

SERFF Tracking Number: ICCI-127126793 State: Arkansas
Filing Company: American Medical and Life Insurance Company State Tracking Number: 49464
Company Tracking Number: AMLI GRP LM 2 0 POL NE (AAA)
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: AMLI GRP LM 2 0 POL NE (AAA)
Project Name/Number: AMLI GRP LM 2 0 POL NE (AAA)/AMLI GRP LM 2 0 POL NE (AAA)

Filing at a Glance

Company: American Medical and Life Insurance Company

Product Name: AMLI GRP LM 2 0 POL NE (AAA) SERFF Tr Num: ICCI-127126793 State: Arkansas

TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed-Approved-Closed State Tr Num: 49464

Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: AMLI GRP LM 2 0 POL NE (AAA) State Status: Approved-Closed

Filing Type: Form

Author: Brenda Dawson

Date Submitted: 08/03/2011

Reviewer(s): Rosalind Minor

Disposition Date: 08/08/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: AMLI GRP LM 2 0 POL NE (AAA)

Project Number: AMLI GRP LM 2 0 POL NE (AAA)

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Association

Filing Status Changed: 08/08/2011

State Status Changed: 08/08/2011

Created By: Brenda Dawson

Corresponding Filing Tracking Number: ICCI-126436306

Filing Description:

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

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Brenda Dawson

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

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Master Group Policy form AMLI GRP LM 2.0 POL NE will be issued to an Association group located outside of your state. The situs state of the group is Nebraska. This American Advantage Association (AAA) was previously approved by your Department on March 8, 2010 under SERFF Tracking # ICCI-126436306.

Form AMLI GRP LM 2.0 CERT NE is the Group Supplemental Hospital and Medical Certificate of Insurance evidencing coverage under the Master Group Policy. This is a fixed indemnity plan. Amendatory Endorsement GRP LM 2011 AE AR will be attached to all Certificates issued in Arkansas.

The Schedule of Benefit page and the endorsement are attached to the Certificate.

We use multiple computer systems to generate forms. Therefore, actual issued forms may have a different font style than the submitted forms. As a result, provisions may appear on different pages and lines may not match up exactly. The wording and its order, however, will remain identical. We do not anticipate refile for a font style variation.

Company and Contact

Filing Contact Information

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

Filing Company Information

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

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

Filing Fees

Fee Required? Yes
Fee Amount: \$200.00
Retaliatory? No
Fee Explanation: \$50 per form
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Medical and Life Insurance Company	\$200.00	08/03/2011	50328980

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/08/2011	08/08/2011

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Authorization Letter 2011	Approved-Closed	Yes
Form	Group Accident and Sickness Hospital Indemnity Policy	Approved-Closed	Yes
Form	Group Certificate	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes

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Form Schedule

Lead Form Number: AMLI GRP LM 2 0 POL NE

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/08/2011	AMLI GRP LM 2 0 POL NE	Policy/Cont	Group Accident and Sickness Hospital Indemnity Policy Certificate	Initial			NE AMLI GRP LM 2 0 POL 5-11-11 clean copy.pdf
Approved-Closed 08/08/2011	AMLI GRP LM 2.0 CERT NE	Certificate	Group Certificate	Initial			NE AMLI GRP LM 2 0 CERT NE 7-15-11 clean copy.pdf
Approved-Closed 08/08/2011	AMLI GRP LM 2.0 SCHED	Schedule Pages	Schedule of Benefits	Initial			AMLI GRP LM 2 0 Schedule of Benefits FINAL 7 6 11 clean copy.pdf
Approved-Closed 08/08/2011	GRP LM 2011 AE AR	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Amendatory Endorsement	Initial			AR GRP LM 2007 AE AR - mandates 12-11-09.pdf

American Medical and Life Insurance Company
8 West 38th Street, Suite 1002, New York, New York

GROUP ACCIDENT AND SICKNESS HOSPITAL INDEMNITY INSURANCE

**THIS IS A GROUP FIXED INDEMNITY POLICY PROVIDING BENEFITS DUE TO ACCIDENT AND SICKNESS.
BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.
THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE.**

Policy Holder: [XYZ Company]
Policy Number: [12345]
Policy Date: [JANUARY 1, 2011]
Anniversary Date: [JANUARY 1, of each year]

MASTER POLICY

This Policy is a legal contract between You and Us. To understand the coverage, You must read this Policy as a whole.

In this Policy, the words You and Your refer to the Holder shown above. The words Named Insured refer to those persons who are members of an eligible class as described in the Certificate Schedule who hold a Certificate of coverage. Benefit payment is governed by the terms of this Policy. The words Covered Person refer to any person covered under this Policy as described on the Certificate Schedule. The words We, Us, Our or Company refer to American Medical and Life Insurance Company. The male pronoun includes the female whenever used.

We agree to insure certain individuals and to pay the benefits provided by this Policy in accordance with its provisions.

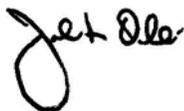
This Policy is issued in consideration of statements made in the application and the payment of premiums by the Holder. A copy of the signed application will be attached and made a part of this Policy.

This Policy is effective on the Policy Date. The Policy Date will be the date of issue. The first Policy Year will end on the anniversary date shown above. Each Policy Year after that will end on the same date of each year. All periods will begin and end at 12:01 A.M. Standard Time at the Holder's main address.

This Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

TO OBTAIN INFORMATION YOU MAY CALL OUR TOLL FREE NUMBER: [1-800-XXX-XXXX].

For American Medical and Life Insurance Company:



John Ollis
Chairman, President and CEO



Executive Vice President, Compliance

This is a limited policy. Please read it carefully.

**This is Guaranteed Renewable Coverage
This is Not Medicare Supplement Coverage**

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INCORPORATION PROVISION

The provisions of the attached Certificate and all amendments to this Group Policy after its effective date are incorporated into and made part of this Group Policy.

The provisions listed below are shown in the Certificate and are hereby incorporated into and made a part of this Group Policy.

Schedule of Benefits
Definitions
Effective Date of Coverage
Conversion
General Provision
Coverage Descriptions
Exclusions and Limitations

Certificate

The *Certificate*, including the Certificate Schedule, amendments, riders and supplements, if any, is a written statement prepared by Us to set forth a summary of:

- benefits to which the Covered Person is entitled;
- to whom the benefits are payable; and
- limitations or requirements that may apply.

ELIGIBILITY AND EFFECTIVE DATE

Policy Effective Date

Coverage under this Policy begins at 12:01 a.m. Standard Time on the effective date shown in the Policy.

Delayed Effective Date of Coverage

The effective date of any Named Insured's coverage will be delayed for any Named Insured if they are not a member of an eligible class on the effective date shown on the Certificate Schedule. The coverage will be effective on the date that the Named Insured returns to status as a member of an eligible class. If this is Named Insured and Spouse coverage or family coverage, coverage on the Spouse and/or Dependent children will be effective on the date that the Named Insured returns to status as a member of an eligible class.

TERMINATION OF INSURANCE

Termination of This Contract

This Policy can be cancelled by you.

If the premium is not paid when it is due or during the grace period, this Policy will terminate at midnight on the last day of the grace period. You must pay all premium due for the full period each Certificate is in force. We will send a notice of termination to each Named Insured within 14 days of the expiration of the grace period if the premium is not paid by the end of the grace period. You must notify each Named Insured within 14 days of the expiration of the grace period if the coverage is canceled or not renewed due to Your intentional nonpayment of the premium.

You may cancel this Policy by written notice delivered to Us at least 31 days prior to the cancellation date. This Policy can be cancelled on an earlier date if We both agree. Coverage will end at 12:00 midnight Standard Time on the cancellation date.

PREMIUMS

When and Where to Pay Premiums

The premiums for the coverage must be paid to Us at Our home office when they are due.

The premium due dates are based on:

- the effective date of the coverage shown on the [Policy] [Certificate Schedule]; and
- the premium frequency.

The *premium frequency* is how often the premiums are paid.

Grace Period (If Premiums Are Not Paid When Due)

After the first premium, if the premium is not paid when it is due, it can be paid during the next 31 days. These 31 days are called the grace period during which time the Policy stays in force. If the premium is not paid before the grace period ends, the coverage provided by this Policy will terminate at midnight on the last day of the grace period.

Our Right to Change Premiums

We have the right to change the premium We charge. If We plan to make a change, We will send You a notice at least 60 days before We make it.

A change in premium rate will not take effect for twelve months after the policy effective date. Provided, however, We may change premium rates at any time for reasons which affect the risk assumed, including the reasons shown below:

- a change occurs in the plan design;
- a division, subsidiary, or affiliated company is added or deleted;
- [a substantial change occurs in the participation level of those eligible employees;]
- the number of insureds changes by 25% or more; or
- a new law or a change in any existing law is enacted which applies to this plan.

GENERAL PROVISIONS

Coverage Provided by This Policy

We insure a Covered Person for a loss according to the provisions of this Policy.

When making a benefit determination under this Policy, We have discretionary authority to determine the Covered Person's eligibility for the benefits and to interpret the terms and provisions of the Policy.

Entire Contract: Changes

This Policy is a legal contract between You and Us. The Policy is issued in consideration for the application(s) and payments, called premiums.

This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by Our executive officer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Furnishing Certificates

The Company will provide certificates to the Holder for delivery to each Named Insured. The Certificate will describe the insurance coverage and to whom payable. If the terms of a Certificate and this Policy differ, the Policy governs.

Benefit Amounts

Benefit amounts will be the amount of coverage selected at the time of application and reflected on the Named Insured's Certificate Schedule.

State Laws

Any provision of this Policy that, on the effective date, does not agree with state laws where the Named Insured lives will be amended to conform to the minimum requirements of those laws.

Conformity with State and Federal Law: Any provision of this Policy which, on its effective date, is in conflict with the law of the federal government or the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such law

Information to Be Furnished By You

As the policyholder, You must keep a record of the Named Insureds and the particulars of the insurance on each. You should provide Us at regular intervals, on forms acceptable to Us, information relative to persons:

- who are eligible to enroll;
- who are insured by the coverage; and/or
- whose coverage terminates pursuant to the "Termination of a Named Insured's Coverage" provision.

You should also provide Us with any other information about the coverage that may be reasonably required, such as Named Insureds on leave of absence, including Named Insureds who are on leave under the Family and Medical Leave Act.

We have the right to inspect Your records which may have a bearing on the insurance provided by this Policy. We may inspect these at any time while this Policy is in force and within one year after the termination of this Policy.

In the absence of fraud or intentional misrepresentation of material fact, all statements made in any application are considered representations and not warranties. No representation of the policyholder in applying for insurance under this Policy will make it void unless the representation is contained in the application, a copy of which has been furnished to the policyholder.

American Medical and Life Insurance Company
8 West 38th Street, Suite 1002, New York, New York 10018

GROUP ACCIDENT AND SICKNESS HOSPITAL INDEMNITY INSURANCE

THIS COVERAGE PROVIDES BENEFITS DUE TO ACCIDENT AND SICKNESS. THIS CERTIFICATE EXPLAINS THE BENEFITS PROVIDED UNDER THE GROUP ACCIDENT AND SICKNESS HOSPITAL INDEMNITY INSURANCE POLICY. BENEFITS PROVIDED ARE LIMITED AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

CERTIFICATE OF COVERAGE

Issued under the terms of
Group Insurance Policy Number: [12345]

Issued to: [XYZ Company]
(herein called the Policy Holder)

Policy Date: [January 1, 2011]

American Medical and Life Insurance Company hereby certifies that members of the class(es) eligible for insurance are insured under the above Policy as determined by the Eligibility and Certificate Effective Date provisions. Class is defined in the Certificate Schedule.

This Certificate is evidence of insurance provided under the Policy. All benefits are paid according to the terms of the Policy. This Certificate describes the essential features of the insurance coverage.

In this Certificate, the words "Named Insured" or "You" means a member of an eligible class as described on the Certificate Schedule, who is insured under the Policy and for whom premiums are remitted. The words "Covered Person" refer to any person covered under the Policy as described on the Certificate Schedule. The words "We", "Us", "Our" or "Company" refer to American Medical and Life Insurance Company. "Policy" means the Group Accident and Sickness Hospital Indemnity Insurance contract owned by the Policy Holder and available for review by You. If the terms of Your Certificate of coverage and the Policy differ, the Policy will govern.

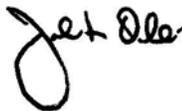
The Policy and this Certificate may be changed in whole or in part or cancelled as stated in the Policy. Such action may be taken without the consent of or notice to any Covered Person. Only an authorized officer at Our home office can approve a change. The approval must be in writing and endorsed on or attached to the Policy. No other person, including an agent, may change the Policy or Certificate or waive any of its provisions. Premiums are subject to periodic changes.

The use of the pronoun "he" refers to both male and female members whenever used.

Coverage under this Policy is delivered in and governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

TO OBTAIN INFORMATION YOU MAY CALL OUR TOLL FREE NUMBER: [1-888-264-1512]

For American Medical and Life Insurance Company:



John Ollis
Chairman and Chief Executive Officer



Kay Phillips
Vice President and Chief Compliance Officer

Please read this Certificate carefully.

THIS IS NOT COMPREHENSIVE MAJOR MEDICAL COVERAGE.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

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CERTIFICATE SCHEDULE

The benefit specifications are shown on the following attachment(s) which are hereby made a part of this Certificate:

AML I GRP LM 2.0 SCHED

Certificate Schedule

GENERAL DEFINITIONS

Additional definitions may be contained in other Certificate benefit provisions or any endorsement or rider.

[Ambulatory Surgical Center

An *Ambulatory Surgical Center (ASC)* is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services. The *Ambulatory Surgical Center* must be certified with the Center for Medicare and Medicaid Services (CMS.) An ASC is either an independent facility or is operated by a Hospital. A hospital-operated facility must be a separately identifiable entity physically and administratively, and be financially independent and distinct from other operations of the Hospital.]

[Cancer In Situ.

A Diagnosis of cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue.

Cancer in Situ includes:

- Early prostate cancer diagnosed as T1N0M0 or equivalent staging; and
- Melanoma not invading the dermis.

Cancer in Situ does not include:

- Other skin malignancies;
- Pre-malignant lesions (such as intraepithelial neoplasia); or
- Benign tumors or polyps.

Cancer in Situ must be diagnosed pursuant to a *Pathological* or *Clinical Diagnosis* as defined in this Certificate.]

Certificate Year

Certificate Year means a consecutive 12-month period, beginning on the Certificate Effective Date and ending on the Certificate Anniversary Date, as specified on the Certificate Schedule.

[Clinical Diagnosis

A Diagnosis of Invasive Cancer or Cancer in Situ based on the study of symptoms and diagnostic test results. We will accept a *Clinical Diagnosis* of Cancer only if the following conditions are met:

- A Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
- There is medical evidence to support the Diagnosis; and
- A Physician is treating the Insured for Invasive Cancer and/or Cancer in Situ.]

[Complications of Pregnancy

Complications of Pregnancy are health conditions requiring medical treatment before or after termination of pregnancy. The health condition must be diagnosed as distinct from pregnancy or as caused by it. Examples are: acute nephritis; cardiac decompensation; miscarriage; disease of the vascular, hemopoietic, nervous or endocrine systems; and similar conditions that cannot be classified as a distinct complication of pregnancy but are connected with the management of a difficult pregnancy. Also included are: medically necessary cesarean sections; terminated ectopic pregnancy; spontaneous termination that occurs during pregnancy in which a viable birth is impossible; hyperemesis gravidarum; and preeclampsia.

Complications of Pregnancy do NOT include: false labor; occasional spotting; rest prescribed during the period of pregnancy; or elective cesarean section.]

[Confined or Confinement

Confined or *Confinement* means the assignment to a bed as a resident inpatient in a Hospital or a licensed Skilled Nursing Facility on the advice of a Physician, or Confinement in an Observation Unit within a Hospital for a period of no less than 24 continuous hours on the advice of a Physician.]

Covered Accident

A *Covered Accident* is an unintended or unforeseeable bodily injury sustained by a Covered Person, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition, from an accident the Covered Person sustains while covered under this Certificate. In addition the accident must not be excluded by name or specific description in this Certificate.

Covered Person(s)

You and Your Dependents who are insured under the Group Policy.

Covered Sickness

A *Covered Sickness* means a Sickness which is not excluded by name or specific description in this Certificate.

[Critical Illness

The First Ever Occurrence, while coverage under the Policy is in force, of one of the following covered conditions or procedure[s], as defined in this Certificate:

- Heart Attack
- Invasive Cancer
- Cancer In Situ
- Stroke
- Major Organ Transplant
- End-Stage Renal Failure]

[Diagnosis

Diagnosis is the definitive establishment of the Critical Illness Condition through the use of clinical and/or laboratory findings. The *Diagnosis* must be made by a Physician who is a board-certified specialist where required under this coverage.]

Doctor or Physician

A person, other than the Named Insured, a member of the Named Insured's immediate family, or a business associate of the Named Insured, who is duly licensed and practicing medicine in the United States, and who is legally qualified to diagnose and treat sickness and injuries. The *Physician* must be providing services within the scope of his or her license, and must be a board-certified specialist where required under the Policy.

[Emergency Services

Emergency Services are:

- Health care services furnished in the emergency department of a Hospital for the treatment of a medical emergency;
- Ancillary services routinely available to the emergency department of a Hospital for the treatment of a medical emergency; and
- Emergency medical services transportation.]

[End-Stage Renal Failure.

The chronic and irreversible failure of both of Your kidneys which requires You to undergo periodic and ongoing dialysis. The *Diagnosis* must be made by a Physician board-certified in Nephrology.]

Experimental/Investigative

A drug, device or medical care or treatment will be considered *Experimental/Investigative* if:

- The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is furnished;
- The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigative phase, or if such a consent document is required by law;
- Either the drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
- Reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine the maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device, medical care or treatment. Benefits will be considered in accordance with the drug or device at the time it is given or when medical care is received.

We will not limit or deny coverage, or impose additional conditions on the payment for the coverage, of routine patient care costs of items, drugs, and services furnished to a Covered Person in connection with participation in an approved clinical trial. We will not pay for costs of items, services, or drugs that are customarily provided by the sponsors of an approved clinical trial.

Approved clinical trial means:

- A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
 - (i) The National Institutes of Health;
 - (ii) The Centers for Disease Control and Prevention;
 - (iii) The Agency for Health Care Research and Quality;
 - (iv) The Centers for Medicare and Medicaid Services;
 - (v) A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS; or
 - (vi) The Department of Defense, the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;
- A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigative new drug or device application reviewed by the FDA; or
- An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

[First Ever Diagnosis or Procedure

This diagnosis or procedure is the first time ever in his/her lifetime that the Covered Person has undergone that specific Procedure included in the Critical Illness definition, or been diagnosed with that specific condition included in the definition of Critical Illness.]

[First Ever Occurrence

The date a Covered Person is positively diagnosed by a Physician as having a Critical Illness for the first time.]

Health Insurance Coverage

Health Insurance Coverage is medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

[Heart Attack.

An acute myocardial infarction resulting in the death of a portion of the heart muscle (myocardium) due to a blockage of one or more coronary arteries and resulting in the loss of the normal function of the heart. The Diagnosis must be made by a Physician board-certified as a Cardiologist and based on both:

- New clinical presentation and electrocardiographic changes consistent with an evolving heart attack; and
- Serial measurement of cardiac biomarkers showing a pattern and to a level consistent with a Diagnosis of Heart Attack.

Established (old) myocardial infarction is excluded.]

Hospital

A *Hospital* means a short-term, acute general hospital that:

- Is primarily engaged in providing to inpatients, by or under continuous supervision of physicians, diagnostic and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a physician or dentist;
- Provides 24-hour nursing care by or under the supervision of registered nurses (RNs);
- Has in effect a hospital review plan applicable to all patients, which meets at least the standards set forth in Section 1861(k) of the United States Public Law 89-97 (42 USCA 1395x[k]);
- Is duly licensed by the agency responsible for licensing such hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for the treatment of drug addicts or alcoholics, or a place for convalescent, custodial, educational or rehabilitatory care.

[Hospital Intensive Care Unit

A *Hospital Intensive Care Unit* is a place that:

- Is a specifically designated area of the Hospital called an Intensive Care Unit that is restricted to patients who are critically ill or injured and who require intensive, comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
- Is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- Is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the Intensive Care Unit on a 24-hour basis; and
- Has a Physician assigned to the Intensive Care Unit on a full-time basis.

A *Hospital Intensive Care Unit* that meets the definition above may include Hospital units with the following names:

- Intensive Care Unit
- Coronary Care Unit
- Neonatal Intensive Care Unit
- Pulmonary Care Unit
- Burn Unit
- Transplant Unit.

A *Hospital Intensive Care Unit* is NOT any of the following step-down units:

- Progressive care unit
- Intermediate care unit
- Private monitored room
- Sub-acute Intensive Care Unit
- Observation Unit; or
- Any facility not meeting the definition of a *Hospital Intensive Care Unit* as defined in this Certificate.]

[Invasive Cancer.

A malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically hereafter excluded. Leukemias and lymphomas are included. The following are not considered *Invasive Cancer*:

- Pre-malignant lesions (such as intraepithelial neoplasia)
- Benign tumors or polyps
- Early prostate cancer diagnosed as T1N0M0 or equivalent staging
- Cancer in Situ; or
- Any skin cancer (other than invasive malignant melanoma in the dermis or deeper, or skin malignancies that have become metastatic).

Invasive Cancer must be diagnosed pursuant to a Pathological or Clinical Diagnosis as explained in the Other Definition section.]

[Major Organ Transplant.

The clinical evidence of major organ(s) failure which requires the malfunctioning organ(s) or tissue of the Named Insured to be replaced with an organ(s) or tissue from a suitable human donor (excluding the Named Insured) under generally accepted medical procedures. The organs and tissues covered by this definition are limited to: liver, kidney, lung, entire heart, small intestine, pancreas, pancreas-kidney or bone marrow. In order for the *Major Organ Transplant* to be covered under this Policy, the Named Insured must be registered by the United Network of Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP).]

Medical Emergency

Medical Emergency means the sudden onset or sudden worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Medically Necessary

Medically Necessary means a service or supply that is necessary and appropriate for the diagnosis or treatment of an Injury or Sickness based on generally accepted current medical practice. A service or supply will not be considered *Medically Necessary* if:

- It is provided only as a convenience to the Covered Person or provider;
- It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
- It exceeds in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
- It is experimental/investigative treatment.

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

[Mental Disability

Mental Disability means any mental condition including but not limited to affective disorders, neuroses, anxiety, stress, adjustment reactions, Alzheimer's disease and other organic senile dementias.]

Named Insured

A *Named Insured* is a person who is a member of an eligible class and holds a certificate of coverage.

Observation Unit

An *Observation Unit* is a specified area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery, or treatment in the emergency room by a Physician; and which:

- Is under the direct supervision of a Physician or registered nurse;
- Is staffed by nurses assigned specifically to that unit; and
- Provides care seven days per week, 24 hours per day.

[Pathological Diagnosis

A Diagnosis of Invasive Cancer or Cancer in Situ based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of Diagnosis must be done by a Physician who is a board-certified pathologist and whose Diagnosis of malignancy conforms to the standards set by the American College of Pathology.]

[Pre-Existing Condition

Pre-Existing Condition means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received from a Physician within a 6-month period preceding the Certificate Effective Date of coverage of the Covered Person, or such treatment which would have been recommended had a reasonable and prudent effort to seek appropriate medical advice been made.]

[Preventive Care Office Visit

An office visit not caused by an Accident or Sickness, to a licensed Physician during which the Covered Person's health status is assessed, and preventive screenings and tests are performed.]

[Resource Based Relative Value System, Referred to as RBRVS.

The methodology used by the federal government to determine benefits payable under Medicare. Medicare assigns a Relative Value Unit or RVU to thousands of procedure codes used to bill physician and other services. The total RVU is the sum of three component RVUs, including the Work RVU, the Practice Expense RVU and the Malpractice RVU. The Work RVU takes into account factors such as the amount of time required to perform the service and the degree of skill required to perform it. The Practice Expense RVU takes into account the location of the service, e.g., office setting, outpatient setting, etc. The Malpractice RVU takes into account the malpractice cost associated with a particular practice. We will base benefits payable on RBRVS.]

Sickness

Sickness means an illness, [pregnancy,] infection, disease or any other abnormal physical condition not caused by an Accident.

[Skilled Nursing Facility

Skilled Nursing Facility means a facility that is operated pursuant to law and is primarily engaged in providing room and board accommodations and skilled nursing care under the supervision of a duly licensed Physician, a licensed registered nurse or licensed practical nurse.]

[Stroke.

Any acute cerebrovascular accident producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit persisting for at least 96 hours and expected to be permanent. Transient ischemic attack (mini-stroke), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are excluded. The Diagnosis must be made by a Physician who is board-certified as a Neurologist.]

[Surgical Fee Schedule

A fixed schedule based on the initial 2010 RBRVS schedule. The surgery benefit will be based on the region where the surgery is performed and Current Procedural Terminology (CPT) code assigned to the surgery involved, as well as any percentage indicated on the Schedule of Benefits.]

[Urgent Care Facility

An *Urgent Care Facility* is a treatment center physically separated from a Hospital, which is staffed by Physicians and registered nurses, and which is dedicated to providing immediate care for non life-threatening illness or injury.]

[Waiting Period

Waiting Period means the period of time a person must be a member in good standing of the Policy Holder before becoming eligible for coverage. The *Waiting Period* is shown on the Certificate Schedule.]

ELIGIBILITY AND CERTIFICATE EFFECTIVE DATE**Certificate Effective Dates of Coverage**

Your coverage under the Policy will start at 12:01 a.m. Standard Time on the Certificate Effective Date of coverage shown on Your Certificate Schedule.

Eligibility

To be eligible to enroll in the coverage, an individual must:

- Be a member of an eligible class as defined on the Certificate Schedule;
- Satisfy the Waiting Period shown on the Certificate Schedule, if applicable;
- [Be between [18] and 64 years of age at the time of enrollment];
- [Be a legal resident of the United States];
- [Not be in full-time service of the Armed Forces];
- [Not be eligible for Medicare];
- [Not receive disability or worker's compensation benefits.]

Coverage under the Policy will terminate on the last day of the month in which the individual attains the age limitation of 65 years or becomes eligible for Medicare.

No member will be eligible for more than one Hospital Indemnity plan of benefits underwritten under policy form number AMLI GRP LM 2.0 POL NE.

Enrollment

An individual who is a member of an eligible class may enroll for coverage during the eligibility period, as shown on the Certificate Schedule, following the later of:

- The date the individual first becomes a member of an eligible class;
- The date the individual completes the Waiting Period shown on the Certificate Schedule, if applicable.

An individual who fails to enroll during the eligibility period may enroll only during the annual Open Enrollment Period shown on the Certificate Schedule.

Delayed Certificate Effective Date of Coverage

The Certificate Effective Date of any Named Insured's coverage will be delayed for any Named Insured if they are not a member of an eligible class on the Certificate Effective Date shown on the Certificate Schedule. The coverage will be effective on the date that the Named Insured returns to status as a member of an eligible class. If this is Named Insured and Spouse or Domestic Partner coverage or family coverage, coverage on the Spouse or Domestic Partner and/or Dependent children will be effective on the date that the Named Insured returns to status as a member of an eligible class.

Who Is Covered By This Certificate

If this is Named Insured coverage as shown on the Certificate Schedule, We insure You, the Named Insured.

If this is Named Insured and Spouse or Domestic Partner coverage as shown on the Certificate Schedule, We insure You and Your Spouse or Domestic Partner.

If this is family coverage, as shown on the Certificate Schedule, We insure You, Your Spouse or Domestic Partner (if applicable), and Your Dependent children.

Spouse means the person married to You on the day We issue Your Certificate.

Domestic Partner means a person with whom You maintain a committed relationship and who has registered. Each partner must:

- Be at least 18 years old and competent to contract;
- Be the sole domestic partner of the other person; and
- Not be married.

Dependent Children are:

- [Any unmarried, natural children, step-children, legally adopted children or children placed into Your custody for adoption who are under the age of 26 years of age.]
- [Any unmarried, natural children, step-children, legally adopted children or children placed into Your custody for adoption who are under the age of 19 years of age; and
- Any unmarried children who are 19 years of age to 26 years of age if the child:
 - is attending an accredited school full-time; and
 - is chiefly dependent upon You for support and maintenance.

Coverage on a Dependent Child will continue for a covered student who takes a leave of absence from school due to illness for a period of 12 months from the last day of attendance in school. However, coverage will not continue beyond the age at which coverage would otherwise terminate. In order to qualify for this continuation, the medical necessity of a leave of absence from school must be certified to by the student's attending Physician. Written documentation of the illness must be submitted to Us.]

Adopted children and step children will be eligible for coverage on the same basis as natural children.

Coverage for the Named Insured's Newborn and Adopted Children

A child born to You or Your insured Spouse or Domestic Partner will automatically become insured as a Dependent. The child must be born to the Named Insured or Spouse or Domestic Partner while this coverage is in force. We will cover each newborn child from the moment of live birth. Such coverage includes:

- The necessary care and treatment of medically diagnosed congenital defects;
- Birth abnormalities;
- Prematurity.

We will cover the Named Insured's adopted child(ren) from the moment of birth if You take physical custody of the infant upon the infant's release from the hospital and consent to the adoption has not been revoked. However, coverage of the initial hospital stay shall not be required where a natural parent has insurance coverage available for the infant's care.

A child adopted by You or Your insured Spouse or Domestic Partner will automatically become insured as a dependent. The Certificate Effective Date of the coverage will be the earlier of:

- The date of placement for the purpose of adoption; or
- the entry of an order granting the adoptive parent custody of the child for purposes of adoption.

Coverage for adopted children will be to the same extent as provided for other covered Dependent Children.

Coverage continues unless the placement is disrupted prior to legal adoption and the child is removed from placement.

For each newborn, step child and/or adopted child, You must:

- Notify Us of the birth or placement in Your residence within 31 days of this occurrence;
- Complete the required application for the child; and
- Pay the required premium for the child, if any.

If a newborn is not enrolled within 31 days of birth or adoption, coverage will be provided from the date that notice is given. Any additional premium required should be made within 31 days of notification of birth or placement for the purposes of a step child and/or adoption.

Court Ordered Custody of Children

Coverage is provided to a Child in the court ordered custody of the Named Insured on the same basis as a newborn Dependent Child. For each Child under court ordered custody, You must notify Us 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.

Continuation of Coverage for Dependents

Upon (1) The death of the Named Insured; (2) The Named Insured becoming age 65 or eligible for Medicare; (3) The Named Insured's enrollment in the health care system of the United States Department of Veterans Affairs; (4) The Named Insured obtaining employee-only major medical insurance through his or her employer or obtaining self-only major medical insurance on the individual market; (5) Entry of a valid decree of divorce between the Named Insured and former Spouse {or termination of the Domestic Partnership between the Named Insured and former Domestic Partner}; or (6) A Dependent reaching the limiting age: A Dependent Spouse, [Dependent Domestic Partner] or Dependent Child may continue coverage without providing evidence of insurability by making the required premium payments for issuance of his or her own Certificate. In addition, under this Continuation of Coverage provision, a covered Dependent spouse [or a covered Domestic Partner] may become the Named Insured under his or her own Certificate with the covered Dependent Children included as Dependents. The eligible Dependent must submit a written request for this continuation of coverage within thirty-one (31) days of the date on which coverage would otherwise terminate.

Changes to this Certificate

No Covered Person can terminate and return to coverage except on the anniversary date [and will be subject to the Pre-Existing Condition limitation as defined in this coverage]. No Named Insured can increase benefits except on the Certificate Anniversary Date. This provision is waived in the event of a Dependent becoming covered under the Continuation of Coverage for Dependents provision.

DESCRIPTION OF BENEFITS

Only those services listed in the following paragraphs are covered under the Policy. Any service not explicitly listed in this Description of Benefits will not be covered.

[ACCIDENT MEDICAL BENEFIT

We will pay the Accident Medical Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges due to injuries received in a Covered Accident. Covered charges are subject to the:

- Accident Medical Benefit Deductible;
- Accident Medical Benefit percent;
- Accident Medical Maximum Benefit amount; and
- Provisions of this coverage.

The Deductible, Accident Medical Benefit percent and Maximum Benefit for the Accident Medical Benefit are shown in the Certificate Schedule.

Covered charges for this benefit are:

- Hospital room and board and general nursing services;
- Hospital miscellaneous expense for medical services and supplies including emergency services;
- Operating and recovery room fees;
- Physician charges for medical treatment, including performing a surgical procedure;
- Diagnostic tests performed by a Physician, including laboratory fees and X-rays;
- The cost of giving anesthesia;
- A private duty nurse;
- Prescription drugs;
- Rental fees for durable medical equipment (if the purchase price is less than the rental, the maximum amount payable will be the purchase price);
- Artificial limbs, eyes and other prosthetic devices, except replacement;

- Casts, splints, trusses, crutches and braces, except dental braces;
- Oxygen and rental of equipment for the administration of oxygen;
- Physiotherapy given by a licensed physical therapist acting within the scope of his/her license.

If a Covered Person is injured in a Covered Accident, this Accident Medical Benefit will be applied to any remaining expenses not covered by the group policy according to the Schedule of Benefits and Policy Provisions.

The Accident Medical Benefit will be paid after other Benefits available under the policy have been exhausted.]

[CRITICAL ILLNESS BENEFIT

We will pay the Critical Illness Benefit for any Covered Person upon the First Ever Diagnosis by a Physician of one of the following covered conditions or procedure[s] as defined in this Certificate:

- | | |
|---------------------------|--------------------------|
| • Cancer In Situ | • Invasive Cancer |
| • End-Stage Renal Failure | • Major Organ Transplant |
| • Heart Attack | • Stroke |

The First Ever Occurrence and Diagnosis must occur while the Policy is in force. Any diagnosis or procedure not specifically listed is excluded. In no event will benefits be payable for more than one occurrence of the same Critical Illness. The Maximum Benefit Amount payable for any covered condition or procedure will be reduced by 50% when the Covered Person reaches age 65. Written proof of loss should include a statement from the Physician verifying the patient's name, the date of treatment, and the Diagnosis.

If a Diagnosis of Cancer In Situ occurs within 30 days of the effective date of this Certificate, 10% of the maximum benefit listed on the Certificate Schedule will be paid, and the Cancer In Situ benefit will be terminated.

If a Diagnosis of Invasive Cancer occurs within 30 days of the effective date of this Certificate, 10% of the maximum benefit listed on the Certificate Schedule will be paid, and the Invasive Cancer benefit will be terminated.]

[DENTAL BENEFITS

We will pay the Maximum Benefit for the corresponding dental procedure listed on the Certificate Schedule for any Covered Person receiving the dental procedure. Any procedure not listed is excluded. If one or more of the listed procedures would be appropriate according to customary dental practice, the Maximum Benefit will be the amount allowable for the lesser charge.]

[DURABLE MEDICAL EQUIPMENT BENEFIT

We will pay the Durable Medical Equipment Benefit as shown on the Certificate Schedule if, due to treatment for a Covered Accident or Covered Sickness, a Covered Person incurs charges for a device which:

- Is primarily and customarily used for medical purposes and is specially equipped with features and functions that are generally not required in the absence of injury;
- Is used exclusively by a Covered Person;
- Is routinely used in a Hospital but can be used effectively in a non-medical facility;
- Can be expected to make a meaningful contribution to the Covered Person's rehabilitation from the injury;
- Is prescribed by a Physician; and
- Is Medically Necessary for a Covered Person's rehabilitation.

Durable Medical Equipment does NOT include:

- Comfort and convenience items;
- Equipment that can be used by family members other than a Covered Person;
- Health exercise equipment; and
- Equipment that may increase the value of a Covered Person's residence.

Such items that do not qualify as Durable Medical Equipment include but are not limited to: modifications to a Covered Person's residence, property or automobiles, such as ramps, elevators, spas, air conditioners, or vehicle hand controls; or corrective shoes, exercise and sports equipment.

Written proof of loss should include a bill verifying the patient's name and date of purchase, the Physician's Diagnosis and the charges incurred.]

HOSPITAL CONFINEMENT BENEFIT

[A)] Hospital Confinement Benefit

We will pay the Hospital Confinement Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and is Confined in a Hospital for more than 24 hours, due to injuries received in a Covered Accident or due to a Covered Sickness. The Confinement to a Hospital must begin while the coverage is in force.

We will pay the amount shown on the Certificate Schedule for each day the Covered Person is confined, up to the Hospital Confinement Maximum Benefit shown on the Certificate Schedule.

We will not pay this benefit for:

- Emergency room treatment;
- Outpatient treatment;
- Charges billed for outpatient facility use or services;
- Confinement of less than 24 hours in a Hospital;
- Treatment for Mental Disability or Chemical Abuse; or
- Routine, post-natal care of a newborn child.

We will not pay the Hospital Confinement benefit and the Hospital Intensive Care Unit Confinement benefit concurrently.

Written proof of loss should include a Hospital bill verifying the patient's name, the dates of Hospital Confinement, the Diagnosis and the charges incurred.

[B)] [Hospital Intensive Care Unit Confinement Benefit

We will pay the Hospital Intensive Care Unit Confinement Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and is Confined to a Hospital Intensive Care Unit as the result of injuries received in a Covered Accident or due to a Covered Sickness. The Confinement to a Hospital Intensive Care Unit must begin while the coverage is in force.

We will pay the Hospital Intensive Care Unit benefit amount shown on the Certificate Schedule for each day a Covered Person is Confined, up to the Hospital Intensive Care Unit Maximum Benefit shown on the Certificate Schedule.

If a Covered Person is Confined to a Hospital care unit that does not meet the definition of a Hospital Intensive Care Unit, We will pay the Hospital Confinement benefit up to the maximum benefit period shown on the Certificate Schedule. We will not pay the Hospital Intensive Care Unit Confinement benefit and the Hospital Confinement benefit concurrently.

Written proof of loss should include a Hospital bill verifying the patient's name, the dates of Hospital Confinement, the Diagnosis and the charges incurred.]

[C)] [Hospital Admission Benefit

We will pay the Hospital Admission Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges and is admitted to a Hospital as the result of injuries received in a Covered Accident or Covered Sickness while this coverage is in force. If admission is due to a Covered Accident, the Covered Person must be admitted within [six] [months] after the Covered Accident.

If a Covered Person is admitted to a Hospital and is discharged and admitted again for the same or related condition within 90 days, We will treat this later Hospital admission as a continuation of the previous Confinement. If more than 90 days have passed between the periods of Hospital Confinement, We will treat this later admission as a new and separate admission.

We will not pay this benefit for:

- Emergency room treatment;
- Outpatient treatment;

- Charges billed for outpatient facility use or services;
- Confinement of less than 24 hours in a Hospital;
- Treatment for Mental Disability or Chemical Abuse; or
- Routine, post-natal care of a newborn child.

This benefit is subject to the Hospital Admission Benefit Maximum Benefit, shown on the Certificate Schedule.]

[D)] [Emergency Room Visit Benefit

We will pay the Emergency Room Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and requires medical care from a hospital emergency room due to injuries received in a Covered Accident or due to a Covered Sickness. The visit must occur while the coverage is in force.

An *Emergency Room Benefit* is a service that will be covered under your policy providing the following conditions are met:

- The treatment is rendered in a facility on a hospital campus and which is fully owned by a licensed, acute care hospital;
- The treatment is medically necessary;
- Services must be rendered by a Physician; and
- Without treatment within 24 hours, the condition could worsen, causing further disability or death.

The Emergency Room Benefit would not cover services rendered by a free-standing urgent care center or a hospital-owned urgent care center.

We will pay the Emergency Room benefit amount shown on the Certificate Schedule, up to the Emergency Room Benefit Maximum Benefit, shown on the Certificate Schedule.

Written proof of loss should include bills verifying the patient name, the date of treatment, the Diagnosis and the charges incurred.]

[E.][Newborn Child Hospital Care Benefit

We will pay the Newborn Child Hospital Care Benefit shown on the Certificate Schedule, if the Named Insured or the Named Insured's covered Spouse or Domestic Partner incurs charges for his or her newborn child's routine, post-natal care in a Hospital.

The newborn child's routine, post-natal care must occur while coverage for the Named Insured and the covered Spouse or Domestic Partner of the Named Insured is in force.

Pregnancy must be included as a Sickness in this Certificate and the newborn child must be born as a result of a pregnancy that began while pregnancy coverage is in force.

We will pay the amount shown on the Certificate Schedule for each day the newborn child is confined, up to the Newborn Child Hospital Care Benefit maximum amount shown on the Certificate Schedule.

We will not pay this benefit if the pregnancy of the Named Insured or the covered Spouse or Domestic Partner of the Named Insured is a Pre-Existing Condition.

We will NOT pay the Newborn Child Hospital Care Benefit for:

- Doctor's office visit charges
- Outpatient treatment
- Charges billed for outpatient facility use or services
- Treatment for any Injury or Sickness or
- A stay of less than one day in a Hospital.

We will not pay the Newborn Child Hospital Care Benefit and the Hospital Confinement Benefit [or the Hospital Admission Benefit] for a newborn child concurrently. The Hospital Confinement Benefit [and Hospital Admission Benefit] will be payable in lieu of the Newborn Child Hospital Care Benefit due to Covered Sickness resulting in Hospital Confinement.]

[SURGERY BENEFIT

We will pay the Surgery Benefit in accordance with the Surgical Fee Schedule shown on the Certificate Schedule, if any Covered Person undergoes a surgical procedure in a Hospital or Ambulatory Surgical Center, as defined in this Certificate, due to a Covered Accident or Covered Sickness. Procedures that are performed or can otherwise be performed in another setting are not covered expenses under this benefit. We will pay this benefit once per covered surgical procedure. If a Covered Person has more than one surgical procedure performed at the same time, We will pay only one surgical procedure benefit, even if caused by more than one Accident or Sickness. We will pay the benefit that has the highest dollar value. The surgical procedure must occur while the coverage is in force.

If a Covered Person has more than one surgery for the same Covered Accident or Covered Sickness in a 90-day time period, We will pay the benefit that has the highest dollar value. If We have already paid a lower benefit amount for the same Covered Accident or Covered Sickness, We will deduct the amount paid from the higher benefit amount and pay the difference.

Written proof of loss should include the surgeon's itemized statement verifying the patient's name, the surgical procedure code(s), the date of treatment, the Diagnosis and the charges incurred.

This benefit is subject to the Surgery Maximum Benefit shown on the Certificate Schedule, which indicates the maximum amount that will be paid in any certificate year for multiple surgeries.

This benefit specifically excludes payment for the services of an assistant or co-surgeon.

[ANESTHESIA BENEFIT

The Anesthesia Benefit is calculated as a percentage of the surgery benefit, as listed in the Certificate Schedule. Written proof of loss should include the anesthesiologist's or certified registered nurse anesthetist's (CRNA's) itemized statement(s) verifying the patient's name, the surgical procedure code(s), the date of treatment, the Diagnosis, and the charges incurred.]]

[AMBULATORY SURGICAL CENTER

We will pay the Ambulatory Surgical Center Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and requires medical care from an Ambulatory Surgical Center due to an outpatient surgery as a result of injuries received in a Covered Accident or due to a Covered Sickness. The surgery must occur while the coverage is in force.

An *Ambulatory Surgical Center Benefit* is payment for a facility charge that will be covered under Your policy provided the following conditions are met:

- The surgery is rendered in a licensed surgical center;
- The surgery is Medically Necessary;
- Surgical services must be rendered by a properly licensed surgeon; and
- There is no Hospital Admission as a direct result of the surgery.]

[PRE-ADMISSION TEST BENEFIT

We will pay the Pre-Admission Test Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for preadmission tests performed in hospital facilities prior to scheduled surgery. Benefits will be provided for tests ordered by a Pphysician and which are performed in the outpatient facilities of a Hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same Hospital provided that:

- Tests are necessary for and consistent with the Diagnosis and treatment of the condition for which surgery is to be performed;
- Reservations for a hospital bed and for an operating room were made prior to the performance of these tests;
- The surgery actually takes place within seven days of such presurgical tests; and
- The patient is physically present at the hospital for the tests.]

[DOCTOR'S OFFICE VISIT BENEFIT

We will pay the Doctor's Office Visit Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and requires a Doctor's office visit due to injuries received in a Covered Accident or due to a Covered Sickness. The visit must occur:

- While the coverage is in force and
- In either the medical office of the Physician or in an Urgent Care Facility.

Services must be rendered by a licensed Physician acting within the scope of his or her license.

We will pay the Doctor's Office Visit benefit amount per visit shown on the Certificate Schedule, up to the Doctor's Office Visit Benefit Maximum Benefit, shown on the Certificate Schedule.

We will not pay the Doctor's Office Visit Benefit for visits within a Hospital during inpatient stays for a Covered Accident or due to a Covered Illness.

Written proof of loss should include bills verifying the patient name, the date of treatment, the Diagnosis and the charges incurred.]

[PREVENTIVE CARE OFFICE VISIT BENEFIT

We will pay the Preventive Care Office Visit Benefit, shown on the Certificate Schedule, if a Covered Person incurs a physician's office visit charge for an annual preventive care and wellness assessment. This benefit will be payable once per Covered Person, per Certificate Year and must occur while the coverage is in force.

We will pay the Preventive Care Office Visit benefit amount per visit shown on the Certificate Schedule, up to the Preventive Care Office Visit Benefit Maximum Benefit, shown on the Certificate Schedule. We will not pay the Preventive Care Office Visit Benefit for any office visit that is prompted by an Accident or Sickness. We will not pay the Preventive Care Office Visit Benefit concurrently with the Doctor's Office Visit Benefit.

Written proof of loss should include bills verifying the patient name, the date of treatment, the Diagnosis and the charges incurred.]

[DIAGNOSTIC, X-RAY AND LABORATORY TESTS BENEFIT

We will pay the Diagnostic X-Ray and Laboratory Tests Benefit shown on the Certificate Schedule when a Covered Person incurs charges for diagnostic, X-Ray and/or laboratory testing caused by a Covered Accident or Covered Sickness, or incurred during a Preventive Care Office Visit as defined in this Certificate. The amount payable will be in accordance with the benefit listed on the Certificate Schedule for each of the following categories of procedures:

- Tier One - MRI, CAT and PET scans; colonoscopy; bone marrow test; stress test
- Tier Two – Mammography; EEG; X-Ray; breast ultrasound; sigmoidoscopy
 - Includes a baseline mammogram for women
 - Includes an annual screening mammogram for women
 - Includes, upon recommendation of a Physician, a mammogram at any age for Covered Persons with a history of breast cancer or who have a first-degree relative with a history of breast cancer
- Tier Three – Other diagnostic, X-Ray and laboratory tests meeting the criteria above and listed below:
 - Blood test for triglycerides
 - CA 15-3 blood test for breast cancer
 - CA 125 blood test for ovarian cancer
 - CEA blood test for colon cancer
 - Eye exam performed by a licensed optometrist or ophthalmologist
 - Fasting blood glucose test
 - Hemocult stool analysis
 - PSA blood test for prostate cancer
 - Serum protein electrophoresis blood test for myeloma
 - Thermography
 - Annual cervical cytological screening for women
 - Cervical cytological screening for women upon certification by an attending Physician that the test is Medically Necessary.
 - A colorectal screening that is in compliance with American Cancer Society colorectal cancer screening guidelines

- A prostate cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society for the ages, family histories and frequencies referenced in such guidelines
- Child health screening services for a Covered Person from birth to age 26, where such services are consistent with the standards and schedules of the American Academy of Pediatrics.

Benefits are subject to:

- The Diagnostic Test Benefit maximum amount per Certificate Year, per Covered Person; and
- The definitions, limitations, exclusions and other provisions of the Policy.

The Diagnostic Test must be performed:

- While the coverage is in force and
- In a Hospital, Ambulatory Surgical Center or Doctor's Office.

The Diagnostic Test must be ordered by a Physician because of a Covered Accident or Covered Sickness, or during the Preventive Care Office Visit as defined in this Certificate.

This benefit is subject to the Diagnostic Tests, X-ray and Laboratory Benefit Maximum Benefit shown on the Certificate Schedule. Charges for the interpretation of a diagnostic X-ray or laboratory test are not payable.

Benefits for a Colonoscopy Test are limited to one test per Certificate Year per Covered Person.

If a Covered Person has a procedure for which a benefit would be payable under the Surgery with Anesthesia benefit, We will pay only the Surgery with Anesthesia benefit and not the Diagnostic, X-Ray and Laboratory Tests Benefit.

Written proof of loss should include a billing statement from the medical provider conducting the Diagnostic Test, verifying the patient's name, the type of Diagnostic Test performed, the Diagnosis and the charges incurred and the date of treatment.]

[MENTAL HEALTH BENEFITS

Inpatient Benefits

For Inpatient Benefits, We will pay the Mental Health Inpatient Benefit, shown on the Certificate Schedule, for each day of confinement if a Covered Person is confined to a Hospital or licensed institution to provide treatment for Mental Disability.

Benefits are subject to the Mental Health Inpatient Benefit Maximum Benefit shown on the Certificate Schedule.

Outpatient Benefits

For Outpatient Benefits, We will pay the Mental Health Outpatient Benefit, shown on the Certificate Schedule, for Covered Persons receiving treatment as a result of Mental Disability.

Benefits are subject to the Mental Health Outpatient Benefit Maximum shown on the Certificate Schedule.

We will not pay any benefit for stays in a half-way house or other place offering treatment for Mental Disability if it is not a licensed facility.]

[CHEMICAL ABUSE AND DEPENDENCE DIAGNOSIS AND TREATMENT BENEFIT

We will pay the Chemical Abuse and Dependence Diagnosis and Treatment Benefit, shown on the Certificate Schedule for Covered Persons receiving services provided in facilities which are accredited by the Joint Commission on Accreditation of Hospitals as alcoholism, substance abuse or chemical dependence treatment programs, for the treatment of Chemical Abuse and Chemical Dependence. Treatment must occur while the coverage is in force.

Benefits for detoxification services as a consequence of chemical dependence are subject to the Detoxification Maximum Benefit, shown on the Certificate Schedule, of 12 days of active treatment per Certificate Year per Covered Person.

Benefits for rehabilitation services are subject to the Rehabilitation Maximum Benefit, shown on the Certificate Schedule, of 60 days of inpatient care per Certificate Year per Covered Person.

For Outpatient Benefits, We will pay the Chemical Abuse and Dependence Outpatient Benefit, up to the maximum benefit shown on the Certificate Schedule, for Covered Persons receiving outpatient services for Chemical Abuse and Dependence.

The term *chemical abuse* means alcohol and substance abuse.]

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Accidental Death Benefit

We will pay the Accidental Death Benefit, shown on the Certificate Schedule if a Covered Person is injured as the result of a Covered Accident, and the injury causes the Covered Person to die within 90 days of the Covered Accident.

Dismemberment Benefit

We will pay the Dismemberment Benefit amount shown on the Certificate Schedule if a Covered Person is injured as the result of a Covered Accident. Loss must occur within 90 days after the Covered Accident.

Only one amount will be paid for all losses resulting from one Accident. We will pay the largest benefit amount to which the Covered Person is entitled. Payment will be made to the Covered Person, or in the event of his death, to the named beneficiary.

Proof of Loss

We must be given written proof of loss within 90 days after the covered loss occurs. In no event will a claim be accepted or considered for payment if submitted to the Company more than 270 days following the date the service was rendered, except in the absence of legal capacity. Written proof of loss must include a claim form and, if loss is due to the death of a Covered Person, a certified copy of the death certificate is required.

Beneficiary

In the event of a benefit payable due to the Named Insured's death, the Accidental Death benefit will be paid to the Named Insured's beneficiary. The beneficiary is the person the Named Insured designated in the enrollment form as the beneficiary, unless it was changed at a later date. If a beneficiary was not named or if the person named is not living at the Named Insured's death, any Accidental Death benefit due will be paid in this order to:

The Named Insured's Spouse or Domestic Partner; or children; or parents; or brothers and sisters; or estate. In the event of a benefit payable due to the death of a Spouse or Domestic Partner or Dependent Child, the Accidental Death benefit will be paid to the Named Insured, if living, otherwise to the estate of the insured Spouse or Domestic Partner or Dependent child.

If benefits are payable to a Covered Person's estate, We can pay benefits up to \$1,000 to someone related to the Covered Person by blood or marriage who We feel is fairly entitled to them. If We do this, We will have no additional responsibility for this payment because We made it in good faith.

Change of Beneficiary

The Named Insured can ask Us to change his beneficiary at any time. The Named Insured should notify Us, and We will send him the form to complete. The request must be witnessed by someone other than his present beneficiary or his proposed beneficiary and returned to Us at Our home office. The change must be approved by Us. If approved, it will go into effect the day he signed the request. The change will not have a bearing on any payment We make before We receive it.]

[UTILIZATION REVIEW

We review proposed and rendered health services to determine whether the services are or were Medically Necessary or Experimental or Investigative. This process is called Utilization Review (UR). Utilization Review includes all review activities, whether they take place prior to the service being rendered (prospective); when the service is being rendered (concurrent); or after the service is rendered (retrospective).

We have developed Utilization Review policies to assist Us in administering the Utilization Review program. These policies describe the process and procedures of Utilization Review activities. Reviews are conducted by registered nurses and our Medical Directors. All determinations that services are not medically necessary will be made by licensed physicians. Our failure to make a utilization review determination within the applicable time frames set forth below shall be deemed an adverse determination subject to an internal appeal.

Processes are available for review of any of the plan's policies, decisions or actions that affect a Covered Person. These processes are voluntary. There are a Standard Appeal Procedure, an Expedited Appeal Procedure, a First Level Grievance Process and a Second-Level Grievance Process. The Grievance Procedures do not apply to Grievances based solely on the basis that the Policy and Certificate do not provide benefits of health care service in

question, if such exclusion is clearly stated in the contract. The Nebraska Department of Insurance is available to assist insurance consumers with insurance related problems and questions. You may inquire in writing to the Department of Insurance at Terminal Building, 941 O Street, Suite 400, Lincoln, NE 68508-3690 or by telephone at 1-402-471-2201.

The following definitions apply to these procedures:

“Adverse Determination” means a determination by a Us or Our designated URO that an admission, availability of care, continued stay or health care service that is a covered benefit has been reviewed and based upon the information provided, does not meet Our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced or terminated.

“Appeals Procedure” means a formal process whereby a Covered Person, a representative of a Covered Person, attending Physician, facility or health care provider can contest an Adverse Determination rendered by the Us or Our designated URO which results in denial, reduction, or termination of a requested health care service.

“Case Management” means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

“Certification” means a determination by Us or Our designated URO that an admission, availability of care, continued stay or health care service that is a covered benefit has been reviewed and based upon the information provided, satisfies Our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

“Clinical Peer” means a Physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

“Clinical Review Criteria” means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by Us to determine the necessity and appropriateness of health care services.

“Concurrent Review” means Utilization Review during a patient’s hospital stay or course of treatment.

“Grievance” means a written complaint submitted in accordance with Our formal Grievance Procedures by or on behalf of a Covered Person regarding any aspect of the Policy or Certificate relative to the Covered Person, such as: (a) Availability, delivery, or quality of health care services, including a complaint regarding an Adverse Determination made pursuant to Utilization Review; (b) Claims payment, handling, or reimbursement for health care services; or (c) Matters pertaining to the contractual relationship between a Covered Person and Us.

“Health Care Provider” or “Provider” means a health care professional, Physician or other health care practitioner or a facility, licensed, certified or registered to perform health services consistent with state law.

Standard Appeal Procedure

The following review procedures are available to a Covered Person, and to the Provider acting on behalf of a Covered Person, of an Adverse Determination.

- A. Standard Appeals will be evaluated by an appropriate Clinical Peer or Clinical Peers in the same or similar specialty as would typically manage the case being reviewed. The Clinical Peer will not have been involved in the initial Adverse Determination.
- B. For standard reviews, both the Covered Person and the Provider will be notified in writing within fifteen (15) working days following the request for a review.
- C. Written decision will include: (a) The names, titles, and qualifying credentials of person evaluating the appeal; (b) A statement of reviewer’s understanding of the reason for the Covered Person’s request for the appeal; (c) The reviewer’s decision in clear terms and the medical rationale in sufficient detail for the Covered Person to respond further to the Our position; (d) A reference to the evidence or documentation used as the basis for the decision, including the Clinical Review Criteria, and instructions for requesting Clinical Review Criteria used to make the determination; and (e) A description of the process for submitting a Grievance in writing or requesting a further review of the case.
- D. In any case where the standard review process does not resolve a difference of opinion, the Covered Person or Provider may submit a written Grievance, unless the Provider is prohibited from filing a Grievance by federal or other state law. We will review an Adverse Determination as a Second Level Grievance.

Expedited Appeal Procedure:

An expedited review will be made available, when a nonexpedited appeal would seriously jeopardize the life or health of a Covered Person or jeopardize the Covered Person's ability to regain maximum function. A request for an expedited review may be submitted orally or in writing.

- A. An expedited review may be initiated by a Covered Person or a Provider acting on behalf of a Covered Person.
- B. We will provide reasonable access, not to exceed one (1) business day after receiving a request for an expedited review, to a Clinical Peer who can perform the expedited review.
- C. We will provide expedited review to all requests concerning an admission, availability of care, continued stay or health care service for a Covered Person who has received emergency services but has not been discharged from a facility.
- D. Expedited reviews which result in an Adverse Determination will be evaluated by an appropriate Clinical Peer or Clinical Peers in the same or similar specialty as would typically manage the case being reviewed. The Clinical Peer or Clinical Peers will not have been involved in the initial Adverse Determination.
- E. In an expedited review, all necessary information, including Our decision, will be transmitted between Us and the Covered Person or the Provider acting on behalf of the Covered Person by telephone, facsimile or the most expeditious method available.
- F. In an expedited review, we will make a decision and notify the Covered Person or the Provider acting on behalf of the Covered Person as expeditiously as the Covered Person's medical condition requires, but in no event more than seventy-two (72) hours after the review is commenced. If the expedited review is a Concurrent Review determination, the service shall be continued without liability to the Covered Person until the Covered Person has been notified of the determination.
- G. We will provide written confirmation of our decision concerning an expedited review within two (2) working days of providing notification of that decision, if the initial notification was not in writing.
- H. The written decision will contain: (1) The names, titles and qualifying credentials of the person or persons participating in the First Level Grievance review process; (2) A statement of the reviewer's understanding of the Covered Person's Grievance; (3) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the Covered Person to respond further to Our position; (4) A reference to the evidence or documentation used as the basis for the decision; (5) In cases involving an Adverse Determination, the instructions for requesting a written statement of the clinical rationale, including the Clinical Review Criteria used to make the determination. (6) If applicable, a statement indicating: (a) A description of the process to obtain a second-level grievance review of a decision; and (b) the written procedures governing a second-level review, including any required timeframe for review; and (6) Notice of the Covered Person's right to contact the Director's office, the telephone number and address of the Director's office.
- I. In any case where the expedited review process does not resolve a difference of opinion between us and the Covered Person, the Covered Person or the Provider acting on behalf of the Covered Person may submit a written Grievance, unless the Provider is prohibited from filing a Grievance procedure by federal or other state law.
- J. We will not provide an expedited review for retrospective Adverse Determinations.

First Level Grievance Process:

- A. A Grievance involving an Adverse Determination may be submitted by the Covered Person, the Covered Person's representative, or a Provider acting on behalf of a Covered Person, except that a Provider may not submit a grievance involving an adverse determination on behalf of a Covered Person in a situation in which federal or other state law prohibits a Provider from taking that action.
- B. A Grievance concerning any manner except an Adverse Determination may be submitted by Covered Person or a Covered Person's authorized representative.
- C. Within three (3) business days of receipt of the Grievance, we will provide the Covered Person with the name, address and telephone number of the Grievance Coordinator who will coordinate the Grievance review.
- D. A Covered Person does not have the right to attend, or have a representative attend, the First Level Grievance review. A Covered Person is entitled to submit written material. To help us identify and process the Grievance, include a photocopy of our original letter or clearly identify in the Grievance, the Covered Person's Policy Number, the name of the person for who the appeal is being filed, and any other information which may be pertinent to the Grievance.
- E. The person or persons reviewing the Grievance will not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the Grievance. We will ensure that a majority of the persons reviewing a grievance involving an Adverse Determination have the appropriate expertise.

- F. A written decision will be issued to the Covered Person or the Covered Person's representative and Provider (if applicable) within fifteen (15) working days of receipt of the Grievance. If we cannot make a decision within fifteen (15) working days due to circumstances beyond our control, we may take up to an additional fifteen (15) working days to issue a written decision, if we provide written notice to the Covered Person of the extension and the reasons for the delay on or before the fifteenth (15) working day after receiving the Grievance.
- G. The written decision will contain: (1) The names, titles and qualifying credentials of the person or persons participating in the First Level Grievance review process; (2) A statement of the reviewer's understanding of the Covered Person's Grievance; (3) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the Covered Person to respond further to the Our position; (4) A reference to the evidence or documentation used as the basis for the decision; (5) In cases involving an Adverse Determination, the instructions for requesting a written statement of the clinical rationale, including the Clinical Review Criteria used to make the determination. (6) If applicable, a statement indicating: (a) A description of the process to obtain a Second Level Grievance review of a decision; and (b) The written procedures governing a Second Level review, including any required time frame for review; and (7) Notice of the Covered Person's right to contact the Director's office, and the telephone number and address of the Director's office.

Second Level Grievance Process:

- A. A Second Level Grievance procedure is available to Covered Persons dissatisfied with the First Level Grievance review decision or an Adverse Determination.
- B. Upon the request of a Covered Person, we will provide to the Covered Person all relevant information that is not confidential and privileged.
- C. A Covered Person has the right to: (a) Attend the Second Level review; (b) Present his or her case to the review panel; (c) Submit supporting material both before and at the review meeting; (d) Ask questions of any Our representatives; and (e) Be assisted or represented by a person of his or her choice.
- D. With respect to a Second Level review of a Grievance, we will appoint a Second Level Grievance review panel for each Grievance. A majority of the panel will be comprised of persons who were not previously involved in the Grievance. However, a person who was previously involved with the Grievance may be a member of the panel or appear before the panel to present information or answer questions. The panel will have the legal authority to bind us to the panel's decision.
- E. We will ensure that a majority of the persons reviewing a Grievance involving an Adverse Determination are health care professionals who have appropriate expertise.
- F. The review panel will schedule and hold a review meeting within forty-five (45) days of receipt of the Second Level review request. The review meeting will be held during regular business hours at a location reasonably accessible to the Covered Person. In cases in which a Covered Person cannot appear in person, we will offer the Covered Person the opportunity to communicate with the review panel by conference call or other appropriate technology. The Covered Person will receive at least fifteen (15) days notice of the review date. We will not unreasonably deny a request for postponement of the review made by the Covered Person.
- G. The Covered Person's right to a fair review will not be made conditional on the Covered Person's appearance at the review. The review shall include: (a) documentation of the substance of the grievance and (b) full investigation of the substance of the grievance, including all aspects of clinical care involved.
- H. The review panel will issue a written decision to the Covered Person and Provider (if applicable) within five (5) working days after the review meeting.

LIMITATIONS AND EXCLUSIONS

Any services not specified in the Certificate of Coverage are not covered services under this Hospital Indemnity Plan.

We will not pay benefits for treatment, services or supplies which:

- Are not Medically Necessary;
- Are not prescribed by a Physician as necessary to treat Sickness or injury, except for the Preventive Care Benefit;
- Are Experimental/Investigative in nature, except as required by law;
- Are received without charge or legal obligation to pay; or
- Are provided by an immediate family member.

Additional Limitations and Exclusions

Except as specifically provided for in this coverage or any attached Riders, We will not pay benefits for Sickness or injuries that are caused by:

Dental Procedures –Except for the Dental Benefit, We will not pay benefits for Dental care or treatment except for such care or treatment necessitated by accidental injury to sound natural teeth within 12 months of the accident, and except for dental care or treatment necessary due to congenital disease or anomaly.

Elective Procedures and Cosmetic Surgery – We will not pay benefits for cosmetic surgery, except for reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered Dependent Child which has resulted in a functional defect. In the case of a Covered Person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, We will pay the Surgery Benefit, shown on the Certificate Schedule for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and the treatment of physical complications at all stages of mastectomy, including lymphedemas.

The maximum benefit paid for breast reconstruction surgery will be defined in the Certificate Schedule.

Felony or Illegal Occupation We will not pay benefits for Sickness or injuries incurred during the commission or attempted commission of a felony, or to which a contributing cause was the Named Insured's being engaged in an illegal occupation.

[Pregnancy

We will not pay for charges related to Pregnancy and childbirth except for those services required to treat Complications of Pregnancy, as defined in the Definitions section of this Certificate.]

Suicide or Injuries Which Any Covered Person Intentionally Does to Himself- We will not pay benefits for Sickness or injuries resulting from suicide, attempted suicide or intentionally self-inflicted injury.

Surgical Fees/Facility Expenses Related to Surgery

The facility expenses incurred in relation to surgery will be paid through either the Hospital Confinement Benefit or the Ambulatory Surgical Center Benefit. No charges other than the surgeon's service fees will be part of the Surgery with Anesthesia Benefit.

The Certificate specifically excludes payment for the services of a co-surgeon or assistant surgeon.

War or Act of War. We will not pay benefits for Sickness or injuries resulting from war or any act of war (whether declared or undeclared); participation in a riot or insurrection; or service in the Armed Forces or units auxiliary thereto.

Worker's Compensation –We will not pay benefits where such benefits would be provided under any State or Federal workers' compensation, employers' liability or occupational disease law.

[Pre-Existing Condition Limitation

There is no coverage for a pre-existing condition for a continuous period of [6] [12] months following the Certificate Effective Date of coverage under this coverage.

[This limitation applies to the following benefits:]

- [Hospital Confinement Benefit]
- [Hospital Admission Benefit]
- [Hospital Intensive Care Unit Confinement Benefit]
- [Pre-Admission Test Benefit]
- [Surgery Benefit]
- [Ambulatory Care Surgical Center]
- [Anesthesia]
- [Doctor's Office Visit Benefit]
- [Diagnostic X-Ray and Laboratory Tests Benefit]
- [Durable Medical Equipment Benefit]
- [Mental Health Benefit]

- [Chemical Abuse and Dependency Diagnosis and Treatment Benefit]

This limitation does not apply to:

- Genetic information in the absence of a diagnosis of the condition related to such information;
- A newborn child who is enrolled in the plan within 31 days after birth; nor to a child who is adopted or placed for adoption before attaining 26 years of age; and as of the last day of the 31-day period beginning on the date of birth, adoption or placement for adoption, is covered under creditable coverage;
- [Pregnancy]
- [The first (\$250-\$2,500) of paid benefits during a Certificate Year]].

[In determining whether a pre-existing condition limitation applies, We will credit the time the Covered Person was previously covered under creditable coverage, if the previous creditable coverage terminated less than 63-days prior to the effective date of the Covered Person's coverage under the Policy.

Creditable coverage includes (a) a group health plan; (b) Health Insurance Coverage, as defined in this Certificate; (c) Part A or Part B of title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) Chapter 55 of title 10, United States Code; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under chapter 89 of title 5, United States Code; (i) a public health plan, including health coverage provided under a plan established or maintained by a foreign country or political subdivision (as defined in regulations); (j) a health plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)) and coverage under S-CHIP.]

TERMINATION OF INSURANCE

Termination of a Named Insured's Coverage

The coverage on a Named Insured will terminate on the earliest of the following dates:

- The date the Policy terminates
- The last day of the month in which the Named Insured reaches the age of 65 or becomes eligible for Medicare
- Midnight on the last day of the grace period
- 90 days after the date written notice was provided that the Named Insured is no longer in an eligible class
- The date the Named Insured's class is no longer included for insurance
- The date the Named Insured asks Us to end their coverage, or
- The date the Named Insured dies.

If We discontinue this coverage to a particular class, we will provide that class the option to purchase other coverage currently offered in such market without regard to the claims experience of the class or the health-related status of any Covered Person or new Named Insureds who may become eligible for such coverage.

Extension of Benefits

Termination of coverage will not affect any claim that began while the coverage was in force.

If a Covered Person is Confined in a Hospital on the date coverage terminates We will continue to pay any applicable benefits until the earlier of:

- The date the Covered Person is discharged from the Hospital; or
- 90 days after the date the coverage terminates.

When Coverage Ends on the Named Insured's Spouse or Domestic Partner and/or Dependents

If this is Named Insured and Spouse or Domestic Partner coverage or two-parent family coverage, coverage on the Named Insured's Spouse or Domestic Partner will end:

- The last day of the month in which the Named Insured's Spouse or Domestic Partner reaches the age of 65 or becomes eligible for Medicare
- If the premiums are not paid for the Named Insured's Spouse or Domestic Partner when they are due
- On the date the Named Insured asks Us to end their Spouse's or Domestic Partner's coverage
- On the date the Named Insured's coverage terminates
- On the date the Named Insured's Spouse or Domestic Partner dies or;
- On the date the next premium is due after the Named Insured divorces their Spouse or terminates the domestic partnership.

If this is family coverage, coverage on the Named Insured's dependents will end:

- If the premium is not paid for the Named Insured's dependents when it is due
- On the date the Named Insured asks Us to end their Dependent coverage; or
- On the date the Named Insured's coverage terminates.

Coverage will end on each Dependent Child when they no longer qualify as a Dependent as defined in the Certificate. It is the Named Insured's responsibility to notify Us if any Dependent no longer qualifies as an eligible Dependent. If this is family coverage and all of the dependents no longer qualify as eligible dependents and We are not notified, the extent of Our liability will be to refund premium for the time period for which they did not qualify. Coverage will not end on a Dependent Child who reaches the limiting age if that child is incapable of self-sustaining employment by reason of , developmental disability or mental disability as defined in the mental health law or physical handicap and who became so incapable prior to the attainment of the age at which dependent coverage would otherwise terminate and who is dependent upon such Named Insured for support and maintenance. Proof of the disability and/or dependency must be furnished to Us within 31 days of the child's attainment of the limiting age and subsequently, as may be required by Us. However, proof may not be required more often than annually after the first 2 years following the Dependent Child's attainment of the limiting age.

PREMIUMS

The premiums for the coverage must be paid when they are due and the Covered Person must remain in good standing with the Policy Holder.

Our Right to Change Premiums

We have the right to change the premium We charge. If We plan to make a change, We will send You a notice at least 45 days before We make it.

GENERAL PROVISIONS

Entire Contract; Changes

The Policy is a legal contract between the Policy Holder and Us. The Policy is issued in consideration for the application and payments, called premiums.

Whenever We use the word Policy, We mean the entire contract. The entire contract consists of:

- The Policy;
- The Certificate, including the Certificate Schedule;
- The application(s), if any; and
- Attached riders or endorsements.

Riders and endorsements add provisions to or change the terms of the Policy.

Any changes made to the Policy must be attached in writing and signed by one of Our executive officers at Our home office. No agent or anyone else can change the coverage provided by the Policy or waive any of its provisions.

Incontestability

After the Policy has been in force for a period of two years during the lifetime of the Named Insured, excluding any period during which the Named Insured is disabled, it shall become incontestable as to the statements contained in the application. (b) No claim for loss incurred or disability, as defined in the Policy, commencing after two years from the date of issue of the Policy shall be reduced or denied on the ground that disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of the Policy.

Coverage Provided by the Policy

We insure a Covered Person for loss according to the provisions of the Policy.

When making a benefit determination under the Policy, We have discretionary authority to determine the Covered Person's eligibility for the benefits and interpret the terms and provisions of the Policy.

Conformity with State and Federal Law

Any provision of the Policy which, on its effective date, is in conflict with the law of the federal government or the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such law.

HOW TO FILE A CLAIM/CLAIM PROVISIONS**How to File a Claim**

A claim form must be completed within 90 days after the covered loss begins or as soon as it is reasonably possible. The claim form, along with proof of loss, should be sent to Us at Our home office.

If the Named Insured does not have a claim form, he must give Us a written statement describing the loss within 90 days after the covered loss begins or as soon as it is reasonably possible. The statement should include his name and Certificate Schedule Number as shown in the Certificate Schedule. It must also include proof of loss and how the loss occurred. The Named Insured should send the statement to Us at Our home office. When We receive the statement describing the loss, We will send him claim forms within 15 days. If he does not receive claim forms, his written statement along with the proof of loss will be used to process his claim.

Proof of Loss

The Named Insured must give Us a written proof of loss within 90 days after the covered loss begins. If he is not able to give Us written proof of loss within 90 days, it will not have a bearing on this claim if proof is given to Us as soon as it is reasonably possible, except in the absence of legal capacity.

Refer to the applicable benefit section(s) for written proof of loss requirement.

Payment of Claim

Benefits will be paid to the Named Insured or to the designated beneficiary on record. If no named beneficiary is on record with Us all or any part of the benefits owed will be paid to the estate. In lieu of paying benefits to the estate We may, at Our option, pay benefits to any one or more of the following surviving relatives:

- spouse or Domestic Partner;
- parent;
- child or children; and
- brothers or sisters.

If there are no survivors in any of these classes, We may pay benefits for expenses on account to a Hospital or Doctor's office or other person actually supporting him or her and who is deemed by Us to be entitled to payment. Any payments made in good faith will end Our liability to the extent of the payment.

Time of Payment of Claim

We will pay any benefits due immediately after We receive written proof of loss.

Physical Examinations

We can require that any Covered Person be examined by a Physician of Our choice at Our expense as often as it is reasonably necessary while his claim is pending.

Legal Action

We cannot be sued for benefits under the Policy until 60 days after written proof of loss has been given as required by the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

American Medical and Life Insurance Company
8 West 38th Street, Suite 1002
New York, New York

GROUP ACCIDENT AND SICKNESS HOSPITAL INDEMNITY INSURANCE CERTIFICATE SCHEDULE

Named Insured: [John Member]

Certificate Schedule Number: [123]

Group Policy Number: [12345]

Policy Holder: [National Congress of Employers]

Certificate Effective Date: [January 1, 2010]

Certificate Anniversary Date: [January 1, of each year]

Open Enrollment Period: [January 1] through [December 31] during each Certificate Year

1. Description of Eligible Classes

[I. - All employees of [Company] who are actively at work for a minimum of [15-20] hours per week.]

[Actively at work means the named insured is working at the worksite for earnings that are paid regularly, and he is performing the material and substantial duties of his regular occupation. Normal vacation is considered active employment. The worksite must be:

- At the usual place of business;
- An alternative worksite; or
- A location to which the named insured's job requires him to travel.]

[I. – All active members of [Association] in the member class as determined by bylaws or charter of the association.]

II. - Dependents of Named Insured as defined in the Policy.

2. [Eligibility Period: 365 days]

3. [Waiting Period [0] days]

4. Plan Type: [Association]
[Member Contribution 100%]
[Voluntary]

5. Coverage: [Named Insured] [Named Insured and Spouse] [Family]

6. Benefits:

[Accident Medical Expense Benefit	
Accident Medical Benefit Deductible	[[50 - \$500] per Certificate Year per [Covered person][Family]
Accident Medical Benefit	[80%- 100%]
Accident Medical Maximum Benefit	[\$500 - \$10,000]per Certificate Year per Covered Person][Family]]
[Critical Illness Benefit	
Heart Attack	100% of Benefit
Invasive Cancer – diagnosis more than 30 days after effective date	100% of Benefit
Invasive Cancer – diagnosis within the first 30 days after effective date	10% of Benefit
End-Stage Renal Failure	100% of Benefit
Stroke	100% of Benefit
Major Organ Transplant	100% of Benefit
Cancer In Situ – diagnosis more than 30 days after effective date	25% of Benefit
Cancer In Situ – diagnosis within the first 30 days after effective date	2.5% of Benefit
Maximum Benefit	[\$5,000][\$10,000][\$15,000] per Original Diagnosis per [Covered Person][Family]]
[Dental Benefit	
Prophylaxis (Cleaning) CDT Codes D1110 and D1120 Maximum Benefit	[\$10][\$15][\$20][\$25] per Cleaning [One][Two] cleanings per Covered Person per Certificate Year
Fluoride Treatment CDT Codes D1203;1204;1206 Maximum Benefit	[\$10][\$15][\$20][\$25] One treatment per Covered Person per Certificate Year
Radiographs (X-Rays) CDT Codes D0210-D0363 Maximum Benefit	[\$10][\$15][\$20][\$25] Once per Covered Person per Certificate Year
Amalgam Fillings CDT Codes D2140;2150;2160;2161 Maximum Benefit	[\$10][\$15][\$20][\$25] per amalgam filling [One][Two] per Covered Person per Certificate Year
Resin-Based Composite Fillings CDT Codes D2330-D2332; D2335; D2390-D2394 Maximum Benefit	[\$10][\$15][\$20][\$25] per composite filling [One][Two] per Covered Person per Certificate Year
[Durable Medical Equipment Benefit	
Maximum Benefit	[\$75 - \$250] per device [One - Five] devices per Certificate Year per [Covered Person][Family]]
[Hospital Confinement/Medical Facility Benefit	
Hospital Confinement Benefit	[\$50 – \$3,000] per day of confinement
Maximum Benefit	[5 -100] days per Certificate Year per [Covered

	Person][Family]
[Hospital Intensive Care Unit Confinement Benefit	[\$50 – \$3,000] per day of confinement
Maximum Benefit Period	Up to [5 -100] days per Certificate Year per [Covered Person][Family]]
[Hospital Admission Benefit	[\$50- \$3,000] per admission
Maximum Benefit	[One- Five] admissions per Certificate Year per [Covered Person][Family]]
[Emergency Room Benefit	[\$50 - \$1,000] per visit
Maximum Benefit	[1- 5] Visits per Certificate Year per [Covered Person][Family]]
[Newborn Child Hospital Care Benefit	
Newborn Child Hospital Care Benefit	[\$100 - \$2,500] per day of hospital care
Maximum Benefit	[1 – 4] days of hospital care per Certificate Year, per newborn child]
[Surgery Benefit	
Maximum Benefit per Surgery	[50% - 150%][2010] RBRVS
Maximum Benefit	[\$100-[Unlimited] per Certificate Year per [Covered Person][Family]]
[Anesthesia Benefit	
	[25 %] of surgical benefit]
[Ambulatory Surgical Center Benefit	
Ambulatory Surgical Center Benefit	[\$250] per admission
Maximum Benefit	[Two] admissions per Certificate Year per [Covered Person][Family]]
[Pre-Admission Test Benefit	
Maximum Benefit	[\$50 - \$500] per Surgical Admission [1 – 5] Surgical Admissions per Certificate Year per [Covered Person][Family]]
[Doctor’s Office Visit Benefit	
Doctor’s Office Benefit	[\$5 to \$200 in increments of \$5] per visit
Maximum Benefit	[1 – 7] visits per Certificate Year per [Covered Person][Family]]
[Preventive Care Office Visit	
Preventive Care Office Benefit	[\$25 - \$250] per Visit
Maximum Benefit	[1 – 3] Visits per Certificate Year per [Covered Person][Family]]
[Diagnostic Tests, X-Ray and Laboratory Benefit	
[Tier One Diagnostic Test Benefit: MRI; CAT; PET; Colonoscopy; Bone Marrow Test; Stress Test]	[\$25 - \$1,500] per test
[Maximum Benefit]	[1-2] tests per Certificate Year per [Covered Person][Family]]
[Tier Two Diagnostic Test Benefit: Mammography; EEG; X-Ray; Breast Ultrasound; Sigmoidoscopy]	[\$25 - \$500] per test
[Maximum Benefit]	[1-3] tests per Certificate Year per [Covered

	Person][Family]
[Tier Three Diagnostic Test Benefit: Blood test for triglycerides; CA 15-3; CA 125; CEA; eye exam; fasting blood glucose test; hemocult stool analysis; PSA; serum protein electrophoresis; thermography; cervical cytological screening; colorectal cancer screening; prostate cancer screening; child health screening]	[\$5 - \$100] per test
[Maximum Benefit]	[1-20] tests per Certificate Year per [Covered Person][Family]]
[Mental Health Benefit	
Mental Health Inpatient Benefit	[\$50 – \$3,000]per day
Mental Health Inpatient Maximum Benefit	[5 -100] days per Certificate Year per [Covered Person][Family]
Mental Health Outpatient Benefit	[\$5 - \$200 in increments of \$5] per visit
Mental Health Outpatient Maximum Benefit	[1 – 20] visits per Certificate Year per [Covered Person][Family]]
[Chemical Abuse and Dependence Diagnosis and Treatment Benefit	
Chemical Abuse and Dependence Diagnosis and Treatment Benefit	[\$50 – \$3,000] per day
Detoxification Maximum Benefit	[5 -100] days per Certificate Year per [Covered Person][Family]
Inpatient Rehabilitation Maximum Benefit	[5 -100] days per Certificate Year per [Covered Person][Family]
Chemical Abuse and Dependence Outpatient Benefit	[\$5 to \$200 in increments of \$5] per visit
Chemical Abuse and Dependence Outpatient Benefit Maximum Benefit	[1 – 7] visits per Certificate Year per [Covered Person][Family]]
[Accidental Death and Dismemberment Benefit	
Accidental Death Benefit	[\$1,000 – \$50,000] Primary Insured; 50% Spouse; 25% Dependent
Dismemberment Benefit	[\$1,000 – \$50,000] Primary Insured; 50% Spouse; 25% Dependent Loss of both hands or both feet - 100% Loss of sight of both eyes - 100% Loss of one hand and one foot - 75% Loss of one hand and sight of one eye - 50% Loss of one foot and sight of one eye - 50% Loss of one hand - 25% Loss of sight of one eye - 25%]

American Medical and Life Insurance Company
New York, New York

ARKANSAS AMENDATORY ENDORSEMENT

This amendatory endorsement is made a part of the Policy or Certificate to which it is attached and is subject to all terms and provisions of such Policy or Certificate not inconsistent herewith. This amendatory endorsement is applicable only to Covered Persons who are residents of Arkansas on the Certificate Date.

A. Under **ELIGIBILITY AND EFFECTIVE DATE, Who is Covered By This Certificate**, the following changes are hereby made:

1. Coverage for the Named Insured's newborn children, is deleted and replaced with the following:

Coverage for the Named Insured's newborn children:

A child born to a Named Insured or a Named Insured's Spouse will automatically become insured as a Dependent. The child must be born to the Named Insured or to his or her Spouse while the Policy is in force. We will cover each newborn child from the moment of live birth, for up to 90 days. Such coverage includes:

- the necessary care and treatment of medically diagnosed congenital defects;
- birth abnormalities;
- prematurity'

For each newborn child, the Named Insured must:

- notify Us within 90 days of birth or when the Named Insured is named a party in a suit in which he or she is adopting the child; and
- pay the required premium for the newborn child, if any.

For each step child and/or adopted child, the Named Insured must:

- notify Us within 60 days of birth or when the Named Insured is named a party in a suit in which he or she is adopting the child; and
- pay the required premium for the child, if any.

If a newborn is not enrolled within 90 days of birth, coverage will be provided from the date that notice is given. Any additional premium required must be made to Us within 31 days of notification of birth or placement for the purposes of a step child and/ or adoption.

If a step child or adopted child is not enrolled within 60 days of birth, coverage will be provided from the date that notice is given. Any additional premium required must be made to Us within 31 days of notification of birth or placement for the purposes of a step child and/ or adoption.

Coverage Continuation for Handicapped Children

A child's attainment of age 25 does not terminate coverage while the child is:

- (1) incapable of self-sustaining employment because of mental retardation or physical disability; and
- (2) chiefly dependent on the Named Insured for support and maintenance.

To continue coverage for a handicapped child the Named Insured must provide proof of the child's incapacity and dependency:

- (1) after the date the child attains the limiting age; and
- (2) no more frequently than annually after the second anniversary of the date the child reaching age 25.

B. Under **DESCRIPTION OF BENEFITS**, the following is hereby added:

[1. Under **[HOSPITAL CONFINEMENT BENEFITS, Hospital Confinement Benefit, Hospital Intensive Care Unit Confinement Benefit, Surgery With Anesthesia Benefit, and HOSPITAL ADMISSION BENEFIT,]** the following is added:

Coverage for Anesthesia and Hospitalization for Dental Procedures

This benefit includes anesthesia and hospital services performed in connection with dental procedures in a hospital if: (1) the physician treating the Covered Person certifies that because of the Covered Person's age

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

C. [Under **LIMITATIONS AND EXCLUSIONS, Additional Limitations and Exclusions**, the following changes are hereby made:

1. [Under Dental Procedures, the following is added: except as provided in the Policy or this Amendatory Endorsement.]
2. [Under Pre-Existing Condition Limitation, the 2nd bullet in the 2nd paragraph pertaining to a newborn child and an adopted child is deleted and replaced with the following:
 - a newborn child who is enrolled in the plan within 90 days after birth; nor to a child who is adopted or placed for adoption before attaining 18 years of age; and as of the last day of a 90-day period beginning on the date of birth, or 60-day period beginning on the date of adoption or placement for adoption, is covered under creditable coverage;]

D. [Under **HOW TO FILE A CLAIM/CLAIM PROVISIONS, Time of Payment of Claim** is deleted and replaced with the following:

Time of Payment of Claim

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

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

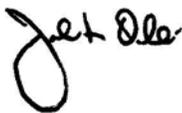
If We fail to pay, settle or deny a clean claim or take other required actions within 30 or 45 calendar days (excluding the time waiting for additional information), We will pay interest at the rate of 12% annually on the amount ultimately allowed on the claim, accruing from the date payment was due.

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

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

This endorsement takes effect and expires concurrently with the policy or certificate to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

In Witness Whereof, We have caused this Endorsement to be signed by



Chairman, President and CEO



Executive Vice President & Chief Compliance Officer

SERFF Tracking Number: ICCI-127126793 State: Arkansas
 Filing Company: American Medical and Life Insurance Company State Tracking Number: 49464
 Company Tracking Number: AMLI GRP LM 2 0 POL NE (AAA)
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: AMLI GRP LM 2 0 POL NE (AAA)
 Project Name/Number: AMLI GRP LM 2 0 POL NE (AAA)/AMLI GRP LM 2 0 POL NE (AAA)

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	08/08/2011
Comments:		
Attachment: Cert of Comp. with Rule 19 AMLI GRP NE 8-3-11.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	08/08/2011
Comments: The Group Application is attached for information purposes only. This application will only be provided to the group situated in Nebraska.		
Attachment: AMLI GRP LM 2 0 APP 7-26-11 clean copy.pdf		

	Item Status:	Status Date:
Satisfied - Item: Authorization Letter 2011	Approved-Closed	08/08/2011
Comments:		
Attachment: auth letter _2011_.pdf		

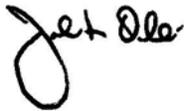
**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: American Medical and Life Insurance Company

Form Number(s):

Group Limited Benefit Accident and Sickness Insurance Policy – AMLI GRP LM 2.0 POL NE
Certificate of Insurance – AMLI GRP LM 2.0 CERT NE
Schedule – AMLI GRP LM 2.0 SCHED
Amendatory Endorsement – GRP LM 2011 AE AR
Group Application – AMLI GRP LM 2.0 APP

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



Signature of Company Officer

John Ollis
Name

CEO and President
Title

August 3, 2011
Date

American Medical and Life Insurance Company
8 West 38th Street, Suite 1002, New York, New York

POLICYHOLDER APPLICATION
FOR GROUP ACCIDENT AND SICKNESS HOSPITAL INDEMNITY INSURANCE

1. Name of [Employer/Association] _____ Group #: _____

2. Address (Street) _____

City: _____ State: _____ Zip Code: _____

3. Phone Number: _____ 4. Plan Administrator: _____

5. Nature of [Business/Association]: _____ 6. Effective Date of Coverage: _____

7. Initial Enrollment: Start Date _____ Stop Date: _____

8. Subsequent Annual Enrollment Period, Subject to the Agreement of the Policyholder and American Medical and Life Insurance Company

Start Date _____ Stop Date: _____

9. [Waiting Period: ___ Days

If this is different by employee/member class or for the initial and future enrollments, please indicate: _____]

10. Eligibility Period: _____

11. Eligible Class

[Employer Group

All active employees working a minimum of _____ regularly scheduled hours per week, per year.

(A minimum of [15 hours] per week is required.)

Are there any special eligibility or employee class requirements or restrictions? If so, please describe.

The participation requirement is the greater of [50] enrolled lives or [50%] If premium is non-contributory must have 100% eligible employee participation. If contributory not less than 50% of eligible employees or less than 50 eligible employees.

Number of eligible employees: _____ (Must be greater than 50). Number Enrolled: _____

Is there any employer contribution? Yes No If yes, what percentage? _____ %

Named Insured Only: 100% 75% 50% _____ (other)

Named Insured and Spouse: 100% 75% 50% _____ (other)

Family: 100% 75% 50% _____ (other)

Plan Applied For:

Employee Class: _____]

[Association Group

All active members of [ABC Association] as determined by bylaws or charter of the Association]

Number of eligible members: _____

Is there any association contribution? Yes No If yes, what percentage? _____ %

Named Insured Only: 100% 75% 50% _____ (other)

Named Insured and Spouse: 100% 75% 50% _____ (other)

Family: 100% 75% 50% _____ (other)

Plan Applied For:

Member Class: _____]

12. Policy Benefits Selected: (See Rate Manual for Options)

[Accident Medical Expense Benefit	
Accident Medical Benefit Deductible	[\$50-500 per Certificate Year per [Covered Person] [Family]
Accident Medical Benefit	[80%-100]
Accident Medical Maximum Benefit	[\$500-10,000] per Certificate Year per [Covered Person][Family]]
[Critical Illness Benefit	
Heart Attack	100% of Benefit
Invasive Cancer– diagnosis more than 30 days after effective date	100% of Benefit
Invasive Cancer – diagnosis within the first 30 days after effective date	10% of Benefit
End-Stage Renal Failure	100% of Benefit
Stroke	100% of Benefit
Major Organ Transplant	100% of Benefit
Cancer In Situ– diagnosis more than 30 days after effective date	25% of Benefit
Cancer In Situ – diagnosis within the first 30 days after effective date	2.5% of Benefit
Maximum Benefit	[\$5,000][\$10,000][\$15,000] per Original Diagnosis per [Covered Person][Family]]
[Dental Benefit	
Prophylaxis (Cleaning) CDT Codes D1110 and D1120 Maximum Benefit	[\$10][\$15][\$20][\$25] per Cleaning [One][Two] cleanings per Covered Person per Certificate Year
Fluoride Treatment CDT Codes D1203;1204;1206 Maximum Benefit	[\$10][\$15][\$20][\$25] One treatment per Covered Person per Certificate Year
Radiographs (X-Rays) CDT Codes D0210-D0363 Maximum Benefit	[\$10][\$15][\$20][\$25] Once per Covered Person per Certificate Year
Amalgam Fillings CDT Codes D2140;2150;2160;2161 Maximum Benefit	[\$10][\$15][\$20][\$25] per amalgam filling [One][Two] per Covered Person per Certificate Year
Resin-Based Composite Fillings CDT Codes D2330-D2332; D2335; D2390- D2394 Maximum Benefit	[\$10][\$15][\$20][\$25] per composite filling [One][Two] per Covered Person per Certificate Year]
[Durable Medical Equipment Benefit	
Maximum Benefit	[\$75-250] per device [one-five] devices per Certificate Year per [Covered Person][Family]]

[Hospital Confinement/Medical Facility Benefit]	
Hospital Confinement Benefit	[\$50 – \$3,000] per day of confinement
Maximum Benefit	[5-100] days per Certificate Year per [Covered Person][Family]
[Hospital Intensive Care Unit Confinement Benefit]	
Maximum Benefit Period	Up to [5-100] days per Certificate Year per [Covered Person][Family]
[Hospital Admission Benefit]	
Maximum Benefit	[\$50-3,000] per admission [One-Five] admissions per Certificate Year per [Covered Person][Family]
[Emergency Room Benefit]	
Maximum Benefit	[\$50-1,000] per visit [1-5] Visits per Certificate Year per [Covered Person][Family]
[Newborn Child Hospital Care Benefit]	
Newborn Child Hospital Care Benefit	[\$100 - \$2,500] per day of hospital care
Maximum Benefit	[1 – 4] days of hospital care per Certificate Year, per newborn child
[Surgery Benefit]	
Maximum Benefit per Surgery	[50%-150%][2010] RBRVS
Maximum Benefit	[\$100-[Unlimited] per Certificate Year per [Covered Person][Family]
[Anesthesia Benefit]	
	[25 %] of surgical benefit]]
[Ambulatory Surgical Center Benefit]	
Ambulatory Surgical Center Benefit	[\$250] per admission
Maximum Benefit	[Two] admissions per Certificate Year per [Covered Person][Family]
[Pre-Admission Test Benefit]	
Maximum Benefit	[\$50-500] per Surgical Admission [1-5] Surgical Admission per Certificate Year per [Covered Person][Family]
[Doctor's Office Visit Benefit]	
Doctor's Office Benefit	[\$5 to \$200 in increments of \$5] per visit
Maximum Benefit	[1-7]visits per Certificate Year per [Covered Person][Family]
[Preventive Care Office Visit]	
Annual Preventive Care Office Benefit	[\$25-250] per Visit
Maximum Benefit	[1-3] visits per Certificate Year per [Covered Person][Family]
[Diagnostic Tests, X-Ray and Laboratory Benefit]	
[Tier One Diagnostic Test Benefit: MRI; CAT; PET; Colonoscopy; Bone Marrow Test; Stress Test]	[\$25-1,500] per test
[Maximum Benefit]	[1-2] tests per Certificate Year per [Covered Person][Family]
[Tier Two Diagnostic Test Benefit: Mammography; EEG; X-Ray; Breast Ultrasound; Sigmoidoscopy]	[\$25-500] per test
[Maximum Benefit]	[1-3] tests per Certificate Year per [Covered Person][Family]
[Tier Three Diagnostic Test Benefit: Blood test for triglycerides; CA 15-3; CA 125; CEA; eye exam; fasting blood glucose test; hemoccult stool analysis; PSA; serum protein	[\$5-100] per test

electrophoresis; thermography; cervical cytological screening; colorectal cancer screening; prostate cancer screening; child health screening]	
[Maximum Benefit]	[1-20] tests per Certificate Year per [Covered Person][Family]]
<u>Mental Health Benefit</u>	
Mental Health Inpatient Benefit	[\$50-3,000] per day
Mental Health Inpatient Maximum Benefit	[5-100] days per Certificate Year per [Covered Person][Family]
Mental Health Outpatient Benefit	[\$5-200 in increments of \$5] per visit
Mental Health Outpatient Maximum Benefit	[1-20] visits per Certificate Year per [Covered Person][Family]]
<u>Chemical Abuse and Dependence Diagnosis and Treatment Benefit</u>	
Chemical Abuse and Dependence Diagnosis and Treatment Benefit	[\$50-3,000] per day
Detoxification Maximum Benefit	[5-100] days per Certificate Year per [Covered Person][Family]
Inpatient Rehabilitation Maximum Benefit	[5-100] days per Certificate Year per [Covered Person][Family]
Chemical Abuse and Dependence Outpatient Benefit	[\$5 to \$200 in increments of \$5] per visit
Chemical Abuse and Dependence Outpatient Benefit Maximum Benefit	[1-7] visits per Certificate Year per [Covered Person][Family]]
<u>Accidental Death and Dismemberment Benefit</u>	
Accidental Death Benefit	[\$1,000-50,000] Primary Insured; 50% Spouse; 25% Dependent
Dismemberment Benefit	[\$1,000-50,000] Primary Insured; 50% Spouse; 25% Dependent Loss of both hands or both feet - 100% Loss of sight of both eyes - 100% Loss of one hand and one foot - 75% Loss of one hand and sight of one eye - 50% Loss of one foot and sight of one eye - 50% Loss of one hand - 25% Loss of sight of one eye - 25%

16. Is this a replacement of similar coverage: Yes No

17. Previous Company: _____

Termination Date of Prior Plan: _____

It is understood and agreed that this application shall be attached as a part of the Policy applied for, and that no Insurance shall be effective until approved by American Medical and Insurance Company at its home office.

I understand that Accident and Sickness Medical Plan covered persons are covered by group insurance benefits. The group insurance benefits vary depending on plan selected. These benefits are provided under a group insurance policy underwritten by American Medical and Life Insurance Company and subject to the exclusions, limitations, terms and conditions of coverage as set forth in the insurance certificate which includes, but is not limited to, limitations for pre-existing conditions. This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is an accident and sickness medical plan that provides for limitations to the coverage for each benefit. The limitations are disclosed in the policy and certificate which are made available at the time of enrollment.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an

insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Dated at: _____
(City, State)

By: _____
(Authorized Signature/Title)

On: _____
Date (mm/dd/yyyy)

By: _____
(Printed Agent/Broker Name)

(Signature of Agent/Broker)

To be Completed by Home Office

On _____ By _____ Plan Effective Date _____
Date (mm/dd/yyyy) Home Office



8 WEST 38TH STREET – SUITE 1002
NEW YORK, NY 10018

MICHAEL F. MURPHY

EXECUTIVE VICE PRESIDENT & CHIEF MARKETING OFFICER

301.299.7802

CELL 301.943.2222

FAX 301.299.3410

mmurphy@usamli.com

www.usamli.com

January 1, 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 American Medical and Life Insurance Company regarding such filings, in all jurisdictions where this form(s) or a state specific variation of it is being filed. American Medical may withdraw this authorization at any time, by giving notice to Insurance Compliance Consultants.

Sincerely,