

SERFF Tracking Number: CATL-128339800 State: Arkansas  
Filing Company: Catlin Insurance Company, Inc. State Tracking Number:  
Company Tracking Number: AHAG 401 (AR) 0412  
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
Product Name: Catlin Group Accident Amendment  
Project Name/Number: Catlin Group Accident Amendment/AHAG 401 (AR) 0412

## Filing at a Glance

Company: Catlin Insurance Company, Inc.

Product Name: Catlin Group Accident  
Amendment

TOI: H02G Group Health - Accident Only

Sub-TOI: H02G.000 Health - Accident Only  
Filing Type: Form

SERFF Tr Num: CATL-128339800 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num:

Co Tr Num: AHAG 401 (AR) 0412 State Status: Approved-Closed

Authors: Carolyn Smart, Darcy  
LeBau

Date Submitted: 05/11/2012

Reviewer(s): Rosalind Minor

Disposition Date: 05/18/2012

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Catlin Group Accident Amendment

Project Number: AHAG 401 (AR) 0412

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer, Association, Trust, Other

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Explanation for Other Group Market Type:

Unions & Customers of Financial Institutions

Filing Status Changed: 05/18/2012

State Status Changed: 05/18/2012

Created By: Carolyn Smart

Corresponding Filing Tracking Number:

Overall Rate Impact:

Deemer Date:

Submitted By: Carolyn Smart

Filing Description:

The Honorable Jay Bradford

Commissioner of Insurance

Arkansas Insurance Department

1200 West Third Street

Little Rock, AR 72201

Attention: Life & Health Division

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Re: Catlin Insurance Company, Inc.

FEIN#: 204929941

NAIC#: 4574 19518

Group Accident Amendment Filing

Forms:

Accident Medical Benefit Rider Form # AHAG 401(AR) 0412

Total Disability Weekly Income Benefit Rider Form # AHAG 402 0412

Blank Endorsement Rider Form # AHAG 403 0412

Honorable Commissioner Bradford:

I respectfully submit the amendment filing referenced above on behalf of Catlin Insurance Company, Inc. ("Catlin") for your review and approval prior to use in your state. Westmont Associates, Inc. has been requested to file these forms on behalf of Catlin. Please see the enclosed authorization letter.

More specifically, Catlin is submitting the three (3) riders listed above to be available with its previously filed and approved Arkansas Group Accident Policy which was approved by your Department on April 12, 2010 under SERFF Tracking # CATL-126536128.

The Accident Medical Benefit Rider is an additional coverage which can be added to the Group Accident Policy by selection of the policyholder. The Accident Medical Benefit allows for payment of either expenses incurred or a fixed indemnity benefit for covered medical charges for treatment(s) directly related to covered accidents. This addition broadens the complete product available with the Group Accident Product. The Accident Medical Benefit Rider is a low cost benefit offering a very limited accident only coverage that is intended to offer supplemental cover, filling gaps in primary Major Medical plans. This coverage is not intended to be a Major Medical plan and will never be modified to include sickness exposures. The coverage will not differentiate between individuals in eligibility, benefits or premiums based on any health factor of an individual.

The Total Disability Weekly Income Benefit Rider amends the current provision in the Group Accident Policy. The revision provides the option for benefits of up to 80% of the covered person's base earnings. This amendment of this provision is a correction to follow the rating structure for this product. There were no other revisions to the remainder of the Total Disability Weekly Income Benefit provision.

The Blank Endorsement Rider is intended to allow for changes with respect to only bracketed items of the policy, within previously filed and approved SOV ranges. There is no intent with this form to change policy language which is not bracketed within the policy.

In accordance with your state's filing requirements, enclosed please find:

- Letter of Authorization
- Forms
- Statement of Variability
- Certification of Compliance with Regulation 19

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I thank you in advance for the time spent on this filing and trust that you will find everything in order. Please do not hesitate to contact me directly at 856-216-0220, x 211 or at Darcy@Westmontlaw.com if you have any questions or require additional information.

Respectfully,  
 Darcy Lebau  
 State Narrative:

## Company and Contact

### Filing Contact Information

Carolyn Smart, carolyn@westmontlaw.com  
 Westmont Associates, Inc. 856-216-0220 [Phone]  
 25 Chestnut Street, Suite 105  
 Haddonfield, NJ 08033

### Filing Company Information

Catlin Insurance Company, Inc. CoCode: 19518 State of Domicile: Texas  
 1600 Market Street Group Code: 4574 Company Type: Property and  
 Casualty  
 Suite 1616 Group Name: Catlin US Insurance State ID Number: 19518  
 Group  
 Philadelphia, PA 19103 FEIN Number: 20-4929941  
 (215) 466-9132 ext. [Phone]

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$150.00  
 Retaliatory? No  
 Fee Explanation: Arkansas fee is \$50 per form.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Catlin Insurance Company, Inc.	\$150.00	05/11/2012	59117121

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/18/2012	05/18/2012

*SERFF Tracking Number:*      *CATL-128339800*                      *State:*                      *Arkansas*  
*Filing Company:*              *Catlin Insurance Company, Inc.*                      *State Tracking Number:*  
*Company Tracking Number:*      *AHAG 401 (AR) 0412*  
*TOI:*                      *H02G Group Health - Accident Only*                      *Sub-TOI:*                      *H02G.000 Health - Accident Only*  
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## **Disposition**

Disposition Date: 05/18/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Letter of Authorization	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Accident Medical Benefit Rider	Approved-Closed	Yes
Form	Total Disability Weekly Income Benefit Rider	Approved-Closed	Yes
Form	Blank Endorsement Rider	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: AHAG 401 (AR) 0412

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/18/2012	AHAG 401 (AR) 0412	Policy/Cont Accident Medical ract/Fratern Benefit Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		52.000	AHAG 401(AR) 0412 CLEAN 042412v2.doc FINAL 051112.pdf
Approved-Closed 05/18/2012	AHAG 402 0412	Policy/Cont Total Disability ract/Fratern Weekly Income al Benefit Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		52.000	AHAG 402 0412 CLEAN 042412.pdf
Approved-Closed 05/18/2012	AHAG 403 0412	Policy/Cont Blank Endorsement ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		52.000	AHAG 403 0412.pdf

**RIDER:** **AHAG 401(AR) 0412**  
POLICY HOLDER: [policy holder]  
POLICY NUMBER: [policy number]  
POLICY EFFECTIVE DATE: [policy effective date]  
POLICY ANNIVERSARY DATE: [policy anniversary date]  
POLICY TERM: [policy term]  
STATE OF ISSUANCE: [State]  
RIDER EFFECTIVE DATE: [rider effective date]

### **ACCIDENT MEDICAL BENEFIT RIDER**

We will pay the [Usual and Customary] charges for Medically Necessary Covered Medical Services after the Deductible is satisfied incurred by the Covered Person resulting from a Covered Accident. The first treatment or service must occur within [90] days of the Covered Accident and all subsequent treatments must be incurred within [52] weeks of the Covered Accident. Benefits will be paid [according to the Schedule of Benefits] up to the amount stated in the Schedule of Benefits.

#### **Definitions**

**Covered Medical Service** means any of the following services, treatments or items:

- **[Hospital Room and Board** – We will pay [the amount shown in the Schedule of Benefits] for the daily room rate when: a Covered Person is Hospital confined; and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this Covered Medical Charges, the date of admission will be counted, but not the date of discharge.]
- **[In-Patient Hospital Services** – We will pay [the amount shown in the Schedule of Benefits] for: confinement in an intensive care unit; cardiac care unit; and any other Hospital confinement.]
- **[Ancillary Hospital Charges** – We will pay [the amount shown in the Schedule of Benefits] for services and supplies including, but not limited to: operating room; laboratory tests; anesthesia; [in-hospital physiotherapy;] [nurse services;] [pre-admission tests;] and medicines (excluding take home drugs when Hospital Confined).]
- **[Medical Emergency Care and Treatment** – We will pay [the amount shown in the Schedule of Benefits] [within [24] hours of a Covered Accident and including:] attending Physician's charges; X-rays; laboratory procedures; use of the emergency room; and supplies [when followed by admission to a Hospital.]
- **[Outpatient Surgical Charges** – We will pay [the amount shown in the Schedule of Benefits] for: surgical room and supply charges for use of the surgical facility; X-Rays; laboratory procedures and tests; CT scans; CAT scans; MRIs; and any radiological procedures.]
- **[Physician Services** – We will pay [the amount shown in the Schedule of Benefits] for the following Physician Services:
  1. [Surgical Charges – charges for performing surgical procedures. Two or more surgical procedures through the same incision will be considered as one procedure.]
  2. [Assistant Physician Charges - charges by an assistant surgeon/Physician assisting the primary Physician.]
  3. [Other Physician Charges – charges including, but not limited to: the treatment of fractured and dislocated bones; operations that involve cutting or incision; and/or suturing of wounds or any other surgical procedure; including aftercare; which is given in the outpatient department of a Hospital.]
  4. [Physician's Surgical Facilities – charges for the use of the Physician's surgical facilities.]
  5. [Second Opinion or Consultation – charges for a second surgical opinion or consultation.]
  6. [Anesthesia Charges – charges for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.]
  7. [In-Hospital or Office Visits – charges for non-surgical treatment/examination expenses (excluding medicines) including: the Physician's initial visit; each necessary follow-up visit; and consultation visits when referred by the attending Physician.]
  8. [Nursing Services – charges for the services of a registered nurse (RN).]
- **[Physical Medicine (Physiotherapy)** – We will pay [the amount shown in the Schedule of Benefits] for inpatient or outpatient physiotherapy treatment(s) to include office visits connected with such treatment when prescribed by a Physician, including: diathermy; ultrasonic; whirlpool; heat treatments; adjustments; manipulation; massage; or any form of physical therapy.]
- **[[Air] Ambulance Services** – We will pay [the amount shown in the Schedule of Benefits] for [air] ambulance service to transport the Covered Person from the emergency site to the Hospital. We

will pay for [air] ambulance transportation from the first Hospital to another Hospital, if a Physician specifies in writing that specialized care not available in the first Hospital to which the Covered Person was transported is necessary to treat his or her Covered Injury(ies).]

- **[Medical Equipment Rental** – We will pay [the amount shown in the Schedule of Benefits] for rental or purchase, if less of a wheelchair, hospital bed or other medical equipment that has permanent or temporary therapeutic value. Permanent or temporary therapeutic value is determined by the Company.]
- **[Medical Services and Supplies** – We will pay [the amount shown in the Schedule of Benefits] for: blood and blood transfusions; oxygen; and other gases. We will pay for the cost and administration of the services and supplies.]
- **[Dental Services** – We will pay [the amount shown in the Schedule of Benefits] for dental charges including dental x-rays for the repair or treatment of each injured tooth that is whole and sound and a natural tooth at the time of the Covered Accident. [Dental charges related to the installation of: crowns; caps; bridges; and dentures; oral surgery; and endodontic as a result of a Covered Accident.] [Repair or replacement of caps and crowns that existed prior to the Covered Accident.]]
- **[Prescription Drugs** – We will pay [the amount shown in the Schedule of Benefits] for prescription drugs that: (a) can only be obtained through a Physician's written prescription; and (b) are approved for such prescription use by the Federal Drug Administration (FDA); unless prescribed by a Physician for therapeutic use. [The expense for a prescription drug is limited to the cost of a generic drug unless: (1) substitution of a generic drug is prohibited by law; or (2) no generic drug is available; or (3) the Covered Person's Physician specifically requests that a non-generic drug be dispensed to the Covered Person.]]
- **[Eyeglasses, Contact Lenses and Hearing Aids** – We will pay [the amount shown in the Schedule of Benefits] for: eyeglasses; contact lenses; and hearing aids when they are damaged in a Covered Accident that requires medical treatment.]
- **[Artificial Instruments** – We will pay [the amount shown in the Schedule of Benefits] for: [initial] artificial limb(s); eye(s); larynx; dental device(s); and any other orthopedic prosthetic appliance(s); including fitting. [We will not pay for future repair or replacement of artificial: limb(s); eye(s); larynx; dental device(s); or any other orthopedic prosthetic appliance(s).]]
- **[Home Health Care** – We will pay [the amount shown in the Schedule of Benefits] for care and treatment rendered to the Covered Person for Home Health Care for: (1) part-time nursing care by or supervised by a registered graduate nurse; (2) part-time home health aide service which consists of caring for the patient; (3) physical, speech and occupational therapies when indicated in conjunction with the Covered Person's discharge placement through a Rehabilitation Facility approved by the attending Physician and by Us; (4) nutritional counseling; and (5) medical social services by a qualified social worker licensed by the jurisdiction in which services are rendered. Home health care services must be preceded by a minimum Hospital stay and must begin within [5] days of discharge from a Hospital or Extended Care or Rehabilitation Facility.]
- **[Rehabilitation Treatment** - We will pay [the amount shown in the Schedule of Benefits] for physical and occupational rehabilitation. Treatment must be provided in a duly licensed Rehabilitation Facility and be under the direction of a Physician.]
- **[Extended Care Facility** – We will pay [the amount shown in the Schedule of Benefits] for Extended Care facility confinement if it begins within [10] days after a Covered Person is Hospital confined as a result of a Covered Accident. We will pay for treatment if a Physician visits the Covered Person at least once every [30] days and certifies the confinement is necessary for the treatment of a Covered Injury(ies).]
- **[Expanded Medical Benefit of Sports Conditions** – We will pay [the amount shown in the Schedule of Benefits] for the treatment of: bursitis; sprains; hernia; strains; muscle tears; tendonitis; and repetitive motion injuries if these conditions are aggravated by participation in a Covered Activity.]
- **[Hernia Treatment** – We will pay [the amount shown in the Schedule of Benefits] for the treatment of a hernia provided the hernia manifested itself as a result of a Covered Injury.]
- **[Mental and Nervous Disorder** – We will pay [the amount shown in the Schedule of Benefits] for psychotherapy charges for treatment of a disorder that results directly or independently of all other causes from a Covered Accident, while Hospital confined or on an outpatient basis. Benefits are limited to [1] treatment per day.]
- **[HMO/PPO Denial** – We will pay [the amount shown in the Schedule of Benefits] when benefits are denied or reduced by an HMO or PPO plan because services provided to treat the Covered

Injury(ies) were: (1) rendered by an Non-Preferred Provider; or (2) received outside of the network's service area. If benefits are reduced rather than denied by an HMO or PPO for the reasons described above, We will pay an amount equal to the charges incurred less the amount paid by the HOM or PPO.]

- **[Pre-Existing Conditions** – We will pay [the amount shown in the Schedule of Benefits] for treatment of an aggravation or re-injury of a Pre-Existing Condition.]
- **[Rehabilitative Braces and Applications** – We will pay [the amount shown in the Schedule of Benefits] for rehabilitative braces and applications prescribed by a Physician. It must be durable medical equipment that has therapeutic value for the Covered Person that: (1) is primarily and customarily used to serve a medical purpose; (2) can withstand repeated use; and (3) generally is not useful to a person in the absence of the Covered Injury. No benefits will be paid for rental charges in excess of the purchase price.]
- **[Temporomandibular Joint or Craniomandibular Disorder** – We will pay [the amount shown in the Schedule of Benefits] for surgical and nonsurgical services including diagnostic and therapeutic procedures by a Physician or dentist for treatment of a disorder caused by a Covered Accident. We will not pay for: orthodontic braces; crowns; bridges; dentures; treatment of periodontal disease; dental root from implants; or root canals.]
- **[Extended Treatment** – We will pay [the amount shown in the Schedule of Benefits] for services that for medical reasons could not be during benefit period including surgery to remove: pins; screws; or other surgically implanted devices used to repair: body parts; or broken bones; or joints; or treatment to repair disfigurement. We must receive notice of the deferred treatment and the estimated cost signed by a Physician within 31 days after the benefit period ends for charges to be covered.]
- **[Skilled Nursing Facility** – We will pay [the amount shown in the Schedule of Benefits] for services at a valid skilled nursing facility where such location is dedicated to the care of individuals in a residential facility, usually there on a long-term basis. **These facilities specialize in the watching, but not serious enough where hospitalization is required.** ]

**Hospital Confine(d)** means admission to a Hospital as a registered resident bed-patient for at least [24] consecutive hours by a Physician.

**Rehabilitation Facility** means a Hospital or special unit of a Hospital designated as a Rehabilitation Facility or a free standing facility which provides: physical therapy; occupational therapy; or speech therapy pursuant to the law of the jurisdiction in which treatment is received.

**Extended Care Facility** means an institution operating pursuant to applicable laws that is engaged in providing, for a fee, **room and board accommodations**, inpatient skilled nursing care and related services under the supervision of a **duly licensed Physician** and **continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.) for at least 8 hours per day and a registered graduate professional nurse (R.N.) or licensed practical nurse (L.P.N.) for the remaining 16 hours**. It must maintain medical records of all its patients.

**Home Health Care** means: nursing care; treatment; and items necessary to a person's care and health provided in the Covered Person's house as part of an overall extended treatment plan. To qualify for Home Health Care:

1. The Home Health Care must be established and approved by the attending Physician, including certification that confinement in a Hospital or Extended Care Facility would be required if it were not for Home Health Care;
2. Nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified home health care agency and nursing service; and
3. Items necessary to a person's care and health must be provided by the attending Physician or by the provider of the nursing care services.

**Pre-Existing Condition** means a condition for which a Covered Person received **or was recommended** medical advice; or treatment **from a physician** within **a five (5) year** period immediately preceding the effective date of the Covered Person's coverage.

**Medical Repatriation** means transporting a Covered Person back to his or her Primary Residence or to the country where he or she was assigned. Such repatriation shall only result from the Covered Person being injured during a Covered Activity.

**Usual and Customary** means the average amount charged by most providers for: treatment; services; or supplies in the geographic area where the: treatment; service; or supply is provided.

**Deductible** means the dollar amount of Covered Medical Charges that must be occurred as an out of pocket charge by each Covered Person on a per [Covered Accident; Policy Term] basis before Accident Medical Benefit benefits are payable under this Rider.

**Health Care Plan** means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

1. Group or blanket insurance, whether on an Insured or self-funded basis;
2. Hospital or medical service organizations on a group basis;
3. Health Maintenance Organization plans;
4. Group labor management plans;
5. Employee benefit organization plan;
6. Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended.

**Covered Expenses** means expenses incurred by or on behalf of a Covered Person for: treatment; services; and supplies covered by this Policy. Coverage under the Policyholder's Policy must remain continuously in force from the date of the Covered Accident until the date: treatment; services; or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such: treatment; service; or supply; that gave rise to the expense or the charge, was rendered or obtained.

**Pro Rata** means the portion of the total benefits payable under this Policy, in the absence of other insurance, relative to the total benefits payable under all Health Care Plans. In no event will the total benefits payable exceed 100% of the incurred expense.

### **Exclusions**

In addition to the General Exclusions stated in the Policy, We will not cover charges under this Rider for:

1. [Pre-Existing Conditions;]
2. [Treatment by persons employed or retained by the Policyholder, or by any Immediate Family Member or member of the Covered Person's household;]
3. [Treatment of: sickness; disease; or infection except: pyogenic infection; or viral or bacterial infections that result from the accidental ingestion of contaminated food substance;]
4. [Treatment of: hernia; Osgood-Schlatter's Disease; osteochondritis; appendicitis; osteomyelitis; cardiac disease or conditions; pathological fractures; congenital weakness; detached retina unless caused by a Covered injury or mental disorder; or psychological or psychiatric care/counseling or treatment (except as provided in the Policy), whether or not caused by a Covered Accident;]
5. [Pregnancy; childbirth; miscarriage; abortion; or any complication of: childbirth; miscarriage; or abortion; unless due to a Covered Injury;]
6. [Mental and Nervous Disorder (except as provided in the Policy);]
7. [Damage to or loss of dentures or bridges; or damage to existing orthodontic equipment (except as specifically covered by the Policy);]
8. [Charges incurred for treatment of temporomandibular or craniomandibular joint dysfunction and associated myofascial pain (except as provided by the Policy);]
9. [Charges for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;]
10. [Charges for injuries caused while: riding in or on; entering into or alighting from; or being struck by a 2 or 3-wheeled motor vehicle; or a motor vehicle not designed primarily for use on public streets or highways;]
11. [Participation in or practice for: interscholastic tackle football; intercollegiate sports; semi-professional sports; or professional sports (unless specifically covered under the Policy);]
12. [Covered Medical Charges for which the Covered Person would not be responsible for in the absence of this Policy;]
13. [Conditions that are not caused by a Covered Accident;]

14. [Any elective: treatment; surgery; health treatment; or examination; (including any: service; treatment; or supplies that: (a) are deemed by Us to be experimental; or (b) are not recognized and generally accepted medical practices in the United States;]
15. [Charges payable by any automobile insurance policy without regard to fault (this exclusion does not apply in any state where prohibited);]
16. [Orthopedic appliance used mainly to protect an Injury so that a Covered Person can take part in the Covered Activity;]
17. [Treatment of injuries that result over a period of time (such as: blisters; tennis elbow; etc.);]
18. [Treatment or services provided by a private duty nurse;]
19. [Replacement of artificial: limbs; eyes; larynx; dental devices; or any other prosthetic appliances;]
20. [Blood; blood plasma; or blood storage; except charges by a Hospital for processing or administration of blood;]
21. [Cosmetic; plastic; or restorative surgery; except needed as a result of the Covered Injury;]
22. [Any: treatment; service; or supply not specifically covered by the Policy;]
23. [Personal comfort or convenience items, such as but not limited to: Hospital telephone charges; television rental; or guest meals;]
24. [Charges incurred for: dental care; treatment; repair; or replacement of sound natural teeth;]
25. [Charges incurred for: eye examinations; eye glasses; contact lenses; or hearing aids or the fitting; repair; or replacement of these items;]
26. [Routine physical examinations and related medical services; elective treatment or surgery; or investigative treatments of procedures;]
27. [A Medical Repatriation;]
28. [Charges for rest cures or custodial care;]
29. [Treatment in any: Veteran's Administration; Federal or state facility; unless there is a legal obligation to pay;]
30. [Services or treatment provided by an infirmary operated by the Policyholder;]
31. [Chiropractic treatment;]
32. [Treatment of an injury resulting from or contributing to by: frostbite; fainting; or seizures; or heatstroke; or heat exhaustion;]
33. [Aggravation of an injury the Covered Person suffered before participating in the activity, unless We receive a written medical release from the Covered Person's Physician;]

## Scope of Coverage

**[Primary Benefits** – If a Covered Person incurs Covered Medical Charges, We will pay the applicable benefit, subject to the Deductible and Benefit Period as shown on the Schedule of Benefits. Such benefits will be paid on a primary basis, regardless of any other coverage the Covered Person may have.]

**[Limited Primary Benefits** – We will pay the first [\$100] of the Covered Medical Charges:

1. After the Covered Person satisfies any Deductible; and
2. Based on Our Pro Rata share.

No further benefits will be paid until the Covered Person has incurred an additional [\$10,000] of Covered Medical Charges. We then pay Covered Charges described in this Policy without regard to any other Health Care Plan.]

**[Primary Excess Benefits** – If a Covered Person incurs Covered Medical Charges, We will pay the first [\$100], subject to any applicable Deductible and Benefit Period as shown on the Schedule of Benefits. Additional Covered Medical Charges will be paid only when they are in excess of amounts payable by any other Health Care Plan; regardless of any Coordination of Benefits provision contained in which Health Care Plan.

[Failure by a Covered Person to follow the terms and conditions of his or her primary coverage will result in a benefit reduction of Covered Expense to [50%] of the amount otherwise payable under the Policy. This limitation will not apply to emergency treatment required within 24 hours after a Covered Accident. Such Covered Accident

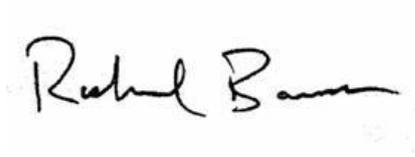
must occur outside the geographic area served by the primary plan's: HMO; PPO; or other similar arrangement for provision of benefits or services, if applicable.]]

**[Full Excess Benefits** – If a Covered Person incurs Covered Medical Charges, We will pay the applicable benefit, subject to any applicable Deductible and Benefit Period shown on the Schedule of Benefits that are in excess of amounts payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

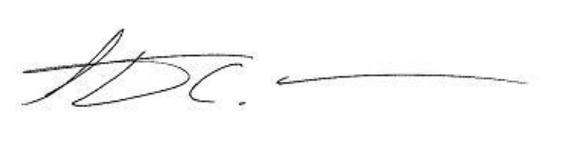
[Failure by a Covered Person to follow the terms and conditions of his or her primary coverage will result in a benefit reduction of Covered Medical Charges to [50%] of the amount otherwise payable under the Policy. This limitation will not apply to emergency treatment required within 24 hours after a Covered Accident. Such Covered Accident must occur outside the geographic area served by the primary plan's HMO, PPO or other similar arrangement for provision of benefits or services, if applicable.]

[If no Health Care Plan exists, this Policy will pay benefits on a primary basis and a deductible of [\$500] will apply to this benefit.]]

The President and Secretary of Catlin Insurance Company, Inc. witness this Rider.



\_\_\_\_\_  
President



\_\_\_\_\_  
Secretary

**RIDER:** **AHAG 402 0412**  
POLICY HOLDER: [policy holder]  
POLICY NUMBER: [policy number]  
POLICY EFFECTIVE DATE: [policy effective date]  
POLICY ANNIVERSARY DATE: [policy anniversary date]  
POLICY TERM: [policy term]  
STATE OF ISSUANCE: [State]  
RIDER EFFECTIVE DATE: [rider effective date]

**TOTAL DISABILITY WEEKLY INCOME BENEFIT RIDER**

We will pay weekly benefits[, up to [80%] of the Covered Person's Base Annual Earnings] shown in the *Schedule of Benefits*, subject to the conditions and exclusions described below, to the Covered Person whose Total Disability results: directly and independently of all other causes from; and within [31 days] of; a Covered Accident. Weekly disability benefits will begin when the Totally Disabled Covered Person satisfies the Benefit Waiting Period shown in the *Schedule of Benefits* and will end on the earliest of the date he:

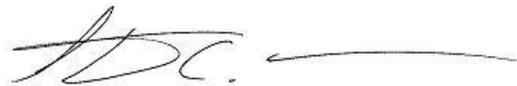
1. dies;
2. is no longer Totally Disabled;
3. fails to provide certification by a Physician that he remains Totally Disabled;
4. is eligible to receive Accidental Death and Dismemberment benefits for the same Covered Accident];
5. reaches the end of the Maximum Benefit Period shown in the *Schedule of Benefits*.

**Definitions** For purposes of this benefit:  
**[Base Annual Earnings** means the Covered Person's base annual earnings [including:][excluding:] overtime; bonuses; tips; commission; and special compensation.]

The President and Secretary of Catlin Insurance Company, Inc witness this Rider.



\_\_\_\_\_  
President



\_\_\_\_\_  
Secretary

**RIDER:** **AHAG 403 0412**  
POLICY HOLDER: [policy holder]  
POLICY NUMBER: [policy number]  
POLICY EFFECTIVE DATE: [policy effective date]  
POLICY ANNIVERSARY DATE: [policy anniversary date]  
POLICY TERM: [policy term]  
STATE OF ISSUANCE: [State]  
RIDER EFFECTIVE DATE: [rider effective date]

**BLANK ENDORSEMENT RIDER**

It is hereby understood and agreed that the following changes are made and incorporated into the Policy and Certificate:

[This endorsement will be used to make the following changes to the Policy and Certificate, which are administrative in nature: (1) changes to the Schedule; (2) addition or deletion of an affiliates; (3) changes to the classes of Covered Persons; (4) annual audit requirement; and (5) other administrative changes to the Policy and Certificate; (6) changes to any bracketed items in the policy.]

The President and Secretary of Catlin Insurance Company, Inc witness this Rider.



\_\_\_\_\_  
President



\_\_\_\_\_  
Secretary

SERFF Tracking Number: CATL-128339800 State: Arkansas  
 Filing Company: Catlin Insurance Company, Inc. State Tracking Number:  
 Company Tracking Number: AHAG 401 (AR) 0412  
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
 Product Name: Catlin Group Accident Amendment  
 Project Name/Number: Catlin Group Accident Amendment/AHAG 401 (AR) 0412

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	05/18/2012

**Comments:**

Certification of Compliance with Regulation 19 is attached. Also attached is the Readability Certification.

**Attachments:**

AR Certificate of Compliance with Rule 19 SIGNED.pdf  
 Amendment Group Accident Readability Cert.docsigned04262012.pdf

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	05/18/2012

**Comments:**

This is an amendment filing to a previously approved policy filing. The policy will utilize the application & enrollment form previously approved with the policy, Form #s AHAG A01 (AR) 0110 and AHAG A02 (AR) 0110, approved by Arkansas 04/12/2010.

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Letter of Authorization	Approved-Closed	05/18/2012

**Comments:**

Letter of Authorization is attached.

**Attachment:**

Amendment Group Accident Letter of Authorization Signed.pdf

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variability	Approved-Closed	05/18/2012

**Comments:**

Statement of Variability is attached.

**Attachment:**

Statement of Variability for Accident Medical and Total Disability Weekly Income Benefit Rider (v1 rhp 2.28.12).pdf

SERFF Tracking Number: CATL-128339800 State: Arkansas  
Filing Company: Catlin Insurance Company, Inc. State Tracking Number:  
Company Tracking Number: AHAG 401 (AR) 0412  
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
Product Name: Catlin Group Accident Amendment  
Project Name/Number: Catlin Group Accident Amendment/AHAG 401 (AR) 0412

	<b>Item Status:</b>	<b>Status</b>
<b>Satisfied - Item:</b> Cover Letter	Approved-Closed	05/18/2012
<b>Comments:</b> Cover Letter is attached.		
<b>Attachment:</b> AR Amendment Group Accident Cover Letter.pdf		

**Catlin Insurance Company**

Home Office: 1330 Post Oak Boulevard, Suite 2325, Houston, TX 77056  
Administrative Office: 3340 Peachtree Road N.E., Suite 295, Atlanta, GA 30326

**CERTIFICATE OF COMPLIANCE**

I certify that the attached submission meets the provisions of Rule 19 as well as all applicable requirements of the Arkansas Insurance Department.

A handwritten signature in black ink, appearing to be "B. C.", is written above a solid horizontal line.

Dated: 5/7/2012

## READABILITY CERTIFICATION

To Whom It May Concern:

This is to certify that the attached forms achieved a combined Flesch Reading Ease Score and are in compliance with applicable laws and regulations as follows:

Title	Combined Flesch Score
GROUP ACCIDENT POLICY	52.0
ACCIDENT MEDICAL BENEFIT RIDER	
TOTAL DISABILITY WEEKLY INCOME BENEFIT RIDER	
ENDORSEMENT RIDER	

Catlin Insurance Company, Inc.



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Bob Eells  
Director – Regulatory Development

April 26, 2012

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Date



1330 Post Oak Boulevard  
Suite 2325  
Houston, TX 77056

April 18, 2012

Catlin Insurance Company, Inc.  
FEIN#: 204929941  
NAIC#: 4574 19518

Letter of Authorization  
Filing of Forms, Rates and Rules

Dear Sir or Madame:

In accordance with the applicable statutes and regulations in your state, Darcy Lebau and Westmont Associates are hereby authorized to file form, rate and rate filings on behalf of Catlin Insurance Company, Inc.

Very truly yours,

A handwritten signature in black ink, appearing to read "Bob Eells".

Bob Eells  
Director – Regulatory Development

**Catlin Insurance Company, Inc.**  
**STATEMENT OF VARIABILITY**

**For**

**Group Accident Policy**

**ACCIDENT MEDICAL BENEFIT RIDER, FORM # AHAG 401 (AR) 0412**  
**TOAL DISABILITY WEEKLY INCOME BENEFIT RIDER, FORM # AHAG 402 0412**

Language that is bracketed in the form is intended to be variable. Below is an explanation of those variables.

<b>Accident Medical Benefit Rider</b>	
POLICY HOLDER: [ABC Company]	Varies based on the Client's legal name
POLICY NUMBER: [1234567]	Each Policyholder will have a unique policy number
RIDER EFFECTIVE DATE: [April 1, 2012]	Date in which the rider is added to the Policy
We will pay the [Usual and Customary] charges for Medically Necessary Covered Medical Services incurred by the Covered Person resulting from a Covered Accident. The first treatment or service must occur within [90] days of the Covered Accident and all subsequent treatments must be incurred within [52] weeks of the Covered Accident. Benefits will be paid [according to the Certificate Schedule] up to the amount stated in the Certificate Schedule.	[the Usual and Customary] will be in or out [90] The range will be 30 – 365 [52] The range will be 12 - 156
<ul style="list-style-type: none"> <li>• <b>[Hospital Room and Board</b> – We will pay [the amount shown in the Schedule of Benefits] for the daily room rate when a Covered Person is Hospital confined and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this Covered Medical Charges, the date of admission will be counted, but not the date of discharge.]</li> </ul>	This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out
<ul style="list-style-type: none"> <li>• <b>[In-Patient Hospital Services</b> – We will pay [the amount shown in the Schedule of Benefits] for: confinement in an intensive care unit or cardiac care unit and any other Hospital confinement.]</li> </ul>	This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out
<ul style="list-style-type: none"> <li>• <b>[Ancillary Hospital Charges</b> – We will pay [the amount shown in the Schedule of Benefits] for services and supplies including, but not limited to, operating room, laboratory tests, anesthesia, [in-hospital physiotherapy,] [nurse services,] [pre-admission tests] and medicines (excluding take home drugs when Hospital Confined).]</li> </ul>	This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out Each of [in-hospital physiotherapy,] [nurse services,] [pre-admission tests] will be in or out
<ul style="list-style-type: none"> <li>• <b>[Medical Emergency Care and Treatment</b> – We will pay [the amount shown in the Schedule of Benefits] [within [24] hours of a Covered Accident and including] attending Physician's charges, X-rays, laboratory procedures, use of the emergency room and supplies [when followed by admission to a Hospital.]</li> </ul>	This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out [within [24] hours of a Covered Accident and including] will be in or out, if in the range for [24] will be 12 - 72
<ul style="list-style-type: none"> <li>• <b>[Outpatient Surgical Charges</b> – We will pay [the amount shown in the Schedule of Benefits] for surgical room and supply charges for use of the surgical facility, X-Rays, laboratory procedures and test, CT scans, CAT scans, MRIs and any radiological procedures.]</li> </ul>	This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out
<ul style="list-style-type: none"> <li>• <b>[Physician Services</b> – We will pay [the amount shown in the Schedule of Benefits] for the following Physician Services: <ol style="list-style-type: none"> <li>1. [Surgical Charges – charges for performing surgical procedures. Two or more surgical procedures through the same incision will be considered as one procedure.]</li> <li>2. [Assistant Physician Charges - charges by an assistant surgeon/Physician assisting the primary Physician.]</li> <li>3. [Other Physician Charges – charges including, but not limited to the treatment of fractured and dislocated bones, operations that</li> </ol> </li> </ul>	This section will be in or out, if in, 1 – 8 will be in or out [the amount shown in the Schedule of Benefits] will be in or out

<p>involve cutting or incision and/or suturing of wounds or any other surgical procedure, including aftercare, which is given in the outpatient department of a Hospital.]</p> <ol style="list-style-type: none"> <li>4. [Physician's Surgical Facilities – charges for the use of the Physician's surgical facilities.]</li> <li>5. [Second Opinion or Consultation – charges for a second surgical opinion or consultation.]</li> <li>6. [Anesthesia Charges – charges for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.]</li> <li>7. [In-Hospital or Office Visits – charges for non-surgical treatment/examination expenses (excluding medicines) including the Physician's initial visit, each necessary follow-up visit and consultation visits when referred by the attending Physician.]</li> <li>8. [Nursing Services – charges for the services of a registered nurse (RN).]</li> </ol>	
<ul style="list-style-type: none"> <li>• <b>[Physical Medicine (Physiotherapy)]</b> – We will pay [the amount shown in the Schedule of Benefits] for inpatient or outpatient physiotherapy treatment(s) to include office visits connected with such treatment when prescribed by a Physician, including: diathermy, ultrasonic, whirlpool, heat treatments, adjustments, manipulation, massage or any form of physical therapy.]</li> </ul>	<p>This section will be in or out, if in, [the amount shown in the Schedule of Benefits] will be in or out</p>
<ul style="list-style-type: none"> <li>• <b>[[Air] Ambulance Services]</b> – We will pay [the amount shown in the Schedule of Benefits] for [air] ambulance service to transport the Covered Person from the emergency site to the Hospital. We will pay for ambulance transportation from the first Hospital to another Hospital, if a Physician specifies in writing that specialized care not available in the first Hospital to which the Covered Person was transported is necessary to treat his or her Covered Injury(ies).]</li> </ul>	<p>This section will be in or out, if in [air] will be in or out [the amount shown in the Schedule of Benefits] will be in or out</p>
<ul style="list-style-type: none"> <li>• <b>[Medical Equipment Rental]</b> – We will pay [the amount shown in the Schedule of Benefits] for rental or purchase, if less of a wheelchair, hospital bed or other medical equipment that has permanent or temporary therapeutic value. Permanent or temporary therapeutic value is solely determined by the Company.]</li> </ul>	<p>This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out</p>
<ul style="list-style-type: none"> <li>• <b>[Medical Services and Supplies]</b> – We will pay [the amount shown in the Schedule of Benefits] for blood and blood transfusions, oxygen and other gases. We will pay for the cost and administration of the services and supplies.]</li> </ul>	<p>This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out</p>
<ul style="list-style-type: none"> <li>• <b>[Dental Services]</b> – We will pay [the amount shown in the Schedule of Benefits] for dental charges including dental x-rays for the repair or treatment of each injured tooth that is whole and sound and a natural tooth at the time of the Covered Accident. [Dental charges related to the installation of crowns, caps, bridges and dentures, oral surgery and endodontic as a result of a Covered Accident.] [Repair or replacement of caps and crowns that existed prior to the Covered Accident.]</li> </ul>	<p>This section will be in or out, if in: [the amount shown in the Schedule of Benefits] will be in or out</p> <p>[Dental charges related to the installation of crowns, caps, bridges and dentures, oral surgery and endodontic as a result of a Covered Accident.] will be in or out [Repair or replacement of caps and crowns that existed prior to the Covered Accident.] will be in or out</p>
<ul style="list-style-type: none"> <li>• <b>[Prescription Drugs]</b> – We will pay [the amount shown in the Schedule of Benefits] for prescription drugs that: (a) can only be obtained through a Physician's written prescription; and (b) are approved for such prescription use by the Federal Drug Administration (FDA), unless prescribed by a Physician for therapeutic use. [The expense for a prescription drug is limited to the cost of a generic drug unless: (1) substitution of a generic drug is prohibited by law; or (2) no generic drug is available; or (3) the Covered Person's Physician specifically requests</li> </ul>	<p>This section will be in or out, if in: [the amount shown in the Schedule of Benefits] will be in or out</p> <p>[The expense for a prescription drug is limited to the cost of a generic drug unless: (1) substitution of a generic drug is prohibited by</p>

that a non-generic drug be dispensed to the Covered Person.]]	law; or (2) no generic drug is available; or (3) the Covered Person's Physician specifically requests that a non-generic drug be dispensed to the Covered Person.] will be in or out
<ul style="list-style-type: none"> <li>• <b>[Eyeglasses, Contact Lenses and Hearing Aids</b> – We will pay [the amount shown in the Schedule of Benefits] for eyeglasses, contact lenses and hearing aids when they are damaged in a Covered Accident that requires medical treatment.]</li> </ul>	This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out
<ul style="list-style-type: none"> <li>• <b>[Artificial Instruments</b> – We will pay [the amount shown in the Schedule of Benefits] for [initial] artificial limb(s), eye(s), larynx, dental device(s) and any other orthopedic prosthetic appliance(s), including fitting. [We will not pay for future repair or replacement of artificial limb(s), eye(s), larynx, dental device(s) or any other orthopedic prosthetic appliance(s).]]</li> </ul>	This section will be in or out, if in: [the amount shown in the Schedule of Benefits] will be in or out [initial] will be in or out [We will not pay for future repair or replacement of artificial limb(s), eye(s), larynx, dental device(s) or any other orthopedic prosthetic appliance(s).] will be in or out
<ul style="list-style-type: none"> <li>• <b>[Home Health Care</b> – We will pay [the amount shown in the Schedule of Benefits] for care and treatment rendered to the Covered Person for Home Health Care for: (1) part-time nursing care by or supervised by a registered graduate nurse, (2) part-time home health aide service which consists of caring for the patient, (3) physical, speech and occupational therapies when indicated in conjunction with the Covered Person's discharge placement through a Rehabilitation Facility approved by the attending Physician and by Us, (4) nutritional counseling and (5) medical social services by a qualified social worker licensed by the jurisdiction in which services are rendered. Home health care services must be preceded by a minimum Hospital stay and must begin within [5] days of discharge from a Hospital or Extended Care or Rehabilitation Facility.]</li> </ul>	This section will be in or out, if in: [the amount shown in the Schedule of Benefits] will be in or out  The range for [5] will be 1 - 10
<ul style="list-style-type: none"> <li>• <b>[Rehabilitation Treatment</b> - We will pay [the amount shown in the Schedule of Benefits] for physical and occupational rehabilitation. Treatment must be provided in a duly licensed Rehabilitation Facility and be under the direction of a Physician.]</li> </ul>	This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out
<ul style="list-style-type: none"> <li>• <b>[Extended Care Facility</b> – We will pay [the amount shown in the Schedule of Benefits] for Extended Care facility confinement if it begins within [10] days after a Covered Person is Hospital confined as a result of a Covered Accident. We will pay for treatment if a Physician visits the Covered Person at least once every [30] days and certifies the confinement is necessary for the treatment of a Covered Injury(ies).]</li> </ul>	This section will be in or out, if in: [the amount shown in the Schedule of Benefits] will be in or out The range for [10] will be 1 – 20  The range for [30] will be 15 - 60
<ul style="list-style-type: none"> <li>• <b>[Expanded Medical Benefit of Sports Conditions</b> – We will pay [the amount shown in the Schedule of Benefits] for the treatment of bursitis, sprains, hernia, strains, muscle tears, tendonitis and repetitive motion injuries if these conditions are aggravated by participation in a Covered Activity.]</li> </ul>	This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out
<ul style="list-style-type: none"> <li>• <b>[Hernia Treatment</b> – We will pay [the amount shown in the Schedule of Benefits] for the treatment of a hernia provided the hernia manifested itself as a result of a Covered Injury.]</li> </ul>	This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out
<ul style="list-style-type: none"> <li>• <b>[Mental and Nervous Disorder</b> – We will pay [the amount shown in the Schedule of Benefits] for psychotherapy charges for treatment of a disorder that results directly or independently of all other causes from a Covered Accident, while Hospital confined or on an outpatient basis. Benefits are limited to [1] treatment per day.]</li> </ul>	This section will be in or out, if in: [the amount shown in the Schedule of Benefits] will be in or out  The range for [1] will be 1 - 5
<ul style="list-style-type: none"> <li>• <b>[HMO/PPO Denial</b> – We will pay [the amount shown in the Schedule of Benefits] when benefits are denied or reduced by an HMO or PPO plan because services provided to treat the Covered Injury(ies) were: (1) rendered by a Non-Preferred Provider; or (2) received outside of the network's service area. If benefits are reduced rather than denied by an HMO or PPO for the reasons described above, We will pay an amount equal to the charges incurred less the amount paid by the HMO or</li> </ul>	This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out

PPO.]	
<ul style="list-style-type: none"> <li>• <b>[Pre-Existing Conditions</b> – We will pay [the amount shown in the Schedule of Benefits] for treatment of an aggravation or re-injury of a Pre-Existing Condition.]</li> </ul>	This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out
<ul style="list-style-type: none"> <li>• <b>[Rehabilitative Braces and Applications</b> – We will pay [the amount shown in the Schedule of Benefits] for rehabilitative braces and applications prescribed by a Physician. It must be durable medical equipment that has therapeutic value for the Covered Person that: (1) is primarily and customarily used to serve a medical purpose, (2) can withstand repeated use, and (3) generally is not useful to a person in the absence of the Covered Injury. No benefits will be paid for rental charges in excess of the purchase price.]</li> </ul>	This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out
<ul style="list-style-type: none"> <li>• <b>[Temporomandibular Joint or Craniomandibular Disorder</b> – We will pay [the amount shown in the Schedule of Benefits] for surgical and nonsurgical services including diagnostic and therapeutic procedures by a Physician or dentist for treatment of a disorder caused by a Covered Accident. We will not pay for orthodontic braces, crowns, bridges, dentures, treatment of periodontal disease, dental root from implants or root canals.]</li> </ul>	This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out
<ul style="list-style-type: none"> <li>• <b>[Extended Treatment</b> – We will pay [the amount shown in the Schedule of Benefits] for services that for medical reasons could not be during benefit period including surgery to remove pins, screws, or other surgically implanted devices used to repair body parts or broken bones or joints or treatment to repair disfigurement. We must receive notice of the deferred treatment and the estimated cost signed by a Physician within 31 days after the benefit period ends for charges to be covered.]</li> </ul>	This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out
<ul style="list-style-type: none"> <li>• <b>[Skilled Nursing Facility</b> – We will pay [the amount shown in the Schedule of Benefits] for services at a valid skilled nursing facility where such location is dedicated to the care of individuals in a residential facility, usually there on a long-term basis. These facilities specialize in the watching, but not serious enough where hospitalization is required. ]</li> </ul>	This section will be in or out, if in [the amount shown in the Schedule of Benefits] will be in or out
Exclusions 1 – 33	Each exclusion will be in or out
<b>Hospital Confine(d)</b> means admission to a Hospital as a registered resident bed-patient for at least [24] consecutive hours by a Physician.	The range for [24] will be 12 - 48
<b>Pre-Existing Conditions</b> means a condition for which a Covered Person received any diagnosis, medical advice, care or treatment was received or recommended within the [6 monthly] period immediately preceding the effective date of the Covered Person's coverage.	The range for [6 monthly] will be 1 – 12
<b>[Primary Benefits</b> – If a Covered Person incurs Covered Medical Charges, We will pay the applicable benefit, subject to the Deductible and Benefit Period as shown on the Schedule of Benefits. Such benefits will be paid on a primary basis, regardless of any other coverage the Covered Person may have.]	This section will be in or out
<b>[Limited Primary Benefits</b> – We will pay the first [\$100] of the Covered Medical Charges: <ol style="list-style-type: none"> <li>1. After the Covered Person satisfies any Deductible; and</li> <li>2. Based on Our Pro Rata share.</li> </ol> <p>No further benefits will be paid until the Covered Person has incurred an additional [\$10,000] of Covered Medical Charges. We then pay Covered Charges described in this Policy without regard to any other Health Care Plan.]</p>	This section will be in or out, if in: The range for [\$100] will be \$50 - \$10,000  The range for [\$10,000] will be \$1,000 - \$10,000
<b>[Primary Excess Benefits</b> – If a Covered Person incurs Covered Medical Charges, We will pay the first [\$100], subject to any applicable Deductible and Benefit Period as shown on the Schedule of Benefits. Additional	This section will be in or out, if in: The range for [\$100] will be \$50 - \$500

<p>Covered Medical Charges will be paid only when they are in excess of amounts payable by any other Health Care Plan; regardless of any Coordination of Benefits provision contained in which Health Care Plan.</p> <p>[Failure by a Covered Person to follow the terms and conditions of his or her primary coverage will result in a benefit reduction of Covered Expense to [50%] of the amount otherwise payable under the Policy. This limitation will not apply to emergency treatment required within 24 hours after a Covered Accident. Such Covered Accident must occur outside the geographic area served by the primary plan's HMO, PPO or other similar arrangement for provision of benefits or services, if applicable.]</p>	<p>This paragraph will be in or out, if in:</p> <p>The range for [50%] will be 25% - 75%</p>
<p><b>[Full Excess Benefits</b> – If a Covered Person incurs Covered Medical Charges, We will pay the applicable benefit, subject to any applicable Deductible and Benefit Period shown on the Schedule of Benefits that are in excess of amounts payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.</p> <p>[Failure by a Covered Person to follow the terms and conditions of his or her primary coverage will result in a benefit reduction of Covered Medical Charges to [50%] of the amount otherwise payable under the Policy. This limitation will not apply to emergency treatment required within 24 hours after a Covered Accident. Such Covered Accident must occur outside the geographic area served by the primary plan's HMO, PPO or other similar arrangement for provision of benefits or services, if applicable.]</p> <p>[If no Health Care Plan exists, this Policy will pay benefits on a primary basis and a deductible of [\$500] will apply to this benefit.]</p>	<p>This section will be in or out, if in:</p> <p>This paragraph will be in or out, if in:</p> <p>The range for [50%] will be 25% - 75%</p> <p>This sentence will be in or out, if in:</p> <p>The range for [\$500] will be \$100 - \$5,000</p>

### Base Policy – Schedule of Benefits

Deductible	[\$50]	The range will be \$0 - \$5,000
[Total] Accident Medical Limit	[\$100]	The range will be \$1,000 - \$5,000,000
[Hospital Room and Board	[[[\$100] per day, subject to a [5] day maximum]]	[[[\$100] per day, subject to a [5] day maximum]] will be in or out, if in: [\$100] will be \$50 - \$1,000 and [5] will be 1 - 365
[In-Patient Hospital Services	[[[\$100] per day, subject to a [5] day maximum]]	[[[\$100] per day, subject to a [5] day maximum]] will be in or out, if in: [\$100] will be \$50 - \$1,000 and [5] will be 1 – 365
[Ancillary Hospital Charges	[[[\$100] per treatment or services up to [5] treatments or services]]	[[[\$100] per treatment or services up to [5] treatments or services]] will be in or out, if in: [\$100] will be \$50 - \$1,000 and [5] will be 1 – 365
[Medical Emergency Care and Treatment	[[[\$100] per day, subject to a [1] visit maximum]]	[[[\$100] per day, subject to a [1] day maximum]] will be in or out, if in: [\$100] will be \$50 - \$1,000 and [1] will be 1 – 365
[Outpatient Surgical Charges	[[[\$100] per visit, subject to a [5] visit maximum]]	[[[\$100] per day, subject to a [5] day maximum]] will be in or out, if in: [\$100] will be \$50 - \$1,000 and [5] will be 1 – 365
[Physician Services	[[[\$100] per visit, procedure or consultation]]	[[[\$100] per visit, procedure or consultation]] will be in or out, if in: [\$100] will be \$50 - \$1,000
[Physical Medicine (Physiotherapy)	[[[\$100] per treatment, subject to a [1] visit per day maximum]]	[[[\$100] per day, subject to a [1] day maximum]] will be in or out, if in: [\$100] will be \$50 - \$1,000 and [1] will be 1 – 365

[Ambulance Services	[\$100]]	[\$100] will be in or out, if in: [\$100] will be [\$50 - \$1,000]
[Medical Equipment Rental	[\$100]]	[\$100] will be in or out, if in: [\$100] will be [\$50 - \$1,000]
[Medical Services and Supplies	[\$100]]	[\$100] will be in or out, if in: [\$100] will be [\$50 - \$1,000]
[Dental Services	[\$50]]	[\$100] will be in or out, if in: [\$100] will be [\$50 - \$1,000]
[Prescription Drugs	[[[\$100] per prescription, subject to a [5] prescription maximum]	[[[\$100] per prescription, subject to a [5] prescription maximum] will be in or out, if in: [\$100] will be [\$50 - \$1,000], [5] will be 1 - 10
[Eyeglasses, Contact Lenses and Hearing Aids	[\$100]]	[\$100] will be in or out, if in: [\$100] will be [\$50 - \$1,000]
[Artificial Instruments	[\$100]]	[\$100] will be in or out, if in: [\$100] will be [\$50 - \$1,000]
[Home Health Care	[[[\$100] per visit, subject to a [10] visit maximum Minimum Hospital Stay – [2] consecutive day(s)]]	[[[\$100] per visit, subject to a [10] visit maximum Minimum Hospital Stay – [2] consecutive day(s)]] will be in or out, if in: [\$100] will be \$50 - \$1,000, [10] will be 5 – 30 and [2] will be 1 - 365
[Rehabilitation Treatment	[[[\$100] per visit, subject to a [5] visit maximum]	[[[\$100] per visit, subject to a [5] visit maximum] will be in or out, if in: [\$100] will be [\$50 - \$1,000], [5] will be 1 - 365
[Extended Care Facility	[\$100]]	[\$100] will be in or out, if in: [\$100] will be [\$50 - \$1,000]
[Expanded Medical Benefit of Sports Conditions	[\$100]]	[\$100] will be in or out, if in: [\$100] will be [\$50 - \$1,000]
[Hernia Treatment	[\$100]]	[\$100] will be in or out, if in: [\$100] will be [\$50 - \$1,000]
[Mental and Nervous Disorder	[Hospital Expenses – [\$50] Maximum Number of Days – [5] Physician Maximum per Treatment – [\$100]]]	[Hospital Expenses – [\$50] Maximum Number of Days – [5] Physician Maximum per Treatment – [\$100]]] will be in or out, if in: [\$50] will be \$50 - \$1,000, [5] will be 1 – 365 and [\$100] will be \$50 - \$1,000
[HMO/PPO Denial	[\$2,000]	[\$2,000] will be in or out, if in: [\$2,000] will be [\$1,000 - \$5,000]
[Pre-Existing Conditions	[\$50]]	[\$100] will be in or out, if in: [\$100] will be [\$50 - \$1,000]
[Rehabilitative Braces and Application	[\$100]]	[\$100] will be in or out, if in: [\$100] will be [\$50 - \$1,000]
[Temporomandibular Joint or Craniomandibular Disorder	[\$100]]	[\$100] will be in or out, if in: [\$100] will be [\$50 - \$1,000]
[Extended Treatment	[\$100]]	[\$100] will be in or out, if in: [\$100] will be [\$50 - \$1,000]
[Skilled Nursing Facility	[\$100] per day up to [5] days]]	[\$100] will be in or out, if in: [\$100] will be [\$50 - \$1,000], [5] will be 1 - 365

### Total Disability Weekly Income Benefit Rider

POLICY HOLDER: [ABC Company]	Varies based on the Client's legal name
POLICY NUMBER: [1234567]	Each Policyholder will have a unique policy number
RIDER EFFECTIVE DATE: [April 1, 2012]	Date in which the rider is added to the Policy
We will pay weekly benefits[, up to [80%] of the Covered Person's Base Annual Salary] shown in the <i>Schedule of Benefits</i> , subject to the conditions and exclusions described below, to the Covered Person whose Total Disability results: directly and independently of all other causes from; and within [31 days] of; a Covered Accident. Weekly disability benefits will begin when the Totally Disabled Covered Person satisfies the Benefit Waiting Period shown in the <i>Schedule of Benefits</i> and will end on the earliest of the date he:	[, up to [80%] of the Covered Person's Base Annual Earnings] will be in or out, if in; [80%] will be 50% - 90%  [31 days] will be 1 – 90 days
[4. is eligible to receive Accidental Death and Dismemberment benefits for the same Covered Accident];	Will be in or out
<b>[Base Annual Earning</b> means the Covered Person's base annual earnings [including][excluding] overtime, bonuses, tips, commission, and special compensation.]	Will be in or out

### Base Policy – Schedule of Benefits

Weekly Benefit Amount	{ \$500 }	The range will be \$100 - \$5,000
Benefit Waiting Period	{ 7 days }	The range will be 7 – 180 days
Maximum Benefit Period per Covered Accident	{ 26 weeks }	The range will be 1 – 104 weeks



**WESTMONT  
ASSOCIATES, INC.**

May 11, 2012

via SERFF

The Honorable Jay Bradford  
Commissioner of Insurance  
Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201  
*Attention: Life & Health Division*

**Re: Catlin Insurance Company, Inc.  
FEIN#: 204929941  
NAIC#: 4574 19518**

**Group Accident Amendment Filing  
Forms:**

**Accident Medical Benefit Rider Form # AHAG 401(AR) 0412  
Total Disability Weekly Income Benefit Rider Form # AHAG 402 0412  
Blank Endorsement Rider Form # AHAG 403 0412**

Honorable Commissioner Bradford:

I respectfully submit the amendment filing referenced above on behalf of Catlin Insurance Company, Inc. ("Catlin") for your review and approval prior to use in your state. Westmont Associates, Inc. has been requested to file these forms on behalf of Catlin. Please see the enclosed authorization letter.

More specifically, Catlin is submitting the three (3) riders listed above to be available with its previously filed and approved Arkansas Group Accident Policy which was approved by your Department on April 12, 2010 under SERFF Tracking # CATL-126536128.

The Accident Medical Benefit Rider is an additional coverage which can be added to the Group Accident Policy by selection of the policyholder. The Accident Medical Benefit allows for payment of either expenses incurred or a fixed indemnity benefit for covered medical charges for treatment(s) directly related to covered accidents. This addition broadens the complete product available with the Group Accident Product. The Accident Medical Benefit Rider is a low cost benefit offering a very limited accident only coverage that is intended to offer supplemental cover, filling gaps in primary Major Medical plans. This coverage is not intended to be a Major Medical plan and will never be modified to include sickness exposures. The coverage will not differentiate between individuals in eligibility, benefits or premiums based on any health factor of an individual.

The Total Disability Weekly Income Benefit Rider amends the current provision in the Group Accident Policy. The revision provides the option for benefits of up to 80% of the covered person's base earnings. This amendment of this provision is a correction to follow the rating structure for this product. There were no other revisions to the remainder of the Total Disability Weekly Income Benefit provision.

The Blank Endorsement Rider is intended to allow for changes with respect to only bracketed items of the policy, within previously filed and approved SOV ranges. There is no intent with this form to change policy language which is not bracketed within the policy.

In accordance with your state's filing requirements, enclosed please find:

- Letter of Authorization
- Forms
- Statement of Variability
- Certification of Compliance with Regulation 19

I thank you in advance for the time spent on this filing and trust that you will find everything in order. Please do not hesitate to contact me directly at 856-216-0220, x 211 or at [Darcy@Westmontlaw.com](mailto:Darcy@Westmontlaw.com) if you have any questions or require additional information.

Respectfully,

***Darcy Lebau***

Darcy Lebau