please review the notice that applies in your state]**

**[FRAUD STATEMENT: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]**

**[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF KANSAS: 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 as determined by a court of law and subject to criminal and/or civil penalties.]**

**[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF LOUISIANA AND ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of 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.]**

**[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF WASHINGTON: Any person who knowingly presents false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.]**

SERFF Tracking Number: INCS-126444889 State: Arkansas  
 Filing Company: Pan-American Life Insurance Company State Tracking Number: 44718  
 Company Tracking Number: PAL-STMIP-2008-AR  
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.004 Short Term  
 Product Name: PALIC STM Ind  
 Project Name/Number: PALIC STM IND/PAL-STMIP-2008-AR

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<p><b>Satisfied - Item:</b> Flesch Certification</p> <p><b>Comments:</b> The Consumer Information Notice is on the face page of the Policy.</p> <p><b>Attachments:</b> Readability Individual.pdf Certification.pdf</p>	Approved-Closed	02/05/2010
<p><b>Satisfied - Item:</b> Application</p> <p><b>Comments:</b> the application is included under the Forms Schedule Tab</p>	Approved-Closed	02/05/2010
<p><b>Satisfied - Item:</b> Health - Actuarial Justification</p> <p><b>Comments:</b></p> <p><b>Attachments:</b> AR PAL-STMIP-2008-AR Actuarial Memorandum - 2010 01 28.pdf AR PAL-STMIP-2008-AR Rate Manual - 2010 01 28.pdf</p>	Approved-Closed	02/05/2010
<p><b>Satisfied - Item:</b> Outline of Coverage</p> <p><b>Comments:</b></p> <p><b>Attachment:</b> AR STM OUTLINE.pdf</p>	Approved-Closed	02/05/2010

**Item Status:**                      **Status  
Date:**

*SERFF Tracking Number:* INCS-126444889      *State:* Arkansas  
*Filing Company:* Pan-American Life Insurance Company      *State Tracking Number:* 44718  
*Company Tracking Number:* PAL-STMIP-2008-AR  
*TOI:* H16I Individual Health - Major Medical      *Sub-TOI:* H16I.004 Short Term  
*Product Name:* PALIC STM Ind  
*Project Name/Number:* PALIC STM IND/PAL-STMIP-2008-AR  
**Satisfied - Item:** AUTHORIZATION LETTER      Approved-Closed      02/05/2010  
**Comments:**  
**Attachment:**  
 ICS Authorization 2010 PALIC.pdf

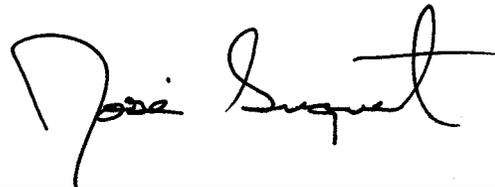
**Item Status:**      **Status**  
**Date:**  
**Satisfied - Item:** POLICY FORMS LIST      Approved-Closed      02/05/2010  
**Comments:**  
**Attachment:**  
 Forms Listing Individual STM AR.pdf

**Item Status:**      **Status**  
**Date:**  
**Satisfied - Item:** EXPLANATION OF VARIABLES      Approved-Closed      02/05/2010  
**Comments:**  
**Attachment:**  
 SOV AR ind.pdf

**CERTIFICATION OF COMPLIANCE  
FOR READABILITY**

<u>Form Number(s)</u>	<u>Flesch Readability Score</u>
PAL-STMIP-2008-AR	45.1
PAL-STMIAR-2008-ACC	45.1

I hereby certify on behalf of Pan-American Life Insurance Company that the Flesch Scale Analysis Readability Score is accurate, based on the computer program used to calculate the scores.



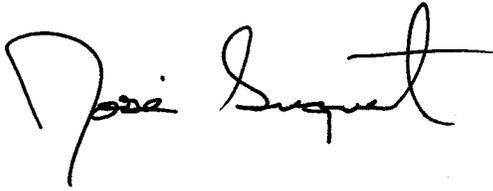
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President and Chief Executive Officer

Dated: January 2010

**ARKANSAS  
CERTIFICATE OF COMPLIANCE**

PanAmerican Life Insurance Company hereby certifies that the policy forms listed below are in compliance with all of the requirements of Arkansas Insurance Department Rule and Regulation 19. The benefits/coverage provided by the forms listed below are available to, and will be administered, in a non-discriminatory manner.



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

President and Chief Executive Officer

(Title)

1/5/10

(Date)

**Policy Form Numbers:**

PAL-STMIP-2008-AR; PAL-STMIAR-2008-ACC, PAL-STMIA-2008

# **Actuarial Memorandum**

Effective February 1, 2010

For

## **PAN-AMERICAN LIFE INSURANCE COMPANY**

Individual Short Term Medical Product  
Form PAL-STMIP-2008-AR

Optional Supplemental Accident Injury Benefit Rider  
Form PAL-STMIAR-2008-ACC

# Actuarial Memorandum

## PAN-AMERICAN LIFE INSURANCE COMPANY

### Individual Short Term Medical Product

#### Form PAL-STMIP-2008-AR

#### Form PAL-STMIAR-2008-ACC

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### Section 1: Purpose of Actuarial Memorandum

This actuarial memorandum in conjunction with the rate manual has been prepared for the purpose of demonstrating the premium rate development for Pan-American Life Insurance Company's short term medical product.

This actuarial memorandum is applicable to Arkansas only. The offered benefits and the statutory mandated requirements in Arkansas are highlighted in Section 2 and Section 3 of this memorandum and detailed in the policy form filed in conjunction with this memorandum. These benefits are accounted for in the premium rates, plan adjustment factors and the geographic adjustment for the state. These rates and factors do not account for mandates become effective after the date of this memorandum. The rate adjustment could be inadequate for future mandated benefits.

### Section 2: Product Summary/Description of Benefits

The policy, supported by this Rate Manual, provides individuals with an opportunity to obtain affordable insurance on a short term basis. Individuals have the option to select from different plans of short term medical. The same level of coverage is available for individual's dependents at additional cost.

The duration of the coverage period ranges from 30 days to 185 days, and 365 days.

The product is not guarantee issued or renewable. Individuals and dependents are underwritten before acceptance.

Premiums are payable lump sum or on a monthly basis via check payment or automated fund transfer.

The policy is marketed by licensed agents and brokers.

#### A. Regular Plan

Benefits are payable after the Per Person Deductible at Coinsurance Percentage up to the Lifetime maximum, subject to benefit limits summarized in Table 1 and other insurance details in Section 3.

Per Person Per Coverage Period	\$500; \$1,000; \$2,500; \$5,000; \$10,000
Deductible option:	

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Per Person Per Cause Deductible option: \$500; \$1,000; \$2,500; \$5,000; \$10,000  
 Coinsurance Percentage option: 50% or 80% up to \$5,000 or \$10,000, and  
 100% thereafter  
 Lifetime Maximum: \$1,000,000

**Table 1: Regular Plan Benefit Limits**

Benefits	Benefit Limits
Doctor's office visits	Maximum \$50 per visit up to 2 visits per year (\$100 maximum per person), Balance applies to deductible and coinsurance apply thereafter.
Knee Surgery	Maximum \$2,500 per person per coverage period
Gallbladder Surgery	Maximum \$2,500 per person per coverage period
Ground and Air Ambulance	Maximum \$250 per incidence
Mammography	Maximum \$50 for each screening mammography

**B. Lite Plan**

Benefits are payable after the Per Person Deductible at Coinsurance Percentage up to the Lifetime maximum, subject to benefit limits summarized in Table 2 and other insurance details in Section 3.

Per Person Per Coverage Period Deductible option: \$500; \$1,000; \$2,500; \$5,000; \$10,000  
 Per Person Per Cause Deductible option: \$500; \$1,000; \$2,500; \$5,000; \$10,000  
 Coinsurance Percentage option: 80% to \$10,000 and 100% thereafter;  
 or 100% for deductible \$2,500 and more  
 Lifetime Maximum: \$750,000

**Table 2: Lite Plan Benefit Limits**

Benefits	Benefit Limits
Doctor's office visits	Maximum \$50 per visit up to 2 visits per year (\$100 maximum per person), Balance applies to deductible and coinsurance apply thereafter.
Inpatient Regular Care	The Average Semi-Private Room Rate \$1,000 per day including all Inpatient Miscellaneous Medical Expense Services.
In Hospital Intensive or Critical Care	Up to \$2,000 per day including all Inpatient Miscellaneous Medical Expense Services
Emergency Room Treatment	Up to \$500 per day including the emergency room

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### PAN-AMERICAN LIFE INSURANCE COMPANY

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**Table 2: Lite Plan Benefit Limits**

Benefits	Benefit Limits
	Doctor charge, 24 hour observation and all miscellaneous medical expenses received during the emergency room visit
Outpatient Hospital Surgery or Ambulatory Surgical Center	Up to \$1,000 per day including all Miscellaneous Medical Expenses
Outpatient Miscellaneous Medical Covered Expenses	Up to \$1,000 per Coverage Period for all Covered Expenses combined. Does not include Inpatient Hospital or outpatient Hospital surgery
In Hospital Doctor Visits	Up to \$500 per in-hospital confinement
Surgery Services	The Surgeon, Anesthetics, Assistance Surgeon and Surgeon's Assistants benefits are limited to \$2,500 per surgery, for all Covered Expenses combined, not to exceed \$5,000 per Coverage Period
Surgeon	Up to \$2,500 per surgery
Anesthesiologist	Up to 20% of the surgeon's benefits
Surgeon's assistant	Up to 15% of the surgeon's benefits
Knee Surgery	Maximum \$2,500 per person per coverage period
Gallbladder Surgery	Maximum \$2,500 per person per coverage period
Acquired Immune Deficiency Syndrome (AIDS)	Maximum \$10,000 per Coverage Period
Ground and Air Ambulance	Maximum \$250 per incidence
Mammography	Maximum \$50 for each screening mammography

#### *C. Supplemental Accidental Injury Benefit Rider*

Benefits	Benefit Limits
Accident Benefits	100% of up to \$300 of inpatient or outpatient Covered Expenses incurred due to an Accidental Injury, payable per accident.

The Company will offer the Supplemental Accident Injury Rider to a block of plan designs and will not determine the offer at the individual applicant level. It is not the Company's intent to design the offering such that there would be an adverse selection against the insured or the

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Company. The insured will not have the option of choosing the same base plan with or without the rider.

### Section 3: General Insurance Details

This section is included only for reference supporting premium rate assumptions. Please refer to the policy and certificate for actual terms and conditions.

Underwriting Requirements: Applicants and dependents must answer no to all the underwriting questions in the application form. This is not a guarantee issued product.

Pre-existing conditions exclusions: The policy does not provide benefits for any loss caused by, or resulting from, a Pre-existing Condition. "Preexisting Conditions" means any medical condition or Sickness for which:

1. Medical advice, care, diagnosis, treatment, Consultation, or medication was recommended by or received from a Doctor within the Look-Back Period immediately prior to a Covered Person's Effective Date of coverage; or
2. Symptoms existed within the Look-Back Period immediately prior to the Covered Persons Effective Date of coverage which would cause a reasonable person to seek diagnosis, care or treatment.

"Consultation" means evaluation, diagnosis, or medical advice was given with or without the necessity of a personal examination or visit.

"Look-Back Period" is 5 years.

Enrollment Eligibility: No other medical coverage; not in armed force; primary insured – age 1 to age 64; legal dependent spouse; dependent children less than 25 and who receives more than one-half of his financial support from the parent, or children of any age who is medically certified as disabled and dependent.

Free look: 10 days

Pre-admission certification: Hospital admissions and lengths of stay are subject to certification by a Professional Review Organization. Notification must occur as 10 days prior to non-emergency admission of the insured person to a Hospital; or within 48 hours or on the first business day following an emergency admission of the insured person to a Hospital, or as soon thereafter as is reasonably possible; or within 48 hours of delivery for complicated birth.

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Reduction of benefits: To the extent that the otherwise Eligible Expense for the Hospital admission and/or length of stay and/or extensions of stay are not certified by the Professional Review Organization, the penalty is 50% of the Eligible Expenses, unless the insured person is incapacitated and unable to contact the Company.

Exclusions:

1. Expenses for the treatment of Preexisting Conditions, as defined in the Preexisting Conditions Limitation provision.
2. Expenses incurred prior to the Effective Date of a Covered Person's coverage or incurred after the Expiration Date, regardless of when the condition originated, except in accordance with the Extension of Benefits provision.
3. Expenses to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the Policy.
4. Expenses incurred for Experimental or Investigational services or treatment or unproven services or treatment.
5. Amounts in excess of the Usual, Reasonable and Customary charges made for covered services or supplies.
6. Expenses the Covered Person is not required to pay, or which would not have been billed, if no insurance existed.
7. Expenses that do not meet the definition of or are not specifically identified under the Group Policy as Covered Expenses.
8. Expenses for purposes determined by the Company to be educational.
9. Expenses to the extent that they are paid or payable under another group insurance or medical prepayment plan.
10. Charges that are eligible for payment by Medicare or any other government program except Medicaid.
11. Expenses for care in government institutions unless the Covered Person is obligated to pay for such care.
12. Expenses for which benefits are paid or payable under workers' compensation or similar laws.
13. Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited).
14. Expenses incurred by a Covered Person while on active duty in the armed forces. Upon written notice to of entry into such active duty, the unused premium will be returned to the Insured on a pro-rated basis.
15. Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.

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16. Expenses incurred while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony or assault.
17. Expenses for the treatment of normal pregnancy or childbirth, except for Complications of Pregnancy.
18. Expenses for voluntary termination of normal pregnancy or elective cesarean section.
19. Expenses incurred for any drug, including birth control pills, implants, injections, supply, treatment device or procedure that prevents conception or childbirth.
20. Expenses for the diagnosis and treatment of infertility, including but not limited to any attempt to induce fertilization by any method, artificial insemination or similar procedures, whether the Covered Person is a donor, recipient or surrogate.
21. Expenses for sterilization or reversal of sterilization.
22. Charges for a Covered Dependent who is a newborn child not yet discharged from the Hospital, except as specifically covered under the Policy. This does not apply to charges that are Medically Necessary to treat premature birth, congenital Injury or Sickness, or Sickness or Injury sustained during or after birth.
23. Expenses related to sex transformation or penile implants or sex dysfunction or inadequacies.
24. Expenses for physical exams or other services not needed for medical treatment, except as specifically covered.
25. Expenses for prophylactic treatment, including surgery or diagnostic testing, except as specifically covered.
26. Expenses for the treatment of mental illness or nervous disorders, including, but not limited to, neurosis, psychoneurosis, psychopathy, psychosis, attention deficit disorder, autism, hyperactivity, or mental or emotional disease or disorder of any kind; unless it is specifically covered.
27. Expenses for the treatment of alcoholism or alcohol abuse, chemical dependency, substance abuse or drug addiction; unless it is specifically covered.
28. Expenses incurred for loss sustained or contracted in consequence of the Covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of a Doctor. Intoxication shall be established conclusively by a blood alcohol level of .10 or the legal limit in the state where the incident occurred, whichever is less.
29. Expenses incurred for a loss that arises out of or in the course of employment.
30. Expenses incurred in connection with programs, treatment, or procedures for tobacco use cessation.
31. Expenses resulting from suicide or attempted suicide or intentionally self-inflicted Injury, while sane or insane.
32. Expenses for dental treatment or care or orthodontia or other treatment involving the teeth or supporting structures, except as specifically covered.
33. Expenses incurred in the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular

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- disorders, myofacial pain dysfunction or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint, except as specifically covered.
34. Expenses of radial keratotomy or correction of refractive error, eye refractions, vision therapy, routine vision exams to assess the initial need for, or changes to prescription eyeglasses or contact lenses, the purchase, fitting or adjustment of eyeglasses or contact lenses, or treatment of cataracts.
  35. Expenses for routine hearing exams to assess the need for or change to hearing aids, or the purchase, fittings or adjustments of hearing aids, except as specifically covered under the Policy.
  36. Expenses for cosmetic or reconstructive procedures, services or supplies; except as specifically covered.
  37. Expenses for breast reduction or augmentation or complications arising from these procedures; except as specifically covered.
  38. Outpatient Prescription or Legend Drugs, medications, vitamins, and mineral or food supplements, including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.
  39. Expenses incurred in connection with any drug or other item used to treat hair loss.
  40. Expenses incurred in the treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions, spurs, or the removal of corns, calluses or toenails, unless specifically for the treatment of a metabolic or peripheral vascular disease or for the prompt repair of an Injury sustained while coverage is in force for the Covered Person.
  41. Expenses incurred in the treatment of acne, or varicose veins.
  42. Expenses of weight loss programs or diets.
  43. Transportation Expenses, except as specifically covered.
  44. Expenses for rest or recuperation cures or care in an extended care facility, convalescent nursing home, a facility providing rehabilitative treatment, Skilled Nursing Facility, or home for the aged, whether or not part of a Hospital.
  45. Expenses for services or supplies for personal comfort or convenience, including homemaker services or supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to bathing, dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops.
  46. Expenses for services or supplies furnished or provided by a member of the Insured's Immediate Family.
  47. Expenses for diagnosis or treatment of a sleeping disorder.
  48. Expenses incurred in the treatment of Injury or Sickness resulting from participation in skydiving, scuba diving, hang or ultra light gliding, riding an all terrain vehicle such as a dirt

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- bike, snowmobile or go-cart, racing with a motorcycle, boat or any form of aircraft, any participation in sports for pay or profit, or participation in rodeo contests.
49. Expenses for the purchase of a noninvasive osteogenesis stimulator (bone stimulator).
  50. Expenses for services or supplies of a common household use, such as exercise cycles, air or water purifiers, air conditioners, allergenic mattresses, and blood pressure kits.
  51. Expenses during the first 6-months after the Effective Date of coverage for a Covered Person for: [(a) total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma; (b) tonsillectomy; (c) adenoidectomy; (d) repair of deviated nasal septum or any type of surgery involving the sinus; (e) myringotomy; (f) tympanotomy; (g) herniorrhaphy; or (h) cholecystectomy;] (subject to all other coverage provisions, including but not limited to, the Pre-existing Conditions exclusion).
  52. Expenses for participating in interscholastic, intercollegiate or organized competitive sports, unless it is specifically covered.
  53. Medical care, treatment, service or supplies received outside of the United States, Canada or its possessions.
  54. Left intentionally blank.
  55. Expenses for private duty nursing services.
  56. Expenses for the repair or maintenance of a wheelchair, hospital-type bed or similar durable mechanical equipment.
  57. Expenses for orthotics, special shoes, spine and arch supports, heel wedges, sneakers or similar devices unless they are a permanent part of an orthopedic leg brace.
  58. Expenses incurred in connection with the voluntary taking of a poison or inhaling gas.
  59. Expenses incurred in connection with obesity treatment or weight reduction including all forms of intestinal and gastric bypass surgery, including the reversal of such surgery even if the Covered Person has other health conditions that might be helped by a reduction of obesity or weight.
  60. Expenses for marital counseling or social counseling.
  61. Expenses for acupuncture.
  62. Expenses for a service or supply whose primary purpose is to provide a Covered Person with (1) training in the requirements of daily living; (2) instruction in scholastic skills such as reading and writing; (3) preparation for an occupation; (4) treatment of learning disabilities, developmental delays or dyslexia; or (5) development beyond a point where function has been demonstrably restored.
  63. Expenses for replacement of artificial limbs or eyes.
  64. Expenses for removal of breast implants.

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#### **Section 4: Renewability Provision**

This is a short-term medical product. Policies do not have any renewal provision.

#### **Section 5: Applicability (Closed/Open Block)**

This is a new product filing.

#### **Section 6: Marketing Method**

The product will be distributed via internet and brochures and serviced by selling brokers or agents.

#### **Section 7: Underwriting Method**

The Company plans to use a short term underwriting approach. The Company will not offer coverage to applicants who answer “yes” to any of the medical questions. The product is intended to be affordable short term insurance coverage for those who do not have any known medical risk.

#### **Section 8: Issue Age Limits**

The product is available to applicants who are age 1 to age 64 at the time of issue.

#### **Section 9: Premium Basis**

Premiums are payable lump sum or on a monthly basis via check payment or automated fund transfer.

#### **Section 10: Nature of Rate Change and Proposed Rate/Methodology Change**

This is a new product filing.

#### **Section 11 For Each Change, Indication if New or Modified**

This is a new product filing.

#### **Section 12: For Each Change Comparison to Status Quo**

This is a new product filing.

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### **Section 13: Summary of How Each Proposed Modification Differs from Corresponding Current/Approved Rate/Methodology**

This is a new product filing.

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Prepared by CP Risk Solutions, LLC  
[www.cprisksolutions.com](http://www.cprisksolutions.com)  
January 28<sup>th</sup>, 2010

*for Pan-American Life Insurance Company only*

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### Section 14: Summary of Each Proposed New Rule

Step 1. Choose a payment option single or monthly.	Single Payment	Monthly Payment	Rate Manual Source Reference
<b>Step 2. Daily rate</b>			
a) Applicant rate			Section 4 - Table 2a or Table 2b
b) Spouse rate	+		Section 4 - Table 2a or Table 2b
Subtotal	=	XX	
<b>Step 3. Per child rate</b>			
Enter the number of dependent children	x		Section 4 - Table 2a or Table 2b
Multiply the rate by the number of children	=	XX	
<b>Step 4. Subtotals daily rate</b>			
Step 2 + Step 3	XX	XX	
<b>Step 5. Plan Option Adjustment</b>			
			Section 4 - Table 3a, Table 3b, Table 4a or Table 4b
<b>Step 6. ZIP Code Factor</b>			
			Section 4 - Table 5
<b>Step 7. Medical and Experience Trend Factor</b>			
			Section 4 - Table 6
<b>Step 8. Monthly factor</b>	1	1.2	
<b>Step 9: Supplemental Accident Injury Rider</b>			
Optional at the group level; Enter 0 if not elected			Section 4 - Table 7
<b>Step 10. Enter the number of days of coverage</b>			
Single Payment – 30 days to 185 days, 365 days			
Monthly Payment – Actual number of days in each month			
<b>Step 11. Total Premium</b>			
{ Step 4 x Step 5 x Step 6 x [1+Step 7] x Step 8+ Step 9 } x Step 10	XX	XX	

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### Section 15: Overall Premium Impact of Filing on Policyholders

This is a new product filing.

### Section 16: Filed Minimum Required Loss Ratio

The product is priced at a 48% loss ratio.

### Section 17: Interest Rate/Persistency/Mortality Assumptions

Due to the very short term nature of the product, there are no mortality or persistency assumptions reflected in the pricing.

### Section 18: Morbidity Assumptions

Rate development for each plan consisted of determining claims costs of the medical benefits provided. To do this, I used

- Apex HRM databases
- CMS cost statistics
- Demographic and other information provided by Pan-American Life Insurance Company and Selected Market Insurance Group
- CP Risk Solutions, LLC proprietary information

Considerations are given to:

- Pre-existing condition exclusions and medical underwriting requirements
- Short accumulation period for policy deductible and out-of-pocket maximum, when compared to regular medical plans
- Medical expenses made at 100% of Medicare payment basis
- Plan designs

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**Table 3: Distribution of Sales by Age and Sex**

Age	Male	Female
To 25	4%	6%
25-29	11%	15%
30-34	7%	9%
35-39	6%	6%
40-44	4%	4%
45-49	4%	4%
50-54	3%	4%
55-59	3%	3%
60-64	2%	2%
Child	3%	
Total	100%	

The projected average enrollment age for this product is 36.

**Table 4: Distribution of Sales by Benefit Duration**

Coverage Period	Single Pay	Monthly Pay
31 or less days	9%	0%
32 to 62 days	7%	0%
63 to 93 days	5%	0%
94 to 185 days	6%	0%
6 months	0%	73%
Total	27%	73%

Coverage Period is based on option chosen at the time of application. Actual coverage period under Monthly Pay could be shortly when insured terminates prior to the full initially selected coverage period. Based on the initially selected coverage period, the average duration of the single pay policies is 71 days and the average duration of the monthly pay is 6 months.

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**Table 5: Regular Plan Average Monthly Claims Cost**

Age	Male	Female
To 20	30.39	32.47
20-24	29.00	33.51
25-29	29.00	38.38
30-34	31.26	42.89
35-39	35.60	44.98
40-44	41.85	49.32
45-49	53.83	59.04
50-54	75.36	80.92
55-59	106.27	99.33
60-64	145.34	122.77
Per Child	18.75	
Average	48.76	

The average claims costs in Table 5 are based on a \$1,000 deductible, 80% coinsurance to \$10,000 plan option, a coverage period of 6 months, a monthly pay option, a 31 day month, no Supplemental Accident Injury Benefit rider and Arkansas geographic adjustment. The final composite average is based on average age/sex mix as show in Table 3.

**Table 6: Lite Plan Average Monthly Claims Cost**

Age	Male	Female
To 20	25.13	24.35
20-24	24.16	24.94
25-29	23.58	29.23
30-34	25.91	32.34
35-39	30.40	35.27
40-44	36.63	38.97
45-49	48.52	46.57
50-54	69.36	63.52
55-59	98.39	79.30
60-64	135.22	101.32
Per Child	15.59	
Average	40.09	

The average claims costs in Table 6 are based on a \$1,000 deductible, 80% coinsurance to \$10,000 plan option, a coverage period of 6 months, a monthly pay option, a 31 day month, no Supplemental

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Accident Injury Benefit rider and Arkansas geographic adjustment. The final composite average is based on average age/sex mix as show in Table 3.

### Section 19: Administrative Expense and Margin Assumptions

Company Overhead, administration and premium tax	17%
Sales/Marketing/Commission	25%
<u>Underwriting Margin</u>	<u>10%</u>
Total Expenses and Margin	52%

Table 7 and Table 8 premium rates are based on Table 5 and Table 6 claim costs, respectively. The premium rates are the claim costs divided by (1- the total expenses and margin).

**Table 7: Regular Plan Average Monthly Premium Rates**

Age	Male	Female
To 20	63.31	67.65
20-24	60.42	69.82
25-29	60.42	79.95
30-34	65.12	89.36
35-39	74.16	93.70
40-44	87.19	102.74
45-49	112.15	123.00
50-54	157.01	168.58
55-59	221.40	206.93
60-64	302.80	255.77
Per Child	39.07	
Average	101.57	

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# Actuarial Memorandum

## PAN-AMERICAN LIFE INSURANCE COMPANY

### Individual Short Term Medical Product

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**Table 8: Lite Plan Average Monthly Premium Rates**

Age	Male	Female
To 20	52.36	50.74
20-24	50.33	51.96
25-29	49.12	60.89
30-34	53.99	67.38
35-39	63.32	73.47
40-44	76.31	81.18
45-49	101.07	97.01
50-54	144.51	132.33
55-59	204.99	165.21
60-64	281.71	211.08
Per Child	32.47	
Average	83.51	

### Section 20: Moderately Adverse Assumption Justification

There is no adverse assumption.

### Section 21: Loss Ratio Analysis

This is a new policy form. There is no policy experience.

### Section 22: State and Countrywide Experience

This is a new policy form. There is no policy experience.

### Section 23: Variability of Results and Experience Monitoring

Future experience will invariably be different from projected experience and other knowledgeable individuals could have a different opinion about what the most appropriate assumptions are. The Company should monitor the experience for premium adequacy and make changes, if necessary.

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## Actuarial Memorandum

### PAN-AMERICAN LIFE INSURANCE COMPANY

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#### Section 24: Actuarial Certification

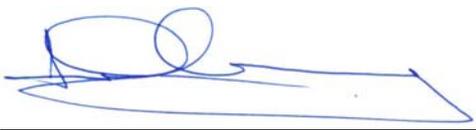
I, Lina S. Cheung, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I meet the Academy's qualification standards for preparing health rate filings. I have been retained by Pan-American Life Insurance Company to prepare this memorandum. Information in this memorandum may not be appropriate for any other purposes.

I have reviewed the forms and the supporting material submitted with the filing. To the best of my knowledge and judgment:

- The filing is in compliance with all applicable laws and regulations of Arkansas;
- The filing is in compliance with Actuarial Standards of Practice No. 8 "Regulatory Filings for Health Plan Entities";
- The benefits are reasonable in relation to the premium charged; and
- The rates are not excessive, inadequate or unfairly discriminatory

This is a short duration and non-renewable product. The acquisition is thus spread over a short period of time. Further, this is a low premium product. Similar to most low premium products, expenses in absolute dollars might be comparable to those of the convention health insurance products but are higher on a % of premium basis.

In preparing this actuarial memorandum, I relied on data Pan-American Life Insurance Company, Selected Marketing Insurance Group and Innovative Compliance Solutions provided to me. I did not audit the information. To the extent that this data is incomplete or inaccurate, the contents of this memorandum may be materially affected.



Lina S. Cheung, FSA, MAAA, FCA  
Partner, CP Risk Solutions, LLC  
January 28<sup>th</sup>, 2010

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Prepared by CP Risk Solutions, LLC  
[www.cprisksolutions.com](http://www.cprisksolutions.com)  
January 28<sup>th</sup>, 2010

*for Pan-American Life Insurance Company only*

# **Rate Manual**

Effective February 1, 2010

For

## **PAN-AMERICAN LIFE INSURANCE COMPANY**

Individual Short Term Medical Product  
Form PAL-STMIP-2008-AR

Optional Supplemental Accident Injury Benefit Rider  
Form PAL-STMIAR-2008-ACC

# Rate Manual

## PAN-AMERICAN LIFE INSURANCE COMPANY Individual Short Term Medical Product Form PAL-STMIP-2008-AR Form PAL-STMIAR-2008-ACC

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### Section 1: Introduction

The rates contained in this Rate Manual shall apply to form PAL-STMIP-2008 and PAL-STMIAR-2008-ACC as of the stated effective date. This rate manual should be used in conjunction with the applicable actuarial memorandum. The rates may not be appropriate for benefit and administrative changes after such a date.

### Section 2: Product Summary

The policy, supported by this Rate Manual, provides individuals with an opportunity to obtain affordable insurance on a short term basis. Individuals have the option to select from different plans of short term medical. The same level of coverage is available for individual's dependents at additional cost.

The duration of the coverage period ranges from 30 days to 185 days, 365 days.

The product is not guarantee issued or renewable. Individuals and dependents are underwritten before acceptance.

Premiums are payable lump sum or on a monthly basis via check payment or automated fund transfer.

The policy is marketed by licensed agents and brokers.

#### A. Regular Plan

Benefits are payable after the Per Person Deductible at Coinsurance Percentage up to the Lifetime maximum, subject to benefit limits summarized in Table 1.

Per Person Per Coverage Period	\$500; \$1,000; \$2,500; \$5,000; \$10,000
Deductible option:	
Per Person Per Cause Deductible option:	\$500; \$1,000; \$2,500; \$5,000; \$10,000
Coinsurance Percentage option:	50% or 80% up to \$5,000 or \$10,000, and 100% thereafter
Lifetime Maximum:	\$1,000,000

**Table 1: Regular Plan Benefit Limits**

Benefits	Benefit Limits
Doctor's office visits	Maximum \$50 per visit up to 2 visits per year (\$100 maximum per person), Balance applies to deductible and coinsurance apply thereafter.

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## PAN-AMERICAN LIFE INSURANCE COMPANY Individual Short Term Medical Product Form PAL-STMIP-2008-AR Form PAL-STMIAR-2008-ACC

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**Table 1: Regular Plan Benefit Limits**

Benefits	Benefit Limits
Knee Surgery	Maximum \$2,500 per person per coverage period
Gallbladder Surgery	Maximum \$2,500 per person per coverage period
Ground and Air Ambulance	Maximum \$250 per incidence
Mammography	Maximum \$50 for each screening mammography

### B. Lite Plan

Benefits are payable after the Per Person Deductible at Coinsurance Percentage up to the Lifetime maximum, subject to benefit limits summarized in Table 2.

Per Person Per Coverage Period Deductible option:	\$500; \$1,000; \$2,500; \$5,000; \$10,000
Per Person Per Cause Deductible option:	\$500; \$1,000; \$2,500; \$5,000; \$10,000
Coinsurance Percentage option:	80% to \$10,000 and 100% thereafter; or 100% for deductible \$2,500 and more
Lifetime Maximum:	\$750,000

**Table 2: Lite Plan Benefit Limits**

Benefits	Benefit Limits
Doctor's office visits	Maximum \$50 per visit up to 2 visits per year (\$100 maximum per person), Balance applies to deductible and coinsurance apply thereafter.
Inpatient Regular Care	The Average Semi-Private Room Rate \$1,000 per day including all Inpatient Miscellaneous Medical Expense Services
In Hospital Intensive or Critical Care	Up to \$2,000 per day including all Inpatient Miscellaneous Medical Expense Services
Emergency Room Treatment	Up to \$500 per day including the emergency room Doctor charge, 24 hour observation and all miscellaneous medical expenses received during the emergency room visit
Outpatient Hospital Surgery or Ambulatory Surgical Center	Up to \$1,000 per day including all Miscellaneous Medical Expenses
Outpatient Miscellaneous Medical Covered Expenses	Up to \$1,000 per Coverage Period for all Covered Expenses combined. Does not include Inpatient Hospital or outpatient Hospital surgery
In Hospital Doctor Visits	Up to \$500 per in-hospital confinement
Surgery Services	The Surgeon, Anesthetics, Assistance Surgeon and

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## PAN-AMERICAN LIFE INSURANCE COMPANY

### Individual Short Term Medical Product

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**Table 2: Lite Plan Benefit Limits**

Benefits	Benefit Limits
Surgeon	Surgeon's Assistants benefits are limited to \$2,500 per surgery, for all Covered Expenses combined, not to exceed \$5,000 per Coverage Period  Up to \$2,500 per surgery
Anesthesiologist	Up to 20% of the surgeon's benefits
Surgeon's assistant	Up to 15% of the surgeon's benefits
Knee Surgery	Maximum \$2,500 per person per coverage period
Gallbladder Surgery	Maximum \$2,500 per person per coverage period
Acquired Immune Deficiency Syndrome (AIDS)	Maximum \$10,000 per Coverage Period
Ground and Air Ambulance	Maximum \$250 per incidence
Mammography	Maximum \$50 for each screening mammography

### C. Supplemental Accidental Injury Benefit Rider

Benefits	Benefit Limits
Accident Benefits	100% of up to \$300 of inpatient or outpatient Covered Expenses incurred due to an Accidental Injury, payable per accident.

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## PAN-AMERICAN LIFE INSURANCE COMPANY Individual Short Term Medical Product Form PAL-STMIP-2008-AR Form PAL-STMIAR-2008-ACC

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### Section 3: Premium Rate Algorithm

Step 1. Choose a payment option single or monthly.	Single Payment	Monthly Payment	Source Reference
<b>Step 2. Daily rate</b>			
a) Applicant rate	[ ]	[ ]	Table 2a or Table 2b
b) Spouse rate	+ [ ]	[ ]	Table 2a or Table 2b
Subtotal	= <u>XX</u>	= <u>XX</u>	
<b>Step 3. Per child rate</b>			
Enter the number of dependent children	[ ]	[ ]	Table 2a or Table 2b
Multiply the rate by the number of children	x [ ]	[ ]	
	= <u>XX</u>	= <u>XX</u>	
<b>Step 4. Subtotals daily rate</b>	XX	XX	
Step 2 + Step 3	_____	_____	
<b>Step 5. Plan Option Adjustment</b>	[ ]	[ ]	Table 3a, Table 3b, Table 4a or Table 4b
<b>Step 6. Area Factor</b>	[ ]	[ ]	Table 5
<b>Step 7. Medical and Experience Trend Factor</b>	[ ]	[ ]	Table 6
<b>Step 8. Monthly factor</b>	1	1.2	
<b>Step 9: Optional Supplemental Accident Injury Benefit Rider</b>	[ ]	[ ]	Table 7
Optional at the group level; Enter 0 if not elected			
<b>Step 10. Enter the number of days of coverage</b>	[ ]	[ ]	
Single Payment – 30 days to 185 days, 365 days			
Monthly Payment – Actual number of days in each month			
<b>Step 11. Total Premium</b>	XX	XX	
{ Step 4 x Step 5 x Step 6 x [1+Step 7] x Step 8+ Step 9 } x Step 10			

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## PAN-AMERICAN LIFE INSURANCE COMPANY

### Individual Short Term Medical Product

#### Form PAL-STMIP-2008-AR

#### Form PAL-STMIAR-2008-ACC

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### Section 4: Rate Tables

**Table 2a: Starting Rates – Regular Plan**

Age	Male	Female
To 20	1.75	1.87
20-24	1.67	1.93
25-29	1.67	2.21
30-34	1.80	2.47
35-39	2.05	2.59
40-44	2.41	2.84
45-49	3.10	3.40
50-54	4.34	4.66
55-59	6.12	5.72
60-64	8.37	7.07
Per Child	1.08	

**Table 2b: Starting Rates – Lite Plan**

Age	Male	Female
To 20	1.29	1.25
20-24	1.24	1.28
25-29	1.21	1.50
30-34	1.33	1.66
35-39	1.56	1.81
40-44	1.88	2.00
45-49	2.49	2.39
50-54	3.56	3.26
55-59	5.05	4.07
60-64	6.94	5.20
Per Child	0.80	

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## PAN-AMERICAN LIFE INSURANCE COMPANY Individual Short Term Medical Product Form PAL-STMIP-2008-AR Form PAL-STMIAR-2008-ACC

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**Table 3a: Regular Plan Adjustment Factors – Deductible per Coverage Period**

Deductible	500	1,000	2,500	5,000	10,000
<b>30 days to 185 days</b>					
80% to \$5,000	1.21	1.03	0.73	0.49	0.27
80% to \$10,000	1.17	1.00	0.71	0.47	0.26
50% to \$5,000	1.03	0.89	0.65	0.44	0.25
50% to \$10,000	0.93	0.81	0.59	0.40	0.23
<b>12 months</b> (not available in CO, CT, IN, LA, MI, NV, ND, OH, OR and SD)					
80% to \$5,000	1.46	1.26	0.91	0.61	0.34
80% to \$10,000	1.42	1.22	0.88	0.58	0.33
50% to \$5,000	1.24	1.09	0.81	0.55	0.31
50% to \$10,000	1.13	0.99	0.73	0.50	0.29

**Table 3b: Lite Plan Adjustment Factors – Deductible per Coverage Period**

Deductible	500	1,000	2,500	5,000	10,000
<b>30 days to 185 days</b>					
80% to \$10,000	1.23	1.00	0.63	0.36	0.14
100%	N/A	N/A	0.72	0.40	0.15
<b>12 months</b> (not available in CO, CT, IN, LA, MI, NV, ND, OH, OR and SD)					
80% to \$10,000	1.50	1.24	0.80	0.46	0.19
100%	N/A	N/A	0.91	0.51	0.21

**Table 4a: Regular Plan Adjustment Factors – Deductible per Cause**

Deductible	500	1,000	2,500	5,000	10,000
<b>30 days to 185 days</b>					
80% to \$5,000	1.16	1.00	0.71	0.47	0.26
80% to \$10,000	1.13	0.96	0.69	0.45	0.25
50% to \$5,000	0.99	0.86	0.63	0.43	0.24
50% to \$10,000	0.90	0.78	0.57	0.39	0.22
<b>12 months</b> (not available in CO, CT, IN, LA, MI, NV, ND, OH, OR and SD)					
80% to \$5,000	1.38	1.20	0.88	0.58	0.32
80% to \$10,000	1.34	1.16	0.85	0.57	0.31
50% to \$5,000	1.18	1.04	0.78	0.53	0.30
50% to \$10,000	1.07	0.94	0.70	0.48	0.28

**Table 4b: Lite Plan Adjustment Factors – Deductible per Cause**

Deductible	500	1,000	2,500	5,000	10,000
<b>30 days to 185 days</b>					
80% to \$10,000	1.20	0.98	0.62	0.35	0.14
100%	N/A	N/A	0.70	0.39	0.15
<b>12 months</b> (not available in CO, CT, IN, LA, MI, NV, ND, OH, OR and SD)					
80% to \$10,000	1.44	1.19	0.78	0.45	0.19
100%	N/A	N/A	0.88	0.50	0.21

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# Rate Manual

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**Table 5: Area Factors**

State	Zip	Regular Plan Adjustment Factor	Lite Plan Adjustment Factor
AR	All	0.97	1.09

The area factors in Table 5 reflect statutory mandates as of the indicated date of update. The factors do not reflect state mandates effective after the indicated dates. The area factors also do not account for any state or pool assessments. The Company could be subject to these assessments as a result of this product.

**Table 6: Medical and Experience Trend Factor**

Arkansas trend factor
0%

There will be no automatic increase for trend in Arkansas.

**Table 7: Optional Supplemental Accidental Injury Rider**

Daily Rate
0.12

The Company will offer the Supplemental Accident Injury Rider to a block of plan designs and will not determine the offer at the individual applicant level. It is not the Company's intent to design the offering such that there would be an adverse selection against the insured or the Company. The insured will not have the option of choosing the same base plan with or without the rider.

### Section 5: Variability of Results, Experience Monitoring and other Considerations

Future experience will invariably be different from projected experience and other knowledgeable individuals could have a different opinion about what the most appropriate assumptions are. The Company should monitor the experience for premium adequacy and make changes, if necessary.

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**PAN-AMERICAN LIFE INSURANCE COMPANY**

**INDIVIDUAL SHORT TERM MAJOR MEDICAL EXPENSE COVERAGE**

**ARKANSAS OUTLINE OF COVERAGE**

Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Individual short term major medical expense coverage is designed to provide limited duration for hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy.

This Policy limits Covered Expenses to Usual, Reasonable and Customary charges which may be less than the billed charges. This means that if a provider charges more than the Usual, Reasonable and Customary charge, you may be responsible for the difference. This plan pays an overall lifetime maximum of [\$100,000-\$2,000,000] for each insured. However certain benefits have individual limitations as shown below and in the Policy, which are included in the overall lifetime maximum.

The following is a brief description of the Usual, Reasonable and Customary charges for Covered Expenses covered under the Policy. You are responsible for your deductible and any coinsurance percentages up to an out of pocket maximum of [\$5,000-\$10,000]. See your Policy for a complete list of all benefits.

- [Hospital Charges —medical care and treatment.
- Ambulatory Surgical Center charges.
- Intensive Care — up to three times the average semi-private room rate.
- Physicians Services for diagnosis, treatment and surgery.
- Anesthesia, oxygen, casts, splints, crutches, braces, surgical dressings, artificial limbs or eyes, rental of necessary medical supplies.
- Blood or blood derivatives and their administration.
- X-ray exams, laboratory tests and analyses.
- X-ray and radioactive isotope therapy.
- Ambulance Services — \$250 per trip
- Acquired Immune Deficiency Syndrome (AIDS).
- Mammography/Pap Smear screens and exams
- Breast Reconstructive Surgery]

**Usual, Reasonable and Customary means:**

- [1. With respect to fees or charges, fees for medical services or supplies which are:
  - a. Usually charged by the provider for the service or supply given; and
  - b. The average charged for the service or supply in the locality in which the service or supply is received; whichever is less, or
2. With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

In reaching a determination as to what amount should be considered as Usual, Reasonable and Customary for services and supplies, We may use and subscribe to a standard industry reference source that collects data and makes it available to its member companies. The data base used reflects the amounts charged by providers for health care services based on geographic zip code areas generating a statistically credible charge distribution. The data is reflective of reported provider charges from the lowest to the highest for each service or supply. The data is also adjusted periodically to reflect negotiated fee schedules with providers not included in the data base.]

**PRE-ADMISSION CERTIFICATION**

This plan requires a Pre-Admission Certification by a Professional Review Organization prior to in-patient Hospitalization or surgery. A Covered Person must call the Professional Review Organization:

1. For elective or non-emergency Hospitalization or surgery, at least 10-days prior to the date of proposed Hospitalization;
2. Within 48-hours of an emergency admission; or
3. Within 48-hours of delivery for complicated childbirth.

Non-compliance with the Pre-Admission Certification procedure will result in a reduction in benefits of 50%, unless the Covered Person is incapacitated and unable to contact us. In such cases, the Covered Person must contact us as soon as possible. You have been provided with information and procedures necessary for Pre-Admission Certification. You may obtain more information regarding Pre-Certification and its procedures from the Company.

## **Exclusions and Limitations.**

We will not pay for loss or expense caused by or resulting from any of the following:

1. Expenses for the treatment of Preexisting Conditions, as defined in the Preexisting Conditions Limitation provision.
2. Expenses incurred prior to the Effective Date of a Covered Person's coverage or incurred after the Expiration Date, regardless of when the condition originated, except in accordance with the Extension of Benefits provision.
3. Expenses to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the Policy.
4. Expenses incurred for Experimental or Investigational services or treatment or unproven services or treatment.
5. Amounts in excess of the Usual, Reasonable and Customary charges made for covered services or supplies.
6. Expenses You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed.
7. Expenses that do not meet the definition of or are not specifically identified under the Policy as Covered Expenses.
8. [Expenses for purposes determined by Us to be educational. ]
9. [Expenses to the extent that they are paid or payable under another group insurance or medical prepayment plan.]
10. [Charges that are eligible for payment by Medicare or any other government program except Medicaid. ]
11. [Expenses for care in government institutions unless You or Your Covered Dependent are obligated to pay for such care. ]
12. [Expenses for which benefits are paid or payable under workers' compensation or similar laws. ]
13. [Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited). ]
14. [Expenses incurred by a Covered Person while on active duty in the armed forces. Upon written notice to us of entry into such active duty, the unused premium will be returned to you on a pro-rated basis. ]
15. [Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection. ]
16. [Expenses incurred while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony or assault. ]
17. [Expenses for the treatment of normal pregnancy or childbirth, except for Complications of Pregnancy. ]
18. [Expenses for voluntary termination of normal pregnancy or elective cesarean section. ]
19. [Expenses incurred for any drug, including birth control pills, implants, injections, supply, treatment device or procedure that prevents conception or childbirth. ]
20. [Expenses for the diagnosis and treatment of infertility, including but not limited to any attempt to induce fertilization by any method, artificial insemination or similar procedures, whether the Covered Person is a donor, recipient or surrogate. ]
21. [Expenses for sterilization or reversal of sterilization. ]
22. [Charges for a Covered Dependent who is a newborn child not yet discharged from the Hospital, except as specifically covered under the Policy. This does not apply to charges that are Medically Necessary to treat premature birth, congenital Injury or Sickness, or Sickness or Injury sustained during or after birth. ]
23. [Expenses related to sex transformation or penile implants or sex dysfunction or inadequacies. ]
24. [Expenses for physical exams or other services not needed for medical treatment, except as specifically covered.]
25. [Expenses for prophylactic treatment, including surgery or diagnostic testing, except as specifically covered. ]
26. [Expenses for the treatment of mental illness or nervous disorders, including, but not limited to, neurosis, psychoneurosis, psychopathy, psychosis, attention deficit disorder, autism, hyperactivity, or mental or emotional disease or disorder of any kind; unless it is specifically covered. ]
27. [Expenses for the treatment of alcoholism or alcohol abuse, chemical dependency, substance abuse or drug addiction; unless it is specifically covered. ]
28. [Expenses incurred for loss sustained or contracted in consequence of the Covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of a Doctor. Intoxication shall be established conclusively by a blood alcohol level of .10 or the legal limit in the state where the incident occurred, whichever is less. ]
29. [Expenses incurred for a loss that arises out of or in the course of employment. ]
30. [Expenses incurred in connection with programs, treatment, or procedures for tobacco use cessation. ]
31. [Expenses resulting from suicide or attempted suicide or intentionally self-inflicted Injury, while sane or insane. ]
32. [Expenses for dental treatment or care or orthodontia or other treatment involving the teeth or supporting structures, except as specifically covered. ]
33. [Expenses of radial keratotomy or correction of refractive error, eye refractions, vision therapy, routine vision exams to assess the initial need for, or changes to prescription eyeglasses or contact lenses, the purchase, fitting or adjustment of eyeglasses or contact lenses, or treatment of cataracts. ]
34. [Expenses for routine hearing exams to assess the need for or change to hearing aids, or the purchase, fittings or adjustments of hearing aids, except as specifically covered under the Policy. ]
35. [Expenses for cosmetic or reconstructive procedures, services or supplies; except as specifically covered. ]
36. [Expenses for breast reduction or augmentation or complications arising from these procedures; except as specifically covered. ]
37. Outpatient Prescription or Legend Drugs, medications, vitamins, and mineral or food supplements, including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.

38. [Expenses incurred in connection with any drug or other item used to treat hair loss. ]
39. [Expenses incurred in the treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions, spurs, or the removal of corns, calluses or toenails, unless specifically for the treatment of a metabolic or peripheral vascular disease or for the prompt repair of an Injury sustained while coverage is in force for the Covered Person. ]
40. [Expenses incurred in the treatment of acne, or varicose veins. ]
41. [Expenses of weight loss programs or diets. ]
42. [Transportation Expenses, except as specifically covered. ]
43. [Expenses for rest or recuperation cures or care in an extended care facility, convalescent nursing home, a facility providing rehabilitative treatment, Skilled Nursing Facility, or home for the aged, whether or not part of a Hospital.]
44. [Expenses for services or supplies for personal comfort or convenience, including homemaker services or supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to bathing, dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops. ]
45. [Expenses for services or supplies furnished or provided by a member of your Immediate Family. ]
46. [Expenses for diagnosis or treatment of a sleeping disorder. ]
47. [Expenses incurred in the treatment of Injury or Sickness resulting from participation in skydiving, scuba diving, hang or ultra light gliding, riding an all terrain vehicle such as a dirt bike, snowmobile or go-cart, racing with a motorcycle, boat or any form of aircraft, any participation in sports for pay or profit, or participation in rodeo contests. ]
48. [Expenses for the purchase of a noninvasive osteogenesis stimulator (bone stimulator). ]
49. [Expenses for services or supplies of a common household use, such as exercise cycles, air or water purifiers, air conditioners, allergenic mattresses, and blood pressure kits. ]
50. [Expenses during the first 6-months after the Effective Date of coverage for a Covered Person for: [(a) total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma; (b) tonsillectomy; (c) adenoidectomy; (d) repair of deviated nasal septum or any type of surgery involving the sinus; (e) myringotomy; (f) tympanotomy; (g) herniorrhaphy; or (h) cholecystectomy;] (subject to all other coverage provisions, including but not limited to, the Pre-existing Conditions exclusion). ]
51. [Expenses for participating in interscholastic, intercollegiate or organized competitive sports, unless it is specifically covered. ]
52. [Medical care, treatment, service or supplies received outside of the United States, Canada or its possessions. ]
53. [Expenses for private duty nursing services. ]
54. [Expenses for the repair or maintenance of a wheelchair, hospital-type bed or similar durable mechanical equipment. ]
55. [Expenses for orthotics, special shoes, spine and arch supports, heel wedges, sneakers or similar devices unless they are a permanent part of an orthopedic leg brace. ]
56. [Expenses incurred in connection with the voluntary taking of a poison or inhaling gas. ]
57. [Expenses incurred in connection with obesity treatment or weight reduction including all forms of intestinal and gastric bypass surgery, including the reversal of such surgery even if the Covered Person has other health conditions that might be helped by a reduction of obesity or weight. ]
58. [Expenses for marital counseling or social counseling. ]
59. [Expenses for acupuncture. ]
60. [Expenses for a service or supply whose primary purpose is to provide a Covered Person with (1) training in the requirements of daily living; (2) instruction in scholastic skills such as reading and writing; (3) preparation for an occupation; (4) treatment of learning disabilities, developmental delays or dyslexia; or (5) development beyond a point where function has been demonstrably restored. ]
61. [Expenses for replacement of artificial limbs or eyes. ]
62. [Expenses for removal of breast implants. ]

**PRE-EXISTING CONDITIONS LIMITATION:** We will not provide benefits for any loss caused by, or resulting from, a Pre-existing Condition. "Preexisting Conditions" means any medical condition or Sickness for which:

1. Medical advice, care, diagnosis, treatment, Consultation, or medication was recommended by or received from a Doctor within the [5-years] immediately prior to a Covered Person's Effective Date of coverage; or
2. Symptoms existed within the [5-years] immediately prior to the Covered Persons Effective Date of coverage which would cause a reasonable person to seek diagnosis, care or treatment.

"Consultation" means evaluation, diagnosis, or medical advice was given with or without the necessity of a personal examination or visit.

### **Premium**

The first premium will be due on the Policy effective date and on the same day of each subsequent month unless You and The Company agree on some other method of premium payment. If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period.

The monthly premium rates may be changed by Us from time to time if We give You at least [thirty-one (31) days] advance written notice. The premium rates may also be changed at any time the terms of the Policy are changed.

**Cancellation by Insured**

The insured may cancel this policy at any time by written notice delivered or mailed to the Company, effective upon receipt of such notice or on such later date as may be specified in such notice.

**Renewability**

Coverage under this policy is NONRENEWABLE.

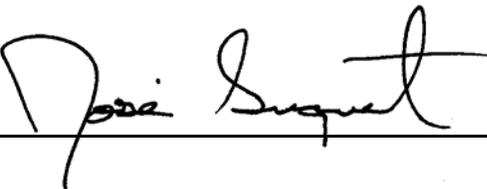
Authorization Letter

January 2010

COMPANY: Pan-American Life Insurance Company  
NAIC Number: 67539  
FEIN Number: 720281240

Please accept this letter as authorization for Innovative Compliance Solutions to act as our agent for submission of policy forms and rate information and to perform each and every act necessary in connection with such submission on behalf of Pan-American Life Insurance Company.

BY:



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TITLE:

President and Chief Executive Officer

Pan-American Life Insurance Company

**PAN-AMERICAN LIFE INSURANCE COMPANY**  
**INDIVIDUAL SHORT TERM MEDICAL EXPENSE POLICY**  
**FORMS LISTING**

<u>Form Number(s)</u>	<u>Description</u>
<u>Policy</u>	
PAL-STMIP-2008-AR	Policy face page
PAL- STMIP-2008-TOC	Table of Contents
PAL- STMIP-2008-SCH-AR	Schedule
PAL- STMIP-2008-DEF-AR	Definitions
PAL- STMIP-2008-ELG	Eligibility Provisions
PAL- STMIP-2008-EFF-AR	Effective Date
PAL- STMIP-2008-TRM-AR	Termination Provisions
PAL- STMIP-2008-BEN-AR	Medical Expense Benefits
PAL-STMIP-2008-LE-AR	Limitations and Exclusions
PAL- STMIP-2008-PREM	Premium Provisions
PAL- STMIP-2008-CLM	Claim Provision
PAL- STMIP-2008-GEN-AR	General Provisions
PAL-STMIP-2008-PSCH	Policy Schedule

**PAN-AMERICAN LIFE INSURANCE COMPANY  
INDIVIDUAL SHORT TERM MEDICAL INSURANCE  
SERIES PAL-STMP-2008  
EXPLANATION OF VARIABLES**

**Forms:**

PAL-STMP-2008-AR

Policy

**All state mandated benefits within text that is bracketed would not be altered below that which is required by the state.**

**POLICY**

**FACE PAGE**

Company Address – the current company address will be shown here.

Policyholder; Policy Number; Effective Date – the specific policyholder information will be input or the words “see Schedule of Insurance” will be shown.

Signature – Current signature and name will be shown

**SCHEDULE**

Section I

Deductible: Benefit range is shown. Family deductible text is variable by omission. When included the range is 1-4

Coinsurance: Range for percentage payable and limits are shown. 100% for deductibles over \$2500 is variable by omission.

Lifetime maximum: Benefit range is shown.

Section II

*Hospital Covered Expenses*

- The percentage range is shown. Inside limits are variable by omission. When inside limits are included the range for hospital is \$1,000-2,000 and for ICU is \$2,000-3,000.
- Emergency Room Treatment. Variable by omission. When included the range is \$500-\$750.
- In Hospital Doctor Visits. Variable by omission. When included the range is \$500-\$750

*Other Covered Expenses*

- Doctors Office –The copay is \$50-75, the maximum visits range is 2-3 visits, a maximum range of \$1,000 – 1,500.
- Ambulatory Surgical Center – the Outpatient Surgery is variable by omission. Maximum benefit range is \$1,000-2,000.
- Anesthetics Coinsurance - Maximum percentage range is 20-25%.
- Assistant Surgeon - Maximum percentage range is 20-25%
- Surgeons Assistant -Maximum percentage range is 15-20%
- Inside Limits for Surgeons is variable by omission. When include the maximum amounts are variable as follows: \$2,500-3,000 for surgery not to exceed \$5,000-\$6,000.
- Ambulance – dollar amount range is \$250-500.
- AIDS – variable by omission. When included, benefit amount range is \$10,000-\$15,000.
- Knee Injury – variable by omission. When included, benefit amount range is \$2,500-3,000. Other conditions are variable by omission.
- Gallbladder surgery – variable by omission. When included, benefit amount is \$2,500-3,000.
- Outpatient Misc. Charges - The percentage range is shown. Inside limits are variable by omission. When inside limits are included the maximum benefit range is \$1,000-2,000.

**DEFINITIONS**

Coverage Period. Bracket text is variable by omission or to indicate the place where this information will be shown.

Deductible. Bracket text is variable by omission or to indicate the place where this information will be shown.

Domestic Partner/Domestic Partnership. Variable by omission

URC. Variable to indicate the process used to determine URC.

**ELIGIBILITY**

You – Bracketed items are variable by omission.

Spouse – Bracketed items are variable by omission.

Dependent Children – 19 is the minimum age and 25 is the maximum age. Items 3 – 5 are variable by omission.

**EFFECTIVE DATES**

You and Eligible Dependents – The text within brackets is variable by content on a case-by-case basis. The company may add or remove other requirements.

When Changes in Coverage Occur – Items 2-3, References to dates can be changed to read: the date; the first day of the month coinciding with or next following; or the US post mark date when received by the Administrator. Item 4 is variable by omission.

**TERMINATION OF INSURANCE**

Termination of the Policy – The time frames within brackets are variable, the range is 30 - 60 days. The bracketed text in the last sentence can be changed to read: the date; or the first premium due date.

**MEDICAL EXPENSE BENEFITS**

Covered Expenses - Text in brackets is variable by omission.

*Hospital Covered Expenses*

Emergency Room Treatment – Text in brackets is variable by omission.

Inpatient Misc - Text in brackets is variable by omission

Inpatient Doctor Visits - Text in brackets is variable by omission

*Covered Expenses for Treatment, Services or Supplies*

Doctor Office Visits - Text in brackets is variable by omission

Outpatient Surgery - Text in brackets is variable by omission

Surgeon Services - Text in brackets is variable by omission

Anesthetics - Text in brackets is variable by omission

Assistant Surgeon - Text in brackets is variable by omission

Surgeon Assistant - Text in brackets is variable by omission

AIDS – Variable by omission

Knee Injury – Variable by omission

Gallbladder Surgery – Variable by omission

*Outpatient Misc Expenses*

Outpatient Misc Maximum - Text in brackets is variable by omission

Each item bracketed is variable by omission

**EXCLUSIONS AND LIMITATIONS***Exclusions*

Items in brackets are variable by omission.

*Limitations*

Time frames are variable as shown.

**PREMIUM PROVISION**

Changes in Premium – range is 31-60 days.

**GENERAL PROVISIONS**

Physical Exam and Autopsy – Autopsy is variable by omission.

Subrogation – Variable by omission

Right of Reimbursement – Variable by omission

Third Party Clause – Variable by omission

Arbitration – Variable by omission.

<i>SERFF Tracking Number:</i>	<i>INCS-126444889</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pan-American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44718</i>
<i>Company Tracking Number:</i>	<i>PAL-STMIP-2008-AR</i>		
<i>TOI:</i>	<i>H16I Individual Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16I.004 Short Term</i>
<i>Product Name:</i>	<i>PALIC STM Ind</i>		
<i>Project Name/Number:</i>	<i>PALIC STM IND/PAL-STMIP-2008-AR</i>		

## Superseded Schedule Items

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

<b>Creation Date:</b>	<b>Schedule</b>	<b>Schedule Item Name</b>	<b>Replacement Creation Date</b>	<b>Attached Document(s)</b>
01/06/2010	Form	POLICY	02/03/2010	AR STM Individual Policy PAL-STMIP-2008.pdf (Superseded)

# PAN-AMERICAN LIFE INSURANCE COMPANY

[601 Poydras Street  
New Orleans, Louisiana 70130  
TOLL FREE: 1-877-569-3075]

## INDIVIDUAL SHORT TERM MEDICAL EXPENSE INSURANCE POLICY

**Policy Number:**[G-123456 or see attached]

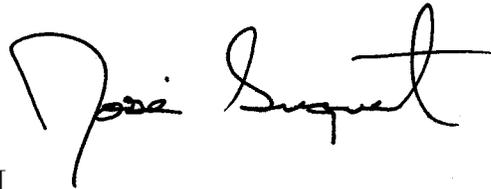
**Policy Effective Date:** [December 1, 2009 or see attached]

**Governing Jurisdiction:** This Policy is delivered in Arkansas and is subject to the laws of that jurisdiction.

### 10-DAY RIGHT TO RETURN THE POLICY

If for any reason you are not satisfied with this Policy, you may return it to us within 10-days after you receive it. We will refund any premium paid and coverage issued under the Policy will be deemed void, just as though coverage had not been issued.

PAN-AMERICAN LIFE INSURANCE COMPANY



[  
[President and Chief Executive Officer]

### THE COVERAGE IS NON-RENEWABLE SHORT TERM INSURANCE.

**Policyholder Service Office of Company:** Pan-American Life Insurance Company

**Address:** [601 Poydras Street, New Orleans, LA 70130]

**Telephone:** [1-800-XXX-XXXX]

If we at Pan-American Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

**Arkansas Insurance Department - Consumer Services Division**

**[1200 West Third Street, Little Rock, Arkansas 72201-1904**

**Telephone: (501) 371-2640] or Toll-Free: [800-852-2640]**

## **TABLE OF CONTENTS**

The following provisions appear within this Policy in the following order:

**Schedule**

**Definitions**

**Eligibility**

**Effective Dates**

**Termination of Insurance**

**Short Term Medical Expense Benefits**

**Exclusions and Limitations**

**Premium Provisions**

**Claim Provisions**

**General Provisions**

## [SCHEDULE

### **PRE-ADMISSION CERTIFICATION NOTICE**

This plan requires a Pre-Admission Certification by a Professional Review Organization prior to in-patient Hospitalization or surgery.

A Covered Person must call the Professional Review Organization:

1. For elective or non-emergency Hospitalization or surgery, at least 10-days prior to the date of proposed Hospitalization;
2. Within 48-hours of an emergency admission; or
3. Within 48-hours of delivery for complicated childbirth.

Non-compliance with the Pre-Admission Certification procedure will result in a **reduction in benefits of 50%**, unless the Covered Person is incapacitated and unable to contact us. In such cases, the Covered Person must contact us as soon as possible. You have been provided with information and procedures necessary for Pre-Admission Certification. You may obtain more information regarding Pre-Certification and its procedures from the Company.

### **SECTION I**

**The Deductible, Coinsurance Percentage, Coinsurance Limit and Lifetime Maximum Amount for Covered Expenses apply to each Covered Person, unless otherwise stated for a specific benefit, including any maximum benefits for each Covered Person, in SECTION II.**

#### **THE FOLLOWING SHALL APPLY TO EACH COVERED PERSON**

**DEDUCTIBLE:** [500-\$10,000 per Coverage Period, as elected and shown in the attached Policy Schedule]

[When 3 insured individuals in a family satisfy their Deductibles, the Deductibles for any remaining insured individual in the insured family are deemed satisfied for the remainder of the Coverage Period.]

**[DEDUCTIBLE Per Cause:** [500-\$10,000 per person, per cause, as elected and shown in the attached Certificate Schedule]

If You elect the per cause Deductible, You must satisfy Your elected Deductible Amount for **each** incident or subsequent incidents for the same Sickness or Injury before any other Covered Expenses will be paid for such incident.]

**COINSURANCE:**  
Coinsurance Percentage: [50% - 80% as elected and shown in the attached Policy Schedule], up to the Coinsurance Limit  
Coinsurance Limit: [100% for deductibles \$2,500 or higher]  
Thereafter: [100%]  
[5,000 - \$10,000 as elected and shown in the attached Policy Schedule]

**LIFETIME MAXIMUM AMOUNT:** [100,000 - \$2,000,000 per Covered Person]

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### **SECTION II**

#### **MAXIMUM BENEFITS FOR EACH COVERED PERSON:**

##### **HOSPITAL COVERED EXPENSES:**

**In Hospital Regular Care:** The Average Semi-Private Room Rate [not to exceed [\$1,000] per day including all Inpatient Miscellaneous Medical Expense Services]

**In Hospital Intensive or Critical Care:** [[3 times the Average Semi-Private Room Rate] [not to exceed [\$2,000] per day including all Inpatient Miscellaneous Medical Expense Services]

**[Emergency Room Treatment:** Up to [\$500] per day including the emergency room Doctor charge, 24 hour observation and all miscellaneous medical expenses received during the emergency room visit]

**[In Hospital Doctor Visits:** Up to [\$500] per in-hospital confinement.]

**OTHER COVERED EXPENSES:**

**Doctor Office Visits:** [Up to [\$50] per visit not to exceed [2] visits per Coverage Period up to a maximum payment of [\$100] per person. The balance of the office visit expense will be payable subject to the Deductible and Coinsurance, up to a maximum benefit of [\$1,000] per Covered Person for each Coverage Period.]

**[Outpatient Hospital Surgery or Ambulatory Surgical Center:** [Up to \$1,000] per day including all Miscellaneous Medical Expenses]

**Surgeon Services** [up to \$2,500 per surgery]

**Anesthetics Coinsurance Percentage:** [up to 20%] of the surgeon's benefit

**Assistant Surgeon Coinsurance Percentage:** [up to 20%] of the surgeon's benefit

**Surgeon's Assistant Coinsurance Percentage:** [up to 15%] of the surgeon's benefit

[The Surgeon, Anesthetics, Assistance Surgeon and Surgeon's Assistants benefits are limited to [\$2,500] per surgery, for all Covered Expenses combined, not to exceed [\$5,000] per Coverage Period]

**Ambulance, Ground or Air** [Up to \$250] per incident

**[Acquired Immune Deficiency Syndrome (AIDS)** [up to \$10,000] per Coverage Period]

**[Knee Injury or Disorder** [up to 2,500] per Coverage Period for both left and right knees]

**[Gallbladder Surgery:** [up to 2,500] per Coverage Period]

**Mammography Benefit**  
Maximum Amount: [\$50] for each screening mammography, which includes payment of both the professional and technical components.\*

\*In cases of Hospital outpatient screening mammography, and comparable situations, where professional services are billed separate from technical services, the professional component will not be less than 40% of the total fee.

**[Outpatient Miscellaneous Medical Covered Expenses:**

[Up to \$1,000] per Coverage Period for all Covered Expenses combined. Does not include Inpatient Hospital or outpatient Hospital surgery]

**MONTHLY PREMIUM RATES**

The monthly premium rates as of the Policy Effective Date for the coverage provided by this Policy are on file with The Company.

## DEFINITIONS

This section provides the meaning of special terms used in this Policy. Whenever the following terms appear capitalized in this Policy, these definitions apply.

**Ambulatory Surgical Center** means a licensed health care facility whose main purpose is the diagnosis or treatment of patients by surgery. It must (1) admit and discharge the patient within the same working day; (2) be supervised by a Doctor; (3) require a licensed anesthesiologist or licensed Certified Registered Nurse Anesthetist to administer anesthesia and remain during the surgery; (4) provide a post-anesthesia recovery room; and (5) have a written agreement with at least one Hospital for immediate acceptance of patients who develop complications.

“Ambulatory surgical center” does not include: (1) a facility whose main purpose is performing terminations of pregnancy; (2) an office maintained by a Doctor for the practice of medicine; or (3) an office maintained for the practice of dentistry.

**Coinsurance Percentage** is the applicable percentage specified in the Schedule that We will use in computing the amount payable for a benefit.

**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, HELLP syndrome, uterine rupture, amniotic fluid embolism, chorioamnionitis, fatty liver in pregnancy, septic abortion, placenta accrete, gestational hypertension, puerperal sepsis, peripartum cardiomyopathy, cholestasis in pregnancy, thrombocytopenia in pregnancy, placenta previa, placental abruption, acute cholecystitis and pancreatitis in pregnancy, post hemorrhage, septic pelvic thrombophlebitis, retained placenta, venous air embolus associated with pregnancy, miscarriage, or an emergency Cesarean section required because of: (a) fetal or maternal distress during labor, (b) severe pre-eclampsia, (c) arrest of descent or dilatation, (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a Cesarean section delivery is not considered to be an emergency Cesarean section if it is merely for the convenience of the patient and/or Doctor solely due to a previous Cesarean section.

(2) Treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: hyperthyroidism, hepatitis B or C; HIV; Human papilloma virus; abnormal PAP; syphilis; Chlamydia; herpes; urinary tract infections; thromboembolism; appendicitis; hypothyroidism; pulmonary embolism; sickle cell disease; tuberculosis; migraine headaches; depression; acute myocarditis; asthma; maternal cytomegalovirus; urolithiasis; DVT prophylaxis; ovarian dermoid tumors; biliary atresia and/or cirrhosis; first trimester adnexal mass; hydatidiform mole; or ectopic pregnancy.

“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.

**Confined/Confinement** means the time in which a Covered Person is a Registered Bed Patient in a Hospital, on the order of a Doctor, for Medically Necessary medical treatment.

**Covered Dependent** means Eligible Dependents who have become Covered Person(s) under this Policy.

**Covered Expenses** means Expenses for treatments, services and supplies which a Doctor recommends (1) as Medically Necessary to treat a Sickness or Injury; (2) which are Usual, Reasonable and Customary; and (3) which do not exceed any amount payable under the terms of the Policy.

**Coverage Period** means the maximum length of time coverage is in force under this Policy.

**Covered Person(s)** means You and Your Covered Dependents.

**Deductible** means the amount of Covered Expenses that each Covered Person must pay before benefits will be payable. [The Deductible is shown in the Schedule.]

**Doctor** means a licensed practitioner of the healing arts who is practicing and treating within the scope and limitations of that license. “Doctor” does not include You, a Covered Dependent, Immediate Family, or a Covered Person’s employer.

**[Domestic Partner]** means a person of the [opposite sex] [same sex] [opposite or same sex] with whom the Covered Person has established a Domestic Partnership. In no event, will a person's legal spouse be considered a Domestic Partner.]

**[Domestic Partnership]** means a relationship between the Covered Person and one other person of the [opposite sex] [same sex] [opposite or same sex]. The following requirements apply to both persons:

1. [They share the same permanent residence and the common necessities of life;
2. They are not related by blood or a degree of closeness which would prohibit marriage in the law of state in which they reside;
3. Each is at least 18 years of age;
4. Each is mentally competent to consent to contract;
5. Neither is currently married to, or Domestic Partner of, another person under either a statutory or common law;
6. They are financially interdependent and have furnished at least two of the following documents evidencing such financial interdependence:
  - a. have a single dedicated relationship of at least 6 months duration;
  - b. joint ownership of residence;
  - c. at least two of the following:
    - i. joint ownership of an automobile;
    - ii. joint checking, bank or investment account;
    - iii. joint credit account;
    - iv. lease for a residence identifying both partners as tenants;
    - v. a will and/or life insurance policies which designates the other as primary beneficiary.
7. The Covered Person and Domestic Partner must jointly sign an affidavit of Domestic Partnership.]

**Effective Date** means the date coverage under the Policy begins for a Covered Person. The Effective Date is shown on the face page of the Policy.

**Evidence of Insurability** means an Eligible Person will satisfy the insurability requirement on the day The Company agrees in writing to accept the person as insured for that amount. To determine a person's acceptability for coverage, The Company will require evidence of good health and may require it to be provided at the Insured Person's expense.

**Expenses** means the amounts billed for treatments, services and supplies rendered to a Covered Person. An expense shall be considered to have been incurred on the date the treatment, service or supply was provided.

**Experimental or Investigational:** means a treatment, drug, device, procedure, supply or service and related services (or any portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any one of the following exists: (1) It cannot be legally marketed without the approval of the United States Food and Drug Administration (FDA) and such approval has not been granted at the time of its proposed use. (2) It is not yet recognized as acceptable medical practice throughout the United States to treat that Illness or Injury. (3) It is the subject of either: (a) a written investigational or research protocol; or (b) a written informed consent or protocol used by the treating facility in which reference is made to it being experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or (c) an ongoing phase I, or phase II clinical trial or as the experimental or research arm of a phase III clinical trial, as the phases are defined in regulations and other official actions and publications issued by the FDA and the Department of Health and Human Services (HHS); or (d) an ongoing review by an Institutional Review Board (IRB); or (4) It does not have either: (a) the positive endorsement of national medical bodies or panels, such as the American Cancer Society; or (b) multiple published peer review medical literature articles, such as the Journal of the American Medical Association (J.A.M.A.), concerning Health Care Service and reflecting its recognition and reproducibility by non-affiliated sources the Claims Administrator determines to be authoritative. (5) It is regarded within a Doctor's profession as appropriate only when provided in a clinical research setting.

We may also determine whether a treatment, drug, device, procedure, supply or service is experimental or investigational by using the following evaluations: (1) Reports in peer review medical literature. (2) Scientific evaluations published by organizations that conduct health care research such as the Agency for Health Care Policy and Research, the National Institutes of Health, the American Medical Association, and the American College of Physicians. (3) Opinions of independent medical consultants. (4) Listings in drug correspondence, including the American Medical Association's Drug Evaluations, the American Hospital Formulary Service Drug Information, and the United States Pharmacopoeia Drug Information. (5) Use of a written informed consent addressing the experimental or investigational nature of the service or supply. This applies whether consent is used by the Covered Person's Doctor or by any other Doctor studying the same or similar service or supply. (6) Any requirement that the use of the service or supply be subject to Institutional Review Board ("IRB") approval. (7) Written protocols used by the health care provider.

**Policy** means the contract issued to You providing the benefits described herein.

**Hospital** means an institution which is legally constituted and operated in accordance with the laws pertaining to Hospitals in the jurisdiction where it is located, which meets all of the following requirements:

1. It is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patient's expense;
2. It provides 24-hour-a-day nursing service by a Nurse;
3. It is under the supervision of a staff of duly-licensed Doctors;
1. It provides organized facilities for diagnosis and for major operative surgery either on its premises or in facilities available on a prearranged basis; and

“Hospital” does not mean primarily a clinic, nursing home, rest or convalescent home, extended care facility, Hospice or similar establishment nor, other than incidentally, a place providing care for persons with mental illness or nervous disorders; the aged; or those suffering from alcoholism or drug addiction.

Confinement in a special unit of a Hospital used primarily as a nursing, rest, or convalescent home shall be deemed to be Confinement in an institution other than a Hospital.

**Immediate Family** means: (1) the parent, spouse, brother, sister or children of a Covered Person; (2) a resident in a Covered Person's household; or (3) any person related to a Covered Person by blood, marriage or legal adoption.

**Injury** means bodily harm caused by an accident, directly and independently of Sickness or bodily infirmity, resulting in unforeseen trauma requiring immediate medical attention. The Injury must occur after the Covered Person's Effective Date of coverage and while such person's coverage is in force. All injuries to the same Covered Person sustained in one accident, including all related conditions and recurring symptoms of the Injuries, will be considered one injury. Bodily damage caused by chewing is not considered an Injury.

**Intensive Care Unit** means a section, ward or wing within a Hospital which is separated from other Hospital facilities and: (1) is operated exclusively for the purpose of providing professional care and treatment for critically ill patients; (2) has special supplies and equipment necessary for such care and treatment which are available on a standby basis for immediate use; (3) provides room and board, and constant observation by a Nurse or other specially-trained Hospital personnel; and (4) is not maintained for the purpose of providing normal postoperative recovery treatment or service.

**Lifetime Maximum Amount** means the total aggregate amount of benefits payable under the Policy for all Covered Expenses which are incurred for Sickness or Injury by each Covered Person during such person's lifetime.

**Medically Necessary** means a Confinement, service, supply, or treatment that meets each of these requirements:

1. It is ordered by a Doctor for the diagnosis or the treatment of a Sickness or Injury;
2. For services, supplies, or treatment, the prevailing opinion within the appropriate specialty of the United States medical profession is that such service, supply, or treatment is safe and effective for its intended use, and that omission would adversely affect the Covered Person's medical condition. For Confinement in a Hospital, the prevailing opinion within the appropriate specialty of the United States medical profession is that inpatient acute care Confinement is necessary and any lesser level of care would adversely affect the Covered Person's medical condition; and
3. It is furnished by a provider with appropriate licensing, training, experience, staff and facilities to offer that particular service or supply.

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

**Nurse** means a licensed registered graduate professional Nurse (R.N.) or a licensed practical Nurse (L.P.N.) who is under the direction of a Doctor. Nurse does not include the Immediate Family of a Covered Person.

**Prescription Or Legend Drugs** means (1) a Legend Drug; (2) injectable insulin prescribed by a Doctor; (3) a compounded drug of which at least one part is a Legend Drug; or (4) any other drug that, under state law, may only be dispensed upon the written prescription of a Doctor. “Prescription or Legend Drugs” does not include oral contraceptives for prevention of pregnancy.

**Registered Bed-Patient** means an individual who, while Confined to a Hospital, is assigned to a bed in any department of the Hospital, and for whom a charge for room and board is made by the Hospital.

**Rehabilitative** means treatment for purposes of restraining bodily function which has been lost due to a Covered Sickness/Injury. Care ceases to be rehabilitative when the patient can perform the activities which are normal for someone of the same age and gender or the patient has reached maximum therapeutic benefit and further treatment cannot restore bodily function beyond the level the patient currently possess.

**Sickness** means an illness, disease, or infection which begins while coverage is in force under this Policy for the Covered Person. All related conditions and recurring symptoms of sickness to the same person will be considered one sickness. Sickness includes Complications of Pregnancy, provided conception occurred after the Covered Person's Effective Date of coverage.

**Usual, Reasonable and Customary** means:

1. With respect to fees or charges, fees for medical services or supplies which are:
  - a. Usually charged by the provider for the service or supply given; and
  - b. The average charged for the service or supply in the locality in which the service or supply is received; whichever is less, or
2. With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

In reaching a determination as to what amount should be considered as Usual, Reasonable and Customary for services and supplies, We may use and subscribe to a standard industry reference source that collects data and makes it available to its member companies. The data base used reflects the amounts charged by providers for health care services based on geographic zip code areas generating a statistically credible charge distribution. The data is reflective of reported provider charges from the lowest to the highest for each service or supply. The data is also adjusted periodically to reflect negotiated fee schedules with providers not included in the data base.]

**We, Us, Our, The Company** means Pan-American Life Insurance Company.

**You or Your** (also, Policyholder) means an Eligible Person who is properly enrolled for coverage under the Policy. You are the person (who is not a Dependent) on whose behalf the Policy is issued.

## ELIGIBILITY

### YOU

You will be eligible for insurance provided:

1. [You are at least 1 but under 65 years of age;
2. You are not covered as a dependent under the Policy;
3. You are not pregnant at the time of application;
4. You have lived in the U.S. for 12 consecutive months;
5. You are not an active member of the armed forces;
6. You submit a written application for insurance, provide Evidence of Insurability, if evidence is required, and meet our enrollment and underwriting requirements; and
7. You pay all required premiums when due.]

### ELIGIBLE DEPENDENTS

**Spouse** - You will be eligible to apply for insurance for Your lawful spouse who:

1. [Is under age 65 at the time of application;
2. Is not pregnant at the time of application;
3. Is not an active member of the armed forces;
4. Has lived in the U.S. for 12 consecutive months; and
5. Has provided a written application for insurance and Evidence of Insurability, if evidence is required, have been approved, and meets our enrollment and underwriting requirements.]

[All references to Your spouse shall include a Domestic Partner.]

**Dependent Children** - You will be eligible to apply for insurance for your dependent children who:

1. Are unmarried children primarily dependent upon You for support and maintenance; and
2. a. Are less than [19 years] or age; or  
b. Are at least [19 years] of age but less than [25 years] and enrolled and attending as a full-time student at an accredited college, university, vocational or technical school.
3. [Are not pregnant at the time of application;
4. Are not active members of the armed forces; and
5. Have provided a written application for insurance and Evidence of Insurability, if evidence is required, have been approved, and meet our enrollment and underwriting requirements.]

“Children” means natural children, stepchildren, legally-adopted children, children placed with You for the purpose of adoption, and children subject to Your legal guardianship.

If You and Your spouse are both Covered Persons, only one parent will be eligible for insurance on any Covered Dependent children You may have.

### ENROLLMENT REQUIREMENTS

You and your Eligible Dependents who desire coverage must complete and submit an application for the plan and complete or provide any other documents (including evidence of insurability) as we deem necessary. You must submit the required premium with Your application form. Any misrepresentation or omission of information in Your application or any documents submitted to Us may result in rescission of all coverage for all Covered Persons.

### UNDERWRITING REQUIREMENTS

You and your Eligible Dependents are subject to our underwriting requirements. We reserve the right to decline or rate any person at Our discretion.

### ADDITIONAL CONDITIONS

Insurance will not be effective unless all eligibility requirements are met and You receive written acceptance from Us. Insurance on a Covered Person will not be effective unless premium is paid and accepted by Us for such insurance. Issuance of a Certificate is not a waiver of any of the above conditions.

## **EFFECTIVE DATES**

### **YOU AND ELIGIBLE DEPENDENTS**

Coverage is effective [as of the Effective Date] for You and any Eligible Dependents who were included in Your initial application, provided that You meet Our eligibility, underwriting and enrollment requirements. Coverage will not become effective for any person whose medical history changes prior to the Effective Date, such that the person's answer would be "Yes" to any of the medical history questions in the Application. If Your medical history changes prior to the Effective Date, coverage is automatically declined for all persons included in Your Application.

### **ADDING PERSONS AFTER THE EFFECTIVE DATE**

You may wish to apply for coverage for a previously uncovered spouse or dependent child. To do so, the following requirements must be met:

1. You must complete and submit to Us for approval an application form for such person;
2. Such person must meet Our definition of an Eligible Dependent; and
3. You must pay any additional premium, if approved for coverage.

### **NEWLY-ACQUIRED DEPENDENT CHILDREN**

Coverage for Your child or children born after the Effective Date will be effective from the moment of birth and will remain in force for 90-days. We must receive this notice within 90-days after the child's date of birth. Coverage for a child whom a petition for adoption has been filed, will become effective the the date the petition is filed, if coverage is applied for within 60 days of such filing. Coverage for an adopted newborn child is from the moment of birth, if coverage is applied for within the 60-days after birth. Coverage ceases upon the dismissal or denial of a petition for adoption. Any required additional premium must accompany Your notice. A claim form or Hospital bill does not constitute written notice. To add the child after the initial period has expired, see the provision titled Adding Persons After The Effective Date.

Coverage for Your child or children will be for Injury or Sickness, including care or treatment of congenital defects, birth abnormalities, and premature birth and tests for hypothyroidism, phenylketonuria, galactosemia, and sickle-cell anemia for a non-Caucasian newborn child. Coverage is not provided for normal newborn care, except as specifically provided.

### **WHEN CHANGES IN COVERAGE OCCUR**

1. Any change in benefits which occurs automatically under the Certificate provisions or Schedule will become effective on the date that the status of the Covered Person changed.
2. If any decrease in benefits or coverage is requested, such decrease shall become effective as of the [first premium due date coinciding with or next following the] date of the approval of such decrease.
3. If any increase in benefits or coverage is requested, such increase shall become effective as of the [first day of the month coinciding with or next following the] date of the approval of such increase.
- [4. If any requested change increases benefits or coverage, the Effective Date of the increase will be delayed for You or a Covered Dependent who is Confined for medical treatment in an institution. The delay will end and the increase shall become effective on the day following final medical discharge from such Confinement.]

## **TERMINATION OF INSURANCE**

### **TERMINATION OF YOUR INSURANCE**

Your insurance will automatically terminate on the earliest of the following dates:

1. The due date of a premium payment that is not paid when due, if such payment has not been made within 31-days following such premium due date;
2. The date that we determine fraudulent statements or a material misrepresentation has been made by the You or with Your knowledge in filing a claim for benefits;
3. The date that You enter full-time active duty in the armed forces of any country or international organization;
4. The date You become eligible for Medicare; or
5. The earlier of: (1) the Expiration Date of Your coverage; or (2) 12-months from the Effective Date of Your insurance, whichever occurs first.

### **TERMINATION OF A COVERED DEPENDENT'S INSURANCE**

A Covered Dependent's insurance will automatically terminate on the earliest of the following dates:

1. The due date of a premium payment that is not paid when due, if such premium payment has not been made within 31-days following such premium due date;
2. The date that we determine fraud or material misrepresentation has been made by You or a Covered Dependent or with Your or a Covered Dependent's knowledge in filing a claim for benefits;
3. The date that Your insurance terminates. However, if termination is due to Your death, a Covered Dependent may elect to continue coverage beyond the original Expiration Date by making written request for such coverage and by continuing payments toward the cost of that insurance. When such an election is made, Your Covered Dependent spouse will be considered the primary insured;
4. The date You or a Covered Dependent becomes eligible for Medicare;
5. The date the Covered Dependent ceases to be eligible. However if, upon attaining any limiting age, a Covered Dependent has a handicapped condition rendering such person incapable of earning his own living and is chiefly dependent upon You or other care providers for lifetime care and supervision because of a handicapped condition that occurred before attainment of the limiting age, benefits with respect to such person may be continued on a premium-paying basis during the continuance of such incapacity up to the end of the Coverage Period, provided that we receive written proof of such incapacity after the date on which the Covered Dependent attains the limiting age. During continuance of insurance, We have the right to require due proof of the continuance of the incapacity and to have such dependent examined by Doctors designated by us at any time during the term of coverage. The continuance of insurance as described will cease in the event of the termination of Your insurance; or
6. The earlier of: (i) the Expiration Date shown in the Schedule; or (ii) 12-months from the Effective Date of Your insurance, whichever occurs first.

### **TERMINATION OF THE POLICY**

The Policy will terminate on the earliest of the following dates:

1. The date there are no insured persons under the Policy; or
2. [The first day of any policy month] The Company gives written notice to You at least [30 days] in advance.

## SHORT TERM MEDICAL EXPENSE BENEFITS

### HOSPITAL PRECERTIFICATION

Hospital admissions and lengths of stay are subject to certification by the pre-certification service, as stated below:

1. You must notify the pre-certification service on behalf of a Covered Person:
  - a. Ten (10) days prior to non-emergency admission of the Covered Person to a Hospital;
  - b. Within 48-hours or on the first business day following an emergency admission of the Covered Person to a Hospital, or as soon thereafter as is reasonably possible; or
  - c. Within 48-hours of delivery for complicated birth.
2. The pre-certification service, after reviewing the applicable information, will certify:
  - a. If the Hospital admission is Medically Necessary;
  - b. The appropriate length of stay; and
  - c. Appropriate extensions beyond the initially-certified length of stay.
3. Reduction of Benefits - If Covered Expenses for the Hospital admission, length of stay, or extensions of stay are not certified by the Professional Review Organization, we will only pay 50% of the benefits which would otherwise have been payable for Covered Expenses, unless the Covered Person is incapacitated and unable to contact us. In such cases, the Covered Person must contact us as soon as possible. No benefits will be payable in the event such Hospital admission, length of stay or extension of stay is not Medically Necessary or Experimental or Investigational.
4. Not a Guarantee of Benefits – Pre-certification does not guarantee that benefits will be paid. Payment of benefits will be determined by Us in accordance with and subject to all terms, conditions, limitations and exclusions of the Policy.

### DESCRIPTION OF BENEFITS

#### WHAT IS COVERED

Subject to the Hospital Precertification provision, if You or a Covered Dependent incurs Covered Expenses for medical treatment, supplies or services as a result of a Sickness or Injury which occurs while coverage is in force, and after satisfaction of the Deductible, We will pay the Coinsurance Percentage for Covered Expenses incurred in excess of the Deductible up to the Maximum Benefit amounts as shown in the Schedule. We will pay this amount for all Covered Expenses unless otherwise noted for a specific benefit or specified as limited or excluded in the Limitations and Exclusions provision.

After Covered Expenses for which benefits are payable at the Coinsurance Percentage have equaled the Coinsurance Limit for a Covered Person, we will pay Covered Expenses in excess of the Coinsurance Limit at the amount shown in the Schedule for each such person while coverage is in force, but not to exceed the Lifetime Maximum Amount payable for each Covered Person.

The Deductible, Coinsurance Percentage, Coinsurance Limit and Lifetime Maximum Amount are shown in the Schedule.

#### COVERED EXPENSES

Covered Expenses means the Usual, Reasonable and Customary charges for the following Medically Necessary services, supplies, or treatment prescribed or provided by a Doctor for a covered Injury or Sickness while coverage is in force for a Covered Person. **[Covered Expenses do not include Expenses which are in excess of the Maximum Amounts shown in the Schedule. Expenses in excess of the Maximum Amounts shown in the Schedule do not apply to the Deductible or the Coinsurance Limit.]**

#### A. HOSPITAL COVERED EXPENSES

**Hospital Room, Board and General Nursing Care** while Confined in a Hospital, not to exceed the Maximum Benefit amount shown in the Schedule. For confinement in a private room, the Covered Expense is limited to the Hospital's average daily charge for a semi-private room not to exceed the Maximum Benefit amount shown in the Schedule.

**Intensive or Specialized Care Unit** provided four or more hours of nursing care is being provided each day, not to exceed the Maximum Benefit amount shown in the Schedule.

**Emergency Room Treatment** for services, supplies and treatment [, not to exceed the Maximum Benefit amount shown in the Schedule].

**Inpatient Miscellaneous Medical Expense Services** for services and supplies provided on an inpatient basis in a Hospital [, not to exceed the In Hospital Maximum Benefit amount shown in the Schedule]. Miscellaneous charges do not include

charges for a telephone, radio, television, extra beds or cots, meals for guests, take home items, or other items of convenience.

**Inpatient Doctor Visits** for treatment provided by a Doctor during a Hospital confinement [, not to exceed the Maximum Benefit amount shown in the Schedule].

**B. COVERED EXPENSES FOR TREATMENT , SERVICES, OR SUPPLIES**

**Doctor Office Visits** for treatment provided by a Doctor in a Doctor's office [, not to exceed the Maximum Benefit amount shown in the Schedule]. This benefit is not payable for treatment provided by a member of your Immediate Family.

**Ambulatory Surgical Center or Outpatient Hospital Surgery** for treatment or services in a state-approved freestanding Ambulatory Surgical Center that is not part of a Hospital, or a Hospital Outpatient Surgery Facility [, not to exceed the Maximum Benefit amount shown in the Schedule].

**Surgeon Services** for Covered Expenses incurred from a Doctor performing surgery in either an inpatient or outpatient setting [, not to exceed the Maximum Benefit amount shown in the Schedule].

**Services** of a Doctor administering anesthetics [, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule].

**Assistant Surgeon** services for a Doctor assisting in the performance of a surgery [, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule].

**Surgeon's Assistant** services for an assistant to the Doctor performing the surgery [, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule].

**Complications of Pregnancy.** Treatment for Complications of Pregnancy on the same basis as any other Sickness.

**Cosmetic or Reconstructive Surgery (except Breast Reconstructive Surgery)** for cosmetic or reconstructive surgery and complications of cosmetic procedures. Benefits are payable, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule, when services and treatment are:

1. Incidental to or follows a covered Injury or Sickness occurring while this coverage is in force; or
2. Performed due to a congenital defect or birth anomaly of a Covered Person born while this coverage is in force.

**Breast Reconstructive Surgery** for a female Covered Person who undergoes a covered mastectomy surgery while such person's coverage under this Certificate is in force. Benefits payable, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule, include:

1. Reconstructive surgery of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast for the purpose of obtaining a symmetrical appearance; and
3. Prostheses and for treatment for physical complications related to the mastectomy.

**Ambulance Services** for local licensed ground ambulance service, or air ambulance service within the 48 contiguous states, to the nearest Hospital qualified to treat the covered Injury or Sickness, not to exceed the Maximum Benefit amount shown in the Schedule. Such service must be Medically Necessary due to a sudden and unexpected Injury or Sickness that involves a life-threatening element.

**Prescription or Legend Drugs** when prescribed on an inpatient basis for a covered Injury or Sickness.

**Dental Treatment** for treatment or care required as a result of a covered Injury to a tooth that is natural, free of disease, and vital where the major portion of the tooth is present regardless of fillings or caps.

[**AIDS** for the treatment of Acquired Immune Deficiency Syndrome (AIDS) or any complication or condition caused by, resulting from or related to AIDS or HIV, not to exceed the Maximum Benefit amount shown in the Schedule.]

[**Knee Injury or Disorder** The knee consists of the bones, muscles, cartilage, ligaments, membranes and menisci of the anterior aspect of the leg at the articulation of the femur and tibia. Coverage does not include charges incurred to diagnose or treat an injury or disorder of the knee including surgery in excess of the maximum benefit amount shown in the Schedule.]

**[Gallbladder Surgery** includes cholecystectomy and any type of surgical procedure to diagnose or treat a disorder of the gallbladder, including any condition related to or caused by a gallstone(s) in the bile duct. Surgery includes the pre-operative and post-operative visits, testing, the services of the surgeon, assistance surgeon, anesthesiologist, radiologist, pathologist, the Hospital or outpatient facility charges, and any other charges related to the surgery or complications there from, not to exceed the maximum benefit shown in the Schedule.]

### **C. OUTPATIENT MISCELLANEOUS MEDICAL EXPENSE SERVICES**

[Outpatient Miscellaneous Medical Expenses as listed below are payable up to the Maximum Benefit amount shown in the Schedule for all services combined.]

[  
**Blood or Blood Plasma** and their administration, if not replaced.

**Artificial limbs or eyes.**

**Casts, non-dental splints, trusses, crutches, or non-orthodontic braces.**

**Equipment Rental** for a wheelchair, hospital-type bed or similar durable medical equipment. At our option, benefits may be available for purchase of such equipment, payable in monthly installments, while Your coverage remains in force under the Policy.

**Oxygen** for oxygen and rental of equipment for the administration of oxygen, not to exceed the purchase price of such equipment.

**Diagnostic Testing Services** for diagnostic tests including related professional fees, incurred on an outpatient basis. Diagnostic tests include x-rays, laboratory tests, electrocardiograms (EKGs), electroencephalograms (EEGs), nuclear medicine imaging, radioimmune assay, ultrasound/echography, computerized tomography (CT), magnetic resonance imaging (MRI), cholecystography, cytourethroscopy, endoscopy, duodenoscopy, hysterosalpingography, laparoscopy, myelography, pyelography, pancreatography, vasography, or venography.

**Therapy Services** for treatment provided by a physical therapist, inhalation therapist (respiratory), and speech therapist for diagnosis and Rehabilitative treatment. This benefit is not payable for treatment provided by a member of your Immediate Family.

**Radiation Therapy and Chemotherapy Services** for therapeutic treatment of covered benign and malignant conditions, including charges for x-rays, radium, radioactive isotopes and chemotherapy drugs and supplies used in treatment.

**Pap Smear** for: one annual cervical cytological screening for a female Covered Person. This benefit is not subject to satisfaction of the Deductible.

**Prostate Cancer Screening** for the early detection of prostate cancer in men forty (40) years of age and older according to the National Comprehensive Cancer Network guidelines and performed by a qualified medical professional. If a medical practitioner recommends that an insured, undergo a prostate specific antigen blood test, coverage may not be denied on the ground that the insured has already had a digital rectal examination and the examination result was negative. These charges are not subject to the Deductible.

**Mammography** for: 1) one baseline mammogram; 2) an annual screening mammogram; 3) a mammogram as recommended by the Doctor for a women who has had a prior history of breast cancer or who's mother or sister has had a history of breast cancer; 4) a diagnostic mammography at any age when prescribed by the woman's Doctor; not to exceed the Maximum Benefit Amount shown in the Schedule..

Benefits for Screening Mammography will not prejudice coverage for Diagnostic Mammography as recommended by a woman's Doctor. For purposes of this benefit, the following Definitions apply:

“Screening mammography” means a radiologic procedure provided to a woman who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer. The procedure entails two views of each breast and includes a Doctor's interpretation of results of the procedure.

“Diagnostic mammography” means a problem-solving radiologic procedure of higher intensity than Screening Mammography provided to women who are suspected to have breast pathology. Patient are usually referred for analysis of palpable abnormalities or for further evaluation of mammographically detected abnormalities. All images are immediately

reviewed by the Doctor interpreting the study, and additional views are obtained as needed. Physical exam of the breast by the interpreting Doctor to correlate the radiologic findings is often performed as part of the study.

**Routine Child Health Care** coverage from the moment of birth through the age of eighteen (18) years for Doctor-delivered or Doctor-supervised preventive health care services at the approximate age intervals of: birth; 2 weeks; 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months; 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years, and 18 years. Services, performed in accordance with prevailing medical standards must be provided by a single physician during the course of one visit and are limited to; medical history, physical examination, developmental assessment, anticipatory guidance, laboratory tests, and appropriate immunizations. All services, with the exception of immunization will be subject to any copayment, coinsurance, deductible or dollar limit appearing within the Policy.

**[Applicable only to a Covered Person with a Coverage Period greater than six (6) months:]**

**Diabetes Self-Management Training and Treatment** when prescribed by a Doctor as being Medically Necessary, and upon certification by an appropriately licensed health care professional of satisfactory completion, coverage will be provided for one lifetime Diabetes Self-management Training program plus additional diabetes self-management training when prescribed by the attending Doctor as being Medically Necessary due to a significant change in the Covered Person's symptoms or condition. This will also include medical coverage for Medically Necessary equipment, supplies, and services for the treatment of Type I, Type II, and gestational diabetes, when prescribed by a Doctor.

Diabetes Self-Management Training means instruction in an inpatient or outpatient setting, including medical nutrition therapy, relating to diet, caloric intake and diabetes management but excluding programs which the primary purpose is weight reduction, when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program developed by the American Diabetes Association.

**Loss or Impairment of Speech or Hearing** for the Medically Necessary diagnosis and treatment of loss or impairment of speech or hearing. Covered Expenses for such treatment will be paid as they would for any other Sickness. No benefits will be paid for hearing instruments or devices. Loss or impairment of speech or hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the State Board of Examiners in Speech Pathology and Audiology that fall within the scope of his area of certification.

**Hospital Newborn Coverage** for routine nursery care and pediatric charges for up to five (5) full days in a Hospital nursery or until discharge of the mother of the newborn from the Hospital following the birth of the child, whichever is the later; and any testing of a newborn child hereafter mandated by law.

**Colorectal Cancer Exams and Lab Tests** for the following colorectal cancer examinations and laboratory tests: (1) an annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five years; (2) a double-contrast barium enema every five years; (3) a colonoscopy every ten years; and (4) any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health, subject to the guidelines for the management or subsequent need for follow-up colonoscopy.

These benefits will be covered for a Covered Person who is: (1) fifty years of age or older; (2) less than fifty years of age and a high risk for colorectal cancer according to the current American Cancer Society colorectal cancer screening guidelines; and (3) experiencing the following symptoms of colorectal cancer as determined by a Doctor: (a) bleeding from the rectum or blood in the stool; or (b) a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five days.

**Medically Necessary Foods** and low protein modified food products for the treatment of a Covered Person afflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism if:

- a. The medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism;
- b. The products are administered under the direction of a Doctor;
- c. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the income tax credit of [two thousand four hundred dollars (\$2,400)] per year per person allowed under Arkansas law.

This includes coverage for amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas prescribed under the direction of a Doctor for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism.

**In Vitro Fertilization** services performed at a medical facility certified by the Department of Health, or a facility certified as conforming to the American College of Obstetricians and Gynecologists Guidelines for In Vitro Fertilization, or which meets the American Fertility Society standards.

**[Hearing Aids** for coverage for a hearing aid or hearing instrument sold by a professional licensed by the state to dispense a hearing aid or hearing instrument, not to exceed one thousand four hundred dollars (\$1,400) per beginning on the first day of coverage. These charges are not subject to the Deductibles or any copayment requirements.]

**[Musculoskeletal Disorders of Bone or Joint in Face, Neck or Head** will include the Medically Necessary diagnosis and treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head. This includes temporomandibular joint disorder and craniomandibular disorder. Treatment includes both surgical and nonsurgical procedures. Benefits are provided for these conditions whether they are the result of accident, trauma, congenital defect, developmental defect or pathology.]

#### **ALLOCATION AND APPORTIONMENT OF BENEFITS**

We reserve the right to allocate the Deductible to any Covered Expenses and to apportion the payment of benefits between You and any person designated by You. Such allocation and apportionment shall be conclusive and shall be binding upon You and all assignees.

#### **EXTENSION OF BENEFITS**

If a Covered Person is Hospital confined on the date insurance ends, other than for failure to pay the required premium, benefits will be continued only for the condition causing the Hospital confinement until the earlier of:

1. the date Hospital confinement ends;
2. the date when treatment for the Hospital confinement is no longer required;
3. the expiration of a 90 day period after the insurance ceases;
4. the date the Covered Person becomes eligible for any other group insurance plan providing coverage for the same conditions causing the Hospital Confinement; or
5. the date the Maximum Lifetime Benefit under the Policy has been reached.

Benefits payable due to the Extension of Benefits provision after the Expiration Date or when a Covered Person's coverage ends, are subject to a new Deductible and satisfaction of the Coinsurance Limit.

## EXCLUSIONS AND LIMITATIONS

We will not pay for loss or expense caused by or resulting from any of the following:

1. Expenses for the treatment of Preexisting Conditions, as defined in the Preexisting Conditions Limitation provision.
2. Expenses incurred prior to the Effective Date of a Covered Person's coverage or incurred after the Expiration Date, regardless of when the condition originated, except in accordance with the Extension of Benefits provision.
3. Expenses to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the Policy.
4. Expenses incurred for Experimental or Investigational services or treatment or unproven services or treatment.
5. Amounts in excess of the Usual, Reasonable and Customary charges made for covered services or supplies.
6. Expenses You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed.
7. Expenses that do not meet the definition of or are not specifically identified under the Policy as Covered Expenses.
8. [Expenses for purposes determined by Us to be educational. ]
9. [Expenses to the extent that they are paid or payable under another group insurance or medical prepayment plan.]
10. [Charges that are eligible for payment by Medicare or any other government program except Medicaid. ]
11. [Expenses for care in government institutions unless You or Your Covered Dependent are obligated to pay for such care. ]
12. [Expenses for which benefits are paid or payable under workers' compensation or similar laws. ]
13. [Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited). ]
14. [Expenses incurred by a Covered Person while on active duty in the armed forces. Upon written notice to us of entry into such active duty, the unused premium will be returned to you on a pro-rated basis. ]
15. [Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection. ]
16. [Expenses incurred while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony or assault. ]
17. [Expenses for the treatment of normal pregnancy or childbirth, except for Complications of Pregnancy. ]
18. [Expenses for voluntary termination of normal pregnancy or elective cesarean section. ]
19. [Expenses incurred for any drug, including birth control pills, implants, injections, supply, treatment device or procedure that prevents conception or childbirth. ]
20. [Expenses for the diagnosis and treatment of infertility, including but not limited to any attempt to induce fertilization by any method, artificial insemination or similar procedures, whether the Covered Person is a donor, recipient or surrogate. ]
21. [Expenses for sterilization or reversal of sterilization. ]
22. [Charges for a Covered Dependent who is a newborn child not yet discharged from the Hospital, except as specifically covered under the Policy. This does not apply to charges that are Medically Necessary to treat premature birth, congenital Injury or Sickness, or Sickness or Injury sustained during or after birth. ]
23. [Expenses related to sex transformation or penile implants or sex dysfunction or inadequacies. ]
24. [Expenses for physical exams or other services not needed for medical treatment, except as specifically covered.]
25. [Expenses for prophylactic treatment, including surgery or diagnostic testing, except as specifically covered. ]
26. [Expenses for the treatment of mental illness or nervous disorders, including, but not limited to, neurosis, psychoneurosis, psychopathy, psychosis, attention deficit disorder, autism, hyperactivity, or mental or emotional disease or disorder of any kind; unless it is specifically covered. ]
27. [Expenses for the treatment of alcoholism or alcohol abuse, chemical dependency, substance abuse or drug addiction; unless it is specifically covered. ]
28. [Expenses incurred for loss sustained or contracted in consequence of the Covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of a Doctor. Intoxication shall be established conclusively by a blood alcohol level of .10 or the legal limit in the state where the incident occurred, whichever is less. ]
29. [Expenses incurred for a loss that arises out of or in the course of employment. ]
30. [Expenses incurred in connection with programs, treatment, or procedures for tobacco use cessation. ]
31. [Expenses resulting from suicide or attempted suicide or intentionally self-inflicted Injury, while sane or insane. ]
32. [Expenses for dental treatment or care or orthodontia or other treatment involving the teeth or supporting structures, except as specifically covered. ]
33. [Expenses of radial keratotomy or correction of refractive error, eye refractions, vision therapy, routine vision exams to assess the initial need for, or changes to prescription eyeglasses or contact lenses, the purchase, fitting or adjustment of eyeglasses or contact lenses, or treatment of cataracts. ]
34. [Expenses for routine hearing exams to assess the need for or change to hearing aids, or the purchase, fittings or adjustments of hearing aids, except as specifically covered under the Policy. ]
35. [Expenses for cosmetic or reconstructive procedures, services or supplies; except as specifically covered. ]
36. [Expenses for breast reduction or augmentation or complications arising from these procedures; except as specifically covered. ]
37. Outpatient Prescription or Legend Drugs, medications, vitamins, and mineral or food supplements, including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.

38. [Expenses incurred in connection with any drug or other item used to treat hair loss. ]
39. [Expenses incurred in the treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions, spurs, or the removal of corns, calluses or toenails, unless specifically for the treatment of a metabolic or peripheral vascular disease or for the prompt repair of an Injury sustained while coverage is in force for the Covered Person. ]
40. [Expenses incurred in the treatment of acne, or varicose veins. ]
41. [Expenses of weight loss programs or diets. ]
42. [Transportation Expenses, except as specifically covered. ]
43. [Expenses for rest or recuperation cures or care in an extended care facility, convalescent nursing home, a facility providing rehabilitative treatment, Skilled Nursing Facility, or home for the aged, whether or not part of a Hospital.]
44. [Expenses for services or supplies for personal comfort or convenience, including homemaker services or supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to bathing, dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops. ]
45. [Expenses for services or supplies furnished or provided by a member of your Immediate Family. ]
46. [Expenses for diagnosis or treatment of a sleeping disorder. ]
47. [Expenses incurred in the treatment of Injury or Sickness resulting from participation in skydiving, scuba diving, hang or ultra light gliding, riding an all terrain vehicle such as a dirt bike, snowmobile or go-cart, racing with a motorcycle, boat or any form of aircraft, any participation in sports for pay or profit, or participation in rodeo contests. ]
48. [Expenses for the purchase of a noninvasive osteogenesis stimulator (bone stimulator). ]
49. [Expenses for services or supplies of a common household use, such as exercise cycles, air or water purifiers, air conditioners, allergenic mattresses, and blood pressure kits. ]
50. [Expenses during the first 6-months after the Effective Date of coverage for a Covered Person for: [(a) total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma; (b) tonsillectomy; (c) adenoidectomy; (d) repair of deviated nasal septum or any type of surgery involving the sinus; (e) myringotomy; (f) tympanotomy; (g) herniorrhaphy; or (h) cholecystectomy;] (subject to all other coverage provisions, including but not limited to, the Pre-existing Conditions exclusion). ]
51. [Expenses for participating in interscholastic, intercollegiate or organized competitive sports, unless it is specifically covered. ]
52. [Medical care, treatment, service or supplies received outside of the United States, Canada or its possessions. ]
53. [Expenses for private duty nursing services. ]
54. [Expenses for the repair or maintenance of a wheelchair, hospital-type bed or similar durable mechanical equipment. ]
55. [Expenses for orthotics, special shoes, spine and arch supports, heel wedges, sneakers or similar devices unless they are a permanent part of an orthopedic leg brace. ]
56. [Expenses incurred in connection with the voluntary taking of a poison or inhaling gas. ]
57. [Expenses incurred in connection with obesity treatment or weight reduction including all forms of intestinal and gastric bypass surgery, including the reversal of such surgery even if the Covered Person has other health conditions that might be helped by a reduction of obesity or weight. ]
58. [Expenses for marital counseling or social counseling. ]
59. [Expenses for acupuncture. ]
60. [Expenses for a service or supply whose primary purpose is to provide a Covered Person with (1) training in the requirements of daily living; (2) instruction in scholastic skills such as reading and writing; (3) preparation for an occupation; (4) treatment of learning disabilities, developmental delays or dyslexia; or (5) development beyond a point where function has been demonstrably restored. ]
61. [Expenses for replacement of artificial limbs or eyes. ]
62. [Expenses for removal of breast implants. ]

**PRE-EXISTING CONDITIONS LIMITATION:** We will not provide benefits for any loss caused by, or resulting from, a Pre-existing Condition. “Preexisting Conditions” means any medical condition or Sickness for which:

1. Medical advice, care, diagnosis, treatment, Consultation, or medication was recommended by or received from a Doctor within the [5-years] immediately prior to a Covered Person's Effective Date of coverage; or
2. Symptoms existed within the [5-years] immediately prior to the Covered Persons Effective Date of coverage which would cause a reasonable person to seek diagnosis, care or treatment.

“Consultation” means evaluation, diagnosis, or medical advice was given with or without the necessity of a personal examination or visit.

## **PREMIUM PROVISIONS**

**Premium Payment:** Premiums are payable at the Home Office of The Company or if We direct, to Our authorized administrator, on or before each premium due date.

**Premium Due Date:** The first premium will be due on the Policy effective date and on the same day of each subsequent month unless You and The Company agree on some other method of premium payment.

If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period.

**Changes in Premium Rates:** The monthly premium rates may be changed by Us from time to time if We give You at least [thirty-one (31) days] advance written notice. The premium rates may also be changed at any time the terms of the Policy are changed.

**Incorrect Premium Payment:** Premiums paid in error for a person who is not eligible to be insured, or for a person after his insurance has ceased, will be refunded without interest when requested by You. These premiums will not be refunded for any period before the last anniversary date.

**Grace Period:** If, before any premium due date except the first, You have not given written notice to The Company that the Policy is to be terminated, a Grace Period of thirty-one (31) days will be given in which to pay the premium then due. The Policy will stay in effect during that time. If any premium is not paid by the end of the Grace Period, the Policy will automatically terminate at the end of the Grace Period; except that if You have given written notice in advance of an earlier date of termination, the Policy will terminate as of the earlier date.

## CLAIM PROVISIONS

**Notice of Claim:** Written notice of claim must be given to The Company within thirty-one (31) days after a covered loss occurs or begins. If this notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible. The notice must be sent to The Company at its Home Office and should include the Your name, address, city, state, zip, and policy number.

**Claim Forms:** The Company will send the claim forms to You upon receipt of notice of claim. If You do not receive these forms within fifteen (15) days, the proof of loss requirement may be met by giving The Company a written statement of the nature and extent of the loss within the time limit stated below.

**Proof of Loss:** The Company requires written proof of loss within ninety (90) days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one (1) year from such time unless the claimant was legally incapacitated.

**Time of Payment of Claims:** We will make payment promptly upon receipt of due written proof of loss.

**Payment of Claims:** Payment will be made directly to You or the provider of the service, as directed by You in writing at the time of submitting proof of loss.

If any benefit under the Policy becomes payable to:

1. A Covered Person's estate;
2. A minor, or
3. Any person who, in the opinion of The Company, is not competent to give a valid release; then The Company, at its option, may make payment to any one or more the following:
  - a. A person who has assumed the care and support of the Covered Person or beneficiary;
  - b. A person who has incurred funeral or other expenses as a result of the Covered Person's last illness or death;
  - c. The personal representative of the Covered Person's estate;
  - d. Any person related to the Covered Person by blood or marriage.

No payments made to anyone named above may exceed \$250, or the maximum allowed by state law. Any payment made in good faith under this section will fully discharge The Company to the extent of the payment.

**Appeal of Claim Denial:** If a claim is denied, You will receive written notice giving the reason for the denial. If You wish to appeal the denial of the claim, such appeal must be submitted to us in writing within sixty (60) days from the date of notice. You must clearly state the reason You believe the claim decision is incorrect.

## GENERAL PROVISIONS

**Execution of Policy:** The Policy is executed at the Home Office of Pan-American Life Insurance Company in New Orleans, Louisiana.

**Consideration:** The Policy is issued to the Covered Person in consideration of the application and payment of premiums.

**Incontestability:** We will not contest the Policy after three (3) years from the date of onset of issue except for failure to pay premium. No statement made by an Covered Person will be used to deny a claim after the person's coverage has been in force for a period of three (3) years during the Covered Person's life; then only if the statement is made in writing and signed by the Covered Person.

**Statements Not Warranties:** All statements made by the Covered Person will, be deemed representations and not warranties. No statement made by the Covered Person to obtain insurance will be used to avoid or reduce the insurance unless:

1. It is made in writing;
2. It is signed by the Covered Person; and
3. A copy is sent to the Covered Person or the Covered Person's Beneficiary.

**Entire Contract:** The entire contract will be made up of the Policy, Certificates, the individual Covered Person's applications, Amendments and Riders will constitute the entire Policy between parties.

**Policy Changes:** Insurance provided by the Policy may be amended, changed or canceled without the consent of any Covered Person and without prior notice to him. Changes may be made in the Policy only by amendment signed by The Company acting through one (1) of its officers. No agent may change or waive any terms of the Policy.

**Clerical Error:** Clerical error will not void insurance otherwise validly in force nor will it keep in force insurance which otherwise would cease.

**Conformity With Statutes:** Any provision of this Policy that is in conflict with the statutes of the jurisdiction in which the Policy is issued is hereby amended to conform to the minimum requirements of such statutes.

**Assignment and Claims of Creditors:** Benefits are not assignable except that You may direct us to pay benefits to the person or institution on whose charges any claim is based. Any such payment that we make will fully discharge Us to the extent of the payment.

**Contract/Changes:** The effective time for any dates used shall be 12:01 A.M. Standard Time at the address of the Covered Person.

**Medical Records:** The Company shall have access to medical and treatment records of the Covered Persons to determine benefits, process claims, utilization review, quality assurance, or for any other purpose reasonably related to the Policy benefits. Each Covered Person shall complete and submit to the Company such additional consents, releases and other documents as may be requested by the Company in order to determine or provide benefits under the Policy. The Company reserves the right to reject or suspend a claim based on lack of supporting medical information or records.

**Physical Exam and Autopsy:** We may require, at Our expense, medical examinations of any person for whom claim is made when and as often as it may reasonably require during the pendency of a claim. We may also make an autopsy, if not forbidden by law.

**Pronouns:** Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine also, unless the context clearly indicates to the contrary.

**Rescission:** A misrepresentation or omission in the application form or other documents provided to Us may be the basis for later rescission of all coverage of all Covered Persons. Rescission voids all coverage as of the Effective Date and means that no benefits will be paid to any person for any claim submitted, whether or not such claim relates to the condition about which information was misrepresented or omitted. We will refund to You premiums paid after deduction for any claims We paid.

**Waiver of Rights:** The Company's failure to enforce any provision of the Policy does not affect Our right to enforce any provision at a later date, and does not affect the Company's right to enforce any other provision of the Policy.

**Workers' Compensation:** This Policy is not a substitute for Workers' Compensation insurance and does not affect any requirement for Workers' Compensation coverage.

**[Subrogation:** As a condition to receiving benefits under the Policy, Covered Persons receiving medical benefits agree to transfer in full to Us their rights to recover damages for these benefits when the Injury or Sickness occurs through the act or omission of another person. 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 Injury or Sickness occurs through the act of a third party. Our subrogation rights of full recovery may be from any person or business entity, in accordance with the laws of the jurisdiction wherein the Injury or Sickness occurred. We may enforce Our right of subrogation by requiring the Covered Person to assert a claim to any of the coverages to which he/she may be entitled. We will not pay fees or expenses associated with a claim/lawsuit without express written authorization.

If We are precluded by law from exercising Our Subrogation Right, We may exercise Our Right of Reimbursement.]

**[Right of Reimbursement:** As a condition to receiving benefits under the Policy, Covered Persons receiving medical care benefits agree to reimburse Us in full any such benefits when they are recovered from another person or business entity. If a repayment agreement is required to be signed, We shall be entitled to full reimbursement regardless of whether it is actually signed. Our right of reimbursement may be from funds received from any person or business entity, in accordance with the laws of the jurisdiction wherein the Injury or Sickness occurred. We may enforce Our right of reimbursement by requiring the Covered Person to assert a claim to any of the coverages to which he/she may be entitled. We will not pay fees or expenses associated with any claim/lawsuit without express written consent.]

**[Third Party Clause:** Medical care benefits are not payable to or for a Covered Person under the Policy when the Injury or Sickness to the Covered Person occurs through the act or omission of another person. However, We may elect to advance payment for medical expenses incurred for an Injury or Sickness caused by a third party. The Covered Person or guardian must sign an agreement to repay Us in full any sums advanced for such medical expenses from any judgment or settlement received. We have the right to recover in full the medical expenses advanced regardless of whether that person actually signs any required repayment agreement. It is only necessary that the Injury or Sickness occurs through the act of a third party. Our right of recovery in full may be from any person or business entity, in accordance with the laws of the jurisdiction wherein the Injury or Sickness occurred. We may enforce this provision by requiring the Covered Person to assert a claim to any of the coverages to which he may be entitled. We will not pay fees or expenses associated with the claim/lawsuit without express written authorization.]

**[Arbitration:** If any Covered Person has a dispute, disagreement or claim against the Company, its authorized administrator, or any employee or agent of the Company or of its authorized administrator, which has not been resolved or settled after exhaustion of the Company's appeals procedures, then the dispute or disagreement shall be resolved by arbitration. This provision shall be applicable to all claims or controversies arising under the Policy. Arbitration shall be conducted in accordance with the Commercial Rules of Arbitration of the American Arbitration Association.]

**Legal Proceedings:** No proceedings to obtain benefits may be brought against us until 60-days after we have received proper written proof of loss and any other documentation necessary to establish the benefits due. No proceedings may be brought more than 3-years after proof is required to be filed.

**Misstatement of Age:** If a Covered Person's age has been misstated, premiums will be subject to an equitable adjustment. If the amount of the benefit depends upon age, then the benefit will be that which would have been payable, based upon the person's correct age.

**Reinstatement:** If any renewal premium is not paid within the time granted the Covered Person for payment, a subsequent acceptance of premium by the Company without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the Company requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the Company or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the Company has previously notified the Covered Person in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects, the Covered Person and the Company shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

**Refund of unearned premiums upon death of insured.** Upon the death of the Covered Person, the proceeds payable to the insured or his or her estate under the Policy shall include premiums paid for any period beyond the end of the Policy month in which the death occurred. The unearned premiums shall be paid in lump sum on a date no later than thirty (30) days after the proof of the Covered Person's death has been furnished to the Company.

[

## POLICY SCHEDULE OF INSURANCE

Policy Number: G-123456  
Policyholder Name: John Doe  
Effective Date: December 1, 2008  
Supplement Accidental Injury Rider: December 1, 2008

Dependent Coverage:  Yes  No  
Coverage Period: 6 months

Deductible: \$500  
Coinsurance: 80% up to \$5,000 and 100% thereafter  
Lifetime Maximum: \$500,000

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