

SERFF Tracking Number: ICCI-127129228 State: Arkansas
Filing Company: Sterling Life Insurance Company State Tracking Number: 49233
Company Tracking Number: SLIC LGPOL 511
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002A Large Group Only - PPO
Product Name: Sterling Large Employer Group Plan
Project Name/Number: Sterling Large Employer Group Plan /SLIC LGPOL 511

Filing at a Glance

Company: Sterling Life Insurance Company

Product Name: Sterling Large Employer Group Plan SERFF Tr Num: ICCI-127129228 State: Arkansas

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved-Closed State Tr Num: 49233

Sub-TOI: H16G.002A Large Group Only - PPO Co Tr Num: SLIC LGPOL 511 State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor

Author: Brenda Dawson Disposition Date: 07/18/2011
Date Submitted: 07/06/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Sterling Large Employer Group Plan

Project Number: SLIC LGPOL 511

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 07/18/2011

State Status Changed: 07/18/2011

Created By: Brenda Dawson

Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms

PPACA Notes: null

Filing Description:

We are hereby submitting the forms under the forms schedule tab for review and approval in your state. These forms are new and are not intended to replace any forms previously approved in your state.

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Overall Rate Impact:

Deemer Date:

Submitted By: Brenda Dawson

A Filing Letter of Authorization from Sterling Life Insurance Company authorizing Insurance Compliance Consultants, Inc., to represent them in this filing and to work with the Department for the purposes of obtaining Departmental filing is enclosed.

SERFF Tracking Number: ICCI-127129228 State: Arkansas
Filing Company: Sterling Life Insurance Company State Tracking Number: 49233
Company Tracking Number: SLIC LGPOL 511
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002A Large Group Only - PPO
Product Name: Sterling Large Employer Group Plan
Project Name/Number: Sterling Large Employer Group Plan /SLIC LGPOL 511

Group Major Medical Policy, SLIC LG POL 511 will be issued to large employer groups in your state.

Group Major Medical Expense Certificate, SLIC LG CER 511 evidences coverage under the Group Major Medical Policy. Amendatory Endorsement SLIC LG AEAR 511 will be attached to all Certificates issued in Arkansas.

The Schedule of Benefits pages are attached to the Certificate based on the benefit levels selected by the employer.

Form SLIC LG ERAPP 511 is the employer application.

Form SLIC LG EEAPP 511 is the employee enrollment form.

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 or to the general print size.

Company and Contact

Filing Contact Information

Brenda Dawson, Authorized Representative Brendaadawson@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)

Sterling Life Insurance Company CoCode: 77399 State of Domicile: Illinois
2219 Rimland Drive Group Code: Company Type:
Bellingham, WA 98226 Group Name: State ID Number:
(360) 647-9080 ext. [Phone] FEIN Number: 13-1867829

Filing Fees

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

SERFF Tracking Number: ICCI-127129228 State: Arkansas
Filing Company: Sterling Life Insurance Company State Tracking Number: 49233
Company Tracking Number: SLIC LGPOL 511
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002A Large Group Only - PPO
Product Name: Sterling Large Employer Group Plan
Project Name/Number: Sterling Large Employer Group Plan /SLIC LGPOL 511
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sterling Life Insurance Company	\$300.00	07/06/2011	49473648

SERFF Tracking Number: ICCI-127129228 State: Arkansas
 Filing Company: Sterling Life Insurance Company State Tracking Number: 49233
 Company Tracking Number: SLIC LGPOL 511
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002A Large Group Only - PPO
 Product Name: Sterling Large Employer Group Plan
 Project Name/Number: Sterling Large Employer Group Plan /SLIC LGPOL 511

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/18/2011	07/18/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	07/14/2011	07/14/2011	Brenda Dawson	07/18/2011	07/18/2011

SERFF Tracking Number: *ICCI-127129228* *State:* *Arkansas*
Filing Company: *Sterling Life Insurance Company* *State Tracking Number:* *49233*
Company Tracking Number: *SLIC LGPOL 511*
TOI: *H16G Group Health - Major Medical* *Sub-TOI:* *H16G.002A Large Group Only - PPO*
Product Name: *Sterling Large Employer Group Plan*
Project Name/Number: *Sterling Large Employer Group Plan /SLIC LGPOL 511*

Disposition

Disposition Date: 07/18/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ICCI-127129228 State: Arkansas
 Filing Company: Sterling Life Insurance Company State Tracking Number: 49233
 Company Tracking Number: SLIC LGPOL 511
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002A Large Group Only - PPO
 Product Name: Sterling Large Employer Group Plan
 Project Name/Number: Sterling Large Employer Group Plan /SLIC LGPOL 511

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Form	Large Group Major Medical Expense Policy	Approved-Closed	Yes
Form	Certificate	Approved-Closed	Yes
Form (revised)	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Replaced	Yes
Form (revised)	Amendatory Endorsement	Approved-Closed	Yes
Form	Amendatory Endorsement	Replaced	Yes
Form	Employee Enrollment form	Approved-Closed	Yes
Form (revised)	Employer Application	Approved-Closed	Yes
Form	Employer Application	Replaced	Yes

SERFF Tracking Number: ICCI-127129228 State: Arkansas
Filing Company: Sterling Life Insurance Company State Tracking Number: 49233
Company Tracking Number: SLIC LGPOL 511
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002A Large Group Only - PPO
Product Name: Sterling Large Employer Group Plan
Project Name/Number: Sterling Large Employer Group Plan /SLIC LGPOL 511

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 07/14/2011

Submitted Date 07/14/2011

Respond By Date

Dear Brenda Dawson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certificate, SLIC LG CER 511 (Form)

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

Objection 2

- Schedule of Benefits, SLIC LGSCH AR 511 (Form)

Comment:

It appears from reviewing the schedule of benefits, that Childhood Immunizations are not paid at 100% for an out of network provider. As outlined under ACA 23-79-141(f)(2)(A)... "Benefit for recommended immunization services shall be exempt from any copayment, coinsurance, deductible, or dollar limit provisions in the health insurance policy. This exemption shall be explicitly stated in the policy....". Benefits are to be paid at 100% for immunizations for in or out of network.

Objection 3

- Schedule of Benefits, SLIC LGSCH AR 511 (Form)

Comment: It is requested that you certify that benefits payable an in network provider vs an out of network provider comply with our Bulletin 9-85 which states in part that there can be no more than a 25% differential in payment between the two.

Objection 4

- Employer Application, SLIC LG ERAPP 511 (Form)

Comment:

The Employer Application must contain a Fraud Statement.

Please feel free to contact me if you have questions.

Sincerely,

SERFF Tracking Number: *ICCI-127129228* *State:* *Arkansas*
Filing Company: *Sterling Life Insurance Company* *State Tracking Number:* *49233*
Company Tracking Number: *SLIC LGPOL 511*
TOI: *H16G Group Health - Major Medical* *Sub-TOI:* *H16G.002A Large Group Only - PPO*
Product Name: *Sterling Large Employer Group Plan*
Project Name/Number: *Sterling Large Employer Group Plan /SLIC LGPOL 511*
Rosalind Minor

SERFF Tracking Number: ICCI-127129228 State: Arkansas
Filing Company: Sterling Life Insurance Company State Tracking Number: 49233
Company Tracking Number: SLIC LGPOL 511
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002A Large Group Only - PPO
Product Name: Sterling Large Employer Group Plan
Project Name/Number: Sterling Large Employer Group Plan /SLIC LGPOL 511

Response Letter

Response Letter Status Submitted to State
Response Letter Date 07/18/2011
Submitted Date 07/18/2011

Dear Rosalind Minor,

Comments:

Thank you for your letter.

Response 1

Comments: Please find attached revised Amendatory Endorsement SLIC AEAR 511. On page 11 Termination of Dependent Insurance, a revision was made to remove the time limit for notifying the company of Incapacity.

Related Objection 1

Applies To:

- Certificate, SLIC LG CER 511 (Form)

Comment:

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

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments: The Schedule of Benefits was revised for Childhood immunization to add to the out of network column "covered at 100%".

Related Objection 1

Applies To:

- Schedule of Benefits, SLIC LGSCH AR 511 (Form)

Comment:

SERFF Tracking Number: ICCI-127129228 State: Arkansas
 Filing Company: Sterling Life Insurance Company State Tracking Number: 49233
 Company Tracking Number: SLIC LGPOL 511
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002A Large Group Only - PPO
 Product Name: Sterling Large Employer Group Plan
 Project Name/Number: Sterling Large Employer Group Plan /SLIC LGPOL 511

It appears from reviewing the schedule of benefits, that Childhood Immunizations are not paid at 100% for an out of network provider. As outlined under ACA 23-79-141(f)(2)(A)... "Benefit for recommended immunization services shall be exempt from any copayment, coinsurance, deductible, or dollar limit provisions in the health insurance policy. This exemption shall be explicitly stated in the policy....". Benefits are to be paid at 100% for immunizations for in or out of network.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Schedule of Benefits	SLIC LGSCH AR 511		Schedule Pages	Initial			AR SLIC LGSCH AR 511 _Schedule of Benefits_. pdf

Previous Version

Schedule of Benefits	SLIC LGSCH AR 511		Schedule Pages	Initial			AR SLIC LGSCH AR 511 _Schedule of Benefits_. pdf
----------------------	-------------------------	--	----------------	---------	--	--	--

No Rate/Rule Schedule items changed.

SERFF Tracking Number: ICCI-127129228 State: Arkansas
 Filing Company: Sterling Life Insurance Company State Tracking Number: 49233
 Company Tracking Number: SLIC LGPOL 511
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002A Large Group Only - PPO
 Product Name: Sterling Large Employer Group Plan
 Project Name/Number: Sterling Large Employer Group Plan /SLIC LGPOL 511

Response 3

Comments: This letter will certify that there will be no more than a 25% differential between in-network and out-of-network providers.

Related Objection 1

Applies To:

- Schedule of Benefits, SLIC LGSCH AR 511 (Form)

Comment:

It is requested that you certify that benefits payable an in network provider vs an out of network provider comply with our Bulletin 9-85 which states in part that there can be no more than a 25% differential in payment between the two.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Schedule of Benefits	SLIC LGSCH AR 511		Schedule Pages	Initial			AR SLIC LGSCH AR 511 _Schedule of Benefits_.pdf

Previous Version

Schedule of Benefits	SLIC LGSCH AR 511		Schedule Pages	Initial			AR SLIC LGSCH AR 511 _Schedule of Benefits_.pdf
----------------------	-------------------	--	----------------	---------	--	--	---

SERFF Tracking Number: ICCI-127129228 State: Arkansas
 Filing Company: Sterling Life Insurance Company State Tracking Number: 49233
 Company Tracking Number: SLIC LGPOL 511
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002A Large Group Only - PPO
 Product Name: Sterling Large Employer Group Plan
 Project Name/Number: Sterling Large Employer Group Plan /SLIC LGPOL 511

No Rate/Rule Schedule items changed.

Response 4

Comments: The Employer application was revised to include the Arkansas fraud warning.

Related Objection 1

Applies To:

- Employer Application, SLIC LG ERAPP 511 (Form)

Comment:

The Employer Application must contain a Fraud Statement.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Schedule of Benefits	SLIC LGSCH AR 511		Schedule Pages	Initial			AR SLIC LGSCH AR 511 _Schedule of Benefits_. pdf

Previous Version

Schedule of Benefits	SLIC LGSCH AR 511		Schedule Pages	Initial			AR SLIC LGSCH AR 511 _Schedule of Benefits_. pdf
----------------------	-------------------------	--	----------------	---------	--	--	--

<i>SERFF Tracking Number:</i>	<i>ICCI-127129228</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Sterling Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>49233</i>
<i>Company Tracking Number:</i>	<i>SLIC LGPOL 511</i>		
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.002A Large Group Only - PPO</i>
<i>Product Name:</i>	<i>Sterling Large Employer Group Plan</i>		
<i>Project Name/Number:</i>	<i>Sterling Large Employer Group Plan /SLIC LGPOL 511</i>		
Amendatory	SLIC	Certificate Amendment,	Initial
Endorsement	AEAR 511	Insert Page, Endorsement	AR SLIC
		or Rider	AEAR
			511.pdf
<i>Previous Version</i>			
Amendatory	SLIC	Certificate Amendment,	Initial
Endorsement	AEAR 511	Insert Page, Endorsement	AR SLIC
		or Rider	AEAR
			511.pdf
Employer Application	SLIC LG	Application/Enrollment	Initial
	ERAPP	Form	AR SLIC
	AR 511		LGERAPP
			AR 511
			_Employer
			App_.pdf
<i>Previous Version</i>			
Employer Application	SLIC LG	Application/Enrollment	Initial
	ERAPP	Form	SLIC
	511		LGERAPP
			511
			_Employer
			App_ 5-
			23-11
			clean
			copy.pdf

No Rate/Rule Schedule items changed.

Thank you.

Sincerely,
Brenda Dawson

SERFF Tracking Number: ICCI-127129228 State: Arkansas
 Filing Company: Sterling Life Insurance Company State Tracking Number: 49233
 Company Tracking Number: SLIC LGPOL 511
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002A Large Group Only - PPO
 Product Name: Sterling Large Employer Group Plan
 Project Name/Number: Sterling Large Employer Group Plan /SLIC LGPOL 511

Form Schedule

Lead Form Number: SLIC LGPOL 511

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 07/18/2011	SLIC LGPOL 511	Policy/Cont ract/Fratern al Certificate	Large Group Major Medical Expense Policy Certificate	Initial			SLI LGPOL 511_Group Policy 5-19- 11_clean copy.pdf
Approved- Closed 07/18/2011	SLIC LG CER 511	Certificate	Certificate	Initial			SLIC LG CER 511 6-6-11 - clean copy.pdf
Approved- Closed 07/18/2011	SLIC LGSCH AR 511	Schedule Pages	Schedule of Benefits	Initial			AR SLIC LGSCH AR 511 _Schedule of Benefits_.pdf
Approved- Closed 07/18/2011	SLIC AEAR 511	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Amendatory Endorsement	Initial			AR SLIC AEAR 511.pdf
Approved- Closed 07/18/2011	SLIC LG EEAPP 511	Application/ Enrollment Form	Employee Enrollment form	Initial			SLIC LG EEAPP 511 _Employee Enrollment Form_ 5-23- 11 clean copy.pdf
Approved- Closed 07/18/2011	SLIC LG ERAPP AR 511	Application/ Enrollment Form	Employer Application Enrollment Form	Initial			AR SLIC LGERAPP AR 511 _Employer

STERLING LIFE INSURANCE COMPANY

[P.O. Box 5348, Bellingham, WA 98227-5348]

[(800) 688-0010]

GROUP POLICY NUMBER: [XXXXXX]

POLICYHOLDER: [XYZ Company]

DATE OF ISSUE: [December 1, 2008]

RENEWAL PREMIUMS ARE DUE MONTHLY beginning on the [1st day of January, 2009] and on the 1st day of each month thereafter, in United States Dollars only.

POLICY ANNIVERSARIES occur annually beginning [January, 2009]

STATE OF DELIVERY: [XXXX]

Sterling Life Insurance Company (hereinafter referred to as the Insurance Company, We, Our, or Us) agrees to pay the Group Insurance Benefits herein provided to each insured Employee of a Policyholder, subject to the terms and conditions of the Policy. Benefits are payable in United States Dollars only.

The Policy is issued to the Policyholder in consideration of application and payment of premiums, to take effect as of the Date of Issue. The Policy will terminate as hereinafter provided.

All periods indicated herein begin and end at 12:01 A.M. Standard Time at the address of the Policyholder.

The first premium is due on the Date of Issue and renewal premiums are due monthly during the continuance of the Policy.

The Policy is delivered in and is governed by the laws of the state of delivery.

The benefits and provisions set forth on the following pages and riders are a part of the Policy as if recited over the parties' signatures.

IN WITNESS WHEREOF, the Insurance Company has caused the Policy to be executed at its Home Office in City, State.

[

]]

]

Secretary

President

TABLE OF CONTENTS

1. Schedule of BenefitsPage 3
2. DefinitionsPage 3
3. The ContractPage 3
4. IncontestabilityPage 3
5. Individual CertificatesPage 3
6. Policyholder Not Insurance Company's AgentPage 3
7. Eligibility for InsurancePage 3
8. Effective Date of InsurancePage 3
9. Termination of InsurancePage 3
10. Renewability of InsurancePage 3
11. PremiumsPage 4
12. Non-Participating.....Page 4
13. Misstatement of AgePage 4
14. Conformity with LawPage 4
15. Employee Participation and Contribution RequirementsPage 4
16. Employer ResponsibilitiesPage 5
17. Consolidated Omnibus Reconciliation Act (COBRA)Page 5

1. SCHEDULE OF BENEFITS:

The attached Certificate of Group Insurance is incorporated into and made a part of this Policy.

The Policyholder/Employer/Plan Administrator (hereinafter referred to as "Employer") selected the following insurance benefits which are described in the attached Certificate of Group Insurance:

MAJOR MEDICAL EXPENSE INSURANCE

The insurance benefits and coverage are as selected and agreed upon between Us and the Employer. All coverages and actual benefit amounts in effect with respect to each insured Employee and his insured Dependents, if any, will be as described in the individual Certificate issued by Us to or for that Employee which will include his or her personal Schedule of Benefits.

2. DEFINITIONS

All terms are as defined in the attached Certificate of Insurance.

3. THE CONTRACT

The Policy, the application of the Employer, the Certificate and the Employees' applications, if any, shall constitute the entire contract between the parties. All statements made by the Employer or by the Employees shall be deemed representations and not warranties. No such statement, in the absence of fraud, shall be used in any contest under the Policy unless it is contained in a written instrument and a copy of the instrument is or has been furnished to the Employer or Employee.

4. INCONTESTABILITY

The validity of the Policy shall not be contested, except for non-payment of premiums by the Employer, after it has been in force for two years from its date of issue. No statement made by the Employer or any Employee, except a fraudulent misstatement, shall be used to contest the validity of any insurance with respect to which that statement was made after the insurance has been in force for two years prior to the contest and is contained in a written instrument signed by the Employee, and a copy of such instrument is or has been furnished to him or to his Employer.

5. INDIVIDUAL CERTIFICATES

We will issue to each Employer for delivery to each Employee, an individual certificate which states the essential features of the insurance to which the Employee is entitled, to whom benefits are payable, each limitation or requirement in the Policy that pertains to the Employee, and the requirements for payment of benefits.

6. POLICYHOLDER NOT INSURANCE COMPANY'S AGENT

The Employer shall not be considered the Insurance Company's agent for any purpose under the Policy.

7. ELIGIBILITY FOR INSURANCE

An Employee and/or his Dependents will be eligible for insurance as provided in Part 2 – ELIGIBILITY FOR INSURANCE in the Certificate of Group Insurance.

8. EFFECTIVE DATE OF INSURANCE

Insurance for an Employee and/or his Dependents shall be effective as provided in Part 3 - EFFECTIVE DATE OF INSURANCE in the Certificate of Group Insurance.

9. TERMINATION OF INSURANCE

Insurance for an Employer, Employee and/or his Dependents shall terminate as provided in Part 10 – RENEWABILITY AND TERMINATION in the Certificate of Group Insurance.

10. RENEWABILITY OF INSURANCE

The Policy is on a monthly renewable basis at the option of the Employer, except for the following reasons:

1. Non-payment of the required premium;
2. Fraud or intentional misrepresentation of a material fact by the Employer, or with respect to coverage of an Insured, fraud or intentional misrepresentation of a material fact by the Insured or such person's representative;
3. For failure to comply with Policy provisions, including failure to provide proof, whenever requested by Us, that the Employer is complying with the contribution and participation requirements;
4. For not maintaining Employee participation requirements for at least six consecutive months ;
5. For not maintaining Employee contribution requirements
6. The Insurance Commissioner of the state of the Employer's residence finds that the continuation of coverage would not be in the best interests of the Policyholder or certificateholders;
7. The Insurance Commissioner of the state of the Employer's residence finds that the continuation of coverage would impair Our ability to meet Our obligations;
8. The type of coverage under the Policy is no longer offered by Us in the state of the Employer's residence in which event We will provide ninety (90) days prior written notice of the discontinuance and We will offer the Employer

the option to purchase any other health insurance coverage currently being offered by Us to employers in the large group market in that state.

9. We decide to discontinue offering all health insurance in the large group market in the state of the Employer's residence in which event We will provide the applicable State authorities and the Employer written notice 180 days prior to the discontinuation and We will discontinue all health insurance issued or issued for delivery in the large group market in the state of the Employer's residence and will not renew coverage in the state of the Employer's residence.

All insurance under the Policy for an Employer, its Employees and their Dependents shall be non-renewed as follows:

1. Lapse due to non-payment of premium, at 12:01 A. M., of the premium due date following the end of the month for which the last premium payment is made on account of the Employer's insurance; or
2. Non-renewal for all other reasons, at 12:01 A. M., of the premium due date coinciding with or next following the date such event took place.

11. PREMIUMS

Payment Of Premium

Premiums are payable by the Employer to Us in accordance with Our then current premium rating manual. No insurance agent, insurance broker or insurance consultant is authorized to accept any premium payment on Our behalf. The Employer must timely pay the monthly premium in order to maintain the Policy. The payment of any premium will not keep the Policy in force beyond the due date of the next premium, except as provided in the Grace Period. If any premium is not received by Us before or at the end of the Grace Period, the Policy will automatically end at the end of the period for which the last premium payment has been paid.

1. We reserve the right to change the rates on any premium due by giving written notice to the Policyholder at least thirty (30) days in advance of the change.
2. If any change or clerical error affects premiums, an equitable adjustment in premiums shall be made on the premium due date next following the date of the change or the discovery of the error. Any premium adjustment that involves refund of unearned premium shall be limited to the three (3) months immediately preceding the date that We determine the adjustment in premium should be made and We will reduce that refund by the amount of benefits paid for claims incurred during the period for which the refund is made.
3. Premium due dates are the first of a calendar month. All insurance shall be charged from and to the premium due date.

Grace Period. The Employer is entitled to a grace period of 31 days for the payment of any Premium due except the first, during which grace period the Policy shall continue in force, unless the Employer has given the Company written notice of discontinuance of the coverage in advance of the date of discontinuance in accordance with the terms of the Policy. The Employer shall be liable to the Company for the payment of a pro rata Premium for the time the coverage was in force during such grace period.

12. NON PARTICIPATING

The Policy does not share in the surplus earnings of the Insurance Company and no refund or assessment shall be made to the Employer or Employee of any excess or deficit earnings of the Insurance Company.

13. MISSTATEMENT OF AGE

If the age of an Insured Person has been misstated, We will make an equitable adjustment of premiums or benefits or both. We will change the benefit to the applicable amount available for the correct age. We will refund to the Employer any excess premium paid over the amount due for the correct benefit amount. We will request payment for any overdue premium for the correct benefit amount.

14. CONFORMITY WITH LAW

If any provision of the Policy is contrary to federal or state law, this Policy is hereby amended to conform thereto.

15. EMPLOYER RESPONSIBILITIES

The Employer agrees:

1. To offer each employee the opportunity to elect group coverage under The Policy when he or she attains the status of an Employee as provided for in The Policy. It is understood that Employees are free to choose either Our Group Coverage or any other such group coverage as may be made available by the Employer. Every Employee will be given a fair opportunity to elect one of such options over the other and will not be penalized by the Employer because of such a choice.
2. To furnish Us on a monthly basis on Our-approved forms, such information as may reasonably be required by Us for the administration of the group coverage, including any change in a Insured Person's eligibility status.
3. To comply with all policies and procedures established by Us in administering and interpreting the group coverage.

4. To furnish all enrollment and termination change notifications to Us solely on Our enrollment and termination forms and within the time periods required by The Policy.
5. At reasonable times while the group coverage is in force, and for 24 months after that, We may inspect any of the Employer's documents, books, or records that may affect the claims arising from The Policy or its premiums.

16. CONSOLIDATED OMNIBUS RECONCILIATION ACT (COBRA)

The Policy will provide its group health coverage as required by COBRA's laws and regulations.

We will allow COBRA continuation, however, only if:

1. A COBRA election form is signed by the qualified beneficiary within the time frames prescribed by COBRA; and
2. The Employer notifies Us in writing, of the qualified beneficiary's request to continue coverage within 31 days from the date the qualified beneficiary signed the COBRA election form.

Any continued coverage allowed under this provision will provide only the minimum benefits for the minimum length of time as required by COBRA on the date a person covered by The Policy becomes a qualified beneficiary.

We assume no liability for any damages resulting from an Employer's non-compliance with any COBRA requirement or regulation. Additionally, an Employer will hold Us harmless and indemnify Us against any and all taxes, fines, penalties, losses, damages, costs, expenses, and legal fees incurred by Us, except to the extent prohibited by law, for any failure on the part of the Employer to comply with COBRA requirements or its regulations.

STERLING LIFE INSURANCE COMPANY

2219 Rimland Drive

Bellingham, Washington 98226

**EMPLOYER GROUP INSURANCE
CERTIFICATE OF GROUP INSURANCE**

This individual Certificate is issued as evidence of the insurance provided under the Group Policy (the Policy), issued to the above Policyholder.

The insurance described herein is effective only if the individual is eligible for such insurance, premiums are paid to the Insurance Company on account of such individual and the individual becomes and remains insured as provided in the Policy. The provisions described in this Certificate are subject to all the provisions, terms and conditions of the Policy. The Policy may be amended, changed, canceled or discontinued in accordance with the provisions thereof, without the consent of the individual. This Certificate supersedes and replaces any and all other insurance certificates and riders that may have been issued to the individual insured under any and all Group Policies issued to the Policyholder by:

STERLING LIFE INSURANCE COMPANY

(Herein referred to as the Insurance Company, We, Our or Us)

[

]]

]

SECRETARY

PRESIDENT

The provisions and benefits described herein may be different from any and all group insurance coverage You may have or have had. Please read this Certificate carefully.

CERTIFICATE FACE PAGE

Certificate Issued To: «Insured_Name»

Herein Called the Employee and to Insured Dependents:

- «Dependent_1» «Dependent_2»
- «Dependent_3» «Dependent_4»
- «Dependent_5» «Dependent_6»
- «Dependent_7» «Dependent_8»
- «Dependent_9» «Dependent_10»
- «Dependent_11» «Dependent_12»

Effective Date of Insured: «Insured_Effective_Date»

Policy Number: «Policy»

Policyholder, Employer and Plan Administrator: «The ABC Company»

Employer Effective Date: «Employer_Effective_Date»

COVERAGE ISSUED: «Coverages»

NOTICE OF PRE-EXISTING CONDITION LIMITATION

Coverage under the Policy is subject to a pre-existing condition limitation until the following date:

<u>Name</u>	<u>Date</u>	<u>Name</u>	<u>Date</u>
«Insured_Name».....	«InsuredPXT»	«Dependent_1».....	«D1PXT»
«Dependent_2».....	«D2PXT»	«Dependent_3».....	«D3PXT»
«Dependent_4».....	«D4PXT»	«Dependent_5».....	«D5PXT»
«Dependent_6».....	«D6PXT»	«Dependent_7».....	«D7PXT»
«Dependent_8».....	«D8PXT»	«Dependent_9».....	«D9PXT»
«Dependent_10».....	«D10PXT»	«Dependent_11».....	«D11PXT»
«Dependent_12».....	«D12PXT»		

If You believe that You and/or Your dependents should not be subject to a pre-existing condition limitation or that the pre-existing limitation should be for a shorter period of time, You and/or Your dependents may request a certificate from a prior plan or issuer that demonstrates prior creditable coverage.

Certificate Index

Part 1 – DefinitionsPage[4]
Part 2 – Eligibility for InsurancePage [11]
Part 3 – Effective Date of Insurance.....Page [13]
Part 4 – Medical ManagementPage [14]
Part 5 – Benefit ProvisionsPage [16]
Part 6 – Covered Charges.....Page [17]
Part 7 – Exclusions and LimitationsPage [25]
Part 8 – Coordination of BenefitsPage [27]
Part 9 – Premium PaymentPage [30]
Part 10 – Renewability and TerminationPage [31]
Part 11 – General ProvisionsPage [32]
Part 12 – Claim ProvisionsPage [33]

PART 1 – DEFINITIONS

ACCIDENT/ACCIDENTAL means any sudden or unforeseen event which:

1. causes harm to the physical structure of the body;
2. results from an external agent or trauma;
3. is definite as to time and place; and
4. happens involuntarily, or if it is the result of a voluntary act, entails unforeseen consequences.

ACUPUNCTURE means the insertion of needles into the human body by piercing the skin of the body, for the purpose of controlling and regulating the flow and balance of energy in the body to assist in rehabilitation and restoration of previously existing normal bodily functions which were lost or compromised after Injury or Sickness, but only if such treatment results in measurable improvement and is provided by a Physician or licensed acupuncturist.

AGGREGATE FAMILY DEDUCTIBLE means that under a family plan, there is only one Deductible (Family Deductible) where each family member's covered medical expenses are combined to meet the Family Deductible.

AGGREGATE FAMILY OUT-OF-POCKET MAXIMUM means that under a family plan, there is only one Out-Of-Pocket Limit (Family Out-of-pocket) where each family member's covered medical expenses are combined to meet the Family Out-of-Pocket Maximum.

ALCOHOLISM means a chronic disorder or illness in which the Insured Person is unable, for psychological or physical reasons, or both, to refrain from the frequent consumption of alcohol in quantities sufficient to produce intoxication and, ultimately, injury to health and effective functioning.

AMBULANCE means a vehicle which is licensed solely as an ambulance by the local regulatory body to provide transportation to a Hospital or transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means or the Hospital cannot provide the needed care. Air ambulance charges are payable only for transportation from the site of an Emergency to the nearest available Hospital that is equipped to treat the condition instead of local Ambulance service.

AMBULATORY SURGICAL CENTER means any public or private establishment: a) with an organized medical staff of Physicians; b) with permanent facilities that are equipped and operated primarily for performing surgical procedures; c) with continuous Physician services and registered professional nursing services whenever a patient is in the facility; d) which does not provide services or other accommodations for patients to stay overnight; and e) is duly licensed as an Ambulatory Surgical Center by the appropriate state authorities.

BENEFIT RIDER means an amendment or endorsement adding a specific Benefit to the Policy, which is attached to this Certificate.

CALENDAR YEAR if shown on the Schedule of Benefits means the period of time which begins on January 1st and ends on the following December 31st. When a person first becomes an Insured Person, the first Calendar Year begins on the Effective Date of coverage and ends the following December 31st.

CERTIFICATE/CERTIFICATE OF INSURANCE means the summary of the Master Group Policy which constitutes evidence of Your coverage under the Policy.

CHEMICAL DEPENDENCY means the abuse of or psychological or physical dependency on or addiction to a controlled substance.

COINSURANCE/COINSURANCE PERCENTAGE means the Insured Person's share of Covered Charges under the Policy after any applicable [Copays and] Deductibles are satisfied and before the Coinsurance Limit is reached. The Coinsurance Percentage is shown in the Schedule of Benefits.

COINSURANCE LIMIT means the maximum amount of Covered Charges an Insured Person will pay in a Year, after any applicable [Copays and the] Deductibles are satisfied and before the Maximum Benefit or other plan maximums are reached. The Coinsurance Limit is shown in the Schedule of Benefits. After the Coinsurance Limit is reached, We will pay the remainder of the Covered Charges incurred by that Insured Person during the rest of that Year.

A higher Coinsurance Limit, as shown in the Schedule, may apply when Out-of-Network Providers are utilized.

COMPLICATIONS OF PREGNANCY (which are considered to be a Sickness under the Policy) means: a) conditions requiring Inpatient treatment (when pregnancy is not terminated); b) whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity; and c) non-scheduled or emergency cesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth, as defined by the World Health Organization, is not possible. Complications of pregnancy does not include a scheduled cesarean section, complicated or difficult pregnancy with diagnoses such as false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning Sickness, hyperemesis gravidarum, preeclampsia and other similar conditions associated with a difficult pregnancy.

COPAY means the amount required to be paid by an Insured Person each time a specific service is provided, as set forth in the Schedule of Benefits and the Policy. In some instances, more than one Copay may be required. Services requiring Copays and Copay amounts are shown in the Schedule of Benefits.

COSMETIC SURGERY means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance or self-esteem.

COVERED CHARGES means charges incurred as a result of an Injury or Sickness by or on behalf of an Insured Person while the Policy is in force with respect to such Insured Person and which:

1. are Medically Necessary for the treatment of an Injury or Sickness and which have been recommended and prescribed by a Physician;
2. are not in excess of Reasonable and Customary Charges, Fees and Expenses made for the services performed or supplies furnished, or are not in excess of such Charges as would have been made in the absence of this insurance;
3. are not excluded from coverage by the terms of the Policy; and
4. do not exceed any amounts payable under the terms of the Policy.

CREDITABLE COVERAGE means benefits or coverage provided under:

1. a group health plan;
2. health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C.A. Section 1395c or 1395j et seq.);
4. Title XIX of the Social Security Act (42 U.S.C.A. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 (42 U.S.C.A. Section 1396s);
5. Chapter 55 of Title 10 of the US Code;
6. a medical care program of the Indian Health Service or of a tribal organization;
7. a state health benefits risk pool;
8. a health plan offered under chapter 89 of Title 5 of the US Code;
9. a public health plan as defined by federal regulations; or
10. a health benefit plan under Section 2504(e) of Title 22 of the US Code;

Creditable Coverage does not include:

1. Benefits not subject to requirements:
 - A. Coverage only for accident or disability income insurance or any combination thereof;
 - B. coverage issued as a supplement to liability insurance;
 - C. liability insurance, including general liability insurance and automobile liability insurance;
 - D. workers' compensation insurance or other similar insurance;
 - E. automobile medical payment insurance;
 - F. credit-only insurance;
 - G. coverage for on-site medical clinics;
 - H. other similar insurance specified by federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
2. Benefits not subject to requirements if offered separately:
 - A. limited-scope dental or vision benefits;
 - B. benefits for long-term care, nursing home care, home health care, or community-based care coverage or any combination thereof;
 - C. such other similar limited benefits specified by federal regulations;
3. Benefits not subject to requirements if offered as independent, noncoordinated benefits:
 - A. coverage only for a specified disease or illness;
 - B. hospital indemnity or other fixed indemnity insurance.
4. Benefits not subject to requirements if offered as separate insurance policy:
 - A. Medicare supplemental health insurance, as defined by Section Section 1395ss(g)91 of the US Code),
 - B. coverage supplemental to the coverage provided under Chapter 55 of Title 10, and

- C. other similar supplemental coverage provided under a group health plan.

CUSTODIAL OR CONVALESCENCE CARE means any care that is provided to an Insured Person who is disabled and needs help to support the essential activities of daily living when the Insured Person is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary for the person to perform the essentials of daily living on his own.

DEDUCTIBLE means the amount of applicable Covered Charges [other than Copays], that must be incurred by an Insured Person in any Year before benefits will be payable under the Policy. A higher Deductible amount may apply when Out-of-Network Providers are utilized for non-Emergency care. The Deductible is shown in the Schedule of Benefits or on an amendment to this Certificate.

[DEPENDENT/ELIGIBLE DEPENDENT (Grandfathered) means an Employee's:

1. lawful spouse;
2. unmarried child, unmarried adopted child, unmarried child placed in Your home for adoption and unmarried child in Your custody pursuant to court order who is primarily dependent upon the Employee for support and maintenance and is who is less than the limiting age shown in the Schedule of Benefits.

Dependent/Eligible Dependent does not include a child who is eligible to enroll in another employer-sponsored group health plan—other than that of another parent's employer.

If both husband and wife are Employees of the Employer, each person must apply as an Employee. If both husband and wife are covered as Employees, a child may be covered as the Dependent of either Employee, but not both.]

[DEPENDENT/ELIGIBLE DEPENDENT (Non Grandfathered) means an Employee's:

1. lawful spouse;
2. child, step child, adopted child, child placed in Your home for adoption and child in Your custody pursuant to court order who is less than the limiting age shown in the Schedule of Benefits.

Placed for adoption means in the physical custody of the adoptive parent.

If both husband and wife are Employees of the Employer, each person must apply as an Employee. If both husband and wife are covered as Employees, a child may be covered as the Dependent of either Employee, but not both.]

DURABLE MEDICAL EQUIPMENT means equipment that is:

1. able to withstand repeated use;
2. primarily and customarily used to serve a medical purpose;
3. not generally useful to a person in the absence of Injury or Sickness; and
4. prescribed by a Physician and Medically Necessary.

ELIGIBLE EMPLOYEE means an Employee who works [the required number of hours as defined by the Master Application] [on a full-time basis as defined by the Master Application] The term does not include an Employee who:

- [1.] [works on a part-time, temporary, seasonal, or substitute basis;]
- [2.] is covered under:
 - A. another health benefit plan; or
 - B. a self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); or
- [3.] elects not to be covered under the Employer's health benefit plan and is covered under:
 - A. the Medicaid program;
 - B. another federal program, including the CHAMPUS program or Medicare program; or
 - C. a benefit plan established in another country.

An Employee also is a [Retiree] [tribal member] [officer][partner][or [director] as designated by the Employer in the Master application and approved by Us.

[EMBEDDED FAMILY DEDUCTIBLE means your plan contains two provisions, an Individual Deductible and a Family Deductible. This allows each family member to receive medical expenses covered at the earlier of the Individual's satisfaction of the Individual Deductible (for that individual only), or collectively when the all Family member's combined Deductible satisfy the Family Deductible (for all family members).]

[EMBEDDED FAMILY OUT-OF-POCKET MAXIMUM means your plan contains two provisions, an Individual Out-of-Pocket and a Family Out-of-Pocket Maximum. This allows each family member to receive medical expenses covered at the earlier of the Individual's satisfaction of the Individual Deductible (for that individual only), or collectively when all Family member's combined Out-of-Pocket Maximum satisfy the Family Out-of-Pocket Maximum (for all family members).]

EMERGENCY ADMISSION means an admission of an Insured Person who experiences an Emergency Medical Condition resulting from an Injury or Sickness.

EMERGENCY MEDICAL CONDITION means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medication attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES With respect to an Emergency Medical Condition, Emergency Services means a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital.

EMPLOYEE means an individual employed by an Employer.

EMPLOYER means in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. An Employer must complete an Employer Application agreeing to all the terms specified by Us and meet all other requirements in the state of the Employer's residence. The Employer is deemed the Plan Administrator for the purposes of compliance with and duties arising under the Employee Retirement Income Security Act ("ERISA") and Consolidated Omnibus Budget Reconciliation Act ("COBRA").

EMPLOYER'S EFFECTIVE DATE means the Effective Date of coverage for Your Employer.

ENROLLMENT DATE means the date an Employee or Dependent enrolls under the Policy or, if earlier, the first day of any Service Waiting Period that must be satisfied before coverage becomes effective.

ENROLLMENT FORM means the form designated by Us that an Employee must complete and submit in order to request enrollment in the Policy. Enrollment Forms are available from Your Employer and must be submitted to Your Employer to be forwarded to Us.

[ESSENTIAL HEALTH BENEFITS has the same meaning as found in section 1302(b) of the federal health care reform's Patient Protection and Affordable Care Act including any amendments, regulations, rules or other guidance issues with respect to the Act.]

EXPERIMENTAL means a service for which one or more of the following is true:

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to phase I, II and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings. We will determine if this item 2. is true based on:
 - A. Published reports in authoritative medical literature; and
 - B. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health and the FDA.
3. In the case of a drug, a device or other supply that is subject to FDA approval:
 - A. It does not have FDA approval; or
 - B. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabeled uses of FDA-approved drugs are not considered Experimental or Investigational if they are determined to be:

- 1) included in substantially accepted peer-reviewed medical literature such as: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopoeia Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
 - 2) included in a prescription drug reference compendium; or
 - 3) in addition, the medical appropriateness of unlabeled uses not included in the compendia can be established based on supportive clinical evidence in peer-reviewed medical publications.
4. The Provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigational and subject to the board's approval.
 5. Research protocols indicate that the service or supply is Experimental or Investigational. This item 5 applies for protocols used by the Insured Person's Provider as well as for protocols used by other Providers studying substantially the same service or supply.

[GEOGRAPHIC AREA means the first three digits of the zip code in which the service, treatment, procedure, drugs or supplies are provided, or a greater area if necessary, to obtain a representative cross-section of charges for a like treatment, service, procedure, device, drug or supply.]

HEALTH BENEFIT PLAN means any Hospital or medical policy or certificate, Hospital or medical service plan contract, or health maintenance organization subscriber contract.

HOME HEALTH CARE AGENCY means a business that provides home health service under a Home Health Care Plan.

HOME HEALTH CARE PLAN means a program for continued care and treatment of an individual established and approved in writing by the individual's attending Physician. An attending Physician must certify that proper treatment of the Bodily Injury or Sickness would require confinement in a Hospital or a Skilled Nursing Facility in the absence of the services and supplies provided as a part of a treatment plan for Home Health Care.

HOSPICE means a facility that:

1. is licensed, accredited or approved by the proper authority to provide a Hospice Care Program;
2. admits individuals who:
 - A. have no reasonable prospect of cure; and
 - B. have a life expectancy of six (6) months or less; and
3. provides care by a Hospice Team coordinating its services with the patient's attending Physician and the patient's Family.

HOSPICE CARE PROGRAM means a coordinated program for meeting the needs of dying individuals and their families by providing medical, nursing and other health services during the Sickness and bereavement.

HOSPICE TEAM means a group of persons composed of a Hospice Physician, a patient care coordinator (a Physician or licensed graduate registered nurse (RN)), a licensed graduate registered nurse (RN), a mental health specialist, a social worker, a Chaplain and a lay volunteer.

HOSPITAL means a facility which:

1. Is licensed as a hospital and operated pursuant to law;
2. Is primarily engaged in providing or operating (either on its premises or in facilities available to the hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians), medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an Inpatient basis for which charge is made;
3. Provides 24 hour nursing care by or under the supervision of a registered nurse (R.N.);
4. Is an institution which maintains and operates a minimum of five beds;
5. Has x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
6. Maintains permanent medical records.

The term "Hospital" includes a Chemical Dependency Treatment Center, but does not include:

1. Military or veteran's hospital or soldier's home or any hospital contracted for or operated by the federal government or any agency thereof for the treatment of members or ex-members of the armed forces;
2. Convalescent homes, convalescent facilities, rest facilities, or nursing facilities; or
3. Home or facilities primarily for the aged, those primarily affording custodial care or educational care.

IMMEDIATE FAMILY means (step) brothers, (step) sisters, (step) children, (step) parents, aunts, uncles and legal spouses.

INITIAL ENROLLMENT PERIOD means the period of time during which an Employee or Dependent is first eligible to enroll under the Policy.

INJECTABLE AND SPECIALTY MEDICATION means those covered drugs that are administered in an Insured Person's home intravenously, intramuscularly, or subcutaneously, or are used as immunosuppressant agents in organ transplant patients.

INJURY means physical harm or damage caused by an Accident. The Injury must be the direct cause of the loss, independent of disease, bodily infirmity, or any other causes. Any loss due to Injury must begin while the Insured Person's coverage is in force.

IN-NETWORK means those Covered Charges received from a Preferred Provider.

INPATIENT means an Insured Person confined and assigned to a Hospital bed for a period of twenty-three (23) consecutive hours or longer upon the advice of a Physician for other than Custodial or Convalescent Care.

INSURED PERSON/INSURED means the Employee named in the Schedule of Benefits and any Covered Dependents whose coverage with Us is in effect and has not terminated.

INTENSIVE CARE UNIT means that part of a Hospital specifically designed as an Intensive Care Unit. It is permanently equipped and staffed to provide more extensive care for critically ill or injured patients than available in other Hospital rooms or wards. This care includes close observation by trained and qualified personnel primarily assigned to this part of the Hospital. This term shall not include Intermediate Care or Stepdown Units.

LATE ENROLLEE means an Employee or Dependent who does not submit an Enrollment Form during the Initial Enrollment Period and who does not qualify for a Special Enrollment Period when the Enrollment Form is submitted.

LIFE-THREATENING means a condition which, if not immediately interrupted by medical treatment, has a high likelihood of: (1) death, if the end point of the medical treatment is survival; or (2) causing major irreversible morbidity (including: loss of arm, leg, hand or foot; loss of sight or hearing; paralysis; or loss of brain function), if the end point of the medical treatment is survival and/or avoiding that morbidity. The attending Physician must verify the condition to be life-threatening.

MEDICALLY NECESSARY means services or supplies that are:

1. Required to identify or treat an Insured Person's diagnosis, symptoms, Sickness, Injury or disease;
2. In accordance with recognized standards of medical care as depicted by:
 - A. use in the state where the Insured Person resides or use throughout the United States; or
 - B. scientific or medical evidence accepted by a majority of the medical specialty involved.
3. Classified, recognized or acknowledged by a governmental agency as proven, safe, effective, and not Investigational, Experimental and/or for Research;
4. not in excess, in scope of duration or intensity, of that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment;
5. Not solely for:
 - A. the convenience of the Insured Person, the Insured Person's family, or Provider;
 - B. educational purposes; and
 - C. Investigational, Experimental and/or for Research, or cosmetic purposes.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII, Social Security Amendments of 1965, as amended.

MENTAL HEALTH CONDITIONS mean Mental or Nervous Disorders or Serious Mental Illness.

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

NEGOTIATED RATE means the rate mutually agreed upon between Us and a Provider in a specific instance.

OCCUPATIONAL THERAPY means treatment of disease by physical agents and methods to assist in rehabilitation and restoration, of previously existing normal bodily functions which were lost or compromised after Injury or Sickness, through a program designed to improve endurance, strength, exercise tolerance, and performance of activities of daily living (ADL), but only if such treatment results in measurable improvement and is provided by a Physician or licensed or registered occupational therapist (O.T.R.). Maintenance therapy or other treatment provided on a routine basis as part of a standard program, and educational training or services designed and adapted to develop a physical function, are not included.

ORTHOPEDIC MANIPULATION means treatment by a Physician for physical therapy or manipulation involving the spine or any joint to assist in rehabilitation and restoration of previously existing normal bodily functions which were lost or compromised after Injury or Sickness, but only if such treatment results in measurable improvement and is provided by a Physician. This includes traction; inversion therapy; hot or cold packs; electrical stimulation therapy; vasopneumatic devices; diathermy; therapeutic exercise; neuromuscular reeducation; gait training; massage therapy; thermography; biofeedback therapy; hydrocollator therapy; passive motion therapy; acupressure; office visits and consultations.

OUT-OF-NETWORK PROVIDER means any Physician, Hospital or other health care Provider who is not a member of a PPO network contracted with Us to provide medical services to Our Insureds.

OUTPATIENT HOSPITAL EXPENSES means Covered Charges incurred by an Insured Person that are not on an Inpatient basis.

PHYSICIAN means a person who has successfully completed the prescribed course of studies in medicine at an officially recognized medical school and has acquired the requisite qualifications for licensure in the practice of medicine. The person must be a legally qualified, licensed practitioner who provides care within the scope of his/her license, and who is not a member of the Insured Person's Immediate Family. An Insured Person will not be considered a Physician for care or treatment rendered to his/herself or his/her Immediate Family.

PHYSICIAN OFFICE VISIT means a direct personal contact between a Physician or other health care practitioner and an Insured Person in the health care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code.

PLAN YEAR if shown on the Schedule of Benefits means the period of time which begins immediately on the Employer's Effective Date and ends each 12 months following the initial Effective Date. When a person first becomes an Insured Person, the first Plan Year begins on the Insured Person's Effective Date and ends on the next following Employer's anniversary date.

POLICYHOLDER OR GROUP POLICYHOLDER means the Employer identified as the Policyholder in the Schedule of Benefits.

PRE-AUTHORIZATION means a screening process using established medical criteria to determine whether the proposed treatment plan is appropriate. It may include proposing alternative treatment plans, concurrent length of stay reviews, and discharge planning.

PRE-EXISTING CONDITION means any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months immediately preceding the Enrollment Date; except that We will not treat genetic information or Pregnancy as a Pre-Existing Condition.

PREFERRED PROVIDER/IN-NETWORK PROVIDER means a Physician, Hospital or other health care Provider that is currently a member of a Preferred Provider Organization (PPO) network contracted with Us to provide medical services to Our Insureds. The PPO network is named on the ID card. We will provide access to a directory listing In-Network Preferred Providers. You should, however, always check to be sure a listed Provider is still a participating member of the PPO network at the time medical services are needed. A toll-free number is provided on Your ID card to locate Preferred Providers.

PREGNANCY means the period following the receipt by an Employee, Dependent spouse or Dependent child of a diagnosis of Pregnancy until the discharge of the Employee, Dependent spouse or Dependent child from the Hospital or other Facility following the delivery of the newborn child. Pregnancy does not include voluntary abortion except where the Employee, Dependent spouse or Dependent child has a Life-Threatening condition.

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

PREVENTIVE CARE SERVICES means the evaluation and management of an Insured Person including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction and the ordering of appropriate immunization(s) and laboratory/diagnostic procedures – when no symptoms exist and there is no diagnosis of a Sickness.

PROVIDER means a Physician, Hospital, or any other duly licensed institution or duly licensed individual providing medical or health services.

REASONABLE AND CUSTOMARY CHARGES means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the Geographic Area in which the charge is incurred, so long as those charges are reasonable. The "most common charge" means the lesser of:

1. the actual amount charged by the Provider;
2. the negotiated rate;
3. the charge which would have been made by the Provider (Physician, Hospital, etc.) in the absence of insurance;
4. the charge which would have been made by the Provider for a comparable service or supply; or
5. the charge by other Providers in the same Geographic Area, as reasonably determined by Us, for the same or comparable service or supply.

In determining whether a charge is reasonable, We may consider other factors, including but not limited to:

1. the complexity of service or supply involved;
2. the degree of professional skill, experience and training required for a Physician to perform the procedure or service;
3. the severity or nature of the Injury or Sickness being treated;
4. the Provider's adherence or failure to adhere to charging and practices generally accepted by an established United States medical society as determined by Us;
5. the cost to the Provider of providing the service or supplies, or performing the procedure; or
6. if the information above is not sufficient to determine whether a charge is reasonable for a Geographic Area, We may refer to National Data Bases reflecting Provider fee data.

REHABILITATION FACILITY means a legally operating institution or distinct part of an institution which is primarily engaged in providing comprehensive, multidisciplinary physical restorative services, post-acute Hospital and rehabilitative Inpatient care, is duly licensed by the appropriate government agency to provide such services and is accredited as such a facility by the Joint Commission on the Accreditation of Health Care Organizations or the Commission for the Accreditation on Rehabilitation Facilities. It does not include institutions that provide only minimal care, Custodial Care, ambulatory or part-time care services.

REHABILITATIVE SERVICES means treatment, services and supplies for the purpose of restoring bodily function, which has been lost due to either an Injury or Sickness. Care ceases to be Rehabilitative Services when either (i) the Insured Person can perform the activities which are normal for the same age and gender; or (ii) the Insured Person has reached the maximum therapeutic benefit and further Rehabilitative Services cannot restore further bodily function beyond the level the Insured Person currently possesses.

RESPIRE CARE means short-term care given to a Hospice patient by another care-giver so that the patient's care-giver can rest or take time off.

RETIREE means any former Employee who is covered under a non-discriminatory, written retirement plan of the Employer that provides for benefits on the same terms and conditions as an Employee.

ROBOTIC ASSISTED SURGERY means technology by which the surgeon views the operative field via a terminal from cameras inserted into the body and manipulates robotic surgical instruments via a control panel.

SERIOUS MENTAL ILLNESS means schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic, manic, depressive and mixed); major depressive disorders (single episode or recurrent); schizo-affective disorders (bipolar or depressive); and obsessive compulsive disorders.

SERVICE WAITING PERIOD means a period of time that must pass with respect to an Employee before the Employee is eligible to be covered for benefits under the terms of the Group Policy. The Service Waiting Period is determined by the Employer on its application for coverage under the Group Policy.

SICKNESS means an illness, disease, Pregnancy, Complications of Pregnancy, Mental Health Condition or Substance Use Disorders that causes loss while an Insured Person's coverage is in force under the Policy.

SKILLED NURSING FACILITY means a place that meets all these requirements:

1. it operates within the law;
2. it provides for the care and treatment of persons recovering from an Injury or Sickness;
3. it provides room, board, and skilled nursing services;
4. it operates under the supervision of a Physician;
5. it has 24-hour nursing service which is under the supervision of a registered nurse (RN) who is on site at all times; and
6. it keeps a daily record of medical care provided to each patient.

It does not mean a rest home, a home for the aged, or a place operated primarily to provide Custodial Care.

SOUND NATURAL TEETH means teeth which are intact with a root, pulp, and have a maximum of two surfaces restored and/or decayed, and no missing tooth structure due to fracture.

SUBSTANCE USE DISORDERS means Alcoholism or Chemical Dependency.

TRANSPLANT NETWORK means a health services organization, designated as a Transplant Network by the Company, which has entered into an agreement with, or on behalf of, the Company, to render Medically Necessary and medically appropriate specialty services. A Transplant Network may or may not be located within an Insured Person's Geographic Area. Services provided through a Transplant Network are coordinated by the Company.

US, WE, OUR or COMPANY means Sterling Life Insurance Company.

YEAR/YEARLY means Calendar Year or Plan Year, as shown on the Schedule of Benefits.

YOU, YOUR, YOURS means the Employee named in the Schedule of Benefits whose coverage has become effective with Us and has not terminated.

PART 2 – ELIGIBILITY FOR INSURANCE

ELIGIBILITY FOR INSURANCE

To be eligible for coverage under the Group Policy, an individual must either meet the definition of Eligible Employee or meet the definition of Dependent.

EMPLOYEE ENROLLMENT ELIGIBILITY

To become an Eligible Employee, You must:

1. Be an Eligible Employee;
2. Complete and submit, through Your Employer, an Enrollment Form, including Dependents, if any, during an enrollment period;
3. Provide any additional information We need to determine eligibility, if requested by Us; and
4. Agree to pay Your portion of the required premium, if required by the Employer.

DEPENDENT ENROLLMENT ELIGIBILITY

1. You may enroll Your current Dependent(s) at the same time You initially enroll.
2. You may enroll any new Dependent who first meets the definition of Dependent, after Your Enrollment Date, by completing and submitting an Enrollment Form to Us through Your Employer. Your Enrollment Form must be submitted to Us within 31 days after the date on which Your Dependent first meets the criteria for a Dependent.
 - A. If Your new Dependent is a newborn child, coverage will be provided and premium charged for the initial period (Initial period is from the date of birth until 31 days after the date of birth). To continue coverage for Your newborn child, You must notify Us within 31 days and pay the required premium.

- B. If Your new Dependent is an adopted child or a child placed in Your home for adoption, coverage will be provided and premium charged from the date of adoption or the date of placement for adoption until 31 days after the date of adoption or date of the date of placement for adoption. To continue coverage of an adopted child or child placed for adoption, You must submit an Enrollment Form within 31 days after the date the child is placed for adoption or the date the adoption becomes final.

EMPLOYEE AND DEPENDENT ENROLLMENT PERIODS (NOT APPLICABLE TO LATE ENROLLEES)

There are two types of enrollment periods for obtaining coverage under the Policy:

1. The Initial Enrollment Period is the period of time during which an Employee or Dependent is first eligible to enroll under the Policy. If You or Your Dependent are enrolling during the Initial Enrollment Period, the Initial Enrollment Period will be as follows:
 - A. With respect to an Employee or Dependent at the time of the Initial Enrollment Period, You must submit an Enrollment Form not later than the 31st day after the date employment begins or on completion of the Service Waiting Period.
 - B. If Your Dependent is a newborn child who is born after the Initial Enrollment Period, You must notify Us within 31 days after the newborn child's birth. Coverage will be provided and premium charged for the initial period (Initial period is from the date of birth until 31 days after the date of birth) for the child. To continue coverage for Your newborn child beyond the 31 days, You must notify Us within 31 days and pay the required premium for your newborn child. In addition to Your newborn child, You may enroll Your eligible spouse at the time You enroll Your newborn child.
 - C. If Your Dependent is an adopted child or child placed for adoption, and the adoption or placement for adoption begins after the Initial Enrollment Period, You must notify Us in writing within 31 days after the date of adoption or date of placement for adoption and any additional premium for the child that is necessary to continue coverage beyond the initial 31 day period must be paid. In addition to Your adopted child or child placed for adoption, You may enroll Your eligible spouse at the time You enroll Your adopted child or child placed for adoption.
 - D. If You are an eligible Employee who waived coverage during the Initial Enrollment Period and get married after the Initial Enrollment Period, You may enroll both Yourself, Your newly eligible spouse and any of Your spouse's children by submitting an Enrollment Form within the first 31 days from the date of marriage.
2. A Special Enrollment Period is a period after the Initial Enrollment Period ends, if all of the following occur:
 - A. You or Your Dependent were covered under a group Health Benefit Plan at the time of Your Initial Enrollment Period; and
 - B. You or Your Dependent declined enrollment during the Initial Enrollment Period; and
 - C. If required by Your Employer, You stated in writing that coverage under another group Health Benefit Plan was the reason that You or Your Dependent declined enrollment; and
 - D. Your coverage or Your Dependent's coverage:
 - 1) Was under a COBRA Continuation Provision and the coverage under such provision was exhausted; or
 - 2) Was not under COBRA Continuation Provision and any of the following occurs:
 - a. You or Your Dependent is no longer eligible for the other coverage as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment;
 - b. The employer sponsoring such other coverage terminates the employer's contributions toward such coverage;
 - c. Your Dependent no longer qualifies as a Dependent under the other coverage;
 - d. The other coverage no longer offers any benefits to a class of similarly situated individuals to which You or Your Dependent belonged;
 - e. The other coverage terminates a benefit package option; or
 - f. You or Your Dependent have a claim denied due to the exhaustion of the lifetime limit on all benefits under the plan.
 - E. If You or Your Dependent have a Special Enrollment Period as described above, the length of the Special Enrollment Period during which You and/or Your Dependent may submit an Enrollment Form will be as follows:
 - 1) 31 days beginning on the date of the termination of coverage or the date on which the employer contributions end; or
 - 2) 30 days from the date on which You or Your Eligible Dependent first receives notice that a claim has been denied under the other plan due to the exhaustion of the lifetime limit on all benefits.

LATE AND OPEN ENROLLEE ELIGIBILITY (EMPLOYEE OR DEPENDENT)

An Employee or Dependent who does not submit an Enrollment Form during the Initial Enrollment Period and who does not qualify for a Special Enrollment Period is a Late Enrollee.

1. Late Enrollees may only enroll during the Plan's Open Enrollment period. Open Enrollment means a 31-day period provided annually during which an Employee and his/her Dependents may enroll for coverage.
2. The Effective Date of coverage for a Late Enrollee that enrolls during the Open Enrollment period under the Policy will be the first day of the month next following the date We receive the Enrollment Form. Pre-Existing Conditions will not be covered until the Late Enrollee is continuously covered under the Policy for a period of 18 months following the Late Enrollee's Enrollment Date.

COURT ORDERED CUSTODY OF CHILDREN

Coverage is provided to a child in the court ordered custody of an Employee on the same basis as a newborn Dependent child.

We must receive notification within 31 days of the date on which the court order establishing custody of the child was issued and any additional premiums that are due for the coverage of the child must be paid. In order to establish court ordered custody, You must send Us a copy of the court order that establishes that You have full legal custody of such child.

ENROLLMENT

If Your or Your Dependent is entitled to enroll during an Initial Enrollment Period or Special Enrollment Period, You must submit an Enrollment Form for Yourself and/or Your Dependent on or before the applicable enrollment deadline as described in this Certificate. You may obtain an Enrollment Form from Your Employer. The Enrollment Form must be received by Us on or before the applicable enrollment deadline as described in this Certificate in order for You not to be considered a Late Enrollee

PART 3 – EFFECTIVE DATE OF INSURANCE

EMPLOYEE EFFECTIVE DATE

Your Effective Date of coverage under the Policy, excluding Late Enrollees, will be determined as follows:

1. If You enroll for coverage when the Employer enrolls for coverage, the coverage will be effective on the Employer's Effective Date.
2. If You become eligible after the Employer's Effective Date and enroll during a Service Waiting Period, an Initial Enrollment Period or a Special Enrollment Period, coverage will be effective [subject to receipt of the Enrollment Form by Us][the first day next following the end of any applicable Service Waiting Period][the first day of the Initial Enrollment Period] [the first day of the Special Enrollment Period]. [the first day or the fifteenth day of the month next following the later of the end of any applicable Service Waiting Period or [receipt of the Enrollment Form by Us].]

DEPENDENT EFFECTIVE DATE

The Effective Date of a Dependent's coverage under the Policy, excluding a Late Enrollee, a newborn child, an adopted child, or a child placed for adoption (See Dependent Enrollment Eligibility provisions above) depends on when You enroll the Dependent. The Dependent's Effective Dates are as follows:

1. If the Dependent is eligible for coverage when the Employer enrolls for coverage, the coverage for the Dependent will become effective on the Employer's Effective Date if You enroll the Dependent for coverage at that time;
2. If You first become eligible after the Employer's Effective Date and You enroll the Dependent during Your Initial Enrollment Period, the coverage for the Dependent will be effective on the same date that Your coverage becomes effective;
3. If the Dependent is a new spouse or step-child who first becomes eligible after Your Effective Date and You timely enroll the new spouse or step-child as described above, coverage will become effective as of [the date of marriage][or the first or fifteenth day of the month next following the date on which We receive the Enrollment Form];
4. If the Dependent is a newborn child who is born after Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of the date of birth;

5. If the Dependent is an adopted child or a child placed for adoption after Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of the date of the adoption or date of placement for adoption; or
6. If the Dependent qualifies as a Dependent for any other reason and first meets the definition of Dependent after Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of [the date the Dependent qualifies as a Dependent][or the first or fifteenth day of the month next following the date on which We receive the Enrollment Form].

Services or supplies that are payable as Covered Charges under the Policy are covered from the Effective Date; *provided however*, services or supplies for a condition that is covered under an extension of benefits from previous health insurance coverage or other benefit arrangement will not be covered under the Policy until the extension of benefits under the prior health insurance coverage or benefit arrangement ends.

PART 4 – MEDICAL MANAGEMENT

HEALTH CARE COORDINATION

Health Care Coordination is the Policy program conducted by the Health Care Coordinator designated by Us which:

- A. identifies cases involving the Insured Person in a clinical situation with the potential for catastrophic claims;
- B. assesses those cases for the appropriate level of patient care and the setting in which it is received;
- C. develops, introduces and implements viable Alternate Treatment Plans for those cases that maintain or enhance the quality of patient care; and
- D. provides cost controls by implementing the agreed upon Alternate Treatment Plan.

The Alternate Treatment Plan is a specific written document developed by the Health Care Coordinator in charge of the case receiving Health Care Coordination. This document is developed through discussion and agreement with the Insured Person or legal guardian (if necessary), the attending Physician and Us. It includes:

- A. Treatment Plan objectives;
- B. course of treatment planned to accomplish those objectives;
- C. responsibility of each party (Health Care Coordinator, attending Physician and Insured Person and his Family, if any) in implementing the plan; and
- D. estimated cost and savings.

If We agree with the Health Care Coordinator, the attending Physician and Insured Person on an Alternate Treatment Plan, We may pay incurred Eligible Expenses at a higher Coinsurance Percentage for services and supplies specified in the Alternate Treatment Plan. In the event the approved Alternate Treatment Plan specifies services or supplies not considered as Eligible Expense under the terms and provisions of the Policy, payment of benefits under the Policy for such services or supplies shall require written approval by Us. If written approval is granted, payment of benefits under the Policy for those services or supplies shall be on the same basis as if those services or supplies were Eligible Expense.

NO INSURED PERSON IS REQUIRED TO ACCEPT AN ALTERNATE TREATMENT PLAN RECOMMENDED BY THE HEALTH CARE COORDINATOR.

PROVIDER NETWORKS

Reimbursement for Covered Charges varies depending on the Provider that the Insured Person selects to provide treatment, services or supplies. An In-Network Provider has affiliated with an organization, association or entity, such as a preferred Provider organization or managed care organization that has established a network of Providers in a specific Geographic Area to provide medical treatment, services and supplies at predetermined rates. An Out-of-Network Provider is a Provider who is not participating in Your Provider network. We make available selected Network(s) to provide an Insured Person an opportunity to select an In-Network Provider for treatment, services or supplies. Your Employer selects the Provider network on behalf of all Employees. If an Insured Person uses an In-Network Provider, We will pay benefits for that treatment, service or supply at the In-Network Provider benefit level as specified in the Schedule of Benefits. If treatment, services or supplies are obtained or received from an Out-Of-Network Provider, unless otherwise stated herein, the following applies: (i) Covered Charges will be reimbursed at the Out-Of-Network Benefit Level; (ii) Charges will be reduced to the Reasonable and Customary Charges for such treatment, service or supply before being considered a Covered Charge; and (iii) the Insured Person will be responsible for any portion of the charges that exceed the Reasonable and Customary Charges for such treatment, service or supply.

When Covered Charges are incurred from an Out-of-Network Provider for Emergency Services, benefits will be paid at the In- Network benefit level shown in the Schedule of Benefits, until the Insured Person is stabilized and can be safely transported to an In-Network Provider as determined by the utilization review manager and the attending Physician. Otherwise, benefits will be reduced to the Out-of-Network Coinsurance Percentage shown in the Schedule of Benefits.

We do not arrange or provide treatment, services or supplies. It is always the Insured Person's responsibility to select a health care Provider of their choice. We have no control over, and are not responsible for, the actions or lack of actions of any Provider or Provider organization pertaining to any treatment, services or supplies rendered to an Insured Person.

[PRE-AUTHORIZATION PROGRAM

The Pre-Authorization Program is a prospective review that allows Us to determine whether the medical care or health care services proposed to be provided to the Insured Person are Medically Necessary and appropriate. The Pre-Authorization Program includes a list of certain medical care and health care services that require preauthorization as a condition of Our payment to a Provider under the Policy without a penalty. On receipt of a request from a Provider for Pre-Authorization, We will review and issue a determination indicating whether the proposed medical care or health care services are preauthorized. The determination will be issued and transmitted not later than the third calendar day after the date the request is received by Us. When We have pre-authorized medical care or health care services, We will not deny or reduce payment to the Physician or health care Provider for those services based on Medical Necessity or appropriateness of care unless the Physician or Provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the proposed medical or health care services. The Pre-Authorization penalty amount is specified in the Schedule of Benefits applicable to Covered Charges incurred in connection with an Inpatient Confinement or other specified medical care or health care services when the Insured Person does not comply with Pre-Authorization. The Pre-Authorization penalty amount is in addition to the applicable Yearly Deductible Copay and Coinsurance and does not accumulate toward any Yearly maximum benefit amount. If the Insured Person complies with Pre-Authorization, the Pre-Authorization penalty amount will not apply. Pre-Authorization is required of all proposed Inpatient Confinements for more than 23 hours. Pre-Authorization is also required of proposed medical care and health care services, as specified in the Schedule of Benefits below.]

[PRE-AUTHORIZATION OF NON-EMERGENCY INPATIENT SERVICES

To request Pre-Authorization, the Insured Person or the Insured Person's attending Physician must contact the designated Pre-Authorization service at least 48 hours prior to obtaining the requested treatment, service or supply. The Pre-Authorization service may be reached by writing; or by telephone during normal business hours each business day. The name of the Pre-Authorization service and instructions are provided to each Insured Person. The Insured Person will be requested to provide:

1. name, address and the telephone number of the attending Physician;
2. the proposed treatment plan;
3. the Insured Person's authorization (or, if a minor, authorization on his behalf) to release medical information.

The Pre-Authorization service will then consult with the Insured Person's attending Physician. If the Pre-Authorization service concurs with the Insured Person's attending Physician with the appropriateness of the setting and Medical Necessity of the proposed treatment plan, the Pre-Authorization service will notify the Insured Person in writing and the Insured Person will be deemed to have complied with the Pre-Authorization requirement described herein.

The Pre-Authorization service may also conduct a continued stay review for any ongoing Inpatient Confinement. The continued stay review is a process of monitoring an Insured Person's progress on a daily basis to determine if the Insured Person will be discharged within the pre-authorized number of days and to determine the appropriate number of additional days of stay that may be required according to the Insured Person's condition and plan of treatment. Hospital admissions will be monitored to assure that the Insured Person will be discharged timely. The attending Physician and the Hospital utilization review nurses will be contacted to determine the progress of the Insured Person and the need, if any, for an extension of authorized Hospital days. If an extension of the Inpatient stay is not authorized for all or part of the requested day(s), the Insured Person and the attending Physician will be notified.

In absence of Pre-Authorization, benefits are subject to the penalty as specified in Your Schedule of Benefits.

No benefits will be paid for Covered Charges incurred for any Inpatient Hospital confinement or treatment plan which extends beyond the number of days deemed by the Pre-Authorization service to be Medically Necessary.

Pre-Authorization is not a guarantee of payment; however we will not deny or reduce payment to the Physician or Provider for those Covered Charges based on Medical Necessity or appropriateness of care. Payment of benefits will be determined by Us in accordance with and subject to all the terms, conditions, limitations and exclusions of the Policy.

If the Pre-Authorization service does not concur with the Insured Person's Physician, the Pre-Authorization service will so notify the Insured Person in writing and the Insured Person will not be deemed to be in compliance with the Pre-Authorization requirement described herein and the additional deductible or limitation on extended number of days will apply.]

[PRE-AUTHORIZATION OF EMERGENCY INPATIENT CARE

Inpatient Confinements for an Emergency Medical Condition must be authorized in the same manner as a non-emergency Inpatient Confinement; however, the Insured Person or the Insured Person's Physician may notify the Pre-Authorization service of the Emergency Inpatient confinement within 48 hours of the Inpatient Admission or as soon as reasonably possible and be in compliance with the Pre-Authorization requirement. The attending Physician must verify that an Emergency condition existed.

In the absence of Pre-Authorization for an Inpatient Confinement for an Emergency Medical Condition, benefits are subject to the additional Deductible specified in the Schedule of Benefits.

If an Insured Person is taken to an Out-Of-Network Provider Hospital for an Emergency Medical Condition, Inpatient Hospital Confinement benefits will be paid by Us at the In-Network level of benefit as specified in the Schedule of Benefits. However, the Insured Person must arrange transfer to an In-Network Hospital within 48 hours, or as soon as the transfer may take place without detriment to the Insured Person's health. Otherwise, benefits will be reduced to the Out-Of-Network Provider benefit level.]

[PRE-AUTHORIZATION OF PREGNANCY

You are not required to obtain Pre-Authorization for Pregnancy or for a post-delivery Inpatient confinement of 48 hours or less for a vaginal delivery or 96 hours or less for delivery by Cesarean Section.

If, following delivery, Your Physician determines that You need to remain confined in a Hospital for more than 48 hours following vaginal delivery or 96 hours following delivery by Cesarean Section, You or Your Physician must notify the Pre-Authorization service of the continuing Hospital Inpatient confinement as soon as reasonably possible following the determination to continue Your Hospital Inpatient Confinement.]

[PRE-AUTHORIZATION OF OTHER NON EMERGENCY MEDICAL CARE OR HEALTH CARE SERVICES

The Insured Person is responsible for assuring that the required Pre-Authorization is received before the charges are incurred by calling the designated Pre-Authorization service. Failure to comply with the Pre-Authorization requirement will result in assessment of the penalty shown in the Schedule of Benefits.

The Insured Person must obtain Pre-Authorization for other non-emergency medical care or health care services, as shown on the Schedule of Benefits.]

PART 5 – BENEFIT PROVISIONS

We will pay Covered Charges due to Injury or Sickness. Covered Charges may during a Year, be subject to Copays, the Deductible, Coinsurance Percentage and Coinsurance Limit, as shown in the Schedule of Benefits. Covered Charges must be incurred while this coverage is in force, and are subject to the terms, conditions, limitations, exclusions, and maximums stated in the Policy, this Certificate and the Schedule of Benefits.

In-Network. Covered Charges incurred from Preferred Providers will be paid according to the Copay, Deductible, Coinsurance Percentage, and Coinsurance Limit shown in the Schedule of Benefits for In-Network Services, and will be based on the Negotiated Rate.

Out-of-Network. Covered Charges incurred from an Out-of-Network Provider will be paid according to the Deductible, Coinsurance Percentage, and Coinsurance Limit shown in the Schedule of Benefits for Out-of-Network services, and will be based on Reasonable and Customary Charges.

BENEFITS MAY BE REDUCED OR EXCLUDED WHEN SERVICES ARE RECEIVED OUT-OF-NETWORK. THIS MAY ALSO INCLUDE AN ADDITIONAL DEDUCTIBLE, REDUCED COINSURANCE PERCENTAGE AND A HIGHER COPAY.

Using Your ID Card. Your ID card identifies You as an Insured Person in the PPO program. You are responsible for showing Your ID card to the Provider at the time of service. If You fail to show Your card before receiving any medical services, the Provider may not recognize You as a PPO Insured Person and Your benefits may be subject to the Out-of-Network Copay, Deductible, Coinsurance Percentage and Coinsurance Limit as if they were rendered by an Out-of-Network Provider.

Use Any Provider You Choose. You are not required to seek treatment from a PPO Provider. Each Insured Person is free to elect the services of any Provider and benefits payable will be in accordance with the terms and conditions of Your coverage under the Policy.

We do not represent Physicians or warrant the medical competence or ability of a PPO Provider, or their respective staff, nor do We have any liability or responsibility for any actions or inactions of a PPO Provider or their staff.

Maximum Benefit. The maximum amounts of benefits payable to, or on behalf of, each Insured Person for all Injuries and Sicknesses are shown in the Schedule of Benefits.

Deductibles. The Deductibles listed in the Schedule of Benefits will apply only once during a Year.

PART 6 – COVERED CHARGES

Covered Charges are the Negotiated Rate or those Reasonable and Customary Charges incurred for services and supplies listed below which are Medically Necessary. A Covered Charge is “incurred” on the date the service or treatment is provided or the supply is obtained. Covered Charges must be incurred while Your coverage is in force. The following benefits are paid for Covered Charges at the levels indicated in the Schedule of Benefits.

1. INPATIENT FACILITY SERVICES

Benefits are payable for the following Inpatient Hospital Services:

- A. Room, board and general nursing service, when You occupy:
 - 1) a Hospital room with 2 or more beds, known as a semi-private room or ward; or
 - 2) a private room. The amount of benefits for a private room is limited to the Hospital's semi-private room rate, or if there is no semi-private room rate, 90% of the private room rate; or
 - 3) a bed in a special care unit. A special care unit is a unit whose main purpose is to provide an intensive level of care for critically ill patients. Examples of a special care unit are a coronary care unit or an Intensive Care Unit.

- B. Miscellaneous Services and Supplies. Examples include:
 - 1) use of operating, and treatment rooms, and equipment;
 - 2) drugs (excluding take home drugs);
 - 3) administration of blood and blood processing (including the cost of blood, plasma or fractionalized blood products);
 - 4) anesthesia, anesthesia supplies and services;
 - 5) medical and surgical dressings, supplies, casts, and splints;
 - 6) diagnostic services;
 - 7) therapy services;
 - 8) nursing services in a special care unit, other than the portion payable under Section 1 above; and
 - 9) one visit per Physician per day during a covered Hospital confinement due to an Injury or Sickness.

2. SURGICAL SERVICES

Benefits are payable as specified in the Schedule of Benefits if You require surgery due to an Injury or Sickness. The surgery must be performed in a Hospital, Hospital Outpatient department or Ambulatory Surgical Center or Physician office. The following services are eligible for coverage:

- A. **Surgical Services.** Services must be performed by a Physician. Additional payment will not be made for related pre- and post- operative care billed separately by the Physician which would or should be customarily included as part of the fee for the surgery. Benefits for surgical services will be paid as follows:
 - 1) **Single Surgical Services.** When a single surgical service is provided by 2 or more Physicians, the benefit will be the same as if the surgical care was rendered by one Physician.
 - 2) **Multiple Surgical Services.** The benefit payable if 2 or more surgical services are performed at the same time through different openings or approaches, is the sum of the following amounts: the greatest Covered Charge for one of the surgical procedures, plus one-half of the Covered Charge for each of the other surgical services performed.
 - 3) **Physician Office Surgery (Major)**
This benefit is payable for the In-Network or Out-of-Network Physician's actual charge for surgical and endoscopic services as specified in the Schedule of Benefits.

4) **Physician Office Surgery (Minor)**

This benefit is payable for the In-Network or Out-of-Network Physician's actual charge for surgical and endoscopic services as specified in the Schedule of Benefits.

- B. Surgical Assistant.** Services of a Physician who actively assists the operating surgeon in the performance of surgery are covered. The benefit payable will not exceed [20%] of the benefit amount payable for the primary surgeon's fee. No coverage will be provided for a Physician on call or placed on standby.
- C. Anesthesia.** Benefits are payable for the administration of anesthesia ordered by the attending Physician and rendered by a Physician in connection with a covered service. If a Certified Registered Nurse Anesthetist (CRNA) is utilized, total benefits for the Anesthesiologists and the CRNA will be limited to the Reasonable and Customary amount of the Anesthesiologist for the anesthesia service. If the only charge submitted for payment is for the services of a CRNA, then benefits will be limited to the Reasonable and Customary Charge of a CRNA for the anesthesia service.
- D. Miscellaneous Services.** Benefits are payable for Covered Charges for the following services provided and supplies obtained in the course of receiving surgical services.
- 1) the processing and administration of blood and blood components, and for whole blood, blood plasma and blood products that are not replaced by a donor for an Insured Person;
 - 2) heart pacemaker;
 - 3) medical and surgical dressings, casts, splints, braces, and crutches;
 - 4) oxygen and other gases, as well as charges for their administration;
 - 5) nursing services in an Ambulatory Surgical Center; or
 - 6) the use of operating and treatment rooms, and equipment, in an Ambulatory Surgical Center.

3. PHYSICIAN OFFICE VISITS

Benefits are payable for Physician Office Visits.

In-Network Physician Office charges for examination, evaluation or consultation will be subject only to the Physician Office Visit Copay amount, limited to one office visit per day. However, charges for other treatment received during a Physician Office Visit are subject to the In-Network Deductible, Coinsurance Percentage and Coinsurance Limit.

Out-of-Network charges will be subject to the Out-of-Network Deductible, Coinsurance Percentage, and Coinsurance Limit shown in the Schedule of Benefits.

4. HUMAN ORGAN, TISSUE, AND BONE MARROW TRANSPLANTS

Benefits are payable for human organ transplant or tissue transplant or replacement. However, the only human organ transplants considered to be Covered Charges are those that are not considered Experimental.

An Insured Person may be directed to a facility designated by Us as a Transplant Network for certain services. If the Insured Person agrees to use the Transplant Network to which We direct the Insured Person, We will provide benefits for the Insured Person's transportation to and from the Transplant Network for the initial treatment, evaluation and for the resulting confinement.

If the Insured Person receives a covered human organ or tissue transplant, the donor's expenses will be considered to be the Insured Person's expenses even if the donor is also insured under the Policy as an Employee or Dependent. We will pay benefits for the donor's Covered Charges to the extent an actual charge is made that is not paid or payable by any other plan covering the donor.

5. DIAGNOSTIC TESTING SERVICES [-] [Minor]

Benefits are payable for diagnostic tests including related professional fees, incurred on a non-Inpatient basis. Diagnostic tests include, x-rays, laboratory tests, electrocardiograms (EKGs) and electroencephalograms (EEGs).

6. SPECIALTY DIAGNOSTIC SERVICES[-] [Major]

Benefits are payable for specialty diagnostic tests, and including related professional fees, incurred on an Outpatient basis. Specialty Diagnostic Tests include nuclear medicine imaging, radioimmune assay, ultrasound/echography, computerized tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), angiography, arthroscopy, cholangiography, cholecystography, cytourethroscopy, endoscopy, duodenoscopy, hysterosalpingography, laparoscopy, myelography, pyelography, pancreatography, vasography, or venography.

7. REHABILITATION SERVICES

Benefits are payable for Rehabilitative Services as shown in the Schedule of Benefits including intensive physical, or speech therapy to treat acute conditions or Injuries, which are provided in a rehabilitative unit of a Hospital or a Rehabilitative Facility, when ordered by the treating Physician and provided by a licensed or registered therapist or psychiatrist. To be eligible for coverage, services must begin within 7 days of a discharge from a covered acute care Inpatient Hospitalization and must be related to the Injury or Sickness resulting in the Hospitalization. We will evaluate the Medical Necessity of such services by monitoring progress toward expected outcome(s). Coverage for Rehabilitation Services will cease when progress toward the established rehabilitation outcome(s) has plateaued or the outcome(s) can be achieved utilizing a less intensive setting. The maximum number of days covered for Inpatient Rehabilitation Services per Injury or Sickness will not exceed the amount shown in the Schedule of Benefits.

8. THERAPY SERVICES

Benefits are payable for the services of a physical therapist, Occupational Therapist, inhalation therapist (respiratory) and speech therapist. Outpatient short-term rehabilitation, Occupational Therapy, and physical therapy services are covered when the provision of such services can be expected to result in the significant improvement of an Insured Person's condition, or the maximum benefit as shown in the Schedule of Benefits has been reached.

9. OUTPATIENT MEDICAL THERAPY

Benefits are payable for facility charges and professional fees incurred for radiation therapy, including treatment planning, chemotherapy, and hemodialysis therapy for treatment following a covered Hospital confinement or a covered Outpatient surgery.

10. ALLERGY SERVICES

Benefits are payable for allergy testing and allergy injections.

11. HEARING AND SCREENING SERVICES

Benefits are payable for one routine hearing and one routine vision examination by a Physician per Year as shown in the Schedule of Benefits.

12. PROSTHETIC DEVICES

Benefits are payable for prosthetic devices in an amount equal to the amount provided under Federal laws for health insurance for the aged and disabled, 42 USC 1395k et seq. and 42 CFR 414.202 et. seq. Covered Charges are limited to the most appropriate model that adequately meets the medical needs of the Insured Person as determined by the Insured Person's treating Physician. Repairs and replacements of prosthetic devices are also covered unless necessitated by misuse or loss.

For the purposes of this benefit, the following definition applies:

Prosthetic devices means an artificial device to replace in whole or in part, an arm or a leg.

13. RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

Benefits are payable for breast reconstructive surgery incident to a mastectomy. Breast reconstruction shall include:

- A. reconstruction of the breast upon which the mastectomy has been prescribed;
- B. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- C. prostheses and treatment for physical complications, including lymphedemas, at all stages of mastectomy;

14. DIABETES EQUIPMENT AND SUPPLIES

Benefits are payable for Diabetes equipment and supplies for which a Physician has written an order including but not limited to:

- A. blood glucose monitors, including non-invasive monitors and monitors designed to be used by or adapted for the legally blind;
- B. test strips specified for use with a corresponding glucose monitor;
- C. lancets and lancet devices;
- D. visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
- E. insulin and insulin analog preparations;
- F. injection aids, including devices used to assist with insulin injection and needleless systems;
- G. insulin syringes;
- H. biohazard disposal containers;

- I. insulin pumps, both external and implantable, and associated appurtenances, which include:
 - 1) insulin infusion devices;
 - 2) batteries;
 - 3) skin preparation items;
 - 4) adhesive supplies;
 - 5) infusion sets;
 - 6) insulin cartridges;
 - 7) durable and disposable devices to assist in the injection of insulin; and
 - 8) other required disposable supplies;
- J. repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
- K. Prescription Medications which bear the legend "Caution: Federal Law prohibits dispensing without a prescription" and medications available without a prescription for controlling the blood sugar level;
- L. podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; and
- M. glucagon emergency kits.

As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies will be covered if determined to be Medically Necessary and appropriate by a treating Physician through a written order.

All supplies, including medications, and equipment for the control of diabetes must be dispensed as written, including brand name products, unless substitution is approved by the Physician who issues the written order for the supplies or equipment.

15. DIABETES SELF-MANAGEMENT TRAINING

Benefits are payable for diabetes self-management training including medical nutrition education limited to:

- A. Three (3) Medically Necessary visits upon initial diagnosis or if the diagnosis was made within 1 year prior to the Effective Date of this coverage, up to 3 Medically Necessary visits within 1 year after that Effective Date; or
- B. up to 2 Medically Necessary visits upon a determination of a significant change in the Insured Person's symptoms or medical condition.

16. PREGNANCY/MATERNITY

Benefits are payable for maternity services provided to an Eligible Employee, Dependent spouse and child.

Coverage includes treatment, services or supplies furnished in connection with a routine Pregnancy and delivery by elective cesarean section for:

- A. A minimum of forty-eight (48) hours after an uncomplicated vaginal delivery; or
- B. A minimum of ninety-six (96) hours after delivery by uncomplicated cesarean section.

The length of stay may be shortened at the discretion of the attending Physician after conferring with the mother.

This benefit includes routine well newborn nursery care while the newborn is Hospital-confined immediately after birth and includes room, board and other normal care for which a Hospital makes a charge.

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

[The newborn establishes a claim as an individual Dependent.]

17. COMPLICATIONS OF PREGNANCY

Benefits are payable for Complications of Pregnancy in the same manner and to the same extent as for any other Sickness covered under the Policy.

18. MENTAL HEALTH CONDITIONS

Benefits are payable for care and treatment of Mental Health Conditions in each Year to each Insured Person on the same basis as any other covered Sickness.

19. SUBSTANCE USE DISORDERS

Benefits are payable for care and treatment of Substance Use Disorders in each Year to each Insured Person on the same basis as any other covered Sickness.

20. DENTAL ANESTHESIA

Benefits are payable for anesthetics in conjunction with dental care that is provided to an Insured Person in a Hospital or an Ambulatory Surgical Center if any of the following applies:

- A. the Insured Person is a child age 6 and under;
- B. the Insured Person has a medical condition that requires Hospitalization or general anesthesia for dental care; or
- C. the Insured Person is disabled.

21. AMBULANCE SERVICES

Benefits are payable, as shown in the Schedule of Benefits, for a local, professional ambulance service to and from the nearest available Hospital or other medical facility which is appropriately staffed and equipped to treat the Insured Person's Injury or Sickness. We will not pay toward charges incurred for non-Emergency ambulance service by air unless such service is needed because of an Emergency Medical Condition. Transportation undertaken to secure treatment by a personal Physician or by a Physician or institution of greater renown or greater specialization is not covered. Preauthorization is required for non-emergency licensed ambulance services to transport an insured from a Hospital or other health care facility to another Hospital or health care facility. Services must be Medically Necessary and appropriate.

22. EMERGENCY SERVICES

Benefits are payable for Emergency Services directly provided by a health care Provider to treat an Insured Person's Emergency Medical Condition. Emergency Services do not require Pre-Authorization. Emergency Services for a covered Sickness or Injury received by an Out-of-Network Provider will be paid at the In-Network Provider benefit level subject to the same cost sharing requirements, such as Deductible, Copay and Coinsurance requirements that would otherwise apply as if the Emergency Services were provided by an In-Network Provider.

The Emergency Services Copay applies as shown in the Schedule of Benefits.

23. SKILLED NURSING FACILITY SERVICES

Benefits are payable for room, board, and general nursing care while confined in a Skilled Nursing Facility if:

- A. the Skilled Nursing Facility stay begins within 14 days after a Hospital stay;
- B. the stay is for the same Injury or Sickness as the Hospital stay; and
- C. a Physician certifies that skilled nursing care is needed for the treatment of the Insured Person's condition.

Covered Skilled Nursing Facility charges will be limited to:

- A. the most common daily semi-private room rate of the Hospital where the Insured Person was last confined; and
- B. the number of days per Year and the Coinsurance Percentage shown in the Schedule of Benefits.

Successive stays in a Skilled Nursing Facility will be considered to be part of one period of Skilled Nursing Facility confinement if:

- A. they result from the same or related causes; and
- B. they are separated by a period of less than 6 months during which the Insured Person is not confined in either a Hospital or Skilled Nursing Facility.

24. HOME HEALTH CARE SERVICES

Benefits are payable for services provided by a Home Health Care Agency under a Home Health Care Plan, up to the maximum number of visits specified in the Schedule of Benefits. Up to four (4) consecutive hours in a twenty-four (24) hour period of Home Health Care services shall be considered as one Home Health Care visit.

Covered Charges for Home Health Care are the Reasonable and Customary Charge made for the following:

- A. part-time skilled nursing care;
- B. physical therapy;
- C. speech therapy;
- D. medical supplies, drugs and medicines prescribed by a Physician;
- E. laboratory services by or on behalf of the Hospital but only to the extent benefits for those services would have been paid under the Policy had the Insured Person remained Hospitalized;
- F. occupational therapy; and

- G. respiratory therapy.

However, benefits will not be paid for charges made by a Home Health Care Agency for:

- A. any charges excluded under Part 7 - Limitations and Exclusions;
- B. full-time nursing care at home;
- C. meals delivered to the home;
- D. homemaker services;
- E. any services of an individual who ordinarily resides in the Insured Person's home or is a member of the Insured Person's Family;
- F. any transportation services; or
- G. Custodial Care.

25. HOSPICE CARE AND RESPITE CARE SERVICES

Benefits are payable for care of an Insured Person with a life expectancy of six (6) months or less in a Hospice Care Program by a Hospice Team as specified in the Schedule of Benefits. The benefit period commences on the date the Insured Person is admitted on the referral of a Physician to the Hospice Care Program and ends six (6) months from that date, or on the date the Insured Person dies, whichever occurs first.

Covered Charges for Hospice Care and Respite Care are the Reasonable and Customary Charges made by a Hospice Care Program, including:

- A. home care services;
- B. Inpatient and Outpatient medical and non-medical care;
- C. emotional support services to the Insured Person; and
- D. bereavement counseling to immediate insured family members (spouse, parents and children) of the Insured Person within the three (3) month period following the death of the Insured Person, not to exceed a maximum of three (3) counseling visits.

Benefits for Hospice Care are in lieu of any similar benefits provided under any other Covered Charges provision of this Part.

26. PREVENTIVE CARE SERVICES

Benefits are payable for the following preventive care services without regard to any cost-sharing requirements such as Deductible, Copay or Coinsurance requirements that would otherwise apply. [Preventive Care Services must be received from an In-Network Provider or benefits will be denied.]:

- A. Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- B. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Insured Person involved;
- C. With respect to Insured Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- D. With respect to Insured Persons who are women, such additional preventive care and screenings not described in paragraph (A.) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

27. PRESCRIPTION DRUGS AND MEDICINES

Benefits are payable for prescription drugs and medicines on Our Formulary including Injectable and Specialty Medications which are in excess of the Copay per prescription order and Yearly Deductible Amount specified in the Schedule of Benefits. Prescription drugs and medicines not on Our Formulary are not covered.

Our Formulary is a list of Generic and Brand Name Drugs including Injectable and Specialty medications, that has been developed by a pharmacy and Therapeutics committee comprised of Physicians, pharmacists and other health care professionals.

This Benefit is not considered as Covered Charges under any other Benefit of the Policy. Payment of any benefits under this Benefit does not waive, or in any manner whatsoever affect, any Limitations and Exclusions of the Policy, including the Pre-Existing Condition Limitation.

Outpatient Covered Prescription Drug Charges

Outpatient covered Prescription Drug charges are those incurred by an Insured Person for Federal Drug Administration (FDA) approved drugs on our Formulary which are: lawfully obtainable only upon the written prescription of a Physician, not excluded below, and obtained from a licensed pharmacist.

Coverage is provided for contraceptive drugs and or devices approved by the United States Food and Drug Administration if this option is shown on the Schedule of Benefits.

Injectable and Specialty Medications

Injectable and Specialty Medications are covered if this option is shown on the Schedule of Benefits. To obtain Injectable and Specialty Medications, the Insured Person must contact a pharmacy Provider designated by Us as a specialty pharmacy Provider. If the Insured Person obtains the benefit from a Provider other than the specialty pharmacy Provider designated by Us, the Insured Person must pay for the services and will be reimbursed at the Negotiated Rate then in force for the specialty Provider. Benefits are subject to the Deductible, Coinsurance Percentage, Coinsurance Limit, and yearly maximum benefit.

Outpatient Prescription Drugs are separated into three categories:

- A. **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 Drug as bioequivalent - meaning they perform in Your body the same as a brand preferred and/or brand non-preferred Prescription Drug. These Prescription Drug's are generally less costly than their brand-name counterparts.
- B. **Brand Preferred Drugs.** Brand-name Prescription Drugs that have been determined to be superior or equal to brand non-Preferred Prescription Drugs, but are more cost effective.
- C. **Brand Non-Preferred Drugs.** These brand-name Prescription Drugs have a more cost-effective therapeutic alternative.

Refer to Your Schedule of Benefits for the benefit level of each category.

If Your Physician writes a prescription that indicates a generic Prescription Drug may be substituted for a brand-name Prescription Drug and the Insured Person elects to obtain the brand name Prescription Drug instead of the generic Prescription Drug equivalent, the Insured Person will be responsible for the Insured Person's brand-name Copay plus the difference between the cost of the generic Prescription Drug and the brand-name Prescription Drug.

The list of Brand Preferred drugs is subject to change without notice. In addition, some drugs listed on the Brand Preferred list may not be covered Prescription Drugs in the Policy. Please refer to the list below for excluded Prescription Drugs.

Pharmacy Benefit Manager

A Pharmacy Benefit Manager (PBM) administers Your Outpatient Prescription Drug Benefit. The PBM has contracted with a network of In-Network pharmacies to dispense Outpatient Prescription Drugs at contracted rates.

- A. If the dispensing Pharmacy is a member of the PBM, the Insured Person must show his or her Prescription Drug card to the Pharmacist (or where applicable, to the Physician) and pay the amount specified in the Schedule of Benefits based on the type of Outpatient Prescription Drug and the level of coverage available as specified in the Schedule of Benefits. The Pharmacy will then bill the PBM for the balance of the charges.
- B. If the dispensing Pharmacy is not a member of the PBM, or if the Insured Person elects not to use his or her Prescription Drug card, the Insured must complete a direct reimbursement claim form, which is available from the PBM upon request, and submit it to the PBM, which will then reimburse the Insured Person as though the prescription card had been utilized.

In-Network Pharmacies provide the PBM with negotiated discounted rates. If the dispensing pharmacy is not a member of the PBM, or if the Insured Person does not use his or her Prescription Drug card, the Insured Person will be reimbursed on the same basis as would have been paid by the PBM to an In-Network Pharmacy.

An Insured Person is responsible for the payment of the following if the Prescription Drug was dispensed by an Out-of-Network pharmacy or where the Prescription Drug is dispensed at an In-Network Pharmacy, but the Insured Person elects a brand-name Prescription Drug when an equivalent generic Prescription Drug is available:

- A. Any Copay, Deductible and Coinsurance as specified in the Schedule of Benefits;
- B. The additional amount over what We would have paid a participating dispensing pharmacy;
- C. The additional cost of any Prescription Drug which, at the request of the Insured Person or attending Physician, is not dispensed in accordance with the Maximum Allowable Cost list;
- D. Prescription Drugs which are dispensed in excess of the dispensing limitation.

Dispensing Limitation

In order for expenses for Outpatient Prescription Drug to be considered Covered Charges, the dispensing Pharmacy may not dispense more than the following at one time:

- A. For other than prescription mail orders - a -, ; See Your Schedule of Benefits regarding supply amounts or
- B. For prescription mail orders - . See Your Schedule of Benefits regarding supply amounts

Right Of Recovery

We have the right to recover by direct payment from an Insured Person any expenses for Outpatient Prescription Drug paid by Us to the extent of the number of days, or doses, dispensed to the Insured Person beyond the date of insurance termination by reason of non-payment of premium.

Excluded Drugs

- A. Over-the-Counter Drugs and Products, except diabetes drugs;
- B. Fertility Agents or drugs for sexual dysfunction;
- C. Vitamins (other than pre-natal);
- D. Anti-Smoking aids, e.g. Nicorette, Nicaderm, Habitrol;
- E. Hair loss medications, e.g. Rogaine, Monoxidil;
- F. Immunization agents, biological sera, blood or blood plasma;
- G. Investigational use or Experimental drugs;
- H. Any charge for administration of injectable insulin;
- I. Drugs covered under Workers' Compensation;
- J. Anorectica drugs for weight control;
- K. Medication taken, prescribed or administered while an Inpatient at a Hospital, Rest Home, Sanitarium, Extended Care Facility, Convalescent Hospital, Nursing Home or similar institution which operates a facility for dispensing pharmaceuticals;
- L. Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use;
- M. Homeopathic medications;
- N. Any drugs purchased outside the United States of America;
- O. Abortifacients or other drugs or devices that terminate a pregnancy; or
- P. Any drugs or medicines not on Our Formulary.

28. ACUPUNCTURE AND ACUPRESSURE

Benefits are payable if indicated on the Schedule of Benefits for acupuncture and acupressure.

29. MANIPULATIVE SERVICES

Benefits are payable if indicated on the Schedule of Benefits up to the maximum amount shown in the Schedule of Benefits per Insured Person for spinal manipulation, manual or electrical muscle stimulation, other manipulative or ultrasound therapy when performed by a Physician, and any other non-surgical treatment of the spine.

30. DURABLE MEDICAL EQUIPMENT

Benefits are payable if indicated on the Schedule of Benefits up to the Maximum shown Schedule of Benefits for the rental or purchase of Durable Medical Equipment (DME) that improves the function of a malformed body member or prevents further deterioration of an Insured Person's medical condition. Total rental payments, if any, will be limited to the purchase price of the equipment. A Physician must prescribe the Durable Medical Equipment for an Insured Person and submit a written statement of Medical Necessity. We will pay for the replacement of Durable Medical Equipment due to normal wear and tear.

If the DME device is covered, the supplies associated with the equipment will also be covered. Maintenance is not covered for purchase or rental equipment.

Durable Medical Equipment does not include supplies for short-term use or minor ailments, equipment which may be used by all family members, or items that may increase the value of Your property. Benefits are not provided for environmental control equipment, modifications to home property such as ramps, elevators and air conditioners, seatlift chairs, automotive vehicles, or modifications to automotive vehicles.

31. TEMPOROMANDIBULAR JOINT DISORDER

Benefits are payable if indicated on the Schedule of Benefits up to the maximum amount shown in the Schedule of Benefits for the care and treatment of temporomandibular joint disorder (TMJ).

32. INFERTILITY

Benefits are payable if indicated on the Schedule of Benefits for Infertility services including consultations, examinations, diagnostic surgical services related to Hospitalizations or facilities, treatment and drug therapy for involuntary infertility.

The level of benefits for all services, including the diagnostic work-up and testing to establish a cause of Infertility are specified in the Schedule of Benefits when obtained with prior authorization.

- A. Covered Charges include artificial insemination (except for donor semen or eggs, and services and supplies related to their procurement and storage), subject to a maximum of one treatment period of up to three (3) cycles per Lifetime; AND **ONE** Gamete intrafallopian transfer (GIFT) **OR** IVF per lifetime. (Lifetime is defined to include services provided under this Policy or any other health insurance.) Medications for the treatment of Infertility require Copay equal to 50% of the contracted prescription cost. Genetic testing and counseling are Covered Charges when medically indicated and are not subject to the Infertility Copays.
- B. No benefits shall be payable under the Policy for any expenses caused by, incurred for, or resulting from:
- 1) Services and supplies to reverse voluntary, surgically induced infertility.
 - 2) Embryo transfers and any services and supplies related to donor sperm or sperm preservation for artificial insemination, are excluded, including all services involved in surrogacy.
 - 3) Frozen embryo transfers and Zygote Intra-Fallopian Transfer (ZIFT).
 - 4) ICSI, Intracytoplasmic Sperm Injection.
 - 5) Ova Sticks (a self-test for infertility).
 - 6) Ovum Transfer/Transplants or Uterine Lavage as part of infertility diagnosis or treatment.
 - 7) Sperm Donor, including the actual collection of the sperm.
 - 8) Sperm Storage. Storage is not for the treatment of a disease or medical condition and is not Medically Necessary.
 - 9) Infertility as a result of previous/prevaling elective vasectomy or tubal ligation, including, but not limited to, procedure reversal attempts and infertility treatment after reversal attempts.
 - 10) Artificial insemination/donor sperm in lieu of a partner is not covered.
 - 11) Treatment of female sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome).
 - 12) Experimental diagnostic studies, procedures or drugs used to treat or determine the cause of Infertility.
 - 13) Laboratory medical procedures involving the freezing or storing of sperm, ovum and/or pre-embryos.
 - 14) Inoculation of women with partner's white cells (considered Experimental).

For purposes of this benefit, the following definition applies:

Infertility means being pre-menopausal with the presence of a condition recognized by a Physician as a cause, or the inability to conceive a Pregnancy or to carry a Pregnancy to a live birth after one year or more of regular sexual relations without contraception.

- [C. Coverage of in vitro fertilization is subject to the following limitations:
- 1) The fertilization or attempted fertilization of the patient's oocytes must be made only with the sperm of the patient's spouse;
 - 2) the patient and the patient's spouse have a history of infertility of at least five continuous years' duration or the infertility is associated with:
 - a. endometriosis;
 - b. exposure in utero to diethylstilbestrol (DES);
 - c. blockage of or surgical removal of one or both fallopian tubes; or
 - d. oligospermia;
 - 3) the patient has been unable to attain a successful Pregnancy through any less costly applicable infertility treatments for which coverage is available under the Policy; and
 - 4) the in vitro fertilization procedures are performed at a medical facility that conforms to the minimal standards for programs of in vitro fertilization adopted by the American Society for Reproductive Medicine.]

33. AUTISM SPECTRUM DISORDER

Benefits are payable if indicated on the Schedule of Benefits for a Dependent child older than two years of age and younger than six years of age who is diagnosed with Autism Spectrum Disorder.

Coverage includes all Generally Recognized Services prescribed in relation to Autism Spectrum Disorder by the Dependent child's Physician in the treatment plan recommended by that Physician.

For purposes of this Benefit, the following definition applies:

“Generally Recognized Services” means services such as:

- A. evaluation and assessment services;
- B. applied behavior analysis;
- C. behavior training and behavior management;
- D. speech therapy;
- E. occupational therapy;
- F. physical therapy; or
- G. medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

PART 7 – EXCLUSIONS AND LIMITATIONS

No benefits are payable for services, procedures, supplies, drugs, devices or treatment that are not Covered Charges or specifically provided in the Benefits sections of this Certificate.

In addition, no benefits are payable for, or relating to, the following services, procedures, supplies, drugs, devices or treatments, regardless of Medical Necessity:

1. **[Absence of Insurance** – expenses for a loss for which no charge would be made in the absence of health care coverage or for a service which your Physician advertises as a free service.
2. **Acupressure/Acupuncture** – beyond the benefit limits stated in Part 6 – Covered Charges and on the Schedule of Benefits.
3. **Addiction** – expenses related to nicotine addiction, caffeine addiction and other addictions including, but not limited to, gambling, sexual, spending, shopping, working and religious. This exclusion does not apply to Substance Use Disorders.
4. **Blood Storage** – expenses related to the storage of blood, except for autologous collection in preparation for surgery.
5. **Commission of a Felony** – expenses related to treatment of an Injury or Sickness of an Insured Person that occurs during or results from the commission of a felony by the Insured Person.
6. **Contraceptives** – expenses related to contraceptive drugs and/or devices unless this option is shown on the Schedule of Benefits.
7. **Cosmetic** – expenses related to Cosmetic Surgery or treatment to improve Your appearance or correct a deformity without restoring a physical bodily function, and complications resulting from Cosmetic Surgery or procedures. This exclusion does not apply to treatment of congenital anomalies of Eligible Dependents covered from birth or to craniofacial abnormalities of an Insured Dependent under 18 years of age. This also does not apply to treatment to correct conditions resulting from a covered Injury or Sickness occurring while Your coverage was in force under the Policy.
8. **Cryopreservation of bodily fluids.**
9. **Custodial Care** – expenses related to care provided in rest homes, health resorts, homes for the aged, halfway houses, or places mainly for domiciliary or Custodial Care.
10. **Dental Care** – expenses related to dental care. This exclusion does not apply to expenses resulting from a covered Injury to Sound Natural Teeth rendered within 1 year of the Injury
11. **Durable Medical Equipment** – beyond coverage provided in Part 6 – Covered Charges and on the Schedule of Benefits.
12. **Eating Disorders** – expenses related to treatment of eating disorders including, but not limited to, anorexia nervosa or bulimia beyond coverage for Mental or Nervous Disorders already provided in Part 6 – Covered Charges.
13. **Employment for Wage or Profit or Worker’s Compensation** – expenses for treatment of an Injury or Sickness arising out of, or in the course of, employment for wage or profit; and expenses for treatment of Injury or Sickness for which the Insured Person has or had a right to recovery under any Workers’ Compensation or similar Law.
14. **Excess Charges** – amounts above the Reasonable and Customary Charges for the services rendered by Out-of-Network Providers except as provided in the Policy.
15. **Experimental Treatment** – expenses related to services that are Experimental in nature.
16. **Family Members** – expenses related to treatment or services performed by a member of Your family or any person who regularly lives in Your home. Family members include You, Your spouse, Your spouse’s parents, children, sisters, and brothers.
17. **Federal Facility** – expenses related to treatment, diagnosis, or care provided while confined in a federal facility, unless You are legally obligated to pay the charges for such confinement.
18. **Foreign Travel and Residency** – expenses related to treatment, drugs or medical care received outside the United States or its possessions, unless expenses are incurred to treat an Emergency Medical Condition while [on a trip] [of not more than 60 days].

19. **Growth Hormones** – expenses for treatment, medication or hormones intended to stimulate growth, unless Medically Necessary.
20. **Hearing Expenses** – expenses related to routine hearing exams to assess the need for, or change to, hearing aids; and the purchase, fittings or adjustments of hearing aids; and the surgical or non-surgical treatment for the improvement of hearing including, but not limited to, the insertion of hearing aids or implants; [beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits. Unless included in a Benefit Rider attached to this Certificate]
21. **Home HealthCare and Hospice Care** – expenses related to Home Health Care and Hospice Care beyond coverage already provided in Part 6 – Covered Charges and the Schedule of Benefits.
22. **Homeopathy.**
23. **Human Organ, Tissue and Bone Marrow Transplant Benefits** – expenses relating to, or arising from, Human Organ, Tissue and Bone Marrow Transplants beyond coverage provided in Part 6 – Covered Charges and the Schedule of Benefits.
24. **Hypnosis** – expenses related to hypnosis, including its use in place of anesthesia.
25. **Infertility** – expenses related to the treatment of infertility, reversal of voluntary sterilization, or fertilization procedures beyond the coverage provided in Part 6 – Covered Charges and on the Schedule of Benefits.
26. **Internet** – expenses related to treatment, diagnosis, or care provided over the Internet, or via electronic mail.
27. **Liposuction** – expenses related to suction-assisted lipectomy or diastasis recti repair, including instances when diastasis recti repair is associated with an umbilical or ventral hernia.
28. **Manipulative Services** – beyond the benefit limits stated in Part 6 – Covered Charges and on the Schedule of Benefits.
29. **Non-Covered Charges** – expenses related to any benefit not specifically provided within the Policy and this Certificate.
30. **Non-Medical Expenses** – non-medical expenses, even if recommended by a Physician. This includes, but is not limited to: work hardening or strengthening programs; travel expenses; self-help training; services or supplies at a health spa or similar facility; a personal trainer; massage therapy; [elastic bandages]; [support hose]; shoes, shoe inserts, and [pressure garments]; personal hygiene and convenience items; water aerobics and cybex machines; television, telephone, cots and visitors' meals; charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form and information required to process Your claims and similar expenses.
31. **Outpatient Prescription Drugs** – beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits.
32. **Physical therapy, Occupational Therapy and speech therapy** – beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits.
33. **Preventive Care Services** – beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits.
34. **Private Duty Nursing services** – except when such services are required for Home Health Care (see Part 6 – Covered Charges).
35. **Research** – expenses related to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research or clinical-research study.
36. **Robotic Assisted Surgery Services** [unless included in a Benefit Rider attached to this Certificate.]
37. **Routine physical examinations** – expenses related to routine physical examinations including immunizations, use of prophylactic injections including gammaglobulins and flu shots, and well-child care including immunizations except as specifically provided in Part 6 – Covered Charges and the Schedule of Benefits.
38. **Self-Harm** – expenses related to treatment of self-inflicted Injuries or Sickneses or attempted suicide, whether sane or insane; except as a result of a medical condition.
39. **Sexual Dysfunctions** – expenses related to gender identity disorders, gender reassignment or sex transformation, [sexual dysfunctions or inadequacies]. This exclusion [includes][excludes] sexual therapy and counseling, penile prosthesis and all other procedures, equipment and drugs developed for male impotency.[unless included in a Benefit Rider attached to this Certificate.]
40. **Take Home Prescription Drugs** – expenses relating to non-prescription drugs or any take home prescriptions.
41. **Temporomandibular Joint Dysfunction (TMJ)** – expenses relating to the treatment of temporomandibular joint dysfunction and cranomandibular joint dysfunction beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits.
42. **Travel Expenses** – beyond coverage already provided in Part 4 - Medical Management.
43. **Vision** – No benefits are payable for expenses related to
 - A. Eye refractions or eye examinations, eye glasses or contact lenses beyond the benefit limits stated in Part 6 – Covered Charges is attached to the Schedule of Benefits. This exclusion does not apply to initial prosthetic lenses, or sclera shells following intra-ocular surgery.
 - B. No benefits are payable for radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy, that are not performed in connection with an Injury or Sickness.[unless included in a Benefit

Rider attached to this Certificate.]

44. **Voluntary Abortion** – except if the mother would have a Life-Threatening condition if the fetus were carried to term. [unless included in a Benefit Rider attached to this Certificate.]
45. **War** – expenses related to Injuries, Sickneses, diseases or disorders as a result of war or act of war, declared or undeclared.
46. **Weight** – expenses related to weight reduction programs, weight management programs, related nutritional supplies, treatment for obesity, or surgery for removal of excess skin or fat.] [unless included in a Benefit Rider attached to this Certificate.]

PRE-EXISTING CONDITIONS LIMITATIONS

Coverage for an Insured Person is subject to the Pre-Existing Condition limitations which are as follows:

1. For Insured Persons who enroll during the Initial Enrollment Period or Special Enrollment Period, Covered Charges incurred for the treatment of Pre-Existing Conditions will not be covered under the Policy for a period of 12 months after the Enrollment Date. A Pregnancy will not be considered a Pre-Existing Condition; and
2. For Insured Persons who enroll outside an Initial Enrollment Period or Special Enrollment Period (Late Enrollees), Covered Charges incurred for the treatment of Pre-Existing Conditions will not be covered under the Policy for a period of 18 months after the Effective Date. A Pregnancy will not be considered a Pre-Existing Condition.

An Insured Person under the age of 19 will not be subject to the Pre-Existing Condition limitation.

Credit for Period of Previous Health Insurance

If on the date You enroll, You have Creditable Coverage that terminated no more than 63 days prior to Your Enrollment Date, You will be given credit for the full or partial satisfaction of the Pre-Existing Condition limitation period. Any period that You were in a Service Waiting Period prior to the effective date of Your coverage under the Policy will not be counted in determining whether You had a break in coverage that exceeded 63 days.

If You had 12 months of prior Creditable Coverage, the Pre-Existing Condition limitation period will be eliminated in its entirety. If You had less than 12 months of prior Creditable Coverage, the Pre-Existing Condition limitation period will be reduced by each month or partial month for which You had prior Creditable Coverage.

PART 8 – COORDINATION OF BENEFITS

Applicability

1. This Coordination of Benefit ("COB") provision applies to the Policy ("This Plan") when an Insured has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.
2. If this COB provision applies, the order of benefit determination rules ("Rules") should be looked at first. Those Rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:
 - A. shall not be reduced when, under the Rules, This Plan determines its benefits before another Plan; but
 - B. may be reduced when, under the Rules, another Plan determines its benefits first.

Definitions

1. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
 - A. Group insurance or group-type coverage, whether insured or self-insured. This includes: (1) prepayment; (2) group or individual practice; (3) individual and group type automobile. This does not include: (1) student accident; (2) blanket; or (3) franchise individual;
 - B. Coverage under a governmental plan (including Medicare) where required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time.) It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

Each contract or other arrangement for coverage under a. or b. above is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. "This Plan" is the part of the Policy that provides benefits for health care expenses.
3. "PRIMARY PLAN"/"SECONDARY PLAN." The Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan,

its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the person, This Plan: (a) may be a Primary Plan as to one or more other Plans; and (b) may be a Secondary Plan as to a different Plan or Plans.

4. "Allowable Expense." This means a Necessary, Reasonable, and Customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition. That is unless the patient's stay in a private Hospital room is Medically Necessary either: (a) in terms of generally accepted Medical practice; or (b) as precisely defined in the Plan.

A Plan might provide benefits in the form of services. In this case the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

5. "Claim Determination Period." This means a Year. But, it does not include any part of a year: (a) during which a person has no coverage under This Plan; or (b) before the date this COB provision or a similar provision takes effect.

Effect on Benefits

1. When This Section Applies. This Section applies when This Plan is a Secondary Plan as to one or more Plans. In that case the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in 2. below.
2. Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:
 - A. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
 - B. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;

exceed those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Order of Benefit Determination Rules

1. General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:
 - A. the other Plan has Rules coordinating its benefits with those of This Plan;
 - B. both those Rules and This Plan's Rules, in item 2 below, require that This Plan's benefits be determined before those of the other Plan.
2. Rules. This Plan decides its order of benefits using the first of the following rules which applies:
 - A. Non-Dependent/Dependent. The benefits of the Plan that covers the person, other than as a dependent, are determined before those of the Plan that covers the person as a dependent except that, if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - 1) secondary to the Plan covering the person as a dependent; and
 - 2) Primary to the Plan covering the person as other than a dependent, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering the person as other than a dependent.
 - B. Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph 2. c. below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents":
 - 1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
 - 2) if both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

However, the other Plan may not have the rule described above. Instead it may have a rule based upon the gender of the parent. If so, and if, as a result, the Plans do not agree on the order of benefits, then the rule in the other Plan will decide the order of benefits.

- C. Dependent Child/Separated or Divorced Parents. Two or more Plans may cover a person as a dependent child of divorced or separated parents. In this case benefits for the child are determined in this order:
- 1) first, the Plan of the parent with custody of the child;
 - 2) the Plan of the spouse of the parent with the custody of the child; and finally
 - 3) the Plan of the parent not having custody of the child.
- However, the specific terms of a court decree might state that one of the parents is responsible for the health care expenses of the child. In this case if the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This item does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- D. Dependent Child/Joint Custody. If the court decree awards joint custody, then benefits are paid as in 2.b. above.
- E. Active/Inactive Employee. The benefits of a Plan that covers a person as an employee who is neither laid off nor retired (nor as that employee's dependent) are determined before those of a Plan that covers that person as a laid off or retired employee (or as that employee's dependent.) The other Plan might not have this rule. If so, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- F. Longer/Shorter Length of Coverage. If none of the above rules decides the order of benefits, the benefits of the Plan that covered the person longer are determined before those of the Plan that covered that person for the shorter time.
- G. Continuation Coverage: If a person whose coverage is provided under a right of continuation plan pursuant to federal or state law and also under this Plan, the following order of benefits applies:
- 1) First, the Plan covering the person as an employee, or as the employee's dependent;
 - 2) Second, the benefits of the continuation coverage.

If the other Plan does not have this rule and the Plans do not agree on the order of benefits, this rule is ignored.

Effect on the Benefits of this Plan

1. When This Section Applies. This Section applies when This Plan is a Secondary Plan as to one or more Plans. In that case the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in 2. below.
2. Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:
 - A. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
 - B. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;
 exceed those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need and to obtain them from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the forms of services. In such a case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

The amount of the payments made by Us might be more than We should have paid under this COB provision. In such a case, We may recover the excess from one or more of these:

1. Any persons to, or for whom, such payments are made; or

2. Any insurance companies; or
3. Any other organizations.

The "amount of the payment made" includes the reasonable cash value of any benefits provided in the form of services. The right of recovery does not include liability settlements. However, the right will not apply unless the Insured Person, whose loss is the basis for applying such provision, is made whole.

Any such right of reimbursement provided to Us under the Policy shall not apply or shall be limited to the extent that states or the state courts eliminate or restrict such rights.

Medicare Coordination

1. Claims will be coordinated with Medicare based on the Medicare Secondary Payor (MSP) Rules.
2. For Employers with 100 or more Employees, this Plan will be the Primary Plan for totally disabled Employees that are covered under this Plan while entitled to Medicare disability benefits.
3. If the Insured Person is retired or on COBRA, Medicare is the Primary Plan and this Plan will be secondary for the Employee and the Employee's enrolled Dependents who are age 65 or over or eligible for Medicare because of disability. Medicare is considered a Plan for the purposes of Coordination of Benefits. The Plan will coordinate benefits with Medicare whether or not the Insured Person or the Insured Person's enrolled Dependents are actually receiving Medicare benefits.
4. The Plan is the Primary Plan and Medicare will be the Secondary Plan for an Employee and the Employee's enrolled Dependents during the first thirty (30) months in which the Employee or the Covered Dependent spouse or child(ren) is/are eligible for Medicare solely because of permanent kidney failure. After the first thirty (30) months, Medicare will be the Primary Plan and this Plan will be the Secondary Plan. Medicare will be considered a Plan for purposes of Coordination of Benefits. This Plan will coordinate benefits with Medicare whether or not the Insured Person or his Dependent spouse or child is/are actually receiving Medicare benefits.

PART 9 – PREMIUM PAYMENT

Payment Of Premium

Premiums are payable to Us. No insurance agent, insurance broker or insurance consultant is authorized to accept any premium payment on Our behalf. The Employer must timely pay the monthly premium in order to maintain the Policy. The payment of any premium will not keep the Policy in force beyond the due date of the next premium, except as provided in the Grace Period. If any premium is not received by Us before or at the end of the Grace Period, the Policy will automatically end at the end of the period for which the last premium payment has been paid.

Grace Period

The Employer is entitled to a grace period of 31 days for the payment of any Premium due except the first, during which grace period the Policy shall continue in force, unless the Employer has given the Company written notice of discontinuance of the coverage in advance of the date of discontinuance in accordance with the terms of the Policy. The Employer shall be liable to the Company for the payment of a pro rata Premium for the time the coverage was in force during such grace period.

Premium Changes

We reserve the right to change premiums under the Policy on any premium due date by giving the Employer at least 31 days prior written notice.

If the Employer has selected a rate guarantee period when applying for coverage under the Policy, the premium will not change during the rate guarantee period except for the following reasons:

1. The addition or deletion of Employees to or from the coverage under the Policy;
2. An Employee enters into a new age rate-band;
3. The Employer changes the network to a network that is different than the network the Employer selected when applying for coverage;
4. The Employer moves to a different location from where the Employer was located at the time the Employer applied for coverage;
5. The Employer requests that coverage under the Policy be modified to increase or decrease benefits from those selected when applying for coverage; or
6. New state or federal statutes, rules or regulations become effective after the Effective Date of coverage and affect Our liability under the Policy.

PART 10 – RENEWABILITY AND TERMINATION

Renewability of the Policy

The Policy is on a monthly renewable basis at the option of the Employer, except for the following reasons:

1. Non-payment of the required premium;
2. Fraud or intentional misrepresentation of a material fact of or by the Employer, or with respect to coverage of an Insured, fraud or intentional misrepresentation of a material fact by the Insured or such person's representative;
3. For failure to comply with Policy provisions, including failure to provide proof, whenever requested by Us, that the Employer is complying with the Employee contribution and participation requirements;
4. For not maintaining Employee participation requirements for at least six consecutive months ;
5. For not maintaining Employee contribution requirements;
6. The Insurance Commissioner of the state of the Employer's residence finds that the continuation of coverage would not be in the best interests of the Policyholder or certificateholders;
7. The Insurance Commissioner of the state of the Employer's residence finds that the continuation of coverage would impair Our ability to meet Our obligations;
8. The type of coverage under the Policy is no longer offered by Us in the state of the Employer's residence in which event We will provide ninety (90) days prior written notice of the discontinuance and We will offer the Employer the option to purchase any other health insurance coverage currently being offered by Us to employers in the large group market in that state.
9. We decide to discontinue offering all health insurance in the large group market in the state of the Employer's residence in which event We will provide the applicable State authorities and the Employer written notice 180 days prior to the discontinuation and We will discontinue all health insurance issued or issued for delivery in the large group market in the state of the Employer's residence and will not renew such coverage in the state of the Employer's residence.

Time For Non-Renewal of the Policy

All insurance under the Policy for an Employer, its Employees and their Dependents shall be non-renewed as follows:

1. Lapse due to non-payment of premium, at 12:01 A. M., of the premium due date following the end of the month for which the last premium payment is made on account of the Employer's insurance; or
2. Non-renewal for all other reasons, at 12:01 A. M., of the premium due date coinciding with or next following the date such event took place.

Termination Of Employee's Coverage

Coverage for an Insured Employee shall automatically terminate on the earliest of the following dates:

1. The date of termination of the Policy; or
2. The date of termination of any section or part of the Policy with respect to insurance under such section or part; or
3. The [last] day of the month in which You no longer meet the eligibility criteria established in the Policy; or as outlined on Your Schedule of Benefits.
4. The date You or Your Employer fails to pay the required premium; or
5. The date You enter the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less or as provided under the Statement of Uniform Services Employment and Reemployment Rights Act of 1994 provision; or
6. The date the Policy is amended to terminate the eligibility of any class of [Retiree][Part-time Employee][tribal member][officer][partner][or [director] of which the [Retiree] [Part-time Employee] [tribal member] [officer][partner]or [director] is a member.

Termination Of Dependent Insurance

Coverage for an Insured Employee with respect to Dependents shall terminate on the earliest of the following dates:

1. The date of termination of the Policy; or
2. The date of termination of any section or part of the Policy in respect to insurance under such section or part; or
3. The date Your insurance terminates; or

4. The date You or Your Employer fails to pay the required premium; or
5. The day of the Policy Month in which a Dependent ceases to meet the definition of "Dependent"; or
6. The date the Dependent enters the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less or as provided by the Statement of Uniform Services Employment and Reemployment Rights Act of 1994 provision; or
7. With respect to an Insured Employee's Dependent spouse, the premium due date coinciding with or next following the date on which the Insured Employee is divorced or legally separated from such spouse; or
8. The premium due date coinciding with or next following the date on which a Dependent child no longer qualifies under the definition of "Dependent." If upon attaining any limiting age specified in the Schedule of Benefits, a Dependent child, because of Mental or Physical Incapacity, as defined below, is incapable of earning his or her own living and is chiefly Dependent upon the Insured Person for support and maintenance, coverage for the Dependent child may be continued during the continuance of such incapacity, providing that:
 - A. Medical proof, in writing, of such incapacity must be given to Us within 31 days after the date on which the Dependent child attains a limiting age; and
 - B. We shall have the right any time during the continuance of insurance under this provision to require due proof of the continuance of the incapacity and to have the Dependent child examined by Physicians designated by Us at any time during the first 2 years of such continuance and not more than once each year thereafter; and
 - C. You continue paying the required premium for the Dependent; and
 - D. The continuance described herein shall cease in the event of the occurrence of any of the circumstances described in paragraphs 1. through 8. above.

For the purposes of the provision, the following definition applies:

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

Modifications

We may modify the Policy and this Certificate if the modification occurs at the time of coverage renewal.

PART 11 – GENERAL PROVISIONS

Entire Contract - Changes

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

Incontestability

The validity of the Policy will not be contested, except for non-payment of premiums, after it has been in force for 2 years from the Date of Issue.

In the absence of fraud, a statement made by any individual covered by the policy relating to the individual's insurability may not be used in contesting the validity of the insurance with respect to which the statement was made: (a) after the insurance has been in force before the contest for two years during the individual's lifetime; and (b) unless the statement is contained in a written instrument signed by the individual making the statement.

Representations

In the absence of fraud, a statement made by the Policyholder or an Insured Person is considered a representation and not a warranty; and a statement made by the Policyholder or an Insured Person may not be used in any contest under the Policy, unless a copy of the written instrument containing the statement is or has been provided to: (a) the person making the statement or (b) if the statement was made by the Insured Person and the Insured Person has died or become incapacitated, the Insured Person's beneficiary or personal representative.

Conformity with Federal and State Laws

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

Ambiguities

Any terms or conditions specified in the Policy that are determined to be ambiguous or in conflict with State or Federal laws shall be considered separately and shall not void or effect the legality of the remaining terms and conditions that are included in the Policy and this Certificate.

Physical Examination

We have the right, at Our own expense, to have an Insured Person for whom claim is made examined as often as is reasonable while a claim is pending under the Policy.

Workers' Compensation

The Policy is not in lieu of and does not affect any requirements for coverage by Workers' Compensation insurance.

Certificates/Booklets

We will issue to the Employer a Certificate for delivery to each Insured Employee.

Waiver Of Rights

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

Required Information

The Insured Person agrees to provide to Us any information or data that we reasonably request for the proper administration of the Policy including; but not limited to, information pertaining to medical history, medical records, the names of all health care Providers from whom the Insured Person has received treatment or services, documentation of prior Creditable Coverage, marriage license, documentation of adoption, documentation of legal custody of a Dependent, student status information, and treating Provider statements.

Effective Date

No insurance under the Policy shall become effective until notice in writing is given to the Employer by Us. Issuance of a Certificate with a Validation of Coverage face page will be deemed proper notification, provided premium due has been paid in accordance with the terms of the Policy.

Misstatement of Age

If the age of an Insured Person has been misstated, We will make an equitable adjustment of premiums or benefits or both. We will change the benefit to the applicable amount available for the correct age. We will refund to the Employer any excess premium paid over the amount due for the correct benefit amount. We will request payment for any overdue premium for the correct benefit amount.

PART 12 – CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given to Us as soon as possible. Written notice of claim given by or on behalf of the Insured to Us with information sufficient to identify such person will be considered notice to Us.

Claim Forms: Upon receipt of written notice of claim, We will furnish the required forms (if any) for filing proof of loss. If We do not send the forms within 15 days, You can satisfy Our requirements by giving Us a written statement. The statement should include the nature and extent of the claim, and be sent to Us in accordance with the proof of loss provision.

Proof of Loss: Written proof of loss must be furnished to Us within 90 days after the date the medical treatment was received. Written proof of loss includes all information necessary for Us to determine that a valid loss occurred. If it is shown that it is not reasonably possible to furnish written proof of loss within that time, the claim will not be rejected or reduced as long as We receive such proof as soon as reasonably possible, and in no event, in the absence of legal incapacity, later than one year from the time proof is otherwise required pursuant to this provision.

Timely Payment of Claims: We will pay all benefits due for Covered Charges, promptly upon receipt of due proof of loss.

Assignment of Claims: All benefits payable will be payable to You unless a written assignment of benefits is filed with Us at Our administrative office. We will not be responsible for the legal effect of any assignment.

Payment of Claims: All benefits for Covered Charges are payable to You unless You have otherwise assigned the benefits to a medical Provider. If any such benefits remain unpaid at Your death, or, if You are, in the opinion of the Company, incapable of giving a legally binding receipt for payment of any benefit, We may, at Our option, pay such benefit to any one or more of the following relatives: Your spouse, mother, father, child, brother or sister. Any payment so made will constitute a complete discharge of Our obligations to the extent of such payment.

Right to Appeal

You or Your Authorized Representative have the right to appeal any decision or action taken by Us to deny, reduce or terminate the provision of or payment for health care services requested or received under the Policy. When We have denied, reduced or terminated a requested service or payment for a service covered by the Policy based on a judgment as to the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of the health care services, You or Your Authorized Representative have the right to have Our decision reviewed by an independent review organization not associated with Us.

We will provide You or Your Authorized Representative with certain written information, including the specific reason for Our decision and a description of Your appeal rights and procedures every time We make a determination to deny, reduce or terminate the provision of or payment for health care services requested or received under the Policy.

For the purpose of this provision, the following definition applies:

Authorized Representative means a person to whom an Insured Person has given consent to represent the Insured Person in an external review. Authorized Representative may include the Insured Person's treating Provider.

Legal Action

No action at law or in equity will be brought to recover under the Group Policy prior to the expiration of 60 days after proof of loss has been filed as required by the Group Policy, nor will any action be brought after 3 years from the date the claim was first incurred.

Recovery of Overpayments

We reserve the right to deduct from any future benefits payable under the Policy the amount of any payment that has been made:

1. In error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or intentional misrepresentation of a material fact made to obtain coverage under the Policy within 2 years after the Effective Date; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under any policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by an Insured Person if claim payments previously were made with respect to such Insured Person.

Subrogation/Right Of Reimbursement

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

SCHEDULE OF BENEFITS / *[Options are in Brackets]*

Policyholder:
Employer:
Required Hours:
Insured:
Certificate Number:
Effective Date:
Premium Due Date: [1 st of the month][15 th of the month]
Schedule Date:
Domestic Partner Coverage: [Yes/No]
Dependent Spouse:
Dependent Child(ren): [Child(ren) Name(s)]
Dependent Limiting Age: [up to 26-99]
Student Eligibility Limiting Age: [26-99]
Pre-Existing Conditions Limitations Apply: [Yes/No][Does not apply to Insured Persons less than age 19-99]
[Health Care Reform Status][-][Non-Grandfathered][Grandfathered]
Year: [Calendar] [Plan] Year
Medical Expense Benefits

Covered Services per	In-Network Cost to Covered Person	Out-of- Network Cost to Covered Person
Year:		
Deductible per Year [(1)]		
Individual	[\$0 - \$10,000] [[Benefit Allowance of first [\$0-\$5000] will be covered at 100%][Does not apply to Copays or Prescription Benefits]][Covered Person's annual Deductible/Coinsurance will then be applicable]	[[2X][3X] In-Network] [\$0 - \$20,000] [[Benefit Allowance of first [\$0-\$5000] will be covered at 100%][Does not apply to Copays or Prescription Benefits]][Covered Person's annual Deductible/Coinsurance will then be applicable]
Family	[Embedded][Aggregate] [[2X][3X] individual] [\$0 - \$20,000] [[Benefit Allowance of first [\$0-\$5000] will be covered at 100%][Does not apply to Copays or Prescription Benefits]][Covered Person's annual Deductible/Coinsurance will then be applicable] [Two][Three][Individuals must each meet their Individual Deductible to satisfy Family Deductible]	[Embedded][Aggregate] [[2X][3X] In-Network] [\$0 - \$40,000] [[Benefit Allowance of first [\$0-\$5000] will be covered at 100%][Does not apply to Copays or Prescription Benefits]][Covered Person's annual Deductible/Coinsurance will then be applicable] [Two][Three][Individuals must each meet their Individual Deductible to satisfy Family Deductible]
Coinsurance for all Eligible Expenses	[0% - 50%]	[0% - 50%]
Out-of-pocket Maximum (OOP)[(2)(3)]		
Individual	[\$0 - \$10,000]	[[2X][3X] In-Network] [\$0 - \$150,000]
Family	[2X][3X] individual] [\$0 - \$20,000] [Two][Three][Individuals must each meet their Individual Out-of-Pocket to satisfy Family Out-of-Pocket]	[[2X][3X] In-Network] [\$0 - 250,000] [Two][Three][Individuals must each meet their Individual Out-of-Pocket to satisfy Family Out-of-Pocket]
Deductible Applies	[Yes, No]	

SCHEDULE OF BENEFITS / [Options are in Brackets]

Coinsurance Applies Copayment Applies Out-of-Network Deductible & OOP apply to In-Network Deductible & OOP	[Yes, No] [Yes, No] [Yes, No]	
Maximum per year:	<p align="center">[Embedded][Aggregate] [Not Applicable]</p> <p>[For [Calendar][Plan] Years beginning before [September 23, 2011] \$750,000] [For [Calendar][Plan] Years beginning on and after [September 23, 2011] but before [September 23, 2012] \$1,250,000] [For [Calendar][Plan] Years beginning on and after [September 23, 2012] but before [January 1, 2014] \$2,000,000] [Effective [January 1, 2014] there is no [Calendar][Plan] Year Maximum Benefit for Essential Health Benefits]]</p>	<p align="center">[Embedded][Aggregate] [Not Applicable]</p> <p>[For [Calendar][Plan] Years beginning before [September 23, 2011] \$750,000] [For [Calendar][Plan] Years beginning on and after [September 23, 2011] but before [September 23, 2012] \$1,250,000] [For [Calendar][Plan] Years beginning on and after [September 23, 2012] but before [January 1, 2014] \$2,000,000] [Effective [January 1, 2014] there is no [Calendar][Plan] Year Maximum Benefit for Essential Health Benefits]]</p>
Covered Services per	In-Network Cost to Covered Person	Out-of-Network Cost to Covered Person
Physician Care • [Office Visit]	<p>[General Practitioner] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]</p> <p>[Specialist] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]</p>	<p>[General Practitioner] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]</p> <p>[Specialist] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]</p>
• [Lab Tests & X-rays]	<p>[Major] [Specialty Diagnostic Services] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]</p> <p>[Minor] [Diagnostic Testing Services] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]</p>	<p>[Major] [Specialty Diagnostic Services] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]</p> <p>[Minor] [Diagnostic Testing Services] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]</p>
• [Office Surgery]	<p>[Major] [Surgical & Endoscopic Services over \$[350-\$1000]] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]</p> <p>[Minor] [Surgical & Endoscopic Services under \$[350-\$1000]] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]</p>	<p>[Major] [Surgical & Endoscopic Services over \$[350-\$1000]] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]</p> <p>[Minor] [Surgical & Endoscopic Services under \$[350-\$1000]] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]</p>

SCHEDULE OF BENEFITS / [Options are in Brackets]

<ul style="list-style-type: none"> [Allergy Injections] 	[Copay] [\$0-\$500][*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Preventive Care Services]	[Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
Cancer Screening Tests		
Mammography Screening	[Covered at 100%]	[Copay][\\$0 - \$500][*][then][deductible][coinsurance]
Colorectal Cancer Screening	[Covered at 100%]	Copay][\\$0 - \$500][*][then][deductible][coinsurance]
Prostate Cancer Screening	[Covered at 100%]	[Copay][\\$0 - \$500][*][then][deductible][coinsurance]
Preventive and Primary Care Services for Children (Birth to age 18)	[Covered at 100%]	[Copay][\\$0 - \$500][*][then][deductible][coinsurance]
Childhood Immunizations	[Covered at 100%]	[Covered at 100%]
[Vision Exam – Routine]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of [\$50 - \$1,000]]	
	[Limited to max benefit of [1] visit[s]][every [[1]] [[2]] [year][s]]	
[Hearing Exam – Routine]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
	[Limited to [Calendar][Plan] Year maximum benefit of [\$50 - \$1,000]]	
	[Limited to max benefit of [1] visit[s]] [every [[1]] [[2]] [year][s]]	
Hearing Aids	[Coinsurance]	[Coinsurance]
	[Limited to \$1,400 per ear for each 3-year period]	
Emergency Services		
<ul style="list-style-type: none"> [Urgent Care] 	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
<ul style="list-style-type: none"> [Emergency Room ([Copay] waived if admitted)] 	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
Ambulance		
<ul style="list-style-type: none"> [Ground] 	[Copay] [\$0-\$10000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$10000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]

SCHEDULE OF BENEFITS / [Options are in Brackets]

<ul style="list-style-type: none"> [Air] 	[Copay] [\$0-\$20000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$20000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
Pregnancy/Maternity Care <ul style="list-style-type: none"> [Office Visit (pre & postnatal)] 	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
<ul style="list-style-type: none"> [Hospitalization] 	[Routine Newborn – Split ((Mother/Newborn)) Copay [\$0-\$1000][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000] [deductible/coinsurance]	[Routine Newborn – Split]((Mother/Newborn)) Copay [\$0-\$2000][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000] [deductible/coinsurance]
[Elective Sterilization]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [no coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [no coverage]
Hospitalization Inpatient Services <ul style="list-style-type: none"> [Semi-private Hospital Room & Board] 	[Copay] [\$0-\$1000][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000] [deductible/coinsurance]	[Copay] [\$0-\$2000][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000] [deductible/coinsurance]
<ul style="list-style-type: none"> [Physician & Surgeon Services] 	[Copay [\$0-\$1000]][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000]] [deductible/coinsurance] [Specialist Services] [Copay [\$0-\$1000]][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000]] [deductible/coinsurance]	[Copay] [\$0-\$2000][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000]] [deductible/coinsurance] [Specialist Services] [Copay] [\$0-\$2000][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000]] [deductible/coinsurance]
<ul style="list-style-type: none"> [Lab, X-ray and other facility charges] 	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
Hospital Outpatient Surgery	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
Hospital Outpatient Services	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
Mental Health Conditions		
<ul style="list-style-type: none"> [Inpatient] 	[Copay] [\$0-\$1000][*]	[Copay] [\$0-\$2000][*]

SCHEDULE OF BENEFITS / [Options are in Brackets]

	[Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000] [deductible/coinsurance]	[Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000] [deductible/coinsurance]
• [Outpatient /Transitional Care]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
• [Office Visit]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
Substance Use Disorders		
• [Inpatient]	[Copay] [\$0-\$1000][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000] [deductible/coinsurance]	[Copay] [\$0-\$2000][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000] [deductible/coinsurance]
• [Outpatient /Transitional Care]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
• [Office Visit]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
Rehabilitation Services		
• [Inpatient]	[Copay] [\$0-\$1000][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000] [deductible/coinsurance]	[Copay] [\$0-\$2000][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000] [deductible/coinsurance]
• [Outpatient]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [Physical] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [Speech] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [Occupational] [Copay] [\$0-\$500] [*][then]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [Physical] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [Speech] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [Occupational] [Copay] [\$0-\$1000] [*][then]

SCHEDULE OF BENEFITS / [Options are in Brackets]

	[deductible][coinsurance] [Covered at 100%]	[deductible][coinsurance] [Covered at 100%]
	[(Limited to [Calendar][Plan] Year maximum benefit of [10 – 365 visits][maximum visits by therapy type]	
	[(Limited to [Calendar][Plan] Year maximum benefit of [\$2,500 – \$20,000]	
Durable Medical Equipment	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
	[Limited to [Calendar][Plan] Year maximum benefit of [\$2,500 – \$10,000] [Rental limited to purchase price]	
Skilled Nursing Facility	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
	[Limited to [Calendar][Plan] Year maximum benefit of [10 – 365 days]	
Home Health Care	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
	[Limited to [Calendar][Plan] Year maximum benefit of [10 – 365 visits] or [\$0-5,000]]	
Hospice and Respite Care Services	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
	[Limited to [Calendar][Plan] Year maximum benefit of \$500 - \$10,000, Not Applicable]	
Organ Transplant	[Copay] [\$0-\$1000]][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000] [deductible/coinsurance] [Donor Fees for Covered Organ Transplant] [Copay] [\$0-\$1000]][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000] [deductible/coinsurance]	[Copay] [\$0-\$2000]][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$20,000] [deductible/coinsurance] [Donor Fees for Covered Organ Transplant] [Copay] [\$0-\$2000]][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$20,000] [deductible/coinsurance]
	[Limited to [Lifetime][Per Transplant] maximum benefit of [\$20000 - \$100000] [Not Applicable]	
Manipulative Services	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
	[Limited to max per Year benefit of [10 - 40 visits]	

SCHEDULE OF BENEFITS / [Options are in Brackets]

[Temporomandibular Joint Dysfunction (TMJ)]	[Non-Surgical] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [Surgical] [Copay] [\$0-\$1000][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000] [deductible/coinsurance]	[Non-Surgical] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [Surgical] [Copay] [\$0-\$2000][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000] [deductible/coinsurance]
[Infertility]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
[Limited to lifetime maximum benefit of [\$15,0000 - \$25,000]]		

[Acupressure/Acupuncture]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
[Limited to [Calendar][Plan] Year maximum benefit of [\$500 - \$5,000]]		
[Limited to max per Year benefit of [10 - 40 visits]		
[Autism Spectrum Disorder]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
Applied Behavior Analysis, for the Diagnosis and Treatment of Autism Spectrum Disorders, is [\$50,000] per [Calendar][Plan Year per Insured Persons through 18 years of age.		
Gastric Pacemakers	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]

OPTIONAL BENEFITS

[Bariatric Surgery]	[Copay] [\$0-\$1000][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000] [deductible/coinsurance]	[Copay] [\$0-\$2000][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000]] [deductible/coinsurance]
[Limited to [Calendar][Plan] Year maximum benefit of [\$5000 - \$10,000]]		
[Cochlear Implants]	[Copay \$0 - \$5,000] [*] [[Covered at [0%-100%]]] [deductible] [coinsurance][No Coverage]	[Copay \$0-\$10,000][*][deductible] [coinsurance] [No Coverage]
[Limited to Year maximum benefit of (\$0 - \$30,000)]		
[Limited to a maximum per lifetime benefit of [\$0 - \$100,000]]		

SCHEDULE OF BENEFITS / [Options are in Brackets]

[Health Education Programs]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage] [Health Education Asthma] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage] [Dietetic Counseling for Anorexia, Bulimia and Polyphagia] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage] [Health Education Asthma] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage] [Dietetic Counseling for Anorexia, Bulimia and Polyphagia] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Limited to [Calendar][Plan] Year maximum benefit of [\$0 - \$5,000]]		
[Hearing Aids]	[Copay \$0 – \$1,000] [*] [Covered at [0%-100%]] [deductible] [coinsurance]	[Copay \$0-\$2,000][*][deductible] [coinsurance]
[Impacted Wisdom Teeth Removal]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Orthotics]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Limited to [Calendar][Plan] Year maximum benefit of [\$100 - \$5,000]]		
[Prosthetics and Orthotic Services and Devices]	[Copay] [\$0-\$500][*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Limited to [Calendar][Plan] Year maximum benefit of [\$100 - \$5,000]]		
[Limited to [Calendar][Plan] Year maximum benefit of [\$500 - \$25,000]]		
[Sexual Dysfunction]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Limited to [Calendar][Plan] Year maximum benefit of [\$100 - \$5,000]]		
[Supplemental Accident Benefit]	Limited to Year maximum benefit of [\$100-\$2000]	
[Teeth Bleaching Following Accident]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Voluntary Abortion]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Limited to a max [1][2] [Year] benefit of [1]]		
[Weight Management]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]

SCHEDULE OF BENEFITS / [Options are in Brackets]

Injectible & Specialty Medications [Paid under Major Medical Benefits]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Generic] [Copay] [\$0-\$1,000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Generic] [Copay] [\$0-\$2,000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Brand Preferred][Copay] [\$0-\$2,500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Brand Preferred] [Copay] [\$0-\$5,000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Brand Non-Preferred] [Copay] [\$0-\$5,000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Brand Non-Preferred] [Copay] [\$0-\$10,000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]

[Prescription Drug]	[deductible] [coinsurance] [Not Covered] [Does not apply to medical][deductible][&][out-of-pocket maximum]][Does apply to medical deductible & out-of pocket maximum]
[RX Deductible]	[Not Applicable] [\$0 - \$10,000]
[Per Individual]	[\$0 - \$5,000] per Year]
[Per Family]	[\$0 - \$10,000] per Year]
[Prescription Out-of-Pocket Maximum]	[Not Applicable] [\$0 - \$20,000]
[Per Individual]	[\$0 - \$10,000] per Year]
[Per Family]	[\$0 - \$20,000] per Year]
[Prescription Contraceptive Coverage]	
• [Drugs]	[Minimum][Maximum][Copay [(\$0 - \$500)][deductible] [coinsurance]
• [Devices]	[Minimum][Maximum][Copay [(\$0 - \$500)][deductible] [coinsurance]
Retail –	[[30-90] day supply]
- [Generic]	[Minimum][Maximum][Copay [(\$0 - \$500)][deductible] [coinsurance] [Not Covered]
- [Brand Preferred]	[Minimum][Maximum][Copay [(\$0 - \$1,000)][deductible] [coinsurance] [Not Covered]
- [Brand Non-Preferred]	[Minimum][Maximum][Copay [(\$0 - \$2,000)][deductible] [coinsurance] [Not Covered]
• [Preventive Drug]	
- [Generic]	[Minimum][Maximum][Copay [(\$0 - \$100)][deductible] [coinsurance] [Not Covered]
- [Brand Preferred]	[Minimum][Maximum][Copay [(\$0 - \$150)][deductible] [coinsurance] [Not Covered]
- [Brand Non-Preferred]	[Minimum][Maximum][Copay [(\$0 - \$200)][deductible] [coinsurance] [Not Covered]

SCHEDULE OF BENEFITS / [Options are in Brackets]

• [Injectible & Specialty Medications]	
- [Generic]	[Minimum][Maximum][Copay [(\$0 - \$1,000)][deductible] [coinsurance] [Not Covered]
- [Brand Preferred]	[Minimum][Maximum][Copay [(\$0 - \$2,000)][deductible] [coinsurance] [Not Covered]
- [Brand Non-Preferred]	[Minimum][Maximum][Copay [(\$0 - \$3,000)][deductible] [coinsurance] [Not Covered]
Mail Order	[[90-100] day supply]
- [Generic]	[Minimum][Maximum][Copay [(\$0 - \$1,500)][deductible] [coinsurance] [Not Covered]
- [Brand Preferred]	[Minimum][Maximum][Copay [(\$0 - \$3,000)][deductible] [coinsurance] [Not Covered]
- [Brand Non-Preferred]	[Minimum][Maximum][Copay [(\$0 - \$6,000)][deductible] [coinsurance] [Not Covered]
• [Preventive Drug]	
- [Generic]	[Minimum][Maximum][Copay [(\$0 - \$100)][deductible] [coinsurance] [Not Covered]
- [Brand Preferred]	[Minimum][Maximum][Copay [(\$0 - \$150)][deductible] [coinsurance] [Not Covered]
- [Brand Non-Preferred]	[Minimum][Maximum][Copay [(\$0 - \$200)][deductible] [coinsurance] [Not Covered]
• [Injectible & Specialty Medications]	
• [Generic]	[Minimum][Maximum][Copay [(\$0 - \$3,000)][deductible] [coinsurance] [Not Covered]
• [Brand Preferred]	[Minimum][Maximum][Copay [(\$0 - \$6,000)][deductible] [coinsurance] [Not Covered]
• [Brand Non-Preferred]	[Minimum][Maximum][Copay [(\$0 - \$9,000)][deductible] [coinsurance] [Not Covered]
	[Refer to the Outpatient Prescription Drug Benefit in the Certificate for coverages and exclusions to prescription coverage.]
[Retail]	[[30-90] day supply]
[Tier 1]	[Minimum][Maximum][Copay [(\$0 - \$200)][deductible] [coinsurance] [Not Covered]
[Tier 2]	[Minimum][Maximum][Copay [(\$0 - \$300)][deductible] [coinsurance] [Not Covered]
[Tier 3]	[Minimum][Maximum][Copay [(\$0 - \$400)][deductible] [coinsurance] [Not Covered]
[Tier 4]	[Minimum][Maximum][Copay [(\$0 - \$500)][deductible] [coinsurance] [Not Covered]
[Tier 5]	[Minimum][Maximum][Copay [(\$0 - \$1,000)][deductible] [coinsurance] [Not Covered]
	[Refer to the Outpatient Prescription Drug Benefit in the Certificate for coverages and exclusions to prescription coverage.]

SCHEDULE OF BENEFITS / [Options are in Brackets]

-	
[Mail Order]	[[90-100] day supply]
- [Tier 1]	[Minimum][Maximum][Copay [(\$0 - \$600)][deductible] [coinsurance] [Not Covered]
- [Tier 2]	[Minimum][Maximum][Copay [(\$0 - \$900)][deductible] [coinsurance] [Not Covered]
- [Tier 3]	[Minimum][Maximum][Copay [(\$0 - \$1,200)][deductible] [coinsurance] [Not Covered]
- [Tier 4]	[Minimum][Maximum][Copay [(\$0 - \$1,500)][deductible] [coinsurance] [Not Covered]
- [Tier 5]	[Minimum][Maximum][Copay [(\$0 - \$3,000)][deductible] [coinsurance] [Not Covered]
	[Refer to the Outpatient Prescription Drug Benefit in the Certificate for coverages and exclusions to prescription coverage.]

[* Benefits marked with an asterisk (*) are not subject to the [Calendar][Plan] Year Deductible.]

[(1)] Copays do not count toward the [Calendar][Plan] Year deductible.]

[(2)] [Deductible does [not] apply to OOP maximum.]

[(3)] [Copay does [not] apply to OOP maximum.]

[Requires Pre-Authorization. There is a penalty of [\$0-10,000] for failure to obtain Pre-Authorization, but in no event will the penalty exceed 50% of the total charges. Penalty payments do not apply toward a deductible or out-of-pocket maximum amounts]

[[Requires Pre-Authorization.

In-Network:

There is a penalty of [\$0 – \$5000] for failure to obtain Pre-Authorization, but in no event will the penalty exceed 50% of the total charges. Penalty payments do not apply toward a deductible or out-of-pocket maximum amounts.]]

Out-of-Network

There is a penalty of [\$0 – \$10,000] for failure to obtain Pre-Authorization, but in no event will the penalty exceed 50% of the total charges. Penalty payments do not apply toward a deductible or out-of-pocket maximum amounts.]]

[Serious Mental Illness diagnoses include; Schizophrenia, Schizoaffective Disorder, Pervasive Developmental Disorder or Autism, Obsessive-Compulsive Disorder, Panic Disorder, Major Depressive Disorder, Anorexia Nervosa and Bulimia Nervosa, Additionally, coverage includes Severe Emotional Disturbances of Children (SED).]

[The following are subject to Pre-Authorization prior to obtaining services:]

[Cardiac and Pulmonary Rehabilitation
Durable Medical Equipment
Hearing Aids
Home Health Care
Hospice Care
Fertility Services
Gastric Pacemakers
Injectable & Specialty Drugs (does not include Insulin or Anaphylactic kits)
Inpatient Admissions
Inpatient Rehabilitation

SCHEDULE OF BENEFITS / [Options are in Brackets]

Mental Health Conditions
Maternity Inpatient Days Beyond (2-4)
Occupational Therapy
Organ Transplant
Orthotics
Outpatient Angiographic Procedures
Outpatient MRI (Including CT and PET scans)
Outpatient Nuclear Imaging
Outpatient Surgery
Pain Management/Pain Clinic Services
Physical Therapy
Prosthetics
Same Day Surgery
Skilled Nursing Care
Speech Therapy
Substance Use Disorders]

--

STERLING LIFE INSURANCE COMPANY

[P.O. Box 5348, Bellingham, WA 98227-5348]

[(800) 688-0010]

ARKANSAS AMENDATORY ENDORSEMENT

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

A. The following information is added to the cover page of the Policy and Certificate:

The Insured Person may write Us at the address listed above or call Us at the telephone number listed above, or You may also contact Your agent.

If We fail to provide You with reasonable and adequate service, You should feel free to contact:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

B. PART 2 – ELIGIBILITY FOR INSURANCE, the following changes are hereby made:

1. **DEPENDENT ENROLLMENT ELIGIBILITY**, item 2. is deleted and replaced with the following:
 2. You may enroll any new Dependent who first meets the definition of Dependent, after Your Enrollment Date, by completing and submitting an Enrollment Form to Us through Your Employer. Your Enrollment Form must be submitted to Us within 31 days after the date on which Your Dependent first meets the criteria for a Dependent.
 - a. If Your new Dependent is a newborn Child, coverage will be provided from the moment of birth and will remain in force for 90 days. To continue coverage for Your newborn Child, You must submit an Enrollment Form for Your newborn Child and pay the required premium.
 - b. If Your new Dependent is an adopted Child, a Child placed in Your home for adoption, or a minor under Your charge, care, and control for whom You have filed a petition to adopt, prior to the Child's 18th birthday, coverage will be provided from the date of adoption or the date of placement for adoption until 60 days after the date of adoption or date of the date of placement for adoption. To continue coverage of an adopted Child or Child placed for adoption, You must submit an Enrollment Form for Your adopted Child or Child placed for adoption and pay the required premium.
2. **EMPLOYEE AND DEPENDENT ENROLLMENT PERIODS (NOT APPLICABLE TO LATE ENROLLES) ELIGIBILITY**, items 1. B and C are deleted and replaced with the following:
 - B. If Your Dependent is a newborn Child, who is born after the Initial Enrollment Period, You must notify Us in writing within 90 days after the newborn Child's birth and any additional premium for the Child that is necessary to continue coverage beyond the initial 90 day period must be paid. In addition to Your newborn Child, You may enroll Your eligible spouse at the time You enroll Your newborn Child.
 - C. If Your Dependent is an adopted Child or Child placed for adoption, and the adoption or placement for adoption begins after the Initial Enrollment Period, You must notify Us in writing within 60 days after the date of adoption or date of placement for adoption and any additional premium for the Child that is necessary to continue coverage beyond the initial 60 day period must be paid. In addition to Your adopted Child or Child placed for adoption, You may enroll Your eligible spouse at the time You enroll Your adopted Child or Child placed for adoption.

C. PART 6 – COVERED CHARGES the following changes are hereby made:

1. Item 3. **PHYSICIANS OFFICE VISITS**, the following is added:

SLIC AEAR 511

We will not refuse to reimburse a Physician at the full rate for health care services provided by a Physician assistant if the practice complies with the laws of Arkansas. We will not impose a practice or supervision restriction of a Physician assistant that is inconsistent with or more restrictive than the restriction already imposed by the laws of Arkansas.

2. Item **15. DIABETIC SELF-MANAGEMENT TRAINING**, is deleted and replaced with the following:

Benefits are payable for services and supplies to enable a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent Hospital care and complications. Covered Charges include services provided by a Physician or medical professional designated by the Physician. Visits for diabetic training, including medical nutrition education, are covered as follows:

- a. one (1) lifetime training program per Insured Person for diabetes self-management training when Medically Necessary as determined by a Physician and when provided by an appropriately licensed health care professional upon certification by the health care professional providing the training that the Insured Person has successfully completed the training;
- b. additional diabetes self-management training in the event that a Physician prescribes additional diabetes self-management training and it is Medically Necessary because of a significant change in the Insured Person's symptoms or conditions; and
- c. diabetes self-management training shall be provided only upon prescription by a licensed Physician.

3. Item **16. PREGNANCY/MATERNITY**, the following is added:

If it is determined that a continued Hospital stay is required for the mother, We will pay benefits for routine nursery charges and pediatric charges for a well newborn child for up to 5 full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time.

4. Item **20. DENTAL ANESTHESIA**, is deleted and replaced with the following:

Benefits are payable for dental anesthesia and Hospital charges for dental procedures in a Hospital or Ambulatory Surgical Center in order to safely and effectively perform dental procedures when the Insured Person is:

- A. A child under 7 years of age, and determined by two dentists to have a significantly complex dental condition;
- B. Diagnosed with a serious medical or physical condition; or
- C. Has a significant behavioral problem as determined by his or her Physician.

5. Item **21. AMBULANCE SERVICES**, the following is added:

If an Insured Person files a claim for covered professional ambulance services, direct reimbursement will be made to the provider of the services if the provider has not received payment for those services from any other source.

6. Item **27. PRESCRIPTION DRUGS AND MEDICINES** the following changes are hereby made:

- a. **Outpatient Covered Prescription Drug Charges**, the following is added:

Coverage is provided for contraceptive drugs and devices approved by the United States Food and Drug Administration.

- b. **Dispensing Limitation**, sub-item B. pertaining to prescription mail orders is deleted in its entirety.

- c. The following is added:

Cancer Drugs:

We will not limit or exclude coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, provided:

- A. 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 the following standard reference compendia:

- 1) The American Hospital Formulary Service Drug Information;
 - 2) The National Comprehensive Cancer Network Drugs and Biological Compendium;
 - 3) The Elsevier Gold Standard's Clinical Pharmacology; or
- B. The drug has been recognized as safe and effective for treatment of that specific type of cancer in two (2) 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.

Coverage of such drug includes Medically Necessary services associated with the administration of the drug.

License or Permit Required:

We will not contract with a pharmacist, pharmacy, pharmacy distributor, or wholesale drug distributor, nonresident or otherwise, to provide benefits for the shipment or delivery of a dispensed legend drug into the State of Arkansas, unless the pharmacist, pharmacy, or distributor has been granted a license or permit from the Arkansas State Board of Pharmacy to operate in the State of Arkansas.

We shall apply the same coinsurance, Copay, and Deductible factors to covered drug prescriptions filled by a pharmacy provider who participates in Our network if the provider meets Our explicit product cost determination. We will not set a limit on the quantity of drugs which an Insured Person may obtain at any one (1) time with a prescription, unless the limit is applied uniformly to all pharmacy providers in Our network.

7. Item **32. INFERTILITY**, the following limitations are added to paragraph C:

Benefits are payable for in vitro-fertilization procedures when:

- 5) The patient is an Employee or Dependent spouse covered under the Policy;
- 6) The patient's oocytes are fertilized with the sperm of the patient's spouse;
- 7) The patient and the patient's spouse have a history of unexplained infertility of at least 2-years duration; or the infertility is associated with one or more of the following medical conditions:
 - a. endometriosis;
 - b. exposure in utero to diethylstilbestrol, commonly known as DES;
 - c. blockage of or removal of one or more fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
 - d. abnormal male factors contributing to the infertility; and
- 8) The in vitro-fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists guidelines for in vitro-fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro-fertilization; or
- 9) The patient has been unable to obtain a successful pregnancy through any less costly applicable infertility treatment for which coverage is available under the Policy.

The following is added to paragraph A:

Cryopreservation is included as an in vitro-fertilization procedure.

8. Item **33. AUTISM SPECTRUM DISORDER**, is deleted and replaced with the following:

Benefits are payable for:

- A. the following care prescribed, provided, or ordered for an Insured Person diagnosed with an Autism Spectrum Disorder by a licensed Physician or a licensed psychologist who determined the care to be Medically Necessary and evidence-based including without limitation:
 - (i) Applied Behavior Analysis when provided by or supervised by a Board Certified Behavior Analyst;
 - (ii) Pharmacy care;
 - (iii) Psychiatric care;
 - (iv) Psychological care;
 - (v) Therapeutic care; and
 - (vi) Equipment determined necessary to provide evidence-based treatment; and
- B. Any care for an Insured Person with Autism Spectrum Disorder that is determined by a licensed Physician to be:

- (i) Medically Necessary; and
- (ii) Evidence-based.

Applied Behavior Analysis services has:

- (1) A [Calendar][Plan] Year limitation of [\$50,000]; and
- (2) Is limited to covered Dependent Children under 18 years of age.

For the purposes of this benefit, the following definitions apply:

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications by a board-certified behavior analyst using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior;

Autism Spectrum Disorder means any of the pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders including: (a) Autistic disorder, (b) Asperger's disorder, and (c) Pervasive developmental disorder not Otherwise Specified;

Board-certified Behavior Analyst means an individual certified by the nationally accredited Behavior Analyst Certification Board, a nationally accredited nongovernmental agency that certifies individuals who have completed academic, examination, training, and supervision requirements in Applied Behavior Analysis;

Evidence-based treatment means treatment subject to research that applies rigorous, systematic, and objective procedures to obtain valid knowledge relevant to Autism Spectrum Disorders;

Medically Necessary means reasonably expected to do the following: (a) prevent the onset of an illness, condition, injury, or disability; (b) reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, or disability; or (c) assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capabilities that are appropriate for individuals of the same age;

Pharmacy care means medications prescribed by a licensed Physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications;

Psychiatric care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

Psychological care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

Therapeutic Care means services provided by licensed speech therapists, occupational therapists, or physical therapists;

- 9. The following benefits are added to **PART 6 – COVERED CHARGES**:

34. PREVENTIVE AND PRIMARY CARE SERVICES FROM BIRTH TO 18 YEARS OF AGE

Benefits are payable for the following child preventive care services including:

- 1. Newborn screening tests for hypothyroidism, PKU, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the state of Arkansas, as well as any testing of newborn infants as mandated by law;
- 2. Routine nursery care and pediatric charges for a well newborn child for up to 5 full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time;
- 3. Children's preventive health care services are provided for covered Dependents for periodic preventive care visits from the moment of birth through 18 years of age. Coverage includes 20 visits under the supervision of a single Physician during the course of one visit, and at the following intervals: birth; 2 weeks; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 2 years; 3 years; 4 years; 5 years; 6 years; 8 years; 10 years; 12 years; 14 years; 16 years; and 18 years.
- 4. Preventive screenings may include, as recommended by a Physician, physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, hereditary and

metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, sickle hemoglobinopathy and other appropriate blood tests.

Recommended immunization services are exempt from any Copay, coinsurance, Deductible and dollar limit provisions.

For purposes of this benefit, the following definitions apply:

Children's preventive health care services means Physician-delivered or Physician-supervised services for eligible Dependents from birth through 18 years of age, with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

Periodic preventive care visits mean the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

35. CANCER SCREENING TESTS

Benefits are payable for the following cancer screening tests:

A. Mammography

- 1) a baseline mammogram for a female Insured Person 35 to 40 years of age;
- 2) a mammogram for a female Insured Person 40 to 49 years of age every one to two years based on the recommendation of the woman's physician;
- 3) a mammogram each year for a female Insured Person who is at least 50 years of age;
- 4) upon the recommendation of a female Insured Person's Physician, without regard to age, when the female Insured Person has had a prior history of breast cancer or when the female Insured Person's mother or sister has had a history of breast cancer; and
- 5) diagnostic mammograms as recommended by the Insured Person's physician.

B. Colorectal Cancer Screening – Examinations and laboratory tests as prescribed by a Physician for:

- 1) Insured Person's who are 50 years of age or older;
- 2) Insured Person's who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines; and
- 3) Insured Person's experiencing the following symptoms of colorectal cancer as determined by a Physician: a) bleeding from the rectum or blood in the stool; or b) a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than 5 days.

An examination of the entire colon, including:

- 1) The following examinations or laboratory tests, or both:
 - a. An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
 - b. A double-contrast barium enema every five (5) years; or
 - c. A colonoscopy every ten (10) years; and
- 2) Any additional medically recognized screening tests for colorectal cancer required by the Director of the Division of Health of the Department of Health and Human Services, determined in consultation with appropriate health care organizations.

The Insured Person shall determine the choice of screening strategies in consultation with a health care provider.

Screenings shall be limited to the following guidelines for the management or subsequent need for follow-up colonoscopy:

- 1) If the initial colonoscopy is normal, follow-up is recommended in ten (10) years;
- 2) For individuals with one or more neoplastic polyps or adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, follow-up is recommended in three (3) years;
- 3) If single tubular adenoma of less than one centimeter (1 cm) is found, follow-up is recommended in five (5) years; and
- 4) For Insured Persons with large sessile adenomas greater than three (3) centimeters (3 cm), especially if removed in piecemeal fashion, follow-up is recommended in six (6) months or until complete polyp removal is verified by colonoscopy.

- C. Prostate Cancer Screening -- One screening per Year for the early detection of prostate cancer in a male Insured Person 40 years of age and older performed by a qualified medical professional according to National Comprehensive Cancer Network guidelines. This benefit is not subject to the Deductible.

36. MEDICAL FOOD OR LOW PROTEIN FOOD PRODUCT

Benefits are payable for Medical Food or Low Protein Modified Food Products for the treatment of an Insured Person inflicted with phenylketonuria (PKU), galactosemia, organic acidemias, and disorders of amino acid metabolism if: (a) the medical food or low protein modified food products are prescribed as Medically Necessary for such treatment; and (b) the products are administered under the direction of a Physician.

For the purposes of this benefit, the following definitions apply:

Low Protein Modified Food Product means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

Medical Food means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

37. TREATMENT OF THE BONES AND JOINT OF THE FACE, HEAD AND NECK

Benefits are payable for treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder. Covered Charges include both surgical and nonsurgical procedures. Coverage will be provided for Medically Necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Coverage shall be the same as that provided for any other musculoskeletal disorder in the body.

38. SPEECH AND HEARING SERVICES

Benefits are payable for care and treatment of loss or impairment of speech or hearing. Loss or impairment of speech or hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification.

39. HEARING AIDS

Benefits are payable as shown in the Schedule of Benefits for a hearing aid or hearing instrument sold by a professional licensed by the state of Arkansas to dispense a hearing aid or hearing instrument. This benefit is not subject to the Deductible or a Copayment.

For the purposes of this benefit, the following definition applies,

Hearing aid or hearing instrument means an instrument or device, including repair and replacement parts, that: (a) Is designed and offered for the purpose of aiding an Insured Person with or compensating for impaired hearing; (b) Is worn in or on the body; and (c) Is generally not useful to a person in the absence of a hearing impairment.

40. PROSTHETICS AND ORTHOTIC SERVICES AND DEVICES

Benefits are payable for eighty percent (80%) of Medicare allowables as defined by the Center for Medicare Medicaid Services, Healthcare Common Procedure Coding System as of January 1, 2009, or as of a later date if adopted by rule of the Insurance Commissioner for: (a) An orthotic device; (b) An orthotic service; (c) A prosthetic device, and (d) A prosthetic service. Benefits are not payable for an orthotic device, an orthotic service, a prosthetic device, or a prosthetic service for a replacement that occurs more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria.

An orthotic device, an orthotic service, a prosthetic device, or a prosthetic service must be prescribed by a licensed Physician of medicine, Physician of osteopathy, or Physician of podiatric medicine and provided by a Physician of medicine, a Physician of osteopathy, a Physician of podiatric medicine, an orthotist, or a prosthetist licensed by the State of Arkansas.

Eligibility for this benefit is based on criteria, which include without limitation: (a) The information and recommendation from the treating Physician in consultation with the Insured Person and (b) the results of a functional limit test.

For the purposes of this benefit, the following definition applies

Functional Limit Test means (a) Medical history, including prior use of orthotic devices or prosthetic devices if applicable; (b) Current condition, including the status of the musculoskeletal system and the nature of other medical problems; and (c) Desire to: (i) Ambulate with respect to lower-limb orthotic devices or prosthetic devices; or (ii) Maximize upper-limb function with respect to upper-limb orthotic devices or prosthetic devices.

41. GASTRIC PACEMAKERS

Benefits are payable for gastric pacemakers that are Medically Necessary. Gastric pacemakers require Preauthorization in the same manner as any other covered benefit.

For the purposes of this benefit, the following definition applies

Gastric pacemaker means a medical device that: (a) uses an external programmer and implanted electrical leads to the stomach; and (b) transmits low-frequency, high-energy electrical stimulation to the stomach to entrain and pace the gastric slow waves to treat gastroparesis.

Gastroparesis means a neuromuscular stomach disorder in which food empties from the stomach more slowly than normal.

D. PART 7 – EXCLUSIONS AND LIMITATIONS, the following changes are hereby made:

1. Item #6 pertaining to contraceptive drugs is deleted in its entirety.
2. Item #41 pertaining to Temporomandibular Joint Dysfunction is deleted in its entirety.

E. PART 8 – COORDINATION OF BENEFITS, is deleted and replaced with the following:

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

DEFINITIONS

- A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
- (1) Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 - (2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan. When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.
- D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

- (1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
- (2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
- (3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
- (4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
- (5) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

- (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
- (1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
 - (2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
 - (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - . The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
 - . If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
 - (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
 - (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - . The Plan covering the Custodial parent;
 - . The Plan covering the spouse of the Custodial parent;
 - . The Plan covering the non-custodial parent; and then
 - . The Plan covering the spouse of the non-custodial parent.
 - (c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

- (3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
- (6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

- A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. [Organization responsibility for COB administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. [Organization responsibility for COB administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give [Organization responsibility for COB administration] any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, [Organization responsibility for COB administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. [Organization responsibility for COB administration] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by [Organization responsibility for COB administration] is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

PART 10 – RENEWABILITY AND TERMINATION, the following changes are hereby made:

1. **Under Termination of Dependent Insurance**, item 8. a., pertaining to medical proof is deleted and replaced with the following:
 - a. Medical proof, in writing, of such incapacity must be given to Us after the date on which the Dependent Child attains a limiting age.
2. The following are hereby added:

Continuation of Coverage

1. Any Insured Person whose coverage would otherwise terminate due to termination of employment or a change in marital status may continue coverage under the Policy for themselves and their eligible Dependents.
2. Continuation of coverage shall be available only to Employees who have been insured continuously under the Policy during the 3-month period prior to the termination of employment or change in marital status.
3. Continuation of coverage shall not be available to an Insured Person who is eligible for:
 - A. Federal Medicare coverage; or
 - B. Full coverage under any other group accident and health policy or contract.
 - 1) The other coverage must provide benefits for all preexisting conditions to be considered full coverage.
 - 2) Accordingly, an Insured Person may continue coverage under the Policy until all Pre-Existing Conditions are covered or would be covered under another group policy or contract or until termination pursuant to paragraph 6 below or pursuant to the applicable provisions of federal law.
4. An Insured Person who wishes to continue coverage must request continuation in writing not later than 10-days after the termination of employment or the change in marital status.
5. An Insured Person who requests continuation of coverage must pay the premium required on a monthly basis and in advance.
6. Continuation of coverage will end upon the earliest of the following dates:
 - A. 120-days after continuation of coverage began;
 - B. The end of the period for which the Insured Person made a timely contribution;
 - C. The contribution due date following the date the Insured Person becomes eligible for Medicare; or
 - D.
 - 1) The date on which the Policy is terminated.
 - 2) However, if the Policy is replaced by Us, continuation shall continue under the new coverage.
7. At the termination of the continued coverage, an Insured Person will be offered a conversion policy (see the Conversion section below).
8. Insured Person's choosing to utilize the Conversion privilege below may do so and thereby waive their right to continuation of coverage under this section.

Conversion

1. An Insured Person whose insurance under the Policy has been terminated for any reason, including the discontinuance of the Policy in its entirety, shall be entitled to have issued to him or her by Us a policy of accident and health insurance referred to in this section as a "conversion policy".
2. An Insured Person shall not be entitled to a conversion policy, if the termination of the coverage under the coverage was a result of his or her failure to pay any required contribution or if the coverage under the Policy

ENROLLMENT & CHANGE FORM

[Product Logo]

Underwritten by: STERLING LIFE INSURANCE COMPANY [Bellingham, WA 98227-5348] [Third Party Administrator: Meritain 1405 Xenium Lane North, Suite 140, Minneapolis, MN 55441 [(xxx) xxx-xxxx or (xxx) xxx-xxxx Fax Enrollment/Change Form to: (xxx) xxx-xxxx] [Visit our website for more information at:]
Name of Employer _____
Group Number _____ Effective Date/Date of Change _____
PPO elected _____

Check Reason for Enrollment or Change <input type="checkbox"/> Address Change <input type="checkbox"/> New Subscriber <input type="checkbox"/> Change Name <input type="checkbox"/> Special Enrollment <input type="checkbox"/> Group Transfer <input type="checkbox"/> Cancel <input type="checkbox"/> Waiver of Insurance Election <input type="checkbox"/> COBRA <input type="checkbox"/> Add a Family Member <input type="checkbox"/> Open Enrollment Date _____	Cancellation Reason _____ Add a Family Member Reason _____ Terminate a Family Member Reason _____ Other Reason _____
--	---

EMPLOYEE INFORMATION

Last Name	Legal First Name	Nickname	Middle Initial	Status
_____				<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other
Home Address (Including mailing address if different) _____				
_____				Date of Full-Time Employment _____
City	State	Zip	County	Classification
_____				<input type="checkbox"/> Out of Area <input type="checkbox"/> Other
Home Telephone () _____				<input type="checkbox"/> Management
Work Telephone () _____		Email Address _____		

EMPLOYEE AND DEPENDENT(S) INFORMATION

NAME (First, MI, Last) (Social Security Number required for processing) (child must be under age 26 unless otherwise noted)	Date of Birth MM/DD/YY	Relationship to Subscriber	Sex M/F
1. Employee Name _____	/ /		
SSN# _____			
2. Name of Spouse/[Domestic Partner] _____	/ /		
SSN# _____		<input type="checkbox"/> Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Stepchild <input type="checkbox"/>	
3. Dependent Name _____	/ /	Guardianship	
SSN# _____		<input type="checkbox"/> Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Stepchild <input type="checkbox"/>	
4. Dependent Name _____	/ /	Guardianship	
SSN# _____		<input type="checkbox"/> Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Stepchild <input type="checkbox"/>	
5. Dependent Name _____	/ /	Guardianship	
SSN# _____		<input type="checkbox"/> Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Stepchild <input type="checkbox"/>	
6. Dependent Name _____	/ /	Guardianship	
SSN# _____			

ENROLLMENT & CHANGE FORM

OTHER INSURANCE COVERAGE INFORMATION

[1. Have you or your dependents had health insurance coverage with another carrier(s) at anytime during the last 12 months?
 Yes No If yes, answer the following:
****Provide information (below) about all the health insurance coverage you have had during the previous 12 months****

Name of Policy/Certificate holder _____ SSN# of Policy/Certificate holder _____

Effective date of plan _____ / _____ / _____ Termination date of plan _____ / _____ / _____
month day year month day year

Reason coverage ended: _____

Type of Plan: Group Individual Other Persons Covered: Self Spouse Child(ren)

Name of Insurance company _____ Telephone Number _____

Was this a group policy offered through an employer? Yes No If yes, provide the following:
Name of Employer _____ Telephone Number _____]

2. Will you or your Dependents continue to be covered under another health insurance plan while you are covered under this plan?
 Yes No If yes, answer the following:

Who will continue to be covered: Self Spouse Child(ren)

Effective date of the plan _____ / _____ / _____ Type of Plan: Group Individual Other
month day year

Name of insurance company _____ Telephone Number (_____) _____

Is this plan through your spouse's employer? Yes No If yes, provide the following:
Name of employer _____ Telephone number (_____) _____

3. Do you or your dependents currently have Medicare coverage? Yes No If yes, answer the following:

Name of person covered by Medicare _____ Medicare claim number _____

Is Medicare eligibility due to? Over age 65 End-stage renal disease Total Disability

Part A effective date _____ / _____ / _____ Part B effective date _____ / _____ / _____
month day year month day year

Part C effective date _____ / _____ / _____ Part D effective date _____ / _____ / _____
month day year month day year

DISCLOSURES, AUTHORIZATION AND SIGNATURE

I have answered the above questions to the best of my knowledge and belief. I understand and agree that no coverage shall be in force until the effective date assigned by Sterling Life Insurance Company. I understand that if I or my dependents are covered by other group insurance, I will cooperate fully with Sterling Life Insurance Company in providing information necessary to coordinate benefits.

Signature of Employee _____ Date Signed _____

ENROLLMENT & CHANGE FORM

[IMPORTANT FRAUD NOTICES]

[FRAUD STATEMENT

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

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF CALIFORNIA

For Your protection, California law requires the following to appear on this form: "Any person who knowingly presents a false or fraudulent claim for payment of loss is guilty of a crime and may be subject to fines and confinement in a state prison."

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF DISTRICT OF COLUMBIA

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF KANSAS

Any person who, with intent to defraud or knowing that he/she is facilitating a fraudulent act against an insurer, submits and application or files a claim containing any false or deceptive statement, may be guilty of insurance fraud as determined by a court of law.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF KENTUCKY

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD WARNING APPLICABLE TO RESIDENTS OF MONTANA AND OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF NEW MEXICO

Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OKLAHOMA

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

ENROLLMENT & CHANGE FORM

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OREGON AND TEXAS

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF TENNESSEE AND WASHINGTON

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF VIRGINIA

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.]

EMPLOYER GROUP APPLICATION

(Becomes part of the Group Policy)

[Product Logo]

Underwritten by: **STERLING LIFE INSURANCE COMPANY**
 [Bellingham, WA 98227-5348]
 [Third Party Administrator: Meritain
 1405 Xenium Lane North, Suite 140, Minneapolis, MN 55441]

COMPANY NAME		GROUP NUMBER (office use)				
STREET ADDRESS (physical address only)		DIVISION NAME AND NUMBER (office use)				
CITY	STATE	ZIP	REQUESTED EFFECTIVE DATE – [First of the Month][Fifteen of the Month]			
BILLING/MAILING ADDRESS		COUNTY	FEDERAL EMPLOYER I.D. NUMBER			
CITY	STATE	ZIP	TYPE OF INDUSTRY			
CHIEF EXECUTIVE OFFICER OR PROPRIETOR		YEARS IN BUSINESS				
BENEFITS ADMINISTRATOR / TITLE		PHONE	FAX			
E-MAIL AND WEBSITE ADDRESS		OTHER LANGUAGE CONSIDERATIONS				
DOES THE APPLICANT OFFER OTHER COVERAGE: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE LIST THE CARRIERS AND TYPE OF COVERAGE OFFERED AND PREMIUM FOR EACH OPTION						
1.		3.				
2.		4.				
PREVIOUS CARRIER(S)		2.				
Are all employees eligible for this plan covered by Worker's Compensation? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, please explain: _____						
Are your benefits subject to ERISA regulation? <input type="checkbox"/> Yes <input type="checkbox"/> No						
TYPE OF ORGANIZATION: <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership Other _____						
ELIGIBLE EMPLOYEES: 1. Total number of employees _____ 2. Total number of employees covered under another employer sponsored plan _____ 3. Number of part-time, seasonal and temporary employees _____ 4. Number of eligible employees (subtract line 2 & 3 from line 1) _____ 5. Number of employees declining (complete waiver) or covered elsewhere _____ 6. Total employees enrolling with Sterling Life Insurance Company _____ (subtract line 5 from line 4)						
CONTINUATION COVERAGE: Employer is responsible to contact current carrier to obtain name(s) and address(es) of current COBRA participants. Please indicate number of current COBRA participants _____ (attach list) Is employer required to offer: <input type="checkbox"/> Federal COBRA						
BENEFITS:						
[PPO Medical Plans		[Preferred Provider Choices				
<input type="checkbox"/> Plan _____]		State _____				
[<input type="checkbox"/> Hardware Vision Option _____]		PPO Network _____]				
[<input type="checkbox"/> Fertility Option _____]		PPO Network _____]				
[<input type="checkbox"/> Acupuncture]		PPO Network _____]				
[<input type="checkbox"/> Autism Spectrum Disorder]		PPO Network _____]				
[<input type="checkbox"/> Preventive Care Services]		PPO Network _____]				
[<input type="checkbox"/> TMJ]		PPO Network _____]				
[<input type="checkbox"/> Manipulative Services]						
RATES (office use):		MEDICAL	EMPLOYEE	EE + SP/1	EE + CH(REN)	EE + SP + CH(REN)
[Option		_____	_____	_____	_____	_____
Option	Option	_____	_____	_____	_____	_____
Option]	_____	_____	_____	_____	_____

EFFECTIVE/RENEWAL DATE _____ RAF:
 _____ OPEN ENROLLMENT:
 _____ TO: _____

Enrollment / Premium Provisions

GROUP NAME	GROUP NUMBER (office use)
<p>SELECTED ELIGIBILITY REQUIREMENTS: A bona-fide employee/employer relationship is required to be maintained; that is the employer must continually compensate the individual in the form of annual, monthly, weekly or hourly wage. Further, the employer and employee must maintain an employment relationship pursuant to which the employer pays those payroll costs (e.g. FICA, FUI, SUI, and Worker's Compensation) normally associated with a bona-fide employer/employee relationship.</p> <p>Eligible employees shall be active, full-time employees who usually work at least __[0 – 40]____ hours per week.</p>	
<p>CATEGORIES OF ELIGIBILITY: <input type="checkbox"/> Dependents [spouse, children] [<input type="checkbox"/>Other Dependents <input type="checkbox"/> Domestic Partner] <input type="checkbox"/> Retired Beneficiaries [<input type="checkbox"/> Early Retirees (under age 65)] [<input type="checkbox"/> Board of Directors][<input type="checkbox"/> Other – provided detailed description](subject to approval)</p>	
<p>COMMENCEMENT OF COVERAGE: <input type="checkbox"/> 1st month following Date of Hire <input type="checkbox"/> 15th month following Date of Hire Note: All terminations are effective the [last] day of the month in which Employee ceases to be eligible under group eligibility provisions. <input type="checkbox"/> 1st month following _____ days from Date of Hire <input type="checkbox"/> 15th month following Date of Hire <input type="checkbox"/> Other (attach description)</p>	
<p>EMPLOYER CONTRIBUTION & PARTICIPATION REQUIREMENTS: (Employer must contribute a minimum of [25% - 75%] of Employee only premium) <input type="checkbox"/> Employee Only \$ _____ or _____ % of Rate <input type="checkbox"/> Dependents \$ _____ or _____ % of Rate</p>	
<p>BROKER INFORMATION: <input type="checkbox"/> Existing Broker Broker Name: _____ Phone: _____ <input type="checkbox"/> New Broker (must complete Carrier Appointment & Commission Agreement/s) Agency: _____ Fax: _____ Broker Number: _____ E-mail: _____ Commission: <input type="checkbox"/> Standard Scale <input type="checkbox"/> Flat _____% <input type="checkbox"/> Other: _____ License Number: _____</p>	
<p>COMMENTS:</p>	

EMPLOYER STATEMENT

We wish to enroll our organization as an employer account with Sterling Life Insurance Company. We understand the eligibility rules applicable to enrollment and understand the premium requirements. Employee participation requirements and employer contribution have been explained and we understand that these must be maintained in order for the account to remain eligible for coverage.

PREMIUM REQUIREMENTS: Monthly premiums are due and payable in full on the first day or the fifteen (to coincide with original effective date) of each calendar month. If premiums are not received from the employer, coverage for enrollees will be terminated on the last day or the fifteen (to coincide with original effective date) of the month for which premium was received. Any other premium payment arrangements require prior approval.

To the best of our knowledge and behalf, the foregoing statements are true and complete. This application shall be the basis for the issuance of coverage under the Group Policy and shall become a part thereof. Sterling Life Insurance Company reserves the right to terminate the Group Policy or the coverage of any individual Certificateholder who has made any intentional material misrepresentation of a material fact.

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

 Signature Date

 Print Name and Title

BROKER STATEMENT

I certify that: All the information contained in this application is correct to the best of my knowledge; the applicant is a bona-fide business establishment; participation requirements have been met; that all coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been carefully explained to the employer. I recommend that such coverage be offered and know of no reason why coverage should be declined.

 Broker Signature Date

Sterling Life Insurance Company

[[EMPLOYER NEW BUSINESS CHECKLIST

[The following documentation should be completed and submitted to [YES Company] by the 5th of the month:

- Employer Group Application (to be completed by Employer)
- Enrollment forms _____ # of forms
- Copy of Rate Quote
- Employers must complete Sterling Life Insurance Company Group Underwriting Questionnaire
- Waiver forms must be completed for eligible employees who refuse coverage for themselves *or* their dependents
- The selected Sterling Life Insurance Company plan is primary to Medicare for *active* employees age 65 or older (and spouses age 65 or older of active employees).
- A copy of [DE6][the employer's most current quarterly wage and tax statement]
- A deposit in the amount of one month's premium]

**Return Materials to: [YES Company
321 Knee Street
Suite 01
Some City, Some State 33333
(XXX) XXX-XXXX Phone
(XXX) XXX-XXXX Fax]
www.YEScompany.com]]]**

SERFF Tracking Number: ICCI-127129228 State: Arkansas
 Filing Company: Sterling Life Insurance Company State Tracking Number: 49233
 Company Tracking Number: SLIC LGPOL 511
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002A Large Group Only - PPO
 Product Name: Sterling Large Employer Group Plan
 Project Name/Number: Sterling Large Employer Group Plan /SLIC LGPOL 511

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Cert of Comp. with Rule 19 SLIC LGPOL 511.pdf	Approved-Closed	07/18/2011
Satisfied - Item: Application Comments: See form schedule tab	Approved-Closed	07/18/2011
Satisfied - Item: PPACA Uniform Compliance Summary Comments: Attachment: PPACA Uniform Compliance Summary.pdf	Approved-Closed	07/18/2011
Satisfied - Item: Authorization Letter Comments: Attachment: SLIC Authorization Letter.pdf	Approved-Closed	07/18/2011

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

Insurer: Sterling Life Insurance Company

Form Number(s):

Group Major Medical Policy – SLIC LGPOL 511

Group Major Medical Expense Certificate – SLIC LGCER 511

Group Major Medical Expense Schedule of Benefits – SLIC LGSCH AR 511

Amendatory Endorsement – SLIC AEAR 511

Employer Application - SLIC LG ERAPP 511

Employee Application - SLIC LG EEAPP 511

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



Signature of Company Officer

Craig Bodway

Name

Vice President, Compliance and Regulatory Affairs

Title

July 6, 2011

Date

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

- INDIVIDUAL HEALTH BENEFIT PLANS** (Complete [SECTION A](#) only)
 SMALL / LARGE GROUP HEALTH BENEFIT PLANS (Complete [SECTION B](#) only)

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as “major medical” in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. *(If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)*

***For all filings, include the Type of Insurance (TOI) in the first column.**

Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Sterling Life Insurance Company	77399	ICCI-127129228	SLIC LGPOL 511	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Appeals Process – Requires establishment of an internal claims appeal process and external review process.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>
	<p>Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>

PPACA Uniform Compliance Summary

Reset Form

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
H16G.002A Large Group Only - PPO	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number: Cert Pg 29			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number: Schedule of Benefits			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number: Schedule of Benefits			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number: Cert Pg 34			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services</p> <p>Explanation:</p> <p>Page Number: Cert - Pg 23; Schedule Pg 3</p>	<p><i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i></p>	N/A	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◇</p> <p>Explanation:</p> <p>Page Number: Schedule Pg 1</p>	<p><i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i></p>	<p><input checked="" type="checkbox"/> Yes[◇] <input type="checkbox"/> No If no, please explain.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Appeals Process – Requires establishment of an internal claims appeal process and external review process.</p> <p>Explanation:</p> <p>Page Number: Cert Page 37</p>	<p><i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i></p>	N/A	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>

◇ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation:</p> <p>Page Number: Cert Page 16</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>
	<p>Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p> <p>Explanation: PCP designation not required</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>
	<p>Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation: Referral not required for OB/GYN</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>

STERLING Life Insurance Company

Real People. Wise Choices.®

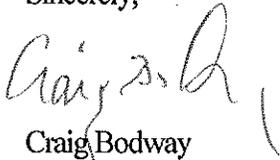
April 19, 2011

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

Dear Mr. Camling:

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

Sincerely,



Craig Bodway
Vice President
Compliance and Regulatory Affairs

SERFF Tracking Number: ICCI-127129228 State: Arkansas
 Filing Company: Sterling Life Insurance Company State Tracking Number: 49233
 Company Tracking Number: SLIC LGPOL 511
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.002A Large Group Only - PPO
 Product Name: Sterling Large Employer Group Plan
 Project Name/Number: Sterling Large Employer Group Plan /SLIC LGPOL 511

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/06/2011	Form	Schedule of Benefits	07/18/2011	AR SLIC LGSCH AR 511 _Schedule of Benefits_.pdf (Superseded)
07/06/2011	Form	Amendatory Endorsement	07/18/2011	AR SLIC AEAR 511.pdf (Superseded)
07/06/2011	Form	Employer Application	07/18/2011	SLIC LGERAPP 511 _Employer App_ 5-23-11 clean copy.pdf (Superseded)

SCHEDULE OF BENEFITS / [Options are in Brackets]

Policyholder:
Employer:
Required Hours:
Insured:
Certificate Number:
Effective Date:
Premium Due Date: [1 st of the month][15 th of the month]
Schedule Date:
Domestic Partner Coverage: [Yes/No]
Dependent Spouse:
Dependent Child(ren): [Child(ren) Name(s)]
Dependent Limiting Age: [up to 26-99]
Student Eligibility Limiting Age: [26-99]
Pre-Existing Conditions Limitations Apply: [Yes/No][Does not apply to Insured Persons less than age 19-99]
[Health Care Reform Status][-][Non-Grandfathered][Grandfathered]
Year: [Calendar] [Plan] Year
Medical Expense Benefits

Covered Services per	In-Network Cost to Covered Person	Out-of- Network Cost to Covered Person
Year:		
Deductible per Year [(1)]		
Individual	[\$0 - \$10,000] [[Benefit Allowance of first [\$0-\$5000] will be covered at 100%][Does not apply to Copays or Prescription Benefits]][Covered Person's annual Deductible/Coinsurance will then be applicable]	[[2X][3X] In-Network] [\$0 - \$20,000] [[Benefit Allowance of first [\$0-\$5000] will be covered at 100%][Does not apply to Copays or Prescription Benefits]][Covered Person's annual Deductible/Coinsurance will then be applicable]
Family	[Embedded][Aggregate] [[2X][3X] individual] [\$0 - \$20,000] [[Benefit Allowance of first [\$0-\$5000] will be covered at 100%][Does not apply to Copays or Prescription Benefits]][Covered Person's annual Deductible/Coinsurance will then be applicable] [Two][Three][Individuals must each meet their Individual Deductible to satisfy Family Deductible]	[Embedded][Aggregate] [[2X][3X] In-Network] [\$0 - \$40,000] [[Benefit Allowance of first [\$0-\$5000] will be covered at 100%][Does not apply to Copays or Prescription Benefits]][Covered Person's annual Deductible/Coinsurance will then be applicable] [Two][Three][Individuals must each meet their Individual Deductible to satisfy Family Deductible]
Coinsurance for all Eligible Expenses	[0% - 50%]	[0% - 50%]
Out-of-pocket Maximum (OOP)[(2)(3)]		
Individual	[\$0 - \$10,000]	[[2X][3X] In-Network] [\$0 - \$150,000]
Family	[2X][3X] individual] [\$0 - \$20,000] [Two][Three][Individuals must each meet their Individual Out-of-Pocket to satisfy Family Out-of-Pocket]	[[2X][3X] In-Network] [\$0 - 250,000] [Two][Three][Individuals must each meet their Individual Out-of-Pocket to satisfy Family Out-of-Pocket]
Deductible Applies	[Yes, No]	

SCHEDULE OF BENEFITS / [Options are in Brackets]

Coinsurance Applies Copayment Applies Out-of-Network Deductible & OOP apply to In-Network Deductible & OOP	[Yes, No] [Yes, No] [Yes, No]	
Maximum per year:	<p align="center">[Embedded][Aggregate] [Not Applicable]</p> <p>[For [Calendar][Plan] Years beginning before [September 23, 2011] \$750,000] [For [Calendar][Plan] Years beginning on and after [September 23, 2011] but before [September 23, 2012] \$1,250,000] [For [Calendar][Plan] Years beginning on and after [September 23, 2012] but before [January 1, 2014] \$2,000,000] [Effective [January 1, 2014] there is no [Calendar][Plan] Year Maximum Benefit for Essential Health Benefits]]</p>	<p align="center">[Embedded][Aggregate] [Not Applicable]</p> <p>[For [Calendar][Plan] Years beginning before [September 23, 2011] \$750,000] [For [Calendar][Plan] Years beginning on and after [September 23, 2011] but before [September 23, 2012] \$1,250,000] [For [Calendar][Plan] Years beginning on and after [September 23, 2012] but before [January 1, 2014] \$2,000,000] [Effective [January 1, 2014] there is no [Calendar][Plan] Year Maximum Benefit for Essential Health Benefits]]</p>
Covered Services per	In-Network Cost to Covered Person	Out-of-Network Cost to Covered Person
Physician Care • [Office Visit]	<p>[General Practitioner] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]</p> <p>[Specialist] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]</p>	<p>[General Practitioner] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]</p> <p>[Specialist] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]</p>
• [Lab Tests & X-rays]	<p>[Major] [Specialty Diagnostic Services] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]</p> <p>[Minor] [Diagnostic Testing Services] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]</p>	<p>[Major] [Specialty Diagnostic Services] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]</p> <p>[Minor] [Diagnostic Testing Services] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]</p>
• [Office Surgery]	<p>[Major] [Surgical & Endoscopic Services over \$[350-\$1000]] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]</p> <p>[Minor] [Surgical & Endoscopic Services under \$[350-\$1000]] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]</p>	<p>[Major] [Surgical & Endoscopic Services over \$[350-\$1000]] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]</p> <p>[Minor] [Surgical & Endoscopic Services under \$[350-\$1000]] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]</p>

SCHEDULE OF BENEFITS / [Options are in Brackets]

<ul style="list-style-type: none"> [Allergy Injections] 	[Copay] [\$0-\$500][*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Preventive Care Services]	[Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
Cancer Screening Tests		
Mammography Screening	[Covered at 100%]	[Copay][\$0 - \$500][*][then][deductible][coinsurance]
Colorectal Cancer Screening	[Covered at 100%]	Copay][\$0 - \$500][*][then][deductible][coinsurance]
Prostate Cancer Screening	[Covered at 100%]	[Copay][\$0 - \$500][*][then][deductible][coinsurance]
Preventive and Primary Care Services for Children (Birth to age 18)	[Covered at 100%]	[Copay][\$0 - \$500][*][then][deductible][coinsurance]
Childhood Immunizations	[Covered at 100%]	[Copay][\$0 - \$500][*][then][deductible][coinsurance]
[Vision Exam – Routine	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of [\$50 - \$1,000]]	
	[Limited to max benefit of [1] visit[s]][every [[1]] [[2]] [year][s]]	
[Hearing Exam – Routine	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
	[Limited to [Calendar][Plan] Year maximum benefit of [\$50 - \$1,000]]	
	[Limited to max benefit of [1] visit[s]] [every [[1]] [[2]] [year][s]]	
Hearing Aids	[Coinsurance]	[Coinsurance]
	[Limited to \$1,400 per ear for each 3-year period]	
Emergency Services		
<ul style="list-style-type: none"> [Urgent Care] 	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
<ul style="list-style-type: none"> [Emergency Room ([Copay] waived if admitted)] 	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
Ambulance		
<ul style="list-style-type: none"> [Ground] 	[Copay] [\$0-\$10000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$10000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]

SCHEDULE OF BENEFITS / [Options are in Brackets]

<ul style="list-style-type: none"> [Air] 	[Copay] [\$0-\$20000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$20000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
Pregnancy/Maternity Care <ul style="list-style-type: none"> [Office Visit (pre & postnatal)] 	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
<ul style="list-style-type: none"> [Hospitalization] 	[Routine Newborn – Split ((Mother/Newborn)) Copay [\$0-\$1000][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000] [deductible/coinsurance]	[Routine Newborn – Split]((Mother/Newborn)) Copay [\$0-\$2000][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000] [deductible/coinsurance]
[Elective Sterilization]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [no coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [no coverage]
Hospitalization Inpatient Services <ul style="list-style-type: none"> [Semi-private Hospital Room & Board] 	[Copay] [\$0-\$1000][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000] [deductible/coinsurance]	[Copay] [\$0-\$2000][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000] [deductible/coinsurance]
<ul style="list-style-type: none"> [Physician & Surgeon Services] 	[Copay [\$0-\$1000]][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000]] [deductible/coinsurance] [Specialist Services] [Copay [\$0-\$1000]][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000]] [deductible/coinsurance]	[Copay] [\$0-\$2000][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000]] [deductible/coinsurance] [Specialist Services] [Copay] [\$0-\$2000][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000]] [deductible/coinsurance]
<ul style="list-style-type: none"> [Lab, X-ray and other facility charges] 	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
Hospital Outpatient Surgery	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
Hospital Outpatient Services	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
Mental Health Conditions		
<ul style="list-style-type: none"> [Inpatient] 	[Copay] [\$0-\$1000][*]	[Copay] [\$0-\$2000][*]

SCHEDULE OF BENEFITS / [Options are in Brackets]

	[Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000] [deductible/coinsurance]	[Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000] [deductible/coinsurance]
• [Outpatient /Transitional Care]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
• [Office Visit]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
Substance Use Disorders		
• [Inpatient]	[Copay] [\$0-\$1000][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000] [deductible/coinsurance]	[Copay] [\$0-\$2000][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000] [deductible/coinsurance]
• [Outpatient /Transitional Care]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
• [Office Visit]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
Rehabilitation Services		
• [Inpatient]	[Copay] [\$0-\$1000][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000] [deductible/coinsurance]	[Copay] [\$0-\$2000][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000] [deductible/coinsurance]
• [Outpatient]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [Physical] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [Speech] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [Occupational] [Copay] [\$0-\$500] [*][then]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [Physical] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [Speech] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [Occupational] [Copay] [\$0-\$1000] [*][then]

SCHEDULE OF BENEFITS / [Options are in Brackets]

	[deductible][coinsurance] [Covered at 100%]	[deductible][coinsurance] [Covered at 100%]
	[(Limited to [Calendar][Plan] Year maximum benefit of [10 – 365 visits][maximum visits by therapy type]	
	[(Limited to [Calendar][Plan] Year maximum benefit of [\$2,500 – \$20,000]	
Durable Medical Equipment	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
	[Limited to [Calendar][Plan] Year maximum benefit of [\$2,500 – \$10,000] [Rental limited to purchase price]	
Skilled Nursing Facility	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
	[Limited to [Calendar][Plan] Year maximum benefit of [10 – 365 days]	
Home Health Care	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
	[Limited to [Calendar][Plan] Year maximum benefit of [10 – 365 visits] or [\$0-5,000]]	
Hospice and Respite Care Services	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
	[Limited to [Calendar][Plan] Year maximum benefit of \$500 - \$10,000, Not Applicable]	
Organ Transplant	[Copay] [\$0-\$1000]][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000] [deductible/coinsurance] [Donor Fees for Covered Organ Transplant] [Copay] [\$0-\$1000]][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000] [deductible/coinsurance]	[Copay] [\$0-\$2000]][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$20,000] [deductible/coinsurance] [Donor Fees for Covered Organ Transplant] [Copay] [\$0-\$2000]][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$20,000] [deductible/coinsurance]
	[Limited to [Lifetime][Per Transplant] maximum benefit of [\$20000 - \$100000] [Not Applicable]	
Manipulative Services	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
	[Limited to max per Year benefit of [10 - 40 visits]	

SCHEDULE OF BENEFITS / [Options are in Brackets]

[Temporomandibular Joint Dysfunction (TMJ)]	[Non-Surgical] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [Surgical] [Copay] [\$0-\$1000][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000] [deductible/coinsurance]	[Non-Surgical] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [Surgical] [Copay] [\$0-\$2000][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000] [deductible/coinsurance]
[Infertility]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
[Limited to lifetime maximum benefit of [\$15,0000 - \$25,000]]		

[Acupressure/Acupuncture]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
[Limited to [Calendar][Plan] Year maximum benefit of [\$500 - \$5,000]]		
[Limited to max per Year benefit of [10 - 40 visits]]		
[Autism Spectrum Disorder]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
Applied Behavior Analysis, for the Diagnosis and Treatment of Autism Spectrum Disorders, is [\$50,000] per [Calendar][Plan Year per Insured Persons through 18 years of age.		
Gastric Pacemakers	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%]

OPTIONAL BENEFITS

[Bariatric Surgery]	[Copay] [\$0-\$1000][*] [Daily Copay [\$0-\$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$5,000] [deductible/coinsurance]	[Copay] [\$0-\$2000][*] [Daily Copay [\$0-\$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [\$0-\$10,000]] [deductible/coinsurance]
[Limited to [Calendar][Plan] Year maximum benefit of [\$5000 - \$10,000]]		
[Cochlear Implants]	[Copay \$0 - \$5,000] [*] [[Covered at [0%-100%]] [deductible] [coinsurance]][No Coverage]	[Copay \$0-\$10,000][*][deductible] [coinsurance] [No Coverage]
[Limited to Year maximum benefit of (\$0 - \$30,000)]		
[Limited to a maximum per lifetime benefit of [\$0 - \$100,000]]		

SCHEDULE OF BENEFITS / [Options are in Brackets]

[Health Education Programs]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage] [Health Education Asthma] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage] [Dietetic Counseling for Anorexia, Bulimia and Polyphagia] [Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage] [Health Education Asthma] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage] [Dietetic Counseling for Anorexia, Bulimia and Polyphagia] [Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Limited to [Calendar][Plan] Year maximum benefit of [\$0 - \$5,000]]		
[Hearing Aids]	[Copay \$0 – \$1,000] [*] [Covered at [0%-100%]] [deductible] [coinsurance]	[Copay \$0-\$2,000][*][deductible] [coinsurance]
[Impacted Wisdom Teeth Removal]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Orthotics]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Limited to [Calendar][Plan] Year maximum benefit of [\$100 - \$5,000]]		
[Prosthetics and Orthotic Services and Devices]	[Copay] [\$0-\$500][*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Limited to [Calendar][Plan] Year maximum benefit of [\$100 - \$5,000]]		
[Limited to [Calendar][Plan] Year maximum benefit of [\$500 - \$25,000]]		
[Sexual Dysfunction]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Limited to [Calendar][Plan] Year maximum benefit of [\$100 - \$5,000]]		
[Supplemental Accident Benefit]	Limited to Year maximum benefit of [\$100-\$2000]	
[Teeth Bleaching Following Accident]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Voluntary Abortion]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Limited to a max [1][2] [Year] benefit of [1]		
[Weight Management]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]

SCHEDULE OF BENEFITS / [Options are in Brackets]

Injectible & Specialty Medications [Paid under Major Medical Benefits]	[Copay] [\$0-\$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [\$0-\$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Generic] [Copay] [\$0-\$1,000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Generic] [Copay] [\$0-\$2,000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Brand Preferred][Copay] [\$0-\$2,500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Brand Preferred] [Copay] [\$0-\$5,000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Brand Non-Preferred] [Copay] [\$0-\$5,000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Brand Non-Preferred] [Copay] [\$0-\$10,000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]

[Prescription Drug]	[deductible] [coinsurance] [Not Covered] [Does not apply to medical][deductible][&][out-of-pocket maximum]][Does apply to medical deductible & out-of pocket maximum]
[RX Deductible]	[Not Applicable] [\$0 - \$10,000]
[Per Individual]	[\$0 - \$5,000] per Year]
[Per Family]	[\$0 - \$10,000] per Year]
[Prescription Out-of-Pocket Maximum]	[Not Applicable] [\$0 - \$20,000]
[Per Individual]	[\$0 - \$10,000] per Year]
[Per Family]	[\$0 - \$20,000] per Year]
[Prescription Contraceptive Coverage]	
• [Drugs]	[Minimum][Maximum][Copay [(\$0 - \$500)][deductible] [coinsurance]
• [Devices]	[Minimum][Maximum][Copay [(\$0 - \$500)][deductible] [coinsurance]
Retail –	[[30-90] day supply]
- [Generic]	[Minimum][Maximum][Copay [(\$0 - \$500)][deductible] [coinsurance] [Not Covered]
- [Brand Preferred]	[Minimum][Maximum][Copay [(\$0 - \$1,000)][deductible] [coinsurance] [Not Covered]
- [Brand Non-Preferred]	[Minimum][Maximum][Copay [(\$0 - \$2,000)][deductible] [coinsurance] [Not Covered]
• [Preventive Drug]	
- [Generic]	[Minimum][Maximum][Copay [(\$0 - \$100)][deductible] [coinsurance] [Not Covered]
- [Brand Preferred]	[Minimum][Maximum][Copay [(\$0 - \$150)][deductible] [coinsurance] [Not Covered]
- [Brand Non-Preferred]	[Minimum][Maximum][Copay [(\$0 - \$200)][deductible] [coinsurance] [Not Covered]

SCHEDULE OF BENEFITS / [Options are in Brackets]

• [Injectible & Specialty Medications]	
- [Generic]	[Minimum][Maximum][Copay [(\$0 - \$1,000)][deductible] [coinsurance] [Not Covered]
- [Brand Preferred]	[Minimum][Maximum][Copay [(\$0 - \$2,000)][deductible] [coinsurance] [Not Covered]
- [Brand Non-Preferred]	[Minimum][Maximum][Copay [(\$0 - \$3,000)][deductible] [coinsurance] [Not Covered]
Mail Order	[[90-100] day supply]
- [Generic]	[Minimum][Maximum][Copay [(\$0 - \$1,500)][deductible] [coinsurance] [Not Covered]
- [Brand Preferred]	[Minimum][Maximum][Copay [(\$0 - \$3,000)][deductible] [coinsurance] [Not Covered]
- [Brand Non-Preferred]	[Minimum][Maximum][Copay [(\$0 - \$6,000)][deductible] [coinsurance] [Not Covered]
• [Preventive Drug]	
- [Generic]	[Minimum][Maximum][Copay [(\$0 - \$100)][deductible] [coinsurance] [Not Covered]
- [Brand Preferred]	[Minimum][Maximum][Copay [(\$0 - \$150)][deductible] [coinsurance] [Not Covered]
- [Brand Non-Preferred]	[Minimum][Maximum][Copay [(\$0 - \$200)][deductible] [coinsurance] [Not Covered]
• [Injectible & Specialty Medications]	
• [Generic]	[Minimum][Maximum][Copay [(\$0 - \$3,000)][deductible] [coinsurance] [Not Covered]
• [Brand Preferred]	[Minimum][Maximum][Copay [(\$0 - \$6,000)][deductible] [coinsurance] [Not Covered]
• [Brand Non-Preferred]	[Minimum][Maximum][Copay [(\$0 - \$9,000)][deductible] [coinsurance] [Not Covered]
	[Refer to the Outpatient Prescription Drug Benefit in the Certificate for coverages and exclusions to prescription coverage.]
[Retail]	[[30-90] day supply]
[Tier 1]	[Minimum][Maximum][Copay [(\$0 - \$200)][deductible] [coinsurance] [Not Covered]
[Tier 2]	[Minimum][Maximum][Copay [(\$0 - \$300)][deductible] [coinsurance] [Not Covered]
[Tier 3]	[Minimum][Maximum][Copay [(\$0 - \$400)][deductible] [coinsurance] [Not Covered]
[Tier 4]	[Minimum][Maximum][Copay [(\$0 - \$500)][deductible] [coinsurance] [Not Covered]
[Tier 5]	[Minimum][Maximum][Copay [(\$0 - \$1,000)][deductible] [coinsurance] [Not Covered]
	[Refer to the Outpatient Prescription Drug Benefit in the Certificate for coverages and exclusions to prescription coverage.]

SCHEDULE OF BENEFITS / [Options are in Brackets]

-	
[Mail Order]	[[90-100] day supply]
- [Tier 1]	[Minimum][Maximum][Copay [(\$0 - \$600)][deductible] [coinsurance] [Not Covered]
- [Tier 2]	[Minimum][Maximum][Copay [(\$0 - \$900)][deductible] [coinsurance] [Not Covered]
- [Tier 3]	[Minimum][Maximum][Copay [(\$0 - \$1,200)][deductible] [coinsurance] [Not Covered]
- [Tier 4]	[Minimum][Maximum][Copay [(\$0 - \$1,500)][deductible] [coinsurance] [Not Covered]
- [Tier 5]	[Minimum][Maximum][Copay [(\$0 - \$3,000)][deductible] [coinsurance] [Not Covered]
	[Refer to the Outpatient Prescription Drug Benefit in the Certificate for coverages and exclusions to prescription coverage.]

[* Benefits marked with an asterisk (*) are not subject to the [Calendar][Plan] Year Deductible.]

[(1)] Copays do not count toward the [Calendar][Plan] Year deductible.]

[(2)] [Deductible does [not] apply to OOP maximum.]

[(3)] [Copay does [not] apply to OOP maximum.]

[Requires Pre-Authorization. There is a penalty of [\$0-10,000] for failure to obtain Pre-Authorization, but in no event will the penalty exceed 50% of the total charges. Penalty payments do not apply toward a deductible or out-of-pocket maximum amounts]

[[Requires Pre-Authorization.

In-Network:

There is a penalty of [\$0 – \$5000] for failure to obtain Pre-Authorization, but in no event will the penalty exceed 50% of the total charges. Penalty payments do not apply toward a deductible or out-of-pocket maximum amounts.]]

Out-of-Network

There is a penalty of [\$0 – \$10,000] for failure to obtain Pre-Authorization, but in no event will the penalty exceed 50% of the total charges. Penalty payments do not apply toward a deductible or out-of-pocket maximum amounts.]]

[Serious Mental Illness diagnoses include; Schizophrenia, Schizoaffective Disorder, Pervasive Developmental Disorder or Autism, Obsessive-Compulsive Disorder, Panic Disorder, Major Depressive Disorder, Anorexia Nervosa and Bulimia Nervosa, Additionally, coverage includes Severe Emotional Disturbances of Children (SED).]

[The following are subject to Pre-Authorization prior to obtaining services:]

[Cardiac and Pulmonary Rehabilitation
Durable Medical Equipment
Hearing Aids
Home Health Care
Hospice Care
Fertility Services
Gastric Pacemakers
Injectable & Specialty Drugs (does not include Insulin or Anaphylactic kits)
Inpatient Admissions
Inpatient Rehabilitation

SCHEDULE OF BENEFITS / [Options are in Brackets]

Mental Health Conditions
Maternity Inpatient Days Beyond (2-4)
Occupational Therapy
Organ Transplant
Orthotics
Outpatient Angiographic Procedures
Outpatient MRI (Including CT and PET scans)
Outpatient Nuclear Imaging
Outpatient Surgery
Pain Management/Pain Clinic Services
Physical Therapy
Prosthetics
Same Day Surgery
Skilled Nursing Care
Speech Therapy
Substance Use Disorders]

--

STERLING LIFE INSURANCE COMPANY

[P.O. Box 5348, Bellingham, WA 98227-5348]

[(800) 688-0010]

ARKANSAS AMENDATORY ENDORSEMENT

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

A. The following information is added to the cover page of the Policy and Certificate:

The Insured Person may write Us at the address listed above or call Us at the telephone number listed above, or You may also contact Your agent.

If We fail to provide You with reasonable and adequate service, You should feel free to contact:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

B. PART 2 – ELIGIBILITY FOR INSURANCE, the following changes are hereby made:

1. **DEPENDENT ENROLLMENT ELIGIBILITY**, item 2. is deleted and replaced with the following:
 2. You may enroll any new Dependent who first meets the definition of Dependent, after Your Enrollment Date, by completing and submitting an Enrollment Form to Us through Your Employer. Your Enrollment Form must be submitted to Us within 31 days after the date on which Your Dependent first meets the criteria for a Dependent.
 - a. If Your new Dependent is a newborn Child, coverage will be provided from the moment of birth and will remain in force for 90 days. To continue coverage for Your newborn Child, You must submit an Enrollment Form for Your newborn Child and pay the required premium.
 - b. If Your new Dependent is an adopted Child, a Child placed in Your home for adoption, or a minor under Your charge, care, and control for whom You have filed a petition to adopt, prior to the Child's 18th birthday, coverage will be provided from the date of adoption or the date of placement for adoption until 60 days after the date of adoption or date of the date of placement for adoption. To continue coverage of an adopted Child or Child placed for adoption, You must submit an Enrollment Form for Your adopted Child or Child placed for adoption and pay the required premium.

2. **EMPLOYEE AND DEPENDENT ENROLLMENT PERIODS (NOT APPLICABLE TO LATE ENROLLES) ELIGIBILITY**, items 1. B and C are deleted and replaced with the following:

- B. If Your Dependent is a newborn Child, who is born after the Initial Enrollment Period, You must notify Us in writing within 90 days after the newborn Child's birth and any additional premium for the Child that is necessary to continue coverage beyond the initial 90 day period must be paid. In addition to Your newborn Child, You may enroll Your eligible spouse at the time You enroll Your newborn Child.
- C. If Your Dependent is an adopted Child or Child placed for adoption, and the adoption or placement for adoption begins after the Initial Enrollment Period, You must notify Us in writing within 60 days after the date of adoption or date of placement for adoption and any additional premium for the Child that is necessary to continue coverage beyond the initial 60 day period must be paid. In addition to Your adopted Child or Child placed for adoption, You may enroll Your eligible spouse at the time You enroll Your adopted Child or Child placed for adoption.

C. PART 6 – COVERED CHARGES the following changes are hereby made:

1. Item 3. **PHYSICIANS OFFICE VISITS**, the following is added:

SLIC AEAR 511

We will not refuse to reimburse a Physician at the full rate for health care services provided by a Physician assistant if the practice complies with the laws of Arkansas. We will not impose a practice or supervision restriction of a Physician assistant that is inconsistent with or more restrictive than the restriction already imposed by the laws of Arkansas.

2. Item **15. DIABETIC SELF-MANAGEMENT TRAINING**, is deleted and replaced with the following:

Benefits are payable for services and supplies to enable a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent Hospital care and complications. Covered Charges include services provided by a Physician or medical professional designated by the Physician. Visits for diabetic training, including medical nutrition education, are covered as follows:

- a. one (1) lifetime training program per Insured Person for diabetes self-management training when Medically Necessary as determined by a Physician and when provided by an appropriately licensed health care professional upon certification by the health care professional providing the training that the Insured Person has successfully completed the training;
- b. additional diabetes self-management training in the event that a Physician prescribes additional diabetes self-management training and it is Medically Necessary because of a significant change in the Insured Person's symptoms or conditions; and
- c. diabetes self-management training shall be provided only upon prescription by a licensed Physician.

3. Item **16. PREGNANCY/MATERNITY**, the following is added:

If it is determined that a continued Hospital stay is required for the mother, We will pay benefits for routine nursery charges and pediatric charges for a well newborn child for up to 5 full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time.

4. Item **20. DENTAL ANESTHESIA**, is deleted and replaced with the following:

Benefits are payable for dental anesthesia and Hospital charges for dental procedures in a Hospital or Ambulatory Surgical Center in order to safely and effectively perform dental procedures when the Insured Person is:

- A. A child under 7 years of age, and determined by two dentists to have a significantly complex dental condition;
- B. Diagnosed with a serious medical or physical condition; or
- C. Has a significant behavioral problem as determined by his or her Physician.

5. Item **21. AMBULANCE SERVICES**, the following is added:

If an Insured Person files a claim for covered professional ambulance services, direct reimbursement will be made to the provider of the services if the provider has not received payment for those services from any other source.

6. Item **27. PRESCRIPTION DRUGS AND MEDICINES** the following changes are hereby made:

- a. **Outpatient Covered Prescription Drug Charges**, the following is added:

Coverage is provided for contraceptive drugs and devices approved by the United States Food and Drug Administration.

- b. **Dispensing Limitation**, sub-item B. pertaining to prescription mail orders is deleted in its entirety.

- c. The following is added:

Cancer Drugs:

We will not limit or exclude coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, provided:

- A. 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 the following standard reference compendia:

- 1) The American Hospital Formulary Service Drug Information;
 - 2) The National Comprehensive Cancer Network Drugs and Biological Compendium;
 - 3) The Elsevier Gold Standard's Clinical Pharmacology; or
- B. The drug has been recognized as safe and effective for treatment of that specific type of cancer in two (2) 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.

Coverage of such drug includes Medically Necessary services associated with the administration of the drug.

License or Permit Required:

We will not contract with a pharmacist, pharmacy, pharmacy distributor, or wholesale drug distributor, nonresident or otherwise, to provide benefits for the shipment or delivery of a dispensed legend drug into the State of Arkansas, unless the pharmacist, pharmacy, or distributor has been granted a license or permit from the Arkansas State Board of Pharmacy to operate in the State of Arkansas.

We shall apply the same coinsurance, Copay, and Deductible factors to covered drug prescriptions filled by a pharmacy provider who participates in Our network if the provider meets Our explicit product cost determination. We will not set a limit on the quantity of drugs which an Insured Person may obtain at any one (1) time with a prescription, unless the limit is applied uniformly to all pharmacy providers in Our network.

7. Item **32. INFERTILITY**, the following limitations are added to paragraph C:

Benefits are payable for in vitro-fertilization procedures when:

- 5) The patient is an Employee or Dependent spouse covered under the Policy;
- 6) The patient's oocytes are fertilized with the sperm of the patient's spouse;
- 7) The patient and the patient's spouse have a history of unexplained infertility of at least 2-years duration; or the infertility is associated with one or more of the following medical conditions:
 - a. endometriosis;
 - b. exposure in utero to diethylstilbestrol, commonly known as DES;
 - c. blockage of or removal of one or more fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
 - d. abnormal male factors contributing to the infertility; and
- 8) The in vitro-fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists guidelines for in vitro-fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro-fertilization; or
- 9) The patient has been unable to obtain a successful pregnancy through any less costly applicable infertility treatment for which coverage is available under the Policy.

The following is added to paragraph A:

Cryopreservation is included as an in vitro-fertilization procedure.

8. Item **33. AUTISM SPECTRUM DISORDER**, is deleted and replaced with the following:

Benefits are payable for:

- A. the following care prescribed, provided, or ordered for an Insured Person diagnosed with an Autism Spectrum Disorder by a licensed Physician or a licensed psychologist who determined the care to be Medically Necessary and evidence-based including without limitation:
 - (i) Applied Behavior Analysis when provided by or supervised by a Board Certified Behavior Analyst;
 - (ii) Pharmacy care;
 - (iii) Psychiatric care;
 - (iv) Psychological care;
 - (v) Therapeutic care; and
 - (vi) Equipment determined necessary to provide evidence-based treatment; and
- B. Any care for an Insured Person with Autism Spectrum Disorder that is determined by a licensed Physician to be:

- (i) Medically Necessary; and
- (ii) Evidence-based.

Applied Behavior Analysis services has:

- (1) A [Calendar][Plan] Year limitation of [\$50,000]; and
- (2) Is limited to covered Dependent Children under 18 years of age.

For the purposes of this benefit, the following definitions apply:

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications by a board-certified behavior analyst using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior;

Autism Spectrum Disorder means any of the pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders including: (a) Autistic disorder, (b) Asperger's disorder, and (c) Pervasive developmental disorder not Otherwise Specified;

Board-certified Behavior Analyst means an individual certified by the nationally accredited Behavior Analyst Certification Board, a nationally accredited nongovernmental agency that certifies individuals who have completed academic, examination, training, and supervision requirements in Applied Behavior Analysis;

Evidence-based treatment means treatment subject to research that applies rigorous, systematic, and objective procedures to obtain valid knowledge relevant to Autism Spectrum Disorders;

Medically Necessary means reasonably expected to do the following: (a) prevent the onset of an illness, condition, injury, or disability; (b) reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, or disability; or (c) assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capabilities that are appropriate for individuals of the same age;

Pharmacy care means medications prescribed by a licensed Physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications;

Psychiatric care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

Psychological care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

Therapeutic Care means services provided by licensed speech therapists, occupational therapists, or physical therapists;

- 9. The following benefits are added to **PART 6 – COVERED CHARGES**:

34. PREVENTIVE AND PRIMARY CARE SERVICES FROM BIRTH TO 18 YEARS OF AGE

Benefits are payable for the following child preventive care services including:

- 1. Newborn screening tests for hypothyroidism, PKU, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the state of Arkansas, as well as any testing of newborn infants as mandated by law;
- 2. Routine nursery care and pediatric charges for a well newborn child for up to 5 full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time;
- 3. Children's preventive health care services are provided for covered Dependents for periodic preventive care visits from the moment of birth through 18 years of age. Coverage includes 20 visits under the supervision of a single Physician during the course of one visit, and at the following intervals: birth; 2 weeks; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 2 years; 3 years; 4 years; 5 years; 6 years; 8 years; 10 years; 12 years; 14 years; 16 years; and 18 years.
- 4. Preventive screenings may include, as recommended by a Physician, physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, hereditary and

metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, sickle hemoglobinopathy and other appropriate blood tests.

Recommended immunization services are exempt from any Copay, coinsurance, Deductible and dollar limit provisions.

For purposes of this benefit, the following definitions apply:

Children's preventive health care services means Physician-delivered or Physician-supervised services for eligible Dependents from birth through 18 years of age, with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

Periodic preventive care visits mean the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

35. CANCER SCREENING TESTS

Benefits are payable for the following cancer screening tests:

A. Mammography

- 1) a baseline mammogram for a female Insured Person 35 to 40 years of age;
- 2) a mammogram for a female Insured Person 40 to 49 years of age every one to two years based on the recommendation of the woman's physician;
- 3) a mammogram each year for a female Insured Person who is at least 50 years of age;
- 4) upon the recommendation of a female Insured Person's Physician, without regard to age, when the female Insured Person has had a prior history of breast cancer or when the female Insured Person's mother or sister has had a history of breast cancer; and
- 5) diagnostic mammograms as recommended by the Insured Person's physician.

B. Colorectal Cancer Screening – Examinations and laboratory tests as prescribed by a Physician for:

- 1) Insured Person's who are 50 years of age or older;
- 2) Insured Person's who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines; and
- 3) Insured Person's experiencing the following symptoms of colorectal cancer as determined by a Physician: a) bleeding from the rectum or blood in the stool; or b) a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than 5 days.

An examination of the entire colon, including:

- 1) The following examinations or laboratory tests, or both:
 - a. An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
 - b. A double-contrast barium enema every five (5) years; or
 - c. A colonoscopy every ten (10) years; and
- 2) Any additional medically recognized screening tests for colorectal cancer required by the Director of the Division of Health of the Department of Health and Human Services, determined in consultation with appropriate health care organizations.

The Insured Person shall determine the choice of screening strategies in consultation with a health care provider.

Screenings shall be limited to the following guidelines for the management or subsequent need for follow-up colonoscopy:

- 1) If the initial colonoscopy is normal, follow-up is recommended in ten (10) years;
- 2) For individuals with one or more neoplastic polyps or adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, follow-up is recommended in three (3) years;
- 3) If single tubular adenoma of less than one centimeter (1 cm) is found, follow-up is recommended in five (5) years; and
- 4) For Insured Persons with large sessile adenomas greater than three (3) centimeters (3 cm), especially if removed in piecemeal fashion, follow-up is recommended in six (6) months or until complete polyp removal is verified by colonoscopy.

- C. Prostate Cancer Screening -- One screening per Year for the early detection of prostate cancer in a male Insured Person 40 years of age and older performed by a qualified medical professional according to National Comprehensive Cancer Network guidelines. This benefit is not subject to the Deductible.

36. MEDICAL FOOD OR LOW PROTEIN MODIFIED FOOD PRODUCT

Benefits are payable for Medical Food or Low Protein Modified Food Products for the treatment of an Insured Person inflicted with phenylketonuria (PKU), galactosemia, organic acidemias, and disorders of amino acid metabolism if: (a) the medical food or low protein modified food products are prescribed as Medically Necessary for such treatment; and (b) the products are administered under the direction of a Physician.

For the purposes of this benefit, the following definitions apply:

Low Protein Modified Food Product means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

Medical Food means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

37. TREATMENT OF THE BONES AND JOINT OF THE FACE, HEAD AND NECK

Benefits are payable for treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder. Covered Charges include both surgical and nonsurgical procedures. Coverage will be provided for Medically Necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Coverage shall be the same as that provided for any other musculoskeletal disorder in the body.

38. SPEECH AND HEARING SERVICES

Benefits are payable for care and treatment of loss or impairment of speech or hearing. Loss or impairment of speech or hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification.

39. HEARING AIDS

Benefits are payable as shown in the Schedule of Benefits for a hearing aid or hearing instrument sold by a professional licensed by the state of Arkansas to dispense a hearing aid or hearing instrument. This benefit is not subject to the Deductible or a Copayment.

For the purposes of this benefit, the following definition applies,

Hearing aid or hearing instrument means an instrument or device, including repair and replacement parts, that: (a) Is designed and offered for the purpose of aiding an Insured Person with or compensating for impaired hearing; (b) Is worn in or on the body; and (c) Is generally not useful to a person in the absence of a hearing impairment.

40. PROSTHETICS AND ORTHOTIC SERVICES AND DEVICES

Benefits are payable for eighty percent (80%) of Medicare allowables as defined by the Center for Medicare Medicaid Services, Healthcare Common Procedure Coding System as of January 1, 2009, or as of a later date if adopted by rule of the Insurance Commissioner for: (a) An orthotic device; (b) An orthotic service; (c) A prosthetic device, and (d) A prosthetic service. Benefits are not payable for an orthotic device, an orthotic service, a prosthetic device, or a prosthetic service for a replacement that occurs more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria.

An orthotic device, an orthotic service, a prosthetic device, or a prosthetic service must be prescribed by a licensed Physician of medicine, Physician of osteopathy, or Physician of podiatric medicine and provided by a Physician of medicine, a Physician of osteopathy, a Physician of podiatric medicine, an orthotist, or a prosthetist licensed by the State of Arkansas.

Eligibility for this benefit is based on criteria, which include without limitation: (a) The information and recommendation from the treating Physician in consultation with the Insured Person and (b) the results of a functional limit test.

For the purposes of this benefit, the following definition applies

Functional Limit Test means (a) Medical history, including prior use of orthotic devices or prosthetic devices if applicable; (b) Current condition, including the status of the musculoskeletal system and the nature of other medical problems; and (c) Desire to: (i) Ambulate with respect to lower-limb orthotic devices or prosthetic devices; or (ii) Maximize upper-limb function with respect to upper-limb orthotic devices or prosthetic devices.

41. GASTRIC PACEMAKERS

Benefits are payable for gastric pacemakers that are Medically Necessary. Gastric pacemakers require Preauthorization in the same manner as any other covered benefit.

For the purposes of this benefit, the following definition applies

Gastric pacemaker means a medical device that: (a) uses an external programmer and implanted electrical leads to the stomach; and (b) transmits low-frequency, high-energy electrical stimulation to the stomach to entrain and pace the gastric slow waves to treat gastroparesis.

Gastroparesis means a neuromuscular stomach disorder in which food empties from the stomach more slowly than normal.

D. PART 7 – EXCLUSIONS AND LIMITATIONS, the following changes are hereby made:

1. Item #6 pertaining to contraceptive drugs is deleted in its entirety.
2. Item #41 pertaining to Temporomandibular Joint Dysfunction is deleted in its entirety.

E. PART 8 – COORDINATION OF BENEFITS, is deleted and replaced with the following:

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

DEFINITIONS

- A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
- (1) Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 - (2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan. When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.
- D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

- (1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
- (2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
- (3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
- (4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
- (5) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

- (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
- (1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
 - (2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
 - (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - . The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
 - . If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
 - (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
 - (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - . The Plan covering the Custodial parent;
 - . The Plan covering the spouse of the Custodial parent;
 - . The Plan covering the non-custodial parent; and then
 - . The Plan covering the spouse of the non-custodial parent.
 - (c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

- (3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
- (6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

- A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. [Organization responsibility for COB administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. [Organization responsibility for COB administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give [Organization responsibility for COB administration] any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, [Organization responsibility for COB administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. [Organization responsibility for COB administration] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by [Organization responsibility for COB administration] is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

PART 10 – RENEWABILITY AND TERMINATION, the following are hereby added:

Continuation of Coverage

1. Any Insured Person whose coverage would otherwise terminate due to termination of employment or a change in marital status may continue coverage under the Policy for themselves and their eligible Dependents.
2. Continuation of coverage shall be available only to Employees who have been insured continuously under the Policy during the 3-month period prior to the termination of employment or change in marital status.
3. Continuation of coverage shall not be available to an Insured Person who is eligible for:
 - A. Federal Medicare coverage; or
 - B. Full coverage under any other group accident and health policy or contract.
 - 1) The other coverage must provide benefits for all preexisting conditions to be considered full coverage.
 - 2) Accordingly, an Insured Person may continue coverage under the Policy until all Pre-Existing Conditions are covered or would be covered under another group policy or contract or until termination pursuant to paragraph 6 below or pursuant to the applicable provisions of federal law.
4. An Insured Person who wishes to continue coverage must request continuation in writing not later than 10-days after the termination of employment or the change in marital status.
5. An Insured Person who requests continuation of coverage must pay the premium required on a monthly basis and in advance.
6. Continuation of coverage will end upon the earliest of the following dates:
 - A. 120-days after continuation of coverage began;
 - B. The end of the period for which the Insured Person made a timely contribution;
 - C. The contribution due date following the date the Insured Person becomes eligible for Medicare; or
 - D.
 - 1) The date on which the Policy is terminated.
 - 2) However, if the Policy is replaced by Us, continuation shall continue under the new coverage.
7. At the termination of the continued coverage, an Insured Person will be offered a conversion policy (see the Conversion section below).
8. Insured Person's choosing to utilize the Conversion privilege below may do so and thereby waive their right to continuation of coverage under this section.

Conversion

1. An Insured Person whose insurance under the Policy has been terminated for any reason, including the discontinuance of the Policy in its entirety, shall be entitled to have issued to him or her by Us a policy of accident and health insurance referred to in this section as a "conversion policy".
2. An Insured Person shall not be entitled to a conversion policy, if the termination of the coverage under the coverage was a result of his or her failure to pay any required contribution or if the coverage under the Policy is replaced by similar coverage within 31-days. An Insured Person wishing to exercise his or her conversion privilege must apply for the conversion policy in writing not later than 30-days after the termination of coverage under the Policy.
3. The conversion policy shall provide coverage equal to or greater than the minimum standards established by the Insurance Commissioner.

EMPLOYER GROUP APPLICATION

(Becomes part of the Group Policy)

[Product Logo]

Underwritten by: **STERLING LIFE INSURANCE COMPANY**
 [Bellingham, WA 98227-5348]
 [Third Party Administrator: Meritain
 1405 Xenium Lane North, Suite 140, Minneapolis, MN 55441]

COMPANY NAME		GROUP NUMBER (office use)				
STREET ADDRESS (physical address only)		DIVISION NAME AND NUMBER (office use)				
CITY	STATE	ZIP	REQUESTED EFFECTIVE DATE – [First of the Month][Fifteen of the Month]			
BILLING/MAILING ADDRESS		COUNTY	FEDERAL EMPLOYER I.D. NUMBER			
CITY	STATE	ZIP	TYPE OF INDUSTRY			
CHIEF EXECUTIVE OFFICER OR PROPRIETOR		YEARS IN BUSINESS				
BENEFITS ADMINISTRATOR / TITLE		PHONE	FAX			
E-MAIL AND WEBSITE ADDRESS		OTHER LANGUAGE CONSIDERATIONS				
DOES THE APPLICANT OFFER OTHER COVERAGE: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE LIST THE CARRIERS AND TYPE OF COVERAGE OFFERED AND PREMIUM FOR EACH OPTION						
1.		3.				
2.		4.				
PREVIOUS CARRIER(S)		2.				
Are all employees eligible for this plan covered by Worker's Compensation? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, please explain: _____						
Are your benefits subject to ERISA regulation? <input type="checkbox"/> Yes <input type="checkbox"/> No						
TYPE OF ORGANIZATION: <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership Other _____						
ELIGIBLE EMPLOYEES: 1. Total number of employees _____ 2. Total number of employees covered under another employer sponsored plan _____ 3. Number of part-time, seasonal and temporary employees _____ 4. Number of eligible employees (subtract line 2 & 3 from line 1) _____ 5. Number of employees declining (complete waiver) or covered elsewhere _____ 6. Total employees enrolling with Sterling Life Insurance Company _____ (subtract line 5 from line 4)						
CONTINUATION COVERAGE: Employer is responsible to contact current carrier to obtain name(s) and address(es) of current COBRA participants. Please indicate number of current COBRA participants _____ (attach list) Is employer required to offer: <input type="checkbox"/> Federal COBRA						
BENEFITS:						
[PPO Medical Plans		[Preferred Provider Choices				
<input type="checkbox"/> Plan _____]		State _____				
<input type="checkbox"/> Hardware Vision Option _____]		PPO Network _____]				
<input type="checkbox"/> Fertility Option _____]		PPO Network _____]				
<input type="checkbox"/> Acupuncture]		PPO Network _____]				
<input type="checkbox"/> Autism Spectrum Disorder]		PPO Network _____]				
<input type="checkbox"/> Preventive Care Services]		PPO Network _____]				
<input type="checkbox"/> TMJ]						
<input type="checkbox"/> Manipulative Services]						
RATES (office use):		MEDICAL	EMPLOYEE	EE + SP/1	EE + CH(REN)	EE + SP + CH(REN)
[Option		_____	_____	_____	_____	_____
Option	Option	_____	_____	_____	_____	_____
Option]	_____	_____	_____	_____	_____

EFFECTIVE/RENEWAL DATE _____ RAF:
 _____ OPEN ENROLLMENT:
 _____ TO: _____

Enrollment / Premium Provisions

GROUP NAME	GROUP NUMBER (office use)
<p>SELECTED ELIGIBILITY REQUIREMENTS: A bona-fide employee/employer relationship is required to be maintained; that is the employer must continually compensate the individual in the form of annual, monthly, weekly or hourly wage. Further, the employer and employee must maintain an employment relationship pursuant to which the employer pays those payroll costs (e.g. FICA, FUI, SUI, and Worker's Compensation) normally associated with a bona-fide employer/employee relationship.</p> <p>Eligible employees shall be active, full-time employees who usually work at least __[0 – 40]____ hours per week.</p>	
<p>CATEGORIES OF ELIGIBILITY: <input type="checkbox"/> Dependents [spouse, children] [<input type="checkbox"/>Other Dependents <input type="checkbox"/> Domestic Partner] <input type="checkbox"/> Retired Beneficiaries [<input type="checkbox"/> Early Retirees (under age 65)] [<input type="checkbox"/> Board of Directors] [<input type="checkbox"/> Other – provided detailed description] (subject to approval)</p>	
<p>COMMENCEMENT OF COVERAGE: <input type="checkbox"/> 1st month following Date of Hire <input type="checkbox"/> 15th month following Date of Hire Note: All terminations are effective the [last] day of the month in which Employee ceases to be eligible under group eligibility provisions. <input type="checkbox"/> 1st month following _____ days from Date of Hire <input type="checkbox"/> 15th month following Date of Hire <input type="checkbox"/> Other (attach description)</p>	
<p>EMPLOYER CONTRIBUTION & PARTICIPATION REQUIREMENTS: (Employer must contribute a minimum of [25% - 75%] of Employee only premium) <input type="checkbox"/> Employee Only \$ _____ or _____ % of Rate <input type="checkbox"/> Dependents \$ _____ or _____ % of Rate</p>	
<p>BROKER INFORMATION: <input type="checkbox"/> Existing Broker Broker Name: _____ Phone: _____ <input type="checkbox"/> New Broker (must complete Carrier Appointment & Commission Agreement/s) Agency: _____ Fax: _____ Broker Number: _____ E-mail: _____ Commission: <input type="checkbox"/> Standard Scale <input type="checkbox"/> Flat _____% <input type="checkbox"/> Other: _____ License Number: _____</p>	
<p>COMMENTS:</p> 	

EMPLOYER STATEMENT

We wish to enroll our organization as an employer account with Sterling Life Insurance Company. We understand the eligibility rules applicable to enrollment and understand the premium requirements.

Employee participation requirements and employer contribution have been explained and we understand that these must be maintained in order for the account to remain eligible for coverage.

PREMIUM REQUIREMENTS: Monthly premiums are due and payable in full on the first day or the fifteen (to coincide with original effective date) of each calendar month. If premiums are not received from the employer, coverage for enrollees will be terminated on the last day or the fifteen (to coincide with original effective date) of the month for which premium was received. Any other premium payment arrangements require prior approval.

To the best of our knowledge and behalf, the foregoing statements are true and complete. This application shall be the basis for the issuance of coverage under the Group Policy and shall become a part thereof. Sterling Life Insurance Company reserves the right to terminate the Group Policy or the coverage of any individual Certificateholder who has made any material misrepresentation.

 Signature Date

 Print Name and Title

BROKER STATEMENT

I certify that: All the information contained in this application is correct to the best of my knowledge; the applicant is a bona-fide business establishment; participation requirements have been met; that all coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been carefully explained to the employer. I recommend that such coverage be offered and know of no reason why coverage should be declined.

 Broker Signature Date

Sterling Life Insurance Company

[[EMPLOYER NEW BUSINESS CHECKLIST

[The following documentation should be completed and submitted to [YES Company] by the 5th of the month:

- Employer Group Application (to be completed by Employer)
- Enrollment forms _____ # of forms
- Copy of Rate Quote
- Employers must complete Sterling Life Insurance Company Group Underwriting Questionnaire
- Waiver forms must be completed for eligible employees who refuse coverage for themselves *or* their dependents
- The selected Sterling Life Insurance Company plan is primary to Medicare for *active* employees age 65 or older (and spouses age 65 or older of active employees).
- A copy of [DE6][the employer's most current quarterly wage and tax statement]
- A deposit in the amount of one month's premium]

**Return Materials to: [YES Company
321 Knee Street
Suite 01
Some City, Some State 33333
(XXX) XXX-XXXX Phone
(XXX) XXX-XXXX Fax]
www.YEScompany.com]]]**