

SERFF Tracking Number: AMFT-126726853 State: Arkansas  
Filing Company: Commercial Travelers Mutual Insurance Company State Tracking Number: 46429  
Company Tracking Number: CTM GAP-P (04/05) AR  
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
Product Name: Group Supplemental Accident  
Project Name/Number: CTM GAP-P (04/05)/CTM GAP-P (04/05)

## Filing at a Glance

Company: Commercial Travelers Mutual Insurance Company

Product Name: Group Supplemental Accident SERFF Tr Num: AMFT-126726853 State: Arkansas

TOI: H02G Group Health - Accident Only SERFF Status: Closed-Approved- Closed State Tr Num: 46429

Sub-TOI: H02G.000 Health - Accident Only Co Tr Num: CTM GAP-P (04/05) State Status: Approved-Closed AR

Filing Type: Form

Reviewer(s): Rosalind Minor  
Author: Rebecca Ewing Disposition Date: 08/12/2010  
Date Submitted: 08/09/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: CTM GAP-P (04/05)

Status of Filing in Domicile: Pending

Project Number: CTM GAP-P (04/05)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 08/12/2010

Explanation for Other Group Market Type:

State Status Changed: 08/12/2010

Deemer Date:

Created By: Rebecca Ewing

Submitted By: Rebecca Ewing

Corresponding Filing Tracking Number:

Filing Description:

This is a supplemental group accident plan and will be marketed to employer groups. This plan will be offered and marketed as supplemental health insurance and not as a substitute for hospital or medical insurance, health care service plans, or major medical expense insurance. This plan is a supplemental, limited benefit medical expense product designed to help cover out-of-pocket expenses incurred that are not payable by a basic, major medical, or comprehensive medical policy.

The following forms are enclosed:

SERFF Tracking Number: AMFT-126726853 State: Arkansas  
Filing Company: Commercial Travelers Mutual Insurance State Tracking Number: 46429  
Company  
Company Tracking Number: CTM GAP-P (04/05) AR  
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Product Name: Group Supplemental Accident  
Project Name/Number: CTM GAP-P (04/05)/CTM GAP-P (04/05)

#### Form Number Description

CTM-GAP-P (04/05) - Supplemental Group Accident Policy  
CTM-GAP-C (04/05) - Supplemental Group Accident Certificate  
CTM -GAP-Sick Rider (04/05) - Sickness Benefit Rider  
CTM-GAP-Allied Service Rider (04/05) - Allied Services Rider  
CTM-GAP-Ded Credit Rider (04/05) - Prior Plan Deductible Credit Rider  
CTM-GAP-HI Rider (04/05) - Hospital Indemnity Sickness Benefit Rider  
CTM-GAP-Outpatient Diagnostic Test and Lab Rider (04/05) - Outpatient Diagnostic Test and Lab Benefit Rider  
CTM-GAP-Wellness Rider (04/05) - Outpatient Physical and Wellness Examination Rider  
CTM-GAP-Generic Drug Rider (04/05) - Generic Prescription Drug Benefit Rider  
CTM-GAP-Brand and Generic Drug Rider (04/05) - Brand and Generic Prescription Drug Benefit Rider  
CTM-GAP-Ambulance Rider (04/05) - Ambulance Benefit Rider  
CTM-GAP-Physician Rider (04/05) - Outpatient Physician's Expense Rider  
CTM-GAP-Enroll App-Employer Paid (04/05) - Enrollment Form  
CTM-GAP-GRP APP (04/05) - Application for Group Accident Limited Benefit Insurance  
CTM-GAP-Enroll App-Voluntary (04/05) - Application for Insurance / Enrollment

## Company and Contact

### Filing Contact Information

Ewing Rebecca, Compliance Consultant rewing@lewisellis.com  
P O Box 851857 972-850-3272 [Phone]  
Richardson, TX 75085 972-850-3273 [FAX]

### Filing Company Information

Commercial Travelers Mutual Insurance CoCode: 81426 State of Domicile: New York  
Company  
70 Genesee Street Group Code: 560 Company Type: Insurance  
Company  
Utica, NY 13502-3502 Group Name: State ID Number:  
(800) 422-6200 ext. 270[Phone] FEIN Number: 15-0274810

## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00

SERFF Tracking Number: AMFT-126726853 State: Arkansas  
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 Project Name/Number: CTM GAP-P (04/05)/CTM GAP-P (04/05)  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Commercial Travelers Mutual Insurance Company	\$50.00	08/09/2010	38607191
Commercial Travelers Mutual Insurance Company	\$700.00	08/10/2010	38661976

SERFF Tracking Number: AMFT-126726853 State: Arkansas  
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 Product Name: Group Supplemental Accident  
 Project Name/Number: CTM GAP-P (04/05)/CTM GAP-P (04/05)

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/12/2010	08/12/2010

### 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	08/11/2010	08/11/2010	Rebecca Ewing	08/12/2010	08/12/2010
Pending Industry Response	Rosalind Minor	08/10/2010	08/10/2010	Rebecca Ewing	08/10/2010	08/10/2010

*SERFF Tracking Number:* AMFT-126726853      *State:* Arkansas  
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*Company*  
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*TOI:* H02G Group Health - Accident Only      *Sub-TOI:* H02G.000 Health - Accident Only  
*Product Name:* Group Supplemental Accident  
*Project Name/Number:* CTM GAP-P (04/05)/CTM GAP-P (04/05)

## **Disposition**

Disposition Date: 08/12/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AMFT-126726853 State: Arkansas  
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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	Filing Authorization Letter	Approved-Closed	Yes
Form (revised)	Supplemental Group Accident Policy	Approved-Closed	Yes
Form	Supplemental Group Accident Policy	Replaced	Yes
Form (revised)	Supplemental Group Accident Certificate	Approved-Closed	Yes
Form	Supplemental Group Accident Certificate	Replaced	Yes
Form	Sickness Benefit Rider	Approved-Closed	Yes
Form	Allied Services Rider	Approved-Closed	Yes
Form	Prior Plan Deductible Credit Rider	Approved-Closed	Yes
Form	Hospital Indemnity Sickness Benefit Rider	Approved-Closed	Yes
Form	Outpatient Diagnostic Test and Lab Benefit Rider	Approved-Closed	Yes
Form	Outpatient Physical and Wellness Examination Rider	Approved-Closed	Yes
Form	Generic Prescription Drug Benefit Rider	Approved-Closed	Yes
Form	Brand and Generic Prescription Drug Benefit Rider	Approved-Closed	Yes
Form	Ambulance Benefit Rider	Approved-Closed	Yes
Form	Outpatient Physician's Expense Rider	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Application for Group Accident Limited Benefit Insurance	Approved-Closed	Yes
Form	Application for Insurance / Enrollment	Approved-Closed	Yes

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Product Name: Group Supplemental Accident  
Project Name/Number: CTM GAP-P (04/05)/CTM GAP-P (04/05)

## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 08/11/2010

Submitted Date 08/11/2010

Respond By Date

Dear Ewing Rebecca,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Supplemental Group Accident Policy, CTM-GAP-P (04/05) (Form)
- Supplemental Group Accident Certificate, CTM-GAP-C (04/05) (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

### Objection 2

- Supplemental Group Accident Certificate, CTM-GAP-C (04/05) (Form)

Comment:

The Time Payment of Claims provision must comply with Rule and Regulation 43, Section 12 which states that..." A Health Carrier shall pay or deny a clean claim within 30 days after receipt by the Health Carrier if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means....".

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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 Product Name: Group Supplemental Accident  
 Project Name/Number: CTM GAP-P (04/05)/CTM GAP-P (04/05)

## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 08/12/2010  
 Submitted Date 08/12/2010

Dear Rosalind Minor,

### Comments:

Thank you for your letter regarding the referenced files. I am responding to your letter as follows:

### Response 1

Comments: The Group Policy and Group Certificate have been revised by removing the time limit set for furnishing proof of incapacity. The form numbers for these forms have been revised by adding "AR" to the end of the form number(s).

### Related Objection 1

Applies To:

- Supplemental Group Accident Policy, CTM-GAP-P (04/05) (Form)
- Supplemental Group Accident Certificate, CTM-GAP-C (04/05) (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

### 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
Supplemental Group Accident Policy	CTM-GAP-P (04/05)		Policy/Contract/Fraternal Certificate	Initial		50.100	CTM-GAP-P_04 05_

SERFF Tracking Number: AMFT-126726853 State: Arkansas  
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 Company:   
 Company Tracking Number: CTM GAP-P (04/05) AR  
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
 Product Name: Group Supplemental Accident  
 Project Name/Number: CTM GAP-P (04/05)/CTM GAP-P (04/05)  
 AR AR.pdf

**Previous Version**

Supplemental Group Accident Policy	CTM- GAP-P (04/05)	Policy/Contract/Fraternal Certificate	Initial	50.100	CTM- GAP-P _04 05_.pdf
Supplemental Group Accident Certificate	CTM- GAP-C (04/05) AR	Certificate	Initial		CTM- GAP-C _0405_ AR.pdf

**Previous Version**

Supplemental Group Accident Certificate	CTM- GAP-C (04/05)	Certificate	Initial		CTM- GAP-C _0405_.pdf
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No Rate/Rule Schedule items changed.

**Response 2**

Comments: The Group Policy and Group Certificate have been further revised by modifying the "Time of Payment of Claims" provision to read as follows: "Any benefit payable under this Policy will be paid not more than 30 days after the Company receives proper written proof of such loss if the claim was submitted electronically or within 45 days after receipt if the claim was submitted by other means."

**Related Objection 1**

Applies To:  
 - Supplemental Group Accident Certificate, CTM-GAP-C (04/05) (Form)  
 Comment:

The Time Payment of Claims provision must comply with Rule and Regulation 43, Section 12 which states that..." A Health Carrier shall pay or deny a clean claim within 30 days after receipt by the Health Carrier if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means....".

**Changed Items:**

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 Company Tracking Number: CTM GAP-P (04/05) AR  
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 Product Name: Group Supplemental Accident  
 Project Name/Number: CTM GAP-P (04/05)/CTM GAP-P (04/05)

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Supplemental Group Accident Certificate	CTM-GAP-C (04/05) AR		Certificate	Initial			CTM-GAP-C _0405_ AR.pdf
<b>Previous Version</b>							
Supplemental Group Accident Certificate	CTM-GAP-C (04/05)		Certificate	Initial			CTM-GAP-C _0405_.pdf

No Rate/Rule Schedule items changed.

Thank you for your continued review of this filing. I trust these forms are now acceptable to you.

Sincerely,  
 Rebecca Ewing

Sincerely,  
 Rebecca Ewing

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Company: Company  
Company Tracking Number: CTM GAP-P (04/05) AR  
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Product Name: Group Supplemental Accident  
Project Name/Number: CTM GAP-P (04/05)/CTM GAP-P (04/05)

## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 08/10/2010

Submitted Date 08/10/2010

Respond By Date

Dear Ewing Rebecca,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Supplemental Group Accident Policy, CTM-GAP-P (04/05) (Form)
- Supplemental Group Accident Certificate, CTM-GAP-C (04/05) (Form)
- Sickness Benefit Rider, CTM-GAP-Sick Rider (04/05) (Form)
- Allied Services Rider, CTM-GAP-Allied Service Rider (04/05) (Form)
- Prior Plan Deductible Credit Rider, CTM-GAP-Ded Credit Rider (04/05) (Form)
- Hospital Indemnity Sickness Benefit Rider, CTM-GAP-HI Rider (04/05) (Form)
- Outpatient Diagnostic Test and Lab Benefit Rider, CTM-GAP-Outpatient Diagnostic Test and Lab Rider (04/05) (Form)
- Outpatient Physical and Wellness Examination Rider, CTM-GAP-Wellness Rider (04/05) (Form)
- Generic Prescription Drug Benefit Rider, CTM-GAP-Generic Drug Rider (04/05) (Form)
- Brand and Generic Prescription Drug Benefit Rider, CTM-GAP-Brand and Generic Drug Rider (04/05) (Form)
- Ambulance Benefit Rider, CTM-GAP-Ambulance Rider (04/05) (Form)
- Outpatient Physician's Expense Rider, CTM-GAP-Physician Rider (04/05) (Form)
- Enrollment Form, CTM-GAP-Enroll App-Employer Paid (04/05) (Form)
- Application for Group Accident Limited Benefit Insurance, CTM-GAP-GRP APP (04/05) (Form)
- Application for Insurance / Enrollment, CTM-GAP-Enroll App-Voluntary (04/05) (Form)

Comment:

Our filing fees under Rule and Regulation 57 has been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$750.00. Please submit an additional \$700.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

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Please feel free to contact me if you have questions.

Sincerely,  
Rosalind Minor

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 08/10/2010  
Submitted Date 08/10/2010

Dear Rosalind Minor,

### Comments:

Thank you for your letter regarding the referenced filing.

### Response 1

Comments: An additional filing fee in the amount of \$700.00 has been submitted to you via EFT.

### Related Objection 1

Applies To:

- Supplemental Group Accident Policy, CTM-GAP-P (04/05) (Form)
- Supplemental Group Accident Certificate, CTM-GAP-C (04/05) (Form)
- Sickness Benefit Rider, CTM-GAP-Sick Rider (04/05) (Form)
- Allied Services Rider, CTM-GAP-Allied Service Rider (04/05) (Form)
- Prior Plan Deductible Credit Rider, CTM-GAP-Ded Credit Rider (04/05) (Form)
- Hospital Indemnity Sickness Benefit Rider, CTM-GAP-HI Rider (04/05) (Form)
- Outpatient Diagnostic Test and Lab Benefit Rider, CTM-GAP-Outpatient Diagnostic Test and Lab Rider (04/05) (Form)
- Outpatient Physical and Wellness Examination Rider, CTM-GAP-Wellness Rider (04/05) (Form)
- Generic Prescription Drug Benefit Rider, CTM-GAP-Generic Drug Rider (04/05) (Form)
- Brand and Generic Prescription Drug Benefit Rider, CTM-GAP-Brand and Generic Drug Rider (04/05) (Form)
- Ambulance Benefit Rider, CTM-GAP-Ambulance Rider (04/05) (Form)
- Outpatient Physician's Expense Rider, CTM-GAP-Physician Rider (04/05) (Form)
- Enrollment Form, CTM-GAP-Enroll App-Employer Paid (04/05) (Form)
- Application for Group Accident Limited Benefit Insurance, CTM-GAP-GRP APP (04/05) (Form)
- Application for Insurance / Enrollment, CTM-GAP-Enroll App-Voluntary (04/05) (Form)

Comment:

Our filing fees under Rule and Regulation 57 has been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.



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## Form Schedule

### Lead Form Number: CTM GAP-P (04/05)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/12/2010	CTM-GAP-P (04/05) AR	Policy/Cont ract/Fratern al	Supplemental Group Accident Policy Certificate	Initial		50.100	CTM-GAP-P _04 05_ AR.pdf
Approved-Closed 08/12/2010	CTM-GAP-C (04/05) AR	Certificate	Supplemental Group Accident Certificate	Initial			CTM-GAP-C _0405_ AR.pdf
Approved-Closed 08/12/2010	CTM-GAP-Sick Rider (04/05) AR	Policy/Cont ract/Fratern al	Sickness Benefit Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			CTM-GAP- Sick Rider _04 05_ .pdf
Approved-Closed 08/12/2010	CTM-GAP-Allied Service Rider (04/05) AR	Policy/Cont ract/Fratern al	Allied Services Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			CTM-GAP- Allied Service Rider _04 05_.pdf
Approved-Closed 08/12/2010	CTM-GAP-Ded Credit Rider (04/05) AR	Policy/Cont ract/Fratern al	Prior Plan Deductible Credit Rider Certificate: Amendmen	Initial			CTM-GAP- Ded Credit Rider _04 05_.pdf





<i>SERFF Tracking Number:</i>	AMFT-126726853	<i>State:</i>	Arkansas
<i>Filing Company:</i>	Commercial Travelers Mutual Insurance Company	<i>State Tracking Number:</i>	46429
<i>Company Tracking Number:</i>	CTM GAP-P (04/05) AR		
<i>TOI:</i>	H02G Group Health - Accident Only	<i>Sub-TOI:</i>	H02G.000 Health - Accident Only
<i>Product Name:</i>	Group Supplemental Accident		
<i>Project Name/Number:</i>	CTM GAP-P (04/05)/CTM GAP-P (04/05)		
08/12/2010 (04/05)	Form	Benefit Insurance	_04 05_.pdf
Approved- CTM-GAP-	Application/	Application for	Initial
Closed	Enroll App-	Enrollment Insurance /	CTM-GAP-
08/12/2010	Voluntary	Form	Enrollment
(04/05)			Voluntary _04 05_.pdf



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**POLICY SCHEDULE OF BENEFITS**

<p><b>Year: [Calendar Year or Policy Year]</b></p> <p><b>Deductible</b></p> <p><b>Coinsurance %</b></p> <p><b>Out of Pocket Maximum (Coinsurance Limit)</b></p> <p><b>Maximum Total Benefit Amount</b></p>	<p>[Calendar]</p> <p>[NA-\$3000]</p> <p>[NA-50%]</p> <p>[NA- \$10,000]</p> <p>[NA to \$9,500]</p>
<p><b>Accident Benefit</b></p> <p>Does the Policy Deductible and Coinsurance apply to this benefit?</p> <p>Co-payment Amount [per date of service]</p> <p><b>Maximum Accident Benefit Amount for <u>All Covered Facilities</u> [per year]:</b></p> <p><b>Maximum Accident Benefit Amount for all Covered <u>Outpatient</u> Facilities [per year]:</b>                      [Maximum Accident Benefit for Ambulatory Surgical Facility or Day Surgery Facility Benefit Amount] [per year]                      [Maximum Accident Benefit Amount for MRI Facility] [per year]                      [Maximum Accident Benefit Amount for Outpatient Department of a Hospital] [per year]                      [Maximum Accident Benefit Amount for Emergency Room of a Hospital] [per year]</p> <p><b>Maximum Accident Benefit Amount for <u>In-Hospital Confinement</u> [per year]</b></p>	<p>[Yes, No]</p> <p>[N/A - \$500]</p> <p>[NA-\$9500]</p> <p>[\$1,000-\$9500]</p> <p>[N/A]</p> <p>[N/A]</p> <p>[N/A]</p> <p>[N/A]</p> <p>[N/A-\$9500]</p>
<p><b>OPTIONAL RIDERS</b></p>	
<p><b>Sickness Benefit Rider:</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider?</p> <p>Co-payment Amount [per date of service]</p> <p><b>Maximum Sickness Benefit Amount for <u>All Covered Facilities</u> [per year]:</b></p> <p><b>Maximum Sickness Benefit Amount for All Covered <u>Outpatient</u> Facilities [per year]:</b>                      [Maximum Sickness Benefit Amount for Ambulatory Surgical Facility or Day Surgery Facility] [per year]                      [Maximum Sickness Benefit Amount for MRI Facility] [ per year]                      [Maximum Sickness Benefit Amount for Outpatient Department of a Hospital] [per year]                      [Maximum Sickness Benefit Amount for Emergency Room of a Hospital] [per year]</p> <p>Maximum Sickness Benefit Amount for <u>In-Hospital Confinement</u> [per year]</p>	<p>[Yes, No]</p> <p>[Yes, No]</p> <p>[N/A- \$500]</p> <p>[NA-\$9,500]</p> <p>[N/A -\$9,500]</p> <p>[N/A- \$9500]</p> <p>[N/A- \$9500]</p> <p>[N/A-\$9500]</p> <p>[N/A-\$9500]</p> <p>[N/A-\$9500]</p>
<p><b>Hospital Indemnity Sickness Benefit Rider</b></p> <p>Maximum Hospital Indemnity Benefit Amount: [per day]</p> <p>Maximum number of days [per insured person per year]</p>	<p>[Yes, No]</p> <p>[N/A -\$5000]</p> <p>[N/A-10]</p>
<p><b>Outpatient Physician's Expense Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider?</p> <p>Co-payment Amount [per visit]</p> <p>Maximum Outpatient Physician's Expense Benefit Amount [per visit]</p> <p>Maximum Outpatient Physician's Expense Benefit – [number of visits per Year]</p> <p>Maximum Outpatient Physician's Expense Benefit Amount [Per Sickness or Injury per Calendar Year]</p> <p>Maximum Outpatient Physician's Expense Benefit Amount [Per Insured Person per Calendar Year]</p> <p>Maximum Outpatient Physician's Expense Benefit Amount [For All Insured Persons per Calendar Year]</p>	<p>[Yes, No]</p> <p>[Yes, No]</p> <p>[N/A -\$50]</p> <p>[N/A-\$500]</p> <p>[N/A – 10]</p> <p>[N/A-\$500]</p> <p>[N/A-\$5000]</p> <p>[N/A-\$10,000]</p>

**OPTIONAL RIDERS**

<p><b>Ambulance Benefit Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider? Benefit Amount [per year per covered person] Maximum Benefit [per year per family]</p>	<p>[Yes, No]</p> <p>[Yes, No] [N/A- \$1000] [N/A-\$3000]</p>
<p><b>Generic Outpatient Prescription Drug Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider? [Dispensing limit] [Prescription Drug Rider Deductible] [Prescription Drug Rider Co-insurance %] [Out of Pocket Maximum –Rider Coinsurance] [Co-payment Amount Generic (greater of)] [Maximum Benefit Amount per Calendar Year per insured] [Maximum Number of Outpatient Prescriptions]</p>	<p>[Yes, No]</p> <p>[N/A- 30 days] [N/A-\$100] [N/A -50%] [N/A-\$5000] [N/A\$10 or 10%] [N/A-\$1000] [N/A-2] [N/A-10] [N/A-20]</p> <p>[Per Sickness or Injury] [Per Insured Person] [For All Insured Persons]</p>
<p><b>Brand [and Generic] Outpatient Prescription Drug Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider? [Dispensing limit] [Prescription Drug Rider Deductible] [Prescription Drug Rider Co-insurance %] [Out of Pocket Maximum –Rider Coinsurance] [Co-payment Amount Generic (greater of)] [Co-payment Amount Preferred Brand (greater of)] [Co-payment Amount Non-Preferred Brand (greater of)] [Co-payment Amount Oral Contraceptives] [Co-payment Amount Migraine Kits]</p> <p>[Brand Name-Outpatient Prescription Drug Expense Benefit Amount per Calendar Year per insured] [Maximum Number of Outpatient Prescriptions]</p>	<p>[Yes, No]</p> <p>[Yes, No] [N/A- 30 days] [N/A-\$100] [N/A -50%] [N/A-\$5000] [N/A-\$10 or 10%] [N/A-\$35 or 35%] [N/A-\$50 or 50%] [N/A- \$50] [One applicable co-pay per kit] [N/A-\$1000]</p> <p>[N/A-2] [N/A-10] [N/A-20]</p> <p>[Per Sickness or Injury] [Per Insured Person] [For All Insured Persons]</p>
<p><b>Outpatient Physical and Wellness Examination Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider? Co-payment Amount Outpatient Physical Examination and Wellness Benefit Amount per person per year Maximum Number of Outpatient Physical Examination and Wellness Benefits Payable for All Insured Persons per Calendar Year</p>	<p>[Yes, No]</p> <p>[Yes, No] [N/A -\$50] [N/A -\$250]</p> <p>[N/A-2]</p>
<p><b>Outpatient Diagnostic Test and Lab Rider</b></p>	<p>[Yes, No]</p>
<p><b>Prior Plan Deductible Credit Rider</b></p>	<p>[Yes, No]</p>
<p><b>Allied Service Rider</b></p>	<p>[Yes, No]</p>

THIS SCHEDULE IS ATTACHED TO AND MADE PART OF YOUR POLICY. THIS SCHEDULE REPLACES AND CANCELS ALL OTHER SCHEDULES ISSUED PRIOR TO THE EFFECTIVE DATE FOR THE ELIGIBLE PERSONS UNDER THIS POLICY.

## Definitions

### Important Notice: Additional Definitions are in the Benefits Provisions of the Policy and/or Rider Provisions

Whenever used in this Policy:

**Accident** means a sudden and unexpected event resulting in Injury

**Calendar Year** means the one (1) year period beginning January 1 and ending December 31 of the same year.

**Certificate** means the Certificate of Insurance issued to the Insured. It describes the coverage under this Policy.

**Company, Our, We or Us** means Commercial Travelers Mutual Insurance Company.

**Coinsurance** means the portion of the Covered Charges which the insured is required to pay after the Deductible before benefits are payable for any benefit that has a coinsurance requirement. The Coinsurance Limit is shown in the schedule.

**Co-payment or Co-payment Amount** means the specified dollar amount of Covered Expenses that must be paid by an Insured Person before benefits are payable under the Policy or Rider that has a Co-payment Amount.

**Covered Charges** means that portion of the charge allowed by the Insured Person's Major Medical Plan or Comprehensive Health Plan for Medically Necessary expenses which are specified, described and limited in the Policy or Rider for which benefits are payable under the Policy as the result of covered Injury of Sickness.

**Covered Hospital Confinement, In-Hospital or In-Hospital Confinement** means Hospital confinement of an Insured Person for which Benefits are payable under the Policy or any Rider elected by the Insured and which is:

1. Due to a covered Injury [or Sickness]; and
2. For a period of no less than [twenty-four (24) hours]; and
3. At the direction of and under the supervision of a Physician.

**Day Surgery Facility or Ambulatory Surgical Center** means any licensed public or private establishment with an organized medical staff of Physicians. The establishment must have permanent facilities equipped and operated solely for performing surgical procedures. This facility must not provide services or other accommodations for patients to stay overnight. It does not include [a Hospital emergency room, trauma center, center for termination of pregnancy, or surgery in a Physician's office].

**Deductible** means that portion of the Covered Charges, incurred during the Year, which an Insured Person is required to pay before benefits are payable for any Benefit that has a Deductible requirement. The Deductible amount is shown in the Schedule.

**Effective Date** means the date insurance begins under the Policy for an Insured Person. Insurance will begin as of the first of the month following Our approval and payment of the first premium. In no event will coverage for any person become effective prior to the Policy Date.

**Eligible Person** means a person who is insured under the Policyholder's Major Medical or Comprehensive Health Plan and who meets the criteria described in the Policy as eligible for insurance. (See the Eligibility Section of the Policy – page 7)

**Hospital** means a legally authorized and operated institution for the care or treatment of sick or injured persons. It must have graduate registered nurses (R.N.) on 24-hour call and organized facilities for diagnosis and surgery under the full-time supervision of a Physician, either on its premises or in facilities available to it on a contractual prearranged basis.

The following do not qualify as a Hospital: an institution, or part of it, which is used mainly as a facility for rest, nursing care, convalescent care, care of the aged, or for remedial education or training. A Hospital is not primarily a psychiatric/substance abuse facility.

**Injury** means bodily harm caused by an accident resulting in trauma. A disease must not directly or indirectly contribute to the bodily harm. The accident must take place while the Policy is in force for the person injured.

**Insured Person** means either an Insured or an Insured Dependent. An **Insured** is an employee of the Policyholder whose coverage under this Policy has become effective and has not been terminated. **Insured Dependent** means any of the following:

- (a) the spouse of an Insured whose coverage under this Policy has become effective and has not terminated; and

(b) the unmarried dependent child or children of an Insured or of an Insured's spouse whose coverage under this Policy has become effective and has not terminated. Dependent children include stepchildren, legally adopted and foster children.

**Intensive Care Unit, Coronary Care Unit, or Neonatal Intensive Care Unit** means that part of a Hospital that is separated from other hospital facilities; is exclusively reserved for critically ill patients when the attending doctor has prescribed audio-visual observation and/or cardiac monitoring; and provides room and board, specialized registered nurses (R.N.'s) and special life saving equipment and supplies.

**Major Medical Coinsurance** means that portion of the Covered Charges an Insured Person is required to pay after the Major Medical Deductible under his/her Major Medical Plan or Comprehensive Health Plan.

**Major Medical Coinsurance Limit** means the level of Covered Charges, above the Major Medical Deductible, which an Insured Person is no longer required to pay any Major Medical Coinsurance under his/her Major Medical Plan or Comprehensive Health Plan.

**Major Medical Deductible** means that portion of the Covered Charges an Insured Person is required to pay before benefits are payable under his/her Major Medical Plan or Comprehensive Health Plan.

**Major Medical Plan or Comprehensive Health Plan** means a written benefit plan that has a Major Medical Deductible and/or Major Medical Coinsurance provision, funded through insurance or otherwise, that covers hospital, physician and prescription drug expenses incurred by an Insured Person.

**Maximum Benefit Amount** means the maximum dollar amount of benefits payable on account of Covered Charges incurred by any (1) one Insured Person for any benefit or combination of benefits as shown in the Schedule.

**Maximum Total Benefit Amount** [means the maximum dollar amount of benefits payable during any one (1) Year on account of all Covered Charges incurred during that Year by any one (1) Insured under the Policy, the Certificate and all Optional Supplemental Benefits or Riders attached to and made a part of the Policy and the Certificate. The Maximum Total Benefit Amount is shown in the Schedule.]

**Out-of-Pocket Maximum** means the amount (due to Coinsurance) of Covered Charges that the Insured Person must pay per Calendar Year, as specified in the Schedule, exclusive of any Co-payments and Deductibles, before benefits will be payable at 100% for that Calendar Year. The amounts paid by the Insured Person for Covered Charges that do not count towards the Out-of-Pocket Maximum are: Any co-payments; Any deductibles; Charges excluded under this Policy or attached riders.

**Outpatient** means the Insured Person is not confined to a Hospital when covered services are received.

**Outpatient Department of a Hospital** means a part or section of a Hospital that does not provide services or other accommodations for patients to stay overnight, but does provide facilities for laboratory services, x-rays, and other services for the diagnosis or treatment of Sickness or Injury. It does not include a Hospital emergency room, trauma center, or center for termination of pregnancy.

**Physician** means a person who is licensed to practice medicine; and renders treatment within the scope of that license; and is not an immediate relative by blood or marriage to the Insured Person.

**Policy** means the Policy of insurance that We have issued to the Policyholder.

**Policy Date** means the date shown as Policy Date on Page one (1) of the Policy.

**Policyholder** means the employer or organization named as Policyholder on Page one (1) of the Policy.

**Policy Year** means the one (1) year period beginning on the Policy Date and ending on the last day of the twelfth (12<sup>th</sup>) month following the Policy Date.

**[Pre-Existing Condition means:**

An Injury or Sickness that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the Effective Date of coverage; or an Injury or Sickness for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the Effective Date of coverage.

We will not deny, exclude or limit benefits for an Insured Person for losses due to a Pre-Existing Condition incurred more than twelve (12) months following the Effective Date of the Insured Person's coverage.]

**Schedule** means a page in the Policy/Certificate, which outlines benefit amounts, maximums, and limitations, for Insured Persons.

**Sickness** means an Insured Person's illness, disease or condition, including all related complications and recurrences that occur while the Insured Person's coverage is in force.

**Year** means the one (1) year period of time specified in the Schedule. It may be either a Calendar Year or a Policy Year.

**You or Your** means the Policyholder as defined.

## **Eligibility**

**Eligible Person as used in this Policy means a person who is insured under a Major Medical Plan or Comprehensive Health Plan (CHAMPUS/ TRICARE or Medicaid is not a comprehensive medical plan) and who is:**

**Eligible Person - If enrollment is voluntary, (all premiums are paid by the employee)**

[All active full-time employees working 18 hours or more per week and who are under age seventy will be eligible for coverage.

Each insured will be eligible for Dependent coverage on the later of the following dates:

1. The day the Insured becomes eligible for insurance; or
2. The day the Insured acquires his or her first Dependent]

**Eligible Person - If employer participates in paying the premiums**

1. [An employee of the Policyholder who is insured by the employer's major medical plan;
2. An employee's dependent spouse or unmarried dependent children who were insured by the employer's major medical plan.]

Eligible new employees or dependents may be added subject to the terms of this Policy.

The first premium must be paid before any insurance is effective. Insurance provided hereunder will terminate with regard to any individual when that individual is no longer an Eligible Person in accordance with the "Termination of Coverage" provision of the Policy.

## **Benefit Provisions**

### **Benefits Payable**

Benefits provided by this Policy and any Rider are those:

1. Described in this Policy or on a Rider; and
2. Shown on the Schedule; and
3. For which premiums are paid.

Riders (if any) issued and made a part of this Policy are listed in the Schedule.

### **Limitation Applicable to All Benefits including Rider Benefits**

If benefits are payable for the same Covered Charges under more than one (1) benefit then, total benefits payable under all such benefits will be limited to the amount of the Covered Charges not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan.

We will not pay during any Year, any amounts otherwise payable, that are subject to the Deductible, Coinsurance or Co-payment amounts (if any), or that exceed the Maximum Benefit Amount(s) or Total Maximum Benefit Amount shown on the Schedule.

### **Accident Benefit**

We will pay the benefits shown on the Schedule, as the result of a covered Accident, subject to the "Exclusions and Limitations" provision of the Policy when:

1. An Insured Person receives treatment for an Accident in the Outpatient Department of a Hospital, the Emergency Room of a Hospital, MRI facility or an Ambulatory Surgical Facility or Day Surgery Facility or for In-Hospital Confinement; and
2. An Insured Person incurs Accident expenses that are covered by the Insured Person's Major Medical Plan or Comprehensive Health Plan.

[After the Insured Person's Deductible, Coinsurance or Co-payment (if any) have been met,] We will pay:

[That portion of the Covered Charges for Accident expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan because they have been applied to the Major Medical Deductible of the Major Medical Plan or Comprehensive Health Plan;] and

[The Major Medical Coinsurance portion of the Covered Charges for Accident expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan;] but

[We will not pay more than the Accident Benefit Amount shown in the Schedule].

### **Limitations Applicable to the Accident Benefit**

[If an Insured Person is not covered by a Major Medical Plan or Comprehensive Health Plan that provides coverage for Accident expenses on the date the Accident expense is incurred, then We will not pay the Benefits described above; but in lieu of those Benefits, We will pay an Accident Indemnity Benefit equal to {\$50}. Benefits payable under this Benefit are limited to the stated portion of Covered Charges made by a Provider.]

### **[Exclusions and Limitations]**

**[The Policy will pay no benefits for any expenses which result from:]**

1. [Suicide or any attempt thereat, while sane or insane (In Missouri the reference to insanity does not apply);
2. Any intentionally self-inflicted injury or sickness;
3. Rest care or rehabilitative care and treatment;
4. Routine newborn care, including routine nursery charges;
5. Voluntary abortion except, with respect to the Insured or the Insured's covered Dependent:
  - Where such person's life would be endangered if the fetus were carried to term; or
  - Where medical complications have arisen from abortion;
6. Pregnancy of a Dependent child, except for medical complications;
7. Participation in a riot, civil commotion, civil disobedience, or unlawful assembly (This does not include a loss which occurs while acting in a lawful manner within the scope of authority.);
8. Commission of a felony;
9. Participation in a contest of speed in power driven vehicles, parachuting, or hang gliding;
10. Air travel, except:
  - As a fare-paying passenger on a commercial airline on a regularly scheduled route; or
  - As a passenger for transportation only and not as a pilot or crew member;
11. Intoxication (Whether or not a person is intoxicated is determined and defined by the laws and jurisdiction of the geographical area in which the loss occurred.);
12. Alcoholism or drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed;
13. Sex changes;
14. Experimental treatment, drug, or surgery;
15. An act of war, whether declared or undeclared while serving in the military service or any auxiliary unit attached thereto, or while performing police duty as a member of any military or naval organization.  
This exclusion includes Accident sustained or Sickness contracted while in the services of any military, naval, or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the Covered Persons is not covered;
16. Accident or Sickness arising out of and in the course of any occupation for compensation wage or profit. This does not apply to sole proprietors not covered by Workers' Compensation;
17. Any dental services, including treatment, surgery, extractions, or x-rays, unless: (a) Resulting from an Accident occurring while the Covered Person's coverage is in force and if performed within 12 months of the date of such Accident; or (b) Due to congenital disease or anomaly of a covered newborn child;
18. Any expenses incurred for eye exams, eye refractions, eye glasses, contact lenses, or the fitting thereof, or elective surgery performed for the correction of vision;
19. Routine examinations, such as health exams, periodic checkups, or routine physicals unless covered by an optional Rider;
20. Any expense for which benefits are not payable under the Covered Person's Other Medical Plan;
21. Air or ground ambulance;
22. Elective or cosmetic surgery;
23. Drugs (prescription or non-prescription) unless covered by a Rider to this Policy;
24. Sterilization and reversal of sterilization;
25. Any expense that does not meet the definition of Covered Charges;

26. Expense or service that exceeds the Maximum Benefit Amounts, as shown in the Schedule of Benefits;]
27. [Mental illness or functional or organic nervous disorders, regardless of the cause;]
28. [Expenses due to Pre-Existing Conditions - expenses incurred due to an Injury or Sickness that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the Effective Date of coverage; or an Injury or Sickness for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the Effective Date of coverage. We will not deny, exclude or limit benefits for an Insured Person for losses due to a Pre-Existing Condition incurred more than twelve (12) months following the Effective Date of the Insured Person's coverage.]

## **TERMINATION OF COVERAGE**

Coverage will terminate under this Policy and any Riders on the earliest date that any of the following events occur:

1. For the Insured:
  - a. On the date the Policy terminates;
  - b. As of the premium due date when the required premium remains unpaid, subject to the Grace Period;
  - c. On the premium due date following the date the Insured ceases to be an Eligible Person as defined in the Policy;
2. For the Insured Dependents:
  - a. On the date the Insured's coverage terminates;
  - b. As of the premium due date when the required premium for the Dependents and or spouse remains unpaid, subject to the Grace Period;
  - c. On the premium due date following the date the Insured Dependent ceases to be an Eligible Person.

If a mental or physical disability prevents an unmarried dependent child from self-support when he or she reaches the termination age, he or she may remain insured under the Policy. Proof of such incapacity and dependency must be furnished to Us. Coverage will continue as long as the Insured's coverage remains in force, premiums for the Insured Dependent child are paid, and the Insured Dependent child is incapable of self-support.

Termination of the insurance will be without prejudice to any claim incurred before the date of termination.

## **CONTINUATION OF COVERAGE**

### **[Family and Medical Leave Act of 1993 (FMLA) - Continuation of Benefits**

(Applies to employers with 50 or more employees)

Insureds who have been employed by the Policyholder for at least 12 months and who have performed at least 1,250 hours of work during that period are entitled to 12 work weeks of leave during any 12 month period for one or more of the following reasons:

- the birth of a child to the Insured;
- the placement of a child with the Insured for adoption or foster care;
- to care for the spouse, child or parent of the Insured if such person has a serious health condition; or
- a serious health condition makes the Insured unable to perform the main functions of his or her employment.

An Insured on FMLA leave may continue benefits for the duration of that leave under the same conditions as applied prior to the leave. The terms of the FMLA supersede state family medical leave laws for employers of 50 or more employees insofar as the FMLA provides greater family or medical leave rights than those established by the state law.

### **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**

An Insured who is absent from work due to a period of duty in the uniformed services may have the right to continue benefits for himself and his Insured Dependents in accordance with USERRA provisions. The Insured must pay the required monthly premium for the continued coverage to the employer.

## **COBRA**

**Continuation of Benefits in Accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (Applies to employers with 20 or more employees).**

## **Applicability**

Federal law requires that employers of 20 or more employees for at least 50% of the preceding year, offer a temporary extension of health coverage to Qualified Beneficiaries when coverage would otherwise end because of the occurrence of one or more of Qualifying Events listed below. Under COBRA, a Qualified Beneficiary is any individual who, on the day before a Qualifying Event, is covered under the Policy and is not already covered under the Policy by reason of another individual's election of COBRA.]

## **Qualifying Event**

For purposes of coverage under COBRA, the term "Qualifying Event" means, with respect to any Insured Person, any of the following events which, but for the continuation coverage required under this part, would result in the loss of coverage for a Qualified Beneficiary.

### **Qualifying Events**

### **Duration of Continued Coverage**

1. death of an Insured	36 months
2. termination of employment for any reason except gross misconduct, or the reduction in hours that would result in loss of coverage	18 months*
3. divorce or legal separation	36 months
4. Insured becomes eligible for Medicare	Dependents and spouse allowed 36 months
5. Insured Dependent no longer meets Insured Dependent eligibility requirements	36 months

\*Coverage may be continued an additional 11 months if the Qualified Beneficiary:

1. is determined disabled for Social Security purposes at the time of the Qualifying Event or within 60 days after continuation coverage begins; and
2. notifies the plan administrator within 60 days from determination (but before the 18 month continuation period ends).

Beneficiaries may be covered by more than one Qualifying Event. However, in no event may the total continuation period exceed 36 months for all Qualifying Events.

## **Notice and Election**

Insured Persons are responsible for notifying the employer in the case of a divorce, legal separation, cessation of dependency or determination of disability by the Social Security Administration. The employer must notify the plan administrator of the Qualifying Event. The employer must notify the Qualified Beneficiaries of their COBRA election rights. The period during which the Qualified Beneficiary must elect or decline continuation of coverage under COBRA ends not earlier than 60 days after the later of (a) the date on which coverage terminates under the Policy by reason of a Qualifying Event, or (b) the date the Qualified Beneficiary receives notice of their COBRA election rights from the plan administrator.

## **Premium Payment**

The Qualified Beneficiary must pay to the employer the required monthly premium. Any Grace Period applying to the employer will also apply to the Qualified Beneficiary, except the first premium payment. Payment of premium for coverage under the period preceding the election must be made within 45 days of the date of election.

**COBRA Termination** occurs at the earlier of:

1. the premium for continued coverage is not paid within 31 days from being due;
2. the Qualified Beneficiary becomes covered under another group medical plan, if that plan does not contain any exclusion or limitation on any Pre-existing Conditions of the Qualified Beneficiary;
3. the Qualified Beneficiary becomes eligible for Medicare;
4. the Qualified Beneficiary, who is divorced from an Insured Employee, remarries and is covered under the new spouse's medical plan; or
5. the employer no longer provides medical benefits of any kind.

## **PREMIUMS**

Premiums must be paid on time to keep this Policy in force. This section explains how and when premiums are to be paid.

**Payments**

Premium payments are payable at Our Administrative Office or to Our designated agent. The first premium is due on the Effective Date. Each subsequent premium is due on the first day following the interval for which the preceding premium was paid.

**Right to Change Premium**

We reserve the right, at any time and from time to time, to change all premiums applicable to the Policy and/or any Rider that is made a part of it on any premium due date by giving written notice to You and the Policyholder at least sixty (60) days in advance of the date premium is to be changed.

## RENEWAL AND TERMINATION

The Policy, and any Rider that is made a part of it, is renewable at Our option and with Our consent may be renewed from month to month by payment of the applicable premium. The Policyholder or We may terminate the Policy, and any attached Rider on any premium due date by giving at least ninety (90) days written notice to the other party.

## CLAIM PROVISIONS

**Notice of Claim**

Written Notice of Claim must be given Us within thirty (30) days after the occurrence or commencement of any covered loss or as soon as reasonably possible thereafter. The Notice of Claim must be sent to Our Administrative Office. Notice must include the name of the Insured Person, the Policy/Certificate number and nature of the loss.

**Claim Forms**

When We receive a Notice of Claim, We will send the Insured forms for filing Proof of Loss if claim forms are required. If such forms are required and are not sent or given to the Insured within fifteen (15) days, the Insured will meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of his/her loss.

**Proof of Loss**

Written proof of loss must be given Us within ninety (90) days after the occurrence or commencement of any covered loss. Proof of loss must include a copy of the Insured's explanation of benefits (EOB) under the Insured's Major Medical Plan or Comprehensive Health Plan. If it is not reasonably possible to give Us written Proof of Loss in the time required, We will not reduce or deny the claim for this reason alone, if the Proof of Loss is filed as soon as reasonably possible. Nonetheless, unless the Insured is legally incompetent, the Proof of Loss must be provided Us within one (1) year of the time specified.

**Time of Payment of Claims**

Any benefit payable under this Policy will be paid not more than 30 days after the Company receives proper written proof of such loss if the claim was submitted electronically or within 45 days after receipt if the claim was submitted by other means.

**Payment of Claims**

All benefits will be payable to the Insured, unless We receive written Assignment of benefits to the provider of covered services. Any accrued benefits unpaid at the Insured's death will be paid to the Insured's estate.

## GENERAL PROVISIONS

**Entire Contract**

The Policy, the Policyholder's Application, along with the Insured's application(s), if any, and any endorsements and/or riders, is the entire contract between the Policyholder and the Company. All statements made by the Insured or the Policyholder, in the absence of fraud, will be deemed representations and not warranties. No such statement will void the insurance or reduce the benefits under this Policy or be used in defense of a claim unless it is contained in a written application and a copy is provided to the Insured Person or beneficiary. No change in this Policy will be valid until approved by one of Our officers. This approval must be endorsed on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

**Grace Period**

We will allow a period of thirty-one (31) days after the premium due date for payment of each premium after the first premium payment. The Insured's coverage is in force during this period.

**Time Limit on Certain Defenses**

After the Policy has been in force for two (2) years, it can only be contested for non-payment of premiums. No statement made by an Insured Person can be used in a contest after his/her insurance has been in force for two years during his/her lifetime. No statement an Insured Person makes can be used in a contest unless it is in writing and signed by him/her.

We will not reduce or deny a claim for covered loss after such two (2) year period has elapsed because a Sickness or physical condition existed prior to the date the Insured Person became insured hereunder, unless the Sickness or physical condition was excluded from coverage by name or specific description on the date the loss was incurred.

**Conformity with State Statutes**

Any provision of the Policy that, on its Effective Date, is in conflict with the laws of the state in which the Policy is issued is amended to conform to the minimum requirements of such laws.

**Certificates**

We will issue Certificates to be provided by the Policyholder to each Insured. The Certificate will describe: the benefits to which each Insured Person is entitled under the Policy; to whom such benefits are payable; the limitations, exclusions and requirements of the Policy.

**Policy Inspection**

The Policy may be inspected by the Insured or the Insured Dependent at any time during the regular business hours of the Policyholder.

**Policy Amendments Provision**

Subject to the laws of the state in which the Policy is issued, it may be changed at any time by written amendment agreed to by the Policyholder and Us. Premium rates may be changed according to the "Premiums" section. Any amendments to the Policy will be binding on You, whether You were insured prior to or after the Effective Date of the amendment.

**Legal Actions**

No action at law or in equity shall be brought to recover under this Policy prior to the expiration of sixty (60) days after written Proof of Loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of [three (3)] years after the time written Proof of Loss is required to be furnished.

**Misstatement of [Sex or] Age**

If relevant facts about the Insured Person were not accurate, an adjustment of premium will be made and the true facts will decide in what amount insurance is valid under this Policy.

**Clerical Error Provisions**

Clerical error or delays in keeping records for the Policy:

1. Will not deny insurance, which would otherwise have been granted;
2. Will not continue insurance which would otherwise have ceased; and
3. Will call for an adjustment of premiums or benefits to correct the error.

**Workers' Compensation or Workmen's Compensation Not Affected**

The Policy is not in place of and does not affect any requirements for coverage by Workers' Compensation Insurance or Workmen's Compensation Insurance.

**Physical Examination**

We have the unqualified right to have any Insured Person medically examined, at Our expense, as often as reasonably necessary while a claim is pending.

**ERISA**

The Policyholder has established and maintains an employee welfare benefit plan as defined in the Employee Retirement Security Act of 1974, as amended, to provide the benefits described in the Policy to its employees and their dependents. These benefits are insured by the Company under the Policy, which the Policyholder endorses. The Policyholder is the Plan Administrator, Plan Sponsor, named fiduciary, and, if applicable, Plan Trustee, for the Plan. For more information about the plan, consult the Policy. ERISA does not apply to certain plans, such as government plans and church plans.



# **Commercial Travelers Mutual Insurance Company**

**70 Genesee Street  
Utica, New York 13502  
Telephone (800) 422-6200**

(Herein called the Company)

## **CERTIFICATE OF INSURANCE**

This Certificate of Insurance summarizes Your rights and benefits under the Policy. Coverage is provided under the Policy for benefits described in the Policy and this Certificate. Benefits payable under this Certificate of Insurance are subject to all of the provisions contained in the Policy. This Certificate provides evidence of coverage under the Policy, but is not the contract of insurance. **READ THESE PAGES WITH CARE.**

All periods of time under the Policy will begin and end at 12:01 A.M. local time at the Policyholder's address.

The insurance of the Insured reflected by this Certificate is further subject to any modifications of the Policy entered into by mutual agreement between the Company and the Policyholder as of the date of such modification.

President

### **Right of Examination**

If for any reason You are not satisfied with this Policy, You may return it to Us within ten (10) days after You receive it. Any premium paid will be refunded.

## **SUPPLEMENTAL GROUP ACCIDENT CERTIFICATE**

**THIS IS A LIMITED HEALTH INSURANCE PLAN NOT BEING OFFERED AS A SUBSTITUTE FOR HOSPITAL OR MEDICAL EXPENSE INSURANCE OR MAJOR MEDICAL EXPENSE INSURANCE**

**RENEWABLE AT THE OPTION OF THE COMPANY**

**NON-PARTICIPATING**

**PLEASE READ CAREFULLY**

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**POLICY SCHEDULE OF BENEFITS**

<p><b>Year: [Calendar Year or Policy Year]</b></p> <p><b>Deductible</b></p> <p><b>Coinsurance %</b></p> <p><b>Out of Pocket Maximum (Coinsurance Limit)</b></p> <p><b>Maximum Total Benefit Amount</b></p>	<p>[Calendar]</p> <p>[NA-\$3000]</p> <p>[NA-50%]</p> <p>[NA- \$10,000]</p> <p>[NA to \$9,500]</p>
<p><b>Accident Benefit</b></p> <p>Does the Policy Deductible and Coinsurance apply to this benefit?</p> <p>Co-payment Amount [per date of service]</p> <p><b>Maximum Accident Benefit Amount for <u>All Covered Facilities</u> [per year]:</b></p> <p><b>Maximum Accident Benefit Amount for all Covered <u>Outpatient</u> Facilities [per year]:</b>                      [Maximum Accident Benefit for Ambulatory Surgical Facility or Day Surgery Facility Benefit Amount] [per year]                      [Maximum Accident Benefit Amount for MRI Facility] [per year]                      [Maximum Accident Benefit Amount for Outpatient Department of a Hospital] [per year]                      [Maximum Accident Benefit Amount for Emergency Room of a Hospital] [per year]</p> <p><b>Maximum Accident Benefit Amount for <u>In-Hospital Confinement</u> [per year]</b></p>	<p>[Yes, No]</p> <p>[N/A - \$500]</p> <p>[NA - \$9500]</p> <p>[\$1,000-\$9500]</p> <p>[N/A]</p> <p>[N/A]</p> <p>[N/A]</p> <p>[N/A]</p> <p>[N/A-\$9500]</p>
<b>OPTIONAL RIDERS</b>	
<p><b>Sickness Benefit Rider:</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider?</p> <p>Co-payment Amount [per date of service]</p> <p><b>Maximum Sickness Benefit Amount for <u>All Covered Facilities</u> [per year]:</b></p> <p><b>Maximum Sickness Benefit Amount for All Covered <u>Outpatient</u> Facilities [per year]:</b>                      [Maximum Sickness Benefit Amount for Ambulatory Surgical Facility or Day Surgery Facility] [per year]                      [Maximum Sickness Benefit Amount for MRI Facility] [ per year]                      [Maximum Sickness Benefit Amount for Outpatient Department of a Hospital] [per year]                      [Maximum Sickness Benefit Amount for Emergency Room of a Hospital] [per year]</p> <p>Maximum Sickness Benefit Amount for <u>In-Hospital Confinement</u> [per year]</p>	<p>[Yes, No]</p> <p>[Yes, No]</p> <p>[N/A- \$500]</p> <p>[NA-\$9,500]</p> <p>[N/A -\$9,500]</p> <p>[N/A- \$9500]</p> <p>[N/A-\$9500]</p> <p>[N/A-\$9500]</p> <p>[N/A-\$9500]</p> <p>[N/A-\$9500]</p>
<p><b>Hospital Indemnity Sickness Benefit Rider</b></p> <p>Maximum Hospital Indemnity Benefit Amount: [per day]</p> <p>Maximum number of days [per insured person per year]</p>	<p>[Yes, No]</p> <p>[N/A -\$5000]</p> <p>[N/A-10]</p>
<p><b>Outpatient Physician's Expense Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider?</p> <p>Co-payment Amount [per visit]</p> <p>Maximum Outpatient Physician's Expense Benefit Amount [per visit]</p> <p>Maximum Outpatient Physician's Expense Benefit – [number of visits per Year]</p> <p>Maximum Outpatient Physician's Expense Benefit Amount [Per Sickness or Injury per Calendar Year]</p> <p>Maximum Outpatient Physician's Expense Benefit Amount [Per Insured Person per Calendar Year]</p> <p>Maximum Outpatient Physician's Expense Benefit Amount [For All Insured Persons per Calendar Year]</p>	<p>[Yes, No]</p> <p>[Yes, No]</p> <p>[N/A -\$50]</p> <p>[N/A-\$500]</p> <p>[N/A – 10]</p> <p>[N/A-\$500]</p> <p>[N/A-\$5000]</p> <p>[N/A-\$10,000]</p>

**OPTIONAL RIDERS**

<p><b>Ambulance Benefit Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider? Benefit Amount [per year per covered person] Maximum Benefit [per year per family]</p>	<p>[Yes, No]</p> <p>[Yes, No] [N/A- \$1000] [N/A-\$3000]</p>
<p><b>Generic Outpatient Prescription Drug Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider? [Dispensing limit] [Prescription Drug Rider Deductible] [Prescription Drug Rider Co-insurance %] [Out of Pocket Maximum –Rider Coinsurance] [Co-payment Amount Generic (greater of)] [Maximum Benefit Amount per Calendar Year per insured] [Maximum Number of Outpatient Prescriptions]</p> <p>[Per Sickness or Injury] [Per Insured Person] [For All Insured Persons]</p>	<p>[Yes, No]</p> <p>[N/A- 30 days] [N/A-\$100] [N/A -50%] [N/A-\$5000] [N/A\$10 or 10%] [N/A-\$1000] [N/A-2] [N/A-10] [N/A-20]</p>
<p><b>Brand [and Generic] Outpatient Prescription Drug Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider? [Dispensing limit] [Prescription Drug Rider Deductible] [Prescription Drug Rider Co-insurance %] [Out of Pocket Maximum –Rider Coinsurance] [Co-payment Amount Generic (greater of)] [Co-payment Amount Preferred Brand (greater of)] [Co-payment Amount Non-Preferred Brand (greater of)] [Co-payment Amount Oral Contraceptives] [Co-payment Amount Migraine Kits]</p> <p>[Brand Name-Outpatient Prescription Drug Expense Benefit Amount per Calendar Year per insured] [Maximum Number of Outpatient Prescriptions]</p> <p>[Per Sickness or Injury] [Per Insured Person] [For All Insured Persons]</p>	<p>[Yes, No]</p> <p>[Yes, No] [N/A- 30 days] [N/A-\$100] [N/A -50%] [N/A-\$5000] [N/A-\$10 or 10%] [N/A-\$35 or 35%] [N/A-\$50 or 50%] [N/A- \$50] [One applicable co-pay per kit] [N/A-\$1000]</p> <p>[N/A-2] [N/A-10] [N/A-20]</p>
<p><b>Outpatient Physical and Wellness Examination Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider? Co-payment Amount Outpatient Physical Examination and Wellness Benefit Amount per person per year Maximum Number of Outpatient Physical Examination and Wellness Benefits Payable for All Insured Persons per Calendar Year</p>	<p>[Yes, No]</p> <p>[Yes, No] [N/A -\$50] [N/A -\$250]</p> <p>[N/A-2]</p>
<p><b>Outpatient Diagnostic Test and Lab Rider</b></p>	<p>[Yes, No]</p>
<p><b>Prior Plan Deductible Credit Rider</b></p>	<p>[Yes, No]</p>
<p><b>Allied Service Rider</b></p>	<p>[Yes, No]</p>

THIS SCHEDULE IS ATTACHED TO AND MADE PART OF YOUR CERTIFICATE. THIS SCHEDULE REPLACES AND CANCELS ALL OTHER SCHEDULES ISSUED PRIOR TO THE EFFECTIVE DATE FOR THE ELIGIBLE PERSONS UNDER THIS CERTIFICATE.

## Definitions

### **Important Notice: Additional Definitions are in the Benefits Provisions of the Policy/Certificate and/or Rider Provisions**

Whenever used in the Policy:

**Accident** means a sudden and unexpected event resulting in Injury

**Calendar Year** means the one (1) year period beginning January 1 and ending December 31 of the same year.

**Certificate** means the Certificate of Insurance issued to the Insured. It describes the coverage under the Policy.

**Company, Our, We or Us** means Commercial Travelers Mutual Insurance Company.

**Coinsurance** means the portion of the Covered Charges which the insured is required to pay after the Deductible before benefits are payable for any benefit that has a coinsurance requirement. The Coinsurance Limit is shown in the schedule.

**Co-payment or Co-payment Amount** means the specified dollar amount of Covered Expenses that must be paid by an Insured Person before benefits are payable under the Policy or Rider that has a Co-payment Amount.

**Covered Charges** means that portion of the charge allowed by the Insured Person's Major Medical Plan or Comprehensive Health Plan for Medically Necessary expenses which are specified, described and limited in the Policy or Rider for which benefits are payable under the Policy as the result of covered Injury of Sickness.

**Covered Hospital Confinement, In-Hospital or In-Hospital Confinement** means Hospital confinement of an Insured Person for which Benefits are payable under the Policy or any Rider elected by the Insured and which is:

1. Due to covered Injury [or Sickness]; and
2. For a period of no less than [twenty-four (24) hours]; and
3. At the direction of and under the supervision of a Physician.

**Day Surgery Facility or Ambulatory Surgical Center** means any licensed public or private establishment with an organized medical staff of Physicians. The establishment must have permanent facilities equipped and operated solely for performing surgical procedures. This facility must not provide services or other accommodations for patients to stay overnight. It does not include [a Hospital emergency room, trauma center, center for termination of pregnancy, or surgery in a physician's office].

**Deductible** means that portion of the Covered Charges, incurred during the Year, which an Insured Person is required to pay before benefits are payable for any Benefit that has a Deductible requirement. The Deductible amount is shown in the Schedule.

**Effective Date** means the date insurance begins under the Policy for an Insured Person. Insurance will begin as of the first of the month following Our approval and payment of the first premium. In no event will coverage for any person become effective prior to the Policy Date.

**Eligible Person** means a person who is insured under the Policyholder's Major medical or Comprehensive Health Plan and who meets the criteria described in the Policy as eligible for insurance. (See the Eligibility Section of the Policy – page 7)

**Hospital** means a legally authorized and operated institution for the care or treatment of sick or injured persons. It must have graduate registered nurses (R.N.'s) on 24-hour call and organized facilities for diagnosis and surgery under the full-time supervision of a Physician, either on its premises or in facilities available to it on a contractual prearranged basis.

The following do not qualify as a Hospital: an institution, or part of it, which is used mainly as a facility for rest, nursing care, convalescent care, care of the aged, or for remedial education or training. A Hospital is not primarily a psychiatric/substance abuse facility.

**Injury** means bodily harm caused by an accident resulting in trauma. A disease must not directly or indirectly contribute to the bodily harm. The accident must take place while the Policy/Certificate is in force for the person injured.

**Insured Person** means either an Insured or an Insured Dependent. An **Insured** is an employee of the Policyholder whose coverage under the Policy has become effective and has not been terminated. **Insured Dependent** means any of the following:

- (a) the spouse of an Insured whose coverage under the Policy has become effective and has not terminated; and
- (b) the unmarried dependent child or children of an Insured or of an Insured's spouse whose coverage under the Policy has become effective and has not terminated. Dependent children include stepchildren, legally adopted and foster children.

**Intensive Care Unit, Coronary Care Unit, or Neonatal Intensive Care Unit** means that part of a Hospital that is separated from other hospital facilities; is exclusively reserved for critically ill patients when the attending doctor has prescribed audio-visual observation and/or cardiac monitoring; and provides room and board, specialized registered nurses (R.N.'s) and special life saving equipment and supplies.

**Major Medical Coinsurance** means that portion of the Covered Charges an Insured Person is required to pay after the Major Medical Deductible under his/her Major Medical Plan or Comprehensive Health Plan.

**Major Medical Coinsurance Limit** means the level of Covered Charges, above the Major Medical Deductible, which an Insured Person is no longer required to pay any Major Medical Coinsurance under his/her Major Medical Plan or Comprehensive Health Plan.

**Major Medical Deductible** means that portion of the Covered Charges an Insured Person is required to pay before benefits are payable under his/her Major Medical Plan or Comprehensive Health Plan.

**Major Medical Plan or Comprehensive Health Plan** means a written benefit plan that has a Major Medical Deductible and/or Major Medical Coinsurance provision, funded through insurance or otherwise, that covers hospital, physician and prescription drug expenses incurred by an Insured Person.

**Maximum Benefit Amount** means the maximum dollar amount of benefits payable on account of Covered Charges incurred by any (1) one Insured Person for any benefit or combination of benefits as shown in the Schedule.

**Maximum Total Benefit Amount** [means the maximum dollar amount of benefits payable during any one (1) Year on account of all Covered Charges incurred during that Year by any one (1) Insured under the Policy, this Certificate and all Optional Supplemental Benefits or Riders attached to and made a part of the Policy and this Certificate. The Maximum Total Benefit Amount is shown in the Certificate Schedule.]

**Out-of-Pocket Maximum** means the amount (due to Coinsurance) of Covered Charges that the Insured Person must pay per Calendar Year, as specified in the Schedule, exclusive of any Co-payments and Deductibles, before benefits will be payable at 100% for that Calendar Year. The amounts paid by the Insured Person for Covered Charges that do not count towards the Out-of-Pocket Maximum are: Any co-payments; Any deductibles; Charges excluded under the Policy or attached riders.

**Outpatient** means the Insured Person is not confined to a Hospital when covered services are received.

**Outpatient Department of a Hospital** means a part or section of a Hospital that does not provide services or other accommodations for patients to stay overnight, but does provide facilities for laboratory services, x-rays, and other services for the diagnosis or treatment of Sickness or Injury. It does not include a Hospital emergency room, trauma center, or center for termination of pregnancy.

**Physician** means a person who is licensed to practice medicine; and renders treatment within the scope of that license; and is not an immediate relative by blood or marriage to the Insured Person.

**Policy** means the Policy of insurance that We have issued to the Policyholder.

**Policy Date** means the date shown as Policy Date on Page one (1) of the Policy.

**Policyholder** means the employer or organization named as Policyholder on Page one (1) of the Policy.

**Policy Year** means the one (1) year period beginning on the Policy Date and ending on the last day of the twelfth (12<sup>th</sup>) month following the Policy Date.

**[Pre-Existing Condition means:**

An Injury or Sickness that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the Effective Date of coverage; or an Injury or Sickness for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the Effective Date of coverage.

We will not deny, exclude or limit benefits for an Insured Person for losses due to a Pre-Existing Condition incurred more than twelve (12) months following the Effective Date of the Insured Person's coverage.]

**Schedule** means a page in the Policy/Certificate, which outlines benefit amounts, maximums, and limitations, for Insured Persons.

**Sickness** means an Insured Person's illness, disease or condition, including all related complications and recurrences that occur while the Insured Person's coverage is in force.

**Year** means the one (1) year period of time specified in the Schedule. It may be either a Calendar Year or a Policy Year.

**You or Your** means the Insured as defined.

## **Eligibility**

**Eligible Person as used in the Policy means a person who is insured under a Major Medical Plan or Comprehensive Health Plan (CHAMPUS/ TRICARE or Medicaid is not a comprehensive medical plan) and who is:**

**Eligible Person - If enrollment is voluntary, (all premiums are paid by the employee)**

[All active full-time employees working 18 hours or more per week and who are under age seventy will be eligible for coverage.

Each insured will be eligible for Dependent coverage on the later of the following dates:

1. The day the Insured becomes eligible for insurance; or
2. The day the Insured acquires his or her first Dependent]

**Eligible Person - If employer participates in paying the premiums**

1. [An employee of the Policyholder who is insured by the employer's major medical plan;
2. An employee's dependent spouse or unmarried dependent children who were insured by the employer's major medical plan.]

Eligible new employees or dependents may be added subject to the terms of the Policy.

The first premium must be paid before any insurance is effective. Insurance provided hereunder will terminate with regard to any individual when that individual is no longer an Eligible Person in accordance with the "Termination of Coverage" Provision of the Policy.

## **Benefit Provisions**

### **Benefits Payable**

Benefits provided by the Policy/Certificate and any Rider are those:

1. Described in the Policy/Certificate or on a Rider; and
2. Shown on the Schedule; and
3. For which premiums are paid.

Riders (if any) issued and made a part of the Policy are listed in the Schedule.

### **Limitation Applicable to All Benefits including Rider Benefits**

If benefits are payable for the same Covered Charges under more than one (1) benefit then, total benefits payable under all such benefits will be limited to the amount of the Covered Charges not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan.

We will not pay during any Year, any amounts otherwise payable, that are subject to the Deductible, Coinsurance or Co-payment amounts (if any), or that exceed the Maximum Benefit Amount(s) or Total Maximum Benefit Amount shown on the Schedule.

### **Accident Benefit**

We will pay the benefits shown on the Schedule, as the result of a covered Accident, subject to the "Exclusions and Limitations" provision of the Policy when:

1. An Insured Person receives treatment for an Accident in the Outpatient Department of a Hospital, the Emergency Room of a Hospital, MRI facility or an Ambulatory Surgical Facility or Day Surgery Facility or for In-Hospital Confinement; and
2. An Insured Person incurs Accident expenses that are covered by the Insured Person's Major Medical Plan or Comprehensive Health Plan.

[After the Insured Person's Deductible, Coinsurance or Co-payment (if any) have been met,] We will pay:

[That portion of the Covered Charges for Accident expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan because they have been applied to the Major Medical Deductible of the Major Medical Plan or Comprehensive Health Plan;] and

[The Major Medical Coinsurance portion of the Covered Charges for Accident expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan;] but

[We will not pay more than the Accident Benefit Amount shown in the Schedule].

### **Limitations Applicable to the Accident Benefit**

[If an Insured Person is not covered by a Major Medical Plan or Comprehensive Health Plan that provides coverage for Accident expenses on the date the Accident expense is incurred; then We will not pay the Benefits described above, but in lieu of those Benefits We will pay an Accident Indemnity Benefit equal to {\$50}. Benefits payable under this Benefit are limited to the stated portion of Covered Charges made by a Provider.]

### **[Exclusions and Limitations]**

**[The Policy will pay no benefits for any expenses which result from:]**

1. [Suicide or any attempt thereat, while sane or insane (In Missouri the reference to insanity does not apply);
2. Any intentionally self-inflicted Injury or Sickness;
3. Rest care or rehabilitative care and treatment;
4. Routine newborn care, including routine nursery charges;
5. Voluntary abortion except, with respect to the Insured or the Insured's covered Dependent:
  - Where such person's life would be endangered if the fetus were carried to term; or
  - Where medical complications have arisen from abortion;
6. Pregnancy of a Dependent child, except for medical complications;
7. Participation in a riot, civil commotion, civil disobedience, or unlawful assembly (This does not include a loss which occurs while acting in a lawful manner within the scope of authority.);
8. Commission of a felony;
9. Participation in a contest of speed in power driven vehicles, parachuting, or hang gliding;
10. Air travel, except:
  - As a fare-paying passenger on a commercial airline on a regularly scheduled route; or
  - As a passenger for transportation only and not as a pilot or crew member;
11. Intoxication (Whether or not a person is intoxicated is determined and defined by the laws and jurisdiction of the geographical area in which the loss occurred.);
12. Alcoholism or drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed;
13. Sex changes;
14. Experimental treatment, drug, or surgery;
15. An act of war, whether declared or undeclared while serving in the military service or any auxiliary unit attached thereto, or while performing police duty as a member of any military or naval organization.  
This exclusion includes an Accident sustained or Sickness contracted while in the services of any military, naval, or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the Covered Persons is not covered;
16. Accident or Sickness arising out of and in the course of any occupation for compensation wage or profit. This does not apply to sole proprietors not covered by Worker's Compensation;
17. Any dental services, including treatment, surgery, extractions, or x-rays, unless: (a) Resulting from an Accident occurring while the Covered Person's coverage is in force and if performed within 12 months of the date of such Accident; or (b) Due to congenital disease or anomaly of a covered newborn child;
18. Any expenses incurred for eye exams, eye refractions, eye glasses, contact lenses, or the fitting thereof, or elective surgery performed for the correction of vision;
19. Routine examinations, such as health exams, periodic checkups, or routine physicals unless covered by an optional Rider;
20. Any expense for which benefits are not payable under the Covered Person's Other Medical Plan;
21. Air or ground ambulance; or
22. Elective or cosmetic surgery;
23. Drugs (prescription or non-prescription) unless covered by a Rider to the Policy / Certificate;
24. Sterilization and reversal of sterilization;
25. Any expense that does not meet the definition of Covered Charges;
26. Expense or service that exceeds the maximum benefit amounts, as shown in the Certificate or Policy Schedule of Benefits;]
27. [Mental illness or functional or organic nervous disorders, regardless of the cause;]

28. [Expenses due to Pre-Existing Conditions –expenses incurred due to an Injury or Sickness that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the Effective Date of coverage; or an Injury or Sickness for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the Effective Date of coverage. We will not deny, exclude or limit benefits for an Insured Person for losses due to a Pre-Existing condition incurred more than twelve (12) months following the Effective Date of the Insured Person’s coverage.]

## **TERMINATION OF COVERAGE**

Coverage will terminate under the Policy and any Riders on the earliest date that any of the following events occur:

1. For the Insured:
  - a. On the date the Policy terminates;
  - b. As of the premium due date when the required premium remains unpaid, subject to the Grace Period;
  - c. On the premium due date following the date the Insured cease to be an Eligible Person as defined in the Policy;
2. For the Insured Dependents:
  - a. On the date the Insured’s coverage terminates;
  - b. As of the premium due date when the required premium for the dependents and or spouse remains unpaid, subject to the Grace Period;
  - c. On the premium due date following the date the Insured Dependent ceases to be an Eligible Person.

If a mental or physical disability prevents an unmarried dependent child from self-support when he or she reaches the termination age, he or she may remain insured under the Policy. Proof of such incapacity and dependency must be furnished to Us. Coverage will continue as long as Your coverage remains in force, premiums for the dependent child are paid, and the dependent child is incapable of self-support.

Termination of the insurance will be without prejudice to any claim incurred before the date of termination.

## **CONTINUATION OF COVERAGE**

### **Family and Medical Leave Act of 1993 (FMLA) - Continuation of Benefits**

(Applies to employers with 50 or more employees)

Insureds who have been employed by the Policyholder for at least 12 months and who have performed at least 1,250 hours of work during that period are entitled to 12 work weeks of leave during any 12 month period for one or more of the following reasons:

- the birth of a child to the Insured;
- the placement of a child with the Insured for adoption or foster care;
- to care for the spouse, child or parent of the Insured if such person has a serious health condition; or
- a serious health condition makes the Insured unable to perform the main functions of his or her employment.

An Insured on FMLA leave may continue benefits for the duration of that leave under the same conditions as applied prior to the leave. The terms of the FMLA supersede state family medical leave laws for employers of 50 or more employees insofar as the FMLA provides greater family or medical leave rights than those established by the state law.

### **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**

An Insured who is absent from work due to a period of duty in the uniformed services may have the right to continue benefits for himself and his Insured Dependents in accordance with USERRA provisions. The Insured must pay the required monthly premium for the continued coverage to the employer.

## **COBRA**

### **Continuation of Benefits in Accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (Applies to employers with 20 or more employees)**

#### **Applicability**

Federal law requires that employers of 20 or more employees for at least 50% of the preceding year, offer a temporary extension of health coverage to Qualified Beneficiaries when coverage would otherwise end because of the occurrence of one or more of

Qualifying Events listed below. Under COBRA, a Qualified Beneficiary is any individual who, on the day before a Qualifying Event, is covered under the Policy and is not already covered under the Policy by reason of another individual's election of COBRA.

### **Qualifying Event**

For purposes of coverage under COBRA, the term "Qualifying Event" means, with respect to any Insured Person, any of the following events which, but for the continuation coverage required under this part, would result in the loss of coverage for a Qualified Beneficiary.

### **Qualifying Events**

### **Duration of Continued Coverage**

1. death of an Insured	36 months
2. termination of employment for any reason except gross misconduct, or the reduction in hours that would result in loss of coverage	18 months*
3. divorce or legal separation	36 months
4. Insured becomes eligible for Medicare	Dependents and spouse allowed 36 months
5. Insured Dependent no longer meets Insured Dependent eligibility requirements	36 months

\*Coverage may be continued an additional 11 months if the Qualified Beneficiary:

1. is determined disabled for Social Security purposes at the time of the Qualifying Event or within 60 days after continuation coverage begins; and
2. notifies the plan administrator within 60 days from determination (but before the 18 month continuation period ends).

Beneficiaries may be covered by more than one Qualifying Event. However, in no event may the total continuation period exceed 36 months for all Qualifying Events.

### **Notice and Election**

Insured Persons are responsible for notifying the employer in the case of a divorce, legal separation, cessation of dependency or determination of disability by the Social Security Administration. The employer must notify the plan administrator of the Qualifying Event. The employer must notify the Qualified Beneficiaries of their COBRA election rights. The period during which the Qualified Beneficiary must elect or decline continuation of coverage under COBRA ends not earlier than 60 days after the later of (a) the date on which coverage terminates under the Policy by reason of a Qualifying Event, or (b) the date the Qualified Beneficiary receives notice of their COBRA election rights from the plan administrator.

### **Premium Payment**

The Qualified Beneficiary must pay to the employer the required monthly premium. Any Grace Period applying to the employer will also apply to the Qualified Beneficiary, except the first premium payment. Payment of premium for coverage under the period preceding the election must be made within 45 days of the date of election.

**COBRA Termination** occurs at the earlier of:

1. the premium for continued coverage is not paid within 31 days from being due;
2. the Qualified Beneficiary becomes covered under another group medical plan, if that plan does not contain any exclusion or limitation on any Pre-existing Conditions of the Qualified Beneficiary;
3. the Qualified Beneficiary becomes eligible for Medicare;
4. the Qualified Beneficiary, who is divorced from an Insured Employee, remarries and is covered under the new spouse's medical plan; or
5. the employer no longer provides medical benefits of any kind.

## **PREMIUMS**

Premiums must be paid on time to keep the Policy/Certificate in force. This section explains how and when premiums are to be paid.

### **Payments**

Premium payments are payable at Our Administrative Office or to Our designated agent. The first premium is due on the Effective Date. Each subsequent premium is due on the first day following the interval for which the preceding premium was paid.

**Right to Change Premium**

We reserve the right, at any time and from time to time, to change all premiums applicable to the Policy and/or any Rider that is made a part of it on any premium due date by giving written notice to You and the Policyholder at least sixty (60) days in advance of the date premium is to be changed.

**RENEWAL AND TERMINATION**

The Policy, and any Rider that is made a part of it, is renewable at Our option and with Our consent may be renewed from month to month by payment of the applicable premium. The Policyholder or We may terminate the Policy, and any Rider on any premium due date by giving at least ninety (90) days written notice to the other party.

**CLAIM PROVISIONS****Notice of Claim**

Written Notice of Claim must be given Us within thirty (30) days after the occurrence or commencement of any covered loss or as soon as reasonably possible thereafter. The Notice of Claim must be sent to Our Administrative Office. Notice must include the name of the Insured Person, the Policy/Certificate number and nature of the loss.

**Claim Forms**

When We receive a Notice of Claim, We will send the Insured forms for filing Proof of Loss if claim forms are required. If such forms are required and are not sent or given to the Insured within fifteen (15) days, the Insured will meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of his/her loss.

**Proof of Loss**

Written proof of loss must be given Us within ninety (90) days after the occurrence or commencement of any covered loss. Proof of loss must include a copy of the Insured's explanation of benefits (EOB) under the Insured's Major Medical Plan or Comprehensive Health Plan. If it is not reasonably possible to give Us written Proof of Loss in the time required, We will not reduce or deny the claim for this reason alone, if the Proof of Loss is filed as soon as reasonably possible. Nonetheless, unless the Insured is legally incompetent, the Proof of Loss must be provided Us within one (1) year of the time specified.

**Time of Payment of Claims**

Any benefit payable under this Policy will be paid not more than 30 days after the Company receives proper written proof of such loss if the claim was submitted electronically or within 45 days after receipt if the claim was submitted by other means.

**Payment of Claims**

All benefits will be payable to the Insured, unless We receive written Assignment of benefits to the provider of covered services. Any accrued benefits unpaid at the Insured's death will be paid to the Insured's estate.

**GENERAL PROVISIONS****Entire Contract**

The Policy, the Policyholder's Application, along with the Insured's application, if any, and any endorsements and/or riders, is the entire contract between the Policyholder and the Company. All statements made by the Insured or the Policyholder, in the absence of fraud, will be deemed representations and not warranties. No such statement will void the insurance or reduce the benefits under the Policy or be used in defense of a claim unless it is contained in a written application and a copy is provided to the Insured Person or beneficiary. No change in the Policy will be valid until approved by one of our officers. This approval must be endorsed on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

**Grace Period**

We will allow a period of thirty-one (31) days after the premium due date for payment of each premium after the first premium payment. Your coverage is in force during this period.

**Time Limit on Certain Defenses**

After the Policy/Certificate has been in force for two (2) years, it can only be contested for non-payment of premiums. No statement made by an Insured Person can be used in a contest after his/her insurance has been in force for two years during his/her lifetime. No statement an Insured Person makes can be used in a contest unless it is in writing and signed by him/her.

We will not reduce or deny a claim for covered loss after such two (2) year period has elapsed because a Sickness or physical condition existed prior to the date the Insured Person became insured hereunder, unless the Sickness or physical condition was excluded from coverage by name or specific description on the date the loss was incurred.

#### **Conformity with State Statutes**

Any provision of the Policy that, on its Effective Date, is in conflict with the laws of the state in which the Policy is issued is amended to conform to the minimum requirements of such laws.

#### **Certificates**

We will issue Certificates to be provided by the Policyholder to each Insured. The Certificate will describe: The benefits to which each Insured Person is entitled under the Policy; to whom such benefits are payable; the limitations, exclusions and requirements of the Policy.

#### **Policy Inspection**

The Policy may be inspected by You or Your Insured Dependent at any time during the regular business hours of the Policyholder.

#### **Policy Amendment Provision**

Subject to the laws of the state in which the Policy is issued, it may be changed at any time by written amendment agreed to by the Policyholder and Us. Premium rates may be changed according to the "Premiums" section. Any amendments to the Policy will be binding on You, whether You were insured prior to or after the Effective Date of the amendment.

#### **Legal Actions**

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

#### **Misstatement of [Sex or] Age**

If relevant facts about the Insured Person were not accurate, an adjustment of premium will be made and the true facts will decide in what amount insurance is valid under this Policy.

#### **Clerical Error Provisions**

Clerical error or delays in keeping records for the Policy:

1. Will not deny insurance which would otherwise have been granted;
2. Will not continue insurance which would otherwise have ceased; and
3. Will call for an adjustment of premiums or benefits to correct the error.

#### **Workers' Compensation or Workmen's Compensation Not Affected**

The Policy is not in place of and does not affect any requirements for coverage by Workers' Compensation Insurance or Workmen's Compensation Insurance.

#### **Physical Examination**

We have the unqualified right to have any Insured Person medically examined, at Our expense, as often as reasonably necessary while a claim is pending.

#### **ERISA**

The Policyholder has established and maintains an employee welfare benefit plan as defined in the Employee Retirement Security Act of 1974, as amended, to provide the benefits described in the Policy to its employees and their dependents. These benefits are insured by the Company under the Policy, which the Policyholder endorses. The Policyholder is the Plan Administrator, Plan Sponsor, named fiduciary, and, if applicable, Plan Trustee, for the Plan. For more information about the plan, consult the Policy. ERISA does not apply to certain plans, such as government plans and church plans.

## Commercial Travelers Mutual Insurance Company

(Herein called the Company, We, or Us)

70 Genesee Street  
Utica, New York 13502  
Telephone (800) 422-6200

### SICKNESS BENEFIT RIDER

By attachment of this Rider, the Policy/Certificate is amended {if the benefit is shown as available in the Schedule} by adding the following:

We will pay the benefits shown on the Schedule, as the result of a covered Sickness, subject to the Provisions and Limitations of the Policy/Certificate and this Rider when:

1. An Insured Person receives treatment for a Sickness in the Outpatient Department of a Hospital, the Emergency Room of a Hospital, MRI facility or an Ambulatory Surgical Facility or Day Surgery Facility or for In-Hospital Confinement; and
2. An Insured Person incurs Sickness expenses that are covered by the Insured Person's Major Medical Plan or Comprehensive Health Plan.

[After the Insured Person's Deductible, Coinsurance or Co-payment (if any) have been met,] We will pay:

[That portion of the Covered Charges for Sickness expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan because they have been applied to the Major Medical Deductible of the Major Medical Plan or Comprehensive Health Plan;] and

[The Major Medical Coinsurance portion of the Covered Charges for Sickness expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan;] but

[We will not pay more than the Sickness Benefit Amount shown in the Schedule].

#### Limitations Applicable to the Sickness Benefit

[If an Insured Person is not covered by a Major Medical Plan or Comprehensive Health Plan that provides coverage for Sickness expenses on the date the Sickness expense is incurred, then We will not pay the Benefits described above, but in lieu of those Benefits We will pay a Sickness Indemnity Benefit equal to {\$50}. Benefits payable under this Benefit are limited to the stated portion of Covered Charges made by a provider.]

We will not pay during any Year, any amounts otherwise payable that are subject to the Deductible, Coinsurance or Co-payment amounts (if any), or that exceed the Maximum Benefits Amount(s) [or Total Maximum Benefit Amount] shown on the Schedule.

This Rider takes effect on the [Effective Date of the Policy/Certificate to which it is attached] [Effective Date shown {above} {below} {in the Schedule}]. The Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions, and conditions of the Policy/Certificate except as stated.

{Effective Date \_\_\_\_\_ }

**Commercial Travelers Mutual Insurance Company**

President

## **Commercial Travelers Mutual Insurance Company**

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### **ALLIED SERVICES RIDER**

By attachment of this Rider, the Policy/Certificate is amended {if the benefit is shown as available in the Schedule} by adding the following:

[After the Insured Person's Deductible, Coinsurance or Co-payment (if any) has been met]:

We will pay the Accident and Sickness Benefits (if any) shown on the Schedule, subject to the Provisions and Limitations of the Policy/Certificate and applicable Riders, for Outpatient treatment received at any Outpatient facility.

Exception: Benefits are not payable for the following:

1. Professional fees for services performed in a doctor's office or medical clinic.
2. Outpatient Prescription Drugs.

This Rider takes effect on the Effective Date {of the Policy/Certificate to which it is attached} [shown {above} {below} {in the Schedule}]. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions, and conditions of the Policy/Certificate except as stated.

This Rider takes effect on the [Effective Date of the Policy/Certificate to which it is attached] [Effective Date shown {above} {below} {in the Schedule}]. The Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions, and conditions of the Policy/Certificate except as stated.

{Effective Date \_\_\_\_\_ }

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**PRIOR PLAN DEDUCTIBLE CREDIT RIDER**

By attachment of this Rider, the Policy/Certificate is amended {if the benefit is shown as available in the Schedule} by adding the following:

This Rider extends the benefits under the Policy/Certificate by applying a credit toward the Deductible applicable to the Policy/Certificate in the first Year.

Charges incurred by You under Your Major Medical or Comprehensive Health Plan (up to the deductible amount stated in the Schedule), that have been applied to meet Your Deductible under the Major Medical or Comprehensive Health Plan prior to the Effective Date of the Policy/Certificate, will be credited to Your Deductible after deduction for the Co-payment (if any). This applies during the first Year the Policy/Certificate takes effect.

This Rider takes effect on the [Effective Date of the Policy/Certificate to which it is attached] [Effective Date shown {above} {below} {in the Schedule}]. The Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions, and conditions of the Policy/Certificate except as stated.

{Effective Date \_\_\_\_\_ }

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### **HOSPITAL INDEMNITY SICKNESS BENEFIT RIDER**

By attachment of this Rider, the Policy/Certificate is amended {if the benefit is shown as available in the Schedule} by adding the following:

We will pay the benefits shown on the Schedule, as the result of a covered Sickness, subject to the Provisions and Limitations of the Policy/Certificate and this Rider when:

1. An Insured Person incurs a Covered Hospital Confinement; and
2. An Insured Person incurs Sickness expenses that are covered by the Insured Person's Major Medical Plan or Comprehensive Health Plan.

[After the Insured Person's Deductible (if any) has been met,] We will pay: The Benefit Amount shown on the Schedule [per day of confinement]; but We will not pay for more than the Maximum Number of Days shown in the Schedule.

#### **Limitation Applicable to Covered In-Hospital Indemnity Sickness Benefits**

[If an Insured Person is not covered by a Major Medical Plan or Comprehensive Health Plan that provides benefits for expenses incurred for in-hospital sickness on the date a covered hospital sickness confinement occurs, we will not pay the Benefits described above, but in place of those Benefits we will pay a Daily Hospital Indemnity Benefit equal to \$100 Per Day for each day of a Covered Hospital Confinement, not to exceed five (5) days per Year.]

We will not pay during any Year, any amounts otherwise payable that are subject to the Deductible (if any) or that exceed the Maximum Benefit Amount(s) [or Total Maximum Benefit Amount] shown on the Schedule.

This Rider takes effect on the [Effective Date of the Policy/Certificate to which it is attached] [Effective Date shown {above} {below} {in the Schedule}]. The Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions, and conditions of the Policy/Certificate except as stated.

{Effective Date \_\_\_\_\_ }

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### **Outpatient Diagnostic Test and Lab Benefit Rider**

By attachment of this Rider, the Policy/Certificate is amended {if the benefit is shown as available in the Schedule} by adding the following:

We will pay the benefits shown on the Schedule, as a result of expenses incurred due to Outpatient Diagnostic and Lab tests, subject to the Provisions and Limitations of the Policy/Certificate and this Rider when: An Insured Person incurs Outpatient Diagnostic Test and Lab expenses that are covered by the Insured Person's Major Medical Plan or Comprehensive Health Plan.

[After the Insured Person's Deductible, Coinsurance or Co-payment (if any) have been met,] We will pay:

[That portion of the Covered Charges for Outpatient Diagnostic Test and Lab expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan because they have been applied to the Major Medical Deductible of the Major Medical Plan or Comprehensive Health Plan;] and

[The Major Medical Coinsurance portion of the Covered Charges for Outpatient Diagnostic Test and Lab expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan;] but

[We will not pay more than the Outpatient Diagnostic Test and Lab Benefit Rider Benefit Amount shown in the Schedule].

#### **Limitations Applicable to the Outpatient Diagnostic Test and Lab Benefit Rider**

[If an Insured Person is not covered by a Major Medical Plan or Comprehensive Health Plan that provides coverage for Outpatient Diagnostic Test and Lab expenses on the date the expense is incurred, then We will not pay the Benefits described above, but in lieu of those Benefits We will pay a Sickness Indemnity Benefit equal to {\$25}.

Benefits payable under this Benefit are limited to the stated portion of Covered Charges made by a Provider.] The deductible or coinsurance charges for professional fees in a doctor's office, or medical clinic and Outpatient Prescription Drugs. We will not pay benefits under this Benefit or under the Policy or any other Rider for the same Eligible Expenses].

This Rider does not cover Charges for professional fees incurred in a doctor's office, or medical clinic and Outpatient Prescription Drugs.

We will not pay benefits under the Policy or any other Rider for the same Eligible Expenses.

We will not pay during any Year, any amounts otherwise payable that are subject to the Deductible, Coinsurance or Co-payment amounts (if any), or that exceed the Maximum Benefits Amount(s) [or Total Maximum Benefit Amount] shown on the Schedule.

This Rider takes effect on the [Effective Date of the Policy/Certificate to which it is attached] [Effective Date shown {above} {below} {in the Schedule}]. The Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions, and conditions of the Policy/Certificate except as stated.

{Effective Date \_\_\_\_\_}

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## Outpatient Physical and Wellness Examination Rider

By attachment of this Rider, the Policy/Certificate is amended {if the benefit is shown as available in the Schedule} by adding the following:

We will pay the benefits shown on the Schedule, as the result of a covered Outpatient Physical and Wellness Examination, subject to the Provisions and Limitations of the Policy/Certificate and this Rider when:

1. An Insured Person receives treatment for an Outpatient Physical and Wellness Examination; and
2. An Insured Person incurs Outpatient Physical and Wellness Examination expenses that are covered by the Insured Person's Major Medical Plan or Comprehensive Health Plan.

After the Insured Person's Deductible, Coinsurance or Co-payment (if any) have been met, We will pay:

[That portion of the Covered Charges for Outpatient Physical and Wellness Examination expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan because they have been applied to the Major Medical Deductible of the Major Medical Plan or Comprehensive Health Plan;] and

[The Major Medical Coinsurance portion of the Covered Charges for Outpatient Physical and Wellness Examination expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan;] but

[We will not pay more than the Outpatient Physical and Wellness Examination Benefit Amount shown in the Schedule].

[The Outpatient Physical and Wellness Examination must be for wellness screening only and it cannot be for the treatment of any illness, Sickness or Injury; nor can it be for the monitoring or evaluation of an Insured Person's response to the treatment of any illness, Sickness or Injury. An Insured Person must be insured under the Policy/Certificate for at least [six (6) months] before Benefits are payable under this Optional Supplemental Rider.]

[The Outpatient Physical and Wellness Examination must include at least [two (2)] of the following tests, otherwise, no benefits are payable under this Optional Supplemental Rider: 1. Mammogram or Mammography; 2. Chest X-ray; 3. Prostate Specific; Antigen (PSA) cancer screening test; 4. Blood profile or SMA blood series; 5. Urinalysis; 6. Cardiac stress test; 7. E.K.G.; 8. PAP Smear; 9. Cholesterol test. ]

### Limitations Applicable to the Outpatient Physical and Wellness Examination Benefit

[If an Insured Person is not covered by a Major Medical Plan or Comprehensive Health Plan that provides coverage for Outpatient Physical and Wellness Examination expenses on the date the Outpatient Physical and Wellness Examination Sickness expense is incurred; then We will not pay the Benefits described above, but in lieu of those Benefits We will pay an Outpatient Physical and Wellness Examination Sickness Indemnity Benefit equal to {\$50}. Benefits payable under this Benefit are limited to the stated portion of Covered Charges made by a Provider.]

We will not pay during any Year any amounts otherwise payable that are subject to the Deductible, Coinsurance or Co-payment amounts (if any), or that exceed the Maximum Benefits Amount(s) [or Total Maximum Benefit Amount] shown on the Schedule.

This Rider takes effect on the [Effective Date of the Policy/Certificate to which it is attached] [Effective Date shown {above} {below} {in the Schedule}]. The Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions, and conditions of the Policy/Certificate except as stated.

{Effective Date \_\_\_\_\_ }

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## Generic Prescription Drug Benefit Rider

By attachment of this Rider, the Policy/Certificate is amended {if the benefit is shown as available in the Schedule} by adding the following:

We will pay the benefits shown on the Schedule, for Generic Prescription Drug expenses, subject to the Provisions and Limitations of the Policy/Certificate and this Rider when: An Insured Person incurs expenses for Generic Prescription Drug that are covered by the Insured Person's Major Medical Plan or Comprehensive Health Plan.

[After the Insured Person's Deductible, Coinsurance or Co-payment (if any) have been met,] We will pay:

[That portion of the Covered Charges for Generic Prescription Drug expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan because they have been applied to the Major Medical Deductible of the Major Medical Plan or Comprehensive Health Plan;] and

[The Major Medical Coinsurance portion of the Covered Charges for Generic Prescription Drug expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan;] but

[We will not pay more than the Generic Prescription Drug Benefit Rider Benefit Amount shown in the Schedule].

The benefits provided herein are administered through the use of a plastic I.D. card that will be provided to the Insured. To fill a prescription, an Insured Person must complete the following steps:

1. Present I.D. card and the Physician's prescription to a Participating Pharmacy;
2. Pay the Co-payment Amount;
3. Receive the prescription.

If an Insured Person has a prescription filled through a pharmacy that is not a Participating Pharmacy, the Insured Person must pay the full cost of the prescription and submit it to: Morgan White Administrators, P.O. Box 14067, Jackson, Mississippi 39236. The Insured Person will be reimbursed the amount of the benefit that would have otherwise been paid.]

### Exclusions Applicable to the Brand and Generic Prescription Drug Benefit Rider

No outpatient Prescription Drug Benefits are payable for any drugs other than covered Generic Prescription Drugs. Brand Name Prescription Drugs are not covered. No outpatient Prescription Drug Benefits are payable for any of the following:

[(a) Drugs or medicines lawfully obtainable without a Physician's prescription; (b) Non-legend drugs; (c) Charges for the administration or injection of any drug; (d) Cosmetic drugs specifically intended for cosmetic use; (e) Fertility agents; (f) Drugs labeled "Caution – limited by Federal Law to investigational use," or experimental drugs, even though a charge is made to the Insured Person; (g) Immunization agents; (h) Medication which is to be taken by or administered to an individual in whole or in part in a Physician's office or while he/she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution, which operates on its premises, a facility for dispensing pharmaceuticals; (i) Any prescription refilled in excess of the number specified by the Physician, or before at least 75% of the previous prescription has been used, or any refill dispensed after one (1) year from the Physician's original order; (j) Toxins or vaccines; (k) Biologicals or anabolic steroids; (l) Anorexients; (m) Immunosuppressants; (n) Acne medications; (o) Stimulants, analeptics, or amphetamines; (p) Contraceptives, regardless of intended use; (q) Fertility or Impotence drugs; (r) Fluoride products; (s) Injectables; (t) Smoking Cessation products; (u) Vitamins and Minerals; (v) Hematinics; (w) Psychotherapeutic Drugs; (x) Laxatives; (y) Ostomy Supplies; (z) Syringes or Needles; (aa) Drugs or medicines prescribed for the treatment of sexual dysfunctions or erectile dysfunctions; (bb) Biological sera, Blood, or Blood Products; (cc) Therapeutic devices or support garments; (dd) Drugs or medicines for treatment of

any condition excluded from coverage under the Policy of Insurance, this Rider, or in any Rider attached; (ee) Any drug or medicine that is not a Covered Prescription Drug.]

### **Definitions Applicable to Generic Prescription Drug Benefit Rider**

**Important Notice:** The General Policy Definitions also apply to this Prescription Drug Rider.

**[Covered Prescription Drugs** means Usual and Customary Charges for the lesser of a thirty-day supply or sixty unit doses of Medically Necessary, Prescription Drugs that are also]:

1. [Legend Drugs; which are
2. prescribed by a Physician for a covered Sickness or Injury; and
3. dispensed by a licensed pharmacist upon the written prescription of a Physician
4. approved by the U.S. Food and Drug Administration for general use.]

**Legend Drugs** means any medical substance, not otherwise excluded under the Policy or this Optional Benefit, the label of which is required under the Federal Food Drug and Cosmetic Act to bear the legend, "Caution: Federal Law prohibits dispensing without a prescription".

**Participating Pharmacy** means a pharmacy that has entered into an agreement with and has been designated as a Participating Pharmacy by the administrator of the Outpatient Generic Prescription Drug Benefit program.

**Prescription Drug Rider Deductible or Coinsurance** means that portion of the Covered Charges, incurred during that year, that an Insured Person is required to pay before any benefits are payable.

### **Limitations Applicable to the Generic Prescription Drug Benefit Rider**

[If an Insured Person is not covered by a Major Medical Plan or Comprehensive Health Plan that provides coverage for Generic Prescription Drug Benefit expenses on the date the expense is incurred, then We will not pay the Benefits described above, but in lieu of those Benefits We will pay a Generic Prescription Drug Benefit Rider Indemnity Benefit equal to {\$10}. Benefits payable under this Benefit are limited to the stated portion of Covered Charges made by a provider.]

We will not pay during any Year, any amounts otherwise payable that are subject to the Deductible, Coinsurance or Co-payment amounts (if any), or that exceed the Maximum Benefits Amount(s) [or Total Maximum Benefit Amount] shown on the Schedule.

This Rider takes effect on the [Effective Date of the Policy/Certificate to which it is attached] [Effective Date shown {above} {below} {in the Schedule}]. The Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions, and conditions of the Policy/Certificate except as stated.

{Effective Date \_\_\_\_\_ }

## **Commercial Travelers Mutual Insurance Company**

President

## **Commercial Travelers Mutual Insurance Company**

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### **Brand and Generic Prescription Drug Benefit Rider**

By attachment of this Rider, the Policy/Certificate is amended {if the benefit is shown as available in the Schedule} by adding the following:

We will pay the benefits shown on the Schedule, for Brand and Generic Prescription Drug expenses, subject to the Provisions and Limitations of the Policy/Certificate and this Rider when: An Insured Person incurs expenses for Brand and Generic Prescription Drug that are covered by the Insured Person's Major Medical Plan or Comprehensive Health Plan.

[After the Insured Person's Deductible, Coinsurance or Co-payment (if any) have been met,] We will pay:

[That portion of the Covered Charges for Brand and Generic Prescription Drug expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan because they have been applied to the Major Medical Deductible of the Major Medical Plan or Comprehensive Health Plan;] and

[The Major Medical Coinsurance portion of the Covered Charges for Brand and Generic Prescription Drug expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan;] but

[We will not pay more than the Brand and Generic Prescription Drug Benefit Rider Benefit Amount shown in the Schedule].

The benefits provided herein are administered through the use of a plastic I.D. card that will be provided to the Insured. To fill a prescription, an Insured Person must complete the following steps:

1. Present I.D. card and the Physician's prescription to a Participating Pharmacy;
2. Pay the Co-payment Amount;
3. Receive the prescription.

If an Insured Person has a prescription filled through a pharmacy that is not a Participating Pharmacy, the Insured Person must pay the full cost of the prescription and submit it to: Morgan White Administrators, P.O. Box 14067, Jackson, Mississippi 39236. The Insured Person will be reimbursed the amount of the benefit that would have otherwise been paid.]

#### **Exclusions Applicable to the Brand and Generic Prescription Drug Benefit Rider**

No outpatient Prescription Drug Benefits are payable for any drugs other than covered Prescription Drugs. No outpatient Prescription Drug Benefits are payable for any of the following:

[(a) Drugs or medicines lawfully obtainable without a Physician's prescription; (b) Non-legend drugs; (c) Charges for the administration or injection of any drug; (d) Cosmetic drugs specifically intended for cosmetic use; (e) Fertility agents; (f) Drugs labeled "Caution – limited by Federal Law to investigational use," or experimental drugs, even though a charge is made to the Insured Person; (g) Immunization agents; (h) Medication which is to be taken by or administered to an individual in whole or in part in a Physician's office or while he/she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution, which operates on its premises, a facility for dispensing pharmaceuticals; (i) Any prescription refilled in excess of the number specified by the Physician, or before at least 75% of the previous prescription has been used, or any refill dispensed after one (1) year from the Physician's original order; (j) Toxins or vaccines; (k) Biologicals or anabolic steroids; (l) Anorexients; (m) Immunosuppressants; (n) Acne medications; (o) Stimulants, analeptics, or amphetamines; (p) Contraceptives, regardless of intended use; (q) Fertility or Impotence drugs; (r) Fluoride products; (s) Injectables; (t) Smoking Cessation products; (u) Vitamins and Minerals; (v) Hematinics; (w) Psychotherapeutic Drugs; (x) Laxatives; (y) Ostomy Supplies; (z) Syringes or Needles; (aa) Drugs or medicines prescribed for the treatment of sexual dysfunctions or erectile dysfunctions; (bb) Biological sera, Blood, or Blood Products; (cc) Therapeutic devices or support garments; (dd) Drugs or medicines for treatment of

any condition excluded from coverage under the Policy of Insurance, this Rider, or in any Rider attached; (ee) Any drug or medicine that is not a Covered Prescription Drug.]

### **Definitions Applicable to Brand and Generic Prescription Drug Benefit Rider**

**Important Notice:** The General Policy Definitions also apply to this Prescription Drug Rider.

**[Covered Prescription Drugs** means Usual and Customary Charges for the lesser of a thirty-day supply or sixty unit doses of Medically Necessary, Prescription Drugs that are also]:

1. [Legend Drugs; which are
2. prescribed by a Physician for a covered Sickness or Injury; and
3. dispensed by a licensed pharmacist upon the written prescription of a Physician;
4. approved by the U.S. Food and Drug Administration for general use.]

**Legend Drugs** means any medical substance, not otherwise excluded under the Policy or this Optional Benefit, the label of which is required under the Federal Food Drug and Cosmetic Act to bear the legend, "Caution: Federal Law prohibits dispensing without a prescription".

**Participating Pharmacy** means a pharmacy that has entered into an agreement with and has been designated as a Participating Pharmacy by the administrator of the Outpatient Generic Prescription Drug Benefit program.

**Prescription Drug Rider Deductible or Coinsurance** means that portion of the Covered Charges, incurred during that year, that an Insured Person is required to pay before any benefits are payable.

### **Limitations Applicable to the Brand and Generic Prescription Drug Benefit Rider**

[If an Insured Person is not covered by a Major Medical Plan or Comprehensive Health Plan that provides coverage for Brand and Generic Prescription Drug Benefit expenses on the date the expense is incurred, then We will not pay the Benefits described above, but in lieu of those Benefits We will pay a Brand and Generic Prescription Drug Indemnity Benefit equal to {\$10}. Benefits payable under this Benefit are limited to the stated portion of Covered Charges made by a provider.]

We will not pay during any Year, any amounts otherwise payable that are subject to the Deductible, Coinsurance or Co-payment amounts (if any), or that exceed the Maximum Benefits Amount(s) [or Total Maximum Benefit Amount] shown on the Schedule.

This Rider takes effect on the [Effective Date of the Policy/Certificate to which it is attached] [Effective Date shown {above} {below} {in the Schedule}]. The Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions, and conditions of the Policy/Certificate except as stated.

{Effective Date \_\_\_\_\_ }

## **Commercial Travelers Mutual Insurance Company**

President

## **Commercial Travelers Mutual Insurance Company**

(Herein called the Company, We, or Us)

70 Genesee Street  
Utica, New York 13502  
Telephone (800) 422-6200

### **AMBULANCE BENEFIT RIDER**

By attachment of this Rider, the Policy/Certificate is amended {if the benefit is shown as available in the Schedule} by adding the following:

We will pay the benefits shown on the Schedule made by a licensed ambulance service, but not to exceed the amount shown in the Schedule for this Benefit, subject to the Provisions and Limitations of the Policy/Certificate and this Rider when:

1. An Insured Person is transported by air or ground ambulance transportation to the nearest qualified Hospital or transfer from one Hospital to another; and
2. An Insured Person incurs Sickness expenses that are covered by the Insured Person's Major Medical Plan or Comprehensive Health Plan.
3. Transportation due to an accident is within 72 hours of the accident.

#### **Limitations Applicable to the Sickness Benefit**

[If an Insured Person is not covered by a Major Medical Plan or Comprehensive Health Plan that provides coverage for Ambulance expenses on the date the Sickness expense is incurred; then We will not pay the Benefits described in above, but in lieu of those Benefits We will pay an Ambulance Indemnity Benefit equal to {\$50}. Benefits payable under this Benefit are limited to the stated portion of Covered Charges made by a provider.]

We will not pay during any Year, any amounts otherwise payable that are subject to the Deductible, Coinsurance or Co-payment amounts (if any), or that exceed the Maximum Benefits Amount(s) [or Total Maximum Benefit Amount] shown on the Schedule.

This Rider takes effect on the [Effective Date of the Policy/Certificate to which it is attached] [Effective Date shown {above} {below} {in the Schedule}]. The Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions, and conditions of the Policy/Certificate except as stated.

{Effective Date \_\_\_\_\_ }

**Commercial Travelers Mutual Insurance Company**

President

# Commercial Travelers Mutual Insurance Company

(Herein called the Company, We, or Us)

70 Genesee Street  
Utica, New York 13502  
Telephone (800)422-6200

## OUTPATIENT PHYSICIAN'S EXPENSE RIDER

By attachment of this Rider, the Policy/Certificate is amended by adding the following:

<b>Optional Supplemental Outpatient Physician's Expense Benefit</b>	
Co-payment Amount [per visit]	[No or Yes]
Maximum Supplemental Outpatient Physician's Expense Benefit Amount [per visit]	[N/A to \$25]
[Per Sickness or Injury per Calendar Year]	[N/A to \$200]
[Per Insured Person per Calendar Year]	N/A to \$500]
[For All Insured Persons per Calendar Year]	[\$100 to \$1000]
	[N/A to \$3000]

We will pay the benefits shown on the Schedule on this page, as the result of covered Outpatient Physician's Expenses, subject to the Provisions and Limitations of the Policy/Certificate and this Rider when:

1. An Insured Person receives Medically Necessary Treatment from a Physician in the Physician's Office, Clinic, or the Emergency Room of a Hospital; and
2. An Insured Person incurs Outpatient Physician's Expenses that are covered by the Insured Person's Major Medical Plan or Comprehensive Health Plan.

[After the Insured Person's Deductible, Coinsurance or Co-payment (if any) have been met,] We will pay:

[That portion of the Covered Charges for Outpatient Physician's Expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan because they have been applied to the Major Medical Deductible of the Major Medical Plan or Comprehensive Health Plan;] and

[The Major Medical Coinsurance portion of the Covered Charges for Outpatient Physician's Expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan;] but

[We will not pay more than the Outpatient Physician's Expenses Benefit Amount shown in the Schedule].

### Limitations Applicable to the Sickness Benefit

[If an Insured Person is not covered by a Major Medical Plan or Comprehensive Health Plan that provides coverage for Outpatient Physician's Expenses on the date the expense is incurred, then We will not pay the Benefits described above, but in lieu of those Benefits We will pay an Outpatient Physician's Expenses Indemnity Benefit equal to [fifty-percent (50%)] of the Outpatient Physician's Expense Benefit Amount shown in the Certificate Schedule. Benefits payable under this Benefit are limited to the stated portion of Covered Charges made by a provider.]

We will not pay during any Year, any amounts otherwise payable that are subject to the Deductible, Coinsurance or Co-payment amounts (if any), or that exceed the Maximum Benefits Amount(s) [or Total Maximum Benefit Amount] shown on the Schedule.

This Rider takes effect on the [Effective Date of the Policy/Certificate to which it is attached] [Effective Date shown {above} {below} {in the Schedule}]. The Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions, and conditions of the Policy/Certificate except as stated.

{Effective Date \_\_\_\_\_ }

**Commercial Travelers Mutual Insurance Company**

**President**

# Commercial Travelers Mutual Insurance Company - Enrollment Form

Utica, NY 13502

Hand Print – Black Ink Only  
 This is an electronically processed form. Please  
 PRINT in the boxes in capital letters:  
 ABCDEFG.12345 DO NOT TOUCH LINES

Group Name	Req. Eff Date M O / D D / YEAR	Hire Date M O / D D / YEAR			
<input type="text"/>	<input type="text"/>	<input type="text"/>			

Last Name (Primary Insured)	First Name	MI	M/F	M O / D D / YEAR	AGE	SSN
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Last Name (Spouse)	First Name	MI	M/F	M O / D D / YEAR	AGE	SSN
<input type="text"/>						

Last Name (Dependents)	First Name	MI	M/F	M O / D D / YEAR	AGE	Student Y/N
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

<input type="text"/>						
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<input type="text"/>						
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<input type="text"/>						
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<input type="text"/>						
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Address	Work Phone	
<input type="text"/>	<input type="text"/>	

City	State	Zip	-		Home Phone	
<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	

Please indicate yes in student status at left for full time students between age 19-25.

- New Application
- Additional Insured
- Delete Insured

Payment Mode Group Payroll Deduction
---

Type of Coverage       Employee       Employee + Spouse       Employee + Children       Employee + Family

Plan Design Code \_\_\_\_\_

Monthly Premium \_\_\_\_\_

Are all proposed insureds now covered under a Major Medical or Comprehensive Health Plan?

yes  no

If "NO," list persons not eligible for coverage: \_\_\_\_\_

### Authorization, Agreements, Representations and Understanding

I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agencies, or employer having information available as to diagnosis treatment and prognosis with respect to any physical or mental condition and/or treatment of me and other members, to give Commercial Travelers Mutual Insurance Company, its reinsurers, or its legal representatives, any and all such information. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s) and referred to elsewhere in this application for Insurance.

The agent and I certify that I have read or had read to me the complete Application. I realize that any false statement or misrepresentation that is material to the risk or hazard assumed may result in loss of coverage under the coverage applied for, subject to the incontestable period, time limit on certain defenses and legal proceedings.

I understand that no agent can: a) accept risks; b) modify policies; or c) waive any rights or requirements of Commercial Travelers Mutual Insurance Company. The acceptance of any certificate or policy issued on this Application shall be an acceptance and ratification by me of all corrections, additions or changes made by Commercial Travelers Mutual Insurance Company. Any changes are shown in the space labeled "Home Office Use"; however, any change in the amount, class, plan or date of birth is subject to my written agreement.

I understand that coverage is effective when: a) the certificate or policy is issued by Commercial Travelers Mutual Insurance Company; b) the certificate or policy is received and accepted by me; and c) the full first premium is paid or an authorization for payroll deduction is received and accepted by Commercial Travelers Mutual Insurance Company; and d) if there has been no change in my health or occupation since the date below.

I understand that the certificate provides limited benefits, specifically only the benefits which I have selected and are set forth in the certificate itself.

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

X \_\_\_\_\_  
Signature of Proposed Insured Date

X \_\_\_\_\_  
Signature of Agent Agent's Printed Name Agent Number

\_\_\_\_\_  
Dated at City State Agent State License Identification Number

**Application for Group Accident Limited Benefit Insurance to:  
Commercial Travelers Mutual Insurance Company  
70 Genesee Street, Utica, NY 13502**

The Information provided by the Applicant in this Application will be the basis on which any insurance is issued. Incorrect information could void Insurance.

Legal Name of Employer (include d/b/a):		Employer Identification Number	
Principal Business or Activity		SIC Code	
Physical Address: (Street Number and Name)		Billing Address: (If bill is to be split and sent to more than one billing address please indicate here and give addresses on an attached sheet.)	
City		City	
State	Zip	State	Zip

Executive Contact Person:	Billing Contact Person:
Title:	Title:
Telephone:	Telephone:
Email Address:	Email Address:
Fax Number	Fax Number

**Employer's Major Medical or Comprehensive Plan Data**

Major Medical Plan Carrier _____
Major Medical Deductible Amount \$ _____
Major Medical Coinsurance % _____ to Maximum Out of pocket (Coinsurance Limit) Amount \$ _____
Are Major Medical Deductibles & Coinsurance per Plan Year or per Calendar Year? _____
Major Medical Plan Anniversary Date _____
Number of Covered: Employees _____ Dependent Spouses _____ Dependent Children _____

**Eligibility**

**Eligible Person as used in the Policy means a person who is insured under a Major Medical Plan or Comprehensive Health Plan (CHAMPUS/ TRICARE or Medicaid is not a comprehensive medical plan) and who is:**

**Eligible Person - If enrollment is voluntary, (all premiums are paid by the employee) -**  
 [All active full-time employees working 18 hours or more per week and who are under age seventy will be eligible for coverage. Each Insured will be eligible for Dependent coverage on the later of the following dates:

1. The day the Insured becomes eligible for insurance; or
2. The day the Insured acquires his or her first dependent]

**Eligible Person - If employer participates in paying the premiums -**

1. [An employee of the Policyholder who is insured by the employer's major medical plan;
2. An employee's dependent spouse or unmarried dependent children who were insured by the employer's major medical plan.] Eligible new employees or dependents may be added subject to the terms of the

Policy.

{Eligible Classes: \_\_\_\_\_}

The first premium must be paid before any insurance is effective. Insurance provided hereunder will terminate with regard to any individual when that individual is no longer an Eligible Person in accordance with the "Termination of Coverage" provisions of the Policy.

### Insurance Applied For

**Employer Contribution** \_\_\_{Premium Saver Plan} \_\_\_ {HSA Saver Plan} \_\_\_ {Med Bridge Plan}  
**Voluntary (Employee Paid Plans)** \_\_\_ {Med Bridge Plan}

Employer will pay \_\_\_\_\_% or \$\_\_\_\_\_ of Employee Costs and \_\_\_\_\_% or \$\_\_\_\_\_ of Dependent Costs

{Important Note: All persons (100 % participation) insured by the Employer's Major Medical or Comprehensive Health Plan must be covered on Employer Contribution plans listed above.}

### Plan Design Selection

#### ATTACH FLIER OR PROPOSAL THAT DESCRIBES THE SPECIFIC BENEFITS

Applicable to {all} {Accident}{Sickness}{Inpatient}{and}{Outpatient} Benefits {Only}

Deductible: \$\_\_\_\_\_ Coinsurance: \_\_\_\_\_% Out-of-Pocket Maximum (Coinsurance Limit) \$\_\_\_\_\_

Maximum Total Benefit Amount \$\_\_\_\_\_

Per Year Benefit Maximum Basis:  Plan Year  Calendar Year

Comments \_\_\_\_\_

#### ACCIDENT BENEFIT

{Co-payment Amount \$\_\_\_\_\_} {Per visit}

Maximum Benefit Amount All Covered Facilities per Year: \$\_\_\_\_\_

Maximum Benefit Amount for In-Hospital Confinement per Year \$\_\_\_\_\_

Maximum Benefit Amount All Covered Outpatient Facilities per Year: \$\_\_\_\_\_

#### OPTIONAL RIDERS

{Sickness Benefit Rider:}  Yes  No

{Co-payment Amount \$\_\_\_\_\_} {Per visit}

{Maximum Benefit Amount All Covered Facilities per Year: \$\_\_\_\_\_}

{Maximum Benefit Amount for In-Hospital Confinement per Year \$\_\_\_\_\_}

{Maximum Benefit Amount All Covered Outpatient Facilities per Year: \$\_\_\_\_\_}

{Hospital Indemnity Sickness Benefit Rider}  Yes  No

{Outpatient Physicians Expense Rider}  Yes  No

{Ambulance Benefit Rider}  Yes  No

{Generic Outpatient Prescription Drug Rider}  Yes  No

{Brand {and Generic} Prescription Drug Rider}  Yes  No

{Outpatient Physical and Wellness Examination Rider}  Yes  No

{Outpatient Diagnostic Test and Lab Rider}  Yes  No

{Allied Services Rider}  Yes  No

**{Prior Plan Deductible Credit Rider} { Yes  No}**

**Policy/Certificate Delivery**

Send Policy & Certificate to: \_\_\_\_\_ Agent \_\_\_\_\_ Employer

**Payroll and Billing Information**

**{Billing is alphabetical -12 monthly Premiums}  
Effective Date can be {the 1st or the 15<sup>th</sup> of the month}**

Make check payable to Commercial Travelers Mutual Insurance Company.  
\$ \_\_\_\_\_ Amount of Attached Check.

**ALL PREMIUMS ARE PAYABLE IN ADVANCE. THE FIRST PREMIUM MUST BE PAID PRIOR TO THE EFFECTIVE DATE OF INSURANCE.**

**Agreements, Representations and Understanding**

**I represent** that all statements made herein are complete and true as of the date I signed this Application, and I understand that Commercial Travelers Mutual Insurance Company (CTMIC) will rely on these statements and this information as the basis for approving this Application.

**I understand** that the Group Accident Insurance Policy for which I have applied is a limited benefit Policy that pays only the benefits selected and set forth in the Policy itself. Our agent has explained the Policy's limitations and exclusions, if any.

**I understand** that only those employees and dependents covered under our company's major medical or comprehensive health plan are eligible for coverage.

Check One

{I **represent** that {100%} of eligible employees and dependents will be enrolled in the plan}. \_\_\_\_\_

{I **represent** that this plan will be offered on a voluntary basis} \_\_\_\_\_

**I understand** that coverage is effective when: a) the Policy is issued by CTMIC; b) the Policy is received and accepted by the Policyholder; c) the full first premium is paid and accepted by CTMIC.

**{We agree** to make any necessary payroll deductions for any employee's share of the cost of this insurance and to remit the total premium for all insurance as premiums become due. We request that the Administrator bill our share of the premiums and any applicable administrative fee due under the insurance Policy issued.}

**I understand** that the Policyholder or CTMIC may terminate the Policy and any Rider(s) on any premium due date by giving at least {90} days written notice to the other party. The Policyholder is responsible for notifying the Insureds of the termination or non-renewal of the Policy.

**I understand** that CTMIC and the Policyholder may agree to amend the Policy at any time without the consent of any employee or other person.

**I represent** that the information herein is true and complete, as of the date I signed this Application, and that I have read and understand this form.

**{I acknowledge and understand** that any misrepresentation on this Application by my agent or me may result in the cancellation or rescission of any Policy issued based on this Application.}

**{I hereby represent that I have reviewed the fraud warning notice (if applicable) included with this Application for the Policyholder's state of domicile.}**

On behalf of the Employer, this Application for Group Insurance is signed by

X \_\_\_\_\_ Print Name \_\_\_\_\_

Official Title \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_

Agent Name (print) \_\_\_\_\_ Signature \_\_\_\_\_

**{FRAUD WARNING NOTICE**

<b>{For residents of all states</b> (except the following)}	{Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.}
<b>{Arkansas}</b>	{Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.}

<b>{Colorado}</b>	{It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, and denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.}
<b>{District of Columbia}</b>	{Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the Applicant.}
<b>{Florida}</b>	{Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.}
<b>{Kentucky}</b>	{Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.}
<b>{Louisiana}</b>	{Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.}
<b>{Maine}</b>	{It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.}
<b>{Nebraska}</b>	{Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.}
<b>{New Jersey}</b>	{Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.}
<b>{New Mexico}</b>	{Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.}
<b>{Pennsylvania}</b>	{Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.}
<b>{Tennessee}</b>	{It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.}}



# Commercial Travelers Mutual Insurance Company

70 Genesee Street

Utica, New York 13502 Telephone: 800-422-6200

## APPLICATION FOR ENROLLMENT

Organization Name & Number: (if applicable)

Effective Date: \_\_\_\_\_

## APPLICATION FOR INSURANCE

New Application     Additional Insured to Certificate No. \_\_\_\_\_

NAME	First	Middle	Last	Social Security #	Birth Date	Age	Sex
Primary Insured:							
Spouse: (Optional)							
Dependent Children: (Optional)							
Resident Address:				Billing Address:			
City	State	Zip		City	State	Zip	
Occupation:				Employer:			
Home Telephone: ( )				Work Telephone: ( )			
Payment Mode: <input type="checkbox"/> Monthly Payroll Deduction							

Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_

**HEALTH QUESTIONS.** If any question is answered "Yes", list the applicable person below who is not eligible for coverage.

1. During the past 5 years has any person intended to be insured: (i) had symptoms of any of the following; (ii) consulted with any member of the medical profession about any of the following; or (iii) been treated by any member of the medical profession for any of the following:
 

	YES	NO
a.) disease or abnormalities of the brain or nervous system, including, but not limited to, stroke, epilepsy, seizure, paralysis, Alzheimer's Disease or other dementia, or any degenerative neurological disorder?.....	___	___
b.) diseases or abnormalities of the heart, including, but not limited to heart attack?.....	___	___
c.) cancer, leukemia or Hodgkin's Disease?.....	___	___
d.) emphysema, cystic fibrosis, chronic obstructive pulmonary disease, diabetes, cirrhosis or Crohn's Disease?.....	___	___
2. During the past 10 years, has any person intended to be insured:
 

a.) been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV)?.....	___	___
b.) tested positive for the HIV Infection?.....	___	___
3. During the past 6 months, has any person intended to be insured:
 

a.) other than for any accident, had any hospital confinement of 3 days or longer?.....	___	___
b.) been advised to have or contemplate having a diagnostic test or surgery which has not been completed?.....	___	___
4. Is any person intended to be insured or any family member (whether or not named in this application) now pregnant?..
5. During the past 3 years, has any person intended to be insured been declined for any health or life insurance?.....
6. Does any person intended to be insured, have current coverage under a Medicare Program?.....

SELECTION OF COVERAGE	Mode Premium*				List any person(s) who answered "Yes" to any questions listed above. This person(s) is/are <u>not</u> eligible for coverage.
	Individual	Individual & Spouse	Individual & Children	Full Family	
Plan Number:	\$	\$	\$	\$	_____
Total Premium	\$	\$	\$	\$	_____

Home Office Use Only:



SERFF Tracking Number: AMFT-126726853 State: Arkansas  
 Filing Company: Commercial Travelers Mutual Insurance State Tracking Number: 46429  
 Company  
 Company Tracking Number: CTM GAP-P (04/05) AR  
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
 Product Name: Group Supplemental Accident  
 Project Name/Number: CTM GAP-P (04/05)/CTM GAP-P (04/05)

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachments:</b> AR Imp Information Notice.pdf GAP-readability-CTM.pdf	Approved-Closed	08/12/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application <b>Comments:</b> See Form Schedule Tab for applications.	Approved-Closed	08/12/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Filing Authorization Letter <b>Comments:</b> <b>Attachment:</b> CT Authorization Letter 2010.pdf	Approved-Closed	08/12/2010

**IMPORTANT INFORMATION FOR  
ARKANSAS POLICYOWNERS**

If you have questions about your policy or a claim you have filed, please contact your insurance company or your agent:

Commercial Travelers Mutual Insurance Company  
Administrative Office:  
P.O. Box 14067  
Jackson, Mississippi 39236

Telephone: 1-800-252-3439

Agent \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

If you are unable to resolve a problem with your insurance company or your agent, you may contact the Arkansas Department of Insurance:

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, AR 72201-1804

Telephone: 1-800-852-5494  
1-501-371-2640

E-Mail: [Insurance@mail.state.ar.us](mailto:Insurance@mail.state.ar.us)  
Web Site: [www.state.ar.us/insurance](http://www.state.ar.us/insurance)

ML-NOTICE-AR

August 9, 2010

State of Arkansas

Re: Readability Certification for Policy Forms  
Commercial Travelers Mutual Insurance Company

To Whom It May Concern:

The following forms have been tested for readability and meet the minimum reading ease score as required by the state of Arkansas.

<b>Form Number</b>	<b>Flesch Score</b>
CTM-GAP-P (04/05), et al	50.1



---

Rebecca Ewing, FLMI, HIA ACS, ACP  
Compliance Consultant  
Lewis & Ellis, Inc. – Actuaries & Consultants

Date: August 9, 2010



April 26, 2010

To: All State Insurance Department Personnel

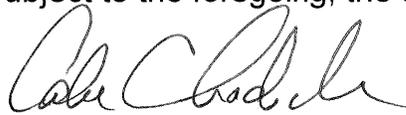
Re: Premium Saver and Dental Insurance Policies Filings  
Commercial Travelers Mutual Insurance Company

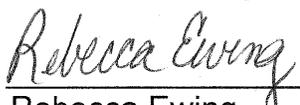
Commercial Travelers Mutual Insurance Company (Commercial Travelers) authorizes Lewis & Ellis, Inc. to submit the above captioned forms on Commercial Travelers' behalf. Under this authorization Lewis & Ellis, Inc. has the authority to:

1. Represent Commercial Travelers in the submission and negotiation of approval of the above forms and related rates
2. Give assurances and make commitments on behalf of Commercial Travelers regarding specific conditions of the approval of above forms and related rates

However, no authority is granted which permits Lewis & Ellis, Inc. to withdraw or modify any existing forms on file with your department.

Subject to the foregoing, the signature of:

  
Cabe Chadick, FSA, MAAA  
Senior Vice President & Principal

  
Rebecca Ewing  
Compliance Consultant

  
Brian Stentz  
Actuarial Associate

When affixed to a letter or certification on intent, will be as binding as if signed by an officer of Commercial Travelers Mutual Insurance Company.

Sincerely,  
  
Paul H. Trevvett  
President & CEO





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GENERAL PROVISIONS .....11

**POLICY SCHEDULE OF BENEFITS**

<p><b>Year: [Calendar Year or Policy Year]</b></p> <p><b>Deductible</b></p> <p><b>Coinsurance %</b></p> <p><b>Out of Pocket Maximum (Coinsurance Limit)</b></p> <p><b>Maximum Total Benefit Amount</b></p>	<p>[Calendar]</p> <p>[NA-\$3000]</p> <p>[NA-50%]</p> <p>[NA- \$10,000]</p> <p>[NA to \$9,500]</p>
<p><b>Accident Benefit</b></p> <p>Does the Policy Deductible and Coinsurance apply to this benefit?</p> <p>Co-payment Amount [per date of service]</p> <p><b>Maximum Accident Benefit Amount for <u>All Covered Facilities</u> [per year]:</b></p> <p><b>Maximum Accident Benefit Amount for all Covered <u>Outpatient</u> Facilities [per year]:</b>                      [Maximum Accident Benefit for Ambulatory Surgical Facility or Day Surgery Facility Benefit Amount] [per year]                      [Maximum Accident Benefit Amount for MRI Facility] [per year]                      [Maximum Accident Benefit Amount for Outpatient Department of a Hospital] [per year]                      [Maximum Accident Benefit Amount for Emergency Room of a Hospital] [per year]</p> <p><b>Maximum Accident Benefit Amount for <u>In-Hospital Confinement</u> [per year]</b></p>	<p>[Yes, No]</p> <p>[N/A - \$500]</p> <p>[NA-\$9500]</p> <p>[\$1,000-\$9500]</p> <p>[N/A]</p> <p>[N/A]</p> <p>[N/A]</p> <p>[N/A]</p> <p>[N/A-\$9500]</p>
<p><b>OPTIONAL RIDERS</b></p>	
<p><b>Sickness Benefit Rider:</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider?</p> <p>Co-payment Amount [per date of service]</p> <p><b>Maximum Sickness Benefit Amount for <u>All Covered Facilities</u> [per year]:</b></p> <p><b>Maximum Sickness Benefit Amount for <u>All Covered Outpatient</u> Facilities [per year]:</b>                      [Maximum Sickness Benefit Amount for Ambulatory Surgical Facility or Day Surgery Facility] [per year]                      [Maximum Sickness Benefit Amount for MRI Facility] [ per year]                      [Maximum Sickness Benefit Amount for Outpatient Department of a Hospital] [per year]                      [Maximum Sickness Benefit Amount for Emergency Room of a Hospital] [per year]</p> <p>Maximum Sickness Benefit Amount for <u>In-Hospital Confinement</u> [per year]</p>	<p>[Yes, No]</p> <p>[Yes, No]</p> <p>[N/A- \$500]</p> <p>[NA-\$9,500]</p> <p>[N/A -\$9,500]</p> <p>[N/A- \$9500]</p> <p>[N/A-\$9500]</p> <p>[N/A-\$9500]</p> <p>[N/A-\$9500]</p> <p>[N/A-\$9500]</p>
<p><b>Hospital Indemnity Sickness Benefit Rider</b></p> <p>Maximum Hospital Indemnity Benefit Amount: [per day]</p> <p>Maximum number of days [per insured person per year]</p>	<p>[Yes, No]</p> <p>[N/A -\$5000]</p> <p>[N/A-10]</p>
<p><b>Outpatient Physician's Expense Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider?</p> <p>Co-payment Amount [per visit]</p> <p>Maximum Outpatient Physician's Expense Benefit Amount [per visit]</p> <p>Maximum Outpatient Physician's Expense Benefit – [number of visits per Year]</p> <p>Maximum Outpatient Physician's Expense Benefit Amount [Per Sickness or Injury per Calendar Year]</p> <p>Maximum Outpatient Physician's Expense Benefit Amount [Per Insured Person per Calendar Year]</p> <p>Maximum Outpatient Physician's Expense Benefit Amount [For All Insured Persons per Calendar Year]</p>	<p>[Yes, No]</p> <p>[Yes, No]</p> <p>[N/A -\$50]</p> <p>[N/A-\$500]</p> <p>[N/A – 10]</p> <p>[N/A-\$500]</p> <p>[N/A-\$5000]</p> <p>[N/A-\$10,000]</p>

**OPTIONAL RIDERS**

<p><b>Ambulance Benefit Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider? Benefit Amount [per year per covered person] Maximum Benefit [per year per family]</p>	<p>[Yes, No]</p> <p>[Yes, No] [N/A- \$1000] [N/A-\$3000]</p>
<p><b>Generic Outpatient Prescription Drug Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider? [Dispensing limit] [Prescription Drug Rider Deductible] [Prescription Drug Rider Co-insurance %] [Out of Pocket Maximum –Rider Coinsurance] [Co-payment Amount Generic (greater of)] [Maximum Benefit Amount per Calendar Year per insured] [Maximum Number of Outpatient Prescriptions]</p> <p>[Per Sickness or Injury] [Per Insured Person] [For All Insured Persons]</p>	<p>[Yes, No]</p> <p>[N/A- 30 days] [N/A-\$100] [N/A- 50%] [N/A-\$5000] [N/A\$10 or 10%] [N/A-\$1000] [N/A-2] [N/A-10] [N/A-20]</p>
<p><b>Brand [and Generic] Outpatient Prescription Drug Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider? [Dispensing limit] [Prescription Drug Rider Deductible] [Prescription Drug Rider Co-insurance %] [Out of Pocket Maximum –Rider Coinsurance] [Co-payment Amount Generic (greater of)] [Co-payment Amount Preferred Brand (greater of)] [Co-payment Amount Non-Preferred Brand (greater of)] [Co-payment Amount Oral Contraceptives] [Co-payment Amount Migraine Kits]</p> <p>[Brand Name-Outpatient Prescription Drug Expense Benefit Amount per Calendar Year per insured] [Maximum Number of Outpatient Prescriptions]</p> <p>[Per Sickness or Injury] [Per Insured Person] [For All Insured Persons]</p>	<p>[Yes, No]</p> <p>[Yes, No] [N/A- 30 days] [N/A-\$100] [N/A- 50%] [N/A-\$5000] [N/A-\$10 or 10%] [N/A-\$35 or 35%] [N/A-\$50 or 50%] [N/A- \$50] [One applicable co-pay per kit] [N/A-\$1000]</p> <p>[N/A-2] [N/A-10] [N/A-20]</p>
<p><b>Outpatient Physical and Wellness Examination Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider? Co-payment Amount Outpatient Physical Examination and Wellness Benefit Amount per person per year Maximum Number of Outpatient Physical Examination and Wellness Benefits Payable for All Insured Persons per Calendar Year</p>	<p>[Yes, No]</p> <p>[Yes, No] [N/A -\$50] [N/A -\$250]</p> <p>[N/A-2]</p>
<p><b>Outpatient Diagnostic Test and Lab Rider</b></p>	<p>[Yes, No]</p>
<p><b>Prior Plan Deductible Credit Rider</b></p>	<p>[Yes, No]</p>
<p><b>Allied Service Rider</b></p>	<p>[Yes, No]</p>

THIS SCHEDULE IS ATTACHED TO AND MADE PART OF YOUR POLICY. THIS SCHEDULE REPLACES AND CANCELS ALL OTHER SCHEDULES ISSUED PRIOR TO THE EFFECTIVE DATE FOR THE ELIGIBLE PERSONS UNDER THIS POLICY.

## Definitions

### Important Notice: Additional Definitions are in the Benefits Provisions of the Policy and/or Rider Provisions

Whenever used in this Policy:

**Accident** means a sudden and unexpected event resulting in Injury

**Calendar Year** means the one (1) year period beginning January 1 and ending December 31 of the same year.

**Certificate** means the Certificate of Insurance issued to the Insured. It describes the coverage under this Policy.

**Company, Our, We or Us** means Commercial Travelers Mutual Insurance Company.

**Coinsurance** means the portion of the Covered Charges which the insured is required to pay after the Deductible before benefits are payable for any benefit that has a coinsurance requirement. The Coinsurance Limit is shown in the schedule.

**Co-payment or Co-payment Amount** means the specified dollar amount of Covered Expenses that must be paid by an Insured Person before benefits are payable under the Policy or Rider that has a Co-payment Amount.

**Covered Charges** means that portion of the charge allowed by the Insured Person's Major Medical Plan or Comprehensive Health Plan for Medically Necessary expenses which are specified, described and limited in the Policy or Rider for which benefits are payable under the Policy as the result of covered Injury of Sickness.

**Covered Hospital Confinement, In-Hospital or In-Hospital Confinement** means Hospital confinement of an Insured Person for which Benefits are payable under the Policy or any Rider elected by the Insured and which is:

1. Due to a covered Injury [or Sickness]; and
2. For a period of no less than [twenty-four (24) hours]; and
3. At the direction of and under the supervision of a Physician.

**Day Surgery Facility or Ambulatory Surgical Center** means any licensed public or private establishment with an organized medical staff of Physicians. The establishment must have permanent facilities equipped and operated solely for performing surgical procedures. This facility must not provide services or other accommodations for patients to stay overnight. It does not include [a Hospital emergency room, trauma center, center for termination of pregnancy, or surgery in a Physician's office].

**Deductible** means that portion of the Covered Charges, incurred during the Year, which an Insured Person is required to pay before benefits are payable for any Benefit that has a Deductible requirement. The Deductible amount is shown in the Schedule.

**Effective Date** means the date insurance begins under the Policy for an Insured Person. Insurance will begin as of the first of the month following Our approval and payment of the first premium. In no event will coverage for any person become effective prior to the Policy Date.

**Eligible Person** means a person who is insured under the Policyholder's Major Medical or Comprehensive Health Plan and who meets the criteria described in the Policy as eligible for insurance. (See the Eligibility Section of the Policy – page 7)

**Hospital** means a legally authorized and operated institution for the care or treatment of sick or injured persons. It must have graduate registered nurses (R.N.) on 24-hour call and organized facilities for diagnosis and surgery under the full-time supervision of a Physician, either on its premises or in facilities available to it on a contractual prearranged basis.

The following do not qualify as a Hospital: an institution, or part of it, which is used mainly as a facility for rest, nursing care, convalescent care, care of the aged, or for remedial education or training. A Hospital is not primarily a psychiatric/substance abuse facility.

**Injury** means bodily harm caused by an accident resulting in trauma. A disease must not directly or indirectly contribute to the bodily harm. The accident must take place while the Policy is in force for the person injured.

**Insured Person** means either an Insured or an Insured Dependent. An **Insured** is an employee of the Policyholder whose coverage under this Policy has become effective and has not been terminated. **Insured Dependent** means any of the following:

- (a) the spouse of an Insured whose coverage under this Policy has become effective and has not terminated; and
- (b) the unmarried dependent child or children of an Insured or of an Insured's spouse whose coverage under this Policy has become effective and has not terminated. Dependent children include stepchildren, legally adopted and foster children.

**Intensive Care Unit, Coronary Care Unit, or Neonatal Intensive Care Unit** means that part of a Hospital that is separated from other hospital facilities; is exclusively reserved for critically ill patients when the attending doctor has prescribed audio-visual observation and/or cardiac monitoring; and provides room and board, specialized registered nurses (R.N.'s) and special life saving equipment and supplies.

**Major Medical Coinsurance** means that portion of the Covered Charges an Insured Person is required to pay after the Major Medical Deductible under his/her Major Medical Plan or Comprehensive Health Plan.

**Major Medical Coinsurance Limit** means the level of Covered Charges, above the Major Medical Deductible, which an Insured Person is no longer required to pay any Major Medical Coinsurance under his/her Major Medical Plan or Comprehensive Health Plan.

**Major Medical Deductible** means that portion of the Covered Charges an Insured Person is required to pay before benefits are payable under his/her Major Medical Plan or Comprehensive Health Plan.

**Major Medical Plan or Comprehensive Health Plan** means a written benefit plan that has a Major Medical Deductible and/or Major Medical Coinsurance provision, funded through insurance or otherwise, that covers hospital, physician and prescription drug expenses incurred by an Insured Person.

**Maximum Benefit Amount** means the maximum dollar amount of benefits payable on account of Covered Charges incurred by any (1) one Insured Person for any benefit or combination of benefits as shown in the Schedule.

**Maximum Total Benefit Amount** [means the maximum dollar amount of benefits payable during any one (1) Year on account of all Covered Charges incurred during that Year by any one (1) Insured under the Policy, the Certificate and all Optional Supplemental Benefits or Riders attached to and made a part of the Policy and the Certificate. The Maximum Total Benefit Amount is shown in the Schedule.]

**Out-of-Pocket Maximum** means the amount (due to Coinsurance) of Covered Charges that the Insured Person must pay per Calendar Year, as specified in the Schedule, exclusive of any Co-payments and Deductibles, before benefits will be payable at 100% for that Calendar Year. The amounts paid by the Insured Person for Covered Charges that do not count towards the Out-of-Pocket Maximum are: Any co-payments; Any deductibles; Charges excluded under this Policy or attached riders.

**Outpatient** means the Insured Person is not confined to a Hospital when covered services are received.

**Outpatient Department of a Hospital** means a part or section of a Hospital that does not provide services or other accommodations for patients to stay overnight, but does provide facilities for laboratory services, x-rays, and other services for the diagnosis or treatment of Sickness or Injury. It does not include a Hospital emergency room, trauma center, or center for termination of pregnancy.

**Physician** means a person who is licensed to practice medicine; and renders treatment within the scope of that license; and is not an immediate relative by blood or marriage to the Insured Person.

**Policy** means the Policy of insurance that We have issued to the Policyholder.

**Policy Date** means the date shown as Policy Date on Page one (1) of the Policy.

**Policyholder** means the employer or organization named as Policyholder on Page one (1) of the Policy.

**Policy Year** means the one (1) year period beginning on the Policy Date and ending on the last day of the twelfth (12<sup>th</sup>) month following the Policy Date.

**[Pre-Existing Condition means:**

An Injury or Sickness that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the Effective Date of coverage; or an Injury or Sickness for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the Effective Date of coverage.

We will not deny, exclude or limit benefits for an Insured Person for losses due to a Pre-Existing Condition incurred more than twelve (12) months following the Effective Date of the Insured Person's coverage.]

**Schedule** means a page in the Policy/Certificate, which outlines benefit amounts, maximums, and limitations, for Insured Persons.

**Sickness** means an Insured Person's illness, disease or condition, including all related complications and recurrences that occur while the Insured Person's coverage is in force.

**Year** means the one (1) year period of time specified in the Schedule. It may be either a Calendar Year or a Policy Year.

**You or Your** means the Policyholder as defined.

## Eligibility

**Eligible Person as used in this Policy means a person who is insured under a Major Medical Plan or Comprehensive Health Plan (CHAMPUS/ TRICARE or Medicaid is not a comprehensive medical plan) and who is:**

**Eligible Person - If enrollment is voluntary, (all premiums are paid by the employee)**

[All active full-time employees working 18 hours or more per week and who are under age seventy will be eligible for coverage.]

Each insured will be eligible for Dependent coverage on the later of the following dates:

1. The day the Insured becomes eligible for insurance; or
2. The day the Insured acquires his or her first Dependent]

**Eligible Person - If employer participates in paying the premiums**

1. [An employee of the Policyholder who is insured by the employer's major medical plan;
2. An employee's dependent spouse or unmarried dependent children who were insured by the employer's major medical plan.]

Eligible new employees or dependents may be added subject to the terms of this Policy.

The first premium must be paid before any insurance is effective. Insurance provided hereunder will terminate with regard to any individual when that individual is no longer an Eligible Person in accordance with the "Termination of Coverage" provision of the Policy.

## Benefit Provisions

### Benefits Payable

Benefits provided by this Policy and any Rider are those:

1. Described in this Policy or on a Rider; and
2. Shown on the Schedule; and
3. For which premiums are paid.

Riders (if any) issued and made a part of this Policy are listed in the Schedule.

### Limitation Applicable to All Benefits including Rider Benefits

If benefits are payable for the same Covered Charges under more than one (1) benefit then, total benefits payable under all such benefits will be limited to the amount of the Covered Charges not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan.

We will not pay during any Year, any amounts otherwise payable, that are subject to the Deductible, Coinsurance or Co-payment amounts (if any), or that exceed the Maximum Benefit Amount(s) or Total Maximum Benefit Amount shown on the Schedule.

### Accident Benefit

We will pay the benefits shown on the Schedule, as the result of a covered Accident, subject to the "Exclusions and Limitations" provision of the Policy when:

1. An Insured Person receives treatment for an Accident in the Outpatient Department of a Hospital, the Emergency Room of a Hospital, MRI facility or an Ambulatory Surgical Facility or Day Surgery Facility or for In-Hospital Confinement; and
2. An Insured Person incurs Accident expenses that are covered by the Insured Person's Major Medical Plan or Comprehensive Health Plan.

[After the Insured Person's Deductible, Coinsurance or Co-payment (if any) have been met,] We will pay:

[That portion of the Covered Charges for Accident expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan because they have been applied to the Major Medical Deductible of the Major Medical Plan or Comprehensive Health Plan;] and

[The Major Medical Coinsurance portion of the Covered Charges for Accident expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan;] but

[We will not pay more than the Accident Benefit Amount shown in the Schedule].

### **Limitations Applicable to the Accident Benefit**

[If an Insured Person is not covered by a Major Medical Plan or Comprehensive Health Plan that provides coverage for Accident expenses on the date the Accident expense is incurred, then We will not pay the Benefits described above; but in lieu of those Benefits, We will pay an Accident Indemnity Benefit equal to {\$50}. Benefits payable under this Benefit are limited to the stated portion of Covered Charges made by a Provider.]

### **[Exclusions and Limitations]**

**[The Policy will pay no benefits for any expenses which result from:]**

1. [Suicide or any attempt thereat, while sane or insane (In Missouri the reference to insanity does not apply);
2. Any intentionally self-inflicted injury or sickness;
3. Rest care or rehabilitative care and treatment;
4. Routine newborn care, including routine nursery charges;
5. Voluntary abortion except, with respect to the Insured or the Insured's covered Dependent:
  - Where such person's life would be endangered if the fetus were carried to term; or
  - Where medical complications have arisen from abortion;
6. Pregnancy of a Dependent child, except for medical complications;
7. Participation in a riot, civil commotion, civil disobedience, or unlawful assembly (This does not include a loss which occurs while acting in a lawful manner within the scope of authority.);
8. Commission of a felony;
9. Participation in a contest of speed in power driven vehicles, parachuting, or hang gliding;
10. Air travel, except:
  - As a fare-paying passenger on a commercial airline on a regularly scheduled route; or
  - As a passenger for transportation only and not as a pilot or crew member;
11. Intoxication (Whether or not a person is intoxicated is determined and defined by the laws and jurisdiction of the geographical area in which the loss occurred.);
12. Alcoholism or drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed;
13. Sex changes;
14. Experimental treatment, drug, or surgery;
15. An act of war, whether declared or undeclared while serving in the military service or any auxiliary unit attached thereto, or while performing police duty as a member of any military or naval organization.  
This exclusion includes Accident sustained or Sickness contracted while in the services of any military, naval, or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the Covered Persons is not covered;
16. Accident or Sickness arising out of and in the course of any occupation for compensation wage or profit. This does not apply to sole proprietors not covered by Workers' Compensation;
17. Any dental services, including treatment, surgery, extractions, or x-rays, unless:
18. (a) Resulting from an Accident occurring while the Covered Person's coverage is in force and if performed within 12 months of the date of such Accident; or (b) Due to congenital disease or anomaly of a covered newborn child;
19. Any expenses incurred for eye exams, eye refractions, eye glasses, contact lenses, or the fitting thereof, or elective surgery performed for the correction of vision;
20. Routine examinations, such as health exams, periodic checkups, or routine physicals unless covered by an optional Rider;
21. Any expense for which benefits are not payable under the Covered Person's Other Medical Plan;
22. Air or ground ambulance;
23. Elective or cosmetic surgery;
24. Drugs (prescription or non-prescription) unless covered by a Rider to this Policy;
25. Sterilization and reversal of sterilization;
26. Any expense that does not meet the definition of Covered Charges;
27. Expense or service that exceeds the Maximum Benefit Amounts, as shown in the Schedule of Benefits;]
28. [Mental illness or functional or organic nervous disorders, regardless of the cause;]
29. [Expenses due to Pre-Existing Conditions - expenses incurred due to an Injury or Sickness that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the Effective Date of coverage; or an Injury or Sickness for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the Effective Date of coverage. We will not deny, exclude or limit benefits for an Insured Person for losses due to a Pre-Existing Condition incurred more than twelve (12) months following the Effective Date of the Insured Person's coverage.]

## TERMINATION OF COVERAGE

Coverage will terminate under this Policy and any Riders on the earliest date that any of the following events occur:

1. For the Insured:
  - a. On the date the Policy terminates;
  - b. As of the premium due date when the required premium remains unpaid, subject to the Grace Period;
  - c. On the premium due date following the date the Insured ceases to be an Eligible Person as defined in the Policy;
2. For the Insured Dependents:
  - a. On the date the Insured's coverage terminates;
  - b. As of the premium due date when the required premium for the Dependents and or spouse remains unpaid, subject to the Grace Period;
  - c. On the premium due date following the date the Insured Dependent ceases to be an Eligible Person.

If a mental or physical disability prevents an unmarried dependent child from self-support when he or she reaches the termination age, he or she may remain insured under the Policy. Proof of such incapacity and dependency must be furnished to Us within thirty-one (31) days of the child's attainment of the termination age and not more frequently than annually thereafter. Coverage will continue as long as the Insured's coverage remains in force, premiums for the Insured Dependent child are paid, and the Insured Dependent child is incapable of self-support.

Termination of the insurance will be without prejudice to any claim incurred before the date of termination.

## CONTINUATION OF COVERAGE

### **[Family and Medical Leave Act of 1993 (FMLA) - Continuation of Benefits**

(Applies to employers with 50 or more employees)

Insureds who have been employed by the Policyholder for at least 12 months and who have performed at least 1,250 hours of work during that period are entitled to 12 work weeks of leave during any 12 month period for one or more of the following reasons:

- the birth of a child to the Insured;
- the placement of a child with the Insured for adoption or foster care;
- to care for the spouse, child or parent of the Insured if such person has a serious health condition; or
- a serious health condition makes the Insured unable to perform the main functions of his or her employment.

An Insured on FMLA leave may continue benefits for the duration of that leave under the same conditions as applied prior to the leave. The terms of the FMLA supersede state family medical leave laws for employers of 50 or more employees insofar as the FMLA provides greater family or medical leave rights than those established by the state law.

### **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**

An Insured who is absent from work due to a period of duty in the uniformed services may have the right to continue benefits for himself and his Insured Dependents in accordance with USERRA provisions. The Insured must pay the required monthly premium for the continued coverage to the employer.

## COBRA

**Continuation of Benefits in Accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (Applies to employers with 20 or more employees).**

### **Applicability**

Federal law requires that employers of 20 or more employees for at least 50% of the preceding year, offer a temporary extension of health coverage to Qualified Beneficiaries when coverage would otherwise end because of the occurrence of one or more of Qualifying Events listed below. Under COBRA, a Qualified Beneficiary is any individual who, on the day before a Qualifying Event, is covered under the Policy and is not already covered under the Policy by reason of another individual's election of COBRA.]

### **Qualifying Event**

For purposes of coverage under COBRA, the term "Qualifying Event" means, with respect to any Insured Person, any of the following events which, but for the continuation coverage required under this part, would result in the loss of coverage for a Qualified Beneficiary.

### **Qualifying Events**

### **Duration of Continued Coverage**

1. death of an Insured	36 months
2. termination of employment for any reason except gross misconduct, or the reduction in hours that would result in loss of coverage	18 months*
3. divorce or legal separation	36 months
4. Insured becomes eligible for Medicare	Dependents and spouse allowed 36 months
5. Insured Dependent no longer meets Insured Dependent eligibility requirements	36 months

\*Coverage may be continued an additional 11 months if the Qualified Beneficiary:

1. is determined disabled for Social Security purposes at the time of the Qualifying Event or within 60 days after continuation coverage begins; and
2. notifies the plan administrator within 60 days from determination (but before the 18 month continuation period ends).

Beneficiaries may be covered by more than one Qualifying Event. However, in no event may the total continuation period exceed 36 months for all Qualifying Events.

### **Notice and Election**

Insured Persons are responsible for notifying the employer in the case of a divorce, legal separation, cessation of dependency or determination of disability by the Social Security Administration. The employer must notify the plan administrator of the Qualifying Event. The employer must notify the Qualified Beneficiaries of their COBRA election rights. The period during which the Qualified Beneficiary must elect or decline continuation of coverage under COBRA ends not earlier than 60 days after the later of (a) the date on which coverage terminates under the Policy by reason of a Qualifying Event, or (b) the date the Qualified Beneficiary receives notice of their COBRA election rights from the plan administrator.

### **Premium Payment**

The Qualified Beneficiary must pay to the employer the required monthly premium. Any Grace Period applying to the employer will also apply to the Qualified Beneficiary, except the first premium payment. Payment of premium for coverage under the period preceding the election must be made within 45 days of the date of election.

**COBRA Termination** occurs at the earlier of:

1. the premium for continued coverage is not paid within 31 days from being due;
2. the Qualified Beneficiary becomes covered under another group medical plan, if that plan does not contain any exclusion or limitation on any Pre-existing Conditions of the Qualified Beneficiary;
3. the Qualified Beneficiary becomes eligible for Medicare;
4. the Qualified Beneficiary, who is divorced from an Insured Employee, remarries and is covered under the new spouse's medical plan; or
5. the employer no longer provides medical benefits of any kind.

## **PREMIUMS**

Premiums must be paid on time to keep this Policy in force. This section explains how and when premiums are to be paid.

### **Payments**

Premium payments are payable at Our Administrative Office or to Our designated agent. The first premium is due on the Effective Date. Each subsequent premium is due on the first day following the interval for which the preceding premium was paid.

### **Right to Change Premium**

We reserve the right, at any time and from time to time, to change all premiums applicable to the Policy and/or any Rider that is made a part of it on any premium due date by giving written notice to You and the Policyholder at least sixty (60) days in advance of the date premium is to be changed.

## **RENEWAL AND TERMINATION**

The Policy, and any Rider that is made a part of it, is renewable at Our option and with Our consent may be renewed from month to month by payment of the applicable premium. The Policyholder or We may terminate the Policy, and any attached Rider on any premium due date by giving at least ninety (90) days written notice to the other party.

## CLAIM PROVISIONS

### Notice of Claim

Written Notice of Claim must be given Us within thirty (30) days after the occurrence or commencement of any covered loss or as soon as reasonably possible thereafter. The Notice of Claim must be sent to Our Administrative Office. Notice must include the name of the Insured Person, the Policy/Certificate number and nature of the loss.

### Claim Forms

When We receive a Notice of Claim, We will send the Insured forms for filing Proof of Loss if claim forms are required. If such forms are required and are not sent or given to the Insured within fifteen (15) days, the Insured will meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of his/her loss.

### Proof of Loss

Written proof of loss must be given Us within ninety (90) days after the occurrence or commencement of any covered loss. Proof of loss must include a copy of the Insured's explanation of benefits (EOB) under the Insured's Major Medical Plan or Comprehensive Health Plan. If it is not reasonably possible to give Us written Proof of Loss in the time required, We will not reduce or deny the claim for this reason alone, if the Proof of Loss is filed as soon as reasonably possible. Nonetheless, unless the Insured is legally incompetent, the Proof of Loss must be provided Us within one (1) year of the time specified.

### Time of Payment of Claims

Any benefit payable under this Policy will be paid not more than 60 days after the Company receives proper written proof of such loss.

### Payment of Claims

All benefits will be payable to the Insured, unless We receive written Assignment of benefits to the provider of covered services. Any accrued benefits unpaid at the Insured's death will be paid to the Insured's estate.

## GENERAL PROVISIONS

### Entire Contract

The Policy, the Policyholder's Application, along with the Insured's application(s), if any, and any endorsements and/or riders, is the entire contract between the Policyholder and the Company. All statements made by the Insured or the Policyholder, in the absence of fraud, will be deemed representations and not warranties. No such statement will void the insurance or reduce the benefits under this Policy or be used in defense of a claim unless it is contained in a written application and a copy is provided to the Insured Person or beneficiary. No change in this Policy will be valid until approved by one of Our officers. This approval must be endorsed on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

### Grace Period

We will allow a period of thirty-one (31) days after the premium due date for payment of each premium after the first premium payment. The Insured's coverage is in force during this period.

### Time Limit on Certain Defenses

After the Policy has been in force for two (2) years, it can only be contested for non-payment of premiums. No statement made by an Insured Person can be used in a contest after his/her insurance has been in force for two years during his/her lifetime. No statement an Insured Person makes can be used in a contest unless it is in writing and signed by him/her.

We will not reduce or deny a claim for covered loss after such two (2) year period has elapsed because a Sickness or physical condition existed prior to the date the Insured Person became insured hereunder, unless the Sickness or physical condition was excluded from coverage by name or specific description on the date the loss was incurred.

### Conformity with State Statutes

Any provision of the Policy that, on its Effective Date, is in conflict with the laws of the state in which the Policy is issued is amended to conform to the minimum requirements of such laws.

### Certificates

We will issue Certificates to be provided by the Policyholder to each Insured. The Certificate will describe: the benefits to which each Insured Person is entitled under the Policy; to whom such benefits are payable; the limitations, exclusions and requirements of the Policy.

**Policy Inspection**

The Policy may be inspected by the Insured or the Insured Dependent at any time during the regular business hours of the Policyholder.

**Policy Amendments Provision**

Subject to the laws of the state in which the Policy is issued, it may be changed at any time by written amendment agreed to by the Policyholder and Us. Premium rates may be changed according to the "Premiums" section. Any amendments to the Policy will be binding on You, whether You were insured prior to or after the Effective Date of the amendment.

**Legal Actions**

No action at law or in equity shall be brought to recover under this Policy prior to the expiration of sixty (60) days after written Proof of Loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of [three (3)] years after the time written Proof of Loss is required to be furnished.

**Misstatement of [Sex or] Age**

If relevant facts about the Insured Person were not accurate, an adjustment of premium will be made and the true facts will decide in what amount insurance is valid under this Policy.

**Clerical Error Provisions**

Clerical error or delays in keeping records for the Policy:

1. Will not deny insurance, which would otherwise have been granted;
2. Will not continue insurance which would otherwise have ceased; and
3. Will call for an adjustment of premiums or benefits to correct the error.

**Workers' Compensation or Workmen's Compensation Not Affected**

The Policy is not in place of and does not affect any requirements for coverage by Workers' Compensation Insurance or Workmen's Compensation Insurance.

**Physical Examination**

We have the unqualified right to have any Insured Person medically examined, at Our expense, as often as reasonably necessary while a claim is pending.

**ERISA**

The Policyholder has established and maintains an employee welfare benefit plan as defined in the Employee Retirement Security Act of 1974, as amended, to provide the benefits described in the Policy to its employees and their dependents. These benefits are insured by the Company under the Policy, which the Policyholder endorses. The Policyholder is the Plan Administrator, Plan Sponsor, named fiduciary, and, if applicable, Plan Trustee, for the Plan. For more information about the plan, consult the Policy. ERISA does not apply to certain plans, such as government plans and church plans.

# **Commercial Travelers Mutual Insurance Company**

**70 Genesee Street  
Utica, New York 13502  
Telephone (800) 422-6200**

(Herein called the Company)

## **CERTIFICATE OF INSURANCE**

This Certificate of Insurance summarizes Your rights and benefits under the Policy. Coverage is provided under the Policy for benefits described in the Policy and this Certificate. Benefits payable under this Certificate of Insurance are subject to all of the provisions contained in the Policy. This Certificate provides evidence of coverage under the Policy, but is not the contract of insurance. **READ THESE PAGES WITH CARE.**

All periods of time under the Policy will begin and end at 12:01 A.M. local time at the Policyholder's address.

The insurance of the Insured reflected by this Certificate is further subject to any modifications of the Policy entered into by mutual agreement between the Company and the Policyholder as of the date of such modification.

President

### **Right of Examination**

If for any reason You are not satisfied with this Policy, You may return it to Us within ten (10) days after You receive it. Any premium paid will be refunded.

## **SUPPLEMENTAL GROUP ACCIDENT CERTIFICATE**

**THIS IS A LIMITED HEALTH INSURANCE PLAN NOT BEING OFFERED AS A SUBSTITUTE FOR HOSPITAL OR MEDICAL EXPENSE INSURANCE OR MAJOR MEDICAL EXPENSE INSURANCE**

**RENEWABLE AT THE OPTION OF THE COMPANY**

**NON-PARTICIPATING**

**PLEASE READ CAREFULLY**

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**POLICY SCHEDULE OF BENEFITS**

<p><b>Year: [Calendar Year or Policy Year]</b></p> <p><b>Deductible</b></p> <p><b>Coinsurance %</b></p> <p><b>Out of Pocket Maximum (Coinsurance Limit)</b></p> <p><b>Maximum Total Benefit Amount</b></p>	<p>[Calendar]</p> <p>[NA-\$3000]</p> <p>[NA-50%]</p> <p>[NA- \$10,000]</p> <p>[NA to \$9,500]</p>
<p><b>Accident Benefit</b></p> <p>Does the Policy Deductible and Coinsurance apply to this benefit?</p> <p>Co-payment Amount [per date of service]</p> <p><b>Maximum Accident Benefit Amount for <u>All Covered Facilities</u> [per year]:</b></p> <p><b>Maximum Accident Benefit Amount for all Covered <u>Outpatient</u> Facilities [per year]:</b>                      [Maximum Accident Benefit for Ambulatory Surgical Facility or Day Surgery Facility Benefit Amount] [per year]                      [Maximum Accident Benefit Amount for MRI Facility] [per year]                      [Maximum Accident Benefit Amount for Outpatient Department of a Hospital] [per year]                      [Maximum Accident Benefit Amount for Emergency Room of a Hospital] [per year]</p> <p><b>Maximum Accident Benefit Amount for <u>In-Hospital Confinement</u> [per year]</b></p>	<p>[Yes, No]</p> <p>[N/A - \$500]</p> <p>[NA - \$9500]</p> <p>[\$1,000-\$9500]</p> <p>[N/A]</p> <p>[N/A]</p> <p>[N/A]</p> <p>[N/A]</p> <p>[N/A-\$9500]</p>
<p><b>OPTIONAL RIDERS</b></p>	
<p><b>Sickness Benefit Rider:</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider?</p> <p>Co-payment Amount [per date of service]</p> <p><b>Maximum Sickness Benefit Amount for <u>All Covered Facilities</u> [per year]:</b></p> <p><b>Maximum Sickness Benefit Amount for All Covered <u>Outpatient</u> Facilities [per year]:</b>                      [Maximum Sickness Benefit Amount for Ambulatory Surgical Facility or Day Surgery Facility] [per year]                      [Maximum Sickness Benefit Amount for MRI Facility] [ per year]                      [Maximum Sickness Benefit Amount for Outpatient Department of a Hospital] [per year]                      [Maximum Sickness Benefit Amount for Emergency Room of a Hospital] [per year]</p> <p>Maximum Sickness Benefit Amount for <u>In-Hospital Confinement</u> [per year]</p>	<p>[Yes, No]</p> <p>[Yes, No]</p> <p>[N/A- \$500]</p> <p>[NA-\$9,500]</p> <p>[N/A -\$9,500]</p> <p>[N/A- \$9500]</p> <p>[N/A-\$9500]</p> <p>[N/A-\$9500]</p> <p>[N/A-\$9500]</p> <p>[N/A-\$9500]</p>
<p><b>Hospital Indemnity Sickness Benefit Rider</b></p> <p>Maximum Hospital Indemnity Benefit Amount: [per day]</p> <p>Maximum number of days [per insured person per year]</p>	<p>[Yes, No]</p> <p>[N/A -\$5000]</p> <p>[N/A-10]</p>
<p><b>Outpatient Physician's Expense Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider?</p> <p>Co-payment Amount [per visit]</p> <p>Maximum Outpatient Physician's Expense Benefit Amount [per visit]</p> <p>Maximum Outpatient Physician's Expense Benefit – [number of visits per Year]</p> <p>Maximum Outpatient Physician's Expense Benefit Amount [Per Sickness or Injury per Calendar Year]</p> <p>Maximum Outpatient Physician's Expense Benefit Amount [Per Insured Person per Calendar Year]</p> <p>Maximum Outpatient Physician's Expense Benefit Amount [For All Insured Persons per Calendar Year]</p>	<p>[Yes, No]</p> <p>[Yes, No]</p> <p>[N/A -\$50]</p> <p>[N/A-\$500]</p> <p>[N/A – 10]</p> <p>[N/A-\$500]</p> <p>[N/A-\$5000]</p> <p>[N/A-\$10,000]</p>

**OPTIONAL RIDERS**

<p><b>Ambulance Benefit Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider?          Benefit Amount [per year per covered person]          Maximum Benefit [per year per family]</p>	<p>[Yes, No]</p> <p>[Yes, No]          [N/A- \$1000]          [N/A-\$3000]</p>
<p><b>Generic Outpatient Prescription Drug Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider?          [Dispensing limit]          [Prescription Drug Rider Deductible]          [Prescription Drug Rider Co-insurance %]          [Out of Pocket Maximum –Rider Coinsurance]          [Co-payment Amount Generic (greater of)]          [Maximum Benefit Amount per Calendar Year per insured]          [Maximum Number of Outpatient Prescriptions]</p> <p style="text-align: right;">[Per Sickness or Injury]          [Per Insured Person]          [For All Insured Persons]</p>	<p>[Yes, No]</p> <p>[N/A- 30 days]          [N/A-\$100]          [N/A -50%]          [N/A-\$5000]          [N/A\$10 or 10%]          [N/A-\$1000]          [N/A-2]          [N/A-10]          [N/A-20]</p>
<p><b>Brand [and Generic] Outpatient Prescription Drug Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider?          [Dispensing limit]          [Prescription Drug Rider Deductible]          [Prescription Drug Rider Co-insurance %]          [Out of Pocket Maximum –Rider Coinsurance]          [Co-payment Amount Generic (greater of)]          [Co-payment Amount Preferred Brand (greater of)]          [Co-payment Amount Non-Preferred Brand (greater of)]          [Co-payment Amount Oral Contraceptives]          [Co-payment Amount Migraine Kits]</p> <p>[Brand Name-Outpatient Prescription Drug Expense Benefit Amount per Calendar Year per insured]          [Maximum Number of Outpatient Prescriptions]</p> <p style="text-align: right;">[Per Sickness or Injury]          [Per Insured Person]          [For All Insured Persons]</p>	<p>[Yes, No]</p> <p>[Yes, No]          [N/A- 30 days]          [N/A-\$100]          [N/A -50%]          [N/A-\$5000]          [N/A-\$10 or 10%]          [N/A-\$35 or 35%]          [N/A-\$50 or 50%]          [N/A- \$50]          [One applicable co-pay per kit]          [N/A-\$1000]</p> <p>[N/A-2]          [N/A-10]          [N/A-20]</p>
<p><b>Outpatient Physical and Wellness Examination Rider</b></p> <p>Does the Policy Deductible and Coinsurance apply to this rider?          Co-payment Amount          Outpatient Physical Examination and Wellness Benefit Amount per person per year          Maximum Number of Outpatient Physical Examination and Wellness Benefits Payable for All Insured Persons per Calendar Year</p>	<p>[Yes, No]</p> <p>[Yes, No]          [N/A -\$50]          [N/A -\$250]</p> <p>[N/A-2]</p>
<p><b>Outpatient Diagnostic Test and Lab Rider</b></p>	<p>[Yes, No]</p>
<p><b>Prior Plan Deductible Credit Rider</b></p>	<p>[Yes, No]</p>
<p><b>Allied Service Rider</b></p>	<p>[Yes, No]</p>

THIS SCHEDULE IS ATTACHED TO AND MADE PART OF YOUR CERTIFICATE. THIS SCHEDULE REPLACES AND CANCELS ALL OTHER SCHEDULES ISSUED PRIOR TO THE EFFECTIVE DATE FOR THE ELIGIBLE PERSONS UNDER THIS CERTIFICATE.

## Definitions

### **Important Notice: Additional Definitions are in the Benefits Provisions of the Policy/Certificate and/or Rider Provisions**

Whenever used in the Policy:

**Accident** means a sudden and unexpected event resulting in Injury

**Calendar Year** means the one (1) year period beginning January 1 and ending December 31 of the same year.

**Certificate** means the Certificate of Insurance issued to the Insured. It describes the coverage under the Policy.

**Company, Our, We or Us** means Commercial Travelers Mutual Insurance Company.

**Coinsurance** means the portion of the Covered Charges which the insured is required to pay after the Deductible before benefits are payable for any benefit that has a coinsurance requirement. The Coinsurance Limit is shown in the schedule.

**Co-payment or Co-payment Amount** means the specified dollar amount of Covered Expenses that must be paid by an Insured Person before benefits are payable under the Policy or Rider that has a Co-payment Amount.

**Covered Charges** means that portion of the charge allowed by the Insured Person's Major Medical Plan or Comprehensive Health Plan for Medically Necessary expenses which are specified, described and limited in the Policy or Rider for which benefits are payable under the Policy as the result of covered Injury of Sickness.

**Covered Hospital Confinement, In-Hospital or In-Hospital Confinement** means Hospital confinement of an Insured Person for which Benefits are payable under the Policy or any Rider elected by the Insured and which is:

1. Due to covered Injury [or Sickness]; and
2. For a period of no less than [twenty-four (24) hours]; and
3. At the direction of and under the supervision of a Physician.

**Day Surgery Facility or Ambulatory Surgical Center** means any licensed public or private establishment with an organized medical staff of Physicians. The establishment must have permanent facilities equipped and operated solely for performing surgical procedures. This facility must not provide services or other accommodations for patients to stay overnight. It does not include [a Hospital emergency room, trauma center, center for termination of pregnancy, or surgery in a physician's office].

**Deductible** means that portion of the Covered Charges, incurred during the Year, which an Insured Person is required to pay before benefits are payable for any Benefit that has a Deductible requirement. The Deductible amount is shown in the Schedule.

**Effective Date** means the date insurance begins under the Policy for an Insured Person. Insurance will begin as of the first of the month following Our approval and payment of the first premium. In no event will coverage for any person become effective prior to the Policy Date.

**Eligible Person** means a person who is insured under the Policyholder's Major medical or Comprehensive Health Plan and who meets the criteria described in the Policy as eligible for insurance. (See the Eligibility Section of the Policy – page 7)

**Hospital** means a legally authorized and operated institution for the care or treatment of sick or injured persons. It must have graduate registered nurses (R.N.'s) on 24-hour call and organized facilities for diagnosis and surgery under the full-time supervision of a Physician, either on its premises or in facilities available to it on a contractual prearranged basis.

The following do not qualify as a Hospital: an institution, or part of it, which is used mainly as a facility for rest, nursing care, convalescent care, care of the aged, or for remedial education or training. A Hospital is not primarily a psychiatric/substance abuse facility.

**Injury** means bodily harm caused by an accident resulting in trauma. A disease must not directly or indirectly contribute to the bodily harm. The accident must take place while the Policy/Certificate is in force for the person injured.

**Insured Person** means either an Insured or an Insured Dependent. An **Insured** is an employee of the Policyholder whose coverage under the Policy has become effective and has not been terminated. **Insured Dependent** means any of the following:

- (a) the spouse of an Insured whose coverage under the Policy has become effective and has not terminated; and
- (b) the unmarried dependent child or children of an Insured or of an Insured's spouse whose coverage under the Policy has become effective and has not terminated. Dependent children include stepchildren, legally adopted and foster children.

**Intensive Care Unit, Coronary Care Unit, or Neonatal Intensive Care Unit** means that part of a Hospital that is separated from other hospital facilities; is exclusively reserved for critically ill patients when the attending doctor has prescribed audio-visual observation and/or cardiac monitoring; and provides room and board, specialized registered nurses (R.N.'s) and special life saving equipment and supplies.

**Major Medical Coinsurance** means that portion of the Covered Charges an Insured Person is required to pay after the Major Medical Deductible under his/her Major Medical Plan or Comprehensive Health Plan.

**Major Medical Coinsurance Limit** means the level of Covered Charges, above the Major Medical Deductible, which an Insured Person is no longer required to pay any Major Medical Coinsurance under his/her Major Medical Plan or Comprehensive Health Plan.

**Major Medical Deductible** means that portion of the Covered Charges an Insured Person is required to pay before benefits are payable under his/her Major Medical Plan or Comprehensive Health Plan.

**Major Medical Plan or Comprehensive Health Plan** means a written benefit plan that has a Major Medical Deductible and/or Major Medical Coinsurance provision, funded through insurance or otherwise, that covers hospital, physician and prescription drug expenses incurred by an Insured Person.

**Maximum Benefit Amount** means the maximum dollar amount of benefits payable on account of Covered Charges incurred by any (1) one Insured Person for any benefit or combination of benefits as shown in the Schedule.

**Maximum Total Benefit Amount** [means the maximum dollar amount of benefits payable during any one (1) Year on account of all Covered Charges incurred during that Year by any one (1) Insured under the Policy, this Certificate and all Optional Supplemental Benefits or Riders attached to and made a part of the Policy and this Certificate. The Maximum Total Benefit Amount is shown in the Certificate Schedule.]

**Out-of-Pocket Maximum** means the amount (due to Coinsurance) of Covered Charges that the Insured Person must pay per Calendar Year, as specified in the Schedule, exclusive of any Co-payments and Deductibles, before benefits will be payable at 100% for that Calendar Year. The amounts paid by the Insured Person for Covered Charges that do not count towards the Out-of-Pocket Maximum are: Any co-payments; Any deductibles; Charges excluded under the Policy or attached riders.

**Outpatient** means the Insured Person is not confined to a Hospital when covered services are received.

**Outpatient Department of a Hospital** means a part or section of a Hospital that does not provide services or other accommodations for patients to stay overnight, but does provide facilities for laboratory services, x-rays, and other services for the diagnosis or treatment of Sickness or Injury. It does not include a Hospital emergency room, trauma center, or center for termination of pregnancy.

**Physician** means a person who is licensed to practice medicine; and renders treatment within the scope of that license; and is not an immediate relative by blood or marriage to the Insured Person.

**Policy** means the Policy of insurance that We have issued to the Policyholder.

**Policy Date** means the date shown as Policy Date on Page one (1) of the Policy.

**Policyholder** means the employer or organization named as Policyholder on Page one (1) of the Policy.

**Policy Year** means the one (1) year period beginning on the Policy Date and ending on the last day of the twelfth (12<sup>th</sup>) month following the Policy Date.

**[Pre-Existing Condition means:**

An Injury or Sickness that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the Effective Date of coverage; or an Injury or Sickness for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the Effective Date of coverage.

We will not deny, exclude or limit benefits for an Insured Person for losses due to a Pre-Existing Condition incurred more than twelve (12) months following the Effective Date of the Insured Person's coverage.]

**Schedule** means a page in the Policy/Certificate, which outlines benefit amounts, maximums, and limitations, for Insured Persons.

**Sickness** means an Insured Person's illness, disease or condition, including all related complications and recurrences that occur while the Insured Person's coverage is in force.

**Year** means the one (1) year period of time specified in the Schedule. It may be either a Calendar Year or a Policy Year.

**You or Your** means the Insured as defined.

## **Eligibility**

**Eligible Person as used in the Policy means a person who is insured under a Major Medical Plan or Comprehensive Health Plan (CHAMPUS/ TRICARE or Medicaid is not a comprehensive medical plan) and who is:**

**Eligible Person - If enrollment is voluntary, (all premiums are paid by the employee)**

[All active full-time employees working 18 hours or more per week and who are under age seventy will be eligible for coverage.

Each insured will be eligible for Dependent coverage on the later of the following dates:

1. The day the Insured becomes eligible for insurance; or
2. The day the Insured acquires his or her first Dependent]

**Eligible Person - If employer participates in paying the premiums**

1. [An employee of the Policyholder who is insured by the employer's major medical plan;
2. An employee's dependent spouse or unmarried dependent children who were insured by the employer's major medical plan.]

Eligible new employees or dependents may be added subject to the terms of the Policy.

The first premium must be paid before any insurance is effective. Insurance provided hereunder will terminate with regard to any individual when that individual is no longer an Eligible Person in accordance with the "Termination of Coverage" Provision of the Policy.

## **Benefit Provisions**

### **Benefits Payable**

Benefits provided by the Policy/Certificate and any Rider are those:

1. Described in the Policy/Certificate or on a Rider; and
2. Shown on the Schedule; and
3. For which premiums are paid.

Riders (if any) issued and made a part of the Policy are listed in the Schedule.

### **Limitation Applicable to All Benefits including Rider Benefits**

If benefits are payable for the same Covered Charges under more than one (1) benefit then, total benefits payable under all such benefits will be limited to the amount of the Covered Charges not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan.

We will not pay during any Year, any amounts otherwise payable, that are subject to the Deductible, Coinsurance or Co-payment amounts (if any), or that exceed the Maximum Benefit Amount(s) or Total Maximum Benefit Amount shown on the Schedule.

### **Accident Benefit**

We will pay the benefits shown on the Schedule, as the result of a covered Accident, subject to the "Exclusions and Limitations" provision of the Policy when:

1. An Insured Person receives treatment for an Accident in the Outpatient Department of a Hospital, the Emergency Room of a Hospital, MRI facility or an Ambulatory Surgical Facility or Day Surgery Facility or for In-Hospital Confinement; and
2. An Insured Person incurs Accident expenses that are covered by the Insured Person's Major Medical Plan or Comprehensive Health Plan.

[After the Insured Person's Deductible, Coinsurance or Co-payment (if any) have been met,] We will pay:

[That portion of the Covered Charges for Accident expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan because they have been applied to the Major Medical Deductible of the Major Medical Plan or Comprehensive Health Plan;] and

[The Major Medical Coinsurance portion of the Covered Charges for Accident expenses charged by the provider and not paid by the Insured Person's Major Medical Plan or Comprehensive Health Plan;] but

[We will not pay more than the Accident Benefit Amount shown in the Schedule].

### **Limitations Applicable to the Accident Benefit**

[If an Insured Person is not covered by a Major Medical Plan or Comprehensive Health Plan that provides coverage for Accident expenses on the date the Accident expense is incurred; then We will not pay the Benefits described above, but in lieu of those Benefits We will pay an Accident Indemnity Benefit equal to {\$50}. Benefits payable under this Benefit are limited to the stated portion of Covered Charges made by a Provider.]

### **[Exclusions and Limitations]**

**[The Policy will pay no benefits for any expenses which result from:]**

1. [Suicide or any attempt thereat, while sane or insane (In Missouri the reference to insanity does not apply);
2. Any intentionally self-inflicted Injury or Sickness;
3. Rest care or rehabilitative care and treatment;
4. Routine newborn care, including routine nursery charges;
5. Voluntary abortion except, with respect to the Insured or the Insured's covered Dependent:
  - Where such person's life would be endangered if the fetus were carried to term; or
  - Where medical complications have arisen from abortion;
6. Pregnancy of a Dependent child, except for medical complications;
7. Participation in a riot, civil commotion, civil disobedience, or unlawful assembly (This does not include a loss which occurs while acting in a lawful manner within the scope of authority.);
8. Commission of a felony;
9. Participation in a contest of speed in power driven vehicles, parachuting, or hang gliding;
10. Air travel, except:
  - As a fare-paying passenger on a commercial airline on a regularly scheduled route; or
  - As a passenger for transportation only and not as a pilot or crew member;
11. Intoxication (Whether or not a person is intoxicated is determined and defined by the laws and jurisdiction of the geographical area in which the loss occurred.);
12. Alcoholism or drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed;
13. Sex changes;
14. Experimental treatment, drug, or surgery;
15. An act of war, whether declared or undeclared while serving in the military service or any auxiliary unit attached thereto, or while performing police duty as a member of any military or naval organization.  
This exclusion includes an Accident sustained or Sickness contracted while in the services of any military, naval, or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the Covered Persons is not covered;
16. Accident or Sickness arising out of and in the course of any occupation for compensation wage or profit. This does not apply to sole proprietors not covered by Worker's Compensation;
17. Any dental services, including treatment, surgery, extractions, or x-rays, unless:
18. (a) Resulting from an Accident occurring while the Covered Person's coverage is in force and if performed within 12 months of the date of such Accident; or (b) Due to congenital disease or anomaly of a covered newborn child;
19. Any expenses incurred for eye exams, eye refractions, eye glasses, contact lenses, or the fitting thereof, or elective surgery performed for the correction of vision;
20. Routine examinations, such as health exams, periodic checkups, or routine physicals unless covered by an optional Rider;
21. Any expense for which benefits are not payable under the Covered Person's Other Medical Plan;
22. Air or ground ambulance; or
23. Elective or cosmetic surgery;
24. Drugs (prescription or non-prescription) unless covered by a Rider to the Policy / Certificate;
25. Sterilization and reversal of sterilization;
26. Any expense that does not meet the definition of Covered Charges;
27. Expense or service that exceeds the maximum benefit amounts, as shown in the Certificate or Policy Schedule of Benefits;]
28. [Mental illness or functional or organic nervous disorders, regardless of the cause;]

29. [Expenses due to Pre-Existing Conditions –expenses incurred due to an Injury or Sickness that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the Effective Date of coverage; or an Injury or Sickness for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the Effective Date of coverage. We will not deny, exclude or limit benefits for an Insured Person for losses due to a Pre-Existing condition incurred more than twelve (12) months following the Effective Date of the Insured Person’s coverage.]

## **TERMINATION OF COVERAGE**

Coverage will terminate under the Policy and any Riders on the earliest date that any of the following events occur:

1. For the Insured:
  - a. On the date the Policy terminates;
  - b. As of the premium due date when the required premium remains unpaid, subject to the Grace Period;
  - c. On the premium due date following the date the Insured cease to be an Eligible Person as defined in the Policy;
2. For the Insured Dependents:
  - a. On the date the Insured’s coverage terminates;
  - b. As of the premium due date when the required premium for the dependents and or spouse remains unpaid, subject to the Grace Period;
  - c. On the premium due date following the date the Insured Dependent ceases to be an Eligible Person.

If a mental or physical disability prevents an unmarried dependent child from self-support when he or she reaches the termination age, he or she may remain insured under the Policy. Proof of such incapacity and dependency must be furnished to Us within thirty-one (31) days of the child’s attainment of the termination age and not more frequently than annually thereafter. Coverage will continue as long as Your coverage remains in force, premiums for the dependent child are paid, and the dependent child is incapable of self-support.

Termination of the insurance will be without prejudice to any claim incurred before the date of termination.

## **CONTINUATION OF COVERAGE**

### **Family and Medical Leave Act of 1993 (FMLA) - Continuation of Benefits**

(Applies to employers with 50 or more employees)

Insureds who have been employed by the Policyholder for at least 12 months and who have performed at least 1,250 hours of work during that period are entitled to 12 work weeks of leave during any 12 month period for one or more of the following reasons:

- the birth of a child to the Insured;
- the placement of a child with the Insured for adoption or foster care;
- to care for the spouse, child or parent of the Insured if such person has a serious health condition; or
- a serious health condition makes the Insured unable to perform the main functions of his or her employment.

An Insured on FMLA leave may continue benefits for the duration of that leave under the same conditions as applied prior to the leave. The terms of the FMLA supersede state family medical leave laws for employers of 50 or more employees insofar as the FMLA provides greater family or medical leave rights than those established by the state law.

### **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**

An Insured who is absent from work due to a period of duty in the uniformed services may have the right to continue benefits for himself and his Insured Dependents in accordance with USERRA provisions. The Insured must pay the required monthly premium for the continued coverage to the employer.

## **COBRA**

**Continuation of Benefits in Accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (Applies to employers with 20 or more employees)**

### **Applicability**

Federal law requires that employers of 20 or more employees for at least 50% of the preceding year, offer a temporary extension of health coverage to Qualified Beneficiaries when coverage would otherwise end because of the occurrence of one or more of Qualifying Events listed below. Under COBRA, a Qualified Beneficiary is any individual who, on the day before a Qualifying Event, is covered under the Policy and is not already covered under the Policy by reason of another individual's election of COBRA.

**Qualifying Event**

For purposes of coverage under COBRA, the term "Qualifying Event" means, with respect to any Insured Person, any of the following events which, but for the continuation coverage required under this part, would result in the loss of coverage for a Qualified Beneficiary.

## **Qualifying Events**

## **Duration of Continued Coverage**

1. death of an Insured	36 months
2. termination of employment for any reason except gross misconduct, or the reduction in hours that would result in loss of coverage	18 months*
3. divorce or legal separation	36 months
4. Insured becomes eligible for Medicare	Dependents and spouse allowed 36 months
5. Insured Dependent no longer meets Insured Dependent eligibility requirements	36 months

\*Coverage may be continued an additional 11 months if the Qualified Beneficiary:

1. is determined disabled for Social Security purposes at the time of the Qualifying Event or within 60 days after continuation coverage begins; and
2. notifies the plan administrator within 60 days from determination (but before the 18 month continuation period ends).

Beneficiaries may be covered by more than one Qualifying Event. However, in no event may the total continuation period exceed 36 months for all Qualifying Events.

## **Notice and Election**

Insured Persons are responsible for notifying the employer in the case of a divorce, legal separation, cessation of dependency or determination of disability by the Social Security Administration. The employer must notify the plan administrator of the Qualifying Event. The employer must notify the Qualified Beneficiaries of their COBRA election rights. The period during which the Qualified Beneficiary must elect or decline continuation of coverage under COBRA ends not earlier than 60 days after the later of (a) the date on which coverage terminates under the Policy by reason of a Qualifying Event, or (b) the date the Qualified Beneficiary receives notice of their COBRA election rights from the plan administrator.

## **Premium Payment**

The Qualified Beneficiary must pay to the employer the required monthly premium. Any Grace Period applying to the employer will also apply to the Qualified Beneficiary, except the first premium payment. Payment of premium for coverage under the period preceding the election must be made within 45 days of the date of election.

**COBRA Termination** occurs at the earlier of:

1. the premium for continued coverage is not paid within 31 days from being due;
2. the Qualified Beneficiary becomes covered under another group medical plan, if that plan does not contain any exclusion or limitation on any Pre-existing Conditions of the Qualified Beneficiary;
3. the Qualified Beneficiary becomes eligible for Medicare;
4. the Qualified Beneficiary, who is divorced from an Insured Employee, remarries and is covered under the new spouse's medical plan; or
5. the employer no longer provides medical benefits of any kind.

## **PREMIUMS**

Premiums must be paid on time to keep the Policy/Certificate in force. This section explains how and when premiums are to be paid.

### **Payments**

Premium payments are payable at Our Administrative Office or to Our designated agent. The first premium is due on the Effective Date. Each subsequent premium is due on the first day following the interval for which the preceding premium was paid.

### **Right to Change Premium**

We reserve the right, at any time and from time to time, to change all premiums applicable to the Policy and/or any Rider that is made a part of it on any premium due date by giving written notice to You and the Policyholder at least sixty (60) days in advance of the date premium is to be changed.

## RENEWAL AND TERMINATION

The Policy, and any Rider that is made a part of it, is renewable at Our option and with Our consent may be renewed from month to month by payment of the applicable premium. The Policyholder or We may terminate the Policy, and any Rider on any premium due date by giving at least ninety (90) days written notice to the other party.

## CLAIM PROVISIONS

### Notice of Claim

Written Notice of Claim must be given Us within thirty (30) days after the occurrence or commencement of any covered loss or as soon as reasonably possible thereafter. The Notice of Claim must be sent to Our Administrative Office. Notice must include the name of the Insured Person, the Policy/Certificate number and nature of the loss.

### Claim Forms

When We receive a Notice of Claim, We will send the Insured forms for filing Proof of Loss if claim forms are required. If such forms are required and are not sent or given to the Insured within fifteen (15) days, the Insured will meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of his/her loss.

### Proof of Loss

Written proof of loss must be given Us within ninety (90) days after the occurrence or commencement of any covered loss. Proof of loss must include a copy of the Insured's explanation of benefits (EOB) under the Insured's Major Medical Plan or Comprehensive Health Plan. If it is not reasonably possible to give Us written Proof of Loss in the time required, We will not reduce or deny the claim for this reason alone, if the Proof of Loss is filed as soon as reasonably possible. Nonetheless, unless the Insured is legally incompetent, the Proof of Loss must be provided Us within one (1) year of the time specified.

### Time of Payment of Claims

Any benefit payable under this Policy will be paid not more than 60 days after the Company receives proper written proof of such loss.

### Payment of Claims

All benefits will be payable to the Insured, unless We receive written Assignment of benefits to the provider of covered services. Any accrued benefits unpaid at the Insured's death will be paid to the Insured's estate.

## GENERAL PROVISIONS

### Entire Contract

The Policy, the Policyholder's Application, along with the Insured's application, if any, and any endorsements and/or riders, is the entire contract between the Policyholder and the Company. All statements made by the Insured or the Policyholder, in the absence of fraud, will be deemed representations and not warranties. No such statement will void the insurance or reduce the benefits under the Policy or be used in defense of a claim unless it is contained in a written application and a copy is provided to the Insured Person or beneficiary. No change in the Policy will be valid until approved by one of our officers. This approval must be endorsed on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

### Grace Period

We will allow a period of thirty-one (31) days after the premium due date for payment of each premium after the first premium payment. Your coverage is in force during this period.

### Time Limit on Certain Defenses

After the Policy/Certificate has been in force for two (2) years, it can only be contested for non-payment of premiums. No statement made by an Insured Person can be used in a contest after his/her insurance has been in force for two years during his/her lifetime. No statement an Insured Person makes can be used in a contest unless it is in writing and signed by him/her.

We will not reduce or deny a claim for covered loss after such two (2) year period has elapsed because a Sickness or physical condition existed prior to the date the Insured Person became insured hereunder, unless the Sickness or physical condition was excluded from coverage by name or specific description on the date the loss was incurred.

**Conformity with State Statutes**

Any provision of the Policy that, on its Effective Date, is in conflict with the laws of the state in which the Policy is issued is amended to conform to the minimum requirements of such laws.

**Certificates**

We will issue Certificates to be provided by the Policyholder to each Insured. The Certificate will describe: The benefits to which each Insured Person is entitled under the Policy; to whom such benefits are payable; the limitations, exclusions and requirements of the Policy.

**Policy Inspection**

The Policy may be inspected by You or Your Insured Dependent at any time during the regular business hours of the Policyholder.

**Policy Amendment Provision**

Subject to the laws of the state in which the Policy is issued, it may be changed at any time by written amendment agreed to by the Policyholder and Us. Premium rates may be changed according to the "Premiums" section. Any amendments to the Policy will be binding on You, whether You were insured prior to or after the Effective Date of the amendment.

**Legal Actions**

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

**Misstatement of [Sex or] Age**

If relevant facts about the Insured Person were not accurate, an adjustment of premium will be made and the true facts will decide in what amount insurance is valid under this Policy.

**Clerical Error Provisions**

Clerical error or delays in keeping records for the Policy:

1. Will not deny insurance which would otherwise have been granted;
2. Will not continue insurance which would otherwise have ceased; and
3. Will call for an adjustment of premiums or benefits to correct the error.

**Workers' Compensation or Workmen's Compensation Not Affected**

The Policy is not in place of and does not affect any requirements for coverage by Workers' Compensation Insurance or Workmen's Compensation Insurance.

**Physical Examination**

We have the unqualified right to have any Insured Person medically examined, at Our expense, as often as reasonably necessary while a claim is pending.

**ERISA**

The Policyholder has established and maintains an employee welfare benefit plan as defined in the Employee Retirement Security Act of 1974, as amended, to provide the benefits described in the Policy to its employees and their dependents. These benefits are insured by the Company under the Policy, which the Policyholder endorses. The Policyholder is the Plan Administrator, Plan Sponsor, named fiduciary, and, if applicable, Plan Trustee, for the Plan. For more information about the plan, consult the Policy. ERISA does not apply to certain plans, such as government plans and church plans.