

SERFF Tracking Number: CMPL-127847478 State: Arkansas  
Filing Company: American Medical and Life Insurance Company State Tracking Number: 50339  
Company Tracking Number: AMLI DE OTS LM2 NCE  
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity  
Product Name: AMLI DE OTS LM2 NCE  
Project Name/Number: AMLI DE OTS LM2 NCE/AMLI DE OTS LM2 NCE

## Filing at a Glance

Company: American Medical and Life Insurance Company

Product Name: AMLI DE OTS LM2 NCE SERFF Tr Num: CMPL-127847478 State: Arkansas

TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed-Approved State Tr Num: 50339

Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: AMLI DE OTS LM2 NCE State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Donna Lambert

Author: Nancy French

Disposition Date: 01/04/2012

Date Submitted: 11/28/2011

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 02/06/2012

State Filing Description:

## General Information

Project Name: AMLI DE OTS LM2 NCE

Status of Filing in Domicile:

Project Number: AMLI DE OTS LM2 NCE

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Group Market Type: Association

Overall Rate Impact:

Filing Status Changed: 01/04/2012

State Status Changed: 01/04/2012

Deemer Date:

Created By: Nancy French

Submitted By: Nancy French

Corresponding Filing Tracking Number:

Filing Description:

Re: American Medical and Life Insurance Company

NAIC #81418 FEIN #13-2562243

Filing of Group Accident and Sickness Benefit Forms:

AMLI GRP LM 2.0 CERT DE AR, et al (See enclosed forms list)

Dear Commissioner:

Compliance Research Services is pleased to submit the enclosed forms on behalf of American Medical and Life Insurance Company (AMLI). A letter of filing authorization is enclosed.

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The purpose of this submission is to allow AMLI to provide group accident and sickness coverage to residents of your state who are members of the National Congress of Employers, an association based in Delaware. Coverage will be provided to individual association members and their dependents. It will not be issued to employers who may be affiliated with the association.

The policy provides coverage for accidents, hospital confinement, hospital intensive care unit confinement, surgery, hospital admission, doctor office visit, preventive care, urgent care/emergency room, diagnostic tests, mental health, chemical dependency, critical illness, accidental death and dismemberment and dental.

Riders are available for ambulance services, skilled nursing facility services and term life insurance.

Variable areas of the certificate are set off in brackets. These include "John Doe" information, the ranges of benefits that will be offered, and benefit options. We have included a Statement of Variables. The certificate includes mandated benefits required under your laws.

The enclosed forms are new and do not replace any forms currently on file with your Department. We have included the association bylaws and any transmittals and certifications required by your Department.

The forms are in final format. Initially, the forms will be issued in paper format. AMLI reserves the right to change the type style and paper size. We also request the right to make the forms available electronically, with enrollment available via the Internet or by telephone. AMLI hereby certifies that information requested in connection with telephone enrollment will include only items included on the enclosed enrollment form.

Regardless of the enrollment process used, AMLI will adopt measures to secure both the integrity of the document once signed, and the confidentiality of any information transmitted, including transmission of information via secured socket layer/secured line. Enrollment information may be transmitted to AMLI's administrative office electronically as well as the electronic signature of the enrollee. Current technology will be used to ensure that the confidential information is not compromised. All processes used will comply with the Uniform Electronic Transactions Act, and to the extent applicable, the Federal E-SIGN Act.

The enrollment information will be collected and linked to the individual in such a manner that the electronic signature is invalidated if any of the data on the application is changed. Electronic signatures intended for use with this enrollment form will not be affixed to or duplicated on any other document.

If you have questions concerning this filing, please contact me at 513-984-6050 or at dsimon@crssolutionsgroup.com.

Sincerely,

SERFF Tracking Number: CMPL-127847478 State: Arkansas  
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J. David Simon  
President

American Medical and Life Insurance Company  
NAIC #81418 FEIN #13-2562243

Form No.	Description
AMLI GRP LM 2.0 CERT DE AR	Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage
AMLI GRP LM 2.0 SCHED (6/11) AR	Group Accident and Sickness Hospital Indemnity Insurance Certificate Schedule
AMLI GRP LM 2.0 ASR	Ambulance Services Rider
AMLI GRP LM 2.0 SNF	Skilled Nursing Facility Benefit Rider
AMLI GRP LM 2.0 TLIR	Term Life Insurance Rider
AMLI GRP LM 2.0 ENRL	Group Accident and Sickness Hospital Indemnity Insurance Enrollment Form

## Company and Contact

### Filing Contact Information

Nancy French, Product Manager                      nfrench@crssolutionsgroup.com  
10921 Reed Hartman Highway                      513-984-6050 [Phone]  
Suite 334                                                      513-984-7212 [FAX]  
Cincinnati, OH 45242

### Filing Company Information

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

American Medical and Life Insurance Company CoCode: 81418	State of Domicile: New York	
8 West 38th Street - Suite 1002	Group Code:	Company Type:
New York, NY 10018	Group Name:	State ID Number:
(513) 984-6050 ext. [Phone]	FEIN Number: 13-2562243	

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$300.00  
Retaliatory? No  
Fee Explanation: 6 forms x 50 = 300.00  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Medical and Life Insurance Company	\$300.00	11/28/2011	54068388

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	01/04/2012	01/04/2012

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	12/15/2011	12/15/2011	Nancy French	01/03/2012	01/03/2012
Pending Industry Response	Donna Lambert	12/05/2011	12/05/2011	Nancy French	12/15/2011	12/15/2011

SERFF Tracking Number: CMPL-127847478 State: Arkansas  
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Project Name/Number: AMLI DE OTS LM2 NCE/AMLI DE OTS LM2 NCE

## Disposition

Disposition Date: 01/04/2012

Implementation Date: 02/06/2012

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Filing Authorization	Approved	Yes
Supporting Document	Statement of Variables	Approved	Yes
Supporting Document	Statement of Variables for Riders	Approved	Yes
Supporting Document	NCE Constitution_and_By-Laws-signed	Approved	Yes
Supporting Document	DE Cert - Incorp	Approved	Yes
Form (revised)	Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage	Approved	Yes
Form	Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage	Replaced	Yes
Form	Group Accident and Sickness Hospital Indemnity Insurance Certificate Schedule	Approved	Yes
Form	Ambulance Services Rider	Approved	Yes
Form	Skilled Nursing Facility Benefit Rider	Approved	Yes
Form	Term Life Insurance Rider	Approved	Yes
Form	Group Accident and Sickness Hospital Indemnity Insurance Enrollment Form	Approved	Yes
Form	Notice	Approved	Yes

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## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/15/2011
Submitted Date	12/15/2011
Respond By Date	01/16/2012

Dear Nancy French,

Dear Nancy - I did not find the Articles of Incorporation attached to this submission. An association's Articles of Incorporation are required by 23-86-106(2)(A)(i). Please attach the Articles so I can approve this filing. Thank you.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 01/03/2012  
Submitted Date 01/03/2012

Dear Donna Lambert,

### Comments:

Thanks for your note of 12-15-2011

### Response 1

Comments: The articles of incorporation are attached as requested.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: DE Cert - Incorporation

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thanks for your continued review of this filing.

Sincerely,

Nancy French

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 12/05/2011  
Submitted Date 12/05/2011  
Respond By Date 01/05/2012

Dear Nancy French,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage, AMLI GRP LM 2.0 CERT DE AR (Form)

Comment: ACA 23-86-108(4) applies to contracts that contain provisions whereby coverage of a dependent in a family group terminates at a specific age. Coverage of an unmarried dependent who is incapable of sustaining employment by reason of mental retardation or physical disability must continue. Please revise the dependent children definition.

### Objection 2

- Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage, AMLI GRP LM 2.0 CERT DE AR (Form)

Comment: Please add the information required by 23-79-138. See Bulletin 15-2009.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

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## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 12/15/2011  
 Submitted Date 12/15/2011

Dear Donna Lambert,

### Comments:

Thank you for your review of the above referenced filing. This letter is intended to address the comments you have raised in connection with the American Medical filing.

### Response 1

Comments: 1. You requested information regarding compliance with the continuation for dependents requirement contained in Section 23-86-108(4). Please refer to the last paragraph in the "When Coverage Ends on the Named Insured's Spouse or Domestic Partner and/or Dependents" provision in the "Termination of Insurance" section which contains the required continuation language.

### Related Objection 1

Applies To:

- Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage, AMLI GRP LM 2.0 CERT DE AR (Form)

Comment:

ACA 23-86-108(4) applies to contracts that contain provisions whereby coverage of a dependent in a family group terminates at a specific age. Coverage of an unmarried dependent who is incapable of sustaining employment by reason of mental retardation or physical disability must continue. Please revise the dependent children definition.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Accident and Sickness Hospital	AMLI GRP LM 2.0		Certificate	Initial		41.000	AR AMLI DE LM 2 0

SERFF Tracking Number: CMPL-127847478 State: Arkansas  
 Filing Company: American Medical and Life Insurance Company State Tracking Number: 50339  
 Company Tracking Number: AMLI DE OTS LM2 NCE  
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity  
 Product Name: AMLI DE OTS LM2 NCE  
 Project Name/Number: AMLI DE OTS LM2 NCE/AMLI DE OTS LM2 NCE  
 Indemnity Insurance CERT DE CERT 12-  
 Certificate of Coverage AR 9-11 Def  
 Doc-.pdf

**Previous Version**

Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage AR	AMLI GRP LM 2.0 CERT DE	Certificate	Initial	41.000	AR AMLI DE LM 2 0 CERT 11-16-11-.pdf
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No Rate/Rule Schedule items changed.

**Response 2**

Comments: 2. Please be advised that form AMLI GRP LM 2.0 NOTICE AR provides the information required by Section 23-79-138.

3. Please be advised that the definition of "Doctor or Physician" has been revised by making the requirement that the Doctor be practicing medicine in the United States a variable. The bracketed phrase will be either included or not, as elected by the Policyholder.

**Related Objection 1**

Applies To:

- Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage, AMLI GRP LM 2.0 CERT DE AR (Form)

Comment:

Please add the information required by 23-79-138. See Bulletin 15-2009.

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Accident and Sickness Hospital	AMLI GRP LM 2.0		Certificate	Initial		41.000	AR AMLI DE LM 2 0

SERFF Tracking Number: CMPL-127847478 State: Arkansas  
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 Product Name: AMLI DE OTS LM2 NCE  
 Project Name/Number: AMLI DE OTS LM2 NCE/AMLI DE OTS LM2 NCE  
 Indemnity Insurance CERT DE CERT 12-  
 Certificate of Coverage AR 9-11 Def  
 Doc-.pdf

**Previous Version**

Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage AR	AMLI GRP LM 2.0 CERT DE AR	Certificate	Initial	41.000	AR AMLI DE LM 2 0 CERT 11- 16-11-.pdf
Notice	AMLI GRP LM 2.0 NOTICE AR	Notice of Coverage	Initial		AR Notice 12-12- 11.pdf

No Rate/Rule Schedule items changed.

Thank you for your continued review of this filing.

Sincerely,  
Nancy French

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## Form Schedule

### Lead Form Number: AMLI GRP LM 2.0 CERT DE AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 12/15/2011	AMLI GRP LM 2.0 CERT DE AR	Certificate	Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage	Initial		41.000	AR AMLI DE LM 2 0 CERT 12-9-11 Def Doc-.pdf
Approved 12/15/2011	AMLI GRP LM 2.0 SCHED (6/11) AR	Schedule Pages	Group Accident and Sickness Hospital Indemnity Insurance Certificate Schedule	Initial		43.000	AR AMLI DE LM 2 0 SCHED 11-16-11-.pdf
Approved 12/15/2011	AMLI GRP LM 2.0 ASR	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Ambulance Services Rider	Initial		48.000	AMLI GRP LM 2 0 ASR _Ambulance Services Rider_ 10-5-11-.pdf
Approved 12/15/2011	AMLI GRP LM 2.0 SNF	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Skilled Nursing Facility Benefit Rider	Initial		51.000	AMLI GRP LM 2 0 SNF _Skilled Nursing Facility Benefit Rider_ 10-5-11-.pdf
Approved 12/15/2011	AMLI GRP LM 2.0 TLIR	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Term Life Insurance Rider	Initial		54.000	AMLI GRP LM 2 0 TLIR _Term Life Insurance Rider_ 10-5-11-.pdf
Approved 12/15/2011	AMLI GRP LM 2.0 ENRL	Application/ Enrollment Form	Group Accident and Sickness Hospital Indemnity Insurance	Initial		53.000	AMLI GRP LM 2 0 ENRL-.pdf

SERFF Tracking Number: CMPL-127847478 State: Arkansas  
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Enrollment Form

Approved AMLI GRP Notice of Notice Initial  
12/15/2011 LM 2.0 Coverage  
NOTICE  
AR

AR Notice 12-  
12-11.pdf

**LIMITED GROUP ACCIDENT AND SICKNESS HOSPITAL INDEMNITY INSURANCE**

**THIS COVERAGE PROVIDES BENEFITS DUE TO ACCIDENT AND SICKNESS. THIS CERTIFICATE EXPLAINS THE BENEFITS PROVIDED UNDER THE LIMITED 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 Limited 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.

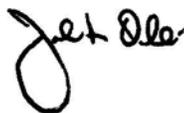
The Policy and this Certificate may be changed in whole or in part or cancelled as stated in the Policy. Such action may be taken without the consent of or notice to any Covered Person. Only an authorized officer at Our home office can approve a change. The approval must be in writing and endorsed on 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:

AMLI GRP LM 2.0 SCHED (6/11) AR

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.]

**[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.

**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 date on which You assume a legal obligation for total or partial support of the child.

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

Coverage will continue for the adopted child unless the placement is disrupted prior to the final adoption; and:

- The child is permanently removed from placement;
- The legal obligation terminates; or
- You rescind, in writing, the agreement of adoption or agreement assuming financial responsibility.

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

- Notify Us of his birth or placement in Your residence;
- Complete the required application for 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 should be made to the Holder within 90 days of notification of birth.

If an adopted child is not enrolled within 90 days of adoption, coverage will be provided from the date that notice is given. Any additional premium required should be made to the Holder within 90 days of notification of placement for the purposes of adoption.

If a step child is not enrolled within 90 days of placement in Your residence, coverage will be provided from the date that notice is given. Any additional premium required should be made to the Holder within 90 days of notification of placement.

#### **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
- End-Stage Renal Failure
- Heart Attack
- Invasive Cancer
- Major Organ Transplant
- 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.

We will not pay for any Hospital Confinement of a newborn child of a Covered Person following birth unless the child is injured or sick.

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.

We will not pay for any Hospital Confinement of a newborn child of a Covered Person following birth unless the child is injured or sick.

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.]

### **[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 Physician 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.

### **Prospective Reviews**

All requests for prior authorization of care are reviewed for medical necessity (including the appropriateness for the proposed level of care and/or provider). The initial review is performed by a nurse. If a nurse determines that the proposed care is medically necessary, the nurse will authorize the care. If the nurse determines that the proposed care is not medically necessary or that further evaluation is needed, the nurse will refer the case to a licensed physician.

If we have all the information necessary to make a determination regarding a prospective review, we will make a determination and provide notice to the Covered Person (or their designee) and the Covered Person's provider, by telephone and in writing, within three business days of receipt of the request. If we need additional information, we will request it within three business days. The covered person or their provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to the Covered Person (or their designee) and the Covered Person's provider, by telephone and in writing, within three business days of the earlier of our receipt of the information or the end of the 45-day time period.

With respect to urgent prospective claims, if we have all the information necessary to make a determination, we will make a determination and provide notice to the Covered Person (or their designee) and the Covered Person's provider, by telephone and in writing, within 72 hours of receipt of the request. If we need additional information, we will request it within 24 hours. The Covered Person or their provider will then have 48 hours to submit the information. We will make a determination and provide notice to the Covered Person and their provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

### **Concurrent Reviews**

When the Covered Person is receiving services that are subject to concurrent review, a nurse will periodically assess the medical necessity and appropriateness of care received throughout the course of treatment. Once a case is assigned for concurrent review, a nurse will determine whether the services are medically necessary. If so, the nurse will authorize the care. If the nurse determines that medical necessity is lacking or that further evaluation is needed, the nurse will refer the case to a licensed physician.

Utilization review decisions for services during the course of care (concurrent reviews) will be made and notice provided to the Covered Person's provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision but no later than 15 calendar days of receipt of the request.

For concurrent reviews that invoke urgent matters, we will make a determination and provide notice to the Covered Person and their provider within 24 hours of receipt of the request.

If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date of onset of services and the date of the next scheduled concurrent review of the case.

### **Retrospective Reviews**

At our option, a nurse will review retrospectively the medical necessity of claims that are subject to utilization review. If the nurse determines that care received was medically necessary, the nurse will authorize the benefits. If the nurse determines that medical necessity was lacking, the nurse will refer the case to a licensed physician.

If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to the Covered Person and their provider within 30 calendar days of receipt of the claim. If we need additional information, we will request it within 30 calendar days. The Covered Person or their provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to the Covered Person and their provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period.

### **Notice of Adverse Determination**

A notice of adverse determination (notice that a service is not medically necessary) will include the reasons, including clinical rationale, for our determination. The notice will also advise the Covered Person of their right to appeal our determination, give instructions for requesting an external appeal and for initiating an external appeal and specify that the Covered Person may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for use to review an appeal. We will send notices of determination to the Covered Person or their designee and the Covered Person's health care provider.

If, prior to making an adverse determination, no attempt was made to consult with the provider who recommended the service at issue, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For prospective and concurrent reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to the provider, by telephone and in writing.

### **Internal Appeals of Adverse Determinations**

The Covered Person, their designee and, in retrospective review cases, the Covered Person's health care provider, may request an internal appeal of an adverse determination, either by phone, in person or in writing. The Covered Person has up to 180 calendar days after he or she receives notice of the adverse determination to file an appeal. We will acknowledge the Covered Person's request for an internal appeal within fifteen calendar days of receipt. This acknowledgment will include the name, address and telephone number of the person handling the Covered Person's appeal and, if necessary, inform the Covered Person of any additional information needed before a decision can be made. A clinical peer reviewer who is in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

We will decide internal appeals related to prospective reviews within 30 calendar days of receipt of the appeal request. Written notice of determination will be provided to the Covered Person or their designee (and the Covered Person's health care provider if he or she requested the review) within two business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

We will decide internal appeals related to retrospective reviews within 60 calendar days of the receipt of the appeal request. Written notice of the determination will be provided to the Covered Person or their designee (and the Covered Person's health care provider if he or she requested the review) within two business days after the determination is made, but no later than 60 calendar days after receipt of the appeal request.

Reviews of continued or extended health care services, additional services rendered in the course of continued treatment, services in which a provider requests an immediate review or any other urgent matter will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews.

For expedited appeals, the Covered Person's provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. The Covered Person's provider and clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours of the appeal request.

If the Covered Person is not satisfied with resolution of his or her expedited appeal, he or she may file a standard internal appeal or an external appeal. Our failure to render a determination of the Covered Person's appeal within 60 calendar days shall be deemed a reversal of the initial adverse determination.

### **Notice of Determination of Internal Appeal**

The notice of determination of the Covered Person's internal appeal will indicate that it is a "final adverse determination" and will include the clinical rationale for our decision. It will also explain the Covered Person's rights to an external appeal, together with a description of the external appeal process and the time frames for initiating an external appeal. We will send notices of determination to the Covered Person or their designee and to the Covered Person's health care provider.]

### **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. Losses as a result of acts of terrorism committed by individuals or groups will not be excluded from coverage unless the Covered Person who suffered the loss committed the act of terrorism.

**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, for which premium was paid, if premium is not paid by the end 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 mental illness, developmental disability, mental retardation as defined in the mental hygiene 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. Upon Our request and at Our expense, the Named Insured must submit proof of incapacity or dependency to Us for a Dependent whose coverage would otherwise terminate if not incapacitated or dependent.

## **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**

Any statement made by the Policy Holder or a Named Insured is considered a representation and not a warranty. A copy of the statement will be provided to the Policy Holder or the Named Insured, whoever made the statement. In the event of the death or incapacity of the Named Insured, a copy of the statement will be provided to the Named Insured's beneficiary or personal representative. No statement will be used to contest the Policy, the validity of coverage or reduce benefits unless it is in writing, signed by the Policy Holder or Named Insured.

### **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 Statutes**

If any provision of the Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

### **Misstatement of Age and Sex**

If the age or sex of a person covered under this Certificate has been misstated, We will make an equitable adjustment of the premium. Such premium will be the difference between the premiums paid and the premiums which would have been paid at Your true age or sex, whichever applies. If coverage would not have been issued, We will refund the premiums paid for such insurance.

## **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, up to an amount not exceeding \$5,000, 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 not more than 30 days after We receive written proof of loss electronically or 45 days if the claim is submitted by other means.

### **Physical Examinations and Autopsy**

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. We have the right and opportunity to make an autopsy in the case of death where it is not prohibited by law.

### **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 or the expiration of 3 years from the time We receive written proof of loss.

**American Medical and Life Insurance Company**  
**8 West 38<sup>th</sup> Street, Suite 1002**  
**New York, New York**

**LIMITED 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 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:

<b>[Accident Medical Expense Benefit</b>	
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]]
<b>[Critical Illness Benefit</b>	
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]]
<b>[Dental Benefit</b>	
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
<b>[Durable Medical Equipment Benefit</b>	
Maximum Benefit	[\$75 - \$250] per device [One - Five] devices per Certificate Year per [Covered Person][Family]]

<b>Hospital Confinement/Medical Facility Benefit</b>	
Hospital Confinement Benefit	[\$50 – \$3,000] per day of confinement
Maximum Benefit	[5 -100] days per Certificate Year per [Covered Person][Family]
<b>[Hospital Intensive Care Unit Confinement Benefit</b>	
[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]
<b>[Hospital Admission Benefit</b>	
[Hospital Admission Benefit	[\$50- \$3,000] per admission
Maximum Benefit	[One- Five] admissions per Certificate Year per [Covered Person][Family]
<b>[Emergency Room Benefit</b>	
[Emergency Room Benefit	[\$50 - \$1,000] per visit
Maximum Benefit	[1- 5] Visits per Certificate Year per [Covered Person][Family]
<b>[Newborn Child Hospital Care Benefit</b>	
Newborn Child Hospital Care Benefit	[\$100 - \$2,500] per day of hospital care
Maximum Benefit	[0 – 3] days of hospital care per Certificate Year, per Covered Newborn Child
<b>[Surgery Benefit</b>	
Maximum Benefit per Surgery	[50% - 150%][2010] RBRVS
Maximum Benefit	[\$100-[Unlimited] per Certificate Year per [Covered Person][Family]
<b>[Anesthesia Benefit</b>	
	[25 %] of surgical benefit]
<b>[Ambulatory Surgical Center Benefit</b>	
Ambulatory Surgical Center Benefit	[\$250] per admission
Maximum Benefit	[Two] admissions per Certificate Year per [Covered Person][Family]
<b>[Pre-Admission Test Benefit</b>	
Maximum Benefit	[\$50 - \$500] per Surgical Admission
	[1 – 5] Surgical Admissions per Certificate Year per [Covered Person][Family]
<b>[Doctor’s Office Visit Benefit</b>	
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]
<b>[Preventive Care Office Visit</b>	
Preventive Care Office Benefit	[\$25 - \$250] per Visit
Maximum Benefit	[1 – 3] Visits per Certificate Year per [Covered Person][Family]
<b>[Diagnostic Tests, X-Ray and Laboratory Benefit</b>	
[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 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]
<b>[Mental Health Benefit]</b>	
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]
<b>[Chemical Abuse and Dependence Diagnosis and Treatment Benefit]</b>	
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]
<b>[Accidental Death and Dismemberment Benefit]</b>	
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**

**[OPTIONAL] Ambulance Services Rider**

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for this Rider and payment of any applicable premium.]

The Benefits provided by this Rider will not duplicate the Benefits provided under the Certificate and any other Rider.

The following Benefit is hereby added:

**Ambulance Services Benefit:**

We will pay the Ambulance Services Benefit, as shown below, up to the maximum number of conveyances as shown below, if a licensed professional ambulance company transports any Covered Person by ground or air transportation to or from a Hospital or between medical facilities, where treatment is received as the result of a Covered Sickness or Covered Accident. The Covered Person must incur charges while the coverage is in force for professional ambulance service to receive this benefit. The ambulance transportation must be within 90 days after a Covered Sickness or Covered Accident. We will pay this amount once per Covered Sickness or Covered Accident.

Ambulance Services Benefit	[\$100 - \$1,000] per Covered Sickness/Accident per Covered Person
Maximum Number of Conveyances	[3-6] per Certificate Year per Covered Person

There are no other changes to the Certificate.

**TERMINATION**

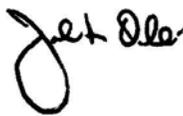
Coverage under this Rider will end on [the earliest of:]

1. the date [a Covered Person's] coverage under the Policy ends[; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate this Rider].

This Rider is endorsed and made a part of the Policy/Certificate as of [its Effective Date] [September 1, 2011] [or] [Your Coverage Effective Date] [whichever is later].

This Rider is subject to all provisions of the Policy which are not in conflict with the terms of this Rider. Nothing in this Rider will be held to vary, alter, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by:



Chairman, President and CEO



Vice President & Chief Compliance Officer

**American Medical and Life Insurance Company  
New York, New York**

**[OPTIONAL] Skilled Nursing Facility Benefit Rider**

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for this Rider and payment of any applicable premium.]

The Benefits provided by this Rider will not duplicate the Benefits provided under the Certificate and any other Rider.

The following Benefit is hereby added:

**Skilled Nursing Facility Benefit:**

We will pay the Skilled Nursing Facility Benefit, as shown below, up to the maximum number of days as shown below, if any Covered Person incurs charges for and is Confined in a Skilled Nursing Facility, after a Hospital Confinement of three days or more, due to injuries received in a Covered Accident or due to a Covered Sickness. Payment of this benefit will be in lieu of any Hospital Confinement benefit.

Skilled Nursing Facility Benefit	[\$100 - \$1,000] per day of confinement
Maximum Benefit	Up to [60-90] days per Calendar Year per Covered Person

We will not pay this benefit for:

- Emergency room treatment;
- Outpatient treatment; or
- Confinement to an Observation Unit.

There are no other changes to the Certificate.

**TERMINATION**

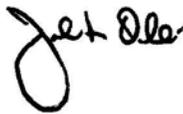
Coverage under this Rider will end on [the earliest of:]

1. the date [a Covered Person's] coverage under the Policy ends; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate this Rider].

This Rider is endorsed and made a part of the Policy/Certificate as of [its Effective Date] [September 1, 2011] [or] [Your Coverage Effective Date] [whichever is later].

This Rider is subject to all provisions of the Policy which are not in conflict with the terms of this Rider. Nothing in this Rider will be held to vary, alter, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by:



Chairman, President and CEO



Vice President & Chief Compliance Officer

**American Medical and Life Insurance Company  
New York, New York**

**[OPTIONAL] Term Life Insurance Rider**

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for this Rider and payment of any applicable premium.]

The Benefits provided by this Rider will not duplicate the Benefits provided under the Certificate and any other Rider.

The following Benefit is hereby added:

**Term Life Insurance Benefit:**

Upon receipt of proof of death of the Named Insured, We will pay to the Beneficiary the Term Life Insurance Benefit, shown below, for the Named Insured who dies while Coverage is in force under this Rider.

[\$5,000 - \$10,000]

[When We receive proof of a Dependent's death while the Dependent was covered by this Rider, We will pay to the Named Insured the Dependent's Term Life Insurance benefit shown below.]

[Covered Spouse [Domestic Partner] Life Insurance Amount	[\$2,000 - \$4,000]
Covered Dependent Children :	Age 14 days, but less than 6 months [\$100] Age 6 months, but less than 26 years of age [\$1,000 - \$2,000]]

In the event of a benefit payable due to the Named Insured's death, the Term Life 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 Term Life 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 Term Life 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.

**Suicide Limitation**

Death by suicide, while sane or insane (while sane in Missouri) is not covered if it occurs within 12 months from [the Named Insured's] [the Covered Person's] effective date. In such event, We will only refund premiums paid. At Our own expense, We have the right and opportunity to request an autopsy in case of death, where it is not prohibited by law, to determine whether the [Name Insured's] [Covered Person's] death was by or due to suicide.

**Conversion Privilege**

If a Named Insured's insurance, or a portion of it, terminates because the Named Insured is no longer in an eligible class, the Named Insured is entitled to have issued to him or her, without Evidence of Insurability, an individual policy of life insurance without disability or other supplementary benefits. Application for the individual policy and the first premium must be received by Us within 31 days from the insurance termination date.

The individual policy will be on any one of the forms then customarily issued by Us or Our designee at the age and for the amount applied for, except for term insurance. The converted amount cannot exceed the terminated amount, less the amount of any life insurance for which the Named Insured becomes eligible under the same or any other group policy within 31 days from the termination date. The premium will be at Our then customary rate for the policy form and benefit amount, to the class of risk to which the Name Insured then belongs, and to the Named Insured's attained age on the policy effective date.

If the Policy terminates or is amended to terminate a class, any Named Insured who was insured by the Policy for at least five years before the termination date will be entitled to the same conversion privilege described above. However, the converted amount cannot exceed the lesser of: (1) the terminated amount less the amount of any life insurance for which the Named Insured is or becomes eligible under a group policy issued by Us or another insurer within 31 days; or (2) \$10,000.

We will give notice to the Named Insured of the right to convert within 15 days prior to the date the insurance terminates. If the notice is not given within that time, the Named Insured has 15 days from the date of the notice to convert. But in no event can the Named Insured convert after 60 days have ended from the last day of the 31 day conversion period. Written notice may be delivered or mailed to the Insured by Us to the last known address of the Named Insured.

#### **Death During Conversion Period**

If the Named Insured dies during the 31 days allowed to convert insurance and before the conversion policy is issued, We will pay the amount of benefit the Named Insured could have converted minus the premium due for the conversion.

There are no other changes to the Certificate.

#### **TERMINATION**

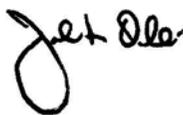
Coverage under this Rider will end on [the earliest of:]

1. the date [a Covered Person's] coverage under the Policy ends; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made a part of the Policy/Certificate as of [its Effective Date] [September 1, 2011] [or] [Your Coverage Effective Date] [whichever is later].

This Rider is subject to all provisions of the Policy which are not in conflict with the terms of this Rider. Nothing in this Rider will be held to vary, alter, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by:



Chairman, President and CEO



Vice President & Chief Compliance Officer

**American Medical and Life Insurance Company**  
**8 West 38<sup>th</sup> Street, Suite 1002, New York, New York**

**GROUP ACCIDENT AND SICKNESS HOSPITAL INDEMNITY INSURANCE**  
**ENROLLMENT FORM**

**GENERAL INFORMATION**

Applicant's Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ [SSN: \_\_\_\_\_]

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Member Class: \_\_\_\_\_ Join Date: \_\_\_\_\_

Member ID: \_\_\_\_\_ Section/Dept. #: \_\_\_\_\_

Plan: \_\_\_\_\_ [Units]: \_\_\_\_\_ [Rider:] \_\_\_\_\_ Monthly Premium: \$ \_\_\_\_\_

Plan: \_\_\_\_\_ [Units]: \_\_\_\_\_ [Rider:] \_\_\_\_\_ Monthly Premium: \$ \_\_\_\_\_

**AD[&D] COVERAGE ELECTIONS\***

Applicant: \$ \_\_\_\_\_  
 AD[&D]  Yes  No

Spouse: \$ \_\_\_\_\_  
 AD[&D]  Yes  No

Child(ren): \$ \_\_\_\_\_  
 AD[&D]  Yes  No

[Are you or any person to be covered Medicare eligible:

Yes  No

Have you received the Guide to Health Insurance for People with Medicare?

Yes  No ]

**[SPOUSE AND DEPENDENT INFORMATION**

Spouse/Dependent Name	Relationship to Applicant	Date of Birth	SSN

[\*If you DO NOT ENROLL for AD&D coverage for you or your dependent(s) during the initial enrollment period, you will need to complete an evidence of insurability form, if required, for all amounts of coverage.]

**[BENEFICIARY INFORMATION**

Beneficiary Name	Relationship to Applicant	Age	SSN	Benefit %	Primary	Contingent
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

**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.

**FRAUD WARNING NOTICE**

**For residents of all States except those listed below:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

**DC Residents: 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.**

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

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

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

**New Mexico Residents:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

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

**Oregon Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of fraud as determined by a court of law.

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

**Texas Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application/enrollment form containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and confinement in prison.

[  I have read and understand the Fraud Warning Notice. ]

Signed at: City \_\_\_\_\_ State \_\_\_\_\_

\_\_\_\_\_  
Date Signature of Applicant

If you have questions concerning this policy, you can contact:

**AMERICAN MEDICAL AND LIFE INSURANCE COMPANY**

8 West 38th Street, Suite 1002  
New York, New York 10018  
[1-888-264-1512]

Should we at American Medical and Life Insurance Company fail to provide adequate service, you should feel free to contact:

**ARKANSAS DEPARTMENT OF INSURANCE**

Consumer Services Division  
1200 West Third Street  
Little Rock, Arkansas 72201-1904  
(501) 371-2640 or (800) 852-5494

SERFF Tracking Number: CMPL-127847478 State: Arkansas  
 Filing Company: American Medical and Life Insurance Company State Tracking Number: 50339  
 Company Tracking Number: AMLI DE OTS LM2 NCE  
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity  
 Product Name: AMLI DE OTS LM2 NCE  
 Project Name/Number: AMLI DE OTS LM2 NCE/AMLI DE OTS LM2 NCE

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved	12/15/2011
<b>Comments:</b>		
<b>Attachment:</b> READABILITY CERTIFICATION to DOI wcert enroll.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved	12/15/2011
<b>Comments:</b> acknowledged		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Filing Authorization	Approved	12/15/2011
<b>Comments:</b>		
<b>Attachment:</b> AMLI Authorization 2011 -10.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variables	Approved	12/15/2011
<b>Comments:</b>		
<b>Attachment:</b> DE AMLI LM 2 SOV 10-3-11.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variables for Riders	Approved	12/15/2011
<b>Comments:</b>		
<b>Attachment:</b>		

SERFF Tracking Number: CMPL-127847478 State: Arkansas  
Filing Company: American Medical and Life Insurance Company State Tracking Number: 50339  
Company Tracking Number: AMLI DE OTS LM2 NCE  
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity  
Product Name: AMLI DE OTS LM2 NCE  
Project Name/Number: AMLI DE OTS LM2 NCE/AMLI DE OTS LM2 NCE  
AMLI LM2 Rider SOV 10-5-11.pdf

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	NCE Constitution_and_By-Laws- signed	Approved	12/15/2011

**Comments:**

**Attachment:**

NCE Constitution\_and\_By-Laws-signed.pdf

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	DE Cert - Incorpor	Approved	01/04/2012

**Comments:**

**Attachment:**

Delaware cert of incorporation.pdf

## READABILITY CERTIFICATION

RE: American Medical and Life Insurance Company

NAIC # 81418

FEIN # 13-2562243

This is to certify that form(s) listed below have achieved at least the minimum required score on the Flesch Reading Ease Test.

<u>Forms</u>		<u>Score</u>
AMLI GRP LM 2.0 CERT DE AR	Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage	41
AMLI GRP LM 2.0 SCHED (6/11) AR	Group Accident and Sickness Hospital Indemnity Insurance Certificate Schedule	43
AMLI GRP LM 2.0 ASR	Ambulance Services Rider	48
AMLI GRP LM 2.0 SNF	Skilled Nursing Facility Benefit Rider	51
AMLI GRP LM 2.0 TLIR	Term Life Insurance Rider	54
AMLI GRP LM 2.0 ENRL	Group Accident and Sickness Hospital Indemnity Insurance Enrollment Form	53



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Signature of Company Officer

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Kay Phillips

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Name

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Vice President and Chief Compliance Officer

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Title

---

11-28-2011

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Date



8 West 38<sup>th</sup> Street, Suite 1002  
New York, NY 10018

Kay Doughty Phillips  
V.P. & Chief Compliance Officer  
646.223.9300 EXT. 831  
TOLL FREE 866.691.9353  
FAX 212.354.9089  
kphillips@usamli.com  
www.usamli.com

October 21, 2011

NAIC Company Code: 81418  
FEIN: 13-2562243

To: All Departments of Insurance

Re: Policies and Related Forms

American Medical and Life Insurance Company hereby authorizes Compliance Research Services, LLC to represent us in the submission of the above-referenced forms and to negotiate with insurance departments for their approval.

Sincerely,

Kay Phillips  
Vice President and Chief Compliance Officer

**Statement of Variables**  
**AMLI GRP LM 2.0 POL DE, et al**  
**Group Accident and Sickness Hospital Indemnity Insurance Policy**

Coverage levels are chosen by the policyholder. Benefit amounts will change according to the level selected by the policyholder and/or the named insured. All numerical variable range levels will comply with the minimum statutory requirements and are provided herein.

**AMLI GRP LM 2.0 POL DE**

1. On the Policy face page, the Policyholder, Policy Number, Policy Date, & Anniversary Date will be unique to each Policyholder.
2. The Phone number is variable to accommodate any new call center number.
3. When and Where to Pay Premiums – The terms “Policy” and “Certificate Schedule” will either be included or omitted from the policy, but one or the other will always appear.

**AMLI GRP LM 2.0 CERT DE and AMLI GRP LM 2.0 SCHED**

1. On the Certificate face page, the Group Insurance Policy Number, the Holder and the Policy Date will be unique to each Policyholder.
2. The Phone number is variable to accommodate any new call center number.
3. The Pre-existing Condition disclosure language will either be included or omitted at the option of the policyholder.
4. The Table of Contents page numbers will vary dependent upon the number of benefits included in policy.
5. The definition of Pre-Existing Condition will either be included or omitted from the policy at the option of the policyholder. The number of months will range from 0-12.
6. The Accident Medical Benefit may be included or omitted at the option of the policyholder. The benefit amounts will also be at the option of the policyholder within the following ranges:
  - Deductible - \$50 - \$500
  - Accident medical benefit payable – 80% - 100%
  - Maximum benefit - \$500 - \$10,000.
7. The Critical Illness Benefit may be included or omitted at the option of the policyholder. The maximum benefit amount will also be at the option of the policyholder, at \$5,000, \$10,000 or \$15,000.

8. Exclusions for Accidental Injuries Benefits will be deleted when Accidental Injuries Benefits are not in the policyholder's chosen plan.
9. Dental Benefits may be included or omitted at the option of the policyholder. The benefit amounts will also be at the option of the policyholder within the following ranges:
  - Prophylaxis (Cleaning) range of \$10 - \$25 per cleaning, 1 or 2 per year
  - Fluoride Treatment range of \$10 - \$25 per year
  - Radiographs (X-Rays) range of \$10 - \$25 per year
  - Amalgam Fillings range of \$10 - \$25 per year, 1 or 2 per year
  - Resin-Based Composite Fillings range of \$10 - \$25 per year, 1 or 2 per year
10. The Durable Medical Equipment Benefit may be included or omitted at the option of the policyholder. The benefit amounts will also be at the option of the policyholder within the following ranges:
  - Range of payment is \$75-\$250 per device
  - Maximum benefit from one to five devices per year.
11. The Hospital Confinement Benefit will available within the following ranges:
  - Range for dollar amount per day - \$50 - \$3,000
  - Maximum benefit per Policy Year – 5 -100 days
12. The Hospital Intensive Care Unit Confinement Benefit may be included or omitted at the option of the policyholder. The benefit amounts will also be at the option of the policyholder within the following ranges:
  - Range for dollar amount per day - \$50 - \$3,000
  - Maximum benefit per Policy Year – 5 -100 days
13. The Hospital Admission Benefit may be included or omitted at the option of the policyholder. The benefit amounts will also be at the option of the policyholder within the following range:
  - \$50 – \$3,000 per admission
  - Maximum benefit of one to five admissions per year.
14. The Emergency Room Visit Benefit may be included or omitted at the option of the policyholder. The benefit amounts will also be at the option of the policyholder within the following range:
  - \$50 - \$1,000 per visit
  - Maximum benefit of 1-5 visits per policy year.
15. The Surgery Benefit may be included or omitted at the option of the policyholder. The benefit amounts will be at the option of the policyholder within the following ranges:
  - Maximum Benefit amount per surgery - 50% - 150% of 2010 RBRVS
  - Maximum Benefit – \$100 – No Annual Limit
16. The Anesthesia Benefit may be included or omitted at the option of the policyholder. The benefit amounts will be at the option of the policyholder, within the range of 10%-25% of the surgery benefit.
17. Ambulatory Surgical Center Benefit may be included or omitted at the option of the policyholder. The benefit amounts will be at the option of the policyholder with in the following ranges:
  - \$50 – \$1,000 per admission
  - Maximum benefit of one to two admissions per year.

18. The Pre-Admission Test Benefit may be included or omitted at the option of the policyholder. The benefit amount will also be at the option of the policyholder within the following range:
  - \$50-\$500 per surgical admission
  - Maximum benefit of one to five surgical admissions per year.
19. Doctor's Office Visit Benefits may be included or omitted at the option of the policyholder. The benefit amounts will also be at the option of the policyholder within the following ranges:
  - \$5 - \$200 per visit
  - Maximum benefit 1-7 visits per year.
20. The Preventive Care Office Visit may be included or omitted at the option of the policyholder. The benefit amounts will also be at the option of the policyholder within the following range:
  - \$25 - \$250 per visit
  - Maximum benefit of one to three visits per year.
21. Diagnostic Tests, X-ray and Laboratory Benefit be included or omitted at the option of the policyholder. The benefit amounts will also be at the option of the policyholder within the following range:
  - Tier 1: \$25 - \$1,500 per test, with a maximum benefit range of 1-2 tests per year.
  - Tier 2: \$25 - \$500 per test, with a maximum benefit range of 1-3 tests per year.
  - Tier 3: \$5 - \$100 per test, with a maximum benefit range of 1-20 tests per year.
22. Mental Health Benefit be included or omitted at the option of the policyholder. The benefit amounts will also be at the option of the policyholder within the following range:
  - Inpatient Benefit - \$50 - \$3,000 per day, maximum benefit range of 5 – 100 days/year.
  - Outpatient Benefit - \$5 - \$200 per visit, maximum benefit range of 1 – 20 visits/year.
23. Chemical Abuse and Dependence Diagnosis and Treatment Benefit. The benefit amounts will also be at the option of the policyholder within following range:
  - Inpatient Benefit range of \$50 - \$3,000 per day
  - Detoxification Maximum Benefit range 5-100 days per year
  - Inpatient Rehabilitation Maximum Benefit range 5-100 days per year
  - Outpatient Benefit Range of \$5 - \$200 per visit
  - Outpatient Maximum Benefit Range 1 – 7 visits per year.
24. Accidental Death with or without the Dismemberment Benefit be included or omitted at the option of the policyholder. The benefit amounts will also be at the option of the policyholder within the following range:
  - Accidental Death benefit range \$1,000 - \$50,000 with 100% coverage for primary insured, 50% coverage for spouse, 25% coverage for dependents.
  - Dismemberment benefit range of \$1,000 - \$50,000, same conditions as above.
25. The Pre-existing Condition Limitation will either be omitted or included, at the option of the policyholder. The number of months will range from 0-12.

Bracketed text contained in enrollment form and application will reflect language appropriate for an association / employer group. Options indicated on the enrollment form will be determined by the options the group chooses.

## Statement of Variables

Coverage levels are chosen by the policyholder. Benefit amounts will change according to the level selected by the policyholder and/or the named insured. All numerical variable range levels will comply with the minimum statutory requirements and are provided herein.

### **AML I GRP LM 2.0 ASR Ambulance Services Rider**

1. The term "OPTIONAL" will either be included or omitted from the Rider.
2. The statement "The consideration for this Rider is the application for this Rider and payment of any applicable premium." will either be included or omitted from the Rider.
3. Termination -
  - The phrase "the earliest of" will either be included or omitted from the Rider.
  - The phrase "a Covered Person's" will either be included or omitted from the Rider.
  - Item #2 will either be included or omitted from the Rider.
  - In the second paragraph, the bracketed phrases will either be included or omitted from the Rider based on when the Rider is effective.

### **AML I GRP LM 2.0 SNF Skilled Nursing Facility Benefit Rider**

1. The term "OPTIONAL" will either be included or omitted from the Rider.
2. The statement "The consideration for this Rider is the application for this Rider and payment of any applicable premium." will either be included or omitted from the Rider.
3. Termination -
  - The phrase "the earliest of" will either be included or omitted from the Rider.
  - The phrase "a Covered Person's" will either be included or omitted from the Rider.
  - Item #2 will either be included or omitted from the Rider.
  - In the second paragraph, the bracketed phrases will either be included or omitted from the Rider based on when the Rider is effective.

### **AML I GRP LM 2.0 TLIR Term Life Insurance Rider**

1. The term "OPTIONAL" will either be included or omitted from the Rider.
2. The statement "The consideration for this Rider is the application for this Rider and payment of any applicable premium." will either be included or omitted from the Rider.
3. Term Life Insurance Benefit – the paragraph describing the Dependent Life Insurance Benefit will either be included or omitted from the Rider. The range for the Dependent Benefit from 14 days to less than 6 months is "\$100 - \$500".
4. Suicide Limitation – Either the phrase "the Named Insured's" or "the Covered Person's" will appear, but not both.
5. Termination -
  - The phrase "the earliest of" will either be included or omitted from the Rider.
  - The phrase "a Covered Person's" will either be included or omitted from the Rider.
  - Item #2 will either be included or omitted from the Rider.
  - In the second paragraph, the bracketed phrases will either be included or omitted from the Rider based on when the Rider is effective.

CONSTITUTION AND BY-LAWS OF  
OF  
NATIONAL CONGRESS OF EMPLOYERS, INC.

ARTICLE I  
NAME & OFFICE

Section 1 - Name

The name of the association shall be the National Congress of Employers, Inc., hereinafter referred to as "NCE" or the "Association". NCE is a corporation incorporated in the State of Delaware with its principal place of business in the District of Columbia. NCE's By-Laws shall be governed and interpreted by the laws of the State of New York.

Section 2 - Office

The principal offices of the Association shall be located at 1101 Pennsylvania Avenue, Washington, D.C. and additional Chapter offices in New York and any other location the Board deems appropriate.

Section 3 - Registered Agent

The registered agent of the Association is National Registered Agent, Inc. located at 160 Greentree Drive, Suite 101, County of Kent, Dover, Delaware, 19904.

ARTICLE II  
SEAL

Section 1 - Seal

The Association shall have a common seal consisting of a design to be determined by vote of the Board of Directors. The seal shall contain the name of the organization in a semi-circular fashion and the year of formal organization, 2006, surrounding or overwritten on an acceptable symbol embodying the purpose of the organization.

ARTICLE III  
PURPOSE

Section 1 - Purpose

The purpose of NCE is to establish facilities and provide a forum for the exchange of ideas, opinions, technical know how and experiences among NCE's members as well as other national and international organizations and to engage in any other lawful purpose.

**ARTICLE IV**  
**MEMBERSHIP**

**Section 1 - Qualifications**

NCE is a private, fraternal organization which neither seeks nor accepts public or corporate funding in any form. Membership is reserved for those individuals that embody the purposes and ideals of the NCE as defined by the Board of Directors. NCE, through its Board of Directors, shall not deny membership to any protected class of people set forth in Title VII of the Civil Rights Act of 1964, the Civil Rights Act of 1866, the Civil Rights Act of 1991, including, but not limited to, on the basis of race, religion, national origin, sexual orientation and/or gender or for any protected class of people as identified by the New York State Human Rights Laws or the Human Rights Laws of any other jurisdiction which NCE does business in.

**Section 2 - Classification of Members**

Membership into this organization shall be classified as follows:

1. **Charter Members** - These shall include the names of founding members: Hon. George F. Sabatella, Hon. Robert DiCarlo, Christopher G. Sabatella, Matthew D. Saronson, Andrea Ceretti and Michael DiFilippo.

2. **Active Members** - These shall include individuals operating sole proprietorships and other like situated individuals duly enrolled and in good standing, having been approved for full membership by the Board of Directors or their duly authorized delegated Membership Committee.

3. **Associate Members** - These shall include individuals that are members of the Association, but do not enjoy voting rights, cannot hold the position of committee chairman, nor have access to the other emollients of Full Membership.

4. **Supporting Members** - These shall include individuals who are conferred membership as such by the Board of Directors with rights as specified thereupon.

**Section 3 - Rights and Privileges**

1. **Charter Member** - They shall be entitled to all the privileges and services offered by the association and shall serve as permanent members of the Board of Directors.

2. **Active Member** - They shall be entitled to all the privileges and services offered by the Association. Each member may vote and be voted upon for office in the Association.

3. **Associate Member** - They shall include individuals that are members of the

Association, but do not enjoy voting rights, cannot head committee chairmanships nor have access to the other emollients of full membership.

4. Other Privileges - Other membership privileges include participation in various activities, programs and publications of the Association as may be designated from time to time by the Board of Directors.

#### **Section 4 - Fees and Dues**

1. The Board of Directors may at any meeting of the Board adjust the membership dues applicable to the classes of members enumerated in these By-Laws without amending the By-Laws. Provided, however, that any dues increase which exceeds the cumulative increase of the Composite Consumer Price Index since the last dues increase must be confirmed by a supermajority of the Board of Directors. A supermajority shall be defined as 75% or more of the then sitting Board of Directors. Dues shall be payable in advance of the month due.

2. The Board of Directors shall determine the charges for all other fees associated with the meetings, publications, or other services provided by the Association.

3. Monthly membership dues will include fees for general membership meetings and publications.

#### **Section 5 - Admission and Effectiveness of Membership**

1. Applications for membership shall be made in writing. Applications shall be processed by the membership committee. The applicant will be advised of action taken on their application.

2. Effectiveness of membership shall start from the payment of entrance fees and membership dues of the applicant and after submission of other requirements that may be imposed by the membership committee and/or Board of Directors.

3. Fees shall be paid within thirty (30) days after official approval of application for membership.

#### **Section 6 - Members in Good Standing**

In order to be a member in good standing, a member shall have paid all dues and assessments within thirty (30) days after the same shall have become due and payable.

#### **Section 7 - Liability of Members**

Members who have not fully paid their annual dues and other obligations to the

Association shall be liable for any indebtedness of the Association to the extent of their unpaid accounts.

**Section 8 - Termination of Membership**

Any member may be separated from membership for any of the following causes:

1. Any member who shall have defaulted in the payment of dues and assessments for two (2) successive months shall be automatically suspended after dues notices had been given and will forfeit all rights and privileges in the Association; provided, however, that any member so suspended may be reinstated to full standing upon payment of all dues in arrears and upon the approval of the majority of the Board of Directors.

2. Any other cause or causes detrimental to the Association upon which, after due notice, investigation and hearing, the Board of Directors votes in favor of termination.

**ARTICLE V**  
**MEETINGS**

**Section 1 - Annual Meetings**

The annual general membership meeting, for the purpose of election of the Board of Directors, shall be held on the third Friday of December of each year at the principal office of the Association or at any place in the State of New York or District of Columbia to be decided on by the Board of Directors.

The order of business shall be as follows:

- Reading of the Minutes and of the last Annual General Membership Meeting and approval thereof;
- Report of the Treasurer;
- Report of the President;
- General Annual Elections of the Board of Directors;
- Unfinished business;
- New and other business;
- Report of the election committee and announcement of the results of the election.

**Section 2 - Special Meeting**

Special meetings of the Association may be called anytime by the Executive Director or by a majority of the Board of Directors whenever either shall deem it necessary.

### **Section 3 - Notice of Meetings**

The notice of the annual meetings or special meetings must be provided to all members in writing at least one (1) week before the meeting, either by letter, fax or electronic mail.

### **Section 4 - Quorum**

A simple majority (50% + 1) of the Active members in good standing, including proxies, shall constitute a quorum for the election of the Directors or for the transaction of any other business except in those cases where the By-Laws require the affirmative vote of a greater proportion.

The final list of candidates, arranged alphabetically, will be circulated to all voting members not later than fifteen (15) days before the election. The list shall not indicate the number of nominations received by each candidate.

In the event that the number of candidates equal or would be less than the number of elective positions, the nomination shall be declared re-opened by the Election Committee on the floor during election day.

### **Section 5 - Voting of Members**

Founding and Active Members in good standing (Voting Members) may vote at all meetings. Each Voting Member is entitled to one vote that may be cast either in person or with approval of the Board of Directors via telephonic participation. In voting for members of the Board of Directors, each Voting Member shall vote a maximum of nine (9) different candidates. If any voting member cannot attend the election, he may submit a written proxy to the committee on election before the election, which shall be used for quorum purposes only.

### **Section 6 - Certification**

Prior to the elections, the Committee on Elections shall certify that the candidates are qualified and have been nominated in accordance with the Constitution and By-Laws of the NCE.

### **Section 7 - Election of Directors**

The election of Directors shall be by secret ballot. Action on all other matters shall be by "aye" or "nay" vote or by other means as the majority present may decide.

### **Section 8 - Manner in Deciding Tie**

Should there be a tie in the election for a Director, the same shall be decided by a flip of a coin by the candidates with an equal number of votes.

**Section 9 - Campaign**

Any candidate for election may campaign for his candidacy by sending personalized letters bearing only the name and address of the sender and not the official letterhead of the Association. Any other form of campaigning is disallowed and considered a violation of election rules. However, on the election floor, candidates may distribute personal business cards.

**Section 10 - Violation of Rules**

Any willful violation of election rules by any member of the Association shall disqualify them from running for office and/or voting during the election and will subject them to disciplinary action.

**ARTICLE VII**  
**BOARD OF DIRECTORS**

**Section 1 - Number and Term of Office**

The management of the affairs of the Association shall be vested in the Board of Directors consisting of no fewer than four (4) and no greater than nine (9) members who shall be elected bi-annually by the voting members of the Association.

**Section 2 - Quorum**

The Directors shall act only as a Board. No individual Director shall have the power to act on behalf of the Board. An attendance of a quorum of Directors is necessary at all meetings for the transaction of any business and every decision of majority of those present shall be valid as an Association act. A Quorum shall consist of a simple majority of Directors (50% + 1).

**Section 3 - Regular Meetings**

The Board of Directors shall hold regular meetings every second Wednesday of the month at the office of the Association or at any date and place to be designated by the Board.

**Section 4 - Special Meetings**

Special meetings of the Board of Directors may be called by the Executive Director or at the written request of the majority of the Directors. Notice of special meetings shall be given at least one (1) week before the date of the meeting. Notice of such meetings shall be deemed waived if all members of the Board are present.

## Section 5 - Powers

The Board of Directors shall exercise the following powers and such other powers as may be provided for by the laws of the State of New York:

1. To promulgate such rules and regulations not inconsistent with these By-Laws;
2. to manage the affairs of the Association within the context of the By-Laws and Articles of Incorporation;
3. To purchase or acquire or sell or dispose of assets for the Association on such terms and conditions as it shall be deemed proper;
4. To employ and fix the compensation of the administrative officer, employees and other officers of the Association;
5. To act on all matters as may be designated by the Association as a whole;
6. To alter, merge or subdivide the Association as the Board sees fit and to best serve the interests of the membership;
7. To perform any and all tasks necessary to further the interests of the Association, limited only by these By-Laws and the laws of the State of New York;
8. To enter into partnership agreements or strategic alliances with like intended Associations or groups;
9. Approves an annual budget and financial audit;
10. Approves the time and place for the annual meetings of the members and the Board of Directors and all business meetings of the Board.
11. Hire and dismiss staff as it deems necessary;
12. Approves all committees and organizational appointments;
13. Fills vacancies on the Board of Directors;
14. Serves as the primary strategic planning unit for the Association;
15. Establishes organizational policies and develops strategies and allocates resources to implement same; and

16. Allow telephonic meetings with a speaker system in place that allows all callers on the call to be heard and to be able to speak to all others present on the telephone call.

**Section 6 - Resignation**

Any Director or officer may resign his office in writing. Such resignation should take effect upon approval and clearance by the Board.

**Section 7 - Vacancy**

In the event of any vacancy in the Board of Directors by reason of resignation, termination, death, inability to discharge responsibilities, or for any other reason acceptable to the Board, said vacancy shall, with the approval of the remaining Board of Directors be filled by the surviving spouse of the Director, for the remainder of that Director's term of office. Subsequent vacancies shall likewise be filled in the same manner.

If the vacancy is in the ranks of principal officers of the Board, it shall be filled by election from among the members of the Board during the next regular or special meeting held for the propose.

**ARTICLE VIII**  
**OFFICERS**

**Section 1 - Principal Officers**

Within the next fifteen (15) days after the election, as provided for in Article V, Section 1, the members of the Board of Directors shall elect from among themselves the Executive Director, President, Secretary and Treasurer.

**Section 2 - Subordinate Officers**

The Board, in its discretion, may create those new, subordinate offices they deem necessary. The subordinate officers shall be members of the Association, shall be appointed by the Board of Directors. The subordinate officers may be employed by the Board of Directors who shall determine the compensation of all subordinate officers.

**Section 3 - Compensation of Officers**

The President, Executive Director, Secretary, Treasurer and members of the Board of Directors shall receive no compensation. Salaries and compensation of other officers shall be fixed by the Board of Directors, provided that no member of the Association shall be appointed or elected to any position carrying with it compensation.

**ARTICLE IX**  
**DUTIES OF OFFICERS**

**Section 1 - Powers and Duties of the Executive Director**

The Executive Director shall be the Chief Executive Officer of the Association and, as such, shall exercise all the powers and discharge all such duties regularly or continually inherent in his office under the law, and such others as may be required by resolutions of the Board of Directors and of the Association.

**Section 2 - Powers and Duties of the President**

The President shall act as Deputy Executive officer and shall exercise and discharge all the powers and the duties of the President in case of the disability or absence of a Deputy Executive Officer. The President shall have direction of the following standing committees:

1. Membership Committee
2. Political Action Committee
3. Member Benefit Committee
4. Education Committee
5. Legal Committee
6. Charitable Works Committee
7. Other committees and functions as may be assigned to him.

Each committee shall be headed by a Chairperson.

**Section 3 - Powers and Duties of the Secretary**

The Secretary, who must be a member of the NCE, shall be the custodian of all corporate records and other minutes of all meetings of the Association and of the Board of Directors. He shall issue notices of meetings and prepare the Order of Business thereof. He shall keep in safe custody the seal of the Association and when authorized by the Board of Directors, shall affix such seal to any instrument requiring the same. The seal so affixed shall be attested by him. He shall perform such other duties as may be delegated to him by the Executive Director or the Board of Directors or as may be required of him.

**Section 4 - Powers and Duties of Treasurer**

The Treasurer shall be the finance officer of the Association and as such shall be the custodian of all funds and properties of the Association. He shall have charge of all the books of accounts of the Association. He shall be responsible for the collection of all the fees and dues from members. He shall make an annual financial report to the Association and such other reports as the Board of Directors may require.

**ARTICLE X**  
**COMMITTEES**

**Section 1 - Standing Committees**

There shall be three major standing committees governed by a fourth, governed by the Executive Committee, namely:

1. Membership Committee
2. Political Action Committee
3. Member Benefit Committee

All standing committees shall submit their master program for the fiscal year to the Board not later than the second regular Board meeting.

**Section 2 - Executive Committee**

It shall be composed of the Executive Director, the President, the Secretary, the Treasurer and the Chairman of each of the three standing committees.

The committee shall be responsible for the preparation of the annual budget for submission to the Board of Directors not later than the second regular meeting of the Board. It shall also formulate policies and procedures in furtherance of the objectives of the Association for submission to the Board, and direct the governance and running of the standing committees. It shall also perform such other duties as may be delegated by the Board of Directors.

**ARTICLE XI**  
**GENERAL PROVISIONS**

**Section 1 - Fiscal Year**

The fiscal year shall begin on January 1 and end on December 31 of the same year.

**Section 2 - Budget**

The Board of Directors shall approve the annual budget of the Association within fifteen (15) days after receipt of the recommended budget from the Executive Committee. The approved budget shall be the appropriate measure of the Association. No expenditures in excess of the budget shall be authorized without the prior approval of the Board of Directors.

**Section 3 - Signatories**

All disbursements of funds of the Association shall be made by checks. Checks shall be signed by the Executive Director and countersigned by the President. The Board of Directors may authorize any officer or officers to sign in place of the duly authorized signatories.

**ARTICLE XII**  
**AMENDMENTS**

**Section 1 - Amendments**

A two-thirds majority of the members of the Board of Directors may amend or repeal these By-Laws or adopt new By-Laws.

**ARTICLE XIII**  
**TRANSITORY PROVISIONS**

**Section 1 - Regular Members**

All Charter, Active Associate and supporting members of the Association in good standing as of the approval of these amended By-Laws are ipso facto members of the Association, together with any other members approved by the Board.

**ARTICLE XIV**  
**ASSOCIATION RELATIONSHIPS**

**Section 1 - Affiliation With Other Professional Organizations**

All members shall be encouraged to maintain active membership in local, national and international organizations. The Association may seek affiliation with like intended organizations as determined by the Board of Directors.

**ARTICLE XV**  
**LIQUIDATION**

**Section 1 - Dissolution**

In the event of the liquidation and dissolution of the NCE, any properties, funds or monies, securities or other assets remaining in the treasury of, or to the account of, or otherwise belonging to, the NCE shall be disposed of as follows:

1. All liabilities and obligations of the NCE shall be paid and discharged, or adequate provision shall be made therefor.

2. Assets held by the NCE subject to legally valid requirements for their return, transfer or conveyance, upon dissolution and liquidation, shall be returned, transferred or conveyed in accordance with such requirements.

3. All remaining assets held by the NCE shall be transferred or conveyed, without obligation, to another association or foundation selected by the Board of Directors in office at the point dissolution as decided upon.



Signature

Christopher Sabatelli

Printed Name

Executive Director

Title

Date

2/15/05

State of Delaware  
Secretary of State  
Division of Corporations  
Delivered 10:16 AM 03/20/2006  
FILED 10:16 AM 03/20/2006  
SRV 060263431 - 4128625 FILE

**STATE of DELAWARE**  
**CERTIFICATE of INCORPORATION**  
**The National Congress of Employees Inc.**  
**A NON-STOCK CORPORATION**

**ARTICLE I**

The name of the Corporation is The National Congress of Employees Inc.

**ARTICLE II**

The name and address information of the Registered Agent and Registered Office of the Corporation in the State of Delaware is:

National Registered Agents, Inc.  
160 Greentree Drive, Suite 101  
Dover, Delaware 19904  
In the county of Kent

**ARTICLE III**

The purpose for which the corporation is formed is: The mission of the Association is to advocate on behalf of members, individually and collectively at the state and federal level and be a key business resource for small, independent business in America. To render public services as non-partisan, non-profit, organization. To develop acquaintance and fellowship, undertake projects, and act upon matters of common interest and welfare to the members of the association; To instill, foster, encourage, and promote among members of the association the importance of adhering to the highest ethical standards of their respective professions; To establish facilities and provide forum for the interchange of ideas, opinions, technical know-how, networking and experiences among members of the association and other national and international organizations. Further, said corporation is organized exclusively for charitable, religious, educational, and scientific purposes, including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under section 501(c)(3) of the Internal Revenue Code, or the corresponding section of any future federal tax code.

#### ARTICLE IV

No part of the net earnings of the corporation shall inure to the benefit of, or be distributable to its members, trustees, officers, or other private persons, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Article Third hereof. No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office. Notwithstanding any other provision of these articles, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code, or the corresponding section of any future federal tax code, or (b) by a corporation, contributions to which are deductible under section 170(c)(2) of the Internal Revenue Code, or the corresponding section of any future federal tax code.

#### ARTICLE V

Upon the dissolution of the corporation, assets shall be distributed for one or more exempt purposes within the meaning of section 501(c)(3) of the Internal Revenue Code, or the corresponding section of any future federal tax code, or shall be distributed to the federal government, or to a state or local government, for a public purpose. Any such assets not so disposed of shall be disposed of by a Court of Competent Jurisdiction of the county in which the principal office of the corporation is then located, exclusively for such purposes or to such organization or organizations, as said Court shall determine, which are organized and operated exclusively for such purposes.

#### ARTICLE VI

The corporation shall not have any capital stock, and the conditions of membership shall be as follows: The conditions of the membership are as stated in the bylaws.

#### ARTICLE VII

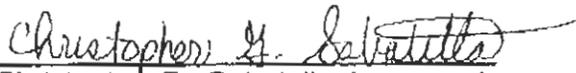
The name and mailing address of the incorporator of the Corporation is as follows:

Christopher G. Sabatella  
3809 Ocean View Ave.  
Brooklyn, New York 11224

**ARTICLE VIII**

I, The Undersigned, for the purpose of forming a corporation under the laws of the State of Delaware, do make, file and record this Certificate, and do certify that the facts herein stated are true, and I have accordingly hereunto set my hand

this 27th day of February, A.D. 2006

  
Christopher G. Sabatella, Incorporator

SERFF Tracking Number: CMPL-127847478 State: Arkansas  
 Filing Company: American Medical and Life Insurance Company State Tracking Number: 50339  
 Company Tracking Number: AMLI DE OTS LM2 NCE  
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity  
 Product Name: AMLI DE OTS LM2 NCE  
 Project Name/Number: AMLI DE OTS LM2 NCE/AMLI DE OTS LM2 NCE

## Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/28/2011	Form	Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage	12/15/2011	AR AMLI DE LM 2 0 CERT 11-16-11-.pdf (Superseded)

**LIMITED GROUP ACCIDENT AND SICKNESS HOSPITAL INDEMNITY INSURANCE**

**THIS COVERAGE PROVIDES BENEFITS DUE TO ACCIDENT AND SICKNESS. THIS CERTIFICATE EXPLAINS THE BENEFITS PROVIDED UNDER THE LIMITED 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 Limited 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.

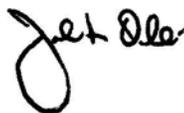
The Policy and this Certificate may be changed in whole or in part or cancelled as stated in the Policy. Such action may be taken without the consent of or notice to any Covered Person. Only an authorized officer at Our home office can approve a change. The approval must be in writing and endorsed on 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:

AMLI GRP LM 2.0 SCHED (6/11) AR

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.]

**[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.

**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 date on which You assume a legal obligation for total or partial support of the child.

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

Coverage will continue for the adopted child unless the placement is disrupted prior to the final adoption; and:

- The child is permanently removed from placement;
- The legal obligation terminates; or
- You rescind, in writing, the agreement of adoption or agreement assuming financial responsibility.

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

- Notify Us of his birth or placement in Your residence;
- Complete the required application for 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 should be made to the Holder within 90 days of notification of birth.

If an adopted child is not enrolled within 90 days of adoption, coverage will be provided from the date that notice is given. Any additional premium required should be made to the Holder within 90 days of notification of placement for the purposes of adoption.

If a step child is not enrolled within 90 days of placement in Your residence, coverage will be provided from the date that notice is given. Any additional premium required should be made to the Holder within 90 days of notification of placement.

#### **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
- End-Stage Renal Failure
- Heart Attack
- Invasive Cancer
- Major Organ Transplant
- 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.

We will not pay for any Hospital Confinement of a newborn child of a Covered Person following birth unless the child is injured or sick.

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.

We will not pay for any Hospital Confinement of a newborn child of a Covered Person following birth unless the child is injured or sick.

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.]

### **[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 Physician 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.

### **Prospective Reviews**

All requests for prior authorization of care are reviewed for medical necessity (including the appropriateness for the proposed level of care and/or provider). The initial review is performed by a nurse. If a nurse determines that the proposed care is medically necessary, the nurse will authorize the care. If the nurse determines that the proposed care is not medically necessary or that further evaluation is needed, the nurse will refer the case to a licensed physician.

If we have all the information necessary to make a determination regarding a prospective review, we will make a determination and provide notice to the Covered Person (or their designee) and the Covered Person's provider, by telephone and in writing, within three business days of receipt of the request. If we need additional information, we will request it within three business days. The covered person or their provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to the Covered Person (or their designee) and the Covered Person's provider, by telephone and in writing, within three business days of the earlier of our receipt of the information or the end of the 45-day time period.

With respect to urgent prospective claims, if we have all the information necessary to make a determination, we will make a determination and provide notice to the Covered Person (or their designee) and the Covered Person's provider, by telephone and in writing, within 72 hours of receipt of the request. If we need additional information, we will request it within 24 hours. The Covered Person or their provider will then have 48 hours to submit the information. We will make a determination and provide notice to the Covered Person and their provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

### **Concurrent Reviews**

When the Covered Person is receiving services that are subject to concurrent review, a nurse will periodically assess the medical necessity and appropriateness of care received throughout the course of treatment. Once a case is assigned for concurrent review, a nurse will determine whether the services are medically necessary. If so, the nurse will authorize the care. If the nurse determines that medical necessity is lacking or that further evaluation is needed, the nurse will refer the case to a licensed physician.

Utilization review decisions for services during the course of care (concurrent reviews) will be made and notice provided to the Covered Person's provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision but no later than 15 calendar days of receipt of the request.

For concurrent reviews that invoke urgent matters, we will make a determination and provide notice to the Covered Person and their provider within 24 hours of receipt of the request.

If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date of onset of services and the date of the next scheduled concurrent review of the case.

### **Retrospective Reviews**

At our option, a nurse will review retrospectively the medical necessity of claims that are subject to utilization review. If the nurse determines that care received was medically necessary, the nurse will authorize the benefits. If the nurse determines that medical necessity was lacking, the nurse will refer the case to a licensed physician.

If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to the Covered Person and their provider within 30 calendar days of receipt of the claim. If we need additional information, we will request it within 30 calendar days. The Covered Person or their provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to the Covered Person and their provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period.

### **Notice of Adverse Determination**

A notice of adverse determination (notice that a service is not medically necessary) will include the reasons, including clinical rationale, for our determination. The notice will also advise the Covered Person of their right to appeal our determination, give instructions for requesting an external appeal and for initiating an external appeal and specify that the Covered Person may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for use to review an appeal. We will send notices of determination to the Covered Person or their designee and the Covered Person's health care provider.

If, prior to making an adverse determination, no attempt was made to consult with the provider who recommended the service at issue, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For prospective and concurrent reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to the provider, by telephone and in writing.

### **Internal Appeals of Adverse Determinations**

The Covered Person, their designee and, in retrospective review cases, the Covered Person's health care provider, may request an internal appeal of an adverse determination, either by phone, in person or in writing. The Covered Person has up to 180 calendar days after he or she receives notice of the adverse determination to file an appeal. We will acknowledge the Covered Person's request for an internal appeal within fifteen calendar days of receipt. This acknowledgment will include the name, address and telephone number of the person handling the Covered Person's appeal and, if necessary, inform the Covered Person of any additional information needed before a decision can be made. A clinical peer reviewer who is in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

We will decide internal appeals related to prospective reviews within 30 calendar days of receipt of the appeal request. Written notice of determination will be provided to the Covered Person or their designee (and the Covered Person's health care provider if he or she requested the review) within two business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

We will decide internal appeals related to retrospective reviews within 60 calendar days of the receipt of the appeal request. Written notice of the determination will be provided to the Covered Person or their designee (and the Covered Person's health care provider if he or she requested the review) within two business days after the determination is made, but no later than 60 calendar days after receipt of the appeal request.

Reviews of continued or extended health care services, additional services rendered in the course of continued treatment, services in which a provider requests an immediate review or any other urgent matter will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews.

For expedited appeals, the Covered Person's provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. The Covered Person's provider and clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours of the appeal request.

If the Covered Person is not satisfied with resolution of his or her expedited appeal, he or she may file a standard internal appeal or an external appeal. Our failure to render a determination of the Covered Person's appeal within 60 calendar days shall be deemed a reversal of the initial adverse determination.

### **Notice of Determination of Internal Appeal**

The notice of determination of the Covered Person's internal appeal will indicate that it is a "final adverse determination" and will include the clinical rationale for our decision. It will also explain the Covered Person's rights to an external appeal, together with a description of the external appeal process and the time frames for initiating an external appeal. We will send notices of determination to the Covered Person or their designee and to the Covered Person's health care provider.]

### **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. Losses as a result of acts of terrorism committed by individuals or groups will not be excluded from coverage unless the Covered Person who suffered the loss committed the act of terrorism.

**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, for which premium was paid, if premium is not paid by the end 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 mental illness, developmental disability, mental retardation as defined in the mental hygiene 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. Upon Our request and at Our expense, the Named Insured must submit proof of incapacity or dependency to Us for a Dependent whose coverage would otherwise terminate if not incapacitated or dependent.

## **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**

Any statement made by the Policy Holder or a Named Insured is considered a representation and not a warranty. A copy of the statement will be provided to the Policy Holder or the Named Insured, whoever made the statement. In the event of the death or incapacity of the Named Insured, a copy of the statement will be provided to the Named Insured's beneficiary or personal representative. No statement will be used to contest the Policy, the validity of coverage or reduce benefits unless it is in writing, signed by the Policy Holder or Named Insured.

### **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 Statutes**

If any provision of the Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

### **Misstatement of Age and Sex**

If the age or sex of a person covered under this Certificate has been misstated, We will make an equitable adjustment of the premium. Such premium will be the difference between the premiums paid and the premiums which would have been paid at Your true age or sex, whichever applies. If coverage would not have been issued, We will refund the premiums paid for such insurance.

## **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, up to an amount not exceeding \$5,000, 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 not more than 30 days after We receive written proof of loss electronically or 45 days if the claim is submitted by other means.

### **Physical Examinations and Autopsy**

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. We have the right and opportunity to make an autopsy in the case of death where it is not prohibited by law.

### **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 or the expiration of 3 years from the time We receive written proof of loss.