

SERFF Tracking Number: ASWX-G126715758 State: Arkansas
 Filing Company: Time Insurance Company State Tracking Number: 46175
 Company Tracking Number: AR01104FI00005
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: Time Insurance-Base Chassis
 Project Name/Number: Time Insurance-Base Chassis/AR01104FI00005

Filing at a Glance

Company: Time Insurance Company

Product Name: Time Insurance-Base Chassis SERFF Tr Num: ASWX-G126715758 State: Arkansas

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved-Closed State Tr Num: 46175

Sub-TOI: H16G.001C Any Size Group - Other Co Tr Num: AR01104FI00005 State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor

Author: SPI Disposition Date: 08/02/2010

AssurantHealthandEmployeeBenef

Date Submitted: 07/09/2010 Disposition Status: Approved-Closed

Implementation Date Requested: 08/09/2010

Implementation Date:

State Filing Description:

General Information

Project Name: Time Insurance-Base Chassis

Project Number: AR01104FI00005

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/02/2010

Deemer Date:

Submitted By: SPI AssurantHealthandEmployeeBenef

PPACA: Grandfathered Immed Mkt Reforms

Filing Description:

NOT PPACA RELATED

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 08/02/2010

Created By: SPI

AssurantHealthandEmployeeBenef

Corresponding Filing Tracking Number:

Re: Time Insurance Company (NAIC #: 69477; FEIN: 39-0658730)

Amendment Rider 9184.XX

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Dear Sir or Madam:

The enclosed form is hereby submitted for your review and approval.

Mater policy form TIM.MPO.XX and all related forms have been issued by Time Insurance Company to an association with situs in the state of Illinois, and the enclosed form will be issued only to individual members of the association residing out of the state of Illinois.

Assurant Health is comprised of Time Insurance Company and John Alden Life Insurance Company. We are submitting identical forms for each company. The only difference is the company names. Since Time and John Alden are sister companies and because the forms are identical, we respectfully request that the same analyst review both filings.

This form is subject only to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. Please see the enclosed Statement of Variability for additional information on form adaptability.

Thank you for your time and attention to this filing. If you have any questions, or if we may be of any assistance during your review, please feel free to contact me via telephone or e-mail.

Best Regards,

Christine Fleming
Senior Contract Compliance Analyst
Legal Department
christine.fleming@assurant.com
T 414.299.1306 or 800.800.1212 ext. 1306
F 414.299.6168

Company and Contact

Filing Contact Information

Christine Fleming, Senior Contract Compliance Analyst christine.fleming@assurant.com
Analyst
501 W. Michigan St. 414-299-1306 [Phone] 1306 [Ext]
Milwaukee, WI 53203 414-299-6168 [FAX]

Filing Company Information

Time Insurance Company CoCode: State of Domicile: Wisconsin

SERFF Tracking Number: ASWX-G126715758 State: Arkansas
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 501 W. Michigan St. Group Code: 19 Company Type:
 Milwaukee, WI 53203 Group Name: State ID Number:
 (800) 800-1212 ext. [Phone] FEIN Number: 39-0658730

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Time Insurance Company	\$50.00	07/09/2010	37858315

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/02/2010	08/02/2010

SERFF Tracking Number: ASWX-G126715758 *State:* Arkansas
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Disposition

Disposition Date: 08/02/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Amendment Rider	Approved-Closed	Yes

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Form Schedule

Lead Form Number: 9184.XX

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/02/2010	9184.XX	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Amendment Rider	Initial		40.000	TIC Payment Assurance Rider 9184.PDF

Amendment Rider

The [policy][certificate] to which this rider is attached is amended as follows:

1. The following are added to the Definitions section:

[[Insert Network Name] Participating Provider]

Any Health Care Practitioner, facility or supplier as identified for this plan by [Us or][the Network Manager] who has agreed to accept a Contracted Rate as payment for specific treatment or services and identified for this plan as part of Our [Insert Network Name] Participating Provider Network on the date services are rendered.

[[Insert Network Name] Participating Provider Network]

The group of [Insert Network Name] Participating Providers as identified for this plan by [Us or][the Network Manager], who have agreed to accept a Contracted Rate as payment in full for specific treatment or services and for whom the Non-Insurance Payment Arrangement Program is designated. The list is subject to change at any time without notice.

2. The following provisions are added to the Other Provisions section:

Non-Insurance Payment Arrangement Program

You have elected to participate in a non-insurance program in addition to Your medical insurance policy offered by Us. This program arranges for payment of Your out-of-pocket cost portion of certain medical [claims][charges] billed by [Insert Network Name] Participating Providers (such as amounts under the Deductible or subject to any Coinsurance[,][or] Copayment[, or Access Fees]) when such medical claims are otherwise [eligible for benefits][Covered Charges] under Your policy.

This program arranges for payment only of charges from [Insert Network Name] Participating Providers. **You are responsible for verifying if Your provider is a[n] [Insert Network Name] Participating Provider before any services are rendered.**

This program does not arrange for payment of any other providers, including but not limited to: [Participating Pharmacies,] Non-Participating Pharmacies, Non-Participating Providers, Designated Transplant Providers, [Designated Specialty Providers,][and][or] providers with whom We have a Negotiated or Contracted Rate for certain [ancillary] services but who are not [Insert Network Name] Participating Providers. [For as long as this program is active for Your policy, Your Participating Provider Network will be the [Insert Network Name] Participating Provider Network.]

When You obtain covered treatment or services from an [Insert Network Name] Participating Provider under this program, We will forward payment of Your out-of-pocket cost portion of Covered Charges[, up to the Maximum Allowable Amount,] to the [Insert Network Name] Participating Provider. You will be notified after such payment has occurred and billed by Us or Our administrator for Your portion of the claim. If You fail to make reimbursement to Us, We

may terminate this payment arrangement program and assign a new Participating Provider Network to Your plan.

If You receive services from a provider that is not a [Insert Network Name] Participating Provider, Your out-of-pocket costs will continue to be payable to the provider by You and We will not make payment on Your behalf.

We reserve the right to terminate this payment arrangement program for any reason at any time[for all persons of a similar class]. If this program terminates, Your out-of-pocket costs for services rendered on or after the date of program termination will be payable to the provider by You and We will not make payment on Your behalf.

If this payment arrangement program terminates for any reason, We will issue a new Benefit Summary and ID cards designating a new Participating Provider Network for Your plan. [The new network will not be the [Insert Network Name] Participating Provider Network.]

We will not make or arrange for payment of any expense in excess of any visit or benefit maximum described in the Benefit Summary or elsewhere in the policy, nor for any service or supply excluded or not covered under the terms of the policy.

Payment Arrangement Program Incentives (Non-Insurance Provisions)

When the Non-Insurance Payment Arrangement Program is in force, We may [elect to furnish] [or] [participate in programs with other organizations that furnish] [the Policyholder][the Certificate Holder][individual applicants for coverage][Covered Persons] [individuals] [who meet common criteria or requirements determined by Us] with a premium discount, credit, refund, or other adjustment. If participation under the Non-Insurance Payment Arrangement Program ends for any reason, We may discontinue any premium discount, credit, refund, or other adjustment from the date the program participation ceased and restore the premium rates applicable to the Covered Person's classification of risk as were last made effective by Us in the state of issue prior to the program termination.

When You arrange payment for premium or out of pocket expenses through a designated form of payment, other gifts, rewards or items of value may be offered or provided to You at no charge or a discount at a time or times or for a period determined by Us or by the administrator of the payment arrangement.

Nothing in this rider will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the [policy] [certificate], other than as stated above.

This rider is effective on the Effective Date of the [policy][certificate] to which it is attached, or the endorsement date if later.



Secretary

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	08/02/2010
Comments:		
Attachment:		
AR - READABILITY CERTIFICATION.PDF		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	08/02/2010
Bypass Reason: n/a		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: PPACA Uniform Compliance Summary	Approved-Closed	08/02/2010
Bypass Reason: NOT PPACA RELATED		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter	Approved-Closed	08/02/2010
Comments:		
Attachment:		
Payment Assurance Cover Letter.PDF		

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Time Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
9184.XX	40

Signed: 
Name: Julia Hix-Royer
Title: VP Regulatory Compliance & AH
Compliance Officer
Date: July 9, 2010



ASSURANT
Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

July 8, 2010

www.assurant.com

Arkansas Department of Insurance
1200 W Third Street
Little Rock, AR 72201

Re: **Time Insurance Company (NAIC #: 69477; FEIN: 39-0658730)**
Amendment Rider 9184.XX

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Best Regards,

Christine Fleming
Senior Contract Compliance Analyst
Legal Department
christine.fleming@assurant.com
T 414.299.1306 or 800.800.1212 ext. 1306
F 414.299.6168