

SERFF Tracking Number: CMPL-128022639 State: Arkansas
Filing Company: American Medical and Life Insurance Company State Tracking Number:
Company Tracking Number: AMLI IL OTS CASA LM-2
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: AMLI IL OTS CASA LM-2
Project Name/Number: AMLI IL OTS CASA LM-2/AMLI IL OTS CASA LM-2

Filing at a Glance

Company: American Medical and Life Insurance Company

Product Name: AMLI IL OTS CASA LM-2 SERFF Tr Num: CMPL-128022639 State: Arkansas

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

Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: AMLI IL OTS CASA LM-2 State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Donna Lambert

Author: Nancy French

Disposition Date: 02/06/2012

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Implementation Date Requested: On Approval

Implementation Date: 03/06/2012

State Filing Description:

General Information

Project Name: AMLI IL OTS CASA LM-2

Status of Filing in Domicile:

Project Number: AMLI IL OTS CASA LM-2

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: 02/06/2012

State Status Changed: 02/06/2012

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 IL (AR), et al

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 Consumer Assistance Services Association, an association based in Illinois. Coverage will be provided to individual association members and their dependents.

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 ESIGN 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,

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 J. David Simon
 President

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$400.00
 Retaliatory? No
 Fee Explanation: 8 forms x 50 = 400
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Medical and Life Insurance Company	\$400.00	01/24/2012	55767521

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Form Schedule

Lead Form Number: AMLI GRP LM 2.0 CERT IL (AR)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 02/06/2012	AMLI GRP LM 2.0 CERT IL (AR)	Certificate	Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage	Initial		41.000	AR AMLI IL LM2 CERT 1-31-12-.pdf
Approved 02/06/2012	AMLI GRP LM 2.0 SCHED (AR)	Schedule Pages	Group Accident and Sickness Hospital Indemnity Insurance Certificate Schedule	Initial		43.000	AR AMLI IL GRP LM2 SCHED 1-13-12-.pdf
Approved 02/06/2012	AMLI GRP LM 2.0 TLIR	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Term Life Insurance Rider	Initial		54.000	AMLI GRP LM2 TLIR _Term Life Insurance Rider_.pdf
Approved 02/06/2012	withdrawn	Other	withdrawn	Other	Other Explanation: withdrawn		
Approved 02/06/2012	AMLI GRP LM 2.0 ASR	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Ambulance Services Rider	Initial		48.000	AMLI GRP LM2 ASR _Ambulance Services Rider_.pdf
Approved 02/06/2012	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 LM2 SNF _Skilled Nursing Facility Benefit Rider_.pdf
Approved	AMLI GRP	Application/Group	Accident and	Initial		53.000	AR AMLI IL

<i>SERFF Tracking Number:</i>	CMPL-128022639	<i>State:</i>	Arkansas
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<i>TOI:</i>	H14G Group Health - Hospital Indemnity	<i>Sub-TOI:</i>	H14G.000 Health - Hospital Indemnity
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02/06/2012 LM 2.0	Enrollment	Sickness Hospital	GRP LM 2 0
ENRL AR	Form	Indemnity Insurance	ENRL 1-31-
		Enrollment Form	12-.pdf
Approved	AMLI GRP	Notice of	AR Notice 12-
02/06/2012 LM 2.0		Coverage	12-11-.pdf
		NOTICE	
		AR	

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

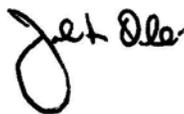
The use of the pronoun "he" refers to both male and female members whenever used.

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

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

For American Medical and Life Insurance Company:

[



John Ollis
Chairman and Chief Executive Officer



Kay Phillips
Vice President and Chief Compliance Officer]

Please read this Certificate carefully.

THIS IS NOT COMPREHENSIVE MAJOR MEDICAL COVERAGE.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

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CERTIFICATE SCHEDULE

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

AML I GRP LM 2.0 SCHED (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, independent of disease, bodily infirmity, illness, bacterial infections except infections which result from an accident or injury or infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance, 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 rehabilitative 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 shows 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,] disease or any other abnormal physical condition not caused by an Accident. Sickness includes bacterial infection, except infections which result from an accidental injury. Sickness includes infection which results from an accidental and involuntary or unintentional ingestion of a contaminated substance.

[Skilled Nursing Facility]

Skilled Nursing Facility means a facility that is operated pursuant to law and is primarily engaged in providing room and board accommodations and skilled nursing care under the supervision of a duly licensed Physician. A licensed rehabilitation facility that meets the definition above will be included.]

[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.

Coverage will not terminate nor will we deny the election of coverage for an unmarried dependent by reason of the dependent's age before the dependent's 30th birthday if the dependent:

- served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States; and
- has received a release or discharge other than a dishonorable discharge.

To be eligible for coverage, the eligible dependent must submit to us a form approved by the Department of Veterans' Affairs stating the date on which the dependent was released from service.

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 on which a child is placed in Your custody pursuant to an interim court order of adoption;
- the date on which a child is placed in Your home; 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.

The Pre-Existing Condition Limitation does not apply to the Critical Illness Benefit.]

[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.

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;
- [The Critical Illness Benefit;]
- [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, except for fraudulent misstatements, 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. 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.

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.

HOW TO FILE A CLAIM/CLAIM PROVISIONS

How to File a Claim

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

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

Proof of Loss

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

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

Payment of Claim

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

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

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

Time of Payment of Claim

We will pay any benefits due 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

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

Legal Action

We cannot be sued for benefits under the Policy until 60 days after written proof of loss has been given as required by the Policy or the expiration of 3 years from the time We receive written proof of loss.

**American Medical and Life Insurance Company
8 West 38th 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: [ABC Association]

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:

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

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

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

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

[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

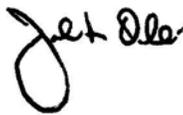
Coverage under this Rider will end on [the earliest of:]

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
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

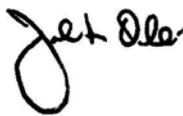
Coverage under this Rider will end on [the earliest of:]

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

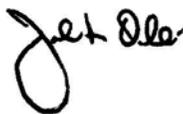
Coverage under this Rider will end on [the earliest of:]

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
8 West 38th 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.

Arkansas and 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.

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.

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-128022639 State: Arkansas
 Filing Company: American Medical and Life Insurance Company State Tracking Number:
 Company Tracking Number: AMLI IL OTS CASA LM-2
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: AMLI IL OTS CASA LM-2
 Project Name/Number: AMLI IL OTS CASA LM-2/AMLI IL OTS CASA LM-2

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved	02/06/2012
Comments:		
Attachment: READABILITY CERTIFICATION AR.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved	02/06/2012
Comments: included on schedule		

	Item Status:	Status Date:
Satisfied - Item: Variables	Approved	02/06/2012
Comments:		
Attachment: AMLI LM2 SOV IL.pdf		

	Item Status:	Status Date:
Satisfied - Item: Authorization	Approved	02/06/2012
Comments:		
Attachment: AMLI Authorization 2011 -10.pdf		

	Item Status:	Status Date:
Satisfied - Item: Articles	Approved	02/06/2012
Comments:		
Attachment:		

SERFF Tracking Number: CMPL-128022639 State: Arkansas
 Filing Company: American Medical and Life Insurance Company State Tracking Number:
 Company Tracking Number: AMLI IL OTS CASA LM-2
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: AMLI IL OTS CASA LM-2
 Project Name/Number: AMLI IL OTS CASA LM-2/AMLI IL OTS CASA LM-2
 CONSUMER ASSISTANCE SERVICES ASSOC ARTICLES O.pdf

		Item Status:	Status
			Date:
Satisfied - Item:	By Laws	Approved	02/06/2012
Comments:			
Attachment:			
	CONS ASSISTANCE SRVCS ASSOC BY LAWS.pdf		

		Item Status:	Status
			Date:
Satisfied - Item:	Master Policy	Approved	02/06/2012
Comments:			
Attachment:			
	AMLI GRP LM2 POL.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 IL (AR)	Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage	41
AMLI GRP LM 2.0 CERT IL (AR)	Group Accident and Sickness Hospital Indemnity Insurance Certificate Schedule	43
AMLI GRP LM 2.0 TLIR	Term Life Insurance Rider	54
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 ENRL	Group Accident and Sickness Hospital Indemnity Insurance Enrollment Form	53



Signature of Company Officer

Kay Phillips

Name

Vice President and Chief Compliance Officer

Title

1-23-2012

Date

Statement of Variables
AMLI GRP LM 2.0 POL, 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

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 IL 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 Officer Signature block is variable to accommodate any change in officers.
4. The Table of Contents page numbers will vary dependent upon the number of benefits included in policy.
5. The bracketed definitions in the General Definitions section will be either included or omitted from the certificate at the option of the policyholder.
6. The bracketed phrase in the definition of “Doctor or Physician will be either included or omitted from the certificate at the option of the policyholder.
7. The word “pregnancy” in the definition of Sickness will be included if pregnancy is not excluded from coverage.
8. The bracketed bullet items in the “Eligibility” provision will either be included or omitted from the certificate at the option of the policyholder. The range for the lower eligibility age is 18 – 21.
9. The bracketed phrases that refer to Domestic Partner in the Continuation of Coverage for Dependents provision will be included in the Certificate at the option of the policyholder.
10. The bracketed phrase referring to Pre-Existing Condition in the “Changes to this Certificate” provision will be included if a Pre-Existing Condition Limitation is included at the option of the policyholder.

11. The bracketed benefits in the “Description of Benefits” section will either be included or omitted from the certificate at the option of the policyholder.
12. For the Hospital Admission Benefit, admission must be made within 6 – 12 months after the Covered Accident.
13. References to the Hospital Admission benefit in the last paragraph Newborn Child Hospital Care Benefit will be included if the Hospital Admission benefit is elected by the policyholder.
14. The benefit amounts for the Anesthesia Benefit will be at the option of the policyholder, within the range of 10%-25% of the surgery benefit.
15. The Ambulatory Surgical Center 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.
16. The Utilization Review provision will either be omitted or included, at the option of the policyholder.
17. Bracketed Limitations and Exclusions will either be omitted or included, at the option of the policyholder.
18. The Pre-existing Condition Limitation will either be omitted or included, at the option of the policyholder. The benefits listed in the second paragraph will either be omitted or included, at the option of the policyholder. The bullet items in the third paragraph will either be omitted or included, at the option of the policyholder. The fourth and fifth paragraphs will either be omitted or included, at the option of the policyholder.

AMLI 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.

AMLI 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.

AMLI 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.

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



8 West 38th 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

File Number 6146-751-3

ARTICLES OF
INCORPORATION
(DIRECT
MEDICAL
BENEFIT
ASSOCIATION)

State of Illinois Office of The Secretary of State

Whereas, ARTICLES OF INCORPORATION OF
E-COMMERCE.COM ASSOCIATION
INCORPORATED UNDER THE LAWS OF THE STATE OF ILLINOIS HAVE BEEN
FILED IN THE OFFICE OF THE SECRETARY OF STATE AS PROVIDED BY THE
GENERAL NOT FOR PROFIT CORPORATION ACT OF ILLINOIS, IN FORCE
JANUARY 1, A.D. 1987.

Now Therefore, I, Jesse White, Secretary of State of the State of Illinois, by virtue of the powers vested in me by law, do hereby issue this certificate and attach hereto a copy of the Application of the aforesaid corporation.

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, at the City of Springfield, this 24TH day of JANUARY A.D. 2001 and of the Independence of the United States the two hundred and 25TH



Jesse White

Secretary of State

C-212.3

*3/20
P3
5:00
MYER
ETC. E*

FILED
http://www.sos.state.il.us

SUBMIT IN DUPLICATE

Payment must be made by certified check, cashier's check, Illinois attorney's check, Illinois C.P.A.'s check or money order, payable to "Secretary of State."

Date 1-24-01

Filing Fee \$50

Approved Be

DO NOT SEND CASH!

JAN 24 2001

JESSE WHITE

SECRETARY OF STATE

TO: JESSE WHITE, Secretary of State

Pursuant to the provisions of "The General Not For Profit Corporation Act of 1986," the undersigned incorporator(s) hereby adopt the following Articles of Incorporation.

Article 1. The name of the corporation is: E-Commerce.com Association

Article 2: The name and address of the initial registered agent and registered office are:

Registered Agent CT CORPORATION SYSTEM

First Name Middle Name Last Name

Registered Office 208 S. LASALLE

Number Street (Do not use P.O. Box)

CHICAGO IL 60604 COOK

City ZIP Code County

Article 3: The first Board of Directors shall be 3 in number, their names and residential addresses being as follows: (Not less than three)

Director's Names	Number	Street	Address City	State
Gary Johnston	2544	Christopher Oaks Ct.	St. Louis, MO	63129
Karen Boeker	13	Bordeaux Place	Lake St. Louis, MO	63367
Tracy MacIntosh	2720	Sunny Meadows Dr.	St. Charles, MO	63303

Article 4. The purposes for which the corporation is organized are:

Educational

Is this corporation a Condominium Association as established under the Condominium Property Act?
 Yes No (Check one)

Is this corporation a Cooperative Housing Corporation as defined in Section 216 of the Internal Revenue Code of 1954? Yes No (Check one)

Is this a Homeowner's Association which administers a common-interest community as defined in subsection (c) of Section 9-102 of the code of Civil Procedure? Yes No

Article 5. Other provisions (please use separate page):

Article 6.

NAMES & ADDRESSES OF INCORPORATORS

The undersigned incorporator(s) hereby declare(s), under penalties of perjury, that the statements made in the foregoing Articles of Incorporation are true.

Dated January 18, 2001.
(Month & Day) (Year)

SIGNATURES AND NAMES

POST OFFICE ADDRESS

1. [Signature]
Signature _____
Name (please print) Gary Johnston

2. [Signature]
Signature _____
Name (please print) Karen Boeker

3. _____
Signature _____
Name (please print) _____

4. _____
Signature _____
Name (please print) _____

5. _____
Signature _____
Name (please print) _____

1. 2544 Christopher Oaks Ct.
Street _____
St. Louis, MO 63129
City/Town State ZIP

2. 13 Bordeaux Place
Street _____
Lake St. Louis, MO 63367
City/Town State ZIP

3. _____
Street _____
City/Town State ZIP

4. _____
Street _____
City/Town State ZIP

5. _____
Street _____
City/Town State ZIP

(Signatures must be in **BLACK INK** on original document. Carbon copied, photocopied or rubber stamped signatures may only be used on the true copy.)

- If a corporation acts as incorporator, the name of the corporation and the state of incorporation shall be shown and the execution shall be by its President or Vice-President and verified by him, and attested by its Secretary or an Assistant Secretary.
- The registered agent cannot be the corporation itself.
- The registered agent may be an individual, resident in this State, or a domestic or foreign corporation, authorized to act as a registered agent.
- The registered office may be, but need not be, the same as its principal office.
- A corporation which is to function as a club, as defined in Section 1-3.24 of the "Liquor Control Act" of 1934, must insert in its purpose clause a statement that it will comply with the State and local laws and ordinances relating to alcoholic liquors.

FOR INSERTS - USE WHITE PAPER - SIZE 8 1/2 x 11

File No. _____

FORM NFP-102.10

ARTICLES OF INCORPORATION

under the

GENERAL NOT FOR PROFIT

CORPORATION ACT

of

SECRETARY OF STATE

DEPARTMENT OF BUSINESS SERVICES

CORPORATION DIVISION

SPRINGFIELD, ILLINOIS 62756

TELEPHONE (217) 782-6522

782-6523

(These Articles Must Be Executed and Filed
in Duplicate)

Filing Fee \$50

C-157.11



OFFICE OF THE SECRETARY OF STATE

JESSE WHITE • Secretary of State

MAY 19, 2003

6146-751-3

NATIONAL ADMINISTRATION COMPANY, INC.
1819 CLARKSON RD, STE 301
CHESTERFIELD, MO 63017

ARTICLES OF
AMENDMENT
TO CHANGE
NAME

RE DIRECT MEDICAL BENEFIT ASSOCIATION

DEAR SIR OR MADAM:

ENCLOSED YOU WILL FIND THE ARTICLES OF AMENDMENT FOR THE ABOVE NAMED CORPORATION.

FEES IN THIS CONNECTION HAVE BEEN RECEIVED AND CREDITED.

THE ENCLOSED DOCUMENT MUST BE RECORDED IN THE OFFICE OF THE RECORDER OF THE COUNTY IN WHICH THE REGISTERED OFFICE OF THE CORPORATION IS LOCATED.

SINCERELY YOURS,

JESSE WHITE
SECRETARY OF STATE

DEPARTMENT OF BUSINESS SERVICES
CORPORATION DIVISION
TELEPHONE (217) 782-6961

JW:CD

NFP-110.30
(Rev. Jan. 1999)

JESSE WHITE
Secretary of State
State of Illinois

File # 6146-751-3

This Space For Use By Secretary of State	
Date	<u>5-19-03</u>
Filing Fee	\$25.00
Approved	<i>[Signature]</i>

Submit in Duplicate
Remit payment in check or money
order, payable to "Secretary of
State."

ARTICLES OF AMENDMENT
under the
GENERAL NOT FOR PROFIT
CORPORATION ACT

DO NOT SEND CASH!

Pursuant to the provisions of "The General Not For Profit Corporation Act of 1986," the undersigned corporation hereby adopts these Articles of Amendment to its Articles of Incorporation.

ARTICLE ONE The name of the corporation is E-Commerce. Com Association

 (Note 1)

ARTICLE TWO The following amendment to the Articles of Incorporation was adopted on 5-12,
2003 in the manner indicated below ("X" one box only.) (Month & Day)
(Year)

By the affirmative vote of a majority of the directors in office, at a meeting of the board of directors, in accordance with Section 110.15. (Note 2)

By written consent, signed by all the directors in office, in compliance with Sections 110.15 and 108.45 of this Act. (Note 3)

FILED

MAY 19 2003

JESSE WHITE
SECRETARY OF STATE

By the members at a meeting of members entitled to vote by the affirmative vote of the members having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the articles of incorporation or the bylaws, in accordance with Section 110.20. (Note 4)

By written consent signed by members entitled to vote having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the articles of incorporation, or the bylaws, in compliance with Sections 107.10 and 110.20 of this Act. (Note 5)

(INSERT RESOLUTION)

BE IT HEREBY RESOLVED, the name of the corporation shall be changed to read: "Direct Medical Benefit Association", and the Articles of Incorporation shall be changed at Article One (1) to reflect the change of name.

(If space is insufficient, attach additional pages size 8 1/2 x 11)

The undersigned corporation has caused these articles to be signed by its duly authorized officers, each of whom affirm, under penalties of perjury, that the facts stated herein are true. (All signatures must be in **BLACK INK.**)

Dated 5-15, 03 E-Commerce.Com Association
 (Month & Day) (Year) (Exact Name of Corporation)
 attested by Karen Becker by Monica Roy
 (Signature of Secretary or Assistant Secretary) (Signature of President or Vice President)
Karen Becker Secretary Monica Roy - Vice President
 (Type or Print Name and Title) (Type or Print Name and Title)

NOTES AND INSTRUCTIONS

- NOTE 1: State the true exact corporate name as it appears on the records of the Office of the Secretary of State, **BEFORE** any amendments herein reported.
- NOTE 2: Directors may adopt amendments without member approval only when the corporation has no members, or no members entitled to vote.
- NOTE 3: Director approval may be (1) by vote at a director's meeting (*either annual or special*) or (2) consent, in writing, without a meeting.
- NOTE 4: All amendments not adopted under Sec. 110.15 require (1) that the board of directors adopt a resolution setting forth the proposed amendment and (2) that the members approve the amendment.

Member approval may be (1) by vote at a members meeting (*either annual or special*) or (2) by consent, in writing, without a meeting.

To be adopted, the amendment must receive the affirmative vote or consent of the holders of at least 2/3 of the outstanding members entitled to vote on the amendment, (*but if class voting applies, then also at least a 2/3 vote within each class is required*).

The articles of incorporation may supersede the 2/3 vote requirement by specifying any smaller or larger vote requirement not less than a majority of the outstanding votes of such members entitled to vote and not less than a majority within each when class voting applies. (Sec. 110.20)

- NOTE 5: When a member approval is by written consent, all members must be given notice of the proposed amendment at least 5 days before the consent is signed. If the amendment is adopted, members who have not signed the consent must be promptly notified of the passage of the amendment. (Sec. 107.10 & 110.20)

FORM NFP-110.30

File No. _____

ARTICLES OF AMENDMENT
 under the
 GENERAL NOT FOR PROFIT
 CORPORATION ACT

Filing Fee \$25

RETURN TO:

Department of Business Services
 Secretary of State
 Springfield, Illinois 62756
 Telephone (217) 782-1832
 http://www.sos.state.il.us

C-130.10



OFFICE OF THE SECRETARY OF STATE

JESSE WHITE • Secretary of State

JANUARY 28, 2004

6146-751-3

GEORGE R KATOSIC & ASSOC.
300 N COIT RD, STE 1050
RICHARDSON, TX 75080

RE CONSUMER ASSISTANCE SERVICES ASSOCIATION

DEAR SIR OR MADAM:

ENCLOSED YOU WILL FIND THE ARTICLES OF AMENDMENT FOR THE ABOVE NAMED CORPORATION.

FEES IN THIS CONNECTION HAVE BEEN RECEIVED AND CREDITED.

THE ENCLOSED DOCUMENT MUST BE RECORDED IN THE OFFICE OF THE RECORDER OF THE COUNTY IN WHICH THE REGISTERED OFFICE OF THE CORPORATION IS LOCATED.

SINCERELY YOURS,

JESSE WHITE
SECRETARY OF STATE

DEPARTMENT OF BUSINESS SERVICES
CORPORATION DIVISION
TELEPHONE (217) 782-6961

JW:CD

FORM NFP 110.30 (rev. Dec. 2003)
ARTICLES OF AMENDMENT
General Not For Profit Corporation Act

Jesse White, Secretary of State
Department of Business Services
Springfield, IL 62756
Telephone (217) 782-1832
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Remit payment in the form of a
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JESSE WHITE
SECRETARY OF STATE

File # 6146-751-3 Filing Fee: \$25.00 Approved: _____
Submit in duplicate Type or Print clearly in black ink Do not write above this line

1. Corporate name (Note 1): Direct Medical Benefits Association

2. Manner of adoption of amendment:
The following amendment of Articles of Incorporation was adopted on December 1, 2003 In the manner
indicated below (Check one only): (Month, Day & Year)

----- By affirmative vote of a majority of the directors in office, at a meeting of the board of directors, in accordance with Section 110.15. (Note 2)

----- By written consent, signed by all the directors in office, in compliance with Sections 110.15 and 108.45 (Note 3)

By members at a meeting of members entitled to vote by the affirmative vote of the members having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the articles of incorporation or the bylaws, in accordance with Section 110.20. (Note 4)

----- By written consent signed by members entitled to vote having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the articles of incorporation, or the bylaws, in compliance with Sections 107.10 and 110.20. (Note 5)

3. Text of amendment
(a.) When an amendment effects a name change, insert the new corporate name below. Use 3 (b) below for all other amendments. *Article 1: The name of the corporation is:

Consumer Assistance Services Association
(New Name)

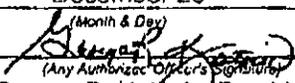
(b) All amendments other than name change.
(If amendment affects the corporate purpose, the amended purpose is required to be set forth in its entirety.) If there is not sufficient space to add the full text of the amendment, add one or more sheets of this size.

(COMPLETE ITEM 4 OR, IF APPLICABLE, ITEM 5.) ALL SIGNATURES MUST BE IN BLACK INK.

(see attached Exhibit A)

4. The undersigned corporation has caused these articles to be signed by duly authorized officer, who affirms, under penalties of perjury, that the facts stated herein are true. (All signatures must be in **BLACK INK**)

Dated December 26 2003 Direct Medical Benefits Association
(Month & Day) (Year) (Exact Name of Corporation)


(Any Authorized Officer's Signature)

George R. Katosic President
(Print Name and Title)

5. If there are no duly authorized officers, then the persons designated under Section 101.10(b)(2) must sign below and print name and title. The undersigned affirms, under penalties of perjury, that the facts stated herein are true.

Dated _____ (Month, Day & Year)

Signature

Print Name and Title

NOTES

Note 1: State the true and exact corporate name as it appears on the records of the Secretary of State, BEFORE any amendment herein reported.

Note 2: Directors may adopt amendments without member approval only when the corporation has no members, or no members entitled to vote pursuant to §110.15

Note 3: Director approval may be (1) by vote at a director's meeting (*either annual or special*) or (2) by consent, in writing, without a meeting.

Note 4: All amendments not adopted under Sec. 110.15 require (1) that the board of directors adopt a resolution setting forth the proposed amendment and (2) that the members approve the amendment.

Member approval may be (1) by vote at a members meeting (*either annual or special*) or (2) by consent, in writing, without a meeting.

To be adopted, the amendment must receive the affirmative vote or consent of the holders of at least 2/3 of the outstanding members entitled to vote on the amendment, (*but if class voting applies, then also at least a 2/3 vote within each class is required*).

The articles of incorporation may supersede the 2/3 vote requirement by specifying any smaller or larger vote requirement not less than a majority of the outstanding votes of such members entitled to vote and not less than a majority within each when class voting applies. (*Sec. 110.20*)

Note 5: When member approval is by written consent, all members must be given notice of the proposed amendment at least 5 days before the consent is signed. If the amendment is adopted, members who have not signed the consent must be promptly notified of the passage of the amendment. (*Sec. 107.10 & 110.20*)

EXHIBIT A

The Corporation is organized and established to (1) promote the availability of benefits and services that assist and protect consumers as well as offer cost savings; (2) engage in nonpartisan research, study and analysis for the benefit of consumers seeking assistive, protective and discounted benefits and services and to publish the results of same when and if applicable; (3) prepare educational materials and conduct educational activities in support of consumers seeking knowledge about and information concerning assistive, protective and discounted benefits and services; (4) conduct and sponsor forums, lectures, debates, newsletters and similar activities concerning information about assistive, protective and discounted benefits and services; and (5) conduct any other appropriate activities permissible under the Illinois General Not for Profit Corporations Act.

SERFF Tracking Number: CMPL-128022639 State: Arkansas
 Filing Company: American Medical and Life Insurance Company State Tracking Number:
 Company Tracking Number: AMLI IL OTS CASA LM-2
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: AMLI IL OTS CASA LM-2
 Project Name/Number: AMLI IL OTS CASA LM-2/AMLI IL OTS CASA LM-2

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)
02/02/2012	Form	Group Accident and Sickness Hospital Indemnity Insurance Enrollment Form	02/02/2012	AR AMLI IL GRP LM 2 0 ENRL 1-31-12-.pdf
01/24/2012	Form	Group Accident and Sickness Hospital Indemnity Insurance Enrollment Form	02/02/2012	AMLI GRP LM2 ENRL.pdf (Superseded)
01/24/2012	Form	Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage	01/24/2012	IN AMLI IL LM2 CERT 1-13-12-.pdf (Superseded)
01/24/2012	Supporting Document	By-Laws	02/03/2012	CONSUMER ASSISTANCE SERVICES ASSOC ARTICLES O.pdf
01/24/2012	Form	Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage	02/02/2012	AR AMLI IL LM2 CERT 1-13-12-.pdf (Superseded)

American Medical and Life Insurance Company
8 West 38th 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

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

GROUP ACCIDENT AND SICKNESS HOSPITAL INDEMNITY INSURANCE

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

CERTIFICATE OF COVERAGE

Issued under the terms of

Group Insurance Policy Number: [12345]

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

Policy Date: [January 1, 2011]

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

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

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

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

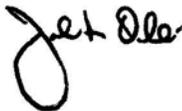
The use of the pronoun "he" refers to both male and female members whenever used.

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

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

For American Medical and Life Insurance Company:

[



John Ollis
Chairman and Chief Executive Officer



Kay Phillips
Vice President and Chief Compliance Officer]

Please read this Certificate carefully.

THIS IS NOT COMPREHENSIVE MAJOR MEDICAL COVERAGE.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

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CERTIFICATE SCHEDULE

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

AML I GRP LM 2.0 SCHED (IN)

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, independent of disease, bodily infirmity, illness, bacterial infections except infections which result from an accident or injury or infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance, or any other abnormal physical condition. 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 rehabilitative 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 shows 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,] disease or any other abnormal physical condition not caused by an Accident. Sickness includes bacterial infection, except infections which result from an accidental injury. Sickness includes infection which results from an accidental and involuntary or unintentional ingestion of a contaminated substance.

[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.

Coverage will not terminate nor will we deny the election of coverage for an unmarried dependent by reason of the dependent's age before the dependent's 30th birthday if the dependent:

- served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States; and
- has received a release or discharge other than a dishonorable discharge.

To be eligible for coverage, the eligible dependent must submit to us a form approved by the Department of Veterans' Affairs stating the date on which the dependent was released from service.

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 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 on which a child is placed in Your home for the purpose of adoption; or
- The date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption

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

For coverage to continue beyond the first 31 days, premium and notification must be received.

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.

[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.

The Pre-Existing Condition Limitation does not apply to the Critical Illness Benefit.]

[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 including but not limited to inpatient or outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate. In the case of a Covered Person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, We will pay the Surgery Benefit, shown on the Certificate Schedule for:

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

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

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

[Pregnancy

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

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

Surgical Fees/Facility Expenses Related to Surgery

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

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

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

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

[Pre-Existing Condition Limitation

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

[This limitation applies to the following benefits:]

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

This limitation does not apply to:

- Genetic information in the absence of a diagnosis of the condition related to such information;
- A newborn child who is enrolled in the plan within 31 days after birth; nor to a child who is adopted or placed for adoption before attaining 26 years of age; and as of the last day of the 31-day period beginning on the date of birth, adoption or placement for adoption, is covered under creditable coverage;
- [The Critical Illness Benefit;]
- [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, developmental disability or mental disability 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. Proof of the disability and/or dependency must be furnished to Us within 31 days of the child's attainment of the limiting age and subsequently, as may be required by Us. However, proof may not be required more often than annually after the first 2 years following the Dependent Child's attainment of the limiting age.

PREMIUMS

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

Our Right to Change Premiums

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

GENERAL PROVISIONS

Entire Contract; Changes

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

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

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

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

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

Incontestability

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. 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. The validity of the Policy may not be contested after the Policy has been in force for two years after its date of issue except for nonpayment of premiums. After two years from the effective date of the Certificate, no misstatements made by the Named Insured in the Enrollment Form shall be used to void the insurance or deny a claim for loss incurred commencing after the expiration of such two year period. Ineligibility of a Covered Person under the Policy may be disputed any time.

Coverage Provided by the Policy

We insure a Covered Person for loss according to the 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.

HOW TO FILE A CLAIM/CLAIM PROVISIONS

How to File a Claim

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

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

Proof of Loss

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

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

Payment of Claim

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

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

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

Time of Payment of Claim

We will pay or deny each clean claim as follows:

- If the claim is filed electronically, within thirty (30) days after the date the claim is received by the insurer.
- If the claim is filed on paper, within forty-five (45) days after the date the claim is received by the insurer.

If we fail to pay or deny a clean claim in the time specified and if we subsequently pay the claim, we will pay the provider that submitted the claim interest on the claim amount. Interest will begin accruing: thirty-one (31) days after the date the claim is filed electronically; or forty-six (46) days after the date the claim is filed on paper; and will stop accruing on the date the claim is paid.

Clean claim means a claim submitted by a provider for payment under an accident and sickness insurance policy issued in Indiana that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

Physical Examinations

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

Legal Action

We cannot be sued for benefits under the Policy until 60 days after written proof of loss has been given as required by the Policy or the expiration of 3 years from the time We receive written proof of loss.

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

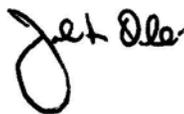
The use of the pronoun "he" refers to both male and female members whenever used.

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

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

For American Medical and Life Insurance Company:

[



John Ollis
Chairman and Chief Executive Officer



Kay Phillips
Vice President and Chief Compliance Officer]

Please read this Certificate carefully.

THIS IS NOT COMPREHENSIVE MAJOR MEDICAL COVERAGE.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

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CERTIFICATE SCHEDULE

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

AML I GRP LM 2.0 SCHED (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, independent of disease, bodily infirmity, illness, bacterial infections except infections which result from an accident or injury or infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance, 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 rehabilitative 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 shows 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,] disease or any other abnormal physical condition not caused by an Accident. Sickness includes bacterial infection, except infections which result from an accidental injury. Sickness includes infection which results from an accidental and involuntary or unintentional ingestion of a contaminated substance.

[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.

Coverage will not terminate nor will we deny the election of coverage for an unmarried dependent by reason of the dependent's age before the dependent's 30th birthday if the dependent:

- served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States; and
- has received a release or discharge other than a dishonorable discharge.

To be eligible for coverage, the eligible dependent must submit to us a form approved by the Department of Veterans' Affairs stating the date on which the dependent was released from service.

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 on which a child is placed in Your custody pursuant to an interim court order of adoption;
- the date on which a child is placed in Your home; 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.

The Pre-Existing Condition Limitation does not apply to the Critical Illness Benefit.]

[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.

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;
- [The Critical Illness Benefit;]
- [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, except for fraudulent misstatements, 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. 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.

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.

HOW TO FILE A CLAIM/CLAIM PROVISIONS

How to File a Claim

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

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

Proof of Loss

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

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

Payment of Claim

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

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

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

Time of Payment of Claim

We will pay any benefits due 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

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

Legal Action

We cannot be sued for benefits under the Policy until 60 days after written proof of loss has been given as required by the Policy or the expiration of 3 years from the time We receive written proof of loss.