

SERFF Tracking Number: HUMA-128225493 State: Arkansas
Filing Company: Kanawha Insurance Company State Tracking Number:
Company Tracking Number: 60860
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: HumanaOne Accident Benefit Plan
Project Name/Number: Individual Accident Benefit Plan/

Filing at a Glance

Company: Kanawha Insurance Company

Product Name: HumanaOne Accident Benefit Plan SERFF Tr Num: HUMA-128225493 State: Arkansas

TOI: H02I Individual Health - Accident Only SERFF Status: Closed-Approved- Closed State Tr Num:

Sub-TOI: H02I.000 Health - Accident Only Co Tr Num: 60860 State Status: Approved-Closed
Filing Type: Form/Rate Reviewer(s): Rosalind Minor

Disposition Date: 05/03/2012

Authors: Judy Lanning, Nancy
Anderson, Glenda Howell, Gary
Newman

Date Submitted: 05/02/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval
State Filing Description:

Implementation Date:

General Information

Project Name: Individual Accident Benefit Plan

Project Number:

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Forms were filed
simultaneously in our state of domicile.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 05/03/2012

State Status Changed: 05/03/2012

Deemer Date:

Created By: Gary Newman

Submitted By: Gary Newman

Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your review and approval is a new individual accident only policy form, the application to be used for the accident policy and the outline of coverage form. All of the forms are new and do not replace any forms currently on file with your Department.

Form number 60860 AR, is an individual accident only policy that provides medical expense coverage for out of pocket medical costs due to an accident. The policy also provides an accidental death benefit. This policy reimburses any out-

SERFF Tracking Number: HUMA-128225493 State: Arkansas
Filing Company: Kanawha Insurance Company State Tracking Number:
Company Tracking Number: 60860
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: HumanaOne Accident Benefit Plan
Project Name/Number: Individual Accident Benefit Plan/

of-pocket medical expenses up to the level of coverage selected at the time of issue for any covered accident. Face amounts available are \$1,000, \$2,500, \$5,000, \$7,500, and \$10,000. Face amounts available to Adults over age 65 will be limited to \$1,000 and \$2,500. Upon the attainment of age 65, benefits and premiums will reduce to \$2,500 for face amounts greater than \$2,500. Expenses must be incurred within 90 days of a covered accident. The policy will also pay a death benefit that is up to 5 times the face amount if the death is from a covered accident. The death benefit for dependent children is limited to \$10,000.

Form number AR-71111 03/2012, is the application that will be used to issue the policy. The company may also alter this form for use in electronic format; however, the overall style and appearance of the application will remain the same. The application may also be used in direct marketing campaigns; for direct marketing campaigns the "Coverage Options" section of the application will be pre-populated with the benefit amount and the corresponding premium amount for that benefit amount. All other sections of the application will be identical to the application used for other marketing methods.

Form number 1758 AR, is the outline of coverage that will be used with the policy and application forms in accordance with the requirements of your state (if any).

The forms are in final printed form subject only to changes in font style, margins, page numbers, ink and paper stock. For example, formatting may change slightly when the document is assembled through an automated document assembly system. Printing standards will never be less than those required by law. Once approved, the company reserves the right to use the forms in their approved format in a variety of media, including the Internet, with the understanding that there may be slight accommodations made for electronic viewing.

All bracketed numbers are variable to the extent by your state's laws. In addition, the bracketed text may or may not be included in the policy when printed. In no event will numbers or text be changed to impact compliance with your law.

While every effort is made to submit filings without mistakes, the company reserves the right to make corrections to any typographical errors or minor grammatical errors noted after the filing and approval.

The product will be marketed through various channels including career agents, independent agents and direct to consumer marketing. The product is a guarantee issue product. It will be made available to any primary insured in the issue age range of 0-99.

State Narrative:

Company and Contact

Filing Contact Information

Nancy Anderson, Regional Contract Analyst nanderson1@humana.com

SERFF Tracking Number: HUMA-128225493 State: Arkansas
 Filing Company: Kanawha Insurance Company State Tracking Number:
 Company Tracking Number: 60860
 TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
 Product Name: HumanaOne Accident Benefit Plan
 Project Name/Number: Individual Accident Benefit Plan/

500 W. Main Street 502-580-4230 [Phone]
 NCT-1
 Louisville, KY 40202

Filing Company Information

Kanawha Insurance Company CoCode: 65110 State of Domicile: South Carolina
 210 South White Street Group Code: 119 Company Type:
 Lancaster, SC 29720 Group Name: State ID Number:
 (800) 635-4252 ext. [Phone] FEIN Number: 57-0380426

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: \$50.00 each for policy and application.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Kanawha Insurance Company	\$100.00	05/02/2012	58867669
Kanawha Insurance Company	\$50.00	05/02/2012	58876911

SERFF Tracking Number: HUMA-128225493 State: Arkansas
 Filing Company: Kanawha Insurance Company State Tracking Number:
 Company Tracking Number: 60860
 TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
 Product Name: HumanaOne Accident Benefit Plan
 Project Name/Number: Individual Accident Benefit Plan/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/03/2012	05/03/2012

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	05/02/2012	05/02/2012	Gary Newman	05/02/2012	05/02/2012

SERFF Tracking Number: HUMA-128225493 State: Arkansas
 Filing Company: Kanawha Insurance Company State Tracking Number:
 Company Tracking Number: 60860
 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only
 Product Name: HumanaOne Accident Benefit Plan
 Project Name/Number: Individual Accident Benefit Plan/

Disposition

Disposition Date: 05/03/2012

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Kanawha Insurance Company	%	%	\$		\$	%	%

SERFF Tracking Number: HUMA-128225493 State: Arkansas
 Filing Company: Kanawha Insurance Company State Tracking Number:
 Company Tracking Number: 60860
 TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
 Product Name: HumanaOne Accident Benefit Plan
 Project Name/Number: Individual Accident Benefit Plan/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Individual Accident Policy	Approved-Closed	Yes
Form	Application for Accident Policy	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Rate	Act5uarial Memorandum	Approved-Closed	No

SERFF Tracking Number: HUMA-128225493 State: Arkansas
Filing Company: Kanawha Insurance Company State Tracking Number:
Company Tracking Number: 60860
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: HumanaOne Accident Benefit Plan
Project Name/Number: Individual Accident Benefit Plan/

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 05/02/2012

Submitted Date 05/02/2012

Respond By Date

Dear Nancy Anderson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Individual Accident Policy, 60860 AR (Form)
- Application for Accident Policy, AR-71111 04/2012 (Form)
- Outline of Coverage, 1758 AR (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$150.00. Please submit an additional \$50.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

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

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: HUMA-128225493 State: Arkansas
Filing Company: Kanawha Insurance Company State Tracking Number:
Company Tracking Number: 60860
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: HumanaOne Accident Benefit Plan
Project Name/Number: Individual Accident Benefit Plan/

Response Letter

Response Letter Status Submitted to State
Response Letter Date 05/02/2012
Submitted Date 05/02/2012

Dear Rosalind Minor,

Comments:

Thank you for your letter dated May 2, 2012, regarding the above captioned filing.

Response 1

Comments: We have submitted an additional \$50.00 as requested.

Related Objection 1

Applies To:

- Individual Accident Policy, 60860 AR (Form)
- Application for Accident Policy, AR-71111 04/2012 (Form)
- Outline of Coverage, 1758 AR (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$150.00. Please submit an additional \$50.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

SERFF Tracking Number: HUMA-128225493 *State:* Arkansas
Filing Company: Kanawha Insurance Company *State Tracking Number:*
Company Tracking Number: 60860
TOI: H02I Individual Health - Accident Only *Sub-TOI:* H02I.000 Health - Accident Only
Product Name: HumanaOne Accident Benefit Plan
Project Name/Number: Individual Accident Benefit Plan/

Thank you for your continued review and subsequent approval.

Sincerely,
Gary Newman, Glenda Howell, Judy Lanning, Nancy Anderson

SERFF Tracking Number: HUMA-128225493 State: Arkansas
 Filing Company: Kanawha Insurance Company State Tracking Number:
 Company Tracking Number: 60860
 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only
 Product Name: HumanaOne Accident Benefit Plan
 Project Name/Number: Individual Accident Benefit Plan/

Form Schedule

Lead Form Number: 60860 AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/03/2012	60860 AR	Policy/Cont ract/Fratern al Certificate	Individual Accident Policy	Initial		41.500	Accident Policy AR.pdf
Approved-Closed 05/03/2012	AR-71111 04/2012	Application/ Enrollment Form	Application for Accident Policy	Initial		40.000	AR-71111- 20120424.pdf
Approved-Closed 05/03/2012	1758 AR	Outline of Coverage	Outline of Coverage	Initial		40.000	OOC Accident Form 60860 AR.pdf

INDIVIDUAL ACCIDENT POLICY

Policy owner: [variable]
Policy number: [variable]
Effective date: [variable]
Initial modal *premium* amount: [variable]

Kanawha Insurance Company agrees to pay benefits for *services* rendered to *covered persons* who are named in the Schedule of Benefits, subject to all the terms of this *policy*. We reserve the full and exclusive right to interpret the terms of this *policy* and to determine the benefits payable hereunder.

This *policy* is issued in consideration of the *policy owner's application*, a copy of which is attached to and made a part of this *policy*, and the *policy owner's* payment of *premium* as provided under this *policy*. **Omissions or misstatements in the *application* may cause your *policy* to be voided and claims to be reduced or denied.** Please check your *application* for errors and write to us if any information is not correct or is incomplete.

This *policy* and the insurance it provides become effective 12:01 a.m. (local time) on the *effective date* stated above. This *policy* and the insurance it provides terminate at 12:00 midnight (local time) as of the date of termination. The provisions stated above and on the following pages are part of this *policy*.

Guaranteed Renewability

You can keep this *policy* during your lifetime as long as *premiums* are paid when due, subject to the *termination of coverage* provisions. You must pay each *premium* due by the due date. Your *premium* can be changed, if we change the *premium* on all policies in your *policy's premium* class. *Premiums* also vary depending on state of residence. If you move, your *premium* may change.

Right to Return Policy

You have the right to return this *policy* within [10] calendar days of its initial delivery. If you choose to return this *policy* within the [10]-day period, we will refund any *premium* that you have paid. If you return this *policy* within the [10]-day period, it will be void and we will have no liability under any of the terms or provisions of this *policy*. There will be no coverage for any claims incurred.

This is not a Medicare Supplement Policy

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us.

THIS IS AN ACCIDENT ONLY POLICY AND IT DOES NOT PAY BENEFITS FOR LOSS FROM SICKNESS. PLEASE READ THIS POLICY CAREFULLY.

THIS IS A LIMITED BENEFIT POLICY – BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.



[
[President]
]

GUIDE TO YOUR POLICY

Contents	Begins on Page
1. Introduction	[4]
2. Schedule of benefits	[5]
3. Your policy benefits	[6]
a. Accident expense benefit.....	[6]
b. Accidental death.....	[6]
4. General exclusions	[7]
5. Premium payment	[8]
a. Premium payment	[8]
b. Grace period.....	[8]
c. Changes to premium	[8]
d. Return of unearned premium.....	[8]
6. Coverage and coverage changes	[9]
a. Coverage	[9]
b. Coverage of eligible dependents.....	[9]
c. Disabled dependent child(ren)	[9]
d. Subsequent spouse	[10]
e. Coverage changes.....	[10]
7. Renewability of insurance and termination	[10]
8. Continuation of Coverage	[11]
a. Conversion.....	[11]
b. Continuation of coverage for surviving dependents	[11]
9. General provisions	[12]
a. Assignment	[12]
b. Beneficiary	[12]
c. Change of beneficiary	[12]
d. Conformity with state statutes.....	[12]
e. [Discount and services programs].....	[12]
f. [Rewards].....	[13]
g. Entire contract.....	[13]
h. Changes.....	[14]
i. Fraud.....	[14]
j. Legal actions.....	[14]
k. Misstatement of age.....	[14]
l. Non-participating.....	[14]
m. Occupational coverage	[14]
n. Physical exam/autopsy.....	[15]
o. Privacy and confidentiality statement	[15]
p. Reinstatement.....	[16]
q. Right to request overpayments	[16]
r. Time limit on certain defenses.....	[16]
s. Workers compensation.....	[16]

10. Making a claim under this policy[17]

- a. Notice of claim.....[17]
- b. Claims forms.....[17]
- c. How to file a claim.....[17]
- d. Proof of loss.....[18]
- e. Payment of benefits.....[18]
- f. Time payment of claims.....[18]

11. Definitions.....[19]

SPECIMEN

1. INTRODUCTION

As *you* read through this *policy*, *you* will notice that certain words and phrases are printed in italics. An italicized word may have a different meaning in the context of this *policy* than it does in general usage. Please check the definitions section for the definitions of italicized words, so *you* can understand their meaning as it relates to *your* insurance coverage.

This *policy* provides *you* with detailed information regarding *your* coverage. It explains what is covered and what is not covered. It is important to remember that *your* coverage has limitations and exclusions. Be sure to read *your policy* carefully before using *your* benefits.

This *policy* should be read in its entirety. Since many of the provisions of this *policy* are related, *you* should read the entire *policy* to get a full understanding of *your* coverage.

Please note that provisions and conditions of this *policy* apply to *you* and to each *covered person(s)*.

Please read the copy of *your application* that is attached to and a part of this *policy*. This *application* may have been captured electronically or on paper. This *policy* was issued on the basis that the answers to all questions shown on the *application* are correct. Please carefully review these answers to make sure they are correct. If an error exists, please notify *us* immediately.

If *you* need to contact someone about this *policy* for any reason, *you* may contact Kanawha Insurance Company by calling [855-448-6982].

2. SCHEDULE OF BENEFITS

This schedule of benefits summarizes benefit information. *You* selected these benefits when *you* applied for this *policy*. As *your* needs change over the time *you* own this *policy*, *you* may change some of these benefits without replacing or purchasing an entirely new *policy*.

Please read *your* entire *policy* to fully understand all terms, conditions, exclusions, and limitations that apply.

Coverage information

Policy owner:	[variable]
Policy number:	[variable]
Primary insured:	[variable]
Dependent(s):	[variable] [variable]
Plan type:	[variable]
Premium mode:	[variable]
[Amendment/rider:]	[variable]

Benefits

Accident Expense Benefit:

[Benefit amount for all *covered persons* until *primary insured* reaches *attained age 65*:] [\$1,000;
\$2,500; \$5,000; \$7,500; \$10,000]

Benefit amount for all *covered persons* after *primary insured* reaches *attained age 65* and over: [\$1,000;
\$2,500]

Accidental Death Benefit:

[Benefit amount for *primary insured* and *spouse* (if covered) until *attained age 65*:] [\$5,000;
\$12,500; \$25,000; \$37,500; \$50,000]

Benefit amount for *primary insured* and *spouse* (if covered) after *attained age 65*: [\$5,000; \$12,500]

[Benefit amount for *dependent child(ren)* (if covered)] [\$5,000; \$10,000]

Benefits automatically reduce, per the schedule above, when the *primary insured* reaches *attained age 65*, unless the \$1000 or \$2500 benefit is the current benefit amount. *Premiums* will be adjusted accordingly.

3. YOUR POLICY BENEFITS

Subject to all terms in this *policy*, we will pay the benefit up to the benefit level shown on the Schedule of Benefits. *Proof of loss* must be submitted. Benefits are only payable for each *covered accident* and *accidental death* for which *proof of loss* has been received by us.

We will pay benefits to the *policy owner*.

a. Accident expense benefit

We will pay the benefit for each *covered accident* up to the benefit level shown on the Schedule of Benefits, when we receive *proof of loss* showing that a *covered person* has *actual out of pocket expenses* for services provided by a *licensed healthcare professional* in a *licensed healthcare professional's office, hospital, emergency room, urgent care center, ambulance or an ambulatory surgical center* in connection with *injuries* sustained in a *covered accident*.

Services provided in an *emergency room* or *urgent care center* must commence within 72 hours after the *accident*.

Services must be rendered in the United States, unless immediate medical care is necessary for a *covered accident* due to *injury* sustained outside of the United States or its possessions.

If a *covered person* has existing medical coverage, we will reimburse the lesser of the *maximum allowable fee* or the *actual out of pocket expenses* incurred by the covered person up to the benefit level selected. When filing a claim, we will require the *explanation of benefits* from your existing insurance company or an itemization of services rendered that includes the dates of service, diagnosis, procedures and charges.

If a *covered person* has no other existing medical coverage, we will reimburse the lesser of the *maximum allowable fee* or the *actual out of pocket expenses* incurred by the *covered person* up to the benefit level selected.

Expenses must be incurred within 90 days of the *covered accident* for services provided in:

- a *hospital*,
- *emergency room*,
- *urgent care center*,
- *ambulance*,
- *ambulatory surgical center*, or
- a *licensed healthcare professional's office*.

b. Accidental death benefit

We will pay the benefit up to the benefit level shown on the Schedule of Benefits, when we receive *proof of loss* showing that a *covered person* has suffered an *accidental* loss of life which is directly due to *injuries* from a *covered accident*, independent of all other causes, that occurred while covered under this *policy*, while coverage is in force and within 90 days of the *accident*.

4. GENERAL EXCLUSIONS

This *policy* does not provide benefits for loss under a *covered accident* or *accidental death* that is contributed to, caused by, or occurs during:

1. *Services* which:
 - a. Are not *medically necessary*;
 - b. Are not prescribed by a *licensed healthcare professional* as necessary to treat an *injury*;
 - c. Are determined to be *experimental/investigational* or for *research purposes*;
 - d. Are elective procedures;
 - e. Are received without charge or legal obligation to pay;
 - f. Are provided by home healthcare or private nursing;
 - g. Are not specifically listed as *covered expenses* in the *policy*.
2. Acts of war, whether declared or not.
3. Being on active duty serving in any armed forces. Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 consecutive days.
4. Being incarcerated.
5. Committing or attempting to commit a felony.
6. Intentionally self-inflicted bodily harm, attempted suicide or suicide whether sane or insane.
7. Being legally intoxicated or under the influence of alcohol while operating a motorized vehicle as defined by the laws of the state or jurisdiction in which the *injury* occurs.
8. Being the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license, except in a Driver's Education Program.
9. Traveling or flying by air, except as a fare-paying passenger and not as a pilot or crew member, on a regularly scheduled commercial airline.
10. Being under the influence of any drugs, narcotics, sedatives, poison or intentional inhalation of any gas or fumes unless taken or inhaled as prescribed to the *covered person* or administered by a *licensed healthcare professional*.
11. Participating in *dangerous sports*.
12. Practicing for or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received.
13. Being over the age of 18 and participating in or practicing for any martial art, mixed martial art or similar organized fight sports activity including but not limited to boxing, wrestling, karate, judo, ultimate fighting, kick boxing or similar disciplines.
14. Testing, racing or otherwise competing with any motorized vehicles, including but not limited to street racing, all-terrain vehicles (ATV's), speed boats and snow mobiles.
15. Being covered by Worker's Compensation, Employer Liability Law or Occupational Disease Act or Law.
16. *Services* rendered to the teeth as a result of chewing or biting or other normal activity of the teeth.
17. *Dental services*, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including, but not limited to, excision of partially or completely erupted impacted teeth, any oral or periodontal surgery and preoperative and post-operative care, implants and related procedures, orthodontic procedures, and any *dental services* related to a *sickness*, unless necessitated by *injury* from a *covered accident*.
18. Prescription drugs filled by a retail and/or mail order pharmacy.
19. Durable medical equipment that is not prescribed or issued by a *licensed healthcare professional*.
20. Treatment in any government or federal *hospital*, except if there is a legal obligation to pay.
21. Cosmetic surgery, except for reconstructive surgery on an injured part of the body for expenses incurred while coverage is in force.
22. Handling, storing or transporting explosives.
23. Handling or working with wild nondomestic animals.
24. Repetitive motion *injuries* including but not limited to carpal tunnel, cubital tunnel, or sprains, strains, hernia, tendonitis, bursitis and heat exhaustion not related to a specific *injury*.
25. Any *sickness* or declining process caused by a *sickness*, including physical or mental infirmity. *We* also will not pay this benefit to diagnose or treat any *sickness*.

26. *Services* that may be needed to correct *injuries* that originated in an *accident* that occurred prior to the *effective date* of this *policy*. Nor does coverage exist for *injuries* sustained after the *effective date* that occur to body parts that have been weakened from an *injury* that preceded the *effective date*.
27. Complications directly related to *services* that were completed for any other cause other than a *covered accident*.
28. Taking part in a riot.
29. Engaging in an illegal occupation.

5. PREMIUM PAYMENT

a. Premium payments

You must pay the required *premium* to us as it becomes due. If you don't pay your *premium* on time, we will terminate coverage.

The first *premium* is due on the date specified by us. Subsequent *premiums* are due on the date we assign. All *premiums* are payable to us at our address.

b. Grace period

You have 31 days from the *premium* due date to remit the required payment. If *premium* is not paid we will terminate the insurance as of the last day of the *premium* period for which *premium* was paid.

c. Changes to premium

Premium amounts are based on the benefits you chose, *plan type*, *attained age*, gender and state of residence of the *primary insured* on the *policy effective date*. The *premium* can be changed for the following reasons:

- If we change the *premium* on all policies in the same *premium* class;
- If you apply for and we approve a change in the coverage amount or *plan type*;
- If you apply for and we approve addition of *covered person(s)*;
- If a *covered person(s)* is deleted;
- If *premium* payment method is changed;
- A misstatement on the *application* that affects the *premium* charged; or
- If your state of residence changes.

If we change the *premium* on all policies in the same *premium* class, we will give you [30] days written notice before such *premium* change occurs. Any increase or decrease in *premiums* will start on the *premium* due date no sooner than [30] days after the written notice is given. Any other change in *premium* will start on the date following the change in coverage.

d. Return of unearned premium

If the *primary insured* dies and *premium* was paid in advance, *premium* paid past the end of the month in which death occurred will be refunded upon notice to us. A certified copy of the death certificate will be required.

Any unearned *premium* returned will be paid to your estate or to your beneficiary if you have named one for this *policy*.

If this *policy* terminates for any reason as stated in the in the Renewability of Insurance and Termination section of this *policy*, and *premium* was paid in advance, the *premium* paid past the end of the month in which termination occurred will be refunded.

6. COVERAGE AND COVERAGE CHANGES

a. Coverage

Each person named in the *application* as a person proposed for coverage is a *covered person* unless excluded by *us* when this *policy* was issued. Coverage begins at 12:01 a.m. local time in *your* state of residence on the *policy effective date*.

Coverage ends as stated in this *policy*. See the Renewability of Insurance and Termination section.

b. Coverage of eligible dependents

If *you* chose a *plan type* that allows coverage for *eligible dependents*, all such *eligible dependents* named in the *application* as persons proposed for coverage are *covered persons* unless:

- excluded by *us* when this *policy* was issued; or
- coverage ends according to the terms of this *policy*.

Premium due for *eligible dependent* coverage must be paid pursuant to the *premium* payment provision.

For an *eligible dependent* not listed on the *application* to be covered under this *policy* as a *covered person*, *you* must:

- apply to *us* in writing;
- include *evidence of insurability* for any such *eligible dependent*; and
- be covered by a *plan type* that would allow for such *eligible dependent* to be covered.

Coverage is only effective if approved by *us*. If coverage is approved by *us*, it will start at 12:01 a.m. local time in *your* state of residence on the date *we* approved it.

Newborn children are covered from the moment of birth provided they are added to the *policy* within 31 days of birth and any necessary *premium* is paid. Adopted children are covered at the earlier of the date of adoption or the date legally placed for adoption provided they are added to the *policy* within 31 days of adoption or placement for adoption and any necessary *premium* is paid.

c. Disabled dependent child(ren)

A *dependent child* who is *disabled* while he/she is a *covered person* under this *policy*, may continue to be covered by this *policy* after his/her coverage as a *dependent child* would otherwise end, as long as he/she:

- is and remains unmarried;
- is and continues to be *disabled*; and
- has not contributed more than one-half toward his or her own support during the prior calendar year.

The proper *premium* must continue to be paid.

We will require proof that such *dependent child* is *disabled*.

We must receive:

- a copy of the *primary insured's* or *primary insured's spouse's* most recent tax return showing this child as a dependent; or
- a copy of the Social Security disability certification for this child.

We may also require a *licensed healthcare professional's* statement regarding the nature and severity of the disability.

Such proof will not be required more frequently than annually.

In no event will coverage for any *covered person* continue beyond the date that this *policy* ends.

d. Subsequent spouse

If *your plan type* allows, the *primary insured's* subsequent *spouse* may be added as a *covered person* while this *policy* is in force. You must:

- apply in writing;
- include *evidence of insurability* for this *spouse*; and
- pay the required *premium* for this *spouse's* coverage.

e. Coverage changes

You may ask *us* to change the benefit level or *plan type*. A *plan type* change is only effective if approved by *us*.

To decrease the benefit level or remove *covered persons*, make a written request to *us* on a form that *we* provide.

To increase the benefit level or change the *plan type*, you must:

- make a written request on a form that *we* provide;
- provide *evidence of insurability* acceptable to *us*; and
- pay the required *premium*.

Upon a coverage change, *we* will adjust *premiums* on the first day of the *policy* month after *we* approve a change.

7. RENEWABILITY OF INSURANCE AND TERMINATION

This *policy* is renewable at the option of the *policy owner*, except for the conditions stated below. *We* will terminate *your policy* at the end of the *policy* month in which any of the following events occur unless stated otherwise:

- the required *premium* was due to *us* and not received by *us*. Termination will be effective on the last day for which the *premium* was paid;
- *you* request termination of the *policy* in writing;
- *you* or a *covered person* commit fraud or make an intentional fraudulent misrepresentation of a material fact. Termination will be effective at 12:01 a.m. local time at *your* state of residence on the date the misrepresentation occurred; or
- the date an *eligible dependent* no longer meets eligibility requirements.

8. CONTINUATION OF COVERAGE

a. Conversion

If a *covered person's* benefits under this *policy* terminate, they may be eligible to convert to a new *policy*. Benefits under the new *policy* may differ from the benefits under this *policy*. The following rules apply to such a change in coverage.

1. Eligibility for a new policy

A *covered person* may be eligible to receive a new *policy* if they have had coverage in-force for 90 days and one of the following events occurs:

- a. Coverage for a *dependent child* under this *policy* terminates due to the child ceasing to meet the definition of a *dependent child* ;or
- b. Coverage under this *policy* terminates for the *spouse* or any covered *dependent child* of the *primary insured* and/or of the *primary insured's spouse* due to dissolution of marriage, annulment or divorce.

If one of the above events occurs, the *covered person* must submit both a written request for the new *policy* and pay the required *premium* within 31 days of the date coverage under this *policy* terminated.

A *policy* applied for under one of the events described above does not require medical underwriting.

A separate *policy* may be issued to each former *covered person*, or a single family *policy* may be issued to all former *covered persons* together. However, if coverage ended due to dissolution of marriage, annulment or divorce, only those *covered persons* who cease to be an *eligible dependent* of the *primary insured* and/or the *primary insured's spouse* are eligible for coverage under the new *policy*.

We may refuse to issue a *policy* if we determine that the *covered person(s)* have other insurance which we determine would result in duplicate benefits, or if the previous coverage was terminated due to fraud, intentional misrepresentation or non-payment of *premium*.

2. Conditions for receiving your new policy

The new *policy* will be effective on the day after coverage under this *policy* ends. The *premium* for the new *policy* will be the *premium* charged by us as of the effective date based upon the new *policy* form, classification of risk, *attained age*, benefit amounts selected and other criteria we use to determine *premium*. The *premium* may change.

The new *policy* is not a continuation of the *covered person's* terminated coverage. The *policy* benefits may differ from those provided under the prior coverage.

b. Continuation of coverage for surviving dependents

If this *policy* has been in-force for at least 90 days and the *policy owner* dies while dependent coverage is in-force, the surviving *eligible dependents* that are covered under this *policy* on the date of death may be eligible to continue coverage under this *policy*.

The surviving *spouse* or legal guardian of the covered *eligible dependent* child(ren) must notify us in writing and request continuation within 31 days of the *policy owner's* death. *Premium* must continue to be paid in order for coverage to continue. The *premium* may change and will be based upon the classification of risk and *attained age* of those continuing coverage.

The surviving *spouse* will become the *policy owner* if covered under this *policy* on the date of death. In the case of child-only coverage, the surviving *eligible dependent's* parent or legal guardian will become the *policy owner* of the continued *policy*.

All terms, conditions, exclusions and limitations in this *policy* will continue to apply.

9. GENERAL PROVISIONS

a. Assignment

Assignment of benefits may be made only with *our* consent. An assignment is not binding until *we* receive and acknowledge in writing the original or copy of the assignment before payment of the benefit. *We* do not guarantee the legal validity or effect of such assignment.

b. Beneficiary

The *policy owner* may name any beneficiary he/she chooses. If a payment is to be made to two or more beneficiaries, but *you* have not specified the portions payable to each, the payment will be shared equally. If *you* have not named a beneficiary, or if the beneficiary named is not alive at *your* death, the payment will be made at *our* option, to any one or more of the following:

- *your* spouse;
- *your* children;
- *your* parents;
- *your* brothers and sisters; or
- *your* estate

c. Change of beneficiary

You can change any beneficiary during the lifetime of the *covered person* unless an irrevocable beneficiary is named.

A change in beneficiary must be made by filing a written request in a form satisfactory to *us*. The change will be effective as of the day it was signed but *we* will not be liable for any action taken before notice is received at *our* Home Office. *We* reserve the right to require this *policy* for endorsement.

d. Conformity with state statutes

Any *policy* term that is in conflict with the statutes of the state in which this *policy* was issued is hereby amended to meet the minimum requirements of such statute(s).

e. [Discount and services programs

From time to time, *we* may offer or provide *you* with access to discount programs. In addition, *we* may arrange for third-party service providers to provide *you* with discounts on goods and services. Some of these third-party service providers may make payments to *us* when these discount programs are used. These payments offset the cost to *us* of making these programs available and may help reduce the costs of *your* plan administration.

Although we may arrange for third parties to offer discounts on these goods and services, these discount programs are not insured benefits under the *policy*. The third-party providers are solely responsible for providing the goods and/or services. We are not responsible for any goods and/or services nor are we liable if vendors refuse to honor such discounts. Further, we are not liable for the negligent provision of such goods and/or services by third-party service providers. Discount programs may not be available to people who "opt out" of marketing communications, or where otherwise restricted by law.]

f. [Rewards

From time to time we may enter into agreements with third parties who administer rewards programs that may be available to you. Through these programs, you may earn rewards by:

- Completing certain activities such as wellness, educational, or informational programs; or
- Reaching certain goals such as lowering blood pressure or becoming smoke free.

The rewards may include non-insurance benefits such as [merchandise][,] [gift cards][,] [debit cards][,] [or] [discounts]. We are not responsible for any rewards that are non-insurance benefits or for your receipt of such reward.

The rewards may also include insurance benefits such as [credits toward *premium*] as permitted under applicable state and federal laws.

The rewards may be taxable income. You may consult a tax advisor for further guidance.

Our agreement with any third party does not eliminate any of your obligations under this *policy* or change any of the terms of this *policy*. Our agreement with the third parties and the program may be terminated at any time, although insurance benefits will be subject to applicable state and federal laws.

Please call the telephone number listed [in the marketing literature issued by the rewards program administrator] for a possible alternative activity if:

- It is unreasonably difficult for you to reach certain goals due to your medical condition; or
- Your licensed healthcare professional advises you not to take part in the activities needed to reach certain goals.

[The rewards program administrator] [or] [we] may require proof in writing from your licensed healthcare professional that your medical condition prevents you from taking part in the available activities. The decision to participate in these programs or activities is voluntary and you may decide to participate anytime during the year.

Refer to the marketing literature issued by the rewards program administrator for their program's eligibility, rules and limitations.]

g. Entire contract

This *policy* includes:

- the *application*;
- the *policy* schedule of benefits;
- any endorsement or amendment;
- any attached riders;
- any *application* for reinstatement, if the *policy* is reinstated after lapse; and
- any *application* adding a covered person.

This *policy* constitutes the entire contract between *us* and *you*. All statements made by *you* are considered to be representations and not warranties. All statements are made in good faith. No statements or omission will void this *policy*, reduce the benefits provided or be used in defense to a claim unless it is contained in the *application* and a copy is furnished to *you*.

h. Changes

Only *our* officers have the authority to waive, alter or change any of the terms or conditions of the *policy*. Any change to the *policy* must be in writing and signed by an officer of the *company*. No insurance producer, agent or broker has the authority to waive, alter or change any of the terms or conditions of this *policy* or make any agreements about this *policy* that are binding on *us*.

i. Fraud

Fraud is when any person(s) willingly and knowingly engage(s) in an activity intended to defraud *us*, by submitting a claim form, *application* or other form that contain(s) a false or deceptive statement, or other false information.

If *you* commit fraud, *you* may also be guilty of the crime of insurance fraud and subject to fine(s) and or imprisonment, or both, if convicted.

If *you* commit fraud against *us*, *your* coverage ends automatically, as of the date fraud is committed or as of the date otherwise determined by *us*. *We* will send written notice of cancellation to *you* at least [30] days prior to the termination of *your* *policy*.

We may notify all state and federal law enforcement agencies of any suspected fraud.

We reserve the right to recover any payments made by *us* that were made to *you* and/or any party on *your* behalf, based on fraudulent or misrepresented information.

j. Legal actions

Legal action cannot be taken against *us*:

- sooner than 60 days after due *proof of loss* has been submitted to *us*; or
- more than 3 years after the time written *proof of loss* is required to be filed according to the terms of this *policy*.

k. Misstatement of age

If the *covered person's* age is misstated in the *application*, *premiums* will be adjusted based upon the correct age. *You* will have to pay any additional *premium* due. In the event the additional *premium* due is not paid, this amount due may be deducted from benefits due.

l. Non-participating

This *policy* is issued on a non-participating basis and will not share in *our* surplus or earnings. This *policy* will not pay dividends.

m. Occupational coverage

A *covered person*, as specified below, who is not eligible to receive Workers' Compensation benefits is eligible for occupational coverage under this *policy*, if the *covered person* is recognized under state law as:

- A sole proprietor in a proprietorship;
- A partner in a partnership; or
- An executive officer in a corporation.

No benefits will be provided for, or on account of:

1. An *injury* eligible for benefits under Workers' Compensation, Employers Liability or similar laws even when a claim for benefits is not filed; and

2. A sole proprietor, partner or executive officer who is engaged in the following professions or activities: actors, actresses, air craft operations, air traffic controllers, services related to the sale of alcoholic beverages, asbestos and toxic chemical workers, armed forces, atomic energy, cage fighting, circus or carnival workers, commercial fishermen, dock workers, drivers (racing or testing), entertainers, explosive workers, firefighters, fireworks, half-way house workers, heavy construction, home building or remodeling, horse trainers, iron workers, jockeys, law enforcement, loggers, models, migrant workers, mining, musicians, oil or natural gas workers, including offshore operations, pilots, private investigators, professional drivers, rodeo participants, roofers, quarry workers, salvage operations, sawmill workers, steel workers, ski instructors, steeplejacks, truckers, tunnel workers, or window cleaners (working over 3 stories).

n. Physical exams/autopsy

We have the right to have any *covered person* examined or autopsied by a *licensed healthcare professional* of *our* choice while a claim is pending unless prohibited by law. This right may be exercised as often as *we* deem reasonably required to determine *policy* benefits and will be at *our* expense.

o. Privacy and confidentiality statement

We understand the importance of keeping *your* personal information private, which includes *your* name, address, telephone number, social security number, medical information and financial information.

Under *our* policies, *we* have a responsibility to protect the privacy of *your* personal information. *We*:

1. Protect *your* privacy by limiting who may see *your* personal information;
2. Limit how *we* may use or disclose *your* personal information;
3. Inform *you* of *your* legal duties with respect to *your* personal information;
4. Explain *our* privacy policies; and
5. Strictly adhere to the policies currently in effect.

We reserve the right to change *our* privacy practices at any time, as allowed by applicable law, rules and regulations. *We* reserve the right to make changes in *our* privacy practices for all personal information that *we* maintain, including information *we* create or received before *we* made the changes. When *we* make a significant change in *our* privacy practices, *we* will send notice to *you*. For more information about *our* privacy practices, please contact *us*.

As a *covered person*, *we* may use and disclose *your* personal information, without *your* consent/authorization, to pay claims for expenses incurred from a *covered accident*. *We* may collect *your* personal information from other Humana affiliated companies to pay claims for expenses incurred from a *covered accident*. *We* may share *your* personal information with other Humana affiliated companies, as permitted by law. To obtain a list of Humana affiliated companies, please contact *us* at [855-448-6982] or visit *our* website at [Humana.com].

It has always been *our* goal to ensure the protection and integrity of *your* personal information. Therefore, we will notify *you* of any potential situations where *your* identification would be used for reasons other than payment and operations activities.

p. Reinstatement

If this *policy* is terminated due to lack of *premium* payment, other than *your* initial *premium* payment, *you* may request reinstatement. We will reinstate *your policy* provided all of the following are met:

- A new *application* is submitted by *you*;
- Coverage has not been terminated for more than 90 days; and
- We approve the reinstatement.

If *your* request for reinstatement is approved, coverage will be reinstated on the date we approve the reinstatement.

No benefits will be paid for any *covered accident* or *accidental death* that occurs during the time between the termination date and the reinstatement date if:

- A *covered person* received medical treatment, diagnosis, consultation or other *services*;
- The *covered accident* produced symptoms or was capable of being diagnosed; or
- The *covered accident* is not disclosed on the *application* for reinstatement.

q. Right to request overpayments

We reserve the right to recover any payments made by *us* that were:

- Made in error;
- Made to *you* and/or any party on *your* behalf, where we determine that such payment made is greater than the amount payable under this *policy*;
- Made to *you* and/or any party on *your* behalf, based on fraudulent or misrepresented information; or
- Made to *you* and/or any party on *your* behalf for charges that were discounted, waived or rebated.

r. Time limit on certain defenses

No misstatements, except fraudulent ones, made by *you* in the *application* for this *policy* can be used to deny a claim for a loss incurred by a *covered person* after two years from the *policy effective date*.

No misstatements, except for fraudulent ones, contained in any *application* submitted after the *policy effective date* can be used to deny a claim for loss incurred by a *covered person* after two years from the date we receive it.

s. Workers compensation

This *policy* is not in lieu of any Workers' Compensation or occupational disease insurance.

If benefits are paid by *us* and we determine that the benefits were for treatment of a *covered accident* or *accidental death* that arose from, or was sustained in the course of, any occupation or employment for compensation, profit, or gain, we have the right to recover as described below. We will exercise *our* right to recover against *you* or the *covered person*.

The recovery rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

- No final determination is made that *injury* was sustained in the course of or resulted from the *covered person's* employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by the *covered person* or the Workers' Compensation carrier; or
- Medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You and the *covered person* hereby agree that, in consideration for the coverage provided by this *policy*, *we* will be notified of any Workers' Compensation claim the *covered person* makes, and that *you* or the *covered person* agree to reimburse *us* as described above.

10. MAKING A CLAIM UNDER THIS POLICY

a. Notice of claim

A written notice of claim must be given to *us* within [20] days after a covered loss starts or as soon thereafter as is reasonably possible. A covered loss is an occurrence for which benefits are provided under the terms of this *policy*.

The notice of claim should include:

- the *covered person's* name;
- *policy* number; and
- a description of the claim.

Mail the notice of claim to:
Kanawha Insurance Company
[PO Box 2000
Lancaster, SC 29721-2000]

b. Claims Forms

Upon receipt of a notice of claim, *we* may provide *you* the forms usually provided by *us* for filing *proof of loss*. If the forms are not provided within [15] days after the date of the notice, *you* shall be considered to have complied with the requirements of this *policy* as to *proof of loss* by submitting, within the time fixed in the *policy* for filing *proofs of loss*, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

c. How to file a claim

On request, *we* will tell the *primary insured* or other claimant what forms or documents are required.

We will give *you* or the claimant a claim form upon request. *You* are responsible for any costs for completing the claim form.

We will not duplicate benefits for expenses that are paid by Medicare. Before filing a claim with *us*, *you* must first file a claim with Medicare, if applicable. After filing the claim with Medicare, *you* must send a copy of the itemized bill and copy of the *explanation of benefits* to *us*.

We may ask for other *proof of loss* from *hospitals* and *licensed healthcare professionals*. We will pay the reasonable cost of obtaining these records.

d. Proof of loss

Proof of loss, which includes a completed claim form if required, showing dates of loss, must be given to *us* within [90] days after the covered loss starts. If *you* are not able to give *proof of loss* within [90] days, *proof of loss* must be given to *us* as soon as is reasonably possible. In any event, *proof of loss* must be given not later than one year from the time the covered loss starts, unless *you* are legally unable to do so.

We have the right to defend any claim for benefits under this *policy* and to investigate any such claim. We may require authorizations to obtain medical and psychiatric information as well as non-medical information prior to processing any claim for benefits.

e. Payment of benefits

Benefits will be paid to the *policy owner* immediately upon receipt of written *proof of loss*.

If benefits are payable to *your* estate or to a beneficiary who cannot give *us* a valid release, we can pay benefits up to [\$1,000] to someone related to the *policy owner* by blood or marriage whom we consider to be entitled to the benefits. Any payment made by *us* in this manner fully discharges *us* and releases *us* from further claims for the benefits paid.

f. Time of payment of claims

Payments due under this *policy* will be paid no more than [30] days after *our* receipt of complete *proof of loss*.

11. DEFINITIONS

The following are definitions of terms as they are used in this *policy*. Defined terms are printed in italic type wherever found in this *policy*.

Accident(al) means a sudden, unforeseen and unexpected external event which occurs without *your* intent, which results in an *injury* to a *covered person* and which is not excluded in the General Exclusions section.

Accidental death means loss of life which results directly from *injury* or infection caused by *injury*.

Actual out of pocket expenses means *medically necessary* expenses incurred by a *covered person* that the *covered person* is responsible to pay for *services* provided for a *covered accident*, including but not limited to co-pays, deductibles, and co-insurance from any other medical health plans.

Attained age means age of a *covered person* as of his/her last birthday.

Ambulance means a motor vehicle, including but not limited to a car, van, airplane, helicopter, ship, specially equipped for carrying a *covered person* with *injuries* sustained from a *covered accident* to a *hospital, urgent care center, emergency room, or an ambulatory surgical center*.

Ambulatory surgical center means a duly licensed facility that is mainly engaged in performing outpatient surgery. It must:

- be staffed by *licensed healthcare professionals*;
- have permanent operating and recovery rooms;
- be staffed and equipped to give emergency care; and
- have written back-up arrangements with a local *hospital* for emergency care.

Applicant means the person who signed the *application* for this *policy*.

Application means the form signed by the *applicant* and submitted to *us* for this *policy*.

Covered accident means an *accident* that:

- occurs on or after the *effective date* of this *policy*;
- occurs while this *policy* is in force, and
- is not excluded by specific description in this *policy*.

Covered person(s) means anyone eligible to receive *policy* benefits. Refer to the Schedule of Benefits for a complete list.

Dangerous sports means certain activities perceived as having a high level of inherent danger and an element of personal risk. These activities may involve speed, height, increased risk of bodily *injury*, and highly specialized gear. *Dangerous sports* include all extreme sports including but not limited to intentional free fall, bungee jumping, sky diving, cliff diving, base jumping, ultra-light flying, hang gliding, parachuting, hot air ballooning, parasailing, flight in a space craft or any craft designed for navigation above or beyond the earth's surface, indoor climbing, rock climbing, adventure racing, caving, street luge, scuba diving, scaling cliffs or mountain walls, parkour or zip lining.

Dependent child(ren) means the natural children and adopted children of the *primary insured* and/or of the *primary insured's spouse* who:

- [are less than [18] years of age] [or are less than [26] years of age [if a full-time student]];
- [are unmarried]; [and]

- [have not contributed more than one-half towards their own support during the prior calendar year].

An adopted child does include a child legally placed for adoption with the *primary insured* or with the *primary insured's spouse*. An adopted child also includes a child for whom the *primary insured* or primary insured's spouse has filed a petition to adopt.

Disabled means inability to engage in self-sustaining employment due to mental incapacity or physical handicap.

Effective date means the first date all the terms and provisions of this *policy* apply. It is the date that appears on the cover page of this *policy* or the date of any amendment, rider or endorsement.

Eligible dependent(s) means those persons, other than the *primary insured*, who may be provided coverage by this *policy*. The *plan type* that you chose on the *application* determines which, if any, *eligible dependents* can be covered by this *policy*.

Eligible dependents are the *primary insured's*:

- *spouse*;
- *dependent children*; and
- *spouse's dependent children*.

Emergency room means a specified area in a *hospital* which is designated for the emergency care of *injuries*. This area must be:

- staffed and equipped to handle trauma;
- be supervised and provide *services* by *licensed healthcare professionals*; and
- providing care seven days per week, 24 hours per day.

Evidence of insurability means a form acceptable to *us* showing that a person meets *our* requirements for coverage under this *policy*.

Experimental, investigational or for research purposes means any procedure, treatment, supply, device, equipment, facility or drug (all *services*) determined by *our* Medical Director or his/her designee to:

- Not be a benefit for diagnosis or treatment of an *injury*;
- Not be as beneficial as any established alternative; or
- Not show improvement outside the investigational setting.

A drug, biological product, device, treatment or procedure that meets any one of the following criteria, as determined by *us*, will be considered *experimental, investigational or for research purposes*:

- Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) for the particular *accident* and which lacks such final FDA approval for the use or proposed use, unless:
 - Found to be accepted for that use in the most recently published edition of the United States Pharmacopoeia-Drug Information for Healthcare Professional or in the most recently published edition of the American Hospital Formulary Service Drug Information;
 - Is identified as safe, widely used, and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or
 - mandated by state law;
- Is a device required to receive Premarket Approval or 510K approval by the FDA, but has not received a PMA or 510K approval;

- Is not identified as safe, widely used, and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;
- Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial, or any trial not recognized by NCI regardless of the Phase;
- Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision except as required by state or federal law;
- The FDA has not determined the device to be contraindicated for the particular *injury* for which the device has been prescribed; or
- The *services* are:
 - Not as effective in improving health outcomes and not as cost effective as established technology; or
 - Not usable in appropriate clinical contexts in which established technology is not employable.

Explanation of benefits means a form or document that may be sent to *you* by *your* group or individual health plan after *you* had a healthcare *service* that was processed by the group or individual health plan.

Grace period means the 31 consecutive day period starting on the day the *premium* is due, except the initial *premium*, during which *you* can pay the *premium* and during which coverage is effective.

Hospital means a public or private institution that meets all of the following requirements:

- It must provide, for a fee, medical care and treatment of sick or injured patients on an inpatient basis;
- It must provide or operate, either on its premises or in facilities available to the *hospital* on a pre-arranged basis, medical, diagnostic, and surgical facilities;
- Care and treatment must be given by and supervised by *licensed healthcare professionals*. Nursing *services* must be provided on a 24-hour basis and must be given by or supervised by nurses;
- It must be licensed by the laws of the jurisdiction where it is located; and
- It must be operated as a *hospital* as defined by those laws; and
 - a. It must not be primarily a convalescent, rest or nursing home; or
 - b. Facility providing custodial, educational or rehabilitative care.

The *hospital* must be accredited by one of the following:

- The Joint Commission on the Accreditation of Hospitals;
- The American Osteopathic Hospital Association; or
- The Commission on the Accreditation of Rehabilitative Facilities.

Injury(ies) means unintentional physical damage or harm caused directly by a *covered accident* and independent of all *sickness*, disease or any other causes.

Licensed Healthcare Professional means any doctor, registered professional nurse, or other individual recognized by law or regulation in the state where *services* are rendered. The person must be licensed and practicing in the United States, unless immediate care is necessary due to *injury* sustained outside of the United States or its possessions.

Licensed healthcare professional does not include:

- a person related to *you* or a *covered person* by blood, adoption or marriage, including but not limited to:
 - *spouse*;
 - *child*;
 - *parent*;

- sibling;
- in-law;
- *your* or a *covered person's* business or professional partner.

Maximum allowable fee means the lesser of:

- The fee charged by the *provider* for the *service*;
- The fee that has been negotiated with the *provider* whether directly or through one or more intermediaries or shared savings contracts for the *services*;
- The fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar *services* from a geographic area determined by *us*;
- The fee based on rates negotiated by *us* or other payers with one or more *providers* in a geographic area determined by *us* for the same or similar *services*;
- The fee equal to the *providers* costs for providing the same or similar *services* as reported by such *provider* in its most recent publicly available Medicare cost report submitted to the Centers for Medicare and Medicaid Services annually; or
- The fee based on a percentage determined by *us* of the fee Medicare allows for the same or similar *services* provided in the same geographic area.

Medically necessary means a *service* that is:

- required to treat an *injury* as prescribed or ordered by a *licensed healthcare professional* or furnished by a *hospital, emergency room, urgent care center or ambulatory surgical center*;
- consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered;
- In accordance with nationally recognized standards of medical practice and identified as safe, widely used, and generally accepted as effective for the proposed use;
- Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration;
- Not primarily for the convenience of the *covered person(s)* or *licensed healthcare professional*;
- Clearly substantiated and supported by the medical records and documentation concerning the *covered person(s)* condition;
- Performed in the most cost effective setting required by the *covered person(s)* condition;
- Supported by the preponderance of nationally recognized peer reviewed medical literature, if any, published in the English language as of the date of service; and
- Not *experimental, investigational or for research purposes*.

A *service* may not be *medically necessary* if a less invasive or more appropriate diagnostic or treatment alternative could have been used. The fact that a *licensed healthcare professional* may prescribe, authorize or direct a *service* does not of itself make it *medically necessary* or covered under this *policy*.

Plan type means either:

- coverage for an individual child or adult (Individual);
- coverage for an individual and his/her *dependent children* (Single Parent);
- coverage for an individual, his/her *spouse* and their *dependent children* (Family); or
- coverage for an individual and his/her *spouse* (Couple).

Plan type is the coverage option *you* chose on the *application*, unless otherwise endorsed or amended. *Plan type* is shown on the Schedule of Benefits.

Policy means this document together with any amendments, riders, and endorsements which describe the agreement between *you* and *us*.

Policy owner means the *applicant*, who is the owner of this *policy*.

If the *applicant* and the *primary insured* are not the same person and the *applicant* dies before this *policy* ends:

- the *primary insured* will be the *policy owner*, if he/she has reached the age of majority; or
- the *primary insured's* legal guardian will be the *policy owner*, if he or she has not reached the age of majority.

This *policy* does not provide for third party owners.

Premium means the amounts that must be paid to *us* for coverage under this *policy* and to keep this *policy* in force.

Primary insured means the person so listed on the Schedule of Benefits.

Proof of loss means a claim form and/or other documents satisfactory to *us*.

Proof of loss may also include statements completed by *you* and/or the *covered person*, and the attending *licensed healthcare professional* showing:

- the nature of the loss;
- the date, or inclusive dates, of loss; and
- the cause of loss.

Provider(s) means a *hospital, emergency room, urgent care center, ambulatory surgical center* or a *licensed healthcare professional* or any other person designated as such, who provides *services* to *covered persons*.

Services means procedures, surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices or technologies.

Sickness means disturbance in function or structure of the *covered person(s)* body which causes physical signs or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of the *covered person(s)*.

Spouse means:

1. the person recognized as the *covered primary insured's* husband or wife under the laws of the state in which the *primary insured* lives; or
2. the person recognized by the *primary insured's* state of residence as:
 - the *primary insured's domestic partner* ;
 - a party to a *civil union* with the *primary insured* ;
 - a *reciprocal beneficiary* of the *primary insured* ; or
 - someone for whom we must provide the coverage of this *policy* on a spousal equivalent basis under the laws or regulations of the state where the *primary insured* lives.

When we provide coverage under this definition "2", we will continue to provide coverage after the *primary insured* or *spouse* moves to a state that does not recognize the relationship described.

We will not continue to provide coverage under these definitions "1" and "2" for the *spouse* when a legal action ends a relationship described.

This *policy* will at no time cover more than one person as a *primary insured's spouse*.

Urgent care center means any licensed public or private non-hospital free standing facility which has permanent facilities equipped to provide urgent care *services* on an outpatient basis.

Us, we and **our** means Kanawha Insurance Company.

You/your means the *policy owner*.

SPECIMEN

**INSURED BY
KANAWHA INSURANCE COMPANY**

SPECIMEN

HumanaOne Individual Insurance Accident Application



Please print clearly in ink. Complete all questions. Fill in all fields or indicate "not applicable."

Date of form: _____ Requested Effective Date: _____

This form is for: New Business (First time applicant) Policy # _____
 Reinstatement (Reenrollment)
 Change/Modification to Existing Policy

ARKANSAS

[Reason for change _____ Change/Modification to Existing Policy # _____]

The effective date is assigned by Humana. The effective date is the later of the day after: **1)** the date this form is signed; **2)** the date this form is postmarked, or **3)** the date received via electronic transmission. An agent cannot assign an effective date.

Coverage Options

Accident Policy Coverage: Please complete this section when selecting a policy.

Policy Type: Individual] Single Parent] Family] Couple] [Benefit Amount _____]
 Benefit Amount _____] Individual \$ _____] Single Parent \$ _____] Family \$ _____] Couple \$ _____]
 Benefit Amount _____] Individual \$ _____] Single Parent \$ _____] Family \$ _____] Couple \$ _____]
 Benefit Amount _____] Individual \$ _____] Single Parent \$ _____] Family \$ _____] Couple \$ _____]
 Benefit Amount _____] Individual \$ _____] Single Parent \$ _____] Family \$ _____] Couple \$ _____]

Proposed Primary Insured Information

First name	MI	Last name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth
Social Security #		[Country or State of birth]	E-mail	
Home address (not P.O. Box)		City	State	ZIP code
Primary phone #		Secondary phone #		
Mailing address (if different from home address)		City	State	ZIP code
[Occupation		Type of business or industry]		

[Policy Owner] (Parent or Guardian) Information: To be completed if Proposed Primary Insured is a minor.

First name	MI	Last name	Relationship to Proposed Primary Insured	
Social Security #		E-mail		
Home address (not P.O. Box)		City	State	ZIP code
Primary phone #		Secondary phone #		

Dependent Information: Please complete only if your spouse/[domestic partner]/[civil union]/[reciprocal beneficiary] and/or dependent children are applying for coverage. Attach an additional family information sheet if necessary. Each additional page must be signed and dated. [If child-only coverage is requested, the application must be filled out by custodial parent or legal guardian.]

Spouse/[Domestic Partner]/[Civil Union]/[Reciprocal Beneficiary] First name		MI	Last name	
Social Security #			Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth
Dependent First name	MI	Last name		Date of birth
[Full-time student (if [0-40] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes]				
Dependent First name	MI	Last name		Date of birth
[Full-time student (if [0-40] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes]				
Dependent First name	MI	Last name		Date of birth
[Full-time student (if [0-40] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes]				

Beneficiary Information Please include an additional page if you need to list multiple beneficiaries. Each additional page must be signed and dated.

Primary beneficiary name	Relationship	Benefit %
Contingent beneficiary name	Relationship	Benefit %

Existing Coverage

[1. No Yes Does any person proposed for coverage have any existing accident insurance coverage in force or an application for similar insurance pending with this or any other company?]

[If yes, please provide details with specific benefit amounts.

Carrier _____ Dates of Coverage _____
 Name of the Insured _____ Policy Name _____ Benefit Value _____]

[2. No Yes Will the policy applied for replace any coverage currently in force?]

Agreement and Signature

True and Complete Acknowledgment: I understand, agree and represent: I have read this document or it has been read to me. The answers are true and complete. I agree to immediately notify Humana of any changes to the information contained in this form that occur prior to the policy effective date. I have received and reviewed any state or federal required disclosures. I acknowledge that neither I nor the agent have the right to waive or incompletely answer any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements. If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the policy. Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the application by Humana. Acceptance of premium and fees does not guarantee coverage. Any misrepresentation on this application may be used by Humana during the first two policy years to void the contract or modify the terms of coverage. This may result in loss of coverage, modification of coverage and/or claim denial. I agree to terminate any existing coverage if this application is approved and coverage begins.

As a covered person, we may use and disclose your personal information, without your consent/authorization, to pay claims for expenses incurred from a covered accident. We may collect your personal information from other Humana affiliated companies to pay claims for expenses incurred from a covered accident. We may share your personal information with other Humana affiliated companies, as permitted by law. To obtain a list of Humana affiliated companies, please contact us at 1 (855) 448-6982 or visit our website at Humana.com.

This document, together with any supplemental forms, will make up part of any contract and be the basis for any policy.

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

If you decide not to sign this agreement, we will decline to enroll you in the accident policy.

Signed at: City _____ State _____

Proposed Primary Insured or [Policy Owner/Legal Guardian Signature] _____ Date _____

Spouse/[Domestic Partner]/[Civil Union]/[Reciprical Beneficiary] Signature (if covered dependent) _____ Date _____

(Optional)

Agent / Producer Information

This section to be completed by Agent or Producer (if applicable).

Agent / Agency of Record: (for commissions and correspondence)	Writing Agent / Producer:
Name (print) _____	Name (print) _____
Humana Agent # _____	Humana Agent # _____

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary insured submitting this application in order to fully and accurately represent the terms and conditions of the policies and services of the insuring entity, or one of its subsidiaries. These provisions are available to me and the primary insured in the benefit summary document or other policy literature.

Writing Agent's Signature _____ Date _____

The original version of this application is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "We" or "Humana."

Accident product is insured by Kanawha Insurance Company

KANAWHA INSURANCE COMPANY

Home Office: Louisville, Kentucky

Mailing Address:

[210 S. WHITE STREET]

[LANCASTER, SC 29720]

[PO BOX 610]

[LANCASTER, SC 29721-0610]

TELEPHONE: [877-207-0158]

ACCIDENT-ONLY COVERAGE

THIS POLICY PROVIDES LIMITED BENEFITS

**BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL
MEDICAL EXPENSES**

**OUTLINE OF COVERAGE
FOR ACCIDENT POLICY FORM 60860 AR**

PLEASE READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that **YOU READ YOUR POLICY CAREFULLY!**

ACCIDENT ONLY EXPENSE COVERAGE. This policy is designed to provide, covered persons with coverage for certain losses resulting from a covered accident **ONLY**, subject to all terms, conditions, exclusions and limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

POLICY BENEFITS SUMMARY. We will pay the benefit for each covered accident up to the benefit level shown below, when we receive proof of loss showing that a covered person has actual out of pocket expenses for services provided by a licensed healthcare professional in a licensed healthcare professional's office, hospital, emergency room, urgent care center, ambulance or an ambulatory surgical center in connection with injuries sustained in a covered accident. Services provided in an emergency room or urgent care center must commence within 72 hours after the accident. Services must be rendered in the United States, unless immediate medical care is necessary for a covered accident due to injury sustained outside of the United States or its possessions.

If a covered person has existing medical coverage, we will reimburse the lesser of the maximum allowable fee or the actual out of pocket expenses incurred by the covered person up to the benefit level selected. When filing a claim, we will require the explanation of benefits from your existing insurance company or an itemization of services rendered that includes the dates of service, diagnosis, procedures and charges.

If a covered person has no other existing medical coverage, we will reimburse the lesser of the maximum allowable fee or the actual out of pocket expenses incurred by the covered person up to the benefit level selected.

Expenses must be incurred within 90 days of the covered accident for services provided in:

- a hospital,
- emergency room,
- urgent care center,
- ambulance,
- ambulatory surgical center, or
- a licensed healthcare professional's office.

Accident expense benefit:

Benefit amount for all covered persons until primary insured reaches attained age 65: [\$1,000; \$2,500; \$5,000; \$7,500; \$10,000]

Benefit amount for all covered persons after primary insured reaches attained age 65 and over: [\$1,000; \$2,500]

We will pay an accidental death benefit up to the benefit level shown below, when we receive proof of loss that a covered person has suffered an accidental loss of life which is directly due to injuries from a covered accident, independent of all other causes, that occurred while covered under this policy, while coverage is in force and within 90 days of the accident.

Accidental Death Benefit:

Benefit amount for primary insured and spouse (if covered) until attained age 65: [\$5,000; \$12,500; \$25,000; \$37,500; \$50,000]

Benefit amount for primary insured and spouse (if covered) after attained age 65: [\$5,000; \$12,500]

Benefit amount for dependent child(ren): [\$5,000; \$10,000]

Benefits automatically reduce when the primary insured reaches attained age 65, unless the \$1000 or \$2500 benefit is the current benefit amount. Premiums will be adjusted accordingly.

GENERAL EXCLUSIONS. This policy does not provide benefits for loss under a covered accident or accidental death that is contributed to, caused by, or occurs during:

1. Services which:
 - a. Are not medically necessary;
 - b. Are not prescribed by a licensed healthcare professional as necessary to treat an injury;
 - c. Are determined to be experimental/investigational or for research purposes;
 - d. Are elective procedures;
 - e. Are received without charge or legal obligation to pay;
 - f. Are provided by home healthcare or private nursing;
 - g. Are not specifically listed as covered expenses in the policy.
2. Acts of war, whether declared or not.
3. Being on active duty serving in any armed forces. Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 consecutive days.
4. Being incarcerated.
5. Committing or attempting to commit a felony.
6. Intentionally self-inflicted bodily harm, attempted suicide or suicide whether sane or insane.
7. Being legally intoxicated or under the influence of alcohol while operating a motorized vehicle as defined by the laws of the state or jurisdiction in which the injury occurs.
8. Being the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license, except in a Driver's Education Program.
9. Traveling or flying by air, except as a fare-paying passenger and not as a pilot or crew member, on a regularly scheduled commercial airline.
10. Being under the influence of any drugs, narcotics, sedatives, poison or intentional inhalation of any gas or fumes unless taken or inhaled as prescribed to the covered person or administered by a licensed healthcare professional.
11. Participating in dangerous sports.
12. Practicing for or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received.
13. Being over the age of 18 and participating in or practicing for any martial art, mixed martial art or similar organized fight sports activity including but not limited to boxing, wrestling, karate, judo, ultimate fighting, kick boxing or similar disciplines.
14. Testing, racing or otherwise competing with any motorized vehicles, including but not limited to street racing, all-terrain vehicles (ATV's), speed boats and snow mobiles.
15. Being covered by Worker's Compensation, Employer Liability Law or Occupational Disease Act or Law.
16. Services rendered to the teeth as a result of chewing or biting or other normal activity of the teeth.
17. Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including, but not limited to, excision of partially or completely erupted impacted teeth, any oral or periodontal surgery and preoperative and post-operative care, implants and related procedures, orthodontic procedures, and any dental services related to a sickness, unless necessitated by *injury* from a *covered accident*.
18. Prescription drugs filled by a retail and/or mail order pharmacy.
19. Durable medical equipment that is not prescribed or issued by a licensed healthcare professional.
20. Treatment in any government or federal hospital, except if there is a legal obligation to pay.
21. Cosmetic surgery, except for reconstructive surgery on an injured part of the body for expenses incurred while coverage is in force.
22. Handling, storing or transporting explosives.
23. Handling or working with wild nondomestic animals.
24. Repetitive motion injuries including but not limited to carpal tunnel, cubital tunnel, or sprains, strains, hernia, tendonitis, bursitis and heat exhaustion not related to a specific injury.
25. Any sickness or declining process caused by a sickness, including physical or mental infirmity. We also will not pay this benefit to diagnose or treat any sickness.

26. Services that may be needed to correct injuries that originated in an accident that occurred prior to the effective date of this policy. Nor does coverage exist for injuries sustained after the effective date that occur to body parts that have been weakened from an injury that preceded the effective date.
27. Complications directly related to services that were completed for any other cause other than a covered accident.
28. Taking part in a riot.
29. Engaging in an illegal occupation.

GUARANTEED RENEWABLE. You can keep this policy during your lifetime as long as premiums are paid when due, subject to the termination of coverage provisions. You must pay each premium due by the due date. Your premium can be changed, if we change the premium on all policies in your policy's premium class.

PREMIUM. You must pay the required premium to us as it becomes due. If you don't pay your premium on time, we will terminate coverage. The first premium is due on the date specified by us. Subsequent premiums are due on the date we assign. All premiums are payable to us at our address.

CHANGES TO PREMIUM. Premium amounts are based on the benefits you chose, plan type, attained age, gender and state of residence of the primary insured on the policy effective date. The premium can be changed for the following reasons:

- if we change the premium on all policies in the same premium class;
- If you apply for and we approve a change in the coverage amount or plan type;
- If you apply for and we approve addition of covered persons;
- If covered person's are deleted;
- If premium payment method is changed;
- A misstatement on the application that affects the premium charged; or
- If your state of residence changes.

If we change the premium on all policies in the same premium class, we will give you [30] days written notice before such premium change occurs. Any increase or decrease in premiums will start on the premium due date no sooner than [30] days after the written notice is given. Any other change in premium will start on the date following the change in coverage.

GRACE PERIOD. You have 31 days from the premium due date to remit the required payment. If premium is not paid we will terminate the insurance as of the last day of the premium period for which premium was paid.

RECEIPT FOR OUTLINE OF COVERAGE FOR POLICY FORM 60860 AR

Signature of Applicant

Date

Signature of Licensed Resident Agent

Date

THIS PORTION RETAINED BY APPLICANT

RECEIPT FOR OUTLINE OF COVERAGE FOR POLICY FORM 60860 AR

Signature of Applicant

Date

Signature of Licensed Resident Agent

Date

THIS PORTION RETAINED BY KANAWHA INSURANCE COMPANY

SERFF Tracking Number: HUMA-128225493

State: Arkansas

Filing Company: Kanawha Insurance Company

State Tracking Number:

Company Tracking Number: 60860

TOI: H02I Individual Health - Accident Only

Sub-TOI: H02I.000 Health - Accident Only

Product Name: HumanaOne Accident Benefit Plan

Project Name/Number: Individual Accident Benefit Plan/

Rate Information

Rate data applies to filing.

Filing Method:

New Policy Form

Rate Change Type:

Neutral

Overall Percentage of Last Rate Revision:

%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Kanawha Insurance Company	%	%				%	%

SERFF Tracking Number: HUMA-128225493 State: Arkansas
 Filing Company: Kanawha Insurance Company State Tracking Number:
 Company Tracking Number: 60860
 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only
 Product Name: HumanaOne Accident Benefit Plan
 Project Name/Number: Individual Accident Benefit Plan/

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 05/03/2012	Act5uarial Memorandum		New		Individual Accident Plan 50% Actuarial Memo - Generic 50%.pdf Individual Accident Rates - 50% MLR Generic.pdf

SERFF Tracking Number: HUMA-128225493 State: Arkansas
 Filing Company: Kanawha Insurance Company State Tracking Number:
 Company Tracking Number: 60860
 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only
 Product Name: HumanaOne Accident Benefit Plan
 Project Name/Number: Individual Accident Benefit Plan/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	05/03/2012
Comments:		
Attachments:		
ARKANSAS CERTIFICATION.pdf		
Readability Certification Accident.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	05/03/2012
Bypass Reason: No previous application. The application is a new form that is attached under the Form Schedule Tab.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Health - Actuarial Justification	Approved-Closed	05/03/2012
Comments:		
Attachments:		
Individual Accident Plan 50% Actuarial Memo - Generic 50%.pdf		
Individual Accident Rates - 50% MLR Generic.pdf		

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved-Closed	05/03/2012
Comments:		
Attachment:		
OOC Accident Form 60860 AR.pdf		

	Item Status:	Status Date:
--	---------------------	-------------------------

SERFF Tracking Number: HUMA-128225493 State: Arkansas
Filing Company: Kanawha Insurance Company State Tracking Number:
Company Tracking Number: 60860
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: HumanaOne Accident Benefit Plan
Project Name/Number: Individual Accident Benefit Plan/
Satisfied - Item: Statement of Variability Approved-Closed 05/03/2012

Comments:

Attachments:

SOV for Outline of Cov Accident.pdf
SOV for Accident Policy.pdf
SOV for Accident Application.pdf

ARKANSAS CERTIFICATION

I, R. Dale Vaughan, President of Kanawha Insurance Company, do hereby attest and certify to the following:

The Company has reviewed its issuance procedures. The Company is in compliance with Regulation 49, Life and Health Insurance Guaranty Association Notices.

This policy form submission, meets the provisions of Regulation 19, Unfair Sex Discrimination in the Sale of Insurance, as well as applicable requirements if the Arkansas Insurance Department.

Kanawha Insurance Company

A handwritten signature in black ink that reads "R. Dale Vaughan". The signature is written in a cursive, flowing style.

R. Dale Vaughan, President

April 4, 2012

Date

READABILITY CERTIFICATION

Company Name: Kanawha Insurance Company

NAIC Number: 65110

FEIN Number: 57-0380426

Subject: Accident Policy, 60860 AR; Application, AR-71111 04/2012; Outline of Coverage, 1758 AR

As an officer of Kanawha Insurance Company, I hereby certify that the following forms achieve a Flesch score that meets or exceeds requirements as follows:

<u>Form Number</u>	<u>Flesch Score</u>
<u>60860 AR</u>	<u>41.5</u>
<u>AR-71111 04/2012</u>	<u>40.0</u>
<u>1758 AR</u>	<u>40.0</u>



R. Dale Vaughan, President

April 4, 2012
Date

KANAWHA INSURANCE COMPANY

Home Office: Louisville, Kentucky

Mailing Address:

[210 S. WHITE STREET]

[LANCASTER, SC 29720]

[PO BOX 610]

[LANCASTER, SC 29721-0610]

TELEPHONE: [877-207-0158]

ACCIDENT-ONLY COVERAGE

THIS POLICY PROVIDES LIMITED BENEFITS

**BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL
MEDICAL EXPENSES**

**OUTLINE OF COVERAGE
FOR ACCIDENT POLICY FORM 60860 AR**

PLEASE READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that **YOU READ YOUR POLICY CAREFULLY!**

ACCIDENT ONLY EXPENSE COVERAGE. This policy is designed to provide, covered persons with coverage for certain losses resulting from a covered accident **ONLY**, subject to all terms, conditions, exclusions and limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

POLICY BENEFITS SUMMARY. We will pay the benefit for each covered accident up to the benefit level shown below, when we receive proof of loss showing that a covered person has actual out of pocket expenses for services provided by a licensed healthcare professional in a licensed healthcare professional's office, hospital, emergency room, urgent care center, ambulance or an ambulatory surgical center in connection with injuries sustained in a covered accident. Services provided in an emergency room or urgent care center must commence within 72 hours after the accident. Services must be rendered in the United States, unless immediate medical care is necessary for a covered accident due to injury sustained outside of the United States or its possessions.

If a covered person has existing medical coverage, we will reimburse the lesser of the maximum allowable fee or the actual out of pocket expenses incurred by the covered person up to the benefit level selected. When filing a claim, we will require the explanation of benefits from your existing insurance company or an itemization of services rendered that includes the dates of service, diagnosis, procedures and charges.

If a covered person has no other existing medical coverage, we will reimburse the lesser of the maximum allowable fee or the actual out of pocket expenses incurred by the covered person up to the benefit level selected.

Expenses must be incurred within 90 days of the covered accident for services provided in:

- a hospital,
- emergency room,
- urgent care center,
- ambulance,
- ambulatory surgical center, or
- a licensed healthcare professional's office.

Accident expense benefit:

Benefit amount for all covered persons until primary insured reaches attained age 65: [\$1,000; \$2,500; \$5,000; \$7,500; \$10,000]

Benefit amount for all covered persons after primary insured reaches attained age 65 and over: [\$1,000; \$2,500]

We will pay an accidental death benefit up to the benefit level shown below, when we receive proof of loss that a covered person has suffered an accidental loss of life which is directly due to injuries from a covered accident, independent of all other causes, that occurred while covered under this policy, while coverage is in force and within 90 days of the accident.

Accidental Death Benefit:

Benefit amount for primary insured and spouse (if covered) until attained age 65: [\$5,000; \$12,500; \$25,000; \$37,500; \$50,000]

Benefit amount for primary insured and spouse (if covered) after attained age 65: [\$5,000; \$12,500]

Benefit amount for dependent child(ren): [\$5,000; \$10,000]

Benefits automatically reduce when the primary insured reaches attained age 65, unless the \$1000 or \$2500 benefit is the current benefit amount. Premiums will be adjusted accordingly.

GENERAL EXCLUSIONS. This policy does not provide benefits for loss under a covered accident or accidental death that is contributed to, caused by, or occurs during:

1. Services which:
 - a. Are not medically necessary;
 - b. Are not prescribed by a licensed healthcare professional as necessary to treat an injury;
 - c. Are determined to be experimental/investigational or for research purposes;
 - d. Are elective procedures;
 - e. Are received without charge or legal obligation to pay;
 - f. Are provided by home healthcare or private nursing;
 - g. Are not specifically listed as covered expenses in the policy.
2. Acts of war, whether declared or not.
3. Being on active duty serving in any armed forces. Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 consecutive days.
4. Being incarcerated.
5. Committing or attempting to commit a felony.
6. Intentionally self-inflicted bodily harm, attempted suicide or suicide whether sane or insane.
7. Being legally intoxicated or under the influence of alcohol while operating a motorized vehicle as defined by the laws of the state or jurisdiction in which the injury occurs.
8. Being the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license, except in a Driver's Education Program.
9. Traveling or flying by air, except as a fare-paying passenger and not as a pilot or crew member, on a regularly scheduled commercial airline.
10. Being under the influence of any drugs, narcotics, sedatives, poison or intentional inhalation of any gas or fumes unless taken or inhaled as prescribed to the covered person or administered by a licensed healthcare professional.
11. Participating in dangerous sports.
12. Practicing for or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received.
13. Being over the age of 18 and participating in or practicing for any martial art, mixed martial art or similar organized fight sports activity including but not limited to boxing, wrestling, karate, judo, ultimate fighting, kick boxing or similar disciplines.
14. Testing, racing or otherwise competing with any motorized vehicles, including but not limited to street racing, all-terrain vehicles (ATV's), speed boats and snow mobiles.
15. Being covered by Worker's Compensation, Employer Liability Law or Occupational Disease Act or Law.
16. Services rendered to the teeth as a result of chewing or biting or other normal activity of the teeth.
17. Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes including, but not limited to, excision of partially or completely erupted impacted teeth, any oral or periodontal surgery and preoperative and post-operative care, implants and related procedures, orthodontic procedures, and any dental services related to a sickness, unless necessitated by *injury* from a *covered accident*.
18. Prescription drugs filled by a retail and/or mail order pharmacy.
19. Durable medical equipment that is not prescribed or issued by a licensed healthcare professional.
20. Treatment in any government or federal hospital, except if there is a legal obligation to pay.
21. Cosmetic surgery, except for reconstructive surgery on an injured part of the body for expenses incurred while coverage is in force.
22. Handling, storing or transporting explosives.
23. Handling or working with wild nondomestic animals.
24. Repetitive motion injuries including but not limited to carpal tunnel, cubital tunnel, or sprains, strains, hernia, tendonitis, bursitis and heat exhaustion not related to a specific injury.
25. Any sickness or declining process caused by a sickness, including physical or mental infirmity. We also will not pay this benefit to diagnose or treat any sickness.

26. Services that may be needed to correct injuries that originated in an accident that occurred prior to the effective date of this policy. Nor does coverage exist for injuries sustained after the effective date that occur to body parts that have been weakened from an injury that preceded the effective date.
27. Complications directly related to services that were completed for any other cause other than a covered accident.
28. Taking part in a riot.
29. Engaging in an illegal occupation.

GUARANTEED RENEWABLE. You can keep this policy during your lifetime as long as premiums are paid when due, subject to the termination of coverage provisions. You must pay each premium due by the due date. Your premium can be changed, if we change the premium on all policies in your policy's premium class.

PREMIUM. You must pay the required premium to us as it becomes due. If you don't pay your premium on time, we will terminate coverage. The first premium is due on the date specified by us. Subsequent premiums are due on the date we assign. All premiums are payable to us at our address.

CHANGES TO PREMIUM. Premium amounts are based on the benefits you chose, plan type, attained age, gender and state of residence of the primary insured on the policy effective date. The premium can be changed for the following reasons:

- if we change the premium on all policies in the same premium class;
- If you apply for and we approve a change in the coverage amount or plan type;
- If you apply for and we approve addition of covered persons;
- If covered person's are deleted;
- If premium payment method is changed;
- A misstatement on the application that affects the premium charged; or
- If your state of residence changes.

If we change the premium on all policies in the same premium class, we will give you [30] days written notice before such premium change occurs. Any increase or decrease in premiums will start on the premium due date no sooner than [30] days after the written notice is given. Any other change in premium will start on the date following the change in coverage.

GRACE PERIOD. You have 31 days from the premium due date to remit the required payment. If premium is not paid we will terminate the insurance as of the last day of the premium period for which premium was paid.

RECEIPT FOR OUTLINE OF COVERAGE FOR POLICY FORM 60860 AR

Signature of Applicant

Date

Signature of Licensed Resident Agent

Date

THIS PORTION RETAINED BY APPLICANT

RECEIPT FOR OUTLINE OF COVERAGE FOR POLICY FORM 60860 AR

Signature of Applicant

Date

Signature of Licensed Resident Agent

Date

THIS PORTION RETAINED BY KANAWHA INSURANCE COMPANY

**STATEMENT OF VARIABLES
OUTLINE OF COVERAGE FORM 1758 AR**

PAGE 1

- In the event of a change in the administrative address and telephone number of the Company, the bracketed addresses and telephone number will be changed accordingly.

[210 S. WHITE STREET]
[LANCASTER, SC 29720]

[PO BOX 610]
[LANCASTER, SC 29721-0610]

TELEPHONE: [877-207-0158]

PAGE 2

- Accident expense benefit and accidental death benefit - The benefits are bracketed to show the range of benefits available for the product. The only benefit items that will appear on a policy that is issued will be the actual benefits selected by the policyowner.

PAGE 4

- The Changes to Premium section has the number of days bracketed. The number of days may change depending on the number of days a written notice is required to be sent prior to a change being made to the premium. The days will range from [10-45] and is currently set at 30 in the filed policy form.

CERTIFICATION

We certify that any change or modification to a variable item shown within the policy of statement of variables, that is outside of the approved ranges will be submitted for prior approval of the change or modification.

KANAWHA INSURANCE COMPANY



R. Dale Vaughan, President

**STATEMENT OF VARIABLES
ACCIDENT ONLY POLICY FORM 60860 AR**

FACE PAGE

- The bracketed information shown for the following sections on the face page are bracketed for client specific information that will vary based on the clients specific information:

Policy owner: [variable]

Policy number: [variable]

Effective date: [variable]

Initial modal premium amount: [variable]

- In the Right to Return Policy provision, the days are bracketed as variable so that the days can be changed based on a state specific requirement. For example, if the policy is a replacement policy, there will be a longer period to review the policy. The number of days will range from 10-30 days. The number of days is currently set at 10.
- The signature of the Company President is bracketed in the event of a change in leadership within the Company.

[President]

INTRODUCTION – PAGE 4

- In the event of a change in the Company's telephone number, the following bracketed telephone number will be changed to a new number: [855-448-6982].

SCHEDULE OF BENEFITS – PAGE 5

- The bracketed information shown for the following sections on the face page are bracketed for client specific information that will vary based on the clients information:

Policy owner: [variable]

Policy number: [variable]

Primary insured: [variable]

The Dependent(s): [variable]

Plan type: [variable]

Premium mode: [variable]

- The [Amendment/rider:] section is bracketed for future use. There are currently no riders available for the product, but the Company would like the bracketing in case riders are developed for future use.

- The benefit amounts are bracketed to show the range of benefits available for the product. The only benefit items that will appear on a policy that is issued will be the actual benefits selected by the policyowner on the application.

PREMIUM PAYMENT – PAGE 8

- The Changes to Premium section has the number of days bracketed. The number of days may change depending on the number of days a written notice is required to be sent prior to a change being made to the premium. The days will range from [10-45] and is currently set at 30 in the filed policy form.

GENERAL PROVISIONS – PAGE 12

- The entire Discount and Service Programs provision is bracketed for flexibility to include the provision within the policy if allowed by a state. If a state does not allow the provision, the entire provision would be deleted from the policy.

GENERAL PROVISIONS – PAGE 12

- The entire Rewards provision is bracketed for flexibility to include the provision within the policy if allowed by a state. If a state does not allow the provision, the entire provision would be deleted from the policy. There are also sections within the Rewards provision that are bracketed to show specific rewards and reward information that may be available.

GENERAL PROVISIONS – PAGE 14

- There is bracketing in the Fraud provision for the number of days of written notice prior to any policy termination. The range of days will be [10-45] for written notice. The current number of days is currently set at 30 days.

MAKING A CLAIM UNDER THIS POLICY – PAGE 17

- The bracketing in the Notice of claim provision is for the time period that a written notice of claim must be given to us. It is currently bracketed for 20 days. The number of days will range from 10 to 30 days.
- The additional bracketing in the Notice of claim provision is for the claims mailing address in the event of a change in the claims mailing address of the company.
- The bracketing in the Claims Forms provision is to the number of days that the Company will provide claim forms within. The number of days is currently bracketed for 15 days. The range for the number of days will be 10-30 days.

MAKING A CLAIM UNDER THIS POLICY – PAGE 18

- The bracketing in the Proof of loss provision is to the number of days that proof of loss must be given to the Company by. The number of days is currently bracketed for 90 days. The range for the number of days will be 90-180.
- The bracketing in the Payment of benefits provision is for the dollar amount that the Company can pay benefits up to for someone related to the policy owner by blood or marriage whom the Company considers to be entitled to the benefits. The current bracketed dollar amount is \$1,000. The range of the dollar amount will be \$1,000 to \$2,500 as necessary for state compliance.

- The bracketing in the Time of payment of claims is to the number of days that payment due under the policy will be made no more than that number of days after the Company receives complete proof of loss. The number of days is currently bracketed at 30 days. The range for the number will be 10-30 days.

DEFINITIONS – PAGE 18

- There is bracketing within the Dependent child(ren) definition for the age requirements of the dependent. The current bracketed ages are [less than 18 years of age] [26 years of age] and [if a full time student]. The bracketing is for state compliance as the definition of Dependent child(ren) may change in the future.

CERTIFICATION

We certify that any change or modification to a variable item shown within the policy of statement of variables, that is outside of the approved ranges will be submitted for prior approval of the change or modification.

KANAWHA INSURANCE COMPANY



R. Dale Vaughan, President

**STATEMENT OF VARIABLES
ACCIDENT APPLICATION FORM AR-71111 04/2012**

Bracketed Sections

1. Bracketed sections will refer to an entire portion of the form such as logos, product offerings, dependent information, existing coverage, or agreements.
2. Bracketed sections vary to the extent that such sections may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to any statutory or regulatory requirements.
 - For example: The Agent /Producer Information is bracketed, for a direct response marketing campaign, that section would not be shown.
3. Bracketed variables such as logos, text, or numbers are subject to change as outlined within the various sections of this document.

Bracketed Numbers

1. With the exception of form numbers and matrix numbers, if allowed by the state, all bracketed numbers are variable.
 - Form numbers are located in the lower left-hand corner of the form and are not subject to change without refilling.
 - Reorder numbers and Revision numbers are located in the lower right-hand corner of the form and are considered variable and included within this statement.
2. Bracketed numbers within a section are determined by the laws of the governing jurisdiction and will be varied only within the confines of the law.
3. Bracketed numbers will include the minimum and maximum ranges.

Bracketed Questions

1. Text language within the bracketed question (replacement question) will not change.
2. Bracketed questions vary only to the extent that such questions may be included, omitted or transferred within the form subject to any statutory or regulatory requirements.

Product Information/Benefit Amount

1. Product information and benefit amount may vary to the extent such information may be included, omitted, or transferred to another page subject to any statutory or regulatory requirements

2. Additional fields within an existing product offering section can be added to an application without refiling for the purpose of offering new insurance products or benefits subject to
 - prior approval of the policy forms for the new products or benefits; and,
 - any statutory or regulatory requirements

Legal Entities

1. New product or benefit plan designs or offerings that create a new or modify an existing legal entity will require filing.
2. Legal entities will be bracketed when multiple entities are listed as insuring or administering entities.
3. If there is only one legal entity listed as insuring or administering then it will not be bracketed

Administrative Changes and Clerical Errors

Humana reserves the right to amend the attached form(s) for any minor administrative changes or to fix clerical errors that may have unintentionally gone unnoticed prior to submitting for approval and to amend the language to clarify the intent within the confines of the law.

Formatting

Forms are submitted in filing version format and are subject only to minor modification in paper size, stock, ink, border, and adaptation to computer printing. The application may be offered in a printed, on line, or digitized audio recorded format.

Certification

Kanawha Insurance Company, a Humana Company, certifies that any change or modification to a variable item shown within the policy of statement of variables that is outside of the approved ranges will be submitted for prior approval of the change or modification.