

SERFF Tracking Number: ICCI-127782409 State: Arkansas
 Filing Company: American Financial Security Life Insurance Company State Tracking Number: 50136
 Company Tracking Number: AF FI POL 410
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: AF FI POL 410 Hospital Indemnity
 Project Name/Number: Hospital Indemnity/AF FI POL 410

Filing at a Glance

Company: American Financial Security Life Insurance Company

Product Name: AF FI POL 410 Hospital Indemnity SERFF Tr Num: ICCI-127782409 State: Arkansas

TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed-Approved-Closed State Tr Num: 50136

Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: AF FI POL 410 State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor

Author: Brenda Dawson Disposition Date: 10/31/2011
 Date Submitted: 10/31/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: Hospital Indemnity
 Project Number: AF FI POL 410
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Group Market Type: Association
 Filing Status Changed: 10/31/2011
 State Status Changed: 10/31/2011
 Created By: Brenda Dawson
 Corresponding Filing Tracking Number:
 Filing Description:

Status of Filing in Domicile:
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Group
 Group Market Size: Small and Large
 Overall Rate Impact:
 Deemer Date:
 Submitted By: Brenda Dawson

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

Insurance Compliance Consultants, Inc., is making this filing on behalf of American Financial Security Life Insurance Company. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc.

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Group Indemnity Health Insurance Policy form AF FI POL 410 will be issued to Association groups located outside of your state. The National Better Living Association, Inc. (NBLA), was previously approved by your Department on January 11, 2010 under SERFF Tracking # ICCL-126911879. The National Congress of Employers Association (NCE) was previously approved for use in Arkansas on October 16, 2009. Attached to the supporting documents tab is a letter from the Department acknowledging that this Association is a valid Association.

Form AF FI CERT 410 is the Group Indemnity Health Insurance Certificate of Insurance evidencing coverage under the Group Policy. Amendatory Endorsement form AF FI AEAR 410 will be attached to all certificates issued in Arkansas.

This coverage is not sold to small employers. It is strictly individual coverage sold to members of the association. The coverage is a Fixed Indemnity plan.

Form AF FI MEM EF 410 AR is the member enrollment form used to apply for coverage.

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

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

Company and Contact

Filing Contact Information

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

Filing Company Information

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

American Financial Security Life Insurance CoCode: 69337 State of Domicile: Missouri
Company
10308 Metcalf Ave., PMB 275 Group Code: Company Type:
Overland Park, KS 66212 Group Name: State ID Number:
(913) 341-1190 ext. [Phone] FEIN Number: 44-0617151

Filing Fees

SERFF Tracking Number: ICCI-127782409 State: Arkansas
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Fee Required? Yes
Fee Amount: \$200.00
Retaliatory? No
Fee Explanation: \$50 per form
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Financial Security Life Insurance Company	\$200.00	10/31/2011	53315388

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/31/2011	10/31/2011

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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	Authorization Letter	Approved-Closed	Yes
Supporting Document	The National Better Living Association (NBLA) previously approved	Approved-Closed	Yes
Supporting Document	The National Congress of Employers (NCE) acknowledged as valid	Approved-Closed	Yes
Form	Group Indemnity Health Insurance Policy	Approved-Closed	Yes
Form	Group Certificate	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes
Form	Enrollment form	Approved-Closed	Yes
Rate	rate manual	Approved-Closed	Yes

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Form Schedule

Lead Form Number: AF FI POL 410

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/31/2011	AF FI POL 410	Policy/Cont	Group Indemnity ract/Fratern Health Insurance al Policy Certificate	Initial			AF FI POL 410_5-12- 10_.pdf
Approved-Closed 10/31/2011	AF FI CERT 410	Certificate	Group Certificate	Initial			AF FI CERT 410 -2010 02- 08-11.pdf
Approved-Closed 10/31/2011	AF FI AEAR 0410	Certificate	Amendatory Amendmen Endorsement t, Insert Page, Endorseme nt or Rider	Initial			AR FI 0410 AEAR.pdf
Approved-Closed 10/31/2011	AF FI MEM EF 410 AR	Application/	Enrollment form Enrollment Form	Initial			AR AF FI MEM EF 410 AR - Enrollment Form.pdf

INCORPORATION AGREEMENT

The attached certificate of group insurance and any endorsements, riders, and amendments, if any, adding or changing the provisions of the certificate are incorporated into and made a part of this Policy.

Each Association that provides a group insurance plan for its Member under this Policy may select some or all of the following insurance benefits, as described in the attached Certificate of group insurance:

[DAILY HOSPITAL OR SKILLED NURSING FACILITY CONFINEMENT INDEMNITY BENEFIT
INPATIENT AND OUTPATIENT SURGICAL INDEMNITY BENEFIT – PROFESSIONAL SERVICES ONLY
OUTPATIENT SURGICAL FACILITY INDEMNITY BENEFIT – FACILITY SERVICES ONLY
HOSPITAL EMERGENCY ROOM VISIT INDEMNITY BENEFIT
OUTPATIENT DIAGNOSTIC TESTING, X-RAY AND LAB INDEMNITY BENEFIT
OUTPATIENT PHYSICIANS OFFICE VISIT INDEMNITY BENEFIT
PREVENTIVE CARE INDEMNITY BENEFIT
AMBULANCE INDEMNITY BENEFIT
PRESCRIPTION DRUG INDEMNITY BENEFIT
SUPPLEMENTAL ACCIDENT MEDICAL INDEMNITY BENEFIT]

All coverage and actual benefit amounts in effect with respect to each insured Member and his insured Dependents, if any, will be as described in the individual Certificate issued by us to or for such Member.

GENERAL PROVISIONS

ENTIRE CONTRACT

This Policy and the attached certificate(s), including any endorsement or amendments in force on the effective date of this Policy or added later, the Association's Application, and the individual application of the Members covered constitute the entire contract between the parties.

No change in this Policy shall be valid unless made by endorsement or amendment signed by an executive officer of the Insurer. No agent has authority to change this Policy or waive any of its provisions.

APPLICATION; STATEMENTS NOT WARRANTIES

A copy of this Policyholder's application, if any, shall be attached to this Policy when issued. All statements made by the Covered Persons shall, in absence of fraud, be deemed representations and not warranties. No statement made by a Covered Person shall be used in a contest under this Policy unless a copy of the instrument containing the statement is or has been furnished to such individual or to his beneficiary, if any.

TIME LIMIT ON CERTAIN DEFENSES

After this Policy has been in force for two years from the date of issue, no statement, except for fraudulent statements, made by this Policyholder shall be used to void the coverage. After two years from a Member's Effective Date of coverage, no misstatement, except for fraudulent misstatements, made by the Member when enrolling for coverage, will be used to void coverage under this Policy, or to deny payment of a claim hereunder for loss incurred or disability commencing with respect to the person commencing after the expiration date of such two year period.

MISSTATEMENT OF FACTS

If it is discovered that relevant facts about a Member or other Covered Person have been misstated:

- (1) If the error has an effect on premium, an adjustment of the premiums will be made; and
- (2) The correct facts will determine whether and in what amount insurance is valid under the contract for such person.

CLERICAL ERROR

Clerical errors or delays in keeping records for the contract by Us, the Third Party Administrator, or the Association:

- (1) Will not deny insurance which should otherwise have been granted; and
- (2) Will not extend insurance which should otherwise have ended; and
- (3) Will be subject to proper adjustment of premium when an adjustment is called for.

DATA REQUIRED

Each Association shall furnish the Insurer, or the Third Party Administrator, with all information and proof which the Insurer, or the Third Party Administrator, may reasonably require with regard to any matters pertaining to this Policy or to any Covered Person covered under this Policy.

INDIVIDUAL CERTIFICATE

The Insurer or the Third Party Administrator will issue to each covered Member, an individual Certificate that will explain in summary form the coverage, rights and privileges under this Policy.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy, which on the date of issue is in conflict with the statutes of the state in which it is delivered, is hereby amended to conform to the minimum requirements of such statutes.

NON-PARTICIPATING

This Policy does not share in the surplus earnings of the Insurer.

POLICYHOLDER NOT OUR AGENT

This Policyholder will not be considered our agent for any purpose under this Policy.

PREMIUMS**PREMIUM PAYMENTS**

Premium required by this Policy shall be payable on or before the premium due date by the Members to the Insurer, or the Third Party Administrator. Payment of any premium shall not maintain coverage in force beyond the due date of the next premium for each coverage month, except as provided under the Grace Period.

"Coverage Month" means the one month period for which premiums are payable, beginning with the Effective Date of coverage under this Policy and thereafter, the corresponding day of each calendar month.

PREMIUM RATE CHANGES

The Insurer may change the premium rates on:

- (1) The Members Effective Date;
- (2) Any premium due date of a Member provided the rate being changed had been in effect at least 6 months and the Insurer, or the Third Party Administrator, gives at least [30] days advance notice in writing;
- (3) The date the terms and conditions of the Member's coverage under this Policy are modified; and
- (4) Following any governmental action that affects Our liability under this Policy.

GRACE PERIOD

A grace period of 31 days is allowed for payment of each premium (except the first) during which coverage under this Policy shall remain in force. Coverage may terminate prior to the end of the grace period by the Member giving at least 31 days advance written notice of cancellation to the Insurer or the Third Party Administrator. Unless the Member so notifies the Insurer, or the Third Party Administrator, failure by the Member to pay a premium within the grace period will cause coverage under this Policy to automatically terminate at the end of the period for which the last premium has been paid.

TERMINATION OF POLICY

This Policy continues from its Date of Issue, unless it is terminated by this Policyholder or the Insurer, as stated below.

After the first anniversary date of this Policy, the Insurer has the right to terminate this Policy and all coverage hereunder on any premium due date by giving 90 days written notice in advance to this Policyholder. In the case of any individual Member, the Insurer has the right to terminate coverage on any premium due date by giving the Member [30] days advance notice.

This Policyholder may terminate this Policy on any premium due date by giving written notice to Us at least [31] days in advance of such due date.

American Financial Security Life Insurance Company

[Jefferson City, Missouri]

CERTIFICATE OF INSURANCE

Issued under the terms of the
Group Insurance Policy

Issued to: [ABC Association]
(herein called the Policyholder)

The insurance Coverage, Benefits and the principal provisions that apply to the Covered Persons named in the Schedule of Benefits are summarized in this Certificate of Insurance and are merely evidence of insurance under the Policy. Insurance Coverage is subject to the terms of the Policy, which alone constitutes the contract under which payment is made. The Policy is a contract between the Policyholder and Us. It may be changed or terminated only by those parties. Coverage is provided under group Policy number [POLICY NO.].

GROUP INDEMNITY HEALTH INSURANCE

**[BENEFITS ARE NOT PROVIDED FOR PRE-EXISTING
CONDITIONS EXCEPT AS DESCRIBED IN THIS CERTIFICATE.]**

**THE POLICY IS RENEWABLE AT THE OPTION OF THE
COMPANY**

READ YOUR CERTIFICATE CAREFULLY

AMERICAN FINANCIAL SECURITY LIFE INSURANCE COMPANY



President

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SCHEDULE OF BENEFITS

INSURED INFORMATION:

Name:[John Doe]

[Policy Effective Date: April 1, 2010]

COVERAGE EFFECTIVE DATE: [May 1, 2010]

[WAITING PERIOD: 30 days immediately following the Coverage Effective Date. The Waiting Period does not apply to an Injury.]

ELIGIBLE DEPENDENTS COVERED: [Janet Doe, Junior Doe, Juniorette Doe]

1. [DAILY HOSPITAL OR SKILLED NURSING FACILITY CONFINEMENT INDEMNITY BENEFIT

Benefit Description	Policy Pays per Covered Person	Additional Limitations and Explanations
[Daily Hospital Confinement	[\$100-\$2,000] per day Maximum number of days per Coverage Year – [5-30]	This Benefit includes all related services (e.g. Inpatient Physician’s visits, Inpatient newborn care, etc.)]
[Inpatient Mental or Nervous Disorders	[\$100-\$250] per day Maximum number of days per Coverage Year – [5-30]	This Benefit includes all related services (e.g. Inpatient Physician’s visits, etc.)]
[Inpatient Substance Use Disorders	[\$100-\$250] per day Maximum number of days per Coverage Year – [5-30]	This Benefit includes all related services (e.g. Inpatient Physician’s visits, etc.)]
[Skilled Nursing Facility	[\$100-\$250] per day Maximum number of days per Coverage Year – [5-30]	This Benefit includes all related services (e.g. Physician’s visits, skilled nursing care, etc.)]

[2. INPATIENT AND OUTPATIENT SURGICAL INDEMNITY BENEFIT – PROFESSIONAL SERVICES ONLY

Benefit Description	Policy Pays per Covered Person	Additional Limitations and Explanations
Inpatient and Outpatient Surgery	Surgeon - [50%-100%] of the 2010 Medicare National Fee Schedule Maximum number of surgeries per Coverage Year - [unlimited].	This Benefit applies to all services received the same day as surgery.]

[3. OUTPATIENT SURGICAL FACILITY INDEMNITY BENEFIT – FACILITY SERVICES ONLY

Benefit Description	Policy Pays per Covered Person	Additional Limitations and Explanations
Outpatient Surgery Facility only	Facility – [\$100 - \$1,000] per surgery Maximum Number of surgeries per Coverage Year - [1-2]	This Benefit does not include Professional fees. This Benefit includes Outpatient Surgical Facilities, Ambulatory Surgical Centers and Hospital Outpatient Surgery.]

[4. HOSPITAL EMERGENCY ROOM VISIT INDEMNITY BENEFIT

Benefit Description	Policy Pays per Covered Person	Additional Limitations and Explanations
Emergency Room Care	[\$50-\$250] per visit Maximum number of visits per Coverage Year - [1-3]	This Benefit is not payable if the Covered Person is admitted to the Hospital as an Inpatient. This Benefit is payable only if Emergency Care is received.]

[5. OUTPATIENT DIAGNOSTIC TESTING, X-RAY AND LAB INDEMNITY BENEFIT

Benefit Description	Policy Pays per Covered Person	Additional Limitations and Explanations
[Option 1:	[\$10-\$100] per day of services. Maximum number of covered days per Coverage Year – [1-3].	This Benefit applies to all diagnostic testing, X-ray and laboratory services received on the same day. This benefit does not include Preventive Care.]
[Option 2:	[Laboratory procedure (pathology): [\$10-\$75] per day Maximum number of covered days per Coverage Year – [1-3].] [X-ray (radiology): [\$10-\$100] per day Maximum number of covered days per Coverage Year – [1-3].] [Advanced Study: [[\$100-\$500] per day Maximum number of covered days per Coverage Year – [1-3].]	This Benefit includes the cost of reading the lab test, x-ray or advanced study. This Benefit does not include Preventive Care.]

[6. OUTPATIENT PHYSICIANS OFFICE VISIT INDEMNITY BENEFIT

Benefit Description	Policy Pays per Covered Person	Additional Limitations and Explanations
[Option 1:	[\$25-\$100] per office visit. Maximum number of visits per Coverage Year – [1-5].	This Benefit applies to all office visits and services rendered in an office visit on the same day. This Benefit includes Urgent Care Facilities. This benefit does not include Preventive Care.]
[Option 2:	[Primary Care Physician: [\$25-\$75] per office visit Maximum number of visits per Coverage Year – [1-5]]	This Benefit includes Urgent Care Facilities. This Benefit does not include Preventive Care.
	[Specialist [\$50-\$150] per office visit Maximum number of visits per Coverage Year – [1-5]]	[Specialist visit does not include a visit for Physical Therapy, Speech Therapy or Occupational Therapy.]]
	[Mental or Nervous Disorder or Substance Use Disorder [[\$25-\$75] per office visit Maximum number of visits per Coverage Year – [5-20]]	[Specialist in care and treatment of Mental or Nervous Disorders or Substance Use Disorders only.]]

[7. PREVENTIVE CARE INDEMNITY BENEFIT

Benefit Description	Policy Pays per Covered Person	Additional Limitations and Explanations
Preventive Care	[Office Visit [\$25-\$100] per visit Maximum number of visits per Coverage Year – [1-2].]	A Benefit payable under the Preventive Care Benefit is not payable under any other Benefit of the Policy.
	[Diagnostics (diagnostic testing, x-ray and laboratory services) [\$25 – \$100] per day Maximum number of covered days per Coverage Year – [1-2]]	[This Benefit applies to all diagnostic testing, X-ray and laboratory services received on the same day.]]

[8. AMBULANCE INDEMNITY BENEFIT

Benefit Description	Policy Pays per Covered Person	Additional Limitations and Explanations
[Land] Ambulance	[\$50-\$100] per conveyance Maximum number of conveyances per Coverage Year – [1-2].	This Benefit includes a conveyance only when Emergency Care is received.
[Air Ambulance	[\$300-\$500] per conveyance. Maximum number of conveyances per Coverage Year – [1-3]	This Benefit includes a conveyance only when Emergency Care is received.]]

[9. PRESCRIPTION DRUG INDEMNITY BENEFIT

Benefit Description	Policy Pays per Covered Person	Additional Limitations and Explanations
Prescription Drugs	<p><u>Generic:</u> [\$5-\$10] per Covered Drug</p> <p><u>Brand:</u> [\$25-\$50] per Covered Drug</p> <p>Maximum amount payable per Coverage Quarter - [\$25-\$375] – Maximum amount payable per Coverage Year - [\$100-\$1,500].</p> <p>If all or any portion of a Covered Person’s maximum amount per Coverage Quarter has not been applied during any Calendar Quarter, the Covered Person’s maximum amount per Coverage Quarter for the next ensuing Calendar Quarter shall be increased by the amount not so applied.</p> <p>However, the amount of the quarterly increases shall not cause the Coverage Year benefit to exceed the maximum amount per Coverage Year per Covered Person. The maximum amount per Coverage Quarter resets at the beginning of each Coverage Year.</p>	<p>Oral contraceptives are included. The maximum amount is for all generic and brand Covered Drugs in a Coverage Quarter or Coverage Year combined.]</p>

[10. SUPPLEMENTAL ACCIDENT MEDICAL INDEMNITY BENEFIT

Benefit Description	Policy Pays per Covered Person	Additional Limitations and Explanations
Additional Amount for Accidental Bodily Injury*	<p>Daily Hospital or Skilled Nursing Facility Confinement Indemnity Benefit – [\$250-\$5000] per Confinement</p> <p>Maximum number of Confinements per Coverage Year – [1-2]</p> <p>Emergency Room Visit Indemnity Benefit – [\$25-\$100] per visit</p> <p>Maximum number of visits per Coverage Year – [1-3]</p> <p>Outpatient Diagnostic Testing, X-ray and Lab Indemnity Benefit (Pathology, Radiology and Advanced Studies combined) – [\$50-\$200] per procedure</p> <p>Maximum number of procedures per Coverage Year [1-3]</p> <p>Outpatient Physicians Office Visit Indemnity Benefit – [\$25-\$100] per visit</p> <p>Maximum number of visits per Coverage Year – [1-2]</p> <p>Ambulance Indemnity Benefit (Land and Air combined) – [\$50-\$200] per conveyance</p> <p>Maximum number of conveyances per Coverage Year – [1-2]</p> <p>Physical Therapy/Speech Therapy/Occupational Therapy – [\$25-\$100] per visit</p> <p>Maximum number of visits [per Coverage Year] [per Accident] – [10-20]</p>	<p>This Benefit pays an amount in addition to other listed covered Benefits except that* Physical Therapy, Speech Therapy and Occupational Therapy is paid only under this Benefit. Physical Therapy, Speech Therapy and Occupational Therapy are not paid under any other Benefit of the Policy.]</p> <p>[*A Benefit payable under the Supplemental Accident Medical Indemnity Benefit is not payable under the Outpatient Physicians Office Visit Indemnity Benefit]</p>

SECTION 1 - DEFINITIONS

MEDICAL DEFINITIONS

Accident (Accidental Bodily Injury) – means a bodily Injury resulting directly from an accident and independently of all other causes occurring while a Covered Person's coverage is in force under the Policy. It does not include an intentional, self-inflicted Injury, while sane.

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

Air Ambulance – means air transport to the nearest acute care Hospital in connection with an emergency room or emergency Inpatient admission or emergency Outpatient care when the following conditions are met:

- (1) Your medical condition requires immediate and rapid ambulance transportation and services cannot be provided by land ambulance due to great distances, and the use of land transportation would pose immediate threat to your health.
- (2) Services are covered to transport you from one acute care Hospital to another, only if the transferring Hospital does not have the adequate facilities to provide the Medically Necessary services needed for your treatment as determined by the Policy, and use of land ambulance would pose an immediate threat to your health.

Ambulatory Surgical Center/Outpatient Surgical Facility – means any public or private establishment with (1) an organized medical staff of doctors; (2) permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; (3) continuous doctors services whenever a patient is in the facility; and which does not provide services or accommodations for patients to stay overnight.

Benefit – means the dollar amount payable by Us to an Eligible Member under the Policy.

Certificate/Certificate of Coverage – means this summary of the Master Group Policy which constitutes evidence of Your coverage under the Policy.

Close Relative – means (1) Your Spouse, or Your child, brother, sister, or parent; or (2) any other person who is part of Your household.

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

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

Cosmetic Surgery – means a surgical procedure undergone for the sole purpose of improving appearance of self-esteem and not as treatment of an Illness or Injury.

Coverage Quarter – means 3 consecutive months immediately following the Certificate Effective Date and every consecutive 3 month period thereafter while this coverage is in force.

Coverage Year – means 12 consecutive months immediately following the Certificate Effective Date and every consecutive 12 month period thereafter while this coverage is in force.

Covered Drug – means only: (1) Legend Drugs; (2) injectable insulin by prescription, including needles and syringes; (3) compounded preparations if one or more ingredients are Legend Drugs; or (4) any medical substance which applicable state laws prohibits dispensing without a prescription.

Covered Person – means an Eligible Member / Eligible Dependent, whose coverage is effective and in-force under the terms of the Policy.

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

Custodial Care – means services (including room and board) or supplies which:

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

Dependents/Eligible Dependents – means:

The spouse and each unmarried child of the Member including an unmarried natural child, an unmarried child who is legally adopted or placed for adoption with the Member and an unmarried stepchild; but excluding: (1) Any such child 25 or more years of age; (2) any such child entitled to benefits under Title XVIII of the Social Security Act, P.L. 89-97, 42 U.S.C. Section 1395, et seq.; (3) a legally separated spouse; and (4) a spouse or child on active duty in any military, naval, or air force of any nation or international authority.

An incapacitated child who: (1) became a covered Dependent before attaining the applicable limited age specified above; (2) remained a covered Dependent until attaining such limiting age; and (3) on the date he/she attains such limiting age is incapable of self-sustaining employment due to mental or physical handicap and chiefly dependent upon the Covered Person for support and maintenance. Proof of such incapacity and dependency must be furnished to Us at least 31 days after the child's attainment of the limiting age and subsequently, as required, but not more frequently than annually following the child's attainment of limiting age.

Effective Date – means the date an individual becomes a Covered Person by fulfilling all the qualifying requirements outlined in Section 2 – Eligibility For Insurance and Section 3 – Effective Date herein.

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

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

Emergency Room – means a facility located on the premises of, or physically a part of, a Hospital that provides initial treatment to patients with a broad spectrum of Illnesses and Injuries that require immediate attention and is especially equipped and staffed for Emergency Care. An Urgent Care Facility is excluded from this definition.

[Evidence of Good Health – means a medical statement that is to be completed to the best of the individual's ability. Evidence of good health is a series of questions regarding the applicant's and/or Dependent's current and previous medical conditions and any treatment they may have received. Such statement must be based on medical fact and must be acceptable to Us and the Third Party Administrator.]

Experimental or Investigational – means the use of any treatment, procedure, facility, equipment, drugs, devices, or supplies not yet recognized as accepted medical practice by the American Medical Association, and any of such items requiring Federal or other government agency approval not granted at the times services were provided.

Hospital – means a legally constituted and operated institution which:

- (1) primarily engages in providing care and treatment of sick or injured persons on an Inpatient basis; and
- (2) provides such care and treatment under the supervision of one or more Physicians and with twenty-four hour nursing service under the supervision of the Physician in charge of the hospital, and
- (3) has organized facilities for laboratory and diagnostic work and major surgery. However, an institution specializing in the care and treatment of mental or emotional illness, disorder or disturbance, which would

qualify under this definition as a hospital, except that it lacks organized facilities on its premises for major surgery, shall nevertheless be deemed a hospital under the Policy.

- (4) The term "hospital" shall also include a residential treatment facility specializing in the care and treatment of alcoholism, drug addiction, or chemical dependency, provided such facility is duly licensed, if licensing is required by law in the jurisdiction where it is located, or otherwise lawfully operated if such licensing is not required. In no event, however, shall the term "hospital" include an institution that is primarily a rest home, a nursing home, a convalescent home, a rehabilitation center, an extended care facility, or home for the aged.

Illness – means only sickness or disease or Complications of Pregnancy, which require treatment by a Physician.

Inpatient – means a Covered Person who is treated as a registered bed patient and is confined in a Hospital and for whom a room and board charge is made. Inpatient also includes any observation or treatment room where the patient is confined more than eighteen (18) hours.

Lab Test – means a test that is done in a laboratory where the appropriate equipment, supplies and certified expertise are available including those procedures in the [CPT Code Range 80000]; but excluding Preventive Care and those procedures in the [CPT Code Range 36400-36416 (Venipuncture)].

Medically Necessary – means the services, care, or supplies that are required to identify or treat a Covered Person's condition and is:

- (1) consistent with the symptom or diagnosis, and treatment is distinctly aimed at improvement of a Covered Person's condition;
- (2) in accordance with standards of good medical practice;
- (3) not mainly for convenience of the Covered Person, a Physician or other provider; and
- (4) the most appropriate medical supply or level of care, which can safely be provided.

The circumstance of being ordered by a Physician will not always be conclusive that a particular service, care, or item was Medically Necessary. When applied to Inpatient care, it further means that the Covered Person's medical symptoms or condition require that the services cannot be safely provided as an Outpatient.

Medically Necessary does not include Experimental or Investigational procedures, treatment, drugs, surgery, or supplies.

Medicare – means the program established by Title 18 of Public Law 80-97 (79 Statutes 291) as amended, entitled Health Insurance for the Aged Act, also popularly known as the "Medicare Act."

Medicare National Fee Schedule – means the schedule used by the Federal Government to calculate Medicare allowances. Benefits for Surgical Procedures are payable based on the Medicare National Fee Schedule.

Mental or Nervous Disorder – means any condition classified as neurosis, psychoneurosis, psychopathy, psychosis, or functional disorders of any type or cause.

Occupational Therapy – means treatment, which consists primarily of instructing a Covered Person in the normal activities of daily working.

Outpatient – means an individual receiving medical care, treatment, services or supplies rendered by a Hospital, clinic, Physician's office, psychiatric facility, alcoholism or drug abuse treatment facility, but not as an Inpatient.

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

Physician – means a person holding a current license to legally practice medicine or surgery, or any other practitioner of the Healing Arts rendering care within the lawful scope of his or her license while performing Covered Services. A Physician includes a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.). Physician shall also include a person legally licensed as Podiatrist or Chiropractor. Physician shall further include a legally Psychotherapist or Psychiatric Social Worker (M.S.W.); provided such individual is working under the direct supervision of an Eligible Physician (Eligible Physician shall mean only a M.D. or a D.O.). The term "Physician" includes a Nurse Practitioner and a Physician Assistant. The term "Physician" does NOT include Christian Science Practitioners, Doctors of Holistic Medicine, Acupuncturists, Naturopathic or Homeopathic Practitioners.

Policy – means the Policy under the terms of which this coverage is written.

Policyholder – means the entity named as Policyholder on the Face Page of this Certificate.

[Pre-Existing Condition – means a condition for which a Covered Person has been medically diagnosed, treated by, or sought advice from, or consulted with, a Physician during the [0-12] months before his/her Effective Date of coverage under the Policy.]

Pregnancy – means Pregnancy or childbirth, or elective cesarean section or abortion.

Prescription – means any written order issued by a Physician for certain FDA approved medicines, supplies or therapies, which are given individually for the person whom prescribed, unless listed in Excluded Drugs. The fact that a drug is recommended or prescribed by a Physician does not make it a Covered Benefit.

Preventive Care – includes, but is not limited to, the following:

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

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

Primary Physician – means a Physician whose primary field of care is Internal Medicine, Pediatrics, Family/General Practice and includes a Nurse Practitioner and Physician Assistant.

Skilled Nursing Facility – means either (1) an institution owned and operated by or affiliated with (under written contractual arrangement) a Hospital, (2) a distinct part of (ward of) a Hospital, or (3) any institution or distinct part of an operation under Medicare. Such facility must be operated, including necessary licensing, in accordance with the laws of the state and/or locality where it is located and must be primarily engaged in providing (for persons who are convalescing from illness or accidental injury) under supervision of a Physician or staff of Physicians whose services are available at all times for the following:

- (1) room and board; and
- (2) skilled 24 hour a day inpatient nursing facilities by a full time Certified Registered Nurse (R.N.) or by such other nursing personnel as needed subject to the supervision of a Physician or such R.N. who is on duty at least 8 hours a day; and
- (3) adequate daily medical records for each patient; and
- (4) necessary and customary special services.

Sound Natural Teeth – means teeth which are intact with a root, pulp and have two surfaces restored and/or decayed, and no missing tooth structure due to fracture.

Specialist – means a Physician whose field of practice is other than that of a Primary Physician; however, the term does not include a Physician whose field of practice includes Physical Therapy, Speech Therapy or Occupational Therapy.

Substance Use Disorder – means the pathological use or abuse of alcohol or other drugs in a manner and to a degree that produces impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

Surgical Procedure – means (a) a cutting operation; (b) suturing of a wound; (c) treatment of a fracture; (d) reduction of a dislocation; (e) radiotherapy (including radioactive isotope therapy) if used in lieu of a cutting operation for removal of a tumor; (f) electro cauterization; (g) diagnostic and therapeutic endoscopic procedures; (h) injection treatment of hemorrhoids and varicose veins.

Third Party Administrator – means the entity performing functions, including processing any payment of claims, as may be delegated to it by the Company. [The Third Party Administrator is International Benefits Administrators, L.L.C.]

Urgent Care Facility – means a free-standing facility, by whatever actual name it may be called, which is engaged primarily in providing minor emergency and episodic, medical care. A Physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. It must be licensed as an urgent care facility, if required by law. However, a facility located on the premises of, or physically a part of, a Hospital is excluded from this definition.

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

[Waiting Period – means a period of consecutive days from the Effective Date of this Certificate during which a Covered Person is not eligible to file a claim or receive benefits. The Waiting Period, if any, for Illness is shown on the Schedule.

The Waiting Period does not apply to an Injury. A Covered Person is eligible to file a claim and receive benefits for an Injury as of the Effective Date.

Waiting Period does not apply to a newborn child, newly adopted child or a child placed with You and in Your physical custody for adoption.]

[The Waiting Period runs concurrently with the Pre-Existing Condition Limitations and Exclusions in Section 5 herein.]

We, Our, Us, Company, Insurer – means American Financial Security Life Insurance Company.

X-ray – means a type or irradiation used for imaging purposes with the image captured on photographic film including those procedures in the [CPT Code Range 70000 and those procedures in the CPT Code Range 90000] and Advanced Studies; but excluding Preventive Care.

You, Your, Yours, Member, Eligible Member – means the primary insured named as the Member on the Schedule of Benefits whose coverage has become effective and has not terminated.

SECTION 2 – ELIGIBILITY FOR INSURANCE (INSURABILITY REQUIREMENTS)

INSURED MEMBER

You will become eligible for coverage under the Policy upon meeting all the following requirements:

- (1) [You are under age 64 years and 6 months;
- (2) You have submitted a written request, upon a form approved by Us, seeking to apply for coverage as a Member insured under the Policy and are a Member of the Group Policyholder.
- (3) You furnish satisfactory Evidence of Good Health and are insurable pursuant to Our then current underwriting guidelines.
- (4) You are a permanent resident of the United States.
- (5) You are not covered under Medicare.]

DEPENDENT INSURANCE

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

- (1) [The Dependent is under age 64 years and 6 months;
- (2) The Member has submitted a written request, upon a form approved by Us, naming the individual as a Dependent;
- (3) The Dependent is insurable pursuant to Our then current underwriting guidelines (unless waived under other provisions of the Policy).
- (4) The Dependent is a permanent resident of the United States.
- (5) You must be insured in order for Your Dependents to be eligible for coverage.]

[Under this Section 2 – Eligibility For Insurance, all evidence that the Member and Dependents are insurable pursuant to Our current underwriting guidelines shall be provided without charge to Us.]

Re-Enrollment

If an Eligible Member's coverage under the Policy lapses because of non-payment of premium or is terminated upon an Eligible Member's request, such Eligible Member may re-enroll for coverage under the Policy provided that the Eligible Member may re-enroll for coverage under the Policy only once in any consecutive 24 month period.

SECTION 3 – EFFECTIVE DATE OF INSURANCE

MEMBER INSURANCE

Your insurance coverage under the Policy shall become effective on the monthly premium due date coincident with or next following the date on which We approve Your written request for coverage and You pay the applicable premium; provided that on the Effective Date You are not Hospital confined as an Inpatient and are able to perform the same activities as those You were able to perform at the time of application. Failure to meet these requirements will void the approval of coverage. A new application will be required to consider coverage in the future.

DEPENDENT INSURANCE

An Eligible Dependent's coverage under the Policy will become effective on the premium due date coincident with or next following the date on which We approve Your written request for Dependent coverage and the applicable premium is paid; provided that on the Effective Date the Dependent is not Hospital confined as an Inpatient and is able to perform the same activities as those he or she was able to perform at the time of application. Failure to meet these requirements will void the approval of coverage. A new application will be required to consider coverage in the future.

DEPENDENTS ACQUIRED AFTER EFFECTIVE DATE

NEWBORN CHILDREN

Coverage will be effective for a newborn child of the Member for 31 days following the moment of birth. Coverage shall continue beyond the 31-day period provided that the Member meets the following requirements:

- (1) Makes a written request for coverage, on forms approved by Us, within 31 days from the birth;
- (2) Makes the required premium payment, if applicable.

[If the above requirements are not met and the Member desires to provide future coverage under the Policy to the newborn, Evidence of the newborn's Good Health must be provided at no charge to Us and the newborn must meet Our then current underwriting guidelines. Coverage shall then take effect on the premium due date coincident with or next following the date on which We approve coverage.]

ADOPTED CHILDREN

All provisions throughout the Policy applicable to natural children also extend to adopted children or children placed with You and in Your physical custody for adoption. Coverage will be effective for adopted children of the Member for 31 days following placement in the custody of the Member. Placement means the assumption by the Member of the physical custody of the adopted child. Coverage shall continue beyond the 31-day period provided that the Member meets the following requirements:

- (1) Makes written request for coverage, on forms approved by Us, within 31 days from placement;
- (2) Makes the required premium payment, if applicable.

[If the above requirements are not met and You desire to provide coverage under the Policy to an adopted child, Evidence of the adopted child's Good Health must be provided at no charge to Us and the adopted child must meet Our then current underwriting guidelines. Coverage will then take effect on the premium due date coincident with or next following the date on which We approve coverage and any applicable premium is paid.]

ADDITIONAL DEPENDENTS

A Member may acquire additional Dependents while covered under the Policy. The insurance coverage with respect to such additional Dependents will become effective on the premium due date coincident with or next following the date on which We approve coverage provided such Dependent satisfies the eligibility requirements as set forth in Section 2 – Eligibility For Insurance and any applicable premium is paid.

SECTION 4 - BENEFITS

INDEMNITY BENEFITS

We will pay a Benefit as shown in the Schedule of Benefits for a Covered Member and their Eligible Dependent(s), in accordance with the provisions and limitations of the Policy, if the treatment, services and supplies are:

- (1) Medically Necessary as a result of an Illness or Injury, as defined in the Policy;
- (2) Received by a Covered Person;
- (3) Recommended and authorized by a licensed Physician.

INDEMNITY BENEFIT PROVISIONS

[[DAILY HOSPITAL OR SKILLED NURSING FACILITY CONFINEMENT INDEMNITY BENEFIT

[This Benefit applies only if it is shown as included in the Schedule of Benefits.]

When a Covered Person, upon recommendation and approval of a Physician, is Confined as an Inpatient in a [Hospital] or [Skilled Nursing Facility] as a result of an Illness or Injury, [or] [Mental or Nervous Disorder] [or Substance Use Disorder], We will pay a Benefit as shown in the Schedule of Benefits.

Confined or Confinement means the assignment to a bed as a resident Inpatient in a Hospital or Skilled Nursing Facility for a period of not less than [18] continuous hours on the advice of a Physician.

Not Covered

In addition to the Limitations and Exclusions in Section 5 herein, the Daily Hospital or Skilled Nursing Facility Confinement Indemnity Benefit will not be paid for the following:

- (1) Inpatient Confinement for dental treatment or oral surgery except when (a) incurred as a result of Injury to Sound Natural Teeth or to the jaw while covered under the Policy, or, (b) for multiple extractions of Sound Natural Teeth removed under general anesthesia, or, (c) removal and/or drainage of tumors, cysts, or abscesses;
- (2) Time the Covered Person is on a leave from the premises;
- (3) Confinement for Mental or Nervous Disorders, except if shown as included in the Schedule of Benefits;
- (4) Confinement for Substance Use Disorders, except if shown as included in the Schedule of Benefits;
- (5) Any period of Custodial Care;
- (6) Home health or hospice care or services;
- (7) Emergency room treatment; or
- (8) Outpatient treatment.

Newborn Care

Benefits for a newborn while in the Hospital are payable only under the mother's coverage.

If the mother is not covered under the Policy, the newborn establishes a claim as an individual and must meet the Eligibility and Effective Date requirements in Section 2 and Section 3 herein.]]

[[INPATIENT AND OUTPATIENT SURGICAL INDEMNITY BENEFIT – PROFESSIONAL SERVICES ONLY

[This Benefit applies only if it is shown as included in the Schedule of Benefits.]

When a Covered Person, while Confined as an Inpatient in a Hospital, or as an Outpatient, has a Surgical Procedure performed by a Surgeon, due to Illness or Injury, We will pay a Benefit as shown in the Schedule of Benefits.

If a Covered Person has more than one Surgical Procedure performed at the same time, a Benefit will be paid for the major procedure only.

For the purposes of this benefit, Surgeon means a Physician who is the primary surgeon, a stand-by surgeon, and any nurses or other persons assisting the primary or stand-by surgeon, in a Surgical Procedure.

This Benefit does not include the services provided by a Hospital or an Outpatient Surgical Facility.

Anesthesiology Benefit

If an anesthesiologist is required for the Surgical Procedure, an additional Benefit will be payable. This Benefit will pay [10%-30%] of the Benefit payable for the Surgical Procedure.

Not Covered

In addition to the Limitations and Exclusions in Section 5 herein, the Inpatient Surgical Indemnity Benefit will not be paid for the following:

- (1) Elective sterilization or reverse sterilization procedures;
- (2) Surgical procedures performed in a Physician's office;
- (3) Physician visits by a Surgeon;
- (4) Sex transformation or surgery related to sexual dysfunction; or
- (5) Facility services.]]

[[OUTPATIENT SURGICAL FACILITY INDEMNITY BENEFIT – FACILITY SERVICES ONLY

[This Benefit applies only if it is shown In the Schedule of Benefits.]

When a Covered Person, as an Outpatient, has a Surgical Procedure performed by a Surgeon, We will pay a Benefit as shown in the Schedule of Benefits.

If a Covered Person has more than one Surgical Procedure performed at the same time, a Benefit will be paid for the major procedure only.

For the purposes of this benefit, Surgeon means a Physician who is the primary surgeon, a stand-by surgeon and any nurses or other persons assisting the primary or stand-by surgeon, in a Surgical Procedure.

Not Covered

In addition to the Limitations and Exclusions in Section 5 herein, the Inpatient Surgical Indemnity Benefit will not be paid for the following:

- (1) Elective sterilization or reverse sterilization procedures;
- (2) Surgical procedures performed in a Physician's office;
- (3) Physician visits by a Surgeon;
- (4) Sex transformation or surgery related to sexual dysfunction; or
- (5) Professional Services.]]

[[HOSPITAL EMERGENCY ROOM VISIT INDEMNITY BENEFIT

[This Benefit applies only if it is shown as included in the Schedule of Benefits.]

When a Covered Person has a Hospital Emergency Room Visit and receives Emergency Care, We will pay a Benefit as shown in the Schedule of Benefits.

This Benefit is not payable if the Emergency Room Visit results in a Hospital Inpatient confinement.

The Hospital Emergency Room Visit must occur within 24 hours from the time the Illness was first manifested or the Injury was first incurred.]]

[[OUTPATIENT DIAGNOSTIC TESTING, X-RAY AND LAB INDEMNITY BENEFIT

[This benefit applies only if it is shown as included in the Schedule of Benefits.]

When a Covered Person, upon recommendation and approval of a Physician, has an Outpatient Lab Test or X-Ray due to an Illness or Injury, We will pay a Benefit as shown in the Schedule of Benefits.

This Benefit includes Advanced Studies as shown in the Schedule of Benefits.

Routine Lab Tests, X-rays and Advanced Studies are not covered under this Benefit. Preventive Care is not covered under this Benefit. Venipuncture is not covered under this Benefit.

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

[[OUTPATIENT PHYSICIAN OFFICE VISIT INDEMNITY BENEFIT

[This Benefit applies only if it is shown as included in the Schedule of Benefits.]

When a Covered Person has a Physician's office visit or Urgent Care Facility visit due to [Illness], [Injury], [Mental or Nervous Disorder] or [Substance Use Disorder], We will pay a Benefit as shown in the Schedule of Benefits.

This benefit includes a Primary Physician and Specialist office visit as shown in the Schedule of Benefits.

[[PREVENTIVE CARE BENEFIT

[This Benefit applies only if it is shown as included in the Schedule of Benefits.]

When a Covered Person has a visit for Preventive Care, We will pay a Benefit as shown in the Schedule of Benefits. Benefits are payable for and limited to:

- (1) Well child care visits, labs, and immunizations;
- (2) Osteoporosis screenings;
- (3) Routine gynecological exams; Mammography;
- (4) Routine prostate exams;
- (5) General health exams;
- (6) Colorectal cancer screening;
- (7) Lead poisoning screening;
- (8) Cancer screenings; and
- (9) Adult immunizations.

This Benefit is not subject to any Limitation and Exclusion that requires treatment or services to be considered Medically Necessary or for the treatment of an Illness or Injury.]]

A Benefit payable under the Preventive Care Benefit is not payable under any other Benefit of the Policy.

[[AMBULANCE INDEMNITY BENEFIT

[This Benefit applies only if it is shown as included in the Schedule of Benefits.]

When a Covered Person has a conveyance by land or air ambulance for/or with Emergency Care, a benefit will be paid as shown in the Schedule of Benefits.]]

[[PRESCRIPTION DRUG INDEMNITY BENEFIT

[This Benefit applies only if it is shown as included in the Schedule of Benefits.]

When a Covered Person incurs a charge for Outpatient Covered Drugs, a Benefit will be paid as shown in the Schedule of Benefits.

Outpatient Prescription Drugs are separated into two categories:

- **Generic Drugs.** These are prescription Drugs that are chemically and therapeutically equivalent to brand name prescription Drugs in the same class but are not protected by a patent. The FDA approves generic prescription Drugs as bioequivalent- meaning they perform in Your body the same as a formulary brand Prescription Drug. These prescription Drugs are generally less costly than their brand-name counterparts.
- **Brand Drugs.** These brand-name prescription Drugs have a more cost-effective therapeutic alternative.

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

Excluded Drugs

The following Outpatient prescription Drugs will not be covered under this Benefit:

- (1) Over-the-Counter drugs, supplies or products; or
- (2) Drugs or other agents to increase or enhance fertility or the likelihood of conception; or
- (3) Drugs for the treatment of erectile dysfunction or to assist in or enhance sexual performance; or
- (4) Vitamins; provided however, pre-natal vitamins will be covered.
- (5) Drugs to eliminate or reduce a dependency or an addiction to tobacco including, but not limited to, the cessation or termination of cigarette, cigar, or tobacco smoking or the use of smokeless tobacco, including nicotine products, gums and transdermal patches;
- (6) Drugs for the treatment of hair loss or for the purpose of regrowing lost hair, such as Rogaine, Minoxidil;
- (7) Immunization agents, biological sera, blood or blood plasma;
- (8) Experimental or Investigational Drugs;
- (9) Drugs covered under Workers' Compensation;
- (10) Drugs for the treatment of obesity or diet control;
- (11) Drugs taken, prescribed or administered while an Inpatient at a Hospital, rest home, sanitarium, Skilled Nursing Facility, convalescent hospital, nursing home or similar institution which operates a facility for dispensing Drugs;
- (12) Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use;
- (13) Homeopathic Drugs; or
- (14) Any Drugs purchased outside the United States of America.]]

[[SUPPLEMENTAL ACCIDENT MEDICAL INDEMNITY BENEFIT

[This Benefit applies only if it is shown as included in the Schedule of Benefits.]

When a Covered Person sustains an Accidental Bodily Injury on or after the Certificate Effective Date, We will pay a Benefit as shown in the Schedule of Benefits.

Except as provided in the paragraphs below pertaining to Physical Therapy, Speech Therapy and Occupational Therapy [and the Physicians Office Visit Indemnity Benefit], this Benefit is in addition to other Indemnity Benefits in force under the Policy. This Benefit will be payable only if the other Indemnity Benefit included in Your coverage is payable because of an Accident within 90 days of the treatment, service or supply.

This Benefit includes Physical Therapy, Speech Therapy and Occupational Therapy.

When a Covered Person has Physical Therapy, Speech Therapy or Occupational Therapy, upon recommendation and approval of a Physician, as a result of Illness or Injury, We will pay a Benefit under the Supplemental Accident Benefit as shown in the Schedule of Benefits.

[A Benefit payable under the Supplemental Accident Medical Indemnity Benefit is not payable under the Outpatient Physicians Office Visit Indemnity Benefit.]

SECTION 5 – EXCLUSIONS AND LIMITATIONS

We will not provide a Benefit for any of the items listed in this section regardless of Medical Necessity or recommendation of a health care provider.

- (1) Treatment, services and supplies which are not related to a specific diagnosis, acute symptoms or course of treatment; medical care or surgery which is not Medically Necessary; and any maintenance type therapy not reasonably expected to improve the patient's condition;
- (2) [Pre-employment or pre-marital examinations; or routine physical examinations;]
- (3) Treatment, services and supplies for an Injury caused by an accident that arises out of or in the course of employment or for which the Covered Person is entitled to benefits under any Worker's Compensation Law, Occupational Disease Law or similar legislation;
- (4) Non-prescription drugs, vitamins, minerals and nutritional supplements;
- (5) Experimental substances and/or drugs not approved by the Food and Drug Administration, or for investigative drugs or substances labeled "Caution – Limited by Federal Law to investigational use";
- (6) Treatment, services and supplies for Experimental or Investigational procedures, drugs or treatment methods;
- (7) Treatment, services and supplies for any Experimental or Investigational organ transplant procedure;
- (8) Treatment, services and supplies for which the Covered Person is not legally required to pay;
- (9) Telephone consultations, failure to keep scheduled appointments, completion of claim forms, or providing medical information necessary to determine coverage;
- (10) Treatment, services and supplies provided by a Close Relative (i.e. spouse, child or parent);
- (11) Enrollment in including, but not limited to, a health, athletic or similar club or weight loss, non-smoking, exercise or similar programs;
- (12) Recreational or educational therapy, or non-medical self-care or self-help training, nutritional counseling, marriage, family or goal oriented counseling;
- (13) Treatment, services and supplies provided outside the scope of the license for the institution or practitioner rendering services;
- (14) Education, training, custodial care or bed and board while confined to an institution which is primarily a school or other institution for training, a place of rest or a place for the aged, a personal residence;
- (15) Cosmetic Surgery;
- (16) Eye examinations, eyeglasses, or contact lenses to correct refractive errors and related services including surgery performed to eliminate the need for eyeglasses, for refractive errors such as radial keratotomy or keratoplasty and hearing exams, hearing aids, or the fitting of hearing aids;
- (17) Illness or Injury that results from war or an act of war, riot or in the commission or attempted commission of an assault or felony. This includes an act of international armed conflict. It also includes a conflict in which the armed force of any international authority is involved;
- (18) To the extent that payment under the Policy is prohibited by any law of the jurisdiction in which the Covered Person resides;
- (19) Travel or transportation by anyone other than professional ground or Air Ambulance;
- (20) Treatment, services or supplies received prior to the Covered Person's Effective Date, or after their termination date of coverage under the Policy;

- (21) Inpatient Hospital admission occurring on a Friday or Saturday in conjunction with a surgical procedure scheduled to be performed during the following week. A Sunday admission will be eligible only for the procedure scheduled to be performed early Monday morning. (This limitation will not apply to necessary medical admissions requiring immediate attention or to Emergency surgical admissions);
- (22) Pregnancy and related services;
- (23) [Custodial Care;]
- (24) [Dental services;]
- (25) Voluntary sterilization or reversal thereof;
- (26) Transsexual surgery and related surgery;
- (27) [Routine foot care;]
- (28) Amniocentesis, ultrasound or any other procedures requested solely for sex determination of the fetus, unless Medically Necessary to determine the existence of a sex linked genetic disorder;
- (29) [Temporomandibular joint dysfunction;]
- (30) Infertility and impregnation procedures, such as but not limited to, artificial insemination, in-vitro fertilization, embryo and fetal implantation and G.I.F.T. (gamete intrafallopian transfer);
- (31) Intentional self-inflicted Illness or Injury while sane; except that this exclusion will not apply to any self inflicted Illness or Injury that is the result of a medical condition ;
- (32) An Illness or Injury incurred (a) during the commission or attempted commission of a crime or felony or while engaged in an illegal act; or (b) while imprisoned;
- (33) [Physical therapy, Speech therapy and Occupational therapy except as specified in the Supplemental Accident Indemnity Benefit, if shown as included in the Schedule of Benefits;]
- (34) [Mental and Nervous Disorders except if shown as included in the Schedule of Benefits];
- (35) [Substance Use Disorders except if shown as included in the Schedule of Benefits;]
- (36) [Physician's Office Visits, except as specified in the Physician's Office Visit Indemnity Benefit, if shown as included in the Schedule of Benefits;]
- (37) [Preventive Care except as specified in the Preventive Care Indemnity Benefit, if shown as included in the Schedule of Benefits;]
- (38) [Venipuncture];
- (39) [Prescription drugs, except as specified in the Outpatient Prescription Drug Indemnity Benefit, if shown as included in the Schedule of Benefits;]
- (40) [Hospice Care;]
- (41) [Home Health Care.]
- (42) [Treatment, services, supplies for obesity, extreme obesity, morbid obesity or weight reduction, including, but not limited to, wiring of the teeth and all forms of surgery including, but not limited to, bariatric surgery, intestinal bypass surgery and complications resulting from any such surgery;] [and]
- (43) [Treatment, services and supplies for an Illness prior to the expiration of the Waiting Period.]

[LIMITATIONS AND EXCLUSIONS FOR PRE-EXISTING CONDITIONS

Benefits shall not be payable for a Pre-Existing Condition as defined herein. This provision will cease to apply to any loss incurred in connection with a Pre-Existing Condition after [0-12] months of continuous coverage.

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

[We will credit the time the Covered Person was covered by a plan of Creditable Coverage against this Pre-existing Condition exclusion period if the no more than 63 days elapsed between the termination of the Covered Person's prior Creditable Coverage and the Covered Person's Effective Date.]

SECTION 6 - PREMIUMS

Premium Payments

Premium shall be payable by You on or before the premium due date to Us or the Third Party Administrator. Payment of any premium shall not maintain coverage in force beyond the due date of the next premium for each Coverage Month.

Premium Rate Changes

We retain the right to change the premium rates for the insurance coverage provided for You as of any premium due date by giving at least 31 days advance written notice of any such premium rate change to You. Changes in the cost of Your insurance that are not due to a premium rate change (such as a change in cost because of a change in Your age) will change on the next following renewal date. Changes in coverage will affect your rate at the time the change occurs.

Grace Period

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

SECTION 7 – TERMINATION OF COVERAGE

Member

A Member's coverage under the Policy will terminate on the earliest of the following dates (except as may be provided in the Continuation of Coverage provision):

- (1) The last day for which Your premium has been paid;
- (2) The date You become a full-time member of the Armed Forces of any country if the period of active duty is to exceed 31 days;
- (3) The date the Policy terminates;
- (4) The date You become effective under Medicare;
- (5) The date You cease to be a Member of the Policyholder;
- (6) [Subject to Section 9 General Provisions, Contesting Coverage,] Your Effective Date in the event of any fraud or material misrepresentation on Your part in obtaining coverage under the Policy;
- (7) The next premium due date in the event of any fraud or material misrepresentation on Your part or the part of Your representative in filing a claim.

Dependents

Insurance on a Dependent will terminate on the date such Dependent ceases to qualify as a Dependent. Except as provided in the Continuation of Coverage provision, Your Dependent insurance will automatically terminate on the earliest of the following dates:

- (1) The date Your insurance terminates;
- (2) The last day for which Your Dependent premium has been paid;
- (3) In the case of Your Dependent child, the date he no longer qualifies as a Dependent by attaining the limiting age (see definition of "Dependents").
- (4) In the case of Your Dependent child, the first day following the Dependent's marriage;
- (5) The date Your Dependent enters active duty with the armed services of any country if the period of active duty is to exceed 31 days;
- (6) In the case of a Dependent spouse, the first day following the date of the final decree of dissolution of marriage.

SECTION 8 – CLAIM PROVISIONS

Notice of Claim

Written notice of claim must be given to Us within 60 days after the Occurrence of any loss covered by the Policy, or as soon thereafter as it is reasonably possible. Notice given by or on behalf of a Covered Person to Us or the Third Party Administrator, with information sufficient to identify the Covered Person, shall be deemed notice to Us.

Claim Forms

Upon receipt of a notice of claim, We will furnish to the Covered Person such forms that are usually furnished by Us for filing proof of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the Occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be submitted within 90 days after the date of loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time the proof is otherwise required.

Time of Payment of Claims

Benefits payable under the Policy will be paid immediately upon receipt of due written proof of such loss.

Payment of Claims

Indemnity for loss of life shall be payable in accordance with the beneficiary designation and the provisions respecting such payment prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to You or Your estate. Any accrued indemnities unpaid at Your death may, at Our option, be paid to Your beneficiary or to Your estate. All other benefits will be payable to You.

Physical Examination and Autopsy

At Our own expense, We shall have the right and opportunity to examine a Covered Person when and as often as it may reasonably require during the pendency of a claim. We also have the right to make an autopsy in case of death where it is not prohibited by law.

Legal Actions

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

Right to Collect Needed Information

It is the Covered Person's responsibility to cooperate when We or Our Third Party Administrator is investigating a claim. Upon request, the Covered Person shall:

- (1) Authorize the release of medical information, including names of all providers from whom medical attention was received.
- (2) Provide details regarding the Illness or Injury.

Claim Appeal

If Your claim is denied in whole or in part, You will receive written notification. If You disagree with the denial, You or anyone authorized to act on Your behalf, may request a review by filing a written inquiry along with supporting documentation to Us or the Third Party Administrator within 60 days of the date such claim denial is received.

We or the Third Party Administrator shall respond within 60 days of receipt of the claim denial appeal request. Special circumstances may require review of the appeal request for up to 120 days. Such response shall state specific reasons for the decision and references to the Policy provisions that are applicable to the final determination of the claim review.

SECTION 9 – GENERAL PROVISIONS

The Contract

Modifications of Contract

No agent has authority to change or waive any part of the Policy. To be valid, any change or waiver must be:

- (1) In writing;
- (2) Approved by an executive officer of Ours; and
- (3) Made a part of the Policy and Certificate.

Clerical Errors

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

[Contesting Coverage]

Representations

In the absence of fraud, any statement made by a Covered Person will be deemed a representation and not a warranty. Such statement will not be used in defense of a claim, unless it is or has been furnished to You or Your beneficiary, if any.

Time Limit on Certain Defenses

After 2 years from the date a Covered Person becomes covered under the Policy, no misrepresentations, except from fraudulent misstatements, made by You or the Covered Person when applying for coverage will be used to void coverage under the Policy, or to deny payment of a claim hereunder for loss incurred or disability commencing with respect to the Covered Person commencing after the expiration date of such two year period.

Misstatement of Age

If a Covered Person's age has been misstated, all benefits payable are those which the premium paid would have purchased at the correct age. If the Covered Person's correct age exceeds the maximum issue age, Our liability shall be limited to the refund of all premiums paid on that Covered Person's behalf.

[Rescission of Coverage]

We or the Third Party Administrator, reserves the right to rescind insurance coverage on any Covered Person due to Your or the Covered Person's material misrepresentation or fraud in the application for coverage. In the event of rescission, premiums will be refunded less any amounts paid for claims on behalf of such Covered Person.]

Other Provisions

Non-Participating

The insurance does not participate in Our surplus earnings.

Time Periods

All time periods begin and end at 12:01 a.m. Standard Time at Your residence.

Workers' Compensation Not Affected

Any coverage herein is not in lieu of and does not effect any requirements for coverage by Workers' Compensation Insurance.

Conformity With State Statutes

Any provision of the Policy which is in conflict with any law or regulation, to which it is subject, is automatically amended to comply with the minimum requirements of such law or regulation.

American Financial Security Life Insurance Company

[Jefferson City, Missouri]

AMENDATORY ENDORSEMENT

(Arkansas Only)

It is hereby understood that the Policy and Certificate of Insurance to which this Amendatory Endorsement is attached are amended as follows, with respect to a Member who resides in Arkansas on the Certificate Effective Date.

[A.] Under **SECTION 1 – DEFINITIONS**, the following change is hereby made:

1. The second paragraph under the definition of **Dependent/Eligible Dependents** is deleted and replaced with the following:

An incapacitated child who: (1) became a covered Dependent before attaining the applicable limited age specified above; (2) remained a covered Dependent until attaining such limiting age; and (3) on the date he/she attains such limiting age is incapable of self-sustaining employment due to mental or physical handicap and chiefly dependent upon the Covered Person for support and maintenance. Proof of such incapacity and dependency must be furnished to Us after the child's attainment of the limiting age and subsequently, as required, but not more frequently than annually following the child's attainment of limiting age.

[B.] Under **SECTION 3 – EFFECTIVE DATE OF INSURANCE, DEPENDENTS ACQUIRED AFTER EFFECTIVE DATE**, the following changes are hereby made:

1. **NEWBORN CHILDREN**, is deleted and replaced with the following:

Your newborn child is automatically covered from the moment of birth and will remain in force for 90 days. Coverage for newborns shall be the same as for all other Dependents. You must notify Us in writing within 90 days of such birth, and pay the required additional premium, if any, in order to have coverage for the newborn child continue beyond such 90 days.

2. **ADOPTED CHILDREN**, is deleted and replaced with the following:

Coverage for an adopted child or a minor under Your charge, care and control for whom You have filed a petition to adopt, is effective upon the earlier of the date of placement for the purpose of adoption, or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage for such child will be the same as for all other Dependents. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. However, You must notify Us in writing within 60 days of such placement for adoption or entry of an order and pay the required additional premium, if any, in order to have coverage for the adopted child continue beyond such 60 day period.

[C.] Under **SECTION 4 – BENEFITS, INDEMNITY BENEFITS**, the following changes are hereby made:

1. If the **[DAILY HOSPITAL OR SKILLED NURSING FACILITY CONFINEMENT INDEMNITY BENEFIT]** **[INPATIENT AND OUTPATIENT SURGICAL INDEMNITY BENEFIT – PROFESSIONAL SERVICES ONLY]** **[OUTPATIENT SURGICAL FACILITY INDEMNITY BENEFIT – FACILITY SERVICES ONLY]** is selected and shown in Your Schedule of Benefits, the following benefit has been added:

Coverage for Anesthesia and Hospitalization for Dental Procedures

This benefit includes anesthesia and hospital services performed in connection with dental procedures in a Hospital if: (1) the Physician treating the Covered Person certifies that because of the Covered Person's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures; and (2) the Covered Person is: (a) a child under 7 years of age who is determined by two dentists to have a significantly complex dental condition; (b) a Covered Person diagnosed with a serious mental or physical condition; or (c) a Covered Person with a significant behavioral problem as determined by his or her Physician. This benefit does not apply to TMJ.]

2. If the **PRESCRIPTION DRUG INDEMNITY BENEFIT** is selected and shown in Your Schedule of Benefits, under **Excluded Drugs** item (8) the following is added:

(8) Experimental or Investigational Drugs. However, coverage will not be limited or excluded for any drug approved by the United States Food and Drug Administration (US FDA) for use in the treatment of cancer on the basis that the drug has not been approved by the US FDA for the treatment of the specific type of cancer for which the drug has been prescribed, provided: (1) the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one of more such compendia: (a) the American Hospital Formulary Service drug information; (b) the US Pharmacopoeia dispensing information; or (2) the drug has been recognized as safe and effective for treatment of that specific type of cancer in two articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature.]

[D.] Under **SECTION 5 – EXCLUSIONS AND LIMITATIONS**, the following changes are hereby made

1. Item (24) pertaining to Dental services] is deleted and replaced with the following:

(24) [Dental Services, except as provided in the Policy or this Amendatory Endorsement;]

2. Item (29) pertaining to Temporomandibular joint dysfunction is deleted in its entirety;

3. **Limitations and Exclusions For Pre-Existing Conditions**, the second paragraph is deleted and replaced with the following:

[This provision does not apply to a newborn or newly adopted child or child placed for adoption under the age of 18 if such child is enrolled for coverage within 90 days from the date of birth, or the 60 period beginning on the date of adoption or placement for adoption.]

[E.] Under **SECTION 8 – CLAIM PROVISIONS**, the following change is hereby made:

1. **Time of Payment of Claims** is deleted and replaced with the following:

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

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

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

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

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

IN WITNESS WHEREOF, the Insurance Company has caused this Amendatory Endorsement to be signed by its [President and Secretary].

This Amendatory Endorsement is subject to all of the exceptions, definitions and conditions of the contract not inconsistent herewith. In all other respects, your contract remains the same.

[]
[PRESIDENT][SECRETARY]

AMERICAN FINANCIAL SECURITY LIFE INSURANCE COMPANY
(JEFFERSON CITY, MISSOURI)

[Please print clearly illegible enrollment forms will not be processed]

[Member's Last Name	First Name	Middle Initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:	Apt.	City	State Zip
Date of Birth: Month/Day/Year	Telephone:	Work	Social Security Number]

[Are you covered by any other Health Insurance?
 No Yes
Insurance company name: _____
Policy/Cert # _____
Effective Date: _____ End Date: _____
Address: _____]

Marital Status:
 Single Married Divorced Widowed

[Dependents to be covered			
Last Name	First Name	SS#	Date of Birth: Month/Day/Year
Spouse			
Child			
Child]			

[Plan Option: 1 _____ 2 _____ 3 _____]

IMPORTANT: I understand these benefits are provided under a group insurance policy underwritten by American Financial Security Life Insurance Company and are subject to exclusions, limitations and conditions of coverage which includes, but is not limited to, an exclusion for pre-existing conditions. Coverage being applied for has limitations on each benefit. I certify that I have read or had read to me the completed enrollment form and the answers given are complete and true to the best of my knowledge and belief.

By signing below I indicate my desire to enroll in a plan of limited medical benefits issued by American Financial Security Life Insurance Company.

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 is guilty of a crime and may be subject to fines and confinement in prison.

[Member must sign here: _____ Date: _____]

[To be completed by Group:

Name of Group:	Group Number:	Effective Date:
Date Submitted:	Approved By:	Processed Date:

]

SERFF Tracking Number: ICCI-127782409 State: Arkansas
 Filing Company: American Financial Security Life Insurance State Tracking Number: 50136
 Company
 Company Tracking Number: AF FI POL 410
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: AF FI POL 410 Hospital Indemnity
 Project Name/Number: Hospital Indemnity/AF FI POL 410

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 10/31/2011	rate manual	AF FI POL 410	New		AFS FI Rate Manual - Group Indemnity Health Ins.pdf

American Financial Security Life Insurance Company

Rate Manual

For

Group Indemnity Health Insurance

Form AF FI POL 410, et al

Prepared by CP Risk Solutions, LLC

January 4th, 2011

**American Financial Security Life Insurance Company
Rate Manual
Group Indemnity Health Insurance
AF FI POL 410**

Section 1 - Applicability

The rates shall apply to American Financial Security Life Insurance Company's ("AFS's") policy form AF FI POL 410 as of June 25th, 2010.

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Group Indemnity Health Insurance
AF FI POL 410

Section 2 – Premium Rate Development and Calculations

Table 1 – Description of Requested Coverage

	Coverage Details
Daily Hospital Confinement Benefits	Complete based on Plan Benefits for each group/association
Inpatient and Outpatient Surgical Benefits – Professional Services	
Outpatient Surgical Facility Benefit – Facility Services	
Emergency Room Visit Benefit	
Outpatient Medical Benefit	
Outpatient Diagnostic Testing, X-Ray and Lab Benefits	
Outpatient Physicians Office Visit Benefit	
Outpatient Mental Health and Substance Abuse Benefit	
Preventive Care Benefit	
Ambulance Benefit	
Prescription Drug Benefit	
Supplemental Accident Medical Benefit	
Effective Date / Renewal Date	
Demographic Mix	
Industry	
Other Pertinent Group/Association Characteristics	
Group/Association Experience	

Table 2 - Manual Per Member Per Month Claim Costs

Coverage ¹	Table Reference ²
1 Daily Hospital Confinement Benefits	
a. Daily Hospital Confinement	Table 6
b. Skilled Nursing Facility	Table 7
c. Inpatient Mental Health	Table 8
d. Inpatient Substance Abuse	Table 9
2 Inpatient and Outpatient Surgical Benefits	
a. Surgeon Fee	Table 10
b. Anesthesiologist Fee	Table 11

¹ Not all categories of coverage are required in the plan. The policyholder has the option to select and the AFS underwriter has the option to offer and authorize.

² Benefit within the ranges of a table could be linearly interpolated.

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Table 2 - Manual Per Member Per Month Claim Costs

Coverage ¹	Table Reference ²
c. Outpatient Surgical Facility Benefit	Table 12
3 Emergency Room Visit Benefit	Table 13
4 Outpatient Medical Benefit	
a. DXL Option 1: Pathology, Radiology, and Advanced Studies Benefit	Table 14
b. DXL Option 2: Pathology Benefit	Table 15
c. DXL Option 2: Radiology Benefit	Table 16
d. DXL Option 2: Advanced Studies Benefit	Table 17
e. Office Visit Option 1: Primary Care/Specialty Care Visits Benefit	Table 18
f. Office Visit Option 2: Primary Care Visits Benefit	Table 19
g. Office Visit Option 2: Specialty Care Visits Benefit	Table 20
h. Outpatient Mental Health and Substance Abuse Benefit	Table 21
i. Preventive Care Benefit	Table 22
5 Ambulance Benefit	
a. Option 1: Land/Air Ambulance	Table 23
b. Option 2: Land Ambulance	Table 24
c. Option 2: Air Ambulance	Table 25
6 Prescription Drug Benefit	Table 26
7 Supplemental Accident Medical Benefit	Table 27
8 Total Unadjusted Manual Rate	Sum of Lines 1 - 7
9 Effective Date / Renewal Date	Table 28
10 Area Adjustment	Table 29
11 Age/Sex Adjustment	Table 30
12 Industry	Table 31
13 Other Pertinent Case Characteristics	Table 32
14 Total Other Manual Rate Adjustment	Product of Lines 9 – 13
15 Adjusted Manual Rate	Line 8 x Line 14

Table 3 – Experience Claim Costs

	Total	Current Year	Current Year - 1	Current Year - 2
1 Paid Claims				
2 Excluded claims for pre-existing conditions				
3 Adjusted claims = (line 1) + (line 2)				
4 Plan design adjustment				

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Table 3 – Experience Claim Costs

	Total	Current Year	Current Year - 1	Current Year - 2
5 Total enrolled primary insured and dependent months with three months lag ³				
6 Average claim cost per person per month = (line 3)x(line 4)/(line 5)				
7 # of months from the center date of the lagged period to the center date of the rating period				
8 Trended claims cost per person per month = (line 6)x (1+annual trend% ⁴)(line 7/12)				
9 Weights (totaled to 100%)				
10 Experience claim cost per person per month (weighted average of line 8 and line 9)				

Table 4 – Experience Blended Claim Costs

	Claim Cost per Person per Month
1 Adjusted manual rate, Table 2 line 17	
2 Experience claim cost, Table 3 line 10	
3 Credibility, Table 33	
4 Experience Adjusted Rate = line 2 x line 3 + line 1 x (1 – line 3)	

Table 5 – Premium Rate Development

1 Estimated claim cost per person per month				
2 Target Loss Ratio				
3 Premium rate per person per month = line 1 / line 2				
4 Conversion Factor from per member to single rate ⁵				1.154
5 Single Rate = line 3 x line 4				
	Single	Ins.+Spouse	Ins.+Child(ren)	Family
6 Premium Tier Relativity, Table 34 ⁶				
7 Premium Rate by Tier = line 5 x line 6				

³ Underwriter shall determine the final number of months lag based on the stability of the enrollment and the administrative processes.

⁴ An annual trend of 4% for non-prescription drug benefits and 12% for prescription drug benefit should be considered based on the current environment. AFS Underwriter should consider emerging development and determine the appropriate trend at the time of underwriting. The selected trend should be applied to all cases with similar characteristics in the same time period.

⁵ Underwriter may develop a conversion factor specific for the case based on the premium ratios and the group's actual tier mix.

⁶ Other premium tiers are available as shown in Table 34. Other premium relativity might be used as long as the underwriter confirmed and authorized that there will be a revenue neutral position. Four-tier rates should always be used for voluntary enrollment.

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Section 3 – Rate Tables and Adjustment Factors

Table 6 – Daily Hospital Confinement Benefit

1	Claim Cost per \$1 daily benefit	\$0.0234
2	Maximum Covered daily benefit (\$100 - \$2,000) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Confinement Days, Table 6a	
5	Adjustment factor - Maximum daily benefit, Table 6b	
6	Adjusted Claim Cost = line 3 x line 4 x line 5	

Table 6a – Maximum # of Covered Confinement Days

Maximum # of Covered Confinement Days Per Coverage Year	Factor
5 days	0.703
10 days	0.849
15 days	0.913
20 days	0.951
25 days	0.979
30 days	1.000

Table 6b – Schedule Plan – Adjustment Factors – Maximum Covered Daily Benefit

Maximum Covered Daily Benefit	Factor
\$100-\$500	0.90
\$501-\$750	0.96
\$751-\$1,250	1.00
\$1,251-\$1,500	1.10

Table 7 – Skilled Nursing Facility Benefit

1	Claim Cost per \$1 daily benefit	\$0.001
2	Maximum Covered daily benefit (\$100-\$250) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Skilled Nursing Facility Days, Table 7a	
5	Adjusted Claim Cost = line 3 x line 4	

Table 7a – Maximum # of Covered Skilled Nursing Facility Days

Maximum # of Covered Confinement Days Per Coverage Year	Factor
5 days	0.4963
10 days	0.7600
15 days	0.8689
20 days	0.9378
25 days	0.9787
30 days	1.0000

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Table 8 – Inpatient Mental Health

1	Claim Cost per \$1 daily benefit	\$0.0035
2	Maximum Covered daily benefit (\$100-\$250) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Inpatient Mental Health Days, Table 8a	
5	Adjusted Claim Cost = line 3 x line 4	

Table 8a – Maximum # of Covered Inpatient Mental Health Days

Maximum # of Covered Confinement Days Per Coverage Year	Factor
5 days	0.444
10 days	0.762
15 days	0.912
20 days	0.972
25 days	0.991
30 days	1.000

Table 9 – Inpatient Substance Abuse

1	Claim Cost per \$1 daily benefit	\$0.0018
2	Maximum Covered daily benefit (\$100-\$250) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Inpatient Substance Abuse, Table 9a	
5	Adjusted Claim Cost = line 3 x line 4	

Table 9a – Maximum # of Covered Inpatient Substance Abuse Days

Maximum # of Covered Confinement Days Per Coverage Year	Factor
5 days	0.475
10 days	0.822
15 days	0.966
20 days	0.988
25 days	0.996
30 days	1.000

Table 10 – Surgery Benefits - Surgeon fee

Max # Covered per Year	% of RBRVS					
	50%	60%	70%	80%	90%	100%
Unlimited	8.54	10.25	11.96	13.67	15.38	17.09
3	8.50	10.20	11.90	13.60	15.30	17.01
2	8.41	10.09	11.77	13.45	15.13	16.81
1	7.73	9.28	10.83	12.37	13.92	15.47

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Table 11 – Surgery Benefits – Anesthesiologist Fee

Surgeon Fee Claim Cost, Table 10	
Anesthesiologist Fee as a % of Surgeon Fee (10%-25%) (Input)	
Anesthesiologist Fee Claim Cost = line 1 x line 2	

Table 12 – Outpatient Surgical Facility Benefit

1 Claim Cost per \$1 daily benefit	\$0.0104
2 Maximum benefit per coverage year (\$100-\$1,000) (Input based on plan design)	
3 Unadjusted claim cost = line 1 x line 2	
4 Adjustment factor - Maximum # of Covered Surgeries, Table 12a	
5 Adjusted Claim Cost = line 3 x line 4	

Table 12a – Maximum # of Covered Outpatient Surgical Facility Benefit

Maximum # of Covered Surgeries Per Coverage Year	Factor
1	0.959
2	1.000

Table 13 – Emergency Room Benefit

1 Claim Cost per \$1 visit benefit	\$0.0237
2 Maximum Covered per visit benefit (\$50-\$250) (Input based on plan design)	
3 Unadjusted claim cost = line 1 x line 2	
4 Adjustment factor - Maximum # of Covered Emergency Room visits, Table 13a	
5 Adjusted Claim Cost = line 3 x line 4	

Table 13a – Maximum # of Covered Emergency Room Visits

Maximum # of Covered Visits Per Coverage Year	Factor
1 visits	0.745
2 visits	0.933
3 visits	1.000

Table 14 – DXL Option 1: Pathology, Radiology, and Advanced Studies Benefit

1 Claim Cost per \$1 day benefit	\$0.1616
2 Maximum Covered daily benefit (\$10-\$100) (Input based on plan design)	
3 Unadjusted claim cost = line 1 x line 2	
4 Adjustment factor - Maximum # of Covered DXL days, Table 14a	
5 Adjusted Claim Cost = line 3 x line 4	

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Table 14a – Maximum # of Covered DXL Days

Maximum # of Covered Days Per Coverage Year	Factor
1 day	0.5137
2 days	0.8133
3 days	1.0000

Table 15 – DXL Option 2: Pathology Benefit

1	Claim Cost per \$1 day benefit	\$0.1327
2	Maximum Covered daily benefit (\$10-\$75) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Pathology Days, Table 15a	
5	Adjusted Claim Cost = line 3 x line 4	

Table 15a – Maximum # of Covered Pathology Days

Maximum # of Covered Days Per Coverage Year	Factor
1 day	0.5524
2 days	0.8393
3 days	1.0000

Table 16 – DXL Option 2: Radiology Benefit

1	Claim Cost per \$1 day benefit	\$0.0565
2	Maximum Covered daily benefit (\$10-\$100) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Radiology Days, Table 16a	
5	Adjusted Claim Cost = line 3 x line 4	

Table 16a – Maximum # of Covered Radiology Days

Maximum # of Covered Days Per Coverage Year	Factor
1 day	0.6406
2 days	0.8844
3 days	1.0000

Table 17 – DXL Option 2: Advanced Studies Benefit

1	Claim Cost per \$1 day benefit	\$0.0173
2	Maximum Covered daily benefit (\$100-\$500) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Advanced Studies Days, Table 17a	
5	Adjusted Claim Cost = line 3 x line 4	

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Table 17a – Maximum # of Covered Emergency Room Visits

Maximum # of Covered Days Per Coverage Year	Factor
1 day	0.7311
2 days	0.9238
3 days	1.0000

Table 18 – Office Visit Option 1: Primary Care/Specialty Care Visits Benefit

1	Claim Cost per \$1 visit benefit	\$0.193
2	Maximum Covered per visit benefit (\$25-\$100) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Office Visits, Table 18a	
5	Adjusted Claim Cost = line 3 x line 4	

Table 18a – Maximum # of Covered Office Visits

Maximum # of Covered Visits Per Coverage Year	Factor
1 visit	0.4943
2 visits	0.8033
3 visits	1.0000
4 visits	1.1274
5 visits	1.2108

Table 19 – Office Visit Option 2: Primary Care Visits Benefit

1	Claim Cost per \$1 visit benefit	\$0.12
2	Maximum Covered per visit benefit (\$25-\$75) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Office Visits, Table 19a	
5	Adjusted Claim Cost = line 3 x line 4	

Table 19a – Maximum # of Covered Office Visits

Maximum # of Covered Visits Per Coverage Year	Factor
1 visit	0.378
2 visits	0.722
3 visits	1.000
4 visits	1.181
5 visits	1.272

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Table 20 – Office Visit Option 2: Specialty Care Visits Benefit

1	Claim Cost per \$1 visit benefit	\$0.15
2	Maximum Covered per visit benefit (\$50-\$150) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Office Visits, Table 20a	
5	Adjusted Claim Cost = line 3 x line 4	

Table 20a – Maximum # of Covered Office Visits

Maximum # of Covered Visits Per Coverage Year	Factor
1 visit	0.413
2 visits	0.760
3 visits	1.000
4 visits	1.165
5 visits	1.287

Table 21 – Outpatient Mental Health and Substance Abuse Benefit

1	Claim Cost per \$1 visit benefit	\$0.0448
2	Maximum Covered per visit benefit (\$25-\$75) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered MHSA visits, Table 21a	
5	Adjusted Claim Cost = line 3 x line 4	

Table 21a – Maximum # of Covered MHSA Visits

Maximum # of Covered Visits Per Coverage Year	Factor
5 visits	0.4742
10 visits	0.7023
20 visits	1.0000

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Table 22 – Preventive Care Benefit

1	Claim Cost per \$1 Office Visit benefit	\$0.0245
2	Maximum Covered per Office Visit benefit (\$25-\$100) (Input based on plan design)	
3	Unadjusted Office Visit claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Preventive Care visits, Table 22a	
5	Adjusted Office Visit Claim Cost = line 3 x line 4	
6	Claim Cost per \$1 DXL benefit	\$0.0245
7	Maximum Covered per DXL benefit (\$25-\$100) (Input based on plan design)	
8	Unadjusted DXL claim cost = line 6 x line 7	
9	Adjustment factor - Maximum # of Covered DXL procedures, Table 22a	
10	Adjusted DXL Claim Cost = line 8 x line 9	
11	Adjusted Total Preventive Care Claim Cost = line 5 + line 10	

Table 22a – Maximum # of Preventive Care Visits

Maximum # of Covered Visits Per Coverage Year	Factor
1 visit	1.0
2 visits	1.5

Table 23 – Option 1: Land/Air Ambulance Benefit

1	Claim Cost per \$1 per conveyance benefit	\$0.0056
2	Maximum Covered per conveyance benefit (\$50-\$100) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Ambulance Conveyances, Table 23a	
5	Adjusted Claim Cost = line 3 x line 4	

Table 23a – Maximum # of Land/Air Ambulance Conveyances

Maximum # of Covered Conveyances Per Coverage Year	Factor
1 conveyance	1.00
2 conveyances	1.10

Table 24 – Option 2: Land Ambulance Benefit

1	Claim Cost per \$1 per conveyance benefit	\$0.0053
2	Maximum Covered per conveyance benefit (\$50-\$100) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Ambulance Conveyances, Table 23a	
5	Adjusted Claim Cost = line 3 x line 4	

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Table 24a – Maximum # of Land Ambulance Conveyances

Maximum # of Covered Conveyances Per Coverage Year	Factor
1 conveyance	1.00
2 conveyances	1.10

Table 25 – Option 2: Air Ambulance Benefit

1	Claim Cost per \$1 per conveyance benefit	\$0.0003
2	Maximum Covered per conveyance benefit (\$300-\$500) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Ambulance Conveyances, Table 23a	
5	Adjusted Claim Cost = line 3 x line 4	

Table 25a – Maximum # of Air Ambulance Conveyances

Maximum # of Covered Conveyances Per Coverage Year	Factor
1 conveyance	1.00
2 conveyances	1.05

Table 26 – Prescription Drugs Benefit

Generic Copay	\$5	\$5	\$5	\$5	\$5	\$5	\$5	\$10	\$10	\$10	\$10	\$10	\$10
Brand Copay	\$25	\$30	\$35	\$40	\$45	\$50	\$25	\$30	\$35	\$40	\$45	\$50	\$50
Quarterly Maximum	Annual Maximum												
\$25	\$100	6.40	6.68	6.86	7.04	7.22	7.40	6.61	6.80	6.98	7.16	7.34	7.43
\$50	\$200	10.38	10.96	11.46	11.91	12.28	12.60	10.78	11.31	11.76	12.18	12.49	12.81
\$75	\$300	13.27	14.20	14.99	15.69	16.26	16.81	13.91	14.75	15.46	16.07	16.63	17.11
\$100	\$400	15.44	16.72	17.80	18.75	19.58	20.30	16.31	17.45	18.44	19.30	20.07	20.77
\$125	\$500	17.16	18.71	20.08	21.27	22.33	23.29	18.22	19.64	20.90	22.00	22.97	23.85
\$150	\$600	18.58	20.37	21.97	23.39	24.67	25.82	19.79	21.44	22.94	24.26	25.45	26.54
\$175	\$700	19.76	21.79	23.57	25.19	26.68	28.03	21.14	23.00	24.67	26.20	27.59	28.85
\$200	\$800	20.71	23.00	25.00	26.78	28.42	29.94	22.26	24.34	26.20	27.89	29.45	30.89
\$225	\$900	21.50	24.01	26.24	28.20	29.98	31.64	23.20	25.50	27.55	29.40	31.10	32.69
\$250	\$1,000	22.18	24.87	27.28	29.45	31.41	33.18	23.99	26.50	28.75	30.75	32.60	34.31
\$275	\$1,100	22.70	25.60	28.18	30.52	32.65	34.61	24.70	27.35	29.79	31.99	33.96	35.81
\$300	\$1,200	23.15	26.22	28.96	31.48	33.76	35.86	25.22	28.08	30.67	33.03	35.21	37.17
\$325	\$1,300	23.52	26.74	29.69	32.33	34.78	37.00	25.73	28.73	31.45	33.96	36.27	38.41
\$350	\$1,400	23.83	27.20	30.25	33.06	35.64	38.04	26.10	29.26	32.18	34.81	37.26	39.51
\$375	\$1,500	24.10	27.57	30.78	33.77	36.42	38.94	26.45	29.77	32.77	35.54	38.13	40.55

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Table 27 – Supplemental Accident Medical Benefit

1	Facility Confinement Adjusted Claim Cost, Table 27a1	
2	Emergency Room Visit Adjusted Claim Cost, Table 27b1	
3	Outpatient Diagnostic Testing, X-ray and Lab Adjusted Claim Cost, Table 27c1	
4	Outpatient Physicians Office Visit Adjusted Claim Cost, Table 27d1	
5	Ambulance Adjusted Claim Cost, Table 27e1	
6	Physical/Speech/Occupational Therapy Adjusted Claim Cost, Table 27f1	
6	Total Adjusted Claim Cost = line 1 + line 2 + line 3 + line 4 + line 5	

Table 27a1 – Supplemental Accident Hospital or Skilled Nursing Facility Confinement

1	Claim Cost per \$1 benefit per confinement	\$0.0008
2	Maximum Covered Confinement benefit (\$250-\$5,000) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Confinement, Table 27a2	
5	Adjusted Claim Cost = line 3 x line 4	

Table 27a2 – Supplemental Accident Maximum # of Covered Hospital or Skilled Nursing Facility Confinement

Maximum # of Covered Confinements Per Coverage Year	Factor
1 Confinement	0.8713
2 Confinements	1.0000

Table 27b1 – Supplemental Accident Emergency Room Visit Benefit

1	Claim Cost per \$1 per visit benefit	\$0.0117
2	Maximum Covered per visit benefit (\$25-\$100) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered ER Visits, Table 27b2	
5	Adjusted Claim Cost = line 3 x line 4	

Table 27b2 – Supplemental Accident Maximum # of Covered Emergency Room Visits

Maximum # of Covered Emergency Room Visits Per Coverage Year	Factor
1 visit	0.9499
2 visits	0.9947
3 visits	1.0000

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Table 27c1 – Supplemental Accident Outpatient Diagnostic Testing, X-ray and Lab Indemnity Benefit

1	Claim Cost per \$1 per procedure benefit	\$0.0088
2	Maximum Covered per procedure benefit (\$50-\$200) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered DXL Procedures, Table 27c2	
5	Adjusted Claim Cost = line 3 x line 4	

Table 27c2 – Supplemental Accident Maximum # of Covered DXL Procedures

Maximum # of Covered DXL Procedures Per Coverage Year	Factor
1 procedure	0.7282
2 procedures	0.9221
3 procedures	1.0000

Table 27d1 – Supplemental Accident Outpatient Physicians Office Visit Benefit

1	Claim Cost per \$1 per visit benefit	\$0.0086
2	Maximum Covered per visit benefit (\$50-\$100) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Office Visits, Table 27d2	
5	Adjusted Claim Cost = line 3 x line 4	

Table 27d2 – Supplemental Accident Maximum # of Covered Office Visits

Maximum # of Covered Office Visits Per Coverage Year	Factor
1 visit	0.8073
2 visits	1.0000

Table 27e1 – Ambulance Benefit

1	Claim Cost per \$1 per conveyance benefit	\$0.00008
2	Maximum Covered per conveyance benefit (\$50-\$200) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Conveyances, Table 27e2	
5	Adjusted Claim Cost = line 3 x line 4	

Table 27e2 – Maximum # of Covered Ambulance Conveyances

Maximum # of Covered Conveyances Per Coverage Year	Factor
1 conveyance	0.9746
2 conveyances	1.0000

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Table 27f1 – Physical Therapy/Speech Therapy/Occupational Therapy Benefit

1	Claim Cost per \$1 per visit benefit	\$0.0134
2	Maximum Covered per visit benefit (\$25-\$100) (Input based on plan design)	
3	Unadjusted claim cost = line 1 x line 2	
4	Adjustment factor - Maximum # of Covered Therapy Visits, Table 27f2	
5	Adjusted Claim Cost = line 3 x line 4	

Table 27f2 – Maximum # of Covered Therapy Visits

Maximum # of Covered Therapy Visits Per Coverage Year	Factor
1 visit	0.7795
2 visits	0.9215
3 visits	1.0000

Table 28 – Effective Date/Renewal Date Adjustment

1	Proposed Rate Effective Date	
2	Months after October 1, 2010	
3	Annual Trend ⁷	
4	Adjustment Factor = $(1 + \text{line 3})^{(\text{line 2} / 12)}$	

⁷ An annual trend of 4% for non-prescription drug benefits and 12% for prescription drug benefit should be considered based on the current environment. AFS Underwriter should consider emerging development and benefit options and determine the appropriate trend at the time of underwriting. The selected trend should be applied to all cases with similar characteristics in the same time period.

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Tables 29 through 32 should be based on best available information. When insufficient information is available, underwriter shall not use any composite adjustment factors of less than 1.0.

Table 29 – Area Adjustment

State	Area Factors	# of Insured	State	Area Factors	# of Insured	State	Area Factors	# of Insured
AL	0.96		MD	0.90		SC	0.96	
AK	1.00		MA	0.85		SD	0.99	
AZ	1.02		MI	0.85		TN	1.01	
AR	0.85		MN	0.87		TX	1.20	
CA	0.95		MS	0.92		UT	0.85	
CO	0.91		MO	0.91		VT	0.85	
CT	0.90		MT	0.85		VA	1.03	
DE	1.00		NE	0.91		WA	0.85	
DC	0.86		NV	1.09		WI	0.87	
FL	1.15		NH	0.85		WV	0.91	
GA	0.85		NJ	1.20		WY	0.85	
HI	0.85		NM	0.90				
ID	0.85		NY	0.90				
IL	1.00		NC	0.93				
IN	0.92		ND	0.85				
IA	0.85		OH	0.93				
KS	0.86		OK	0.93				
KY	0.91		OR	0.85				
LA	0.99		PA	1.00				
ME	0.90		RI	0.87				

Composite Area Factor = sum (state area factor x # of insured in state) / total # of insured

Table 30 – Age/Sex Adjustment

Age	Insured without Dependents				Insured with Dependents			
	Age/Sex Factor	# of Insured	Age/Sex Factor	# of Insured	Age/Sex Factor	# of Insured	Age/Sex Factor	# of Insured
	Male		Female		Male		Female	
to 25	0.46		0.49		0.48		0.48	
25-29	0.60		0.57		0.59		0.58	
30-34	0.71		0.77		0.74		0.74	
35-39	0.85		0.74		0.80		0.78	
40-44	1.00		1.18		1.08		1.10	
45-49	1.04		1.30		1.17		1.19	
50-54	1.40		1.58		1.49		1.50	
55-59	1.90		1.89		1.89		1.89	
60-64	2.50		2.33		2.42		2.41	
65+	3.37		3.04		3.21		3.19	

Composite Age/Sex Factor = sum (individual age/sex factor x # of insured) / total # of insured

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Table 31 – Industry Adjustment

SIC Code	Adjustment Factor
36-3699; 38-3999; 48-4899	95%
01-0259; 07-0851; 17-1752; 20-2399; 25-2796; 29-3291; 34-348; 349-3599; 37-3799; 40-4013; 47-4785; 49-6163; 63-7041; 73-734; 75-7941; 82-8299; 84-862; 87-9199; 93-9999;	100%
027-0291;09-0971;15-1629;176-1799;24-2499;28-2899;3292-3399;3482- 3489;41-4581;62-6289;72-7299;7342-7389;7948-7999;81-8111;83- 8399;8621-8699;92-9229;	110%
10-1499; 46-4619; 80-8099	Referral

Table 32 can only be used by AFS underwriter authorized to adjust rates for this product.

Table 32 – Other Case Characteristics

Characteristics	Adjustment Factor
1 Rich Plan Design (add 0% - 5%)	
2 Low Plan Design (reduce 0% - 5%)	
3 Employer sponsor (payroll slot, etc., other than contribution) (reduce 0%-2%)	
4 Other benefit offerings by AFS (reduce 0%-2%)	
5 Other pertinent characteristics (-5% to +5%)	
6 Total	Sum of line 1 to line 5
7 Adjustment Factor	1 + line 6

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The # of lives for Table 33 is the (Total of Table 3, line 5) / 12. Credibility factors - interpolate linearly. Factors will be increased or decreased based on the persistency in experience fluctuation, plan designs, change in brokers, change in carriers and other documented items that could affect credibility of the experience.

Table 33 – Credibility Factors

# of lives	Credibility Factor
500	25%
1,000	50%
1,500	75%
2,000	100%

Table 34 – Standard Premium Tier Factors

Premium Tier	Factor
Three-Tier	
Single	1.00
2 Person	1.92
Family	2.60
Four Tier	
Single	1.00
Plus Spouse	2.00
Plus Child(ren)	1.80
Family	2.70

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SERFF Tracking Number: ICCI-127782409 State: Arkansas
 Filing Company: American Financial Security Life Insurance State Tracking Number: 50136
 Company
 Company Tracking Number: AF FI POL 410
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: AF FI POL 410 Hospital Indemnity
 Project Name/Number: Hospital Indemnity/AF FI POL 410

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	10/31/2011
Comments:		
Attachment: Cert of Comp. with Rule 19 AFSLIC AF FI.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	10/31/2011
Comments: see form schedule tab		

	Item Status:	Status Date:
Satisfied - Item: Authorization Letter	Approved-Closed	10/31/2011
Comments:		
Attachment: ICC Authorization letter 01-11.pdf		

	Item Status:	Status Date:
Satisfied - Item: The National Better Living Association (NBLA) previously approved	Approved-Closed	10/31/2011
Comments:		
Attachments: AR NBLA Association previously approved 1-14-11 ICCI-126911879.pdf AR AFSLIC NBLA Group Insurance Filing Supporting Information.pdf		

	Item Status:	Status
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SERFF Tracking Number: ICCI-127782409 State: Arkansas
Filing Company: American Financial Security Life Insurance State Tracking Number: 50136
Company
Company Tracking Number: AF FI POL 410
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: AF FI POL 410 Hospital Indemnity
Project Name/Number: Hospital Indemnity/AF FI POL 410

Satisfied - Item:

The National Congress of
Employers (NCE) acknowledged as
valid

Approved-Closed

Date:
10/31/2011

Comments:

Attachment:

AR NCE previously approved 10-16-09.pdf

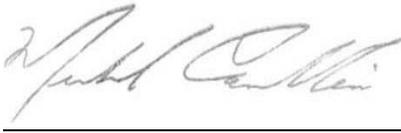
**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: American Financial Security Life Insurance Company

Form Number(s):

Group Hospital Indemnity Health Insurance Policy – AF FI POL 410
Group Hospital Indemnity Certificate of Insurance – AF FI CERT 410
Amendatory Endorsement – AF FI AEAR 410
Member Enrollment form – AF FI MEM EF 410 AR

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



Signature of Company Officer

Mike Camilleri
American Financial Security Life Insurance
Company

President and Secretary
Title

October 31, 2011
Date

American Financial Security Life Insurance Company

Jefferson City, Missouri

January 1, 2011

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

RE: American Financial Security Life Insurance Company

NAIC Company #: 69337
NAIC Group #: 4510
FEIN #: 44-0617151

AUTHORIZATION STATEMENT

The undersigned hereby certifies that *Insurance Compliance Consultants, Inc.*, has the authority to act on behalf of the above Company for the sole purpose of filing with the state insurance department those policy, amendment, endorsement, rider, certificate, reports, rates, surveys and/or application forms approved by the Companies for use in Company's transaction of business.

Authorized by:



Mike Camilleri
President and Secretary
American Financial Security Life Insurance Company

SERFF Tracking Number: ICCI-126911879 State: Arkansas
Filing Company: American Medical and Life Insurance Company State Tracking Number: 47699
Company Tracking Number: AMLI GRP LM 2010 POL GA
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: AMLI GRP LM 2010 POL GA
Project Name/Number: AMLI GRP LM 2010 POL GA /AMLI GRP LM 2010 POL GA

Filing at a Glance

Company: American Medical and Life Insurance Company

Product Name: AMLI GRP LM 2010 POL GA SERFF Tr Num: ICCI-126911879 State: Arkansas
TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed-Approved-
Closed State Tr Num: 47699

Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: AMLI GRP LM 2010 State Status: Approved-Closed
POL GA

Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
Author: Brenda Dawson Disposition Date: 01/14/2011
Date Submitted: 01/13/2011 Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

General Information

Project Name: AMLI GRP LM 2010 POL GA
Project Number: AMLI GRP LM 2010 POL GA
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Association
Filing Status Changed: 01/14/2011
State Status Changed: 01/14/2011
Created By: Brenda Dawson
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Overall Rate Impact:
Company Status Changed:
Deemer Date:
Submitted By: Brenda Dawson

Filing Description:

We are submitting the captioned forms for filing for use in your state. These are new forms and are not intended to replace any previously approved forms.

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

Master Group Policy form AMLI GRP LM 2007 POL GA will be issued to an Association group located outside of your state. The National Better Living Association is domiciled in Georgia and this Association has previously been approved

SERFF Tracking Number: ICCI-126911879 State: Arkansas
Filing Company: American Medical and Life Insurance Company State Tracking Number: 47699
Company Tracking Number: AMLI GRP LM 2010 POL GA
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: AMLI GRP LM 2010 POL GA
Project Name/Number: AMLI GRP LM 2010 POL GA /AMLI GRP LM 2010 POL GA
in Arkansas on January 11, 2010.

Application AMLI GRP LM 2007 GA AR is the group application.

Form AMLI GRP LM 2007 CERT GA is the Group Accident and Sickness Fixed Indemnity Certificate of Insurance evidencing coverage under the Master Group Policy. This is a fixed indemnity plan. Amendatory Endorsement GRP LM 2007 AE AR will be attached to all Certificates issued in Arkansas.

The Schedule of Benefits, AMLI GRP LM 2007 SCHED GA, is attached to the Certificate.

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Company and Contact

Filing Contact Information

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

Filing Company Information

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

American Medical and Life Insurance Company CoCode: 81418 State of Domicile: New York
8 West 38th Street Group Code: Company Type:
Suite 1002 Group Name: State ID Number:
New York City, NY 10018 FEIN Number: 13-2562243
(646) 223-9300 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$250.00
Retaliatory? No
Fee Explanation: \$50 per form x 5 forms
Per Company: No

EXHIBIT E: ASSOCIATION INFORMATION, BYLAWS, ARTICLES OF INCORPORATION

ASSOCIATION INFORMATION

Legal Name:	The National Better Living Association, Inc.
Principal Office Address:	6470 East Johns Crossing, Suite 170, Duluth, Georgia, 30097 (Gwinnett County)
Website Address:	www.acinbla.com
Year Established:	1995
Purpose/Mission:	To offer and serve association members' specific needs as relates to quality of life, wellness and healthcare.
Membership Classes:	<u>2 Classes</u> a) Regular Member: any person so designated by the Board b) Associate Member: any person who is a member of a group classified by the Board as eligible for membership may be an Associate Member. Each person or entity having a fully paid membership in the association shall be an Associate Member for as long as such person or entity continues to hold a valid and effective membership in the association.
Current Membership:	3,734 of which 3,666 are NBLA Limited Medical Benefit members.
Membership Benefits:	Several Lifestyle and Wellness programs including enhanced wellness opportunities, personal advice and savings in non-medical services. (Exhibit A: NBLA Benefits Matrix by Membership)
Satisfaction Guarantee:	Full refund of membership fees is guaranteed if a member becomes dissatisfied for any reason. Refund typically processed within 10 days.

**UNANIMOUS WRITTEN CONSENT
OF THE BOARD OF DIRECTORS
OF
THE NATIONAL BETTER LIVING ASSOCIATION, INC.**

The undersigned, being all of the members of the board of directors (the "Directors") of The National Better Living Association, Inc. (the "Corporation"), pursuant to Section 14-3-821 of the Georgia Nonprofit Corporation Code, hereby adopt the following resolutions by written consent:

Adoption of Amended and Restated Articles of Incorporation and Bylaws

WHEREAS, the Directors have determined that it is in the best interest of the Corporation to amend and restate the Articles of Incorporation and Bylaws of the Corporation to revise and clarify certain governing provisions of the Corporation.

NOW, THEREFORE, BE IT RESOLVED, that the Amended and Restated Articles of Incorporation and Amended and Restated Bylaws accompanying this Consent are hereby approved and adopted as the Articles of Incorporation and Bylaws of the Corporation, effective as of the date hereof, and shall be placed in the minute book of the Corporation.

FURTHER RESOLVED, that the officers of the Corporation shall be and hereby are authorized to execute and file the Amended and Restated Articles of Incorporation with the Georgia Secretary of State.

Designation of Associate Members

WHEREAS, the Directors have determined that it is in the best interest of the Corporation to deem each person or entity having a fully paid membership in The National Better Living Association as an Associate Member of the Corporation, as permitted by the Amended and Restated Bylaws.

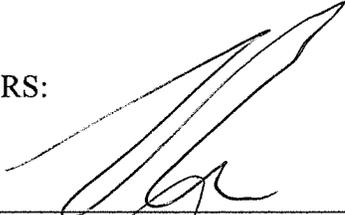
NOW, THEREFORE, BE IT RESOLVED, that each person or entity having a fully paid membership in The National Better Living Association shall be and hereby is deemed to be an Associate Member of the Corporation, for as long as such person or entity continues to hold a valid and effective membership in The National Better Living Association.

FURTHER RESOLVED, that the officers of the Corporation shall be and hereby are authorized to execute such instruments and take such actions as may be necessary or advisable to carry out the intent of the foregoing resolutions.

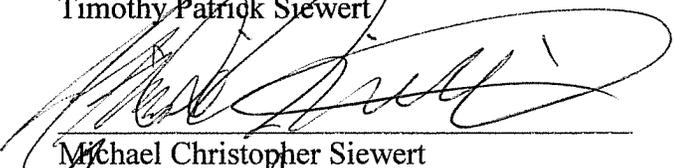
[SIGNATURES APPEAR ON NEXT PAGE]

IN WITNESS WHEREOF, the undersigned have executed this Consent effective as of September 24, 2008.

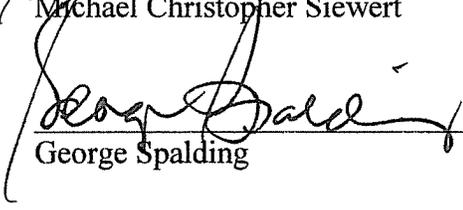
DIRECTORS:



Timothy Patrick Siewert



Michael Christopher Siewert



George Spalding

**AMENDED AND RESTATED BYLAWS
OF
THE NATIONAL BETTER LIVING ASSOCIATION, INC.
A Georgia Nonprofit Corporation**

ARTICLE I

Name

The name of the corporation is The National Better Living Association, Inc. (the “Corporation”).

ARTICLE II

Offices

The principal office of the Corporation in the State of Georgia shall be located at 6470 East Johns Crossing, Suite 170, Duluth, Gwinnett County, Georgia, 30097, or at such other place as shall be lawfully designated by the board of directors (the “Board”). The Corporation may have such other offices, either within or without the State of Georgia, as the Board may designate or as the affairs of the Corporation may require from time to time.

ARTICLE III

Purposes

The purposes of the Corporation shall be as provided in the Articles of Incorporation. The purposes of the Corporation may be carried out through any and all lawful activities, including others not specifically stated in the Articles of Incorporation but incidental to the stated purposes.

ARTICLE IV

Members

4.1. Classes of Members. The Corporation shall have two (2) classes of members (“Members”), as follows:

(a) Regular Member: any person so designated by the Board may be a Regular Member. Without limiting the generality of the foregoing, each of the following persons shall be a Regular Member: Timothy Patrick Siewert, Michael Christopher Siewert, George Spalding, David John Siewert, and Susan Spalding.

(b) Associate Member: any person who is a member of a group classified by the Board as eligible for membership may be an Associate Member.

Members shall be entitled to such rights, privileges, and benefits as may be determined by the Board from time to time. Except as otherwise required by applicable law, Members shall have the right to elect directors but shall not have the right to vote on any other matter affecting the Corporation.

4.2. Terms and Conditions of Membership. Except as otherwise provided in these Bylaws, the Board shall have authority to set the terms and conditions of membership in the Corporation, including without limitation eligibility for membership, length of membership, enrollment fees, periodic dues, termination of membership, and any other matters with respect to Members.

4.3. Dues. All Members shall pay dues in the amounts determined by the Board from time to time.

ARTICLE V

Meetings of Members

5.1. Annual Meeting. The annual meeting of the Members shall be held on or before the fifteenth (15) day of the sixth month of each fiscal year of the Corporation, or at such other time as may be determined by the Board, for the purpose of electing directors. If the day fixed for the annual meeting is a legal holiday in the State in which the meeting is to be held, the meeting shall be held on the next succeeding business day.

5.2. Special Meetings. Special meetings of Members for any purpose, unless otherwise proscribed by statute, may be called by the President or the Board.

5.3. Place of Meeting. The Board may designate any place, either within or without the State of Georgia, as the place for any annual or special meeting. In the absence of any designation, all meetings shall be held at the principal office of the Corporation in the State of Georgia.

5.4. Notice of Meeting. Written or printed notice stating the place, day and hour of the meeting and, in the case of a special meeting or a meeting that is required by statute to be held for any special purpose or any annual meeting at which special action is to be taken, the purpose for which the meeting is called or the special action that is proposed to be taken, shall be delivered not less than ten (10) nor more than sixty (60) days before the date of the meeting, either personally or by mail, by or at the direction of the President, the Secretary, or the persons calling the meeting, to each Member of record entitled to vote at the meeting. If mailed, the notice shall be deemed to be delivered when deposited in the United States mail addressed to the Member at his or her address as it appears in the records of the Corporation, with postage prepaid. If given personally, the notice shall be deemed to have been delivered when handed to the Member or left at his or her place of business or residence.

5.5. Quorum. Except as otherwise provided by law, the holders of ten percent (10%) of the votes entitled to be cast shall constitute a quorum at a meeting of Members. If the holders of less than ten percent (10%) of the votes entitled to be cast are present at a meeting, persons holding a majority of the votes present may adjourn the meeting from time to time without further notice. At an adjourned meeting at which a quorum is present, any business may be transacted that might have been transacted at the meeting as originally noticed. The Members present at a duly organized meeting may continue to transact business until adjournment, notwithstanding the withdrawal of enough Members to leave less than a quorum.

5.6. Voting. Each Regular Member shall be entitled to one thousand (1,000) votes on each matter submitted to a vote at a meeting of Members. Each Associate Member shall be entitled to one (1) vote on each matter submitted to a vote at a meeting of Members. Unless otherwise required by the Articles of Incorporation, these Bylaws or applicable law, all questions submitted to the Members shall be decided the affirmative vote of holders of a majority of the votes entitled to be cast at a meeting at which a quorum is present.

5.7. No Proxies or Action Without Meeting. At all meetings of Members, a Member must be present in person in order to vote. No voting by proxy will be permitted, and no Member action may be taken by written consent or ballot without a meeting.

ARTICLE VI

Board of Directors

6.1. General Powers. The business and affairs of the Corporation shall be managed by the Board.

6.2. Number, Election and Tenure of Directors. The Corporation shall have five (5) directors. Each principal officer (President, Secretary and Treasurer) shall be a director; the Associate Members, voting as a class, shall be entitled to elect one (1) director; and the Regular Members, voting as a class, shall be entitled to elect one (1) director. Each director of the Corporation shall serve for a one (1)-year term, or until his or her successor has been elected and qualified. Except as otherwise provided in Section 6.9, a successor director shall be elected by a majority of the Members entitled to vote for such director at the annual meeting of the Members.

6.3. Annual and Regular Meetings. An annual meeting of the Board shall be held, without notice other than these Bylaws, immediately after and at the same place as the annual meeting of Members; provided, however, that any annual meeting may be held at any other time or place specified in a notice given as provided below for special meetings, or in a consent and waiver of notice thereof signed by all directors. The Board may provide, by resolution, the time and place, either within or without the State of Georgia, for the holding of regular meetings without other notice than such resolution.

6.4. Special Meetings. Special meetings of the Board may be called by or at the request of the President or any two (2) directors. The person or persons authorized to call special meetings of the Board may fix any place, either within or without the State of Georgia, as the place for holding any special meeting of the Board.

6.5. Notice. Notice of any special meeting shall be given either by (a) written notice at least forty-eight (48) hours in advance of such meeting, delivered in person, by facsimile or by leaving such notice at the place of business or residence of each director, or by depositing such notice in the United States mail, postage prepaid, addressed to the director at his or her address as it appears on the records of the Corporation; or (b) verbally in person or by telephone at least twenty-four (24) hours in advance of such meeting. Neither the business to be transacted at nor the purpose of any regular or special meeting of the Board need be specified in the notice or waiver of notice of such meeting.

6.6. Quorum. A majority of the directors shall constitute a quorum for the transaction of business at any meeting of the Board, but if less than a majority is present at a meeting, a majority of the directors present may adjourn the meeting from time to time without further notice. If a quorum is present when the meeting is convened, the directors present may continue to do business, taking action by a vote of a majority of a quorum as fixed above, until adjournment, notwithstanding the withdrawal of enough directors to leave less than a quorum or the refusal of any director present to vote.

6.7. Manner of Acting. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board, unless the act of a greater number is required by statute, the Articles of Incorporation or these Bylaws.

6.8. Action Without a Meeting. Any action required or permitted to be taken by the Board at a meeting may be taken without a meeting if a consent in writing, setting forth the action so taken, is signed by that number of directors that would be necessary to take such action at a meeting and included in the minutes filed with the corporate records. Such action shall be effective when the last director signs the consent, unless the consent specifies a different effective date.

6.9. Vacancies. Any vacancy occurring in the Board shall be filled by the affirmative vote of a majority of the remaining directors, though less than a quorum. Any director elected to fill a vacancy shall serve until the next annual meeting of the Members. Any directorship to be filled by reason of an increase in the number of directors shall be filled by election at the next annual meeting of the Members or, if there are no Members, at a meeting of directors called for that purpose.

6.10. Compensation. Directors shall not receive any stated compensation for their services as such, but by resolution of the Board a fixed sum and expenses of attendance, if any, may be allowed for attendance at any annual, regular or special meeting. Nothing in this Section shall be construed to preclude a director from serving the Corporation in any other capacity and receiving compensation therefor.

6.11. Presumption of Assent. A director of the Corporation who is present at a meeting of the Board at which action on any corporate matter is taken shall be presumed to have assented to the action taken unless his or her dissent is entered in the minutes of the meeting or unless he or she files a written dissent to such action with the person acting as the secretary of the meeting before the adjournment thereof or forwards such dissent by registered or certified mail or personal delivery to the Secretary of the Corporation immediately after the adjournment of the meeting. This right to dissent shall not apply to a director who voted in favor of such action.

6.12. Resignation. Any director of the Corporation may resign at any time either by oral tender of resignation at any meeting of the Board or by giving written notice to the Secretary of the Corporation. Any such resignation shall take effect upon receipt of such notice or at any later time specified therein. Unless otherwise specified in the notice, the acceptance of such resignation shall not be necessary to make it effective.

6.13. Removal of Directors. Any director may be removed from office for any reason whatsoever upon the affirmative vote of a majority of the members of the Board.

6.14. Participation in Meetings by Conference Telephone. Members of the Board or any committee designated thereby may participate in a meeting of the Board or committee by means of a conference telephone or similar communications equipment if all persons participating in the meeting can hear each other at the same time, and participation by such means shall constitute presence in person at such meeting.

6.15. Committees. The Board, by resolution adopted by a majority of the entire Board, may designate one or more committees, each consisting of two (2) or more persons, who may or may not be directors, and may delegate to any such committee all authority of the Board that the directors may legally delegate. Each committee, and each member of any committee, shall serve at the pleasure of the Board. The designation of any such committee and the delegation thereto of authority shall not relieve any director of any responsibility imposed by law or these Bylaws. To the extent applicable, the provisions of these Bylaws relating to the conduct of meetings of the Board also shall govern meetings of committees.

ARTICLE VII

Officers

7.1. Principal and Other Officers. The principal officers of the Corporation shall be elected by the Board and shall include a President, a Secretary and a Treasurer. The Board, in its discretion, also may elect such other officers as it deems necessary. Any number of offices may be held by the same person.

7.2. Election of Officers; Term of Office. The officers of the Corporation shall be elected by the Board at each annual meeting of the Board. If the election of officers is not held at such meeting, such election shall be held as soon thereafter as may be convenient. Each officer shall hold office until his or her successor has been duly elected and qualified or until his or her death, resignation or removal in the manner provided below. If the Board fails to fill any office at the annual meeting, any vacancy in any office occurs or any office is newly created, such office may be filled at any regular or special meeting of the Board.

7.3. Delegation of Duties of Officers. The Board may delegate the duties and powers of any officer of the Corporation to any other officer or to any director for a specified period of time for any reason that the Board may deem sufficient.

7.4. Removal of Officers or Agents. Any officer or agent of the Corporation may be removed by the Board whenever in its judgment the best interests of the Corporation will be served thereby, but such removal shall be without prejudice to the contract rights, if any, of the person so removed. Election or appointment of any officer or agent shall not of itself create contract rights.

7.5. Resignation. Any officer may resign at any time by giving written notice of resignation to the Board, the President or the Secretary of the Corporation. Any such resignation shall take effect upon receipt of such notice or at any later time specified therein. Unless

otherwise specified in the notice, the acceptance of a resignation shall not be necessary to make the resignation effective.

7.6. Vacancies. A vacancy in any office, whether due to death, resignation, removal, disqualification or otherwise, may be filled by the Board or any committee or officer to whom authority has been delegated by these Bylaws or by resolution of the Board.

7.7. President. The President shall preside at all meetings of the Board at which he or she is present. The President shall be the chief executive officer of the Corporation and, subject to the control of the Board, shall have general supervision over the business and affairs of the Corporation. The President shall have all powers and duties usually incident to the office of president, except as specifically limited by resolution of the Board. The President shall have such other powers and perform such other duties as may be assigned from time to time by the Board.

7.8. Secretary. The Secretary shall act as secretary of all meetings of the Board at which he or she is present, shall record all the proceedings of all such meetings in a book to be kept for that purpose and shall have supervision over the care and custody of the records and seal of the Corporation. The Secretary shall be empowered to affix the corporate seal to documents, the execution of which on behalf of the Corporation under its seal is duly authorized, and when so affixed may attest the same. The Secretary shall have all powers and duties usually incident to the office of secretary, except as specifically limited by a resolution of the Board. The Secretary shall have such other powers and perform such other duties as may be assigned from time to time by the Board or the President.

7.9. Treasurer. The Treasurer shall have general supervision over the care and custody of the funds and the receipts and disbursements of the Corporation and shall cause the funds of the Corporation to be deposited in the name of the Corporation in such banks or other depositories as the Board may designate. The Treasurer shall have supervision over the care and safekeeping of the securities of the Corporation. The Treasurer shall have all powers and duties usually incident to the office of treasurer, except as specifically limited by a resolution of the Board. The Treasurer shall have such other powers and perform such other duties as may be assigned from time to time by the Board or the President.

ARTICLE VIII

Contracts, Checks, Deposits and Funds

8.1. Authorization. The Board may authorize any officer or agent, in addition to the specific authorization given to the President and Secretary above, to enter into any contract or execute and deliver any instrument in the name of and on behalf of the Corporation, and such authority may be general or confined to specific instances. All checks, drafts, or other orders for the payment of money, notes, or other evidences of indebtedness issued in the name of the Corporation shall be signed by such officer or agent of the Corporation and in such manner as determined from time to time by resolution of the Board.

8.2. Funds. All funds of the Corporation not otherwise employed shall be deposited to the credit of the Corporation in such banks, trust companies, or other depositories as the Board

may select, or as may be designated by any officer or agent of the Corporation to whom such power may be delegated by the Board.

8.3. Acceptance of Gifts. The Board, or any officer or agent of the Corporation to whom such authority may be delegated by the Board, may accept on behalf of the Corporation any contribution, gift, bequest or devise for the general purposes or for any special purpose of the Corporation.

8.4. Bond. At the direction of the directors, any officer or employee of the Corporation shall be bonded. The expense of furnishing any such bond shall be paid by the Corporation.

ARTICLE IX

Liability and Indemnification of Directors and Officers

9.1. Limited Liability of Directors. The liability of the directors of the Corporation shall be limited in accordance with the provisions of Section 14-3-830 of the Georgia Nonprofit Corporation Code and the Articles of Incorporation.

9.2. Indemnification. To the full extent permitted by applicable law and the Articles of Incorporation, the Corporation shall indemnify any person (and the heirs, executors and administrators of such person) who, by reason of the fact that he or she is or was a director, officer, employee or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, partner, employee or agent of another corporation, partnership, joint venture, trust or other enterprise, was or is a party or is threatened to be made a party to:

(a) any threatened, pending or completed claim, action, suit or proceeding, whether civil, criminal, administrative or investigative, including appeals (other than an action by or in the right of the Corporation), against expenses (including attorneys' fees), judgments, fines and amounts paid in settlement actually and reasonably incurred by such person in connection with any such claim, action, suit or proceeding; or

(b) any threatened, pending or completed claim, action or suit by or in the right of the Corporation to procure a judgment in its favor, against expenses (including attorneys' fees) actually and reasonably incurred by such person in connection with the defense or settlement of such action or suit.

Any such indemnification by the Corporation shall be made in the manner and to the extent authorized by applicable law and the Articles of Incorporation.

9.3. Success on Merits or Otherwise. To the extent that a person who is or was a director, officer, employee or agent of the Corporation, or of any other corporation, partnership, joint venture, trust or other enterprise with which he or she is or was serving in such capacity at the request of the Corporation, has been successful on the merits or otherwise in defense of any action, suit or proceeding referred to in this Article or in defense of any claim, issue or matter therein, such person shall be indemnified against expenses (including attorneys' fees) actually and reasonably incurred by such person in connection therewith.

9.4. Applicable Standard. Any indemnification under this Article (unless ordered by a court) shall be made by the Corporation only as authorized in the specific case upon a determination that indemnification of the director or officer is proper in the circumstances because he or she has met the applicable standard of conduct. Such determination shall be made: (a) by the Board by a majority vote of a quorum consisting of directors who were not parties to such action, suit or proceeding; or (b) if such a quorum is not obtainable, or even if obtainable but a quorum of disinterested directors so directs, by independent legal counsel in a written opinion.

9.5. Non-Exclusivity of Article. The indemnification provided by this Article shall not be deemed exclusive of any other rights to which a director or officer seeking indemnification may be entitled under the Articles of Incorporation, these Bylaws, any statute, agreement, vote of members or disinterested directors or otherwise, both as to action in such person's official capacity and as to action in another capacity while holding such office, and shall continue as to a person who has ceased to be a director or officer and shall inure to the benefit of the heirs, executors and administrators of such person.

9.6. Insurance. The Corporation shall have the power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, partner, employee or agent of another corporation, partnership, joint venture, trust or other enterprise against any liability asserted against such person and incurred by him or her in any such capacity or arising out of his or her status as such, whether or not the Corporation would have the power to indemnify such person against such liability under applicable.

9.7. Definition. For purposes of this Article, references to "the Corporation" shall include, in addition to the resulting corporation, any constituent corporation (including any constituent of a constituent) absorbed in a consolidation or merger which, if its separate existence had continued, would have had power and authority to indemnify its directors, officers, employees or agents, so that any person who is or was a director, officer, employee or agent of such constituent corporation, or is or was serving at the request of such constituent corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise, shall stand in the same position under the provisions of this Article with respect to the resulting or surviving corporation as he would have with respect to such constituent corporation if its separate existence had continued.

9.8. Intent. The intent of this Article is to permit indemnification of directors and officers of the Corporation to the fullest extent permitted by the Georgia Nonprofit Corporation Code. If the Georgia Nonprofit Corporation Code or, to the extent applicable, the Georgia Business Corporation Code is amended to authorize the further elimination or limitation of the liability of directors or officers, then the liability of a director or officer of the Corporation, in addition to the limitation on personal liability provided herein, shall be limited to the fullest extent permitted by the amended Georgia Nonprofit Corporation Code or Georgia Business Corporation Code, as appropriate.

9.9. Severability. The invalidity or unenforceability of any provision in this Article shall not affect the validity or enforceability of the remaining provisions of this Article.

ARTICLE X
Dissolution

Upon dissolution of the Corporation, the Board shall, after paying or making provision for payment of all of the liabilities and obligations of the Corporation, dispose of all of the remaining assets of the Corporation by distributing those assets pro rata to the Members in accordance with their relative voting percentages.

ARTICLE XI
Amendment

These Bylaws may be amended or repealed, and new Bylaws may be adopted, by the affirmative vote of a majority of the members of the Board, in person or by proxy, at any regular or special meeting.

ARTICLE XII
Books and Records

The Corporation shall keep correct and complete books and records of account and shall also keep minutes of the proceedings of its Board and any committees.

ARTICLE XIII
Fiscal Year

The fiscal year shall end on the last day of December in each year, or such other date as the Board may designate.

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MELISSA L. HULL, OF COUNSEL
Direct Dial: 615.726.5681
Direct Fax: 615.744.5681
E-Mail Address: mhull@bakerdonelson.com

John Fabbrini
President
The National Better Living Association, Inc.
6470 East Johns Crossing
Suite 170
Duluth, Georgia 30097

Re: Approval as an Association
Arkansas Insurance Department

Dear Mr. Fabbrini:

Please find enclosed a copy of the approval letter and filing from Arkansas Insurance Department ("AID") as it relates to The National Better Living Association, Inc. ("NBLA"). The AID has approved NBLA as an association authorized to be an eligible group policyholder in the state pursuant to A.C.A. §23-86-106. The effective date is January 7, 2010.

The AID's approval for NBLA to operate as an association eligible as group policyholder remains in effect provided that NBLA maintains the following:

1. Has articles of incorporation or by-laws demonstrating that it is an association;
2. Maintains over 100 members; and
3. Has been organized and maintained in good faith in active existence for at least two years for purposes other than that of obtaining insurance or insuring members.

A.C.A. § 23-86-106(2)(A). Under this section, the AID can periodically require NBLA to provide proof that it continues to comply with the above-listed requirements. The AID may also revoke NBLA's approval status, presuming it finds a violation of A.C.A. § 23-86-106. For your convenience, I have enclosed a copy of the Arkansas statute related to associations.

January 11, 2010

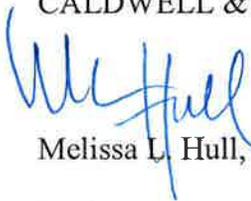
Page 2

While it is not necessarily required by statute, it may be prudent to inform the AID of any changes that would alter any of the documentation submitted by this office in December of 2009, on which the AID based its approval.

Feel free to contact me should you have any questions.

Best,

BAKER, DONELSON, BEARMAN,
CALDWELL & BERKOWITZ, P.C.



Melissa L. Hull, Of Counsel

Enclosures

cc: Dan Siewert
Tim Siewert
Angus Morrison
David Cooper

Arkansas Insurance Department

Mike Beebe
Governor



Jay Bradford
Commissioner

January 7, 2010

Ms. Melissa L. Hull, Of Counsel
Baker, Donelson, Bearman,
Caldwell & Berkowitz, P.C.
Baker Donelson Center
Suite 1000
211 Commerce Street
Nashville, TN 37201

RE: Association Filing Request
The National Better Living Association, Inc.

Dear Ms. Hull:

Our Department has reviewed the information which you submitted on The National Better Living Association, Inc.

We find that the association is in compliance with ACA §23-86-106. Our Department is approving the association on this date.

If we could be of further assistance in the future, please let us know.

Sincerely,

A handwritten signature in cursive script that reads "Rosalind D. Minor".

Rosalind D. Minor
Life & Health Compliance Officer
Life & Health Division

RDM

JAN 11 2010

**BAKER
DONELSON**
BEARMAN, CALDWELL
& BERKOWITZ, P.C.

BAKER DONELSON CENTER
SUITE 1000
211 COMMERCE STREET
NASHVILLE, TENNESSEE 37201
PHONE 615.726.5600
FAX 615.726.0464
MAILING ADDRESS
P.O. BOX 190611
NASHVILLE, TENNESSEE 37219

www.bakerdonelson.com

MELISSA L. HULL, OF COUNSEL
Direct Dial 615.726.5681
Direct Fax 615.744.5681
E-Mail Address mhull@bakerdonelson.com

December 11, 2009

Dan Honey
Insurance Deputy Commissioner
Life & Health Division
1200 West Third Street
Little Rock, Arkansas 72201

Re: Association Filing Request

Dear Mr. Honey:

On behalf of my client, The National Better Living Association, Inc., I am respectfully submitting documentation related to its status as an association in the State of Arkansas as required under Arkansas Insurance Code § 23-86-106. I would also like to provide an explanation about The National Better Living Association, Inc., including a brief history and recent changes.

History

The National Better Living Association™ ("NBLA™")¹ was established in Delaware in 1994 under its original name, CCC Plus Association. The mission and purpose of NBLA has always been to help improve the quality of life of its members by developing and promoting healthy lifestyles and wellness programs, including its own chiropractic and alternative networks. Beginning in 2002, NBLA began selling association memberships and its first member is still active.

During the ensuing years, NBLA marketed and sold memberships that included various health discount wellness and lifestyle programs to its members, including chiropractic, vision, hearing, podiatry, diabetic, respiratory, dental, pharmacy, hospital, MRI/X-ray, laboratory, nursing home/home care, travel, flowers, nurse consultation, "CallMD," and hospital negotiation services.

¹ "National Better Living Association" and "NBLA" are trademarks of The National Better Living Association, Inc.

APPROVED

JAN 07 2010

LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

RECEIVED

DEC 14 2009

LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

In 2002, NBLA filed an Amended Certificate of Incorporation in Delaware and officially changed its name to "The National Better Living Association." In December 2006, NBLA became a non-profit association, and expanded its product membership offerings to include not only the wellness and lifestyle benefits but also expanded memberships that included various levels of limited medical insurance benefits, as well as other defined benefits such as generic pharmacy, critical illness, dental and a primary accident policy. In 2007, the Delaware non-profit association merged into The National Better Living Association, Inc., a Georgia non-profit corporation.

In addition, and because of the discrepancies in state law related to associations, NBLA has obtained a resident insurance agency license in Georgia, and non-resident agency licenses in other states, including Arkansas. NBLA does not sell insurance nor has it ever received any commissions. If you feel that this is incorrect, please let me know.

Recent Leadership Changes

Until November of this year, George Spalding was the President and Treasurer of NBLA and served in those capacities since 2002. As part of a recent reorganization of NBLA, Mr. Spalding resigned from those positions to be able to devote more time to the development of a proprietary chiropractic network.

As his replacement, NBLA hired John Fabbrini to assume the role of President. Mr. Fabbrini comes to NBLA after an extensive search for an innovative leader to continue NBLA's progress and goal of becoming one of the country's premier associations that promotes a wellness and healthy lifestyle for its members. Please find enclosed a copy of Mr. Fabbrini's background information.

Status as an Association

As mentioned, NBLA is an association operating pursuant to Georgia's not-for-profit code and also falls under the definitions found under Georgia laws related to associations. We also believe NBLA meets the requirements set forth in Arkansas Insurance Code § 23-86-106(2)(A).

NBLA's mission is two-fold: (i) educating its members about better balancing work, family and personal demands and activities; and (ii) providing, collecting and disseminating information to its members about effectively accessing and taking advantage of quality health and medical care and services. I have enclosed a copy of its Certificate of Reinstated Articles, which reflects its mission.

As of today's date, NBLA has 5,245 members.

Programs

NBLA offers access to health, wellness and other lifestyle programs along with access (via the group association policies) to limited medical benefits and other insurance benefits. NBLA currently offers to prospective members four basic memberships and four expanded memberships. My Wellness Plus is also sold through the My Wellness Live web site. These memberships include both the basic wellness and defined insurance benefits. NBLA continues to look for additional programs, benefits and services

that will improve the quality of life of its members. Below is a brief description of each class of current membership.

A. Basic Memberships

- 1.) Basic Wellness – Includes access to MyEWellness.com, personal fitness and wellness site for members. Basic Wellness is a 12 month membership with Expanded Memberships.
- 2.) MyWellness Plus – Includes "Basic Wellness" membership benefits plus access to and savings from discounts on the followings services offered through the Careington International Corporation DMPO Discount Programs including dental, alternative medicine, chiropractic, vision, laboratory, diagnostic imagining, prescription, and diabetes.
- 3.) Basic Silver – Includes "MyWellness Plus" membership plus access to Karis Patient Advocacy Service.
- 4.) Basic Gold – Includes "Basic Silver" membership plus access to Careington's PHCS Physician Discount.

B. Expanded Memberships

- 1.) NBLA 250 Platinum – Includes "Basic Wellness" membership benefits plus added lifestyle and wellness benefits and access to and savings from discounts on the followings services: legal services, Taxline Financial Services, stolen identity coverage, internet service provider, 1-800-Flowers, Meineke Auto Repair, roadside assistance, travel discounts, national hotel discounts, "Ask-A-Nurse" Hotline, travel assistance, and helicopter emergency rescue. Health services include: PPO/Doctor/Patient Advocacy Service (MultiPlan Practitioner Network and patient advocacy with The Karis Group) and insurance benefits (doctor visits, preventative care/wellness, daily hospital confine, intensive care unit, and inpatient/outpatient surgical), insured pharmacy, accident medical and AD&D.
- 2.) NBLA 300 Platinum – Includes "NBLA 250 Platinum" features plus added lifestyle and wellness benefits including RV motor home savings and interstate moving. Additional health benefits include: ambulance and emergency room and higher levels of coverage for doctor visits, hospitalization, ICU and surgery.
- 3.) NBLA 500 Platinum – Includes "NBLA 300 Platinum" features plus discounts on fitness clubs/equipment and other insurance benefits such as critical illness, dental and higher levels of coverage for doctor visits, hospitalization, ICU and surgery.

- 4.) NBLA 1000 Platinum – Includes "NBLA 500 Platinum" features plus access to automobile financing, discounts on vitamins/nutritional supplements, and prescription assistance and higher levels of coverage for doctor visits, hospitalization, ICU and surgery.

For your convenience, I have enclosed a color copy of the new Basic Memberships and Expanded Membership² material.

As of December 1, 2009, NBLA switched its limited benefits group carrier from AIG (via "The United States Life Insurance Company") to Cigna (via "Life Insurance Company of America"). I have enclosed copies of the new certificates of insurance. We believe – but cannot confirm – that neither company submitted information related to the requirements under Arkansas Insurance Code § 23-86-106. With the change in carriers, we have discovered this possible deficiency. As such, we are filing this information now.

Recent Activity

NBLA has made a lot of changes and still has more to go. NBLA is constantly pursuing new avenues of lifestyle and wellness programs for its members. In 2009, NBLA updates its membership material and its website. In 2010, NBLA plans to introduce these new benefits to its members: (i) a new wellness assessment program; (ii) a new Wellness (Based) Weight Management program; (iii) a new program for Home PC Technical Support; and (iv) a new program for dental teeth whitening. Also, NBLA plans to hold the annual membership meeting of its members in the first quarter of 2010.

We look forward to working with you and trust this material is sufficient to obtain the Arkansas Insurance Department's approval. Please feel free to call me should you need additional information or have any questions.

Best,

BAKER, DONELSON, BEARMAN,
CALDWELL & BERKOWITZ, P.C.


Melissa L. Hull, Of Counsel

² Please note that I have only enclosed a copy of the NBLA 1000 Platinum materials in that these materials encompass the same programs as the NBLA 250 Platinum, NBLA 350 Platinum and NBLA 500 Platinum plans. If you would like copies of this material, please let me know.

Mr. Honey
December 11, 2009
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cc: John Fabbrini

Enclosures:

- 1.) John Fabbrini's Background Information
- 2.) NBLA's Certificate of Reinstated Articles
- 3.) Sample of Current NBLA Membership Materials
- 4.) Sample of Current NBLA 1000 Platinum Materials
- 5.) Certificates of Insurance

Arkansas Insurance Department

Mike Beebe
Governor



Jay Bradford
Commissioner

October 16, 2009

Mr. Derek Wooley
Taplin & Associates
Regions Financial Tower
1555 Palm Beach Lakes Blvd., Suite 1510
West Palm Beach, FL 33401

Re: National Congress of Employers (NCE)

Dear Mr. Wooley,

Thank you for your recent letter seeking acknowledgment by our Department that National Congress of Employers is a fully compliant Association under Arkansas state law and regulation. We have concluded that National Congress of Employers is a valid Association allowed to do business in the state of Arkansas pursuant to A.C.A. §23-86-106(2)(A).

We trust that this letter is responsive to your inquiry. If you have questions or need anything further in this regard please let me know.

Sincerely yours,

A handwritten signature in cursive script that reads "Daniel W. Honey".

Daniel W. Honey
Deputy Commissioner