Filing at a Glance

Company: American Medical Security Life Insurance Company

Product Name: Individual
TOI: H16I Individual Health - Major Medical
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
Filing Type: Form/Rate

SERFF Tr Num: AMMS-128344640
SERFF Status: Closed-Approved-Closed
Co Tr Num: GIP28-P-AMS-03, ETC.

Authors: Cindy Newell, Anna Ferrell, Renee Jonet
Date Submitted: 05/09/2012

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

Reviewer(s): Rosalind Minor
Disposition Date: 06/12/2012

Disposition Status: Approved-Closed
Implementation Date: 01/01/2013

Implementation Date Requested: On Approval
State Filing Description:

General Information

Project Name: GIP28-AMS-03, ETC.
Project Number: GIP28-AMS-03, ETC.
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Cindy Newell
PPACA: Non-Grandfathered Immed Mkt Reforms
PPACA Notes: null
Healthcare.gov ID:
Filing Description:
Request for Individual Health Approval
Company Tracking No.: GIP28-AMS-03
Forms Listed on the Attached Forms Listing

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 06/12/2012
State Status Changed: 06/12/2012
Created By: Anna Ferrell
Corresponding Filing Tracking Number:

Actuarial Memorandum and Rates

This individual health policy form filing is submitted for your review and approval, and it includes the forms listed on the forms listing attached under the Supporting Documentation tab.

Please note: Policy forms identical to the ones in this filing (except for the form numbers) have also been filed for Golden Rule Insurance Company and will also be filed for All Savers Insurance Company. It would be most efficient for your review if all three filings could be assigned to the same reviewer. Not only will it save your department time and resources, but it would also serve to ensure that identical forms receive an identical review.

Policy form GIP28-P-AMS is a preferred provider organization type policy that provides comprehensive medical benefits. This policy form includes financial incentives to utilize network providers for non-emergency services.

The policy form includes provisions requiring referrals for specialists, which may or may not be used. Therefore, these provisions are filed in brackets. If used, benefits may be reduced or denied if the required referrals are not obtained.

The policy form includes a notification provision that requires the insured to notify the Company for a hospital stay longer than three days or prior to evaluation for an organ or tissue transplant. However, the Company may decide to move to a prior authorization requirement. If so, Prior Authorization Rider form SA-S-1547-AMS, which replaces the Notification section of the policy, will be attached to the policy and the corresponding prior authorization requirements provision will be included in Section 2, Data Page.

The following benefit riders for use with these policy forms are also included in this filing:

1. Arkansas Mandates Rider includes the medical benefits and other policy variations mandated by Arkansas law. One of the anticipated impacts of the Patient Protection and Affordable Care Act is that states may have to bear the costs of some of the medical benefits (non-essential health benefits) mandated by their respective state laws. Consequently, states may choose to no longer require health insurers to provide coverage of some benefits. In order to prepare for this scenario, the Company has elected to file each medical benefit mandated by your state in a separate matrix form. In addition, other mandates applicable only to residents of your state have also been included in matrix forms. The matrix forms have been compiled into one document, which is the Arkansas Mandates Rider included in this filing. The form numbers for the matrix forms all begin with "MTI" and can be found in the lower left corner at the end of each form.
2. Copayment Amount Rider forms SA-S-1417R-AMS and SA-S-1418R-AMS will be issued to applicants who elect one of our copay plans. These plans provide benefits after a copayment for inpatient hospitalization and outpatient doctor office visits. Which rider is used depends on whether the applicant selects an optional benefit that limits

copayments for office visits to the first four office visits per calendar year.

3. Rider forms SA-S-1559-P-AMS and SA-S-1560-P-AMS are very similar to the Copayment Amount Riders described above. The only difference is that this rider is written to be used with high deductible health plans intended for use with a health savings account. The copayment amount would not be applied until after the deductible amount has been met.

4. Rider form SA-S-1528-P-AMS is a Prescription Drugs Expense Benefits Rider that is used with plans that feature tiered benefits for prescription drugs. This rider will allow a covered person, after meeting the calendar year deductible, to purchase prescription drugs subject to a copayment.

5. Outpatient Prescription Drug Rider SA-S-1561-P-AMS is very similar to rider SA-S-1528-P-AMS described above. The only difference is that this rider is written to be used with high deductible health plans intended for use with a health savings account.

6. Outpatient Generic Prescription Drug Expense Benefits Rider SA-S-1542-P-AMS is an optional rider that, if elected by an applicant, provides coverage only for generic prescription drugs on an outpatient basis. This optional benefit will allow an applicant to choose lower-cost prescription drug coverage for only generic drugs instead of the full prescription drug coverage the policy would normally include.

7. Outpatient Generic Prescription Drug Expense Benefits Rider SA-S-1562-P-AMS is very similar to the Outpatient Generic Prescription Drug Expense Benefits Rider described above. The only difference is that this rider is written to be used with high deductible health plans intended for use with a health savings account.

8. At this time, it is not known whether the federal requirements for essential health benefits will mandate full mental health parity for individual policies or mandate coverage of biologically-based mental illnesses. Therefore, this filing includes two riders that provide benefits for mental disorders and substance abuse. Rider form SA-S-1499N-AMS provides coverage, the same as a physical illness, for all mental disorders and substance abuse. Rider form SA-S-1570-AMS provides coverage, the same as a physical illness, for biologically-based mental illnesses and substance abuse. The Company will use whichever rider is required by law.

9. Rider form SA-S-1356RN-AMS is an optional vision benefits rider. If elected by an applicant, the rider will provide coverage for vision expenses.

10. Rider form SA-S-1366RN-AMS is an optional term life insurance rider. If purchased, this rider will provide term life insurance coverage on the life of the insured and/or spouse, if covered under the policy.

11. Rider form SA-S-1367RN-AMS is an optional accidental death benefit rider. If purchased, this rider will provide accidental death benefits for the insured and/or spouse, if covered under the policy.

12. Supplemental Accident Expense Benefits Rider SA-S-1451N-AMS is an optional rider that, if elected by an applicant, provides benefits, up to the amount specified in the rider, for coverage of certain covered expenses incurred within the specified time period following an accidental injury.

13. At this time it is not known if federal law will require health insurers to cover or offer coverage of normal pregnancy and childbirth. Rider form SA-S-1505-AMS will be offered or provided only if federal law should mandate such.

14. Rider-Amendments SA-S-9-AMS and SA-S-10-AMS are variable riders used for administrative (non-underwriting)

purposes, such as a name change, adding a dependent, etc. The SA-S-10-AMS rider is used when acceptance by the primary insured is required.

15. Also included in this filing are optional riders SA-S-1457N-AMS, Arkansas Optional Hearing Aids Rider, and SA-S-1574-AMS, Arkansas Optional Musculoskeletal Disorders Rider. These riders will be offered to insureds, as required by Arkansas law.

Application form GIP-AP-144-AMS-03, also included in this filing, is the application form that will be used with the forms in this filing.

Amendment to Application form SA-AP-1.1-AMS will be used if an applicant needs to amend his or her application for health insurance. It is not used to change or add any questions on the application form, but only to complete unanswered questions or to provide details to answers to the medical history questions. If coverage is issued, this amendment form is made a part of the application, which is then made a part of the policy.

The grievance/appeals External Review Notice form to be used with the policy forms in this filing will be filed separately.

These policy forms will be issued to ages 17 through 64. They will be marketed to individuals and families, and they are designed for sale by independent brokers.

Because these forms have been drafted to reflect the requirements of Arkansas law, they have not been filed in our domiciliary state of Wisconsin. To the best of my knowledge, these forms comply with the various statutory and regulatory requirements of Arkansas. Readability Certificates indicating the Flesh scores of these forms are included.

This filing does not contain any unusual or potentially controversial items from normal company or industry standards. The Actuarial Memorandum and rates for these policy forms are included with this filing.

To the best of my knowledge, this filing complies with the statutory and regulatory requirements of your state. If you should want to communicate regarding this filing outside of the SERFF system, you may call me at 800-926-7602 ext 77709 or you may e-mail me at clnewell@goldenrule.com.

State Narrative:

Company and Contact

Filing Contact Information

Cindy Newell, Senior Contract Analyst clnewell@goldenrule.com
7440 Woodland Drive 800-926-7602 [Phone] 7709 [Ext]

Indianapolis, IN 46278-9645 317-328-9645 [FAX]

Filing Company Information

American Medical Security Life Insurance Company	CoCode: 97179	State of Domicile: Wisconsin
3100 AMS Blvd	Group Code: 707	Company Type:
PO Box 19032	Group Name:	State ID Number:
Green Bay, WI 54307-9032	FEIN Number: 86-0207231	
(800) 232-5432 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$1,950.00
Retaliatory?	No
Fee Explanation:	$50.00 per form x 39 forms = $1950.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Medical Security Life Insurance Company	$1,950.00	05/09/2012	59062187

SERFF Tracking Number:	*AMMS-128344640*	*State:*	*Arkansas*
Filing Company:	*American Medical Security Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*GIP28-P-AMS-03, ETC.*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Individual*		
Project Name/Number:	*GIP28-AMS-03, ETC./GIP28-AMS-03, ETC.*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/12/2012	06/12/2012

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	05/23/2012	05/23/2012	Cindy Newell	06/05/2012	06/11/2012

Disposition

Disposition Date: 06/12/2012
Implementation Date: 01/01/2013
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed by Actuary
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):**
American Medical Security Life Insurance Company	%	%	$		$	%	%
	Percent Change Approved:						
	Minimum:	%	**Maximum:**	%	**Weighted Average:**		%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Rate Summary Worksheet	Approved-Closed	Yes
Supporting Document	Consumer Disclosure Form	Approved-Closed	Yes
Supporting Document *(revised)*	Forms List GIP28 Arkansas	Approved-Closed	Yes
Supporting Document	Forms List GIP28 Arkansas	Replaced	Yes
Form *(revised)*	Individual Health PPO Policy	Approved-Closed	Yes
Form	Individual Health PPO Policy	Replaced	Yes
Form *(revised)*	Individual Health PPO Outline of Coverage	Approved-Closed	Yes
Form	Individual Health PPO Outline of Coverage	Replaced	Yes
Form *(revised)*	Administrative Rider	Approved-Closed	Yes
Form	Administrative Rider	Replaced	Yes
Form *(revised)*	Administrative Rider	Approved-Closed	Yes
Form	Administrative Rider	Replaced	Yes
Form	Vision Benefit Rider	Approved-Closed	Yes
Form	Term Life Insurance Rider	Approved-Closed	Yes
Form	Accidental Death Insurance Rider	Approved-Closed	Yes
Form	Copayment Amount Rider	Approved-Closed	Yes
Form	Copayment Amount Rider (w4OVs)	Approved-Closed	Yes
Form	Supplemental Accident Benefits Rider	Approved-Closed	Yes
Form	Pregnancy Benefits Rider	Approved-Closed	Yes
Form	Outpatient Prescription Drug Expense Benefits Rider	Approved-Closed	Yes
Form	Outpatient Generic Prescription Drug Expense Benefits Rider	Approved-Closed	Yes
Form	Prior Authorization Rider	Approved-Closed	Yes
Form	Copayment Amount Rider (for HSA)	Approved-Closed	Yes
Form	Copayment Amount Rider (for HSA	Approved-Closed	Yes

	w4OVs)		
Form	Outpatient Prescription Drug Expense Benefits Rider (for HSA)	Approved-Closed	Yes
Form	Outpatient Generic Prescription Drug Expense Benefits Rider (for HSA)	Approved-Closed	Yes
Form	[Optional] Mental Disorder Benefits Rider	Approved-Closed	Yes
Form	[Optional] Biologically-Based Mental Illness Benefits Rider	Approved-Closed	Yes
Form	AR Optional Hearing Aids Rider	Approved-Closed	Yes
Form	AR Optional Musculoskeletal Disorders Rider	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Arkansas Mandates Rider GIP28-GRI	Approved-Closed	Yes
Form	Amendment to Application	Approved-Closed	Yes
Rate	Arkansas GIP28-AMS Actuarial Memorandum	Approved-Closed	No
Rate	Arkansas GIP-28-AMS Rate Manual	Approved-Closed	Yes

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/23/2012
Submitted Date	05/23/2012
Respond By Date	06/23/2012

Dear Cindy Newell,

This will acknowledge receipt of the captioned filing.

Objection 1

- Individual Health PPO Policy, GIP28-P-AMS (Form)
- Individual Health PPO Outline of Coverage, GIP28-P-AMS-OC (Form)

Comment:

The Type of Insurance which was selected on your submission is Major Medical Expense. The face page of your policy and the Outline of Coverage reads: Medical Expense Insurance Policy. The title of the policy should read: Major Medical Expense Coverage as outlined under Rule and Regulation 18, Section 7 E.

Objection 2

- Arkansas GIP-28-AMS Rate Manual, [] (Rate)

Comment:

Under the Rate/Rule Schedule Tab, the Rate Review Detail indicates that the Annual PMPM $ amount is a min. of $137, Weighted Aver. Of $391 and a Max. of $4971. Please explain and/or clarify if the $4971 is correct.

Objection 3

- Individual Health PPO Policy, GIP28-P-AMS (Form)

Comment:

It is requested that you certify that benefits payable a PPO and Non PPO is in compliance with our Bulletin 9-85.

Objection 4

- Arkansas GIP-28-AMS Rate Manual, [] (Rate)

Comment:

It is stated that the base premium is $836.33 while the average rate under the Rate Review Detail shows an average

rate of $391. Why such a big difference?

Objection 5

- Individual Health PPO Policy, GIP28-P-AMS (Form)

Comment:

Do you have an adequate number of Preferred Providers in the areas that you will be marketing this product?

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

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/05/2012
Submitted Date	06/11/2012

Dear Rosalind Minor,

Comments:
Please see the Company's responses below.

Response 1

Comments: The word "Major" is not included in the policy and OOC title, because the coverage may not always satisfy the definition of "major medical expense coverage" in Regulation 18, Section 7E, due to the possibility that the coinsurance amount the insured pays may be up to 30%. However, there is no TOI selection for Medical Expense Coverage. The closest choice is Major Medical Expense Coverage.

Related Objection 1

Applies To:

- Individual Health PPO Policy, GIP28-P-AMS (Form)
- Individual Health PPO Outline of Coverage, GIP28-P-AMS-OC (Form)

Comment:

The Type of Insurance which was selected on your submission is Major Medical Expense. The face page of your policy and the Outline of Coverage reads: Medical Expense Insurance Policy. The title of the policy should read: Major Medical Expense Coverage as outlined under Rule and Regulation 18, Section 7 E.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments: The max of $4971 is correct. The total rate is comprised of multiple components including factors for plan, age, tobacco, and area. The minimum and maximum PMPMs were calculated by taking the min and max factors from each of the different components. It is unlikely that anyone would hit this theoretical maximum.

Related Objection 1

Applies To:

- Arkansas GIP-28-AMS Rate Manual, [] (Rate)

Comment:

Under the Rate/Rule Schedule Tab, the Rate Review Detail indicates that the Annual PMPM $ amount is a min. of $137, Weighted Aver. Of $391 and a Max. of $4971. Please explain and/or clarify if the $4971 is correct.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

Comments: Your letter asked the Company to certify that benefits payable under the network provider benefits of the policy will comply with Bulletin 9-85. Bulletin 9-85 states that the difference in benefit levels for services by a network provider and a non-network provider must not be so great as to require that health care services be rendered by a particular provider or hospital.

The Company asserts that benefits payable under the policy for services by a network provider do not require that a particular hospital or provider render health care services. The Company intends to make available to insureds network providers who have agreed to participate in a UnitedHealthcare provider network. Non-emergency eligible expenses incurred at a non-network provider will be subject to a 25% reduction and then a non-network deductible amount. After that the applicable coinsurance percentage is the same regardless of whether the provider is a network provider or a non-network provider.

Covered expenses incurred for emergency treatment by a non-network provider are considered eligible expenses at the

lesser of either the billed charge or an amount negotiated with the non-network provider. Also, if a covered person incurs covered expenses for services or supplies which are not of the type provided by a network provider, those covered expenses will be considered eligible expenses at the lesser of either the billed charge or an amount negotiated with the non-network provider.

The Company considers its treatment of benefits payable for services from a network provider and from a non-network provider to be consistent with the rest of the industry. While the difference in benefits is clearly intended to provide incentive for a covered person to utilize the services of a network provider, benefits payable for services of a non-network provider are also available at significant levels that do not negate an insured's freedom to utilize non-network providers.

Related Objection 1

Applies To:

- Individual Health PPO Policy, GIP28-P-AMS (Form)

Comment:

It is requested that you certify that benefits payable a PPO and Non PPO is in compliance with our Bulletin 9-85.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 4

Comments: The rate manual lists a monthly base rate of $836.33. This base rate is then multiplied by other factors to calculate the total premium. Other factors used in rating include plan, age, tobacco use, trend, area, and optional benefits selected. When adjusting for these other factors, the average rate calculated is $391 as shown in the rate Review Detail.

Related Objection 1

Applies To:

- Arkansas GIP-28-AMS Rate Manual, [] (Rate)

Comment:

It is stated that the base premium is $836.33 while the average rate under the Rate Review Detail shows an average rate of $391. Why such a big difference?

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 5

Comments: The zip codes include the entire state of Arkansas. Yes, the network has adequate providers in the state.

Related Objection 1

Applies To:

- Individual Health PPO Policy, GIP28-P-AMS (Form)

Comment:

Do you have an adequate number of Preferred Providers in the areas that you will be marketing this product?

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Forms List GIP28 Arkansas

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document

Individual Health PPO Policy	GIP28-P-AMS	Policy/Contract/Fraternal Certificate	Initial	53.700	GIP28-P-AMS PPO Policy.pdf
Previous Version					
Individual Health PPO Policy	*GIP28-P-AMS*	*Policy/Contract/Fraternal Certificate*	*Initial*	*53.700*	GIP28-P-AMS PPO Policy.pdf
Individual Health PPO Outline of Coverage	GIP28-P-AMS-OC	Outline of Coverage	Initial	43.400	GIP28-P-AMS-OC PPO Outline.pdf
Previous Version					
Individual Health PPO Outline of Coverage	*GIP28-P-AMS-OC*	*Outline of Coverage*	*Initial*	*43.400*	GIP28-P-AMS-OC PPO Outline.pdf
Administrative Rider	SA-S-9N-AMS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		SA-S-9N-AMS Rdr.pdf
Previous Version					
Administrative Rider	*SA-S-9-AMS*	*Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider*	*Initial*		SA-S-9-AMS Rdr.pdf
Administrative Rider	SA-S-10N-AMS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		SA-S-10N-AMS Rdr.pdf
Previous Version					
Administrative Rider	*SA-S-10-AMS*	*Policy/Contract/Fraternal Certificate: Amendment,*	*Initial*		SA-S-10-AMS

Insert Page, Endorsement or Rider Rdr.pdf

No Rate/Rule Schedule items changed.

We have made some technical updates to a few of the forms, which are attached. The changes are non-substantive.

Sincerely,
Anna Ferrell, Cindy Newell, Renee Jonet

Form Schedule

Lead Form Number: GIP28-P-AMS-03

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/12/2012	GIP28-P-AMS	Policy/Contract/Fraternal Certificate	Individual Health PPO Policy	Initial		53.700	GIP28-P-AMS PPO Policy.pdf
Approved-Closed 06/12/2012	GIP28-P-AMS-OC	Outline of Coverage	Individual Health PPO Outline of Coverage	Initial		43.400	GIP28-P-AMS-OC PPO Outline.pdf
Approved-Closed 06/12/2012	SA-S-9N-AMS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Administrative Rider	Initial			SA-S-9N-AMS Rdr.pdf
Approved-Closed 06/12/2012	SA-S-10N-AMS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Administrative Rider	Initial			SA-S-10N-AMS Rdr.pdf
Approved-Closed 06/12/2012	SA-S-1356RN-AMS	Policy/Contract/Fraternal	Vision Benefit Rider	Initial			SA-S-1356RN-AMS Vsn Rdr

		Certificate: Amendment, Insert Page, Endorsement or Rider			PPO.pdf
Approved-Closed 06/12/2012	SA-S-1366RN-AMS	Policy/Contract/Fraternal Term Life Insurance Rider	Initial		SA-S-1366RN-AMS TL Rdr.pdf
		Certificate: Amendment, Insert Page, Endorsement or Rider			
Approved-Closed 06/12/2012	SA-S-1367RN-AMS	Policy/Contract/Fraternal Accidental Death Insurance Rider	Initial		SA-S-1367RN-AMS AD Rdr.pdf
		Certificate: Amendment, Insert Page, Endorsement or Rider			
Approved-Closed 06/12/2012	SA-S-1417R-AMS	Policy/Contract/Fraternal Copayment Amount Rider	Initial		SA-S-1417R-AMS Copay Rdr PPO.pdf
		Certificate: Amendment, Insert Page, Endorsement or Rider			
Approved-Closed 06/12/2012	SA-S-1418R-AMS	Policy/Contract/Fraternal Copayment Amount Rider (w4OVs)	Initial		SA-S-1418R-AMS Copay Rdr w4OV

		Certificate: Amendment, Insert Page, Endorsement or Rider			PPO.pdf
Approved-Closed 06/12/2012	SA-S-1451N-AMS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Supplemental Accident Benefits Rider	Initial	SA-S-1451N-AMS Supp Acc Rdr.pdf
Approved-Closed 06/12/2012	SA-S-1505-AMS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Pregnancy Benefits Rider	Initial	SA-S-1505-AMS Pregnancy Rdr.pdf
Approved-Closed 06/12/2012	SA-S-1528-P-AMS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Outpatient Prescription Drug Expense Benefits Rider	Initial	SA-S-1528-P-AMS Rx Rdr PPO.pdf
Approved-Closed 06/12/2012	SA-S-1542-P-AMS	Policy/Contract/Fraternal	Outpatient Generic Prescription Drug Expense Benefits	Initial	SA-S-1542-P-AMS Generic Rx Rdr

		Certificate: Amendment, Insert Page, Endorsement or Rider	Rider		PPO.pdf
Approved-Closed 06/12/2012	SA-S-1547-AMS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Prior Authorization Rider	Initial	SA-S-1547-AMS Prior Auth Rdr.pdf
Approved-Closed 06/12/2012	SA-S-1559-P-AMS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Copayment Amount Rider (for HSA)	Initial	SA-S-1559-P-AMS Copay Rdr HSA PPO.pdf
Approved-Closed 06/12/2012	SA-S-1560-P-AMS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Copayment Amount Rider (for HSA w4OVs)	Initial	SA-S-1560-P-AMS Copay Rdr w4OV HSA PPO.pdf
Approved-Closed 06/12/2012	SA-S-1561-P-AMS	Policy/Contract/Fraternal	Outpatient Prescription Drug Expense Benefits	Initial	SA-S-1561-P-AMS Rx Rdr HSA PPO.pdf

		Certificate: Amendment, Insert Page, Endorsement or Rider	Rider (for HSA)		
Approved-Closed 06/12/2012	SA-S-1562-P-AMS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Outpatient Generic Prescription Drug Expense Benefits Rider (for HSA)	Initial	SA-S-1562-P-AMS Generic Rx Rdr HSA PPO.pdf
Approved-Closed 06/12/2012	SA-S-1499N-AMS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	[Optional] Mental Disorder Benefits Rider	Initial	SA-S-1499N-AMS Mental Rdr.pdf
Approved-Closed 06/12/2012	SA-S-1570-AMS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	[Optional] Biologically-Based Mental Illness Benefits Rider	Initial	SA-S-1570-AMS BBMI Rdr.pdf
Approved-Closed 06/12/2012	SA-S-1457N-AMS	Policy/Contract/Fraternal	AR Optional Hearing Aids Rider	Initial	SA-S-1457N-AMS.pdf

		Certificate: Amendment, Insert Page, Endorsement or Rider			
Approved-Closed 06/12/2012	SA-S-1574-AMS	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	AR Optional Musculoskeletal Disorders Rider	Initial	SA-S-1574-AMS.pdf
Approved-Closed 06/12/2012	GIP-AP-144-AMS-03	Application/Enrollment Form	Application	Initial	GIP-AP-144-AMS-03 022412 FV.pdf
Approved-Closed 06/12/2012	MTI00359, etc.	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Arkansas Mandates Rider GIP28-GRI	Initial	AR Mandates Rider AMS.pdf
Approved-Closed 06/12/2012	SA-AP-1.1-AMS	Application/Enrollment Form	Amendment to Application	Initial	SA-AP-1.1-AMS 012012.pdf

American Medical Security
A UnitedHealthcare Company

American Medical Security Life Insurance Company
3100 AMS Boulevard
P.O. Box 19032
Green Bay, WI 54307-9032
For Inquiries: [(800) 232-5432]

In this *policy, "you"* or *"your"* will refer to the Insured named on page 3, and *"we," "our,"* or *"us"* will refer to American Medical Security Life Insurance Company, a stock company.

Section 1

AGREEMENT AND CONSIDERATION

We will pay benefits for a *loss* as set forth in this *policy.* This *policy* is issued in exchange for and on the basis of the statements made on *your* application and payment of the first premium. It takes effect on the applicable *effective date* shown on the Data Page. It will remain in force until the first premium due date, and for such further periods for which premium payment is received by *us* when due, subject to the renewal provision below. All periods will begin and end at 12:01 A.M., Standard Time, where *you* live.

GUARANTEED RENEWABLE SUBJECT TO LISTED CONDITIONS

You may keep this *policy* in force by timely payment of the required premiums. However, *we* may refuse renewal as of the anniversary of the *policy effective date* if: (A) *we* refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* then live[, as explained under the Discontinuance clause]; or (B) there is fraud or a material misrepresentation made by or with the knowledge of a *covered person* in filing a claim for *policy* benefits.

From time to time, *we* will change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The policy plan, age and sex of *covered persons,* type and level of benefits, time the *policy* has been in force, and place of residence on the premium due date are some of the factors used in determining *your* premium rates. Premium rates are expected to increase over time.

At least [31] days notice of any plan to take an action or make a change permitted by this clause will be mailed to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *policy* or a change in a *covered person's* health. While this *policy* is in force, *we* will not restrict coverage already in force.

10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this *policy.* If *you* are not satisfied, *you* may notify *us* within 10 days after *you* received it. Any premium paid will be refunded, less claims paid. This *policy* will then be void from its start.

Check the attached application. If it is not complete or has an error, please let *us* know. An intentional misrepresentation of a material fact or a fraudulent misstatement in the application may cause *your policy* to be voided, or a claim to be reduced or denied.

This *policy* is signed for *us* as of the *effective date* for *injuries* as shown on the Data Page.

President

Medical Expense Insurance Policy

This policy is renewable, subject only to the two conditions set forth in the renewal clause. We have the right to change premiums as set forth above.

As a cost containment feature, this policy contains [notification/prior authorization] requirements. Benefits are reduced if the requirements are not met. Please refer to [the Notification and Predetermination section/the Prior Authorization Rider].

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Important Notice

This *policy* is a legal contract between *you* and *us*.

READ *YOUR POLICY* CAREFULLY.

Section 2
Data Page

[**Policy Number -** 999-999-999
Insured - John Doe
Plan - Individual/Husband-Wife/All Family/One-Parent Family
Total Premium - $XXXX.XX

Premium Mode - Monthly/Quarterly
Effective Date:
For Injuries - Month Day, Year
For Illnesses - Month Day, Year]

[**Premiums for Optional Benefits** (These are already included in the Total Premium above.)

Vision..... $XX.XX
Supplemental Accident ..... $XX.XX
Lower Copayment Amount for Doctor Office Visits..... $XX.XX
Prescription Drug Copay Card ..... $XX.XX
Lower Prescription Drug Deductible ..... $XX.XX
24-Month Rate Guarantee ..... $XX.XX
Term Life (initial premium*) ..... $XX.XX
Accidental Death (initial premium*) ..... $XX.XX

*Please see the Term Life and Accidental Death sections of the Data Page for renewal premium amounts.]

[**See rider-amendment(s) attached to policy.**]

[**IMPORTANT: If covered expenses are incurred at a non-network provider, benefits for non-network eligible expenses will be less than the amount that would have otherwise been payable for the services of a network provider. Please refer to the Amount Payable section of this policy and the information listed below.**]

[**DEDUCTIBLE AMOUNT -- Stated Deductible,** per *covered person,* per calendar year

Inpatient

Network Provider .....[Range = $1,000 - $10,000]

Maximum number of *covered persons* required to meet the *inpatient network provider* stated deductible per family, per calendar year ..... Two

Unless otherwise stated, the *network provider* stated deductible will not apply to *covered expenses* subject to a *copayment amount*.

Non-Network Provider (including *covered expenses* credited to the *network provider* stated deductible) .....[Range = $2,000 - $20,000]

Outpatient

Network Provider .....[Range = $1,000 - $10,000]

Maximum number of *covered persons* required to meet the outpatient *network provider* stated deductible per family, per calendar year ..... Two

Unless otherwise stated, the *network provider* stated deductible will not apply to *covered expenses* subject to a *copayment amount*.

Non-Network Provider (including *covered expenses* credited to the *network provider* stated deductible) .....[Range = $2,000 - $20,000]

Variable Deductible is equal to the amount of *covered expenses* payable under any *other plan*. The *variable deductible* will be applied even if the stated deductible has been satisfied.][1]

[1] Note to Reviewer (NTR): This provision will print in plans that are not intended to be used with a qualified health savings account.

[**DEDUCTIBLE AMOUNT**

Stated Deductible, per calendar year

Individual Plan

Network Provider .....[Range = $1,250 - $6,000[2]]

Non-Network Provider ..... [Range = $2,500 - $12,000]

Family Plan

Network Provider .....[Range = $2,500 - $12,000[3]]

Non-Network Provider ..... [Range = $5,000 - $24,000]

Variable Deductible is equal to the amount of *covered expenses* payable under any *other plan*. The *variable deductible* will be applied even if the stated deductible has been satisfied.

Your stated deductible is likely to increase each year. If *you* have chosen the maximum stated deductible, the increase will be based on the cost-of-living adjustment (COLA) levels set annually by the Internal Revenue Service (IRS) with regard to the maximum deduction allowed by law for Health Savings Accounts (HSAs). If *you* have chosen a lower stated deductible, the increase will be based on COLA levels set annually by the IRS for the minimum deductible required of an HSA high deductible health plan. The increase is currently calculated as a percentage rounded to the nearest $50. All stated deductibles may be adjusted, even if not required to maintain tax-qualified status.][4]

[**DEDUCTIBLE CREDIT**

Qualified covered person for 1 year .....20% of the *network provider* stated deductible

Qualified covered person for 2 consecutive years .....40% of the *network provider* stated deductible

Qualified covered person for 3+ consecutive years .....50% of the *network provider* stated deductible]

[**COINSURANCE PERCENTAGE**

Inpatient

For *covered expenses* in excess of the applicable stated deductible [Range=60%-100%]

Outpatient

For *covered expenses* in excess of the applicable stated deductible [Range=60%-100%]

{(Not applicable to *covered expenses* subject to a *copayment amount*, unless otherwise specifically stated)}[5]

COINSURANCE OUT-OF-POCKET MAXIMUM

Per *covered person*, per calendar year ..... [Range = $0-$10,000]

If payment is calculated using the *variable deductible*, the *coinsurance percentage* will be 100 percent. The effect of the *variable deductible* is to pay 100 percent of the *covered person's out-of-pocket* expenses, excluding any *copayment amounts*.][6]

[**COINSURANCE PERCENTAGE**

Inpatient

For *covered expenses* in excess of the applicable stated deductible [Range=70%-100%]

Outpatient

For *covered expenses* in excess of the applicable stated deductible [Range=70%-100%]

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[2] NTR: Or the IRS limit for high deductible health plans.

[3] NTR: Or the IRS limit for high deductible health plans.

[4] NTR: This provision will print in high deductible health plans used with a qualified health savings account.

[5] NTR: This sentence will print in plans with a copayment amount.

[6] NTR: This provision will print in plans that are not intended for use with a qualified health savings account.

If payment is calculated using the *variable deductible*, the *coinsurance percentage* will be 100 percent. The effect of the *variable deductible* is to pay 100 percent of the *covered person's out-of-pocket* expenses, excluding any *copayment amounts*.][7]

[**OUT-OF-POCKET MAXIMUM**

Individual Plan .....[Range = $1,250-$6,000]

Family Plan.....[Range = $2,500-$12,000]

The out-of-pocket maximum includes applicable stated deductibles, *copayment amounts,* and coinsurance amounts.][8]

[**NON-NETWORK PROVIDER BENEFITS**

Covered expenses do not include amounts in excess of the *eligible expense*. Non-*emergency non-network eligible expenses* will be reduced by 25% before application of any applicable *deductible amounts* and coinsurance provisions. This means, for example, $100 of *non-network eligible expenses* will be considered as $75 in *eligible expenses* for purposes of determining benefits. These reduced *non-network eligible expenses* will then be subject to any applicable *deductible amounts* and coinsurance provisions.]

[**BENEFIT LIMITS/SPECIFICS**]

[**EMERGENCY ROOM DEDUCTIBLE** (for each visit for *illness* to an *emergency* room when the *covered person* is not directly admitted to the *hospital*) .....[Range = $100-$1,000]

Note: After satisfaction of the *emergency* room deductible, *covered expenses* are subject to any applicable *deductible amounts* and coinsurance provisions.][9]

[**BENEFIT REDUCTION FOR FAILURE TO OBTAIN REFERRAL: Failure to obtain a referral from your primary care physician will result in a benefit reduction. Reduced benefits will be 80% of regular policy benefits.**][10]

[**NETWORK PROVIDER COPAYMENT AMOUNTS***

Office Visits for Injury or Illness: *Copayment amount* per office visit (excluding *surgery*) performed by a *doctor*, limited to the charge for the office visit (history and exam only)

Network Primary Care Physician (PCP).....[Range = $25-$50]

Network Specialist Physician

With PCP Referral.....[Range = $25-$100]

Without Referral .....[2 x Specialist Copay / $50-$200]

Hospital Inpatient

{*Copayment amount* per *inpatient* stay in a *hospital*.....[Range = $500-$1,000]}

{*Copayment amount* per *inpatient* day in a *hospital* .....[Range = $250-$750]}

Urgent Care Center

Copayment amount per visit to an *urgent care center*.....[Range = $75-$100]

MRI/CT Scan/PET Scan

Copayment amount per service** .....[Range = $150-$250]

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[7] NTR: This provision will print in high deductible health plans for use with a qualified health savings account.

[8] NTR: This provision will print in high deductible health plans for use with a qualified health savings account.

[9] NTR: This provision will print in plans that are not intended to be used with a qualified health savings account.

[10] NTR: This provision will print in non-copay plans.

{The *copayment amount* will be applied after the *deductible amount* has been met. After the *copayment amount,* benefits will then be subject to the applicable *coinsurance percentage*.}[11]

Covered expenses incurred at a non-*network provider* will be reduced by 25%. Benefits will then be subject to the non-*network provider deductible amount* and the applicable *coinsurance percentage*.

**Benefits will then be subject to the *network provider deductible amount*.][12]

[**NETWORK PROVIDER COPAYMENT AMOUNTS***

Office Visits 1-4 (per *covered person,* per calendar year)**

Copayment amount per office visit (excluding *surgery*) performed by a *doctor,* limited to the charge for the office visit (history and exam only)

Network Primary Care Physician (PCP).....[Range = $25-$50]

Network Specialist Physician

With PCP Referral.....[Range = $25-$100]

Without Referral .....[2 x Specialist Copay / $50-$200]

Hospital Inpatient

{*Copayment amount* per *inpatient* stay in a *hospital*.....[Range = $500-$1,000]}

{*Copayment amount* per *inpatient* day in a *hospital* .....[Range = $250-$750]}

Urgent Care Center

Copayment amount per visit to an *urgent care center*.....[Range = $75-$100]

MRI/CT Scan/PET Scan

Copayment amount per service***.....[Range = $150-$250]

{The *copayment amount* will be applied after the *deductible amount* has been met. After the *copayment amount,* benefits will then be subject to the applicable *coinsurance percentage*.}[13]

Covered expenses incurred at a non-*network provider* will be reduced by 25%. Benefits will then be subject to the non-*network provider deductible amount* and the applicable *coinsurance percentage.*

**Additional office visits will be subject to the applicable *deductible amount* and *coinsurance percentage.*

***Benefits will then be subject to the *network provider deductible amount*.][14]

[**PRESCRIPTION DRUGS**

Tier 1, *prescription drug copayment amount* per *prescription order* or refill.....{$15-$30}

Tier 2, *prescription drug copayment amount* per *prescription order* or refill
{after satisfaction of a [Range = $500 - $1,000] calendar year *prescription drug deductible amount*,}[15] per *covered person*.....{$35-$50}

Tier 3, *prescription drug copayment amount* per *prescription order* or refill
{after satisfaction of a [Range = $500 - $1,000] calendar year *prescription drug deductible amount,*}[16] per *covered person*..... {$65-$80}

Tier 4, *prescription drug copayment amount* per *prescription order* or refill
{after satisfaction of a [Range = $500 - $1,000] calendar year *prescription drug deductible amount*,}[17] per *covered person*

[11] NTR: This statement will print in high deductible health plans for use with a qualified health savings account.
[12] NTR: This copayment provision will print if the optional four office visits benefit is not selected.
[13] NTR: This statement will print in high deductible health plans for use with a qualified health savings account.
[14] NTR: This copayment provision will print when the optional four office visits benefit is selected.
[15] NTR: This phrase will not print in high deductible health plans for use with a health savings account.
[16] NTR: This phrase will not print in high deductible health plans for use with a health savings account.
[17] NTR: This phrase will not print in high deductible health plans for use with a health savings account.

At *member pharmacies* ..... {25%-35%} of negotiated rate
At non-*member pharmacies* ..... {25%-35%} of *predominant reimbursement rate*

NOTE: Tier status for a *prescription drug* may be determined by accessing *your prescription drug* benefits via *our* website or by calling the telephone number on *your* identification card. The tier to which a *prescription drug* is assigned may change as detailed in the *policy*.

{The *copayment amount* will be applied after the *deductible amount* has been met. After the *copayment amount,* benefits will then be subject to the applicable *coinsurance percentage*.}[18]

No benefits are payable for expenses in excess of the cost of the *generic drug* when a name brand drug is purchased and the *generic drug* is available.

"*Generic drug*" means a prescription drug product that: (1) is chemically equivalent to a brand-name drug; or (2) *we* identify as a generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. *You* should know that all products identified as a "generic" by the manufacturer, pharmacy or *your* physician may not be classified as a *generic drug* by *us*.][19]

[**NETWORK PROVIDER COPAYMENT AMOUNTS**

Outpatient Generic Prescription Drugs, per *prescription order* or refill ..... {$15-$30}

"Generic drug" means a prescription drug product that: (1) is chemically equivalent to a brand-name drug; or (2) *we* identify as a generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. *You* should know that all products identified as a "generic" by the manufacturer, pharmacy, or *your* physician may not be classified as a *generic drug* by *us*.][20]

[**Spine and Back Disorders Benefits**

Maximum number of outpatient visits, per *covered person,* per calendar year .....15]

[**Supplemental Accident Expense Benefits** (Benefits are not subject to the stated deductible, but benefits paid will be credited to any *network provider* stated deductible and *coinsurance percentage*.)

Maximum Benefit.....[Range = $250 - $10,000]
Benefit Period ..... Within 90 days of an accidental *injury*][21]

[**This policy is intended to be and will be administered to qualify as a high deductible health plan for purposes of tax qualified Health Savings Account plans.**][22]

[**24-MONTH INITIAL RATE GUARANTEE**
(Not applicable to dependent eligibility changes, address changes, or benefit changes requested by the insured or mandated by law.)
The rate guarantee expires 24 calendar months after the *effective date* shown on the Data Page.][23]

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[18] NTR: This statement will print in high deductible health plans for use with a qualified health savings account.
[19] NTR: Included in some plans. An optional benefit for other plans.
[20] NTR: This provision will print if the optional generic prescription drugs only benefit is selected.
[21] NTR: This provision will print if the optional supplemental accident benefit is selected.
[22] NTR: This provision will print in high deductible health plans used with a qualified health savings account.
[23] NTR: This provision will print only if the optional 24-month rate guarantee benefit is selected.

[**NOTIFICATION REQUIREMENTS**

You must notify *us* at the phone number listed on *your* ID card when a *covered person's hospital* stay exceeds three days, or when a *covered person* is evaluated for an organ or tissue transplant. Failure to notify *us* will result in a benefit reduction. Notification does not guarantee payment.]

[PRIOR AUTHORIZATION REQUIREMENTS

We require prior authorization for certain *covered expenses.* In general, when services or supplies are received from a *network provider,* the *network provider* is responsible for obtaining the prior authorization, and when services or supplies are received from a non-*network provider, you* are responsible for obtaining the prior authorization. However, there are exceptions. Services and supplies for which *you* are responsible for obtaining prior authorization are listed below.

Failure to obtain prior authorization will result in a reduction of benefits. Reduced benefits will be 80% of regular *policy* benefits that would have otherwise been payable.

Obtaining prior authorization does not guarantee payment. Please see the Prior Authorization Rider for more information.

SERVICES AND SUPPLIES FOR WHICH YOU MUST OBTAIN PRIOR AUTHORIZATION

[**Ambulance, non-emergency**

You must obtain authorization for non-*emergency* ambulance transportation as soon as possible prior to transport.

Clinical Trials

You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises.

Congenital Heart Disease Surgery

For *network* and non-*network* benefits, *you* must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) *surgery* arises.

Dental Expenses - Injuries Only

For *network* and non-*network* benefits, *you* must obtain prior authorization 5 business days before follow-up (post-*emergency*) treatment begins. *You* do not have to obtain prior authorization before the initial *emergency* treatment.

Diabetes Services

For non-*network* benefits, *you* must obtain prior authorization before obtaining any equipment, for the management and treatment of diabetes, [that exceeds {Range = $1,000-$5,000} in cost (either retail purchase cost or cumulative retail rental cost of a single item)].

Durable Medical Equipment

For non-*network* benefits, *you* must obtain prior authorization before obtaining any *durable medical equipment* [that exceeds {Range = $1,000-$5,000} in cost (either retail purchase cost or cumulative retail rental cost of a single item)].

Home Health Care

For non-*network* benefits, *you* must obtain prior authorization 5 business days before receiving *home health care* services, or as soon as reasonably possible.

Hospice Care

For non-*network* benefits, *you* must obtain prior authorization 5 business days before admission for an *inpatient* stay in a *hospice*, or as soon as reasonably possible.

Hospital Inpatient Stay

For non-*network* benefits, *you* must obtain prior authorization:

5 business days before a scheduled admission; or

As soon as is reasonably possible for a non-scheduled admission, including *emergency* admissions.

Lab, X-Ray, and Major Diagnostics - CT, PET, MRI, MRA, and Nuclear Medicine

For non-*network* benefits, *you* must obtain prior authorization:

5 business days before scheduled services are received; or

For non-scheduled services, within one business day or as soon as is reasonably possible.

{**Mental Health and Substance Abuse Services**

For non-*network* benefits for treatment of a [*biologically-based mental illness/mental disorder*] or *substance abuse, you* must obtain authorization:

5 business days before a scheduled admission;

As soon as is reasonably possible for a non-scheduled admission, including *emergency* admissions; or

Prior to receiving services on an outpatient basis.}[24]

Outpatient Prescription Drugs

For non-*network* benefits for intravenous infusions, *you* must obtain prior authorization:

5 business days before receiving scheduled services; or

For non-scheduled services, within one business day or as soon as is reasonably possible.

For non-*network* benefits for other outpatient *prescription drugs, you* must obtain prior authorization 5 business days before certain *prescription drugs* are received, or as soon as is reasonably possible. *You* may determine whether a particular *prescription drug* requires prior authorization by calling *us* at the telephone number listed on *your* health insurance identification card.

Outpatient Surgery

For non-*network* benefits for *outpatient surgery, you* must obtain prior authorization:

5 business days before receiving scheduled services; or

For non-scheduled services, within one business day or as soon as is reasonably possible.

Prosthetic Devices

For non-*network* benefits, *you* must obtain prior authorization before obtaining prosthetic devices [that exceed {range = $1,000-$5,000} in cost per device].

Reconstructive Surgery

For non-*network* benefits, *you* must obtain prior authorization:

5 business days before a scheduled *reconstructive surgery* is performed; or

For a non-scheduled *reconstructive surgery*, within one business day or as soon as is reasonably possible.

Rehabilitation and Extended Care Facility Services

For non-*network* benefits for *rehabilitation therapy* services, *you* must obtain prior authorization 5 business days before receiving *rehabilitation* services, or as soon as is reasonably possible.

For non-*network* benefits for *inpatient rehabilitation* or confinement in an *extended care facility, you* must obtain prior authorization:

5 business days before a scheduled admission; or

As soon as is reasonably possible for a non-scheduled admission.

Sleep Studies

For non-*network benefits, you* must obtain prior authorization 5 business days before scheduled services are received.

Temporomandibular Joint (TMJ) Services

For non-*network* benefits, *you* must obtain prior authorization 5 business days before TMJ services are performed during an *inpatient* stay in a *hospital.*

Therapeutic Treatments

For non-*network* benefits, *you* must obtain prior authorization for dialysis, chemotherapy, radiation therapy:

5 business days before scheduled services are received; or

For non-scheduled services, within one business day or as soon as is reasonably possible.

Transplants

For *network* and non-*network* benefits, *you* must obtain prior authorization as soon as the possibility of a transplant arises and before the time a pre-transplant evaluation is performed at a transplant center.]**]**

[24] NTR: This paragraph will print only if optional rider SA-S-1499N or SA-S-1570 is attached to the policy.

[**We may from time to time negotiate fee discounts with health care professionals and facilities. Benefit calculations will be based upon the discounted price, if any. We share discounts with you in proportion to payment. Discounts taken by us contribute to lower future rate increases.**]

[**ACCIDENTAL DEATH BENEFIT**

Accidental Death Proceeds

Attained Age*	**Primary Insured Accidental Death Proceeds**	**Spouse Accidental Death Proceeds**
18-64	$ 50,000	$ 50,000
65 and older	$ 0	$ 0

*For purposes of determining the accidental death proceeds, *attained age* means the age of the primary insured or *spouse* at the start of the *premium period* in which death occurs.

Annual Renewal Premiums

Primary Insured	**Spouse**
PrimaryPremium1	SpousePremium1

Quarterly - .25 x Annual **Monthly - .08333 x Annual**

Covered Persons: Primary Insured and Spouse Only][25]

[**VISION BENEFIT**

Eye Exam ..... [$10 copay then 100%]
Eye Exam *Vision Benefit Non-Preferred Provider* ..... [up to $40 allowance]
Frames[C] ..... [$25[A] copay then 100%]
Frames *Vision Benefit Non-Preferred Provider* ..... [up to $45 allowance]
Standard Single Vision Lenses ..... [$25[A] copay then 100%]
Single Vision Lenses *Vision Benefit Non-Preferred Provider* ..... [up to $40 allowance]
Standard Bifocal Lenses ..... [$25[A] copay then 100%]
Bifocal Lenses *Vision Benefit Non-Preferred Provider* ..... [up to $60 allowance]
Standard Trifocal Lenses ..... [$25[A] copay then 100%]
Trifocal Lenses *Vision Benefit Non-Preferred Provider* ..... [up to $80 allowance]
Standard Lenticular Lenses ..... [$25[A] copay then 100%]
Lenticular Lenses *Vision Benefit Non-Preferred Provider* ..... [up to $80 allowance]
Covered-in-Full Elective Contacts[B] ..... [$25 copay then 100%[D]]
Contacts *Vision Benefit Non-Preferred Provider* ..... [up to $105 allowance]
Necessary Contacts ..... [$25 copay then 100%[D]]
Contacts *Vision Benefit Non-Preferred Provider* ..... [up to $210 allowance]

[A] If you purchase eyeglass lenses and eyeglass frames at the same time from the same *vision benefit preferred provider*, only one copayment will apply to those eyeglass lenses and eyeglass frames together.

[25] NTR: This provision will print only if the optional accidental death benefit is selected.

[B] You are eligible to select only one of either eyeglasses (eyeglass lenses and/or eyeglass frames) or contact lenses. If you select more than one of these services, only one service will be covered.

[C] You may purchase from your *vision benefit preferred provider* eyeglass frames that are outside of the covered eyeglass frames selection. Non-selection eyeglass frames will receive an allowance. The eyeglass frame allowance will be [$50] wholesale or [$130] retail, depending upon the type of *vision benefit preferred provider* selected. No copayment will apply to non-selection eyeglass frames.

[D] You may purchase from your *vision benefit preferred provider* contact lenses that are outside of the covered contact lens selection. Non-selection contact lenses will receive an allowance of [$105] for elective contacts and [$210] for necessary contacts. No copayment will apply to non-selection contact lenses.][26]

[26] NTR: This provision will print only if the optional vision benefit is selected.

Section 3
GENERAL DEFINITIONS

In this *policy, italicized* words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this *policy*:

- *"Acute rehabilitation"* means two or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for three or more hours per day, five to seven days per week, while the *covered person* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *extended care facility*.

- *"At risk for ovarian cancer"* means:

  (A) A female *covered person* having a family history of:

    (1) One or more first-degree relatives with ovarian cancer;

    (2) Two or more female relatives with breast cancer; or

    (3) Nonpolyposis colorectal cancer; or

  (B) A female *covered person* testing positive for BRCA1 or BRCA2 mutations.

- *"Coinsurance percentage"* means the percentage of *covered expenses* that are payable by *us*.

If payment is calculated using the *variable deductible,* the *coinsurance percentage* will be 100 percent.

- *"Complications of pregnancy"* means:

  (A) Conditions whose diagnoses are distinct from *pregnancy,* but are adversely affected by *pregnancy* or are caused by *pregnancy* and not, from a medical viewpoint, associated with a normal *pregnancy.* This includes: ectopic *pregnancy,* spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, *doctor* prescribed rest during the period of *pregnancy,* morning sickness, and conditions of comparable severity associated with management of a difficult *pregnancy,* and not constituting a medically classifiable distinct complication of *pregnancy*.

  (B) An *emergency* caesarean section or a *non-elective caesarean section*.

- *"Copayment amount"* means the amount of *covered expenses* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Data Page), before [benefits are payable for remaining *covered expenses* for that service under the *policy*][i] [application of any *coinsurance percentage*][ii].

- *"Cosmetic treatment"* means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an *injury*, *illness*, or congenital anomaly.

- *"Covered expense"* means an expense that is:

  (A) Incurred while *your* or *your dependent's* insurance is in force under this *policy*;

  (B) Covered by a specific benefit provision of this *policy*; and

  (C) Not excluded anywhere in this *policy*.

- *"Covered person"* means *you*, *your* lawful *spouse* and each *eligible child*:

  (A) Named in the application; or

  (B) Whom *we* agree in writing to add as a *covered person*.

- *"Custodial care"* means care that is administered for assistance (rather than for training or education) of the patient in performing the activities of daily living. *Custodial care* also includes nonacute care for the comatose, semicomatose, paralyzed, or mentally incompetent patient.

- *"Deductible amount"* means the amount of *covered expenses*, shown in the Data Page, that must actually be paid by [each/all][iii] *covered person[s]* during any calendar year before any benefits are payable. The *deductible amount* does not include any *copayment amount.* The *deductible amount* is the larger of the stated deductible shown in the Data Page or the *variable deductible*.

A new stated deductible must be met each calendar year.

[The maximum number of *covered persons* in a family that must meet the stated deductible in a calendar year is shown in the Data Page.][iv]

- [*"Deductible credit"* means the amounts shown on the Data Page that may be offset against a

qualified covered person's individual/family stated deductible for the following calendar year.]

- *"Dental expenses"* means *surgery* or services provided to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue and any related supplies or oral appliances. Expenses for such treatment are considered *dental expenses* regardless of the reason for the services.

- *"Dependent"* means *your* lawful *spouse* and/or an *eligible child*.

- *"Doctor"* means a duly licensed practitioner of the medical arts, limited to a physician holding an M.D. or D.O. degree, optometrist, dentist, podiatrist, chiropractor, or clinical psychologist. With regard to medical services provided to a *covered person*, a *doctor* must be currently licensed by the state in which the services are provided, and the services must be provided within the scope of that license. With regard to consulting services provided to *us*, a *doctor* must be currently licensed by the state in which the consulting services are provided.

- *"Durable medical equipment"* means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an *illness* or *injury*, can withstand repeated use, are generally not useful to a person in the absence of *illness* or *injury*, and are appropriate for use in the patient's home.

- *"Effective date"* means the applicable date a *covered person* becomes insured for *illness* or *injury*. The applicable *effective date* is shown:

  (A) In the Data Page of this *policy* for initial *covered persons*; and

  (B) On the rider adding any new *covered person*.

[The *effective date* for *illness* will always be on the 15th day after the *effective date* for *injury*.]

- *"Eligible child"* means *your* or *your spouse's* child, if that child is less than 26 years of age.

As used in this definition, "child" means: (A) a natural child; (B) a legally adopted child; (C) a child placed with *you* for adoption; or (D) a child for whom legal guardianship has been awarded to *you* or *your spouse*.

It is *your* responsibility to notify *us* if *your* child ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* pay for a child at a time when the child did not qualify as an *eligible child*.

- *"Eligible expense"* means a *covered expense* as determined below.

  (A) For *network providers* (excluding Transplant Benefits): When a *covered expense* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.

  (B) For non-*network providers*:

    (1) When a *covered expense* is received from a non-*network provider* as a result of an *emergency* or as otherwise approved by *us*, the *eligible expense* is the lesser of the billed charge or a lower amount negotiated with the provider [or authorized by state law].

    (2) When a *covered expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible expense* is the lesser of the billed charge or a lower amount negotiated with the provider [or authorized by state law].

    (3) Except as provided under (1) and (2) above, when a *covered expense* (excluding Transplant Benefits) is received from a non-*network provider*, the *eligible expense* is determined based on [the lesser of/the first of the following rules that can be applied in the order shown below]:

      (a) [The fee that has been negotiated with the provider; or

      (b) [110%] of the fee Medicare allows for the same or similar services provided in the same geographical area; or

      (c) 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 geographical area determined by *us*; or

      (d) The fee charged by the provider for the services; or

      (e) A fee schedule that *we* develop.]

- *"Emergency"* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(A) Placing the health of the *covered person* (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

- *"Experimental or investigational treatment"* means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

(A) Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"USFDA"*) regulation, regardless of whether the trial is subject to *USFDA* oversight.

(B) An *unproven service.*

(C) Subject to *USFDA* approval, and:

(1) It does not have *USFDA* approval;

(2) It has *USFDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or

(3) It has *USFDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *USFDA*-approved drug is a use that is determined by *us* to be:

(a) Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;

(b) Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or

(c) Not an *unproven service;* or

(4) It has *USFDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *USFDA* or has not been determined through peer-reviewed medical literature to treat the medical condition of the *covered person.*

(D) Experimental or investigational according to the provider's research protocols.

Items (C) and (D) above do not apply to phase III or IV *USFDA* clinical trials.

- *"Extended care facility"* means an institution, or a distinct part of an institution, that:

(A) Is licensed as a *hospital*, *extended care facility*, or *rehabilitation facility* by the state in which it operates;

(B) Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *doctor* and the direct supervision of a registered nurse;

(C) Maintains a daily record on each patient;

(D) Has an effective utilization review plan;

(E) Provides each patient with a planned program of observation prescribed by a *doctor;* and

(F) Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing standards of medical practice for that condition.

Extended care facility does not include a facility primarily for rest, the aged, treatment of *substance abuse, custodial care,* nursing care, or for care of *mental disorders* or the mentally incompetent.

- *"Generally accepted standards of medical practice"* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered expense* under the *policy*. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

- *"Hospital"* means an institution that:

(A) Operates as a *hospital* pursuant to law;

(B) Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients*;

(C) Provides 24-hour nursing service by registered nurses on duty or call;

(D) Has staff of one or more *doctors* available at all times;

(E) Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and

(F) Is not primarily a long-term care facility; an *extended care facility*, nursing, rest, *custodial care*, or convalescent home; a halfway house, transitional facility, or *residential treatment facility;* a place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *covered person* will be deemed not to be confined in a *hospital* for purposes of this *policy*.

- *"Illness"* means a sickness, disease, disorder, or abnormal condition of a *covered person*. *Illness* does not include *pregnancy*, learning disabilities, attitudinal disorders, or disciplinary problems. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

- *"Immediate family"* means the parents, *spouse*, children, or siblings of any *covered person*, or any person residing with a *covered person*.

- *"Injury"* means accidental bodily damage sustained by a *covered person* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

- *"Inpatient"* means that medical services, supplies, or treatment are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

- *"Intensive care unit"* means a Cardiac Care Unit, or other unit or area of a *hospital*, that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

- *"Intensive day rehabilitation"* means two or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for three or more hours per day, five to seven days per week.

- *"Loss"* means an event for which benefits are payable under this *policy*. A *loss* must occur while the *covered person* is insured under this *policy*.

- *"Maximum therapeutic benefit"* means the point in the course of treatment where no further improvement in a *covered person's* medical condition can be expected, even though there may be fluctuations in levels of pain and function.

- *"Medical practitioner"* means a *doctor*, nurse anesthetist, physician's assistant, [physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* acupuncturist, speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, *emergency* medical technician, social worker, family counselor, marriage counselor, child counselor, naturopath, perfusionist, massage therapist or sociologist.] With regard to medical services provided to a *covered person*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification. With regard to consulting services provided to *us*, a *medical practitioner* must be licensed or certified by the state in which the consulting services are provided.

- *"Medically necessary"* means a health care service, supply, or drug provided for the purpose of preventing, evaluating, diagnosing, or treating an *illness, injury,* condition, disease, or its symptoms, that is determined by *us* or in consultation with an appropriate medical professional to be:

(A) In accordance with *generally accepted standards of medical practice*.

(B) Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the *covered person's illness, injury,* condition, disease, or its symptoms.

(C) Not provided mainly for the *covered person's* convenience or that of the *covered person's doctor* or other health care provider.

(D) Not furnished solely to promote athletic achievement, a desired lifestyle, or to improve the *covered person's* environmental or personal comfort.

(E) As cost effective as any established alternative service, supply, or drug that is as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the *covered person's illness, injury,* condition, disease, or its symptoms.

A health care service, supply, or drug will not meet this definition based solely on the fact that a *doctor* or health care provider of a *covered person* performs, provides, prescribes, orders, recommends, or approves that service, supply, or drug.

- *"Medically stabilized"* means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*.

- *"Medicare opt-out practitioner"* means a *medical practitioner* who:

(A) Has filed an affidavit with the Department of Health and Human Services stating that he, she, or it will not submit any claims to Medicare during a two-year period; and

(B) Has been designated by the Secretary of that Department as a *Medicare opt-out practitioner*.

- *"Medicare-participating practitioner"* means a *medical practitioner* who is eligible to receive reimbursement from Medicare for treating Medicare-eligible individuals.

- *"Mental disorder"* means a mental or emotional disease or disorder that is:

(A) A disease of the brain with predominant behavioral symptoms;

(B) A disease of the mind or personality, evidenced by abnormal behavior; or

(C) A disorder of conduct evidenced by socially deviant behavior.

Mental disorder includes psychiatric *illnesses* listed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders of the American Psychiatric Association.

- *"Necessary medical supplies"* means medical supplies that are:

(A) Necessary to the care or treatment of an *injury* or *illness*;

(B) Not reusable or *durable medical equipment*; and

(C) Not able to be used by others.

Necessary medical supplies do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

- "*Network*" means a group of *doctors* and providers who have contracts that include an agreed upon price for health care expenses.

- "*Network eligible expense*" means the *eligible expense* for services or supplies that are provided by a *network provider*. For facility services, this is the *eligible expense* that is provided at and billed by a *network* facility for the services of either a *network* or non-*network provider*. *Network eligible expense* includes benefits for *emergency* health services even if provided by a non-*network provider*.

- *"Network provider"* means a *doctor* or provider who is identified [in the most current list for the *network* shown on *your* identification card.]

- *"Non-elective caesarean section"* means:

(A) A caesarean section where vaginal delivery is not a medically viable option; or

(B) A repeat caesarean section.

- *"Non-network eligible expense"* means the *eligible expense* for services or supplies that are provided and billed by a non-*network provider.*

- *"Other plan"* means any plan or policy that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, health maintenance organization subscriber contracts, self-insured group plans, prepayment plans, and Medicare when the *covered person* is enrolled in Medicare. *Other plan* will not include Medicaid.

- *"Out-of-pocket expenses"* means those expenses that a *covered person* is required to pay that: (A) qualify as *covered expenses*; and (B) are not paid or payable if a claim were made under any *other plan*.

- *"Outpatient surgical facility"* means any facility with a medical staff of *doctors* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics,

free-standing emergency facilities, and *doctor* offices.

- *"Pain management program"* means a program using interdisciplinary teams providing coordinated, goal-oriented services to a *covered person* who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and decreasing dependence on the health care system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

- *"Policy"* when *italicized,* means this *policy* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

- *"Pregnancy"* means the physical condition of being pregnant, but does not include *complications of pregnancy*.

- [*"Primary care physician"* means a *doctor* who is a family practitioner, general practitioner, pediatrician, or internist.]

- *"Proof of loss"* means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, and *network* repricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.

- [*"Qualified covered person"* means a *covered person* who, for any given calendar year:

  (A) Did not, individually or when combined with all *covered persons* under the *policy*, incur sufficient *covered expenses* to meet the individual/family applicable stated deductible after applying any applicable *deductible credit*; and

  (B) Has been a *covered person* for at least 6 consecutive months.]

- *"Reconstructive surgery"* means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient's appearance, to the extent possible.

- *"Rehabilitation"* means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation*, *subacute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and *pain management programs*. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment under a *pain management program*.

- *"Rehabilitation facility"* means an institution or a separate identifiable *hospital* unit, section, or ward that:

  (A) Is licensed by the state as a *rehabilitation facility*; and

  (B) Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care,* nursing care*,* or for care of the mentally incompetent.

- *"Rehabilitation medical practitioner"* means a *doctor*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

- *"Rehabilitation therapy"* means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

- *"Residence"* means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address (not a P.O. Box) shown on *your* United States income tax return as *your* residence will be deemed to be *your* place of residence. If *you* do not file a United States income tax return, the *residence* where *you* spend the greatest amount of time will be deemed to be *your* place of *residence*.

- *"Residential treatment facility"* means a facility that provides (with or without charge) sleeping accommodations, and:

  (A) Is not a *hospital, extended care facility,* or *rehabilitation facility;* or

  (B) Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

- [*"Specialist physician"* means a *doctor* who is not a *primary care physician.*]

- *"Spouse"* means *your* lawful wife or husband.

- *"Subacute rehabilitation"* means one or more different types of therapy provided by one or more

rehabilitation medical practitioners and performed for one-half hour to two hours per day, five to seven days per week, while the *covered person* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *extended care facility*.

- *"Substance abuse"* means alcohol, drug or chemical abuse, overuse, or dependency.

- *"Surgery"* or *"surgical procedure"* means:

  (A) An invasive diagnostic procedure; or

  (B) The treatment of a *covered person's illness* or *injury* by manual or instrumental operations, performed by a *doctor* while the *covered person* is under general or local anesthesia.

- *"Surveillance tests for ovarian cancer"* means annual screening using: (A) CA-125 serum tumor marker testing; (B) transvaginal ultrasound; or (C) pelvic examination.

- *"Terminally ill"* means a *doctor* has given a prognosis that a *covered person* has six months or less to live.

- *"Unproven service(s)"* means services, including medications, that are determined not to be effective for treatment of the medical condition, and/or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from *well-conducted randomized controlled trials* or *well-conducted cohort studies* in the prevailing published peer-reviewed medical literature.

  (A) *"Well-conducted randomized controlled trials"* means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.

  (B) *"Well-conducted cohort studies"* means patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

- *"Urgent care center"* means a facility, not including a *hospital emergency* room or a *doctor's* office, that provides treatment or services that are required:

  (A) To prevent serious deterioration of a *covered person's* health; and

  (B) As a result of an unforeseen *illness, injury,* or the onset of acute or severe symptoms.

- *"Variable deductible"* means an amount equal to the amount of benefits payable for *covered expenses* by any *other plan*.

We may apply the *variable deductible* even though the stated deductible has been satisfied. The effect of the *variable deductible* is to pay 100 percent of the *covered person's out-of-pocket expenses*, excluding any copayment amounts as shown on the Data Page.

Section 4
PREMIUMS

PREMIUM PAYMENT: Each premium is to be paid to *us* on or before its due date. A due date is the last day of the period for which the preceding premium was paid.

GRACE PERIOD: *You* have until the 31st day following each premium due date to pay all premiums due. *We* may pay benefits for *your covered expenses* incurred during this 31-day grace period. Any such benefit payment is made in reliance on the receipt of the full premium due from *you* by the end of the grace period.

However, if *we* pay benefits for any claims during the grace period, and the full premium is not paid by the end of the grace period, *we* will require repayment of all benefits paid from *you* or any other person or organization that received payment on those claims. If repayment is due from another person or organization, *you* agree to assist and cooperate with *us* in obtaining repayment. *You* are responsible for repaying *us* if *we* are unsuccessful in recovering *our* benefits from these other sources.

MISSTATEMENT OF AGE OR SEX: If a *covered person's* age or sex has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age or sex.

CHANGE OR MISSTATEMENT OF RESIDENCE: If *you* change *your residence*, *you* must notify *us* of *your* new *residence* within 60 days of the change. *Your* premium will be based on *your* new *residence* beginning on the [first premium due date/first day of the next calendar month] after the change. If *your residence* is misstated on *your* application, or *you* fail to notify *us* of a change of *residence*, *we* will apply the correct premium amount beginning on the [first premium due date/first day of the first full calendar month] *you* resided at that place of *residence*. If the change results in a lower premium,

we will refund any excess premium. If the change results in a higher premium, *you* will owe *us* the additional premium.

BILLING/ADMINISTRATIVE FEES: Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* will charge a [$20] fee for any check or automatic payment deduction that is returned unpaid.

Section 5
DEPENDENT COVERAGE

DEPENDENT ELIGIBILITY: *Your dependents* become eligible for insurance on the latter of: (A) the date *you* became insured under this *policy;* or (B) the first day of the [premium period/first full calendar month] after the date of becoming *your dependent*.

EFFECTIVE DATE FOR INITIAL DEPENDENTS: The *effective date* for *your* initial *dependents,* if any, is shown on the Data Page. Only *dependents* included in the application for this *policy* will be covered on *your effective date*.

ADDING A NEWBORN CHILD: An *eligible child* born to *you* or *your spouse* will be covered from the time of birth until [the 31st day] after its birth. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond [the 31st day] after the date of birth of the child. The required premium will be calculated from the child's date of birth. Coverage of the child will terminate on [the 31st day] after its birth, unless *we* have received both: (A) written notice of the child's birth; and (B) the required premium within [90 days] of the child's birth.

ADDING AN ADOPTED CHILD: An *eligible child* legally placed for adoption with *you* or *your spouse* will be covered from the date of *placement* until [the 31st day] after *placement,* unless the *placement* is disrupted prior to legal adoption and the child is removed from *your* or *your spouse's* custody.

The child will be covered for *loss* due to *injury* and *illness*, including *medically necessary* care and treatment of conditions existing prior to the date of *placement.*

Additional premium will be required to continue coverage beyond [the 31st day] following *placement* of the child. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on [the 31st day] following *placement*, unless *we* have received both: (A) written notice of *your* or *your spouse's* intent to adopt the child; and (B) any additional premium required for the addition of the child within [90 days] of the date of *placement.*

As used in this provision, *"placement"* means the earlier of:

(A) The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or

(B) The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption.

ADDING OTHER DEPENDENTS: If *you* apply in writing for insurance on a *dependent* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent* is insured.

Section 6
CONTINUING ELIGIBILITY

[**FOR ALL COVERED PERSONS:** A *covered person's* eligibility for insurance under this *policy*] will cease on the earlier of:

(A) The date that a *covered person* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *policy*; or

(B) The date a *covered person's* employer and a *covered person* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes.

FOR DEPENDENTS: A *dependent* will cease to be a *covered person* at the end of the premium period in which he or she ceases to be *your dependent* due to divorce or if a child ceases to be an *eligible child*.

We must receive notification within 90 days of the date an insured ceases to be an eligible *dependent*. If notice is received by *us* more than 90 days from this date, any unearned premium will be credited only from the first day of the [*policy*/calendar] month in which *we* receive the notice.

A *covered person* will not cease to be a *dependent eligible child* solely because of age if the *eligible child* is:

(A) Not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and

(B) Mainly dependent on *you* for support.

Section 7
AMOUNT PAYABLE

AMOUNT PAYABLE: The *deductible amount* is the larger of the stated deductible shown in the Data Page or the *variable deductible*. *We* may apply the *variable deductible* even though the stated deductible has been satisfied. A new stated deductible must be met each calendar year.

If payment is calculated using the *variable deductible,* the *coinsurance percentage* will be 100 percent. The effect of the *variable deductible* is to pay 100 percent of the *covered person's out-of-pocket expenses,* excluding any *copayment amounts* as shown in the Data Page.

We will pay the applicable *coinsurance percentage* in excess of the applicable *deductible amount(s)* and *copayment amount(s)* for a service or supply that:

(A) Qualifies as a *covered expense* under one or more benefit provisions; and

(B) Is received while the *covered person's* insurance is in force under the *policy* if the charge for the service or supply qualifies as an *eligible expense*.

[When the out-of-pocket maximum has been met, additional *covered expenses* will be payable at 100%.][v]

The amount payable will be subject to:

(A) Any specific benefit limits stated in the *policy*;

(B) A determination of *eligible expenses*; and

(C) Any reduction for expenses incurred at a non-*network provider*. (Please refer to the information on the Data Page.)

The applicable *deductible amount(s), coinsurance percentage,* and *copayment amounts* are shown on the Data Page.

Note: The bill *you* receive for services or supplies from a non-*network provider* may be significantly higher than the *eligible expenses* for those services or supplies. In addition to the *deductible amount*, [copayment, and coinsurance,] *you* are responsible for the difference between the *eligible expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible expense* will not apply to *your deductible amount* or maximum out-of-pocket expenses.

[**PRIMARY CARE PHYSICIAN:** In order to obtain benefits, *you* must designate a *network primary care physician* for each *covered person. You* may select any *network primary care physician* who is accepting new patients. If *you* do not select a *network primary care physician* for each *covered person,* one will be assigned. *You* may obtain a list of *network primary care physicians* at *our* website or by calling the telephone number shown on the front page of *your policy.*

Your network primary care physician will be responsible for coordinating all covered health services and making referrals for services from other *network providers. You* do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* must obtain a referral from *your network primary care physician* in order to be eligible for [maximum] benefits under *your policy.*

You may change *your network primary care physician* by submitting a written request, [online at *our* website], or by contacting *our* office at the number shown on *your* identification card. The change to *your network primary care physician* of record will be effective no later than 30 days from the date *we* receive *your* request.]

[**REFERRAL REQUIRED** {**FOR MAXIMUM BENEFITS**}**:** *You* do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* must obtain a referral from *your network primary care physician* {for benefits to be payable under *your policy.*}{or benefits payable under *your policy* will be reduced. Please refer to the Data Page.}]

NETWORK AVAILABILITY: *Your network* is subject to change upon advance written notice. A *network* may not be available in all areas. If *you* move to an area where *we* are not offering access

to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible expense*[, subject to the *deductible amount* for *network providers*]. *You* will be notified of any increase in premium.

[**DEDUCTIBLE CREDIT:** A *qualified covered person* will be eligible for a *deductible credit*. The *deductible credit*, if any, will be determined on a specific date, the *"determination date,"* by the end of the first month of the calendar year to which it applies. The *deductible credit* will be based on the individual/family applicable stated deductible as of the *determination date*. The *deductible credit* will not be affected by any changes to the individual/family applicable stated deductible stated in a rider to the *policy* and required as a condition of issuance of a *covered person's* coverage under the *policy*.

If a *covered person* is a *qualified covered person* for consecutive years, that *covered person* will be eligible for an increased *deductible credit* as shown on the Data Page.

NOTE: If the *policy* was issued to meet the requirements for a tax-qualified status for a health savings account, the *deductible credit* will never reduce the individual/family applicable stated deductible below the minimum *deductible amount* required to maintain that tax-qualified status.]

CHANGING THE STATED DEDUCTIBLE: *You* may increase the stated deductible to an amount currently available.

An increase in the stated deductible will become effective as of the [next premium due date/first day of the calendar month] after *we* receive *your* request. *Your* premium will then be adjusted to reflect this change.

COVERAGE UNDER OTHER POLICY PROVISIONS: Charges for services and supplies that qualify as *covered expenses* under one benefit provision will not qualify as *covered expenses* under any other benefit provision of this *policy.*

Section 8
MEDICAL BENEFITS

Standard medical *covered expenses* are limited to charges:

(A) Made by a *hospital* for:

(1) Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.

(2) Daily room and board and nursing services while confined in an *intensive care unit*.

(3) *Inpatient* use of an operating, treatment, or recovery room.

(4) Outpatient use of an operating, treatment, or recovery room for *surgery.*

(5) Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients.*

(6) *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. [However, charges for use of the emergency room itself for treatment of an *illness* will be reduced by $100 unless the *covered person* is directly admitted to the *hospital* for further treatment of that *illness*.][vi]

(B) For *surgery* in a *doctor's* office or at an *outpatient surgical facility,* including services and supplies.

(C) Made by a *doctor* for professional services, including *surgery.*

(D) Made by an assistant surgeon, limited to [20] percent of the *eligible expense* for the *surgical procedure.*

(E) Made by a *medical practitioner* who is not a *doctor* and who is acting as a surgical assistant, limited to [14] percent of the *eligible expense* for the *surgical procedure.*

(F) For the professional services of a *medical practitioner.*

(G) For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*

(H) For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).

(I) For chemotherapy and radiation therapy or treatment.

(J) For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.

(K) For the cost and administration of an anesthetic.

(L) For oxygen and its administration.

(M) For *dental expenses* when a *covered person* suffers an *injury,* after the *covered person's effective date* of coverage, that results in:

(1) Damage to his or her natural teeth; and

(2) Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *doctor* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.

(N) For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint, limited to a combined [$10,000] lifetime maximum for each *covered person.*

(O) For artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not the replacement thereof, unless required by a physical change in the *covered person* and the item cannot be modified). If more than one prosthetic device can meet a *covered person's* functional needs, only the charge for the most cost effective prosthetic device will be considered a *covered expense*.

(P) For one pair of foot orthotics per *covered person*.

(Q) For *medically necessary* genetic blood tests.

(R) For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).

(S) For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.

(T) For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.

(U) For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.

(V) For the cost of one wig per *covered person*, up to [$500], necessitated by hair loss due to cancer treatments or traumatic burns.

(W) For occupational therapy following a covered treatment for traumatic hand injuries.

(X) For one pair of eyeglasses or contact lenses per *covered person,* up to [$200], following a covered cataract surgery.

(Y) For one digital rectal examination and one prostate specific antigen test each calendar year for male *covered persons.*

(Z) For *surveillance tests for ovarian cancer* for female *covered persons* who are *at risk for ovarian cancer.*

(AA) For one annual FDA-approved test or screening for the detection of the human papillomavirus.

(BB) For the following, when provided to a *covered person* who is receiving benefits for *covered expenses* in connection with a mastectomy and who elects breast reconstruction:

(1) All stages of reconstruction of the breast on which the mastectomy has been performed.

(2) *Surgery* and reconstruction of the other breast to produce a symmetrical appearance.

(3) Prostheses and treatment for physical complications of mastectomy, including lymphedemas.

LIMITATION ON SPINE AND BACK DISORDERS: If the diagnosis or treatment of a spine or back disorder is rendered to a *covered person* on an outpatient basis, *covered expenses* will be limited. The *covered expenses* for professional fees of a *medical practitioner,* and all services and supplies provided in the *medical practitioner's* office, are limited to [15 visits] per *covered person,* per calendar year. *Covered expenses* are also limited to *eligible expenses* and all other terms and conditions of the *policy,* including deductible and coinsurance provisions. This limitation does not apply to MRI and CAT scan expenses.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT STATEMENT OF RIGHTS: If expenses for *hospital* confinement in connection with childbirth are otherwise included as *covered expenses*, *we* will not limit the number of days for these expenses to less than that stated in this provision.

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, *we* may provide benefits for *covered expenses* incurred for a shorter stay if the attending provider (e.g., *your* physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

The level of benefits and out-of-pocket costs for any later part of the 48-hour (or 96-hour) stay will not be less favorable to the mother or newborn than any earlier part of the stay. *We* do not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Note: This provision does not amend the *policy* to include *pregnancy* expense benefits as *covered expenses* or to restrict any other terms, limits, or conditions that may otherwise apply to *covered expenses* for childbirth.

AMBULANCE SERVICE BENEFITS: *Covered expenses* will include ambulance services for local transportation:

(A) To the nearest *hospital* that can provide services appropriate to the *covered person's illness* or *injury*.

(B) To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

Benefits for air ambulance services are limited to:

(A) Services requested by police or medical authorities at the site of an *emergency*.

(B) Those situations in which the *covered person* is in a location that cannot be reached by ground ambulance.

Exclusions: No benefits will be paid for:

(A) Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law.

(B) Non-*emergency* air ambulance.

(C) Air ambulance:

(1) Outside of the 50 United States and the District of Columbia;

(2) From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or

(3) From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.

(D) Ambulance services provided for a *covered person's* comfort or convenience.

Preventive Care Expense Benefits

[**PREVENTIVE CARE EXPENSE BENEFITS:** *Covered expenses* are expanded to include the charges incurred by a *covered person* for the following preventive health services if appropriate for that *covered person* in accordance with the following recommendations and guidelines [in effect as of March 23, 2010]:

(A) Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.

(B) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.

(C) Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.

(D) Additional preventive care and screenings not included in (C) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.

Benefits for preventive health services listed in this provision[, except under the administration of reasonable medical management techniques discussed in the next paragraph,] are exempt from any [stated deductibles, coinsurance provisions, and *copayment amounts*] under the *policy* when the services are provided by a *network provider.*

[Benefits for *covered expenses* for preventive care expense benefits may include the use of reasonable medical management techniques authorized by federal law to promote the use of high value preventive services from *network providers*. Reasonable medical management techniques may result in the application of stated deductibles, coinsurance provisions, or *copayment amounts* to services when a *covered person* chooses not to use a high value service (as identified on myuhone.com) that is otherwise exempt from deductibles, coinsurance provisions, and *copayment amounts*, when received from a *network provider*.]

As new recommendations and guidelines are issued, those services will be considered *covered expenses* when required by [the United States Secretary of Health and Human Services], but not earlier than one year after the recommendation or guideline is issued.]

[**SERVICES OF NON-NETWORK PROVIDERS:** *Covered expenses* incurred at a non-*network provider* will be reduced by 25%, then subject to the applicable *deductible amount* and *coinsurance percentage*.]

Transplant Expense Benefits

TRANSPLANT EXPENSES COVERED UNDER MEDICAL EXPENSE BENEFITS: The following types of tissue transplants are *covered expenses* under the Medical Benefits provision:

(A) Cornea transplants.

(B) Artery or vein grafts.

(C) Heart valve grafts.

(D) Prosthetic tissue replacement, including joint replacements.

(E) Implantable prosthetic lenses, in connection with cataracts.

ALL OTHER COVERED EXPENSES FOR TRANSPLANT EXPENSES: If *we* determine that a *covered person* is an appropriate candidate for a *listed transplant,* Medical Benefits *covered expenses* will be provided for:

(A) Pre-transplant evaluation.

(B) Pre-transplant harvesting.

(C) Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *covered person* to prepare for a later transplant, whether or not the transplant occurs.

(D) High dose chemotherapy.

(E) Peripheral stem cell collection.

(F) The transplant itself, not including the acquisition cost for the organ or bone marrow (except at a *Center of Excellence*).

(G) Post transplant follow-up.

TRANSPLANT DONOR EXPENSES: *We* will cover the medical expenses incurred by a live donor as if they were medical expenses of the *covered person* if:

(A) They would otherwise be considered *covered expenses* under the *policy;*

(B) The *covered person* received an organ or bone marrow of the live donor; and

(C) The transplant was a *listed transplant.*

ANCILLARY "CENTER OF EXCELLENCE" BENEFITS: A *covered person* may obtain services in connection with a *listed transplant* from any willing provider of such services. However, if a *listed transplant* is performed in a *Center of Excellence:*

(A) *Covered expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.

(B) *We* will pay a maximum of [$5,000 per transplant] for the following services:

(1) Transportation for the *covered person,* any live donor, and the *immediate family* to accompany the *covered person* to and from the *Center of Excellence.*

(2) Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *covered person* while the *covered person* is confined in the *Center of Excellence.*

We must make the arrangements and pay the costs directly for transportation and lodging.

DEFINITIONS: As used in this provision, the following terms have the meanings indicated:

- *"Allogeneic bone marrow transplant"* or *"BMT"* means a procedure in which bone marrow from a related or non-related donor is infused into the

transplant recipient and includes peripheral blood stem cell transplants.

- *"Autologous bone marrow transplant"* or *"ABMT"* means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

- *"Center of Excellence"* means a *hospital* that:

  (A) Specializes in a specific type or types of *listed transplants*; and

  (B) Has agreed with *us* or an entity designated by *us* to meet quality of care criteria on a cost efficient basis.

The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence.*

- *"Listed transplant"* means one of the following procedures and no others:

  (A) Heart transplants.

  (B) Lung transplants.

  (C) Heart/lung transplants.

  (D) Kidney transplants.

  (E) Liver transplants.

  (F) Bone marrow transplants for the following conditions:

    (1) [*BMT* or *ABMT* for Non-Hodgkin's Lymphoma.

    (2) *BMT* or *ABMT* for Hodgkin's Lymphoma.

    (3) *BMT* for Severe Aplastic Anemia.

    (4) *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.

    (5) *BMT* for Chronic Myelogenous Leukemia.

    (6) *ABMT* for Testicular Cancer.

    (7) *BMT* for Severe Combined Immunodeficiency.

    (8) *BMT* or *ABMT* for Stage III or IV Neuroblastoma.

    (9) *BMT* for Myelodysplastic Syndrome.

    (10) *BMT* for Wiskott-Aldrich Syndrome.

    (11) *BMT* for Thalassemia Major.

    (12) *BMT* or *ABMT* for Multiple Myeloma.

    (13) *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.

    (14) *BMT* for Fanconi's anemia.

    (15) *BMT* for malignant histiocytic disorders.

    (16) *BMT* for juvenile myelo-monocytic leukemia.]

EXCLUSIONS: No benefits will be paid under these Transplant Expense Benefits for charges:

(A) For search and testing in order to locate a suitable donor.

(B) For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.

(C) For animal to human transplants.

(D) For artificial or mechanical devices designed to replace a human organ temporarily or permanently.

(E) For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.

(F) To keep a donor alive for the transplant operation.

(G) For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.

(H) Related to transplants not included under this provision as a *listed transplant.*

(I) For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"USFDA"*) regulation, regardless of whether the trial is subject to *USFDA* oversight.

LIMITATIONS ON TRANSPLANT EXPENSE BENEFITS: In addition to the exclusions and limitations specified elsewhere in this section:

(A) *Covered expenses* for *listed transplants* will be limited to [two transplants during any 10-year period] for each *covered person*.

(B) If a designated *Center of Excellence* is not used, *covered expenses* for a *listed transplant* will be limited to a maximum of

[one transplant in any twelve-month period, and a maximum benefit limit of $100,000] for all expenses associated with the transplant.

(C) If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Home Health Care Expense Benefits

HOME HEALTH CARE EXPENSES: *Covered expenses* for *home health care* are limited to the following charges:

(A) *Home health aide services*.

(B) Services of a private duty registered nurse rendered on an outpatient basis.

(C) Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*

(D) I.V. medication and pain medication.

(E) Hemodialysis, and for the processing and administration of blood or blood components.

(F) *Necessary medical supplies*.

(G) Rental of the *durable medical equipment* set forth below:

(1) I.V. stand and I.V. tubing.

(2) Infusion pump or cassette.

(3) Portable commode.

(4) Patient lift.

(5) Bili-lights.

(6) Suction machine and suction catheters.

Charges under (D) and (G) are *covered expenses* to the extent they would have been *covered expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase. If the equipment is purchased, the *covered person* must return the equipment to *us* when it is no longer in use.

DEFINITIONS: As used in this provision, the following terms have the meanings indicated:

- *"Home health aide services"* means those services provided by a home health aide employed by a *home health care agency* and supervised by a registered nurse, which are directed toward the personal care of a *covered person.*

- "*Home health care*" means care or treatment of an *illness* or *injury* at the *covered person's* home that is:

(A) Provided by a *home health care agency*; and

(B) Prescribed and supervised by a *doctor*.

- *"Home health care agency"* means a public or private agency, or one of its subdivisions, that:

(A) Operates pursuant to law as a *home health care agency*;

(B) Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;

(C) Maintains a daily medical record on each patient; and

(D) Provides each patient with a planned program of observation and treatment by a *doctor,* in accordance with existing standards of medical practice for the *injury* or *illness* requiring the *home health care.*

An agency that is approved to provide *home health care* to those receiving Medicare benefits will be deemed to be a *home health care agency*.

- *"Respite care"* means home health care services provided temporarily to a *covered person* in order to provide relief to the *covered person's immediate family* or other caregiver.

LIMITATIONS: *Covered expenses* for *home health aide services* will be limited to:

(A) [Seven] visits per week; and

(B) A lifetime maximum of [365] visits.

Each [eight-hour] period of *home health aide services* will be counted as one visit.

Covered expenses for outpatient private duty registered nurse services will be limited as follows:

(A) Outpatient private duty registered nurse services will be limited to a lifetime maximum of [1,000 hours].

(B) Intermittent private duty registered nurse visits (not to exceed [4 hours] each) will be:

(1) Limited to [$75] per visit.

(2) Deemed to be [2 hours] applied towards the lifetime maximum above.

EXCLUSION: No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

Hospice Care Expense Benefits

HOSPICE CARE EXPENSES: This provision only applies to a *terminally ill covered person* receiving *medically necessary* care under a *hospice care program*.

The list of *covered expenses* in the Medical Benefits provision is expanded to include:

(A) Room and board in a *hospice* while the *covered person* is an *inpatient.*

(B) Occupational therapy.

(C) Speech-language therapy.

(D) The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *policy* if the *covered person* had been confined in a *hospital.*

(E) Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.

(F) Counseling the *covered person* regarding his or her *terminal illness.*

(G) *Terminal illness counseling* of members of the *covered person's immediate family.*

(H) Up to [$250] for *bereavement counseling*.

EXCLUSIONS AND LIMITATIONS: Any exclusion or limitation contained in the *policy* regarding:

(A) An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;

(B) Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program;* or

(C) Expenses for other persons,

to the extent those expenses are described above, will not be applied to this provision.

Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person* for one continuous period up to [180 days in a *covered person's* lifetime]. For each day the *covered person* is confined in a *hospice,* benefits for room and board will not exceed:

(A) For a *hospice* that is associated with a *hospital* or nursing home, the most common semiprivate room rate of the *hospital* or nursing home with which the *hospice* is associated.

(B) For any other *hospice,* the lesser of the billed charge or [$200] per day.

DEFINITIONS: As used in this provision, the following terms have the meanings indicated:

- *"Bereavement counseling"* means counseling of members of a deceased person's *immediate family* that is designed to aid them in adjusting to the person's death.

- *"Hospice"* means an institution that:

(A) Provides a *hospice care program*;

(B) Is separated from or operated as a separate unit of a *hospital, hospital*-related institution, *home health care agency,* mental health facility, *extended care facility,* or any other licensed health care institution;

(C) Provides care for the *terminally ill;* and

(D) Is licensed by the state in which it operates.

- *"Hospice care program"* means a coordinated, interdisciplinary program prescribed and supervised by a *doctor* to meet the special physical, psychological, and social needs of a *terminally ill covered person* and those of his or her *immediate family.*

- *"Terminal illness counseling"* means counseling of the *immediate family* of a *terminally ill* person for the purpose of teaching the *immediate family* to care for and adjust to the *illness* and impending death of the *terminally ill* person.

Rehabilitation and Extended Care Facility Expense Benefits

COVERED EXPENSES: *Covered expenses* include expenses incurred for *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

(A) *Covered expenses* available to a *covered person* while confined primarily to receive *rehabilitation* are limited to those specified in this provision.

(B) *Rehabilitation services* or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.

(C) *Covered expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:

(1) Daily room and board and nursing services.

(2) Diagnostic testing.

(3) Drugs and medicines that are prescribed by a *doctor*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.

(D) *Covered expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

MAXIMUM BENEFITS: Subject to the limitations otherwise stated in this Rehabilitation and Extended Care Facility Expense Benefits provision, benefits for *covered expenses* under this provision are limited to [60 days per calendar year for each *covered person*.]

Care ceases to be *rehabilitation* upon *our* determination of any of the following:

(A) The *covered person* has reached *maximum therapeutic benefit*.

(B) Further treatment cannot restore bodily function beyond the level the *covered person* already possesses.

(C) There is no measurable progress toward documented goals.

(D) Care is primarily *custodial care*.

EXCLUSION: No benefits will be paid under these Rehabilitation and Extended Care Facility Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

DEFINITION: As used in this provision, *"provider facility"* means a *hospital, rehabilitation facility*, or *extended care facility*.

Outpatient Prescription Drug Expense Benefits

COVERED EXPENSES: *Covered expenses* in this benefit subsection are limited to charges from a licensed *pharmacy* for:

(A) A *prescription drug.*

(B) Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *doctor.*

The appropriate drug choice for a *covered person* is a determination that is best made by the *covered person* and his or her *doctor.*

NOTICE AND PROOF OF LOSS: In order to obtain payment for *covered expenses* incurred at a *pharmacy* for *prescription orders,* a notice of claim and *proof of loss* must be submitted directly to *us.*

DEFINITIONS: As used in this benefit subsection, the following terms have the meanings indicated:

- *"Managed drug limitations"* means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.
- *"Prescription drug"* means any medicinal substance whose label is required to bear the legend "RX only."
- *"Prescription order"* means the request for each separate drug or medication by a *doctor* or each authorized refill or such requests.

EXCLUSIONS AND LIMITATIONS: No benefits will be paid under this benefit subsection for expenses incurred:

(A) For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance.

(B) For immunization agents, blood, or blood plasma.

(C) For medication that is to be taken by the *covered person,* in whole or in part, at the place where it is dispensed.

(D) For medication received while the *covered person* is a patient at an institution that has a facility for dispensing pharmaceuticals.

(E) For a refill dispensed more than 12 months from the date of a *doctor's* order.

(F) Due to a *covered person's* addiction to, or dependency on, tobacco or foods.

(G) For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.

(H) For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent.

(I) For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.

(J) [For a *prescription drug* that contains (an) active ingredient(s) that is/are:

(1) Available in and *therapeutically equivalent* to another covered *prescription drug;* or

(2) A modified version of and *therapeutically equivalent* to another covered *prescription drug.*

Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.]

(K) For more than a 34-day supply when dispensed in any one prescription or refill [(a 90-day supply when dispensed by mail order)].

(L) [In excess of the cost of the generic equivalent, if any, regardless of whether the *doctor* specifies name brand on the written prescription.]

(M) [For *prescription drugs* for any *covered person* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.]

Section 9
NOTIFICATION AND PREDETERMINATION

NOTIFICATION REQUIRED: *You* must notify *us* by phone **at the phone number listed on *your* health insurance identification card** on or before the day a *covered person:*

(A) Begins the 4th day of an *inpatient* hospitalization; or

(B) Is evaluated for an organ or tissue transplant.

BENEFIT REDUCTION FOR FAILURE TO NOTIFY: Failure to comply with notification requirements will result in a benefit reduction. Reduced benefits will be 80% of regular *policy* benefits that would have otherwise been payable. When there is a failure to notify, benefit reduction of an expense requiring notification will be a maximum of $1,000.

Benefits will not be reduced for failure to comply with notification requirements in any case in which:

(A) An *inpatient hospital* admission is for *emergency* treatment of an *illness* or *injury*; and

(B) It is impossible for *you* to notify *us* by the 4th day after *emergency inpatient hospital* admission.

In such a case, *you* must contact *us* as soon as reasonably possible after the *emergency inpatient hospital* admission.

NOTIFICATION DOES NOT GUARANTEE BENEFITS: *Our* receipt of notification does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *policy*.

REQUESTS FOR PREDETERMINATIONS: *You* may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause us to reverse the predetermination:

(A) The predetermination was based on incomplete or inaccurate information initially received by *us.*

(B) The medical expense has already been paid by someone else.

(C) Another party is responsible for payment of the medical expense.

We will make all benefit determinations after a *loss* in good faith. All benefit determinations are subject to *our* receipt of proper *proof of loss*.

Section 10
GENERAL EXCLUSIONS AND LIMITATIONS

No benefits will be paid for:

(A) Any service or supply that would be provided without cost to *you* or *your* covered *dependent* in the absence of insurance covering the charge.

(B) Expenses/surcharges imposed on *you* or *your* covered *dependent* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.

(C) Any services performed by a member of a *covered person's immediate family.*

(D) Any services not identified and included as *covered expenses* under the *policy*. *You* will be fully responsible for payment for any services that are not *covered expenses.*

Even if not specifically excluded by this *policy,* no benefit will be paid for a service or supply unless it is:

(A) Administered or ordered by a *doctor;* and

(B) *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

(A) For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*[, except as expressly provided for under the Benefits After Coverage Terminates clause in this *policy's* Termination section].

(B) For any portion of the charges that are in excess of the *eligible expense.*

(C) For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*.

(D) For breast reduction or augmentation.

(E) For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *covered person,* such as sex-change *surgery*.

(F) For any drug, treatment, or procedure that promotes conception or prevents childbirth, including but not limited to artificial insemination or treatment for infertility or impotency.

(G) For sterilization or reversal of sterilization.

(H) For abortion (unless the life of the mother would be endangered if the fetus were carried to term).

(I) For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered expenses* of the Medical Benefits provision.

(J) For routine well-baby care of a newborn infant, except as specifically provided by this *policy.*

(K) For expenses for television, telephone, or expenses for other persons.

(L) For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.

(M) For telephone consultations or for failure to keep a scheduled appointment.

(N) For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.

(O) For stand-by availability of a *medical practitioner* when no treatment is rendered.

(P) For *dental expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*[, except as expressly provided for under Medical Benefits].

(Q) For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child who has been a *covered person* from its birth until the date *surgery* is performed.

(R) For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.

(S) For diagnosis or treatment of nicotine addiction, [except as otherwise covered under the Preventive Care Expense Benefits provision of this *policy*].

(T) For charges related to, or in preparation for, tissue or organ transplants[, except as expressly provided for under the Transplant Expense Benefits].

(U) For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*[, except as specifically provided under the Transplant Expense Benefits].

(V) For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

(W) While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services [(unless expressly provided for by the *policy)*].

(X) For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy[, except as expressly provided for in this *policy*].

(Y) For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.

(Z) For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices[, except as specifically provided under the *policy*].

(AA) Due to *pregnancy* (except for *complications of pregnancy*)[, unless the optional Pregnancy Expense Benefits Rider is attached to this *policy*].

(BB) For any expenses, including expenses for diagnostic testing, incurred while confined primarily for well-baby care.

(CC) For treatment of *mental disorders, substance abuse,* or for court ordered treatment programs for *substance abuse*, [unless the Optional Mental Disorders Benefits rider or the Optional Biologically-Based Mental Illness Benefits rider is attached to this *policy*].

(DD) For preventive or prophylactic care, including routine physical examinations, premarital examinations, and educational programs[, except as required under applicable state and federal law or as expressly provided for in this *policy*].

(EE) For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.

(FF) For expenses incurred outside of the United States, except for expenses incurred for *emergency* treatment of a *covered person*.

(GG) As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *covered person* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *covered person's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *covered person's* workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.

(HH) As a result of:

(1) Intentionally self-inflicted bodily harm [(whether the *covered person* is sane or insane)].

(2) An *injury* or *illness* caused by any act of declared or undeclared war.

(3) The *covered person* taking part in a riot.

(4) The *covered person's* commission of a felony, whether or not charged.

(II) For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications therefrom[, except as expressly provided for under the Medical Benefits].

(JJ) For any *illness* or *injury* incurred as a result of the *covered person* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *doctor*.

(KK) For or related to surrogate parenting.

(LL) For or related to treatment of hyperhidrosis (excessive sweating).

(MM) For fetal reduction surgery.

(NN) Except as specifically identified as a *covered expense* under the *policy*, for expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

(OO) [As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: [operating or riding on a motorcycle;] professional or semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; [racing or speed testing any non-motorized vehicle or conveyance (if the *covered person* is paid to participate or to instruct);] scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; [horseback riding (if the *covered person* is paid to participate or to instruct);] rock or mountain climbing (if the *covered person* is paid to participate or to instruct); or skiing (if the *covered person* is paid to participate or to instruct).]

(PP) [As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *covered person* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.]

(QQ) While at a *residential treatment facility.*

(RR) [For prescription drugs for any *covered person* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date.]

[**WAITING PERIODS:** Coverage for all *illnesses* will begin 14 days after the *effective date* for *injuries,* unless otherwise excluded under this *policy*. However, there is a six-month waiting period for certain conditions.

Expenses incurred by a *covered person* for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs will not be covered during the *covered person's* first six months of coverage under this *policy.* This exclusion will not apply if the treatment is provided on an *emergency* basis or for treatment for cancer.

After the six-month period, the condition will be subject to all the terms of this *policy,* just like any other condition.]

LIMITATION ON BENEFITS FOR SERVICES PROVIDED BY MEDICARE OPT-OUT PRACTITIONERS: Benefits for *covered expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare-participating practitioner*. (Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare-participating practitioner*.)

Section 11
REIMBURSEMENT

If a *covered person's illness* or *injury* is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*. However, if payment by or for the *third party* has not been made by the time *we* receive acceptable *proof of loss, we* will pay regular *policy* benefits for the *covered person's loss*. *We* will have the right to be reimbursed to the extent of benefits *we* paid for the *illness* or *injury* if the *covered person* subsequently receives any payment from any *third party*. The *covered person* (or the guardian, legal representatives, estate, or heirs of the *covered person*) shall promptly reimburse *us* from the settlement, judgment, or any payment received from any *third party*.

As a condition for *our* payment, the *covered person* or anyone acting on his or her behalf (including, but not limited to, the guardian, legal representatives, estate, or heirs) agrees:

(A) To fully cooperate with *us* in order to obtain information about the *loss* and its cause.

(B) To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *covered person* in connection with the *loss*.

(C) To include the amount of benefits paid by *us* on behalf of a *covered person* in any claim made against any *third party*.

(D) That *we*:

(1) Will have a lien on all money received by a *covered person* in connection with the *loss* equal to the amount *we* have paid.

(2) May give notice of that lien to any *third party* or *third party's* agent or representative.

(3) Will have the right to intervene in any suit or legal action to protect *our* rights.

(4) Are subrogated to all of the rights of the *covered person* against any *third party* to the extent of the benefits paid on the *covered person's* behalf.

(5) May assert that subrogation right independently of the *covered person*.

(E) To take no action that prejudices *our* reimbursement and subrogation rights.

(F) To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.

(G) To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.

(H) To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.

(I) That *we* may reduce other benefits under the *policy* by the amounts a *covered person* has agreed to reimburse *us*.

Furthermore, as a condition of *our* payment, *we* may require the *covered person* or the *covered person's* guardian (if the *covered person* is a minor or legally incompetent) to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

We have a right to be reimbursed in full regardless of whether or not the *covered person* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

We will not pay attorney fees or costs associated with the *covered person's* claim or lawsuit unless *we* previously agreed in writing to do so.

If a dispute arises as to the amount a *covered person* must reimburse *us*, the *covered person* (or the guardian, legal representatives, estate, or heirs of the *covered person*) agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by *us* until the dispute is resolved.

Definition: As used in this provision, the following term has the meaning indicated:

- *"Third party"* means a person or other entity that is or may be obligated or liable to the *covered person* for payment of any of the *covered person's* expenses for *illness* or *injury*. The term *"third party"* includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term *"third party"* will not include any insurance company with a policy under which the *covered person* is entitled to benefits as a named insured person or an insured *dependent* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

Section 12
TERMINATION

TERMINATION OF POLICY: All insurance will cease on termination of this *policy.* This *policy* will terminate on the earliest of:

(A) Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*.

(B) The date *we* receive a request from *you* to terminate this *policy,* or any later date stated in *your* request.

(C) The date *we* decline to renew this *policy,* as stated in the Guaranteed Renewable provision or as explained in the Discontinuance provision.

(D) The date of *your* death, if this *policy* is an Individual Plan.

(E) [The date that a *covered person* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *policy,* or the date a *covered person's* employer and a *covered person* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes.]

(F) The date a *covered person's* eligibility for insurance under this *policy* ceases due to any of the reasons stated in [the Continuing Eligibility section in this *policy*].

We will refund any premium paid and not earned due to *policy* termination.

If this *policy* is other than an Individual Plan, it may be continued after *your* death:

(A) By *your spouse*, if a *covered person;* otherwise,

(B) By the youngest child who is a *covered person.*

This *policy* will be changed to a plan appropriate, as determined by *us,* to the *covered person(s)* that continue to be covered under it. *Your spouse* or youngest child will replace *you* as the insured. A proper adjustment will be made in the premium required for this *policy* to be continued. *We* will also refund any premium paid and not earned due to *your* death. The refund will be based on the number of full months that remain to the next premium due date.

DISCONTINUANCE:

[90]-Day Notice: If *we* discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where *you* reside, *we* will provide a written notice to *you* at least [90] days prior to the date that *we* discontinue coverage. *You* will be offered an option to purchase any other coverage in the individual market *we* offer in *your* state at the time of discontinuance of this *policy*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

[180]-Day Notice: If *we* discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where *you* reside, *we* will provide a written notice to [*you* and the Commissioner of Insurance] at least [180] days prior to the date that *we* stop offering and terminate all existing individual policies/certificates in the individual market in the state where *you* reside.

PORTABILITY OF COVERAGE: If a person ceases to be a *covered person* due to the fact that the person no longer meets the definition of *dependent* under the *policy*, the person will be eligible for continuation of coverage. [If elected,] *we* will continue the person's coverage under the *policy* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the residence of the person continuing coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this *policy*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts*, waiting periods and maximum benefit limits will be satisfied under the new policy to the extent satisfied under this *policy* at the time that the continuation of coverage is issued. (If the original coverage contains a family deductible which must be met by all *covered persons* combined, only those expenses incurred by the *covered person* continuing coverage under the new policy will be applied toward the satisfaction of the *deductible amount* under the new policy.)

Notification Requirements: It is the responsibility of *you* or *your* former *dependent* to notify *us* within 31 days of *your* legal divorce or *your dependent's* marriage. *You* must notify *us* of the address at which their continuation of coverage should be issued.

Continuation of Coverage: *We* will issue the continuation of coverage:

(A) [No less than 30 days] prior to a *covered person's* 26th birthday; or

(B) Within [30 days] after the date *we* receive timely notice of *your* legal divorce or *dependent's* marriage.

Your former *dependent* must pay the required premium within [31 days] following notice from *us* or the new *policy* will be void from its beginning.

REINSTATEMENT: If *your policy* lapses due to nonpayment of premium, it may be reinstated provided:

(A) *We* receive from *you* a written application for reinstatement within one year after the date coverage lapsed; and

(B) The written application for reinstatement is accompanied by the required premium payment.

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than 60 days before the date of reinstatement.

The Rescissions provision will apply to statements made on the reinstatement application, based on the date of reinstatement.

Changes may be made in *your policy* in connection with the reinstatement. These changes will be sent to *you* for *you* to attach to *your policy.* In all other respects, *you* and *we* will have the same rights as before *your policy* lapsed.

BENEFITS AFTER COVERAGE TERMINATES: Benefits for *covered expenses* incurred after a *covered person* ceases to be insured are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *policy* is terminated because of:

(A) A request by *you*;

(B) Fraud or material misrepresentation on *your* part; or

(C) *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before insurance of the *covered person* ceases under this *policy*. No benefits are provided for *covered expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *policy* is terminated because *we* refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* live, termination of this *policy* will not prejudice a claim for a *continuous loss* that begins before insurance of the *covered person* ceases under this *policy.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

(A) The date the *continuous loss* ends; or

(B) [12] months after the date renewal is declined.

During coverage for a *period of extended loss* or a *continuous loss,* as described above, the terms and conditions of this *policy,* including those stated in the Premiums section of this *policy,* will apply as though insurance had remained in force for that *illness* or *injury*.

Definitions: As used in this provision, the following terms have the meanings indicated:

- *"Continuous loss"* means that *covered expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered expense* for the *illness* or *injury* must have been incurred before insurance of the *covered person* ceased under this *policy*. Whether or not *covered expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

- *"Period of extended loss"* means a period of consecutive days:

(A) Beginning with the first day on which a *covered person* is a *hospital inpatient;* and

(B) Ending with the 30th consecutive day for which he or she is not a *hospital inpatient*.

Section 13
CLAIMS

CLAIM FORMS: *We* will furnish claim forms after *we* receive notice of a claim. If *our* usual claim forms are not furnished within 15 days, *you* or *your* covered *dependent* may file a claim without them. The claim must contain written *proof of loss.*

NOTICE OF CLAIM: *We* must receive notice of claim within 30 days of the date the *loss* began or as soon as reasonably possible.

PROOF OF LOSS: *You* or *your* covered *dependent* must give *us* written *proof of loss* within [90 days] of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than [one year late] will not be accepted, unless *you* or *your* covered *dependent* had no legal capacity in that year.

COOPERATION PROVISION: Each *covered person*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *policy* and, as often as may be reasonably necessary:

(A) Sign, date and deliver to *us* authorizations to obtain any medical or other information, records or documents *we* deem relevant from any person or entity.

(B) Obtain and furnish to *us*, or *our* representatives, any medical or other

information, records or documents *we* deem relevant.

(C) Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask.

(D) Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*).

If any *covered person*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *policy*.

In addition, failure on the part of any *covered person*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of claims of all *covered persons*.

TIME FOR PAYMENT OF CLAIMS: Benefits will be paid as soon as *we* receive proper *proof of loss*.

PAYMENT OF CLAIMS: Except as set forth in this provision, all benefits are payable to *you.* Any accrued benefits unpaid at *your* death, or *your dependent's* death may, at *our* option, be paid either to the beneficiary or to the estate. If any benefit is payable to *your* or *your dependent's* estate, or to a beneficiary who is a minor or is otherwise not competent to give valid release, *we* may pay up to [$1,000] to any relative who, in *our* opinion, is entitled to it.

We may pay all or any part of the benefits provided by this *policy* for *hospital,* surgical, nursing, or medical services, directly to the *hospital* or other person rendering such services.

Any payment made by *us* in good faith under this provision shall fully discharge *our* obligation to the extent of the payment. [*We* reserve the right to deduct any overpayment made under this *policy* from any future benefits under this *policy*.]

FOREIGN CLAIMS INCURRED FOR EMERGENCY CARE: Claims incurred outside of the United States for *emergency* care and treatment of a *covered person* must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper *proof of loss*.

[**ASSIGNMENT:** The life insurance provided under this *policy,* if any, is not assignable. *We* will reimburse a *hospital* or health care provider if:

(A) *Your* health insurance benefits are assigned by *you* in writing; and

(B) *We* approve the assignment.

Any assignment to a *hospital* or person providing the treatment, whether with or without *our* approval, shall not confer upon such *hospital* or person, any right or privilege granted to *you* under the *policy* except for the right to receive benefits, if any, that *we* have determined to be due and payable.]

MEDICAID REIMBURSEMENT: The amount payable under this *policy* will not be changed or limited for reason of a *covered person* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *policy* to the state if:

(A) A *covered person* is eligible for coverage under his or her state's Medicaid program; and

(B) *We* receive proper *proof of loss* and notice that payment has been made for *covered expenses* under that program.

Our payment to the state will be limited to the amount payable under this *policy* for the *covered expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

CUSTODIAL PARENT: This provision applies if the parents of a covered *eligible child* are divorced or legally separated and both the custodial parent and the non-custodial parent are subject to the same court or administrative order establishing custody. The custodial parent, who is not a *covered person*, will have the rights stated below if *we* receive a copy of the order establishing custody.

Upon request by the custodial parent, *we* will:

(A) Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the *policy*;

(B) Accept claim forms and requests for claim payment from the custodial parent; and

(C) Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge *our* obligations.

A custodial parent may, with *our* approval, assign claim payments to the *hospital* or *medical practitioner* providing treatment to an *eligible child*.

PHYSICAL EXAMINATION: *We* shall have the right and opportunity to examine a *covered person* while a claim is pending or while a dispute over the claim is pending. These examinations are made at *our* expense and as often as *we* may reasonably require.

LEGAL ACTIONS: No suit may be brought by *you* on a claim sooner than [60 days] after the required *proof of loss* is given. No suit may be brought more than three years after the date *proof of loss* is required.

No action at law or in equity may be brought against *us* under the *policy* for any reason unless the *covered person* first completes all the steps in [the complaint/grievance procedures made available to resolve disputes in *your* state under the *policy*]. After completing that complaint/grievance procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date [*we* notified *you* of the final decision on *your* complaint/grievance].

Section 14
GENERAL PROVISIONS

ENTIRE CONTRACT: This *policy,* with the application and any rider-amendments is the entire contract between *you* and *us.* No change in this *policy* will be valid unless it is approved by one of *our* officers and noted on or attached to this *policy.* No agent may:

(A) Change this *policy*;

(B) Waive any of the provisions of this *policy*;

(C) Extend the time for payment of premiums; or

(D) Waive any of *our* rights or requirements.

NON-WAIVER: If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *policy*, that will not be considered a waiver of any rights under the *policy*. A past failure to strictly enforce the *policy* will not be a waiver of any rights in the future, even in the same situation or set of facts.

RESCISSIONS: No misrepresentation of fact made regarding a *covered person* during the application process that relates to insurability will be used to void/rescind the insurance coverage or deny a claim unless:

(A) The misrepresented fact is contained in a written application, including amendments, signed by a *covered person;*

(B) A copy of the application, and any amendments, has been furnished to the *covered person(s),* or to their beneficiary; and

(C) The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *covered person.*

A *covered person's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud.

REPAYMENT FOR FRAUD, MISREPRESENTATION OR FALSE INFORMATION: During the first two years a *covered person* is insured under the *policy*, if a *covered person* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *covered person* under this *policy* or in filing a claim for *policy* benefits, *we* have the right to demand that *covered person* pay back to *us* all benefits that *we* paid during the time the *covered person* was insured under the *policy*.

MISSTATEMENT OF TOBACCO USE: The answer to the tobacco question on the application is material to *our* correct underwriting. If a *covered person's* use of tobacco has been misstated on the *covered person's* application for coverage under this *policy, we* have the right to rescind that person's coverage, subject to the Rescissions provision in this *policy*.

CONFORMITY WITH STATE LAWS: Any part of this *policy* in conflict with the laws of the state where *you* reside on this *policy's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

CONDITIONS PRIOR TO LEGAL ACTION: On occasion, *we* may have a disagreement related to coverage, benefits, premiums, or other provisions under this *policy*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, *you* must give written notice to *us* of *your* intent to sue *us* as a condition prior to bringing any legal action. *Your* notice must:

(A) Identify the coverage, benefit, premium, or other disagreement;

(B) Refer to the specific *policy* provision(s) at issue; and

(C) Include all relevant facts and information that support *your* position.

Unless prohibited by law, *you* agree that *you* waive any action for statutory or common law extra-contractual or punitive damages that *you* may have if the specified contractual claims are paid, or the issues giving rise to the disagreement are resolved or corrected, within [30 days] after *we* receive *your* notice of intention to sue *us*.

[i] Note to Reviewer (NTR): Prints in plans that are not high deductible health plans for use with a health savings account.
[ii] NTR: Prints in high deductible health plans for use with a health savings account.
[iii] NTR: The phrase "each covered person" prints in plans that are not high deductible health plans for use with a health savings account, and the phrase "all covered persons" prints in high deductible health plans for use with a health savings account.
[iv] NTR: Does not print in high deductible health plans for use with a health savings account.
[v] NTR: Prints in high deductible health plans for use with a health savings account.
[vi] NTR: Does not print in high deductible health plans for use with a health savings account.

American Medical Security Life Insurance Company
3100 AMS Boulevard
P.O. Box 19032
Green Bay, WI 54307-9032
For Inquiries: [(800) 232-5432]

In this outline, "you" or "your" will refer to the person for whom this outline has been prepared, and "we," "our," or "us" will refer to American Medical Security Life Insurance Company.

Medical Expense Coverage
Outline of Coverage for Policy Form GIP28-P-AMS
(Please retain this outline for your records)

Read Your Policy Carefully -- This outline sets forth a brief description of the important aspects of your policy. This is not the insurance contract. Only the actual policy will control. The policy sets forth in detail your and our rights and obligations. For this reason, it is important that you READ YOUR POLICY CAREFULLY!

Medical Expense Coverage -- Plans of this type are designed to provide covered persons with coverage for the major costs of hospital, medical, and surgical care. The cost must be due to a covered illness or injury. Coverage is provided for daily hospital room and board, other hospital services, surgical services, anesthesia services, inpatient medical services, and out-of-hospital care. Coverage is subject to any deductible amounts, copayment provisions, or other limitations that may be set forth in the policy.

State Mandates -- Some provisions addressed in this outline of coverage may change according to the laws of the state where you reside. Please see the state mandates rider attached to your policy.

Amount Payable

Definitions:

"Coinsurance percentage" means the percentage of covered expenses that are payable by us, as shown on the policy Data Page.

"Deductible amount" means the amount of covered expenses that must be paid by [each/all][i] covered person[s] before any benefits are payable. The deductible amount does not include any copayment amount.

"Eligible expense" means a covered expense that is determined as follows:

(A) For network providers (excluding Transplant Benefits), the eligible expense is the contracted fee with that provider.

(B) For non-network providers:

(1) The eligible expense is the lesser of the billed charge or a lower amount negotiated with the provider [or authorized by state law] for covered expenses that are:

(a) Received as a result of an emergency or otherwise approved by us; or

(b) For a service or supply that is not of a type provided by any network provider.

(2) Except as provided under (1) above, when a covered expense (excluding Transplant Benefits) is received from a non-network provider, the eligible expense is determined based on [the lesser of]:

(a) [The fee that has been negotiated with the provider;

(b) [110%] of the fee Medicare allows for the same or similar services provided in the same geographical area;

(c) 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 geographical area determined by us;

(d) The fee charged by the provider for the services; or

(e) A fee schedule that we develop.]

The "variable deductible" is equal to the amount of benefits payable for covered expenses by any other plan.

Amount Payable: The deductible amount is the larger of the stated deductible or a variable deductible. The stated deductible varies according to the type of plan and amount selected by the insured. (Please see the policy Data Page for more information.) We may apply the variable deductible even though the stated deductible has been satisfied.

If payment is calculated using the variable deductible, the coinsurance percentage will be 100 percent. The effect of the variable deductible is to pay 100 percent of the covered person's out-of-pocket expenses.

We will pay the applicable coinsurance percentage in excess of the applicable deductible amount(s) and copayment amount(s) for a service or supply that qualifies as a covered expense and is received while the covered person's coverage is in force under the policy, if the charge for the service or supply qualifies as an eligible expense.

The amount payable will be subject to any specific benefit limits stated in the policy, a determination of eligible expenses, and any reduction for expenses incurred at a non-network provider.

The deductible amount(s), coinsurance percentage, and copayment amount(s) are shown in the policy Data Page.

Non-emergency non-network eligible expenses will be reduced by [25%] before application of any applicable deductible amount(s), coinsurance provisions, and/or copayment amounts.

Note: The bill you receive for services or supplies from a non-network provider may be significantly higher than the eligible expenses for those services or supplies. In addition to the deductible amount, coinsurance, and copayment, you are responsible for the difference between the eligible expense and the amount the provider bills you for the services or supplies. Any amount you must pay to the provider in excess of the eligible expenses will not apply to your deductible amount or maximum out-of-pocket expenses.

[**Primary Care Physician:** In order to obtain benefits, you must designate a network primary care physician for each covered person. If you do not select a network primary care physician for each covered person, one will be assigned. You may obtain a list of network primary care physicians at our website or by calling the telephone number shown on the front page of your policy.

Specialist Physician: For network specialist physicians, a referral from your primary care physician is required in order to be eligible for [maximum] benefits. A referral is not required for emergencies or for care received from an obstetrician or gynecologist.][ii]

[**Deductible Credit:** A covered person will be eligible for a deductible credit if, in any given calendar year, he or she did not meet the applicable stated deductible and has been a covered person for at least 6 consecutive months. The deductible credit will apply to the stated deductible in the following calendar year.]

Medical Benefits

Covered expenses set forth in the policy include the charges:

(A) Made by a hospital for:

(1) Daily room and board and nursing services at the most common semi-private room rate.

(2) Daily room and board and nursing services while confined in an intensive care unit, not to exceed the eligible expense.

(3) Inpatient use of an operating, treatment, or recovery room.

(4) Outpatient use of an operating, treatment, or recovery room for surgery.

(5) Other routine services and supplies provided to an inpatient.

(6) Emergency treatment of an illness or injury. [However, charges for use of the emergency room itself for treatment of an illness will be reduced by $100 unless the covered person is directly admitted to the hospital for further treatment of that illness.][iii]

(B) For surgery in a doctor's office or at an outpatient surgical facility.

(C) Made by a doctor for professional services, including surgery.

(D) Made by an assistant surgeon, limited to [20] percent of the eligible expense for the surgical procedure.

(E) Made by a medical practitioner who is not a doctor and who is acting as a surgical assistant surgeon, limited to [14] percent of the eligible expense for the surgical procedure.

(F) Made by a medical practitioner for professional services.

(G) For dressings, crutches, orthopedic braces, splints, casts, or other necessary medical supplies.

(H) For diagnostic testing using radiologic, ultrasonographic, or laboratory services, but not including psychometric, behavioral, and educational testing.

(I) For chemotherapy and radiation therapy or treatment.

(J) For hemodialysis and the charges by a hospital for processing and administration of blood or blood components.

(K) For the cost and administration of oxygen or an anesthetic.

(L) For dental expenses when a covered person suffers an injury, after the effective date of coverage, that results in: (1) damage to the person's natural teeth; and (2) expenses that are incurred within six months of the accident.

(M) For surgery, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint, limited to a combined [$10,000] lifetime maximum per person.

(N) For artificial eyes or larynx, breast prostheses, or basic artificial limbs (but not replacement, unless required by a physical change in the person and the item cannot be modified).

(O) For one pair of foot orthotics per covered person.

(P) For medically necessary genetic blood tests.

(Q) For medically necessary immunizations to prevent respiratory syncytial virus (RSV).

(R) For two mastectomy bras per year if the covered person has undergone a covered mastectomy.

(S) For the rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.

(T) For the cost of one Continuous Passive Motion machine per person following a covered joint surgery.

(U) For the cost of one wig per person, up to [$500], that is necessitated by hair loss due to cancer treatments or traumatic burns.

(V) For occupational therapy following a covered treatment for traumatic hand injuries.

(W) For one pair of eyeglasses or contact lenses per person, up to [$200], following a covered cataract surgery.

(X) For routine annual digital rectal examinations, prostate specific antigen tests, and human papillomavirus (HPV) tests or screenings.

(Y) For surveillance tests for ovarian cancer for females who are at risk for ovarian cancer.

(Z) For breast reconstruction following a mastectomy, prostheses, and treatment for physical complications of mastectomy, including lymphedemas.

(AA) For emergency ground or air ambulance service to the nearest hospital, or the nearest neonatal special care unit for newborns.

(BB) For other benefits as required by the laws of the state where you reside. Please see the state mandates rider attached to your policy.

[**Preventive Care:** Covered expenses include the charges for the following preventive health services if appropriate per the guidelines [in effect as of March 23, 2010]:

(A) Evidence based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force.

(B) Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(C) Preventive care and screenings for children in accordance with guidelines supported by

the Health Resources and Services Administration.

(D) Additional preventive care and screenings not included in (A) above, in accordance with guidelines supported by the Health Resources and Services Administration for women.

Benefits for the preventive health services listed above[, except under the administration of reasonable medical management techniques as discussed in the policy,] are exempt from any [stated deductibles, coinsurance provisions, and copayment amounts] when the services are provided by a network provider.

Covered expenses incurred at a non-network provider will be reduced by 25%, then subject to the applicable deductible amount and coinsurance percentage.]

Limitation on Spine and Back Disorders: If the diagnosis or treatment of a spine or back disorder is rendered to a covered person while an outpatient, covered expenses for the medical practitioner's fees and all services and supplies will be limited to [15 visits] per person per calendar year.

Transplant Expense Benefits: The following types of tissue transplants are covered expenses: cornea transplants, artery or vein grafts, heart valve grafts, prosthetic tissue replacement (including joint replacement), and implantable prosthetic lenses in connection with cataracts. The policy also provides coverage for listed transplants, which include heart, lung, heart/lung, kidney, and liver transplants, and bone marrow transplants as listed in the policy. The amount of benefits under the policy for a listed transplant depends upon whether it is performed in one of our Centers of Excellence.

Home Health Care Expense Benefits: The policy provides benefits for home health care. Benefits for home health aide services are limited to [7] visits per week and a lifetime maximum of [365] visits. Benefits for outpatient private duty registered nurse services are limited to a lifetime maximum of [1,000 hours]. Benefits for intermittent private duty registered nurse services are limited to [$75] per visit.

Hospice Care Expense Benefits: The policy provides benefits for hospice care for a terminally ill covered person who receives medically necessary care under a hospice care program, limited to 180 days in a covered person's lifetime.

Rehabilitation and Extended Care Facility Expense Benefits: The policy provides benefits for rehabilitation services or an inpatient stay in a rehabilitation facility or extended care facility that begins within [14 days] of a hospital stay of at least [3 days] and is for treatment of, or rehabilitation related to, the same illness or injury that required the hospital stay. Covered expenses are limited to [60 days per calendar year for each covered person].

Outpatient Prescription Drug Expense Benefits: The policy provides benefits for outpatient prescription drugs that must be prescribed by a doctor, limited to a 34-day supply for each prescription or refill (excludes drugs for addiction to, or dependency on, tobacco or foods).

[Notification

You must notify us on or before the day a covered person begins the 4th day of an inpatient hospitalization or is evaluated for an organ or tissue transplant. If you fail to notify us, benefits will be reduced to 80% of the regular policy benefits, up to a maximum reduction of $1,000. This does not apply to an inpatient hospital admission for emergency treatment.]

[Prior Authorization

Some covered expenses require prior authorization. In general, network providers must obtain authorization from us prior to providing a service or supply to a covered person. However, there are some network eligible expenses for which you must obtain the prior authorization. A list of which services require prior authorization, and who must obtain the prior authorization, is shown in the policy Data Page. Failure to obtain prior authorization will result in benefits being reduced, except in the case of an emergency. Please see the policy Data Page for details.][iv]

What Is Not Covered

No benefits will be paid for:

(A) Loss for which no charge would be made in the absence of insurance;

(B) Charges that are actually the responsibility of the provider to pay;

(C) Any services performed by a member of a covered person's immediate family; or

(D) Services not identified as covered expenses under the policy.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

(A) For services and supplies provided prior to the effective date or after the termination date of the policy.

(B) For any portion of the charges that are in excess of the eligible expense.

(C) For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.

(D) For breast reduction or augmentation.

(E) For modification of the physical body to improve the psychological, mental, or emotional well-being of the covered person, such as sex-change surgery.

(F) For any drug, treatment, or procedure that promotes conception or prevents childbirth, including but not limited to, artificial insemination or treatment for infertility or impotency; for sterilization or reversal of sterilization; or for abortion (unless a pregnancy carried to term would endanger the mother's life).

(G) For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders[, except as described in the policy].

(H) For routine well-baby care of a newborn infant, except as specifically provided by the policy.

(I) For television, telephone, or expenses for other persons.

(J) For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.

(K) For telephone consultations or failure to keep a scheduled appointment.

(L) For hospital room and board and nursing services for the first Friday or Saturday of an inpatient stay that begins on one of those days, unless it is an emergency or medically necessary inpatient surgery is scheduled for the date after the date of admission.

(M) For stand-by availability of a medical practitioner when no treatment is rendered.

(N) For dental expenses, including braces, or surgery and treatment for oral surgery[, except as described in the policy].

(O) For cosmetic treatment, except reconstructive surgery that is incidental to or follows surgery or an injury that was covered under the policy or is performed to correct a birth defect in a child who has been covered under the policy since birth.

(P) For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.

(Q) For diagnosis or treatment of nicotine addiction, [except as otherwise covered under the Preventive Care Expense Benefits provision of the policy].

(R) For charges related to, or in preparation for, tissue or organ transplants[, except as expressly provided for by the policy].

(S) For high dose chemotherapy prior to, in conjunction with, or supported by bone marrow transplant[, except as specifically provided by the policy].

(T) For eye refractive surgery when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

(U) While confined primarily to receive rehabilitation, custodial care, educational care, or nursing services [(unless expressly provided for by the policy)].

(V) For vocational or recreational therapy, vocational rehabilitation, occupational therapy, or outpatient speech therapy[, except as provided by the policy].

(W) For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.

(X) For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any related examinations or fittings.

(Y) For pregnancy (except for complications of pregnancy)[, unless the optional Pregnancy Expense Benefits Rider is attached to the policy,] or for confinement primarily for well-baby care.

(Z) For treatment of mental disorders, substance abuse, or for court ordered treatment programs for substance abuse, [unless the Optional Mental Disorders Benefits rider or the Optional Biologically-Based Mental Illness Benefits rider is attached to the policy].

(AA) For preventive care or prophylactic care, including routine physical examinations, premarital examinations, and educational programs[, except as required by law or as provided by the policy].

(BB) For experimental or investigational treatment or for unproven services, as defined in the policy.

(CC) For expenses incurred outside of the United States, except for emergency treatment.

(DD) For injury or illness caused by employment[, except as may be covered by the policy].

(EE) As a result of intentionally self-inflicted bodily harm (whether sane or insane); an injury or illness caused by an act of war; from taking part in a riot; or from the commission of a felony, whether or not charged.

(FF) For durable medical equipment, except as expressly provided for by the policy.

(GG) For any illness or injury that occurs as a result of the covered person being intoxicated or under the influence of illegal narcotics or controlled substance, unless administered or prescribed by a doctor.

(HH) For or related to surrogate parenting.

(II) For or related to treatment of hyperhidrosis (excessive sweating).

(JJ) For fetal reduction surgery.

(KK) Except as expressly provided for by the policy, expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

(LL) [As a result of any injury sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: [operating or riding on a motorcycle;] professional or semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; [racing or speed testing any non-motorized vehicle or conveyance (if the covered person is paid to participate or to instruct);] scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; [horseback riding (if the covered person is paid to participate or to instruct);] rock or mountain climbing (if the covered person is paid to participate or to instruct); or skiing (if the covered person is paid to participate or to instruct).]

(MM) [As a result of any injury sustained while operating, riding in, or descending from any type of aircraft if the covered person is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.]

(NN) While at a residential treatment facility.

(OO) [For prescription drugs for a person who enrolls in Medicare Part D.]

In no event will we pay for charges that are: (A) not made or ordered by a doctor; or (B) not medically necessary to the diagnosis or treatment of an illness or injury.

[Coverage for illness will begin 14 days after coverage for injury. There is a 6-month waiting period for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, and disorders of the reproductive organs, unless provided on an emergency basis or for treatment of cancer.]

Term of Coverage and Renewability

The policy term begins as of the effective date of the policy. You may keep the policy in force by paying us the required premium as it comes due. However, we may cancel the policy or deny a claim if a covered person commits fraud or makes a material misrepresentation in the application.

We may refuse to renew the policy if:

(A) We refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where you then live; or

(B) There is fraud or a material misrepresentation made by or with the knowledge of a covered person in filing a claim for policy benefits.

Benefits will continue to be paid for an illness or injury after a person's coverage terminates, provided the illness or injury causes a period of extended loss that begins while the covered person is still covered by the policy.

[i] NTR: The phrase "each covered person" prints in plans that are not high deductible health plans for use with a health savings account, and the phrase "all covered persons" prints in high deductible health plans for use with a health savings account.
[ii] The Primary Care Physician and Specialist Physician provisions are bracketed so that they may be included or omitted.
[iii] The bracketed portion does not print in high deductible health plans for use with a health savings account.
[iv] Either the Notification provision or the Prior Authorization provision will be included.

Rider-Amendment to Policy

American Medical Security Life Insurance Company, Green Bay, Wisconsin

To be attached to and form a part of Policy Number [XXX-XXX-XXX]

Issued to [Policyholder Name]

By the attachment of this rider it is understood and agreed that the insurance under this policy is amended as follows:

[ ]

* * * * * * * * * * * * * *

Nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, provisions or limitations of this Policy, other than as herein provided. [This Rider-Amendment to Policy is not applicable to any life insurance.]

This Rider is effective as of [DATE].

Countersigned by [signature]

Authorized Representative

[signature]

President

Rider-Amendment to Policy

American Medical Security Life Insurance Company, Green Bay, Wisconsin

To be attached to and form a part of Policy Number [XXX-XXX-XXX]

Issued to [Insured Name]

By the attachment of this rider it is understood and agreed that the insurance under this policy is amended as follows:

[ ]

* * * * * * * * * * * * * *

Nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, provisions or limitations of this Policy, other than as herein provided. [This Rider-Amendment to Policy is not applicable to any life insurance.]

This Rider is effective as of [DATE].

Accepted _____
Insured

Countersigned by [signature]
Authorized Representative

[signature]
President

VISION BENEFIT RIDER

By attachment of this rider, the *policy* is amended as follows:

DEFINITIONS: For the purposes of this benefit, the following definitions apply:

A. *"Comprehensive eye examination"* means an examination by an ophthalmologist or optometrist to determine the health of the eye, including glaucoma tests and refractive examinations to measure the eye for corrective lenses.

B. *"Vision benefit preferred provider"* is an ophthalmologist or optometrist who has contracted with the vision benefit network, as identified on *your* identification card, and is licensed and otherwise qualified to practice vision care and/or provide vision care materials.

C. *"Vision benefit non-preferred provider"* is any ophthalmologist, optometrist, optician, or other licensed and qualified vision care provider who has not contracted with the vision benefit network, as identified on *your* identification card, to provide vision care services and/or vision care materials.

HOW THE VISION BENEFIT PROGRAM WORKS: Copayment, *deductible amounts,* and coinsurance may differ when services are rendered and billed directly by a:

A. *Vision benefit preferred provider;* or

B. *Vision benefit non-preferred provider.*

See *your* Data Page for the different amounts.

We have a contract with the vision benefit network, as identified on *your* identification card. *Vision benefit preferred providers* agree to discount their service fees. *You* or *your* covered *dependents* pay any applicable copayments, *deductible amount,* or coinsurance. *Vision benefit preferred providers* then agree to accept *our* benefit payment as payment in full for *covered expenses.*

We do not have a contract with *vision benefit non-preferred providers. You* or *your* covered *dependent* must pay any applicable copayments, *deductible amount,* or coinsurance. After satisfaction of applicable copayments, *deductible amount,* or coinsurance, benefits are limited to the applicable allowance amount listed on the Data Page.

When the amount of actual charges exceeds the allowance amount listed on the Data Page, the *vision benefit non-preferred providers* may bill *you* or *your* covered *dependent* for the excess amount.

COVERED EXPENSES: *Covered expenses* are payable for *you* and *your* covered *dependent* as shown in the Data Page and are limited to charges for:

A. Comprehensive eye examinations. Benefits are limited to [1-3] exam[s] per [6-36] months.

B. [Prescription eyewear. Benefits are limited to [1-3] pair of prescription single vision lenses per [6-36] months and [1-3] pair of frames per [6-36] months.

   1. Spectacle lenses as prescribed by an ophthalmologist or optometrist; frames and their fitting and subsequent adjustments to maintain comfort and efficiency; or

   2. Elective contact lenses that are in lieu of prescription spectacle lenses and frames; and

   3. *Medically necessary* contact lenses and professional services when prescribed or received under the following circumstances:

      (a) Following cataract surgery; or

      (b) To correct extreme visual acuity problems that cannot be corrected with spectacle lenses.

This vision benefit program is designed to cover vision needs rather than cosmetic extras. Cosmetic extras include:

A. Blended lenses.

B. Oversize lenses.

C. Photochromic lenses.

D. Tinted lenses, except pink #1 or #2.

E. Progressive multifocal lenses.

F. Coating of a lens or lenses.

G. Laminating of a lens or lenses.

H. Frames that cost more than the plan allowance.

I. Cosmetic lenses.

J. Optional cosmetic processes.

K. UV (ultraviolet) protected lenses.

If *you* or *your* covered *dependent* select a cosmetic extra, the plan will pay the *medically necessary* costs of the allowed lenses and *you* or *your* covered *dependent* will be responsible for the additional cost of the cosmetic extra.]

EXCLUSIONS AND LIMITATIONS: The following exclusion is removed from the *policy:*

For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices,

and is replaced with:

For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, unless expressly provided for under this vision benefit.

Covered expenses will not include and no benefits are payable under this rider for any charges incurred for the following:

A. Orthoptics or vision therapy training and any associated supplemental testing.

B. [Plano lenses (a lens with no prescription on it).]

C. [Replacement of lenses and frames furnished under this plan, which are lost or broken, except at the normal intervals when services are otherwise available.]

D. Medical or surgical treatment of the eyes.

E. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.

F. Corrective vision treatment of an experimental or investigative nature.

G. Corrective surgical procedures such as, but not limited to, Radial Keratotomy (RK) and Photorefractive Keratectomy (PRK).

H. [Elective contact lenses if prescription spectacle lenses and frames are received in any [6-36]-month period.]

I. [Prescription spectacle lenses and frames if elective contact lenses are received in any [6-36]-month period.]

J. Eyewear [except prescription eyewear].

K. Charges that exceed the allowance amount listed on the Data Pages.

L. Services or treatments that are already excluded in the General Exclusions and Limitations section of the *policy.*

This rider will not change, waive, or extend any part of the *policy,* other than as stated herein.

This rider is effective [at the same time as the *policy*, unless a later date is shown below].

American Medical Security Life Insurance Company

President

TERM LIFE INSURANCE RIDER

By attachment of this rider, the *policy* is amended as follows:

If a *covered person* dies while insured under this rider, *we* will pay, subject to the terms and conditions of this rider, to the *covered person's beneficiary* the term life *proceeds* in one lump sum.

DEFINITIONS

As used in this rider:

"Beneficiary" means the person designated by the *covered person,* on a form approved by *us,* to receive any amount of the term life *proceeds* becoming payable under the terms of the *policy* due to a *covered person's* death.

"Covered Person" means the primary insured and/or *spouse* who has applied for and been approved under this rider.

[*"Due proof of death"* shall mean sufficient information to allow *us* to determine if *proceeds* are payable and in the form of written documentation, such as a certified copy of the death certificate, autopsy report, police/accident report(s), and other information and proof necessary to establish liability.]

"Proceeds" means the amount for which a *covered person's* life is insured under this rider at the time of death. The respective term life *proceeds* for each *covered person* under this rider are shown in [Section 2].

"Spouse" means the person named as *your* spouse in the application or any amendment. This term does not include a spouse who is not a *covered person.*

PREMIUM

The premiums for this rider are [shown in the Data Page, Section 2]. This premium is to be paid at the same time and in the same manner as the premium for the *policy*. The premium for this rider will cease when the rider ends. If the type of plan shown in the Data Page of the *policy* is changed because of an addition or removal of a *covered person* insured by this rider, the premium for this rider will change. The new premium for this rider will be shown in the written notice sent to *you.*

NOTICE OF DEATH

We will pay to the *beneficiary* the term life *proceeds* of this rider upon receipt of *due proof of death.* Written proof of death must be furnished to *us* within 90 days from the *covered person's* date of death or as soon as reasonably possible.

BENEFICIARY

The *covered person* can name any person, other than the *covered person's* employer, as *beneficiary.* The *covered person* can change the *beneficiary* at any time without the consent of the designated *beneficiary* by notifying *us* in writing on a form furnished by *us.* The new designation will be effective when the notice is received by *us.* If *we* pay the *proceeds* before *we* receive the *covered person's* change request, *we* are released from further liability to the extent of *our* payment. A new designation of *beneficiary* terminates the interests of the previous *beneficiary.*

If more than one *beneficiary* is designated, but their respective interests are not specified, the *beneficiaries* will share the *proceeds* equally. The interest of a *beneficiary* who dies before the *covered person* will terminate and be shared equally by the *beneficiaries* surviving the *covered person,* unless otherwise provided in the *beneficiary* designation. If the *beneficiary* dies at the same time as the *covered person,* or within 15 days after the date the *covered person* dies, payment will be made by *us* as if the *covered person* survived the *beneficiary.* If there is not a designated *beneficiary* surviving at the death of the *covered person,* payment will be made in a single sum to the *covered person's* estate; however, at *our* option, payment may be made to one or more of the following surviving relatives of the *covered person:*

A. *Spouse;*

B. Children, including legally adopted children;

C. Parents; or

D. Brothers and sisters.

In the absence of a parent or the appointment of a legal guardian, if any *beneficiary* is:

A. A minor; or

B. In *our* opinion, legally incapable of giving valid receipt for any payment due,

we may pay term life *proceeds* in monthly installments to the person or persons who, in *our* opinion, have assumed custody and principal support of the *beneficiary.*

If *proceeds* are not paid within 30 days after *we* received *due proof of death, we* will pay interest on the *proceeds.* Interest will be paid at the rate of [3%] a year from the date *we* receive *due proof of death* until the date the *proceeds* are paid. If the law in the state where the *policy* is issued requires payment of a greater amount, *we* will pay that amount.

We may, at *our* option, pay an amount of up to [$250] to any person appearing to be entitled to the payment who incurred expense because of the last illness or burial of the *covered person.* Any payment *we* make in good faith fully discharges *us* to the extent of the payment.

TERMINATION OF THIS RIDER

All insurance under this rider will cease on its termination. This rider will terminate on the earlier of:

A. The date *we* receive a written request from the *covered person* for its termination, or on any later date stated in *your* request;

B. The date no *covered person* remains insured under this rider; or

C. The date the *covered person's* coverage under the *policy* terminates.

We will refund any premium paid and not earned due to termination of this rider. The refund will be based on the number of full months that remain in the premium period.

TERMINATION OF COVERED PERSONS

You will cease to be a *covered person* under this rider at the end of the premium period in which *you* attain [65] years of age.

Your spouse will cease to be a *covered person* under this rider at the end of the premium period in which any of these events occur:

A. He or she attains [65] years of age; [or]

B. [*You* attain [65] years of age; or]

C. *You* become legally divorced, if earlier.

[ASSIGNING YOUR RIDER

During *your* life, *you* may assign some or all of *your* rights under this rider to someone else.

A signed copy of the assignment trust must be sent to *our* home office on a form *we* accept. The assignment will go into effect when it is signed, subject to any payments *we* make or other actions *we* take before *we* record it. *We* are not responsible for the validity or effect of any assignment.]

MISTAKE OF AGE, SEX, OR TOBACCO STATUS

If *your* or *your spouse's* age, sex, or tobacco status is misstated in the application, *we* will adjust the *proceeds.* The *proceeds* of this rider will then be those *your* premiums would have bought at the correct age, sex, and tobacco status. By age, *we* mean age as of *your* or *your spouse's* last birthday on the *policy's effective date.*

GENERAL TERMS

This rider is made a part of *your policy* in consideration of *your* application and payment of the first premium for this rider. The following clauses indicate whether the *policy* provisions will apply to this rider. The *policy* provisions will either apply to this rider, not apply to this rider, or apply to this rider as modified below.

A. **Policy provisions that do not apply to this rider** - The following *policy* provisions do not apply to this rider:

1. The Preexisting Conditions Limitation section and the Reimbursement section; and

2. The Dependent Coverage section, except for the Dependent Eligibility clause and the Adding Other Dependents clause.

B. **Policy provisions that apply to this rider with modification** - The following *policy* provision applies to this rider as modified below:

The Reinstatement clause, as found in the [Termination section of the *policy*], will apply to this rider. However, death/accidental death occurring between the date the *policy* lapses and the date the *policy* is reinstated will not be covered under this rider.

C. **Policy provisions that do apply to this rider** - Other than as stated in A or B above, all other *policy* provisions will apply to this rider.

BENEFIT EXCLUSIONS

No *proceeds* are payable if a loss results from:

A. Suicide or intentionally self-inflicted *injury* or *illness* while sane or insane [if committed during the first [24 months] of coverage under this rider];

B. Service in the armed forces of any country, including non-military units supporting such forces;

C. An act of declared or undeclared war; or

D. Death due to an accident occurring while riding in or on, boarding, or alighting from any aircraft as a:

1. Pilot, crewmember, or student pilot; or
2. Flight instructor or examiner.

LIFE INSURANCE CONVERSION PRIVILEGE

A *covered person* will be eligible to convert [coverage under this rider/this term life insurance coverage] to an [individual policy of life insurance (*"conversion policy"*)], made available, without evidence of insurability, under this provision, if:

A. The *covered person's* coverage under this rider terminates for reasons other than:

1. Termination of the *policy;* or
2. Failure to make the required premium payment when due; or
3. The attainment of age [65].

B. The *covered person* has been continuously insured under this rider for at least [one (1) year] immediately prior to the termination.

This privilege is subject to the following additional terms and conditions:

A. Written application and the first premium payment are submitted as directed on the *conversion policy* application by the later of:

1. 31 days after termination of coverage under this rider; or
2. A later date as required by the statutes or regulations of the state in which the *covered person* resides at that time; but
3. In no event later than 60 days after the date of termination of coverage under this rider.

B. The amount of coverage under the *conversion policy* will not exceed the amount of coverage for which the *covered person* is insured under this rider. The terms of coverage under the *conversion policy* will not be the same as the terms of coverage under this rider.

C. The *conversion policy* will be a policy offered by a life insurer designated by *us* in the state in which the *covered person* resides.

D. The premium to be paid for the *conversion policy* by the former *covered person* will depend on:

1. Rates for that *conversion policy* in that state at that time;
2. The attained age of the *covered person;*
3. The class of risk to which the *covered person* belongs; and

4. The form and amount of the *conversion policy* coverage.

E. Any *conversion policy* issued in accordance with the provisions of this rider:

1. Will become effective the date immediately following termination of coverage under this rider; and
2. Will be in place of the terminated coverage under this rider.

F. A *covered person's* insurance under this rider will remain in force during the thirty-one (31) days within which the *covered person* is eligible to exercise the conversion privilege, whether or not there has been an application for conversion. If the *covered person* dies during that period, *we* will:

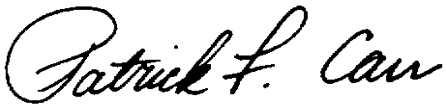
1. Pay, as a death benefit, the maximum amount eligible for conversion;
2. Void any *conversion policy* issued in accordance with this conversion privilege; and
3. Return any premium paid for that *conversion policy.*

G. If the life insurer designated by *us* to offer *conversion policies* in the state in which a *covered person* resides ceases to offer *conversion policies* in that state, no *conversion policies* will be available in that state under this provision.

This rider will not change, waive, or extend any part of the *policy,* other than as stated herein.

This rider is effective at the same time as the *policy* to which it is attached, unless a later date is shown below.

American Medical Security Life Insurance Company



President

ACCIDENTAL DEATH INSURANCE RIDER

By attachment of this rider, the *policy* is amended as follows:

If a *covered person* suffers an *accidental death* while insured under this rider, *we* will pay, subject to the terms and conditions of this rider, to the *covered person's beneficiary* the *accidental death proceeds* in one lump sum.

In order to qualify for a benefit:

A. The death must occur within 180 consecutive days after the accident that caused the death; and

B. The accident must occur while the *covered person* is covered under this rider.

DEFINITIONS

As used in this rider:

"Accidental death" means loss of life resulting directly from:

A. *Injury;*

B. Infection caused by *injury* or resulting from accidental ingestion of contaminated substances; or

C. Drowning.

"Beneficiary" means the person designated by the *covered person,* on a form approved by *us,* to receive any amount of the *accidental death proceeds* becoming payable under the terms of the *policy* due to a *covered person's* death.

"Covered Person" means the primary insured and/or *spouse* who has applied for and been approved under this rider.

[*"Due proof of death"* shall mean sufficient information to allow *us* to determine if *accidental death proceeds* are payable and in the form of written documentation, such as a certified copy of the death certificate, autopsy report, police/accident reports, and other information and proof necessary to establish liability.]

"Proceeds" means the amount for which a *covered person's* life is insured under this rider at the time of death. The respective *accidental death proceeds* for each *covered person* under this rider are shown in [Section 2].

"Spouse" means the person named as *your* spouse in the application or any amendment. This term does not include a spouse who is not a *covered person.*

PREMIUM

The premiums for this rider are [shown in the Data Page, Section 2]. This premium is to be paid at the same time and in the same manner as the premium for the *policy*. The premium for this rider will cease when the rider ends. If the type of plan shown in the Data Page of the *policy* is changed because of an addition or removal of a *covered person* insured by this rider, the premium for this rider will change. The new premium for this rider will be shown in the written notice sent to *you.*

NOTICE OF DEATH

We will pay to the *beneficiary* the *accidental death proceeds* of this rider upon receipt of *due proof of death.* Written proof of death must be furnished to *us* within 90 days from the *covered person's* date of death or as soon as reasonably possible.

BENEFICIARY

The *covered person* can name any person, other than the *covered person's* employer, as a *beneficiary.* The *covered person* can change the *beneficiary* at any time without the consent of the designated *beneficiary* by notifying *us* in writing on a form furnished by *us.* The new designation will be effective when the notice is received by *us.* If *we* pay the *proceeds* before *we* receive the *covered person's* change request, *we* are released from further liability to the extent of *our* payment. A new designation of *beneficiary* terminates the interests of the previous *beneficiary.*

If more than one *beneficiary* is designated, but their respective interests are not specified, the *beneficiaries* will share the *proceeds* equally. The interest of a *beneficiary* who dies before the *covered person* will terminate and be shared equally by the *beneficiaries* surviving the *covered person,* unless otherwise provided in the *beneficiary*

designation. If the *beneficiary* dies at the same time as the *covered person,* or within 15 days after the date the *covered person* dies, payment will be made by *us* as if the *covered person* survived the *beneficiary.* If there is not a designated *beneficiary* surviving at the death of the *covered person,* payment will be made in a single sum to the *covered person's* estate; however, at *our* option, payment may be made to one or more of the following surviving relatives of the *covered person:*

A. *Spouse;*

B. Children, including legally adopted children;

C. Parents; or

D. Brothers and sisters.

In the absence of a parent or the appointment of a legal guardian, if any *beneficiary* is:

A. A minor; or

B. In *our* opinion, legally incapable of giving valid receipt for any payment due,

we may pay *accidental death proceeds* in monthly installments to the person or persons who, in *our* opinion, have assumed custody and principal support of the *beneficiary.*

If *proceeds* are not paid within 30 days after *we* received *due proof of death, we* will pay interest on the *proceeds.* Interest will be paid at the rate of [3%] a year from the date *we* receive *due proof of death* until the date the *proceeds* are paid. If the law in the state where the *policy* is issued requires payment of a greater amount, *we* will pay that amount.

[*We* rely on an affidavit to determine payment of *proceeds,* unless *we* receive written notice of a valid claim from a person before *we* make the payment. The affidavit releases *us* from further liability.]

We may, at *our* option, pay an amount of up to [$250] to any person appearing to be entitled to the payment who incurred expense because of the last illness or burial of the *covered person.* Any payment *we* make in good faith fully discharges *us* to the extent of the payment.

TERMINATION OF THIS RIDER

All insurance under this rider will cease on its termination. This rider will terminate on the earlier of:

A. The date *we* receive a written request from the *covered person* for its termination, or on any later date stated in *your* request;

B. The date no *covered person* remains insured under this rider; or

C. The date the *covered person's* coverage under the *policy* terminates.

We will refund any premium paid and not earned due to termination of this rider. The refund will be based on the number of full months that remain in the premium period.

TERMINATION OF COVERED PERSONS

You will cease to be a *covered person* under this rider at the end of the premium period in which *you* attain [65] years of age.

Your spouse will cease to be a *covered person* under this rider at the end of the premium period in which any of these events occur:

A. He or she attains [65] years of age; [or]

B. [*You* attain [65] years of age; or]

C. *You* become legally divorced, if earlier.

[ASSIGNING YOUR RIDER

During *your* life, *you* may assign some or all of *your* rights under this rider to someone else.

A signed copy of the assignment must be sent to *our* home office on a form *we* accept. The assignment will go into effect when it is signed, subject to any payments *we* make or other actions *we* take before *we* record it. *We* are not responsible for the validity or effect of any assignment.

If there are permanent *beneficiaries, you* need their consent before assigning the payment of *proceeds.*]

GENERAL TERMS

This rider is made a part of *your policy* in consideration of *your* application and payment of the first premium for this rider. The following clauses indicate whether the *policy* provisions will apply to this rider. The *policy* provisions will either apply to this rider, not apply to this rider, or apply to this rider as modified below.

A. **Policy provisions that do not apply to this rider** - The following *policy* provisions do not apply to this rider:

   1. The Preexisting Conditions Limitation section and the Reimbursement section; and
   2. The Dependent Coverage section, except for the Dependent Eligibility clause and the Adding Other Dependents clause.

B. **Policy provisions that apply to this rider with modification** - The following *policy* provision applies to this rider as modified below:

   The Reinstatement clause, as found in the Termination section of the *policy*, will apply to this rider. However, death/accidental death occurring between the date the *policy* lapses and the date the *policy* is reinstated will not be covered under this rider.

C. **Policy provisions that do apply to this rider** - Other than as stated in A or B above, all other *policy* provisions will apply to this rider.

BENEFIT EXCLUSIONS

No *proceeds* are payable if a loss results from:

A. Suicide or intentionally self-inflicted *injury* or *illness* while sane or insane [if committed during the first [24 months] of coverage under this rider].

B. Voluntary taking of any sedative or drug, or inhalation of any gas, unless taken or inhaled as *your doctor* prescribes or administers it.

C. Death due to an accident occurring while riding in or on, boarding, or alighting from any aircraft as a:

   1. Pilot, crewmember, or student pilot; or
   2. Flight instructor or examiner.

D. *Your* committing or attempting to commit a civil or criminal battery or felony.

E. Service in the armed forces of any country, including non-military units supporting such forces.

F. An act of declared or undeclared war.

G. Participating in a riot, rebellion or insurrection. Participating means *you* are taking an active part in common with others. Riot means any use or threat to use force or violence by three or more persons without authority of law.

H. Bodily or mental infirmity, or related surgery or medical treatment or any infection, unless direct result of *injury,* or unless resulting from accidental ingestion of a contaminated substance.

I. *Injury* or *illness* arising from any occupation or employment.

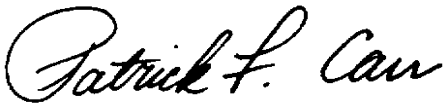
J. Participating in hazardous activities, including, but not limited to: auto or motorcycle racing; hang gliding; bungee jumping; rock climbing; skydiving and any extreme sports.

K. Driving while legally intoxicated from alcohol, or driving while under the influence of drugs unless taken as prescribed by a *doctor.*

This rider will not change, waive, or extend any part of the *policy,* other than as stated herein.

This rider is effective at the same time as the *policy* to which it is attached, unless a later date is shown below.

American Medical Security Life Insurance Company



President

COPAYMENT AMOUNT RIDER

This rider is effective [at the same time as the *policy* to which it is attached, unless a later date is shown below].

By attachment of this rider the [Medical Benefits section of the *policy*] is amended by the addition of the following:

A. [**Doctor Office Visits:** *Covered expenses* for outpatient *doctor* office visits will be payable as follows:

1. **At network providers:** *Covered expenses* for services that are provided by a *network provider* will be subject to the *copayment amount* (as shown in the Data Page) before the benefits are payable under the *policy*.

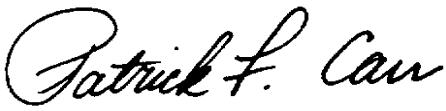
2. **At non-network providers:** *Covered expenses* for services that are provided by a non-*network provider* will be reduced by 25%. The remaining *covered expenses* will then be subject to the non-*network provider deductible amount* and the applicable *coinsurance percentage* (as shown on the Data Page).]

[If *you* move to an area where *we* are not offering access to a *network*, the *covered expenses* for outpatient *doctor* visits will be subject to any applicable *deductible amount* and *coinsurance percentage* (as shown on the Data Page).]

Except as otherwise specified above, *covered expenses* under this rider are subject to all the terms, conditions, exclusions and limits of the *policy*, other than as set forth above.

This rider does not change, waive or extend any part of the *policy*, other than as set forth above.

American Medical Security Life Insurance Company



President

COPAYMENT AMOUNT RIDER

This rider is effective [at the same time as the *policy* to which it is attached, unless a later date is shown below].

By attachment of this rider the [Medical Benefits section of the *policy*] is amended by the addition of the following:

A. [**Doctor Office Visits:** *Covered expenses* for outpatient *doctor* office visits will be payable as follows:

1. **At network providers:** The first four visits per calendar year for each *covered person* will be subject to the *copayment amount* (as shown in the Data Page) before the benefits are payable under the *policy*. Subsequent visits for the same *covered person* during the same calendar year will be subject to the applicable *deductible amount* and *coinsurance percentage.*

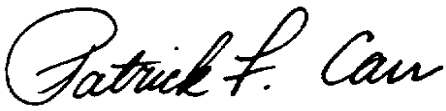
2. **At non-network providers:** *Covered expenses* for visits at a non-*network provider* will be reduced by 25%. The remaining *covered expenses* will then be subject to the non-*network provider deductible amount* and the applicable *coinsurance percentage* (as shown on the Data Page).]

[If *you* move to an area where *we* are not offering access to a *network*, the *covered expenses* for outpatient *doctor* visits will be subject to any applicable *deductible amount* and *coinsurance percentage* (as shown on the Data Page).]

Except as otherwise specified above, *covered expenses* under this rider are subject to all the terms, conditions, exclusions and limits of the *policy*, other than as set forth above.

This rider does not change, waive or extend any part of the *policy*, other than as set forth above.

American Medical Security Life Insurance Company



President

SUPPLEMENTAL ACCIDENT BENEFITS RIDER

This rider is effective [on DATE or at the same time as the *policy*, whichever is later].

By attachment of this rider the *policy* is amended as follows:

We will pay up to [$500 - $10,000] for *covered expenses* [shown in the Medical Benefits provision] that:

A. Result from an accidental *injury* while a *covered person's* insurance is in force; and

B. Are incurred within [90 days after the *injury* / {90 - 365} days following the *injury,* providing that the first *covered expense* is incurred within {60 - 90} days of the *injury*].

Supplemental Accident Expense Benefits will be subject only to a [$50 - $500] deductible, per *covered person,* per accident, and [will/will not] be applied toward the *policy deductible amount. Covered expenses* incurred in excess of the [$500 - $10,000] maximum will be subject to all provisions of the *policy,* including but not limited to, [the exclusion for outpatient expenses,] the *deductible amount,* and *coinsurance percentage* applicable to *covered expenses* under the *policy* in general.

This rider does not change, waive or extend any part of the *policy*, other than as stated herein.

American Medical Security Life Insurance Company

President

PREGNANCY BENEFITS RIDER

This rider is effective [on DATE or at the same time as the *policy*, whichever is later].

By the attachment of this rider, *covered expenses* under the *policy* are amended to include the charges incurred by a *covered person* for normal *pregnancy* and childbirth.

Covered expenses under this rider are subject to all the terms, conditions, exclusions, and limitations of the *policy,* including any [applicable {stated deductibles/*deductible amounts*}, *copayment amounts,* coinsurance provisions, [notification/prior authorization requirements, or maximum dollar limits].

This rider will not change, waive, or extend any part of the *policy*, other than as stated herein.

American Medical Security Life Insurance Company

President

OUTPATIENT PRESCRIPTION DRUG EXPENSE BENEFITS RIDER

This rider is effective [on DATE or at the same time as the *policy*, whichever is later].

By the attachment of this rider, *covered expenses* specified in the *policy* for covered services for outpatient *prescription drug* expenses are deleted and replaced with the following:

DEFINITIONS: As used in this rider, the following terms have the meanings set forth below:

A. *"Ancillary charge"* means the additional charge incurred by the *covered person* when two drugs are *chemically equivalent* and the higher-tiered drug of the two is dispensed. In addition to the *prescription drug copayment amount* that applies to the lower-tiered drug, the *covered person* is responsible for an ancillary charge of the difference between the cost of the lower-tiered drug and the higher-tiered drug dispensed. The *ancillary charge* does not apply to the *prescription drug deductible amount*.

B. *"Brand-name drug"* means a *prescription drug* that:

   1. Is manufactured and marketed under a trademark or name by a specific drug manufacturer; or

   2. *We* identify as a brand-name product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. A drug identified as a "brand-name" by the manufacturer, pharmacy, or *your* physician may not be classified as a brand-name drug by *us*.

C. *"Chemically equivalent"* means that *prescription drugs* contain the same active ingredient.

D. *"Designated pharmacy"* means a pharmacy that has entered into an agreement with *us* or with *our* pharmacy benefits manager to provide specific *prescription drugs*, including, but not limited to, *specialty prescription drugs*. The fact that a pharmacy is a *member pharmacy* does not mean that it is a *designated pharmacy*.

E. *"Generic drug"* means a *prescription drug* that:

   1. Is *chemically equivalent* to a *brand-name drug;* or

   2. *We* identify as a generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. A drug identified as a "generic" by the manufacturer, pharmacy, or *your* physician may not be classified as a generic drug by *us*.

F. *"Managed drug limitations"* means limits in coverage based upon time period, amount, or dose of a drug, or other specified predetermined criteria.

G. *"Member pharmacy"* means a licensed pharmacy that has entered into a contract with *our* pharmacy benefits manager to provide *prescription drugs* to *covered persons* at a negotiated rate.

H. *"Predominant reimbursement rate"* means the charges incurred for a *prescription drug* not dispensed at a *member pharmacy* that will be considered *covered expenses* under the *policy*. The *predominant reimbursement rate* for a particular *prescription drug* includes the dispensing fee and sales tax. The *predominant reimbursement rate* will be set at the *prescription drug* cost that *our* pharmacy benefits manager and most *member pharmacies* have agreed to for that *prescription drug*.

I. *"Prescription drug"* means any medicinal substance whose label is required to bear the legend "RX only".

J. *"Prescription drug card"* means a [current, valid card, issued by *us* or *our* pharmacy benefits manager, that is properly used].

K. *"Prescription drug copayment amount"* means the amount to be deducted from the total *covered expense* incurred for each separate *prescription order*. The *prescription drug deductible amount* must be satisfied before the *prescription drug copayment amount* will be applied.

L. *"Prescription drug deductible amount"* means the amount of *covered expenses* incurred for *prescription drugs* that must be paid by each *covered person* during any calendar year before any benefits are payable subject to payment of any *prescription drug copayment amount*.**Error! Bookmark not defined.**

M. *"Prescription order"* means the request for each separate drug or medication by a *doctor* or each authorized refill of such requests.

N. *"Specialty prescription drug"* means *prescription drugs* that are generally high cost, self-injectable biotechnology drugs used to treat patients with certain *illnesses*. *You* may access a complete list of *specialty prescription drugs* by [accessing *your prescription drug* benefits via *our* website or by calling the telephone number on *your* identification card].

O. *"Therapeutic class"* means a group or category of *prescription drugs* with similar uses and/or actions.

P. *"Therapeutically equivalent"* means that two or more *prescription drugs* can be expected to produce essentially the same therapeutic outcome and toxicity.

COVERED EXPENSES: *Covered expenses* for outpatient *prescription drugs* are limited to charges from a licensed pharmacy for drugs that, under the applicable state law, may be dispensed only upon the written prescription of a *doctor*.

A. **Member Pharmacies:** For *covered expenses* incurred at a *member pharmacy* when a *prescription drug card* is used, *we* will pay the charges at the negotiated rate, subject to the [*prescription drug***Error! Bookmark not defined.** *deductible amount* and the *prescription drug copayment amount* shown in the Data Page].

B. **Non-Member Pharmacies:** For *covered expenses* that are not incurred at a *member pharmacy* and for *covered expenses* incurred at a *member pharmacy* when *your prescription drug card* is not used, charges will be limited to the *predominant reimbursement rate*, subject to the [*prescription drug***Error! Bookmark not defined.** *deductible amount* and the applicable *prescription drug copayment amount* shown in the Data Page]. This may be less than the expense incurred by the *covered person* for the *prescription order*.

NOTICE AND PROOF OF LOSS: In order to obtain payment for *covered expenses* incurred at a non-*member pharmacy*, or at a *member pharmacy* when a *prescription drug card* is not used, notice of claim and proof of loss must be submitted directly to *our* pharmacy benefits manager on forms approved by *our* pharmacy benefits manager and *us*. *Prescription drug* claim forms may be obtained by [accessing *our* website or by calling the telephone number on *your* identification card]. For *covered expenses* incurred at a *member pharmacy* when a *prescription drug card* is used, the *member pharmacy* has agreed to file necessary notice of claim and proof of loss with *our* pharmacy benefits manager.

[NOTIFICATION/PRIOR AUTHORIZATION] REQUIREMENTS: Before certain *prescription drugs* are dispensed to *you,* either *your medical practitioner, your* pharmacist, or *you* are required to [notify/obtain prior authorization from] *us* or *our* designee. The reason for [notifying/obtaining prior authorization] is to determine whether the *prescription drug,* in accordance with *our* approved guidelines:

A. Meets the definition of a *covered expense;* and

B. Is not *experimental or investigational treatment* or an *unproven service.*

[Notification/Prior authorization] may also be required:

A. To determine if the *prescription drug* was prescribed by a *specialist physician;* and

B. For certain programs that may have specific requirements for participation and/or activation of an enhanced level of benefits.

The *prescription drugs* requiring [notification/prior authorization] are subject to periodic review and modification. *You* may access information on available programs and any applicable [notification/prior authorization], participation, or activation requirements through the Internet at [www.goldenrule.com] or by calling the telephone number on *your prescription drug card*.

If [*we* or *our* designee are not notified/prior authorization is not obtained from *us* or *our* designee] before the *prescription drug* is dispensed, *you* may pay more for that *prescription order* or refill. *You* will be required to pay for the *prescription drug* at the pharmacy. *You* can ask *us* to consider reimbursement after *you* receive the *prescription drug.*

TIER ASSIGNMENTS: The [*prescription drug copayment amount* and the *prescription drug***Error! Bookmark not defined.** *deductible amount*] [is/are] determined by the tier to which the *prescription drug* is assigned. [United Healthcare's Prescription Drug List Management Committee (*"PDLMC"*) assigns] each *prescription*

drug to a tier. *You* can determine the tier status for a *prescription drug* by [accessing *your* prescription benefits via *our* website or by calling the telephone number on *your* identification card].

TIER CHANGES: [The *PDLMC*] determines changes in tier placement over time. They consider multiple factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluation of the place in therapy, relative safety or relative efficacy of the *prescription drug,* as well as whether supply limits should apply. Economic factors may include, but are not limited to, the *prescription drug's* acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the *prescription drug*. The tier to which a *prescription drug* is assigned may change periodically. These changes generally occur quarterly. If a *prescription drug's* tier changes, the [*prescription drug copayment amount* and the *prescription drug***Error! Bookmark not defined.** *deductible amount*] may change and *you* may be required to pay more or less for the *prescription drug*.

Some *prescription drugs* are more cost effective for treatment of specific indications as compared to others. Therefore, a *prescription drug* may be listed on multiple tiers, depending on the condition for which the *prescription drug* was prescribed.

SUPPLY LIMITS: *Prescription drugs* are subject to supply limits which may restrict the amount dispensed per *prescription order* or the amount dispensed per month's supply. For the stated *prescription drug copayment amount*, *you* may receive a *prescription drug* in quantities up to the stated supply limit. Supply limits are subject to review and may change periodically. *You* may determine the supply limits applicable to a particular *prescription drug* by [calling the telephone number on *your* identification card].

DESIGNATED PHARMACIES: For certain *prescription drugs*, including, but not limited to, *specialty prescription drugs*, *we* may direct *you* to a *designated pharmacy*. If *you* choose not to obtain *your prescription drug* from the *designated pharmacy* to which *you* are directed, no benefits will be payable for that *prescription drug*.

[**STEP THERAPY:** In order to receive benefits for a *prescription drug* subject to step therapy requirements, *we* may require that *your doctor* prescribe another *prescription drug* proven to be effective for treatment of *your* condition first. *You* may determine whether a particular *prescription drug* or pharmaceutical product is subject to step therapy requirements by calling the telephone number on *your* identification card.]

THERAPEUTIC CLASS/THERAPEUTIC EQUIVALENT MAXIMUM ALLOWABLE CHARGE: *We* may determine a maximum allowable charge for *prescription drugs* in a particular *therapeutic class* or that are *therapeutically equivalent*. If *you* or *your medical practitioner* elect a *prescription drug* included in the same class that is more than the maximum allowable charge assigned, *you* will be responsible for the costs in excess of the maximum allowable charge, in addition to the *prescription drug copayment amount*.

MANUFACTURER'S COUPONS AND INCENTIVES: *We* may send *you* information about various *prescription drugs*. Mailings may include offers from pharmaceutical manufacturers that enable *you*, at *your* discretion, to purchase a particular product at a discount or to obtain it free of charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only *your medical practitioner* may determine whether a change in *your prescription order* is appropriate for *your* medical condition.

EXCLUSIONS AND LIMITATIONS: No benefits will be paid under this rider for expenses:

A. For *prescription drugs* for treatment of impotency or enhancement of sexual performance.

B. For immunization agents, blood, or blood plasma.

C. For medication that is to be taken by the *covered person*, in whole or in part, at the place where it is dispensed.

D. For medication received while the *covered person* is a patient at an institution that has a facility for dispensing pharmaceuticals.

E. For a refill dispensed more than 12 months from the date of a *doctor's* order.

F. Due to a *covered person's* addiction to, or dependency on, tobacco or foods.

G. Incurred for more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.

H. [Incurred for a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is *therapeutically equivalent*.]

I. [Incurred for drugs labeled "Caution - limited by federal law to investigational use," or for investigational or experimental drugs.]

J. [Incurred for a *prescription drug* that contains (an) active ingredient(s) that is/are:

1. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
2. A modified version of and *therapeutically equivalent* to another covered *prescription drug.*

Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.]

K. Incurred for *ancillary charges*.

L. In excess of the maximum allowable charge paid for a *therapeutic class* of/*therapeutically equivalent prescription drugs*.

M. Incurred for *prescription drugs* dispensed in excess of the supply limit assigned.

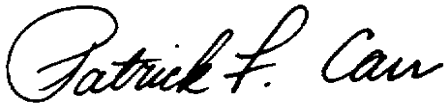
N. Incurred for a new *prescription drug* and/or new dosage form until the date it is reviewed and assigned to a tier by *our PDLMC.*

LIMITATION ON SELECTION OF PHARMACIES: If *we* determine that *you* may be using *prescription drugs* in a harmful or abusive manner, or with harmful frequency, *we* may require *you* to select a *member pharmacy* to provide and coordinate all future prescription services. If *you* do not make a selection within 31 days of the date that *we* notify *you*, *we* will assign *you* a single *member pharmacy*. Benefits will be paid only when *you* use the assigned pharmacy.

NO ASSIGNMENT OF BENEFITS: Benefits payable for drugs dispensed by a non-*member pharmacy*, or by a *member pharmacy* without using a *prescription drug card*, will not be assignable unless *we* are required by the laws of the state where *you* live to recognize all benefit assignments. Otherwise, any assignment or attempted assignment of these benefits will be void.

This rider will not change, waive, or extend any part of the *policy*, other than as stated herein.

American Medical Security Life Insurance Company



President

OUTPATIENT GENERIC PRESCRIPTION DRUG EXPENSE BENEFITS RIDER

This rider is effective [on DATE or at the same time as the *policy*, whichever is later].

By the attachment of this rider, the *policy* is amended as follows:

BENEFITS: *We* will pay for the *covered expenses* described below, subject to the *prescription drug copayment amount,* if applicable[, as shown in the Data Page,] if:

A. The *prescription order* is dispensed by a *member pharmacy;* and

B. A [*prescription drug card*] is used to assign the benefit to the *member pharmacy.*

We will pay for the *covered expenses* described below, limited to the *predominant reimbursement rate,* subject to the *prescription drug copayment amount,* if applicable[, as shown in the Data Page,] if:

A. The *prescription order* is not dispensed by a *member pharmacy;* or

B. A [*prescription drug card*] is not used.

This may be less than the expense incurred by the *covered person* for the *prescription order.*

DEFINITIONS: As used in this rider, the following terms have the meanings set forth below:

A. *"Managed drug limitations"* means limits in coverage based upon time period, amount, or dose of a drug, or other specified predetermined criteria.

B. *"Member pharmacy"* means a licensed pharmacy that has entered into a contract with *our* pharmacy benefits manager to provide *prescription drugs* to *covered persons* at a negotiated rate.

C. *"Predominant reimbursement rate"* means the charges incurred for a *prescription drug* not dispensed at a *member pharmacy* that will be considered *covered expenses* under the *policy*. The *predominant reimbursement rate* for a particular *prescription drug* includes the dispensing fee and sales tax. The *predominant reimbursement rate* will be set at the prescription drug cost that [*our* pharmacy benefits manager] and most *member pharmacies* have agreed to for that *prescription drug*.

D. *"Prescription drug"* means any medicinal substance whose label is required to bear the legend "RX only".

E. [*"Prescription drug card"* means a current, valid, properly used card issued by *us* or *our* pharmacy benefits manager.]

F. *"Prescription drug copayment amount"* means the amount to be deducted from the total *covered expense* incurred for each separate *prescription order*. The *prescription drug deductible amount* must be satisfied before the *prescription drug copayment amount* will be applied.

G. *"Prescription order"* means the request for each separate drug or medication by a *doctor* or each authorized refill of such requests.

COVERED EXPENSES: *Covered expenses* are limited to charges from a licensed pharmacy for outpatient *generic drugs* that:

A. Are a *prescription drug,* including oral or injectable insulin, but not any device for injecting insulin; and

B. Under the applicable state law, may be dispensed only upon the written prescription of a *doctor.*

The appropriate drug choice for a *covered person* is a determination that is best made by the *covered person* and his or her *doctor.*

[NOTIFICATION/PRIOR AUTHORIZATION] REQUIREMENTS: Before certain *prescription drugs* are dispensed to *you,* either *your medical practitioner, your* pharmacist, or *you* are required to [notify/obtain prior authorization from] *us* or *our* designee. The reason for [notifying/obtaining prior authorization] is to determine whether the *prescription drug,* in accordance with *our* approved guidelines:

A. Meets the definition of a *covered expense;* and

B. Is not *experimental or investigational treatment* or an *unproven service.*

[Notification/Prior authorization] may also be required:

A. To determine if the *prescription drug* was prescribed by a *specialist physician;* and

B. For certain programs that may have specific requirements for participation and/or activation of an enhanced level of benefits.

The *prescription drugs* requiring [notification/prior authorization] are subject to periodic review and modification. *You* may access information on available programs and any applicable [notification/prior authorization], participation, or activation requirements through the Internet at [www.goldenrule.com] or by calling the telephone number on *your prescription drug card*.

If [*we* or *our* designee are not notified/prior authorization is not obtained from *us* or *our* designee] before the *prescription drug* is dispensed, *you* may pay more for that *prescription order* or refill. *You* will be required to pay for the *prescription drug* at the pharmacy. *You* can ask *us* to consider reimbursement after *you* receive the *prescription drug*.

EXCLUSIONS AND LIMITATIONS: No benefits will be paid under this rider for expenses incurred:

A. For prescription drugs for treatment of impotency or enhancement of sexual performance.

B. For prescription drugs that do not meet the definition of a *generic drug.*

C. For immunization agents, blood, or blood plasma.

D. For medication that is to be taken by the *covered person*, in whole or in part, at the place where it is dispensed.

E. For medication received while the *covered person* is a patient at an institution that has a facility for dispensing pharmaceuticals.

F. For a refill dispensed more than 12 months from the date of a *doctor's* order.

G. Due to a *covered person's* addiction to, or dependency on, tobacco or foods.

H. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.

I. [For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent.]

J. [For drugs labeled "Caution - limited by federal law to investigational use," or for investigational or experimental drugs.]

K. [Incurred for a *prescription drug* that contains (an) active ingredient(s) that is/are:

   1. Available in and therapeutically equivalent to another covered *prescription drug;* or

   2. A modified version of and therapeutically equivalent to another covered *prescription drug.*

   Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.]

L. For more than a [34]-day supply, when dispensed in any one *prescription order* or refill.

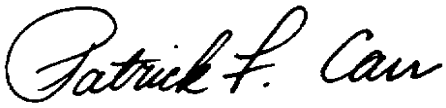
M. [For prescription drugs for any *covered person* who enrolls in Medicare Part D, as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later day.]

NO ASSIGNMENT OF BENEFITS: Benefits payable for drugs dispensed by a non-*member pharmacy*, or by a *member pharmacy* without using a [*prescription drug card*], will not be assignable unless *we* are required by the laws of the state where *you* live to recognize all benefit assignments. Otherwise, any assignment or attempted assignment of these benefits will be void.

NOTICE AND PROOF OF LOSS: In order to obtain payment for *covered expenses* incurred at a non-*member pharmacy*, or at a *member pharmacy* when a [*prescription drug card*] is not used, notice of claim and *proof of loss* must be submitted directly to [*our* pharmacy benefits manager] on forms approved by [*our* pharmacy benefits manager] and *us*. *Prescription drug* claim forms may be obtained by [accessing *our* website or by calling the telephone number on *your* identification card]. For *covered expenses* incurred at a *member pharmacy* when a [*prescription drug card*] is used, the *member pharmacy* has agreed to file necessary notice of claim and *proof of loss* with [*our* pharmacy benefits manager].

This rider will not change, waive, or extend any part of the *policy*, other than as stated herein.

American Medical Security Life Insurance Company



President

PRIOR AUTHORIZATION RIDER

This rider is effective [on DATE or at the same time as the *policy*, whichever is later].

By the attachment of this rider, the *policy* is amended as follows:

A. The Notification and Predetermination section is removed from the *policy.* Any reference in the *policy* to notification requirements is removed from the *policy.*

B. The notification requirements paragraph at the bottom of the *policy's* face page is deleted and replaced with the following:

As a cost containment feature, this policy contains prior authorization requirements. Benefits may be reduced if the requirements are not met. Please refer to the Data Page and the Prior Authorization Rider.

C. The following section is added to the *policy:*

SECTION 9 - PRIOR AUTHORIZATION

PRIOR AUTHORIZATION REQUIRED: Some *covered expenses* require prior authorization. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to a *covered person.* However, there are some *network eligible expenses* for which *you* must obtain the prior authorization.

In general, for services or supplies that require prior authorization, as shown on the Data Page, *you* must obtain authorization from *us* before the *covered person:*

1. Receives a service or supply from a non-*network provider;*
2. Is admitted into a *network* facility by a non-*network provider;* or
3. Receives a service or supply from a *network provider* to which the *covered person* was referred by a non-*network provider.*

HOW TO OBTAIN PRIOR AUTHORIZATION: To obtain prior authorization or to confirm that a *network provider* has obtained prior authorization, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *covered person.*

FAILURE TO OBTAIN PRIOR AUTHORIZATION: Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *policy* Data Page for specific details.

Network providers cannot bill *you* for services for which they fail to obtain prior authorization as required.

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

PRIOR AUTHORIZATION DOES NOT GUARANTEE BENEFITS: *Our* authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *policy.*

REQUESTS FOR PREDETERMINATIONS: *You* may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

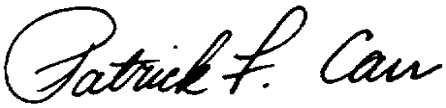
1. The predetermination was based on incomplete or inaccurate information initially received by *us.*
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.

We will make all benefit determinations after a *loss* in good faith. All benefit determinations are subject to *our* receipt of proper *proof of loss.*

Any provision in the *policy* that conflicts with this rider is changed to conform to this rider, but only to the extent of the conflict.

This rider will not change, waive, or extend any part of the *policy*, other than as stated herein.

American Medical Security Life Insurance Company



President

COPAYMENT AMOUNT RIDER

This rider is effective [at the same time as the *policy* to which it is attached, unless a later date is shown below].

By attachment of this rider the [Medical Benefits section of the *policy*] is amended by the addition of the following:

A. [**Doctor Office Visits:** *Covered expenses* for outpatient *doctor* office visits will be payable as follows:

1. **At network providers:** After satisfaction of the *deductible amount, covered expenses* for services that are provided by a *network provider* will be subject to the *copayment amount* (as shown in the Data Page) before the benefits are payable under the *policy*.

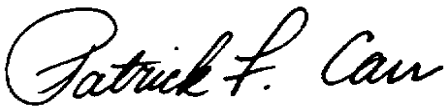
2. **At non-network providers:** *Covered expenses* for services that are provided by a non-*network provider* will be reduced by 25%. The remaining *covered expenses* will then be subject to the non-*network provider deductible amount* and the applicable *coinsurance percentage* (as shown on the Data Page).]

[If *you* move to an area where *we* are not offering access to a *network*, the *covered expenses* for outpatient *doctor* visits will be subject to any applicable *deductible amount* and *coinsurance percentage* (as shown on the Data Page).]

Except as otherwise specified above, *covered expenses* under this rider are subject to all the terms, conditions, exclusions and limits of the *policy*, other than as set forth above.

This rider does not change, waive or extend any part of the *policy*, other than as set forth above.

American Medical Security Life Insurance Company



President

COPAYMENT AMOUNT RIDER

This rider is effective [at the same time as the *policy* to which it is attached, unless a later date is shown below].

By attachment of this rider the [Medical Benefits section of the *policy*] is amended by the addition of the following:

A. [**Doctor Office Visits:** *Covered expenses* for outpatient *doctor* office visits will be payable as follows:

1. **At network providers:** After satisfaction of the *deductible amount,* the first four visits per calendar year for each *covered person* will be subject to the *copayment amount* (as shown in the Data Page) before the benefits are payable under the *policy*. Subsequent visits for the same *covered person* during the same calendar year will be subject to the applicable *coinsurance percentage.*

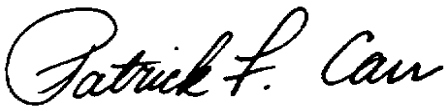
2. **At non-network providers:** *Covered expenses* for visits at a non-*network provider* will be reduced by 25%. The remaining *covered expenses* will then be subject to the non-*network provider deductible amount* and the applicable *coinsurance percentage* (as shown on the Data Page).]

[If *you* move to an area where *we* are not offering access to a *network*, the *covered expenses* for outpatient *doctor* visits will be subject to any applicable *deductible amount* and *coinsurance percentage* (as shown on the Data Page).]

Except as otherwise specified above, *covered expenses* under this rider are subject to all the terms, conditions, exclusions and limits of the *policy*, other than as set forth above.

This rider does not change, waive or extend any part of the *policy*, other than as set forth above.

American Medical Security Life Insurance Company



President

OUTPATIENT PRESCRIPTION DRUG EXPENSE BENEFITS RIDER

This rider is effective [on DATE or at the same time as the *policy*, whichever is later].

By the attachment of this rider, *covered expenses* specified in the *policy* for covered services for outpatient *prescription drug* expenses are deleted and replaced with the following:

DEFINITIONS: As used in this rider, the following terms have the meanings set forth below:

A. *"Ancillary charge"* means the additional charge incurred by the *covered person* when two drugs are *chemically equivalent* and the higher-tiered drug of the two is dispensed. In addition to the *prescription drug copayment amount* that applies to the lower-tiered drug, the *covered person* is responsible for an ancillary charge of the difference between the cost of the lower-tiered drug and the higher-tiered drug dispensed. The *ancillary charge* does not apply to the *deductible amount*.

B. *"Brand-name drug"* means a *prescription drug* that:

   1. Is manufactured and marketed under a trademark or name by a specific drug manufacturer; or

   2. *We* identify as a brand-name product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. A drug identified as a "brand-name" by the manufacturer, pharmacy, or *your* physician may not be classified as a brand-name drug by *us*.

C. *"Chemically equivalent"* means that *prescription drugs* contain the same active ingredient.

D. *"Designated pharmacy"* means a pharmacy that has entered into an agreement with *us* or with *our* pharmacy benefits manager to provide specific *prescription drugs*, including, but not limited to, *specialty prescription drugs*. The fact that a pharmacy is a *member pharmacy* does not mean that it is a *designated pharmacy*.

E. *"Generic drug"* means a *prescription drug* that:

   1. Is *chemically equivalent* to a *brand-name drug;* or

   2. *We* identify as a generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. A drug identified as a "generic" by the manufacturer, pharmacy, or *your* physician may not be classified as a generic drug by *us*.

F. *"Managed drug limitations"* means limits in coverage based upon time period, amount, or dose of a drug, or other specified predetermined criteria.

G. *"Member pharmacy"* means a licensed pharmacy that has entered into a contract with *our* pharmacy benefits manager to provide *prescription drugs* to *covered persons* at a negotiated rate.

H. *"Predominant reimbursement rate"* means the charges incurred for a *prescription drug* not dispensed at a *member pharmacy* that will be considered *covered expenses* under the *policy*. The *predominant reimbursement rate* for a particular *prescription drug* includes the dispensing fee and sales tax. The *predominant reimbursement rate* will be set at the *prescription drug* cost that *our* pharmacy benefits manager and most *member pharmacies* have agreed to for that *prescription drug*.

I. *"Prescription drug"* means any medicinal substance whose label is required to bear the legend "RX only".

J. *"Prescription drug card"* means a [current, valid card, issued by *us* or *our* pharmacy benefits manager, that is properly used].

K. *"Prescription drug copayment amount"* means the amount to be deducted from the total *covered expense* incurred for each separate *prescription order*. The *deductible amount* must be satisfied before the *prescription drug copayment amount* will be applied.

L. *"Prescription order"* means the request for each separate drug or medication by a *doctor* or each authorized refill of such requests.

M. *"Specialty prescription drug"* means *prescription drugs* that are generally high cost, self-injectable biotechnology drugs used to treat patients with certain *illnesses*. *You* may access a complete list of

specialty prescription drugs by [accessing *your prescription drug* benefits via *our* website or by calling the telephone number on *your* identification card].

N. *"Therapeutic class"* means a group or category of *prescription drugs* with similar uses and/or actions.

O. *"Therapeutically equivalent"* means that two or more *prescription drugs* can be expected to produce essentially the same therapeutic outcome and toxicity.

COVERED EXPENSES: *Covered expenses* for outpatient *prescription drugs* are limited to charges from a licensed pharmacy for drugs that, under the applicable state law, may be dispensed only upon the written prescription of a *doctor*.

A. **Member Pharmacies:** For *covered expenses* incurred at a *member pharmacy* when a *prescription drug card* is used, *we* will pay the charges at the negotiated rate, subject to the [*deductible amount* and the *prescription drug copayment amount* shown in the Data Page].

B. **Non-Member Pharmacies:** For *covered expenses* that are not incurred at a *member pharmacy* and for *covered expenses* incurred at a *member pharmacy* when *your prescription drug card* is not used, charges will be limited to the *predominant reimbursement rate*, subject to the [*deductible amount* and the applicable *prescription drug copayment amount* shown in the Data Page]. This may be less than the expense incurred by the *covered person* for the *prescription order*.

NOTICE AND PROOF OF LOSS: In order to obtain payment for *covered expenses* incurred at a non-*member pharmacy*, or at a *member pharmacy* when a *prescription drug card* is not used, notice of claim and proof of loss must be submitted directly to *our* pharmacy benefits manager on forms approved by *our* pharmacy benefits manager and *us*. *Prescription drug* claim forms may be obtained by [accessing *our* website or by calling the telephone number on *your* identification card]. For *covered expenses* incurred at a *member pharmacy* when a *prescription drug card* is used, the *member pharmacy* has agreed to file necessary notice of claim and proof of loss with *our* pharmacy benefits manager.

[NOTIFICATION/PRIOR AUTHORIZATION] REQUIREMENTS: Before certain *prescription drugs* are dispensed to *you,* either *your medical practitioner, your* pharmacist, or *you* are required to [notify/obtain prior authorization from] *us* or *our* designee. The reason for [notifying/obtaining prior authorization] is to determine whether the *prescription drug,* in accordance with *our* approved guidelines:

A. Meets the definition of a *covered expense;* and

B. Is not *experimental or investigational treatment* or an *unproven service.*

[Notification/Prior authorization] may also be required:

A. To determine if the *prescription drug* was prescribed by a *specialist physician;* and

B. For certain programs that may have specific requirements for participation and/or activation of an enhanced level of benefits.

The *prescription drugs* requiring [notification/prior authorization] are subject to periodic review and modification. *You* may access information on available programs and any applicable [notification/prior authorization], participation, or activation requirements through the Internet at [www.goldenrule.com] or by calling the telephone number on *your prescription drug card*.

If [*we* or *our* designee are not notified/prior authorization is not obtained from *us* or *our* designee] before the *prescription drug* is dispensed, *you* may pay more for that *prescription order* or refill. *You* will be required to pay for the *prescription drug* at the pharmacy. *You* can ask *us* to consider reimbursement after *you* receive the *prescription drug.*

TIER ASSIGNMENTS: The [*prescription drug copayment amount* and the *deductible amount*] [is/are] determined by the tier to which the *prescription drug* is assigned. [United Healthcare's Prescription Drug List Management Committee (*"PDLMC"*) assigns] each *prescription drug* to a tier. *You* can determine the tier status for a *prescription drug* by [accessing *your* prescription benefits via *our* website or by calling the telephone number on *your* identification card].

TIER CHANGES: [The *PDLMC*] determines changes in tier placement over time. They consider multiple factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluation of the place in therapy, relative safety or relative efficacy of the *prescription drug,* as well as whether supply limits should apply. Economic factors may include, but are not limited to, the *prescription drug's* acquisition cost including, but not limited to, available rebates and assessments on the cost

effectiveness of the *prescription drug*. The tier to which a *prescription drug* is assigned may change periodically. These changes generally occur quarterly. If a *prescription drug's* tier changes, the [*prescription drug copayment amount* and the *deductible amount*] may change and *you* may be required to pay more or less for the *prescription drug*.

Some *prescription drugs* are more cost effective for treatment of specific indications as compared to others. Therefore, a *prescription drug* may be listed on multiple tiers, depending on the condition for which the *prescription drug* was prescribed.

SUPPLY LIMITS: *Prescription drugs* are subject to supply limits which may restrict the amount dispensed per *prescription order* or the amount dispensed per month's supply. For the stated *prescription drug copayment amount*, *you* may receive a *prescription drug* in quantities up to the stated supply limit. Supply limits are subject to review and may change periodically. *You* may determine the supply limits applicable to a particular *prescription drug* by [calling the telephone number on *your* identification card].

DESIGNATED PHARMACIES: For certain *prescription drugs*, including, but not limited to, *specialty prescription drugs*, *we* may direct *you* to a *designated pharmacy*. If *you* choose not to obtain *your prescription drug* from the *designated pharmacy* to which *you* are directed, no benefits will be payable for that *prescription drug*.

[**STEP THERAPY:** In order to receive benefits for a *prescription drug* subject to step therapy requirements, *we* may require that *your doctor* prescribe another *prescription drug* proven to be effective for treatment of *your* condition first. *You* may determine whether a particular *prescription drug* or pharmaceutical product is subject to step therapy requirements by calling the telephone number on *your* identification card.]

THERAPEUTIC CLASS/THERAPEUTIC EQUIVALENT MAXIMUM ALLOWABLE CHARGE: *We* may determine a maximum allowable charge for *prescription drugs* in a particular *therapeutic class* or that are *therapeutically equivalent*. If *you* or *your medical practitioner* elect a *prescription drug* included in the same class that is more than the maximum allowable charge assigned, *you* will be responsible for the costs in excess of the maximum allowable charge, in addition to the *prescription drug copayment amount*.

MANUFACTURER'S COUPONS AND INCENTIVES: *We* may send *you* information about various *prescription drugs*. Mailings may include offers from pharmaceutical manufacturers that enable *you*, at *your* discretion, to purchase a particular product at a discount or to obtain it free of charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only *your medical practitioner* may determine whether a change in *your prescription order* is appropriate for *your* medical condition.

EXCLUSIONS AND LIMITATIONS: No benefits will be paid under this rider for expenses:

A. For *prescription drugs* for treatment of impotency or enhancement of sexual performance.

B. For immunization agents, blood, or blood plasma.

C. For medication that is to be taken by the *covered person*, in whole or in part, at the place where it is dispensed.

D. For medication received while the *covered person* is a patient at an institution that has a facility for dispensing pharmaceuticals.

E. For a refill dispensed more than 12 months from the date of a *doctor's* order.

F. Due to a *covered person's* addiction to, or dependency on, tobacco or foods.

G. Incurred for more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.

H. [Incurred for a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is *therapeutically equivalent*.]

I. [Incurred for drugs labeled "Caution - limited by federal law to investigational use," or for investigational or experimental drugs.]

J. [Incurred for a *prescription drug* that contains (an) active ingredient(s) that is/are:

   1. Available in and *therapeutically equivalent* to another covered *prescription drug;* or

   2. A modified version of and *therapeutically equivalent* to another covered *prescription drug.*

Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.]

K. Incurred for *ancillary charges*.

L. In excess of the maximum allowable charge paid for a *therapeutic class* of/*therapeutically equivalent prescription drugs*.

M. Incurred for *prescription drugs* dispensed in excess of the supply limit assigned.

N. Incurred for a new *prescription drug* and/or new dosage form until the date it is reviewed and assigned to a tier by *our PDLMC.*

LIMITATION ON SELECTION OF PHARMACIES: If *we* determine that *you* may be using *prescription drugs* in a harmful or abusive manner, or with harmful frequency, *we* may require *you* to select a *member pharmacy* to provide and coordinate all future prescription services. If *you* do not make a selection within 31 days of the date that *we* notify *you*, *we* will assign *you* a single *member pharmacy*. Benefits will be paid only when *you* use the assigned pharmacy.

NO ASSIGNMENT OF BENEFITS: Benefits payable for drugs dispensed by a non-*member pharmacy*, or by a *member pharmacy* without using a *prescription drug card*, will not be assignable unless *we* are required by the laws of the state where *you* live to recognize all benefit assignments. Otherwise, any assignment or attempted assignment of these benefits will be void.

This rider will not change, waive, or extend any part of the *policy*, other than as stated herein.

American Medical Security Life Insurance Company

President

OUTPATIENT GENERIC PRESCRIPTION DRUG EXPENSE BENEFITS RIDER

This rider is effective [on DATE or at the same time as the *policy*, whichever is later].

By the attachment of this rider, the *policy* is amended as follows:

BENEFITS: *We* will pay for the *covered expenses* described below, subject to the *prescription drug copayment amount,* if applicable[, as shown in the Data Page,] if:

A. The *prescription order* is dispensed by a *member pharmacy;* and

B. A [*prescription drug card*] is used to assign the benefit to the *member pharmacy.*

We will pay for the *covered expenses* described below, limited to the *predominant reimbursement rate,* subject to the *prescription drug copayment amount,* if applicable[, as shown in the Data Page,] if:

A. The *prescription order* is not dispensed by a *member pharmacy;* or

B. A [*prescription drug card*] is not used.

This may be less than the expense incurred by the *covered person* for the *prescription order.*

DEFINITIONS: As used in this rider, the following terms have the meanings set forth below:

A. *"Managed drug limitations"* means limits in coverage based upon time period, amount, or dose of a drug, or other specified predetermined criteria.

B. *"Member pharmacy"* means a licensed pharmacy that has entered into a contract with *our* pharmacy benefits manager to provide *prescription drugs* to *covered persons* at a negotiated rate.

C. *"Predominant reimbursement rate"* means the charges incurred for a *prescription drug* not dispensed at a *member pharmacy* that will be considered *covered expenses* under the *policy*. The *predominant reimbursement rate* for a particular *prescription drug* includes the dispensing fee and sales tax. The *predominant reimbursement rate* will be set at the prescription drug cost that [*our* pharmacy benefits manager] and most *member pharmacies* have agreed to for that *prescription drug*.

D. *"Prescription drug"* means any medicinal substance whose label is required to bear the legend "RX only".

E. [*"Prescription drug card"* means a current, valid, properly used card issued by *us* or *our* pharmacy benefits manager.]

F. *"Prescription drug copayment amount"* means the amount to be deducted from the total *covered expense* incurred for each separate *prescription order*. [The *deductible amount* must be satisfied before the *prescription drug copayment amount* will be applied.]

G. *"Prescription order"* means the request for each separate drug or medication by a *doctor* or each authorized refill of such requests.

COVERED EXPENSES: *Covered expenses* are limited to charges from a licensed pharmacy for outpatient *generic drugs* that:

A. Are a *prescription drug,* including oral or injectable insulin, but not any device for injecting insulin; and

B. Under the applicable state law, may be dispensed only upon the written prescription of a *doctor.*

The appropriate drug choice for a *covered person* is a determination that is best made by the *covered person* and his or her *doctor.*

[NOTIFICATION/PRIOR AUTHORIZATION] REQUIREMENTS: Before certain *prescription drugs* are dispensed to *you,* either *your medical practitioner, your* pharmacist, or *you* are required to [notify/obtain prior authorization from] *us* or *our* designee. The reason for [notifying/obtaining prior authorization] is to determine whether the *prescription drug,* in accordance with *our* approved guidelines:

A. Meets the definition of a *covered expense;* and

B. Is not *experimental or investigational treatment* or an *unproven service.*

[Notification/Prior authorization] may also be required:

A. To determine if the *prescription drug* was prescribed by a *specialist physician;* and

B. For certain programs that may have specific requirements for participation and/or activation of an enhanced level of benefits.

The *prescription drugs* requiring [notification/prior authorization] are subject to periodic review and modification. *You* may access information on available programs and any applicable [notification/prior authorization], participation, or activation requirements through the Internet at [www.goldenrule.com] or by calling the telephone number on *your prescription drug card*.

If [*we* or *our* designee are not notified/prior authorization is not obtained from *us* or *our* designee] before the *prescription drug* is dispensed, *you* may pay more for that *prescription order* or refill. *You* will be required to pay for the *prescription drug* at the pharmacy. *You* can ask *us* to consider reimbursement after *you* receive the *prescription drug*.

EXCLUSIONS AND LIMITATIONS: No benefits will be paid under this rider for expenses incurred:

A. For prescription drugs for treatment of impotency or enhancement of sexual performance.

B. For prescription drugs that do not meet the definition of a *generic drug.*

C. For immunization agents, blood, or blood plasma.

D. For medication that is to be taken by the *covered person*, in whole or in part, at the place where it is dispensed.

E. For medication received while the *covered person* is a patient at an institution that has a facility for dispensing pharmaceuticals.

F. For a refill dispensed more than 12 months from the date of a *doctor's* order.

G. Due to a *covered person's* addiction to, or dependency on, tobacco or foods.

H. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.

I. [For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent.]

J. [For drugs labeled "Caution - limited by federal law to investigational use," or for investigational or experimental drugs.]

K. [Incurred for a *prescription drug* that contains (an) active ingredient(s) that is/are:

1. Available in and therapeutically equivalent to another covered *prescription drug;* or

2. A modified version of and therapeutically equivalent to another covered *prescription drug.*

Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.]

L. For more than a [34]-day supply, when dispensed in any one *prescription order* or refill.

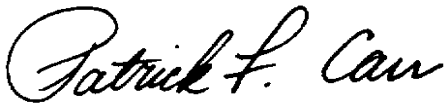
M. [For prescription drugs for any *covered person* who enrolls in Medicare Part D, as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later day.]

NO ASSIGNMENT OF BENEFITS: Benefits payable for drugs dispensed by a non-*member pharmacy*, or by a *member pharmacy* without using a [*prescription drug card*], will not be assignable unless *we* are required by the laws of the state where *you* live to recognize all benefit assignments. Otherwise, any assignment or attempted assignment of these benefits will be void.

NOTICE AND PROOF OF LOSS: In order to obtain payment for *covered expenses* incurred at a non-*member pharmacy*, or at a *member pharmacy* when a [*prescription drug card*] is not used, notice of claim and *proof of loss* must be submitted directly to [*our* pharmacy benefits manager] on forms approved by [*our* pharmacy benefits manager] and *us*. *Prescription drug* claim forms may be obtained by [accessing *our* website or by calling the telephone number on *your* identification card]. For *covered expenses* incurred at a *member pharmacy* when a [*prescription drug card*] is used, the *member pharmacy* has agreed to file necessary notice of claim and *proof of loss* with [*our* pharmacy benefits manager].

This rider will not change, waive, or extend any part of the *policy*, other than as stated herein.

American Medical Security Life Insurance Company



President

[OPTIONAL] MENTAL DISORDER BENEFITS RIDER

This rider is effective [on DATE or at the same time as the *policy*, whichever is later].

By the attachment of this rider, the *policy* is amended to the extent of any conflict with the following:

Covered expenses are amended to include the charges incurred for the diagnosis and treatment of *mental disorders,* including *substance abuse,* to the same extent as any other *illness* under the *policy.* Unless specifically stated otherwise, benefits for *mental disorders* and *substance abuse* are subject to the terms and conditions of the *policy,* including any applicable [*deductible amounts,* coinsurance provisions, *copayment amounts,* and notification/prior authorization requirements].

This rider will not change, waive, or extend any part of the *policy*, other than as stated herein.

American Medical Security Life Insurance Company

President

[OPTIONAL] BIOLOGICALLY-BASED MENTAL ILLNESS BENEFITS RIDER

This rider is effective [on DATE or at the same time as the *policy*, whichever is later].

By the attachment of this rider, the *policy* is amended to the extent of any conflict with the following:

> *Covered expenses* are amended to include the charges incurred for the diagnosis and treatment of *biologically-based mental illnesses* and *substance abuse* to the same extent as any other *illness* under the *policy.* Unless specifically stated otherwise, benefits for *biologically-based mental illnesses* and *substance abuse* are subject to the terms and conditions of the *policy,* including any applicable [*deductible amounts,* coinsurance provisions, *copayment amounts,* and notification/prior authorization requirements].

As used in this rider, *"biologically-based mental illnesses"* means bipolar disorder, major depressive disorder, obsessive compulsive disorder, panic disorder, schizophrenia, and schizo-affective disorder. *Biologically-based mental illness* does not include alcoholism, *substance abuse,* or any other *mental disorder* not listed in this definition.

This rider will not change, waive, or extend any part of the *policy*, other than as stated herein.

American Medical Security Life Insurance Company

President

ARKANSAS OPTIONAL HEARING AIDS RIDER

This rider is effective [on DATE or at the same time as the *policy*, whichever is later].

By the attachment of this rider, *covered expenses* are amended to include the charges incurred by a *covered person* for *hearing aids* purchased from a professional licensed by the state of Arkansas to dispense a hearing aid or hearing instrument, limited to a maximum of $1,400 per ear in a 3-year period. *Covered expenses* for hearing aids are exempt from any *deductible amount*, copayment amount, or *coinsurance percentage*.

As used in this rider, *"hearing aid"* means an instrument or device, including repair and replacement parts, that is:

A. Designed and offered for the purpose of aiding persons with, or compensating for, impaired hearing;

B. Worn in or on the body; and

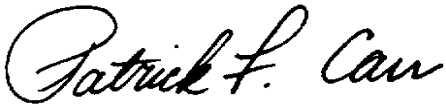
C. Generally not useful to a person in the absence of a hearing impairment.

Any limitation or exclusion in the *policy* that conflicts with this rider is amended to conform to this rider only to the extent of the conflict.

Except as otherwise stated in this rider, *covered expenses* under this rider are subject to all the terms, conditions, exclusions, and limitations of the *policy,* including any [applicable {notification/prior authorization} requirements].

This rider will not change, waive, or extend any part of the *policy*, other than as stated herein.

American Medical Security Life Insurance Company



President

ARKANSAS OPTIONAL MUSCULOSKELETAL DISORDERS RIDER

This rider is effective [on DATE or at the same time as the *policy*, whichever is later].

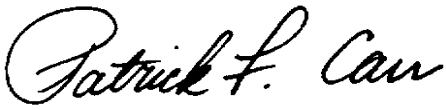
By the attachment of this rider, *covered expenses* are amended to include the charges incurred by a *covered person* for surgical and nonsurgical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder.

Any limitation or exclusion in the *policy* that conflicts with this rider is amended to conform to this rider only to the extent of the conflict.

Covered expenses under this rider are subject to all the terms, conditions, exclusions, and limitations of the *policy,* including any [applicable *deductible amounts,* coinsurance provisions, {notification/prior authorization} requirements, or maximum dollar limits].

This rider will not change, waive, or extend any part of the *policy*, other than as stated herein.

American Medical Security Life Insurance Company



President

AMERICAN MEDICAL SECURITY LIFE INSURANCE COMPANY
APPLICATION FOR INSURANCE

[MUST BE COMPLETED BY THE APPLICANT(S)] **[PLEASE PRINT IN BLACK INK]**

A. APPLICANT(S) INFORMATION

[1. **REASON FOR APPLICATION:** ❍ New Application ❍ Add a dependent ❍ Reinstatement ❍ Change deductible ID Number _____
(for additions, reinstatements, or deductible changes)]

[2.] **PRIMARY APPLICANT'S INFORMATION:**

a. Name (Last, First, M.I.): _____

b. Mailing Address _____
Street (Include Apt.)
_____ _____ _____
City State ZIP

c. **A physical address is required if different than your mailing address. P.O. Boxes are not accepted as a physical address.**

Physical Address _____
Street (Include Apt.)
_____ _____ _____
City State ZIP

d. Phone Numbers: ( ) ( ) _____
Home Other Best number and time to call [Email Address]

e. Payor (If not You): Name [Email Address] _____
_____
Street City State ZIP

f. Your Beneficiary: _____ You will be the beneficiary for your spouse.
Name Relationship Age

[g. Marital Status: ❍ Married ❍ Single]

[3.] **APPLICANTS FOR COVERAGE:** Please list only those persons needing coverage.

Gender	Name (Last, First, M.I.)	Social Security No.	Birth Date	Age	MUST BE ACCURATE Height	Weight
❍ Male ❍ Female	a. Primary (You)					
❍ Male ❍ Female	b. Spouse					
❍ Male ❍ Female	c. Child					
❍ Male ❍ Female	d. Child					
❍ Male ❍ Female	e. Child					
❍ Male ❍ Female	f. Child					
❍ Male ❍ Female	g. Child					

If you need to list additional dependents, please use lined paper, sign and date it, and check here. ❍

[4.] Do all applicants, other than dependent children, read, write, speak, and understand the English language? ..... ❍ Yes ❍ No

B. COVERAGE INFORMATION — Must complete for all new applications.

5. Requested Effective Date: __ __/__ __ / __ __ __ __

6. All plans include a preferred network. Network Name:_____

7. Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? (If yes, indicate who below.) ..... ❍ Yes ❍ No

a. Primary	b. Spouse	c. Child	d. Child	e. Child	f. Child	g. Child
❍ Yes	❍ Yes	❍ Yes	❍ Yes	❍ Yes	❍ Yes	❍ Yes

C. PRODUCT SELECTION & BILLING (or attach a health insurance quote)
For additions and reinstatements, complete only if changing the deductible for all insureds.

❍ Plan A
❍ Deductible 1 ❍ Deductible 2 ❍ Deductible 3
❍ Deductible 4 ❍ Deductible 5 ❍ Deductible 6
Coinsurance Choices
❍ xx% ❍ xx% ❍ xx%
❍ Plan B
❍ Plan C
❍ Deductible 1 ❍ Deductible 2 ❍ Deductible 3
❍ Deductible 4 ❍ Deductible 5 ❍ Deductible 6
❍ Plan D
❍ Plan E
❍ Deductible 1 ❍ Deductible 2 ❍ Deductible 3
❍ Deductible 4 ❍ Deductible 5 ❍ Deductible 6

Base Premium Amount $ _____

OPTIONAL BENEFITS — See current brochure and inserts for availability

❍ Benefit 1 + $_____ Optional
❍ Benefit 2
❍ Benefit 3
❍ Benefit 4
❍ Benefit 5
❍ Treatment of Temporomandibular Joint Disorder and Craniomandibular Disorder
(Note: Rejection of this optional benefit means the policy will not include coverage of these disorders.)

Total Monthly Payment = $_____

Initial Monthly Payment (Payable to ["American Medical Security"]) = $ _____

If Quarterly, Total Monthly Payment x 3 = $_____

Initial Quarterly Payment (Payable to ["American Medical Security"]) = $ _____

8. **Initial Payment With Application:** ❍ Check ❍ EFT ❍ Credit Card
Ongoing Payments: Monthly ❍ EFT (no billing fee) ❍ Direct Bill ($10 monthly billing fee)
Quarterly ❍ Direct Bill ($10 quarterly billing fee)

Premium will be verified and may be adjusted up or down during the processing of your application.
Electronic Funds Transfer (EFT) and Credit Card payments will only be collected upon approval of your application.
Checks are deposited upon receipt.

D. PREVIOUS OR CURRENT HEALTH INSURANCE COVERAGE [(Completing this section may make you eligible for an earlier effective date for illnesses.)]

Yes No

[9.] Within the last [63] days, has any applicant **been covered by** any type of **medical** insurance? ..... ❍ ❍
If yes, complete chart below. Your signature on this application indicates your agreement to terminate any existing coverage listed below as being replaced.

Applicant's Name	Company Name	Policy/Certificate Number	Type (Individual, Employer Group, Short Term, COBRA, Medicaid, Other)	Is this to be replaced?	Termination Date

D. PREVIOUS OR CURRENT HEALTH INSURANCE COVERAGE — Continued
[(Completing this section may make you eligible for an earlier effective date for illnesses.)]

	Yes	No
[10. Will the term life benefit replace any existing **life** insurance?	❍	❍

Company Name_____ Policy Number _____]

[11.] Has any applicant ever had an application or policy voided, declined, rated, or had coverage modified (including medical exclusion riders) by any health or life insurer? (If yes, list name and give details.)	❍	❍

Person: Company: Action Taken:

Date: Reason for Action:

E. MEDICAL HISTORY — FOR ALL APPLICANTS

IMPORTANT! YOU MUST PROVIDE DETAILS OF EACH YES ANSWER IN "MEDICAL HISTORY DETAILS."

	Yes	No
[12.] Are you, or is any family member (whether or not named in this application), pregnant or an expectant mother or father, or in the process of surrogate pregnancy, or do you or any family member have an adoption pending?	❍	❍
[13.] Has any applicant had or been advised to have: (a) any testing (other than routine testing, such as pap or mammogram); or (b) any treatment that has not yet been completed?	❍	❍
[14.] In the last 6 months, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind?	❍	❍
[15.] In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more?	❍	❍
[16.] In the last 5 years, has any applicant:		
a. Filed a claim and/or received benefits from disability insurance or Worker's Compensation?	❍	❍
b. Used an illegal drug; had any diagnosis or treatment of an alcohol or drug dependency, problem, or abuse; been advised to reduce alcohol intake; or had any alcohol- or drug-related moving violation, arrest, or driver's license suspension?	❍	❍
c. Been a user of alcoholic beverages in excess of 14 drinks* per week? (*One drink equals 12 oz. of beer, 4 oz. of wine, or 1 oz. of hard liquor.) If yes, show who and how many drinks* per week in "Medical History Details"	❍	❍
[17.] In the last 10 years, has any applicant:		
a. Consulted a health care provider for any condition or symptom(s) for which a diagnosis has not been established?	❍	❍
b. Had any, signs, symptoms, diagnosis, or treatment of Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness, or tested positive for antibodies to the HIV virus?	❍	❍
c. Had any abnormal physical exam, X-ray, EKG, MRI, CT scan, or any adverse or abnormal laboratory or other test results?	❍	❍
d. Been confined in a hospital?	❍	❍
e. Had surgery?	❍	❍
f. Had placement, treatment, or maintenance of an internal or external implant or prosthetic device?	❍	❍
[18.] **In the last 10 years, has any applicant had testing or additional tests recommended for, or had any, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of, any of the following:**	Yes	No
a. **Digestive System** (gallbladder; pancreas; liver; ulcers; rectal bleeding; or other disorder or condition)?	❍	❍
b. **Urinary System** (kidney; or other disorder or condition)?	❍	❍
c. **Eyes, Ears, Nose** (ear or sinus infections {more than two in the past 12 months}; or other disorder or condition)?	❍	❍
d. **Mouth, Throat, or Jaw**?	❍	❍
e. **Skin Disorders**?	❍	❍
f. **Heart or Circulatory System** (chest pain; high or low blood pressure; elevated cholesterol; stroke; shunts, stents, or pacemaker; or other disorder or condition)?	❍	❍
g. **Male or Female Reproductive System** (infertility or erectile dysfunction; sexually transmitted disease; abnormal mammogram or Pap smear; or other disorder or condition)?	❍	❍
h. **Blood, Gland, Endocrine, or Metabolic** (thyroid, breast, or other glands; diabetes or sugar in the blood or urine; anemia; immune system disorder, other than AIDS or HIV; or other disorder or condition)?	❍	❍
i. **Brain and Nervous System** (migraines or chronic or severe headache; seizures or epilepsy; mental, emotional, or behavioral disorder, including anorexia or bulimia; multiple sclerosis or paralysis; or other disorder or condition)?	❍	❍
j. **Muscular or Skeletal System** (joints, bones, spine, or back; arthritis or fibromyalgia; amputation; or other disorder or condition)?	❍	❍
k. **Respiratory System** (asthma or allergies; sleep apnea; or other disorder or condition)?	❍	❍
l. **Cancer, Cyst, or Tumor** (or polyp, lump, or growth of any kind)?	❍	❍
m. **Birth Defects or Congenital Abnormalities** (Down's syndrome; cerebral palsy; or other birth defect or congenital anomaly?	❍	❍

E. MEDICAL HISTORY — Continued

[19.] In the last 5 years, has any applicant had any signs, symptoms, diagnosis, or treatment for any other disease, disorder, injury, or condition (excluding childbirth) that is not listed on this application? ❍ ❍

[20.] **List in "Medical History Details" any additional doctors or other health care professionals that any applicant has consulted with or been treated by in the last 5 years, and give full details.**

F. MEDICAL HISTORY DETAILS — FOR ALL APPLICANTS

Question Number: _____ Person: _____ Dates: _____

Symptoms or Conditions: _____

Prescriptions (include dose, how often taken, dates taken): _____

Treatment, Advice Given, Results, and Other Details: _____

Name, Address, Phone of Doctors, Hospitals, etc.: _____

Question Number: _____ Person: _____ Dates: _____

Symptoms or Conditions: _____

Prescriptions (include dose, how often taken, dates taken): _____

Treatment, Advice Given, Results, and Other Details: _____

Name, Address, Phone of Doctors, Hospitals, etc.: _____

Question Number: _____ Person: _____ Dates: _____

Symptoms or Conditions: _____

Prescriptions (include dose, how often taken, dates taken): _____

Treatment, Advice Given, Results, and Other Details: _____

Name, Address, Phone of Doctors, Hospitals, etc.: _____

If you need more space to provide complete and accurate information, please use lined paper, sign and date it, and check here. ❍

G. SPECIAL INSTRUCTIONS

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

H. STATEMENT OF UNDERSTANDING — Review the completed application and read the section below carefully before signing.

I personally completed this application. I represent that the answers and statements on it are true, complete, and correctly recorded. **I understand and agree that:**

(1) This application and the initial payment do not give me immediate coverage.

(2) I should not terminate existing coverage until I have accepted the American Medical Security coverage.

[(3) With regard to medical coverage, unless American Medical Security agrees to an earlier date, coverage for illness begins on the 15th day after a person becomes insured for injury.]

(4) **Incorrect or incomplete information on this application may result in voidance of coverage and claim denial.**

(5) This completed application, and any supplements or amendments, will be a part of any policy, if issued.

(6) The broker may only submit the application and initial payment, and may not promise me coverage, modify American Medical Security's underwriting policy or terms of coverage, or change or waive any right or requirement.

(7) The broker may receive copies of any correspondence about my medical history when correspondence is required.

(8) **If I continue other coverage existing on the American Medical Security effective date for more than [90] days after that date, the American Medical Security coverage will be void.**

(9) I must notify American Medical Security of any medical conditions or treatment arising between the date of this application and the effective date of my coverage.

(10) I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding all listed dependents.

(11) If American Medical Security rejects this application, under no circumstances will any benefits be payable. Receipt of money, cashing of my check, or charging my credit card by American Medical Security does not constitute approval of my application or create American Medical Security coverage.

(12) American Medical Security may request additional information, and this may delay the processing of this application. If the health care provider charges a fee for these services, American Medical Security will determine its payment, and I will be responsible for any difference.

(13) American Medical Security has the right to rely upon the answers and statements in this application, without requesting medical records from any provider listed.

I have received a Notice of Information Practices [a Summary of Benefits and Coverage,] and a Conditions Prior to Coverage.

X _____
Primary Applicant (You)

X _____
Spouse (if to be covered)

X _____
Parent/Guardian (if You are a minor) Relationship

_____/_____/_____
Date

ARKANSAS MANDATES RIDER

This rider is effective [on DATE or at the same time as the *policy*, whichever is later].

By the attachment of this rider, the *policy* is amended to the extent of any conflict with the following:

MTI00359

A. The definition of *"complications of pregnancy"* is amended to include the following:

1. *Hospital* confinement required to treat the following: acute nephritis; nephrosis; cardiac decompensation; HELLP syndrome; uterine rupture; amniotic fluid embolism; chorioamnionitis; fatty liver in *pregnancy;* septic abortion; placenta accreta; gestational hypertension; puerperal sepsis; peripartum cardiomyopathy; cholestasis in *pregnancy;* thrombocytopenia in *pregnancy;* placenta previa; placental abruption; acute cholecystitis and pancreatitis in *pregnancy;* postpartum hemorrhage; septic pelvic thromboplebitis; retained placenta; venous air embolus associated with *pregnancy;* miscarriage.

2. An *emergency* caesarean section required because of:

   (a) Fetal or maternal distress during labor;

   (b) Severe pre-eclampsia;

   (c) Arrest of descent or dilitation;

   (d) Obstruction of the birth canal by fibroids or ovarian tumors; or

   (e) The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy.

   A caesarean section is not considered to be an *emergency* if it is for the convenience of a patient or *doctor* or if it is performed solely because a previous *pregnancy* resulted in a caesarean section.

3. Treatment, diagnosis, or care for conditions, including the following, in a pregnant female, when the condition was caused by, necessary because of, or was aggravated by the *pregnancy:* hyperthyroidism or hypothyroidism; hepatitis B or C; HIV; human papillomavirus; abnormal Pap test; syphilis, chlamydia, or herpes; urinary tract infections; thromboembolism or pulmonary embolism; appendicitis; sickle cell disease; tuberculosis; migraine headaches; depression; acute myocarditis; asthma; maternal cytomegalovirus; urolithiasis; DVT prophylaxis; ovarian dermoid tumors; biliary atresia and/or cirrhosis; first trimester adnexal mass; hyditiform mole; or ectopic pregnancy.

MTI00368-03

B. The definition of *"medical practitioner"* in the *policy* is amended to include the following as *medical practitioners*: speech therapist and audiologist.

MTI00408-03

C. The Adding a Newborn Child provision of the *policy* is deleted and replaced with the following:

ADDING A NEWBORN CHILD: An *eligible child* born to *you* or *your spouse* will be covered from the time of birth until the 91st day after its birth. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 91st day after the date of birth of the child. The required premium will be calculated from the child's date of birth. Coverage of the child will terminate on the 91st day after its birth, unless *we* have received both: (A) written notice of the child's birth; and (B) the required premium within 90 days of the child's birth.

MTI00393-03

D. The Adding an Adopted Child provision of the *policy* is deleted and replaced with the following:

ADDING AN ADOPTED CHILD: An *eligible child* legally placed for adoption with *you* or *your spouse* will be covered from:

1. The date of birth if the petition for adoption is filed within 60 days of the child's birth; or
2. The date of the filing of the petition for adoption if written notice and any additional premium required (as explained in this provision) is given to *us* within 60 days after the filing of the petition for adoption.

The adopted child will be covered until [the 31st day] after birth or the filing of the petition for adoption, unless the *placement* is disrupted prior to legal adoption and the child is removed from *your* or *your spouse's* custody.

The child will be covered for *loss* due to *injury* and *illness*, including *medically necessary* care and treatment of conditions existing prior to the date of *placement*.

Additional premium will be required to continue coverage beyond [the 31st day] following birth or the filing of the petition for adoption of the child. The required premium will be calculated from the date of birth or the filing of the petition for adoption. Coverage of the child will terminate on [the 31st day] following birth or the filing of the petition for adoption, unless *we* have received both: (A) written notice of *your* or *your spouse's* intent to adopt the child; and (B) any additional premium required for the addition of the child within [90 days] of the date of *placement*.

As used in this provision, *"placement"* means the earlier of:

1. The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or
2. The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption.

MTI00394-03

E. *Covered expenses* under the *policy* are amended to include the charges incurred by a *covered person* for the following for the treatment of diabetes:

1. Equipment, supplies, and services.
2. One *diabetes self-management training* program that is prescribed by a *doctor* as necessary and provided by an appropriately licensed health care professional.
3. Additional *diabetes self-management training* if prescribed by a *doctor* as *medically necessary* because of a change in the *covered person's* symptoms or conditions.

"Diabetes self-management training" means instruction in an *inpatient* or outpatient setting, including medical nutrition therapy, that enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications. *Diabetes self-management training* must be provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. *Diabetes self-management training* does not include programs primarily for the purpose of weight reduction.

MTI00363-03

F. *Covered expenses* under the *policy* are amended to include the charges incurred by a *covered person* for the *medically necessary* care and treatment of loss or impairment of speech or hearing, including communicative disorders.

MTI00364-03

G. *Covered expenses* under the *policy* are amended to include the charges incurred by a *covered person* for special dietary products and formulas prescribed by a *doctor* for the therapeutic treatment of phenylketonuria (PKU), galactosemia, organic acidemias, and disorders of amino acid metabolism.

MTI00366-03

H. *Covered expenses* under the *policy* are amended to include the charges incurred by a newborn *covered person* for:

1. Tests for hypothyroidism, phenylketonuria, galactosemia, sickle cell anemia, and all other disorders of metabolism, as well as any testing of newborn infants mandated by law.
2. Routine nursery care, pediatric charges, and testing for a well newborn child performed within the first 5 days following birth or before the mother ceases to be an *inpatient,* whichever occurs first.

MTI00367-03

I. If *your policy* includes benefits for normal *pregnancy* and childbirth, *covered expenses* will include the charges incurred by a *covered person* for in vitro fertilization, subject to the following conditions:

1. The *covered person's* oocytes must be fertilized with the sperm of the *covered person's* spouse.
2. The *covered person* and the *covered person's* spouse must have:
   (a) A history of unexplained infertility of at least 2 years' duration; or
   (b) Infertility that is associated with one or more of the following medical conditions:
      (i) Endometriosis.
      (ii) Exposure in utero to diethylstilbestrol, commonly known as DES.
      (iii) Blockage or removal of one of both fallopian tubes not a result of voluntary sterilization.
      (iv) Abnormal male factors contributing to the infertility.
3. The in vitro fertilization procedures must be performed at:
   (a) A medical facility that is licensed or certified by the Arkansas Department of Health;
   (b) A facility certified by the Arkansas Department of Health that conforms to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics; or
   (c) A facility certified by the Arkansas Department of Health that meets the American Fertility Society's minimal standards for programs of in vitro fertilization.
4. Benefits for in vitro fertilization are limited to a lifetime maximum of $15,000 per *covered person*.

MTI00427-03

J. The Reimbursement section of the *policy* is deleted and replaced with the following:

If a *covered person's illness* or *injury* is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*. However, if payment by or for the *third party* has not been made by the time *we* receive acceptable *proof of loss, we* will pay regular *policy* benefits for the *covered person's loss*. *We* will have the right to be reimbursed to the extent of benefits *we* paid for the *illness* or *injury* if the *covered person* subsequently receives any payment from any *third party*. The *covered person* (or the guardian, legal representatives, estate, or heirs of the *covered person*) shall promptly reimburse *us* from the settlement, judgment, or any payment received from any *third party*.

As a condition for *our* payment, the *covered person* or anyone acting on his or her behalf (including, but not limited to, the guardian, legal representatives, estate, or heirs) agrees:

1. To fully cooperate with *us* in order to obtain information about the *loss* and its cause.
2. To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *covered person* in connection with the *loss*.
3. To include the amount of benefits paid by *us* on behalf of a *covered person* in any claim made against any *third party*.
4. That *we*:
   (a) Will have a lien on all money received by a *covered person* in connection with the *loss* equal to the amount *we* have paid.
   (b) May give notice of that lien to any *third party* or *third party's* agent or representative.

(c) Will have the right to intervene in any suit or legal action to protect *our* rights.

(d) Are subrogated to all of the rights of the *covered person* against any *third party* to the extent of the benefits paid on the *covered person's* behalf.

(e) May assert that subrogation right independently of the *covered person*.

5. To take no action that prejudices *our* reimbursement and subrogation rights.

6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.

7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.

8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.

9. That *we* may reduce other benefits under the *policy* by the amounts a *covered person* has agreed to reimburse *us*.

Furthermore, as a condition of *our* payment, *we* may require the *covered person* or the *covered person's* guardian (if the *covered person* is a minor or legally incompetent) to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

Definition: As used in this provision, the following term has the meaning indicated:

"Third party" means a person or other entity that is or may be obligated or liable to the *covered person* for payment of any of the *covered person's* expenses for *illness* or *injury*. The term *"third party"* includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term *"third party"* will not include any insurance company with a policy under which the *covered person* is entitled to benefits as a named insured person or an insured *dependent* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

MTI00123-03

K. The *variable deductible* feature of the *policy* is removed. The definitions of *"other plan," "out-of-pocket expenses,"* and *"variable deductible"* are removed. Any reference in the *policy* to the stated deductible is changed to refer to the *deductible amount*. The *deductible amount* is equal to the stated deductible.

The following provision is added to the *policy*:

MEDICARE CARVE-OUT BENEFIT REDUCTION: When a *covered person* reaches 65 years of age (or such other age as may be set by Medicare for eligibility) and becomes enrolled in Medicare, all *policy* benefits otherwise payable will be reduced by any benefits that are payable, or the value of any services provided, for the same *loss* under Medicare. Therefore, *we* will reduce *our* premium costs and benefits if the *covered person* is enrolled in Medicare.

If *we* do not promptly receive notice of the benefits actually paid by Medicare, *we* may estimate the Medicare payments and pay *our* benefits. If *we* do so, *we* will adjust *our* benefits once *we* know what Medicare actually paid.

MTI00410

L. The following provision is added to the *policy*:

Coordination of Benefits

Some people have health care coverage through more than one *plan* at the same time. COB allows these *plans* to work together so that the total amount of all benefits will never be more than 100 percent of the *allowable expenses* during any calendar year. This helps to hold down the costs of health coverage. The order of benefit determination rules determine which *plan* will pay as the *primary plan* and which will be considered the *secondary plan*.

This Coordination of Benefits ("COB") provision applies to this *plan* when a *covered person* has health care coverage under more than one *plan*. COB does not apply to life insurance, accidental death and dismemberment, or disability benefits.

DEFINITIONS: As used in this provision, the following terms have the meanings set forth below:

"Allowable expense" means a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any of the *plans* covering the person. When a *plan* provides benefits in the form of service, the reasonable cash value of each service will be considered as both an *allowable expense* and a benefit paid.

If all *plans* covering a person are *high deductible health plans* and the person intends to contribute to a health savings account established in accordance with the Internal Revenue Code, the *primary high deductible health plan's* deductible is not an *allowable expense,* except for any expense incurred that is not subject to the deductible. An expense or portion of an expense that is not covered by any of the *plans* is not an *allowable expense*. Any expense that a provider, by law or in accordance with a contractual agreement, is prohibited from charging a *covered person* is not an *allowable expense*. The following are examples of expenses or services that are not *allowable expenses*:

1. If a *covered person* is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and private (unless the patient's stay in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice, or one of the *plans* routinely provides coverage for private *hospital* rooms) is not an *allowable expense*.
2. If a person is covered by two or more *plans* that compute their benefit payments on the basis of reasonable and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest of the reasonable and customary fees for a specific benefit is not an *allowable expense*.
3. If a person is covered by two or more *plans* that compute their benefit payments on the basis of negotiated fees, any amount in excess of the highest negotiated fee is not an *allowable expense*.
4. If a person is covered by one *plan* that calculates its benefits or services on the basis of reasonable and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, and another *plan* that provides its benefits or services on the basis of negotiated fees, the *primary plan's* payment arrangement shall be the *allowable expense* for all *plans*. However, if the provider has contracted with the *secondary plan* to provide the benefit or service for a specific negotiated fee or payment amount that is different than the *primary plan's* payment arrangement, and if the provider's contract permits, that negotiated fee or payment shall be the *allowable expense* used by the *secondary plan* to determine benefits.
5. The amount that benefits are reduced under the *primary plan* because a *covered person* does not comply with the *plan* provisions will not be considered an *allowable expense*. Examples of these provisions are those related to second surgical opinions, precertification requirements, and preferred provider arrangements.

"Closed panel plan" is a *plan* that provides health benefits to *covered persons* primarily in the form of services through a panel of providers that have contracted with or are employed by the *plan*, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

"Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

"High deductible health plan" is a health plan that has a higher deductible than typical health plans, and has a maximum limit on the sum of the annual deductible and out-of-pocket medical expenses that *you* must pay for covered services, as determined by the Internal Revenue Service.

"Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same *plan* and there is no COB among those separate contracts.

"Plan" includes:

1. Group and nongroup insurance, *closed panel plans,* or other forms of group or group-type coverage (whether insured or uninsured).
2. Medical care components of group long-term care contracts, such as skilled nursing care.
3. Medical benefits under group or individual automobile contracts.
4. Medicare or other governmental benefits, as permitted by law.

"Plan" does not include:

1. Hospital indemnity coverage benefits or other fixed indemnity coverage.
2. Accident only coverage, including school-accident type coverage.
3. Specified disease or specified accident coverage.
4. Limited benefit health coverage.
5. Benefits for non-medical components of group long-term care policies.
6. Medicare supplement policies, Medicaid policies, and coverage under other governmental plans, unless permitted by law.

Each contract for coverage is a separate *plan*. If a *plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan*.

"Primary plan" or *"primary"* is the *plan* that pays first without regard to the possibility that another *plan* may cover some expenses.

"Secondary plan" or *"secondary"* is the *plan* that pays after the *primary plan*. The *secondary plan* may reduce the benefits it pays so that payments from all *plans* do not exceed 100 percent of the total *allowable expense*.

If a person is covered by more than one *secondary plan*, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other. The benefits of each *secondary plan* may take into consideration the benefits of the *primary plan* or *plans* and the benefits of any other *plan* which, under the order of benefit determination rules, has its benefits determined before those of that *secondary plan*.

ORDER OF BENEFIT DETERMINATION RULES: When two or more *plans* pay benefits, the rules for determining the order of payment are as follows:

1. The *primary plan* pays or provides its benefits as if the *secondary plan* or *plans* did not exist.

   If the *primary plan* is a *closed panel plan* and the *secondary plan* is not a *closed panel plan,* the *secondary plan* shall pay or provide benefits as if it were the *primary plan* when a *covered person* uses a nonpanel provider, except for emergency services or authorized referrals that are paid by the *primary plan*.

2. A *plan* which does not have a COB provision that is consistent with state regulation will always be the *primary plan*. There is one exception: coverage that is obtained by virtue of membership in a group that is designated to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the *plan* provided by the policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a *closed panel plan* to provide out-of-network benefits.

3. A *plan* may consider the benefits paid or provided by another *plan* in determining its benefits only when it is *secondary* to that other *plan*.

4. The first of the following rules that describes which *plan* pays its benefits before another *plan* is the rule to use:

   (a) **Non-Dependent/Dependent** - The *plan* that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is *primary,* and the *plan* that covers the person as a dependent is *secondary*. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is *secondary* to the *plan* covering the person as a dependent and *primary* to the *plan* covering the insured person as other than a dependent

(e.g. a retired employee), then the order of benefits between the two *plans* is reversed so that the *plan* covering the person as an employee, member, subscriber or retiree is *secondary* and the other *plan* is *primary*.

(b) **Child Covered Under More Than One Plan** - Unless there is a court decree stating otherwise, the order of benefits when a child is covered by more than one *plan* is as follows:

(i) For a dependent child whose parents are married or living together, whether or not they have ever been married:

(a) The *plan* of the parent whose birthday falls earlier in the calendar year is the *primary plan*.

(b) If both parents have the same birthday, the *plan* that has covered the parent the longest is the *primary plan*.

(ii) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(a) If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the *plan* of that parent has actual knowledge of those terms, that is the *primary plan*. This rule applies to the plan years commencing after the *plan* is given notice of the court decree.

(b) If a court decree states that both parents are responsible or have joint custody, without specifying that one parent has responsibility, for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (i) above shall determine the order of benefits.

(c) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows: (1) the *plan* covering the *custodial parent;* (2) the *plan* covering the spouse of the *custodial parent;* (3) the *plan* covering the noncustodial parent; and (4) the *plan* covering the spouse of the noncustodial parent.

(iii) For a dependent child covered under more than one *plan* of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under paragraph (i) or (ii) above, as if those individuals were the parents of the child.

(c) **Active/Inactive Employee** - The *plan* that covers a person as an employee who is neither laid off nor retired, or as a dependent of an active employee, is *primary*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under rule 4(a).

(d) **Continuation Coverage** - If a person whose coverage is provided under COBRA or a right of continuation pursuant to federal or state law is also covered under another *plan*, the *plan* covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is *primary*, and the continuation coverage is *secondary*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.

(e) **Longer/Shorter Length of Coverage** - The *plan* that covered the person as an employee, member, subscriber or retiree longer is *primary*.

(f) If the preceding rules do not determine the *primary plan*, the *allowable expenses* shall be shared equally between the plans meeting the definition of *plan*. In addition, this *plan* will not pay more than it would have paid had it been *primary*.

EFFECT ON THE BENEFITS OF THIS PLAN: When this *plan* is *secondary*, it will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any *allowable expense* under its *plan* that is unpaid by the *primary plan.* Payments may be reduced by an amount so that, when combined with the amount paid by the *primary plan,* the total benefits paid or provided by all *plans* for the claim do not exceed 100 percent of the total *allowable expenses* for that claim. The *plan* deductible will be credited any amounts it would have credited in the absence of other health care coverage.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION: Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this *plan* and other *plans*. The claims processing department may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this *plan* and other *plans* covering the person claiming benefits. The claims processing department need not tell, or get the consent of, any person to do this. Each person claiming benefits under this *plan* must give the claims processing department any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT: A payment made under another *plan* may include an amount that should have been paid under this *plan*. If it does, the claims processing department may pay that amount to the organization that made that payment. That amount will be treated as though it were a benefit paid under this *plan*. The claims processing department will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY: If the amount of payments made by the claims processing department is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the *covered person*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

MTI00395-03

M. The Conditions Prior to Legal Action provision is deleted and replaced with the following:

PRIOR TO LEGAL ACTION: On occasion, *we* may have a disagreement related to coverage, benefits, premiums, or other provisions under this *policy*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, *we* request that *you* give written notice to *us* of *your* intent to sue *us* prior to bringing any legal action. *Your* notice must: (A) identify the coverage, benefit, premium, or other disagreement; (B) refer to the specific *policy* provision(s) at issue; and (C) include all relevant facts and information that support *your* position

MTI00396-03

Except as specifically stated in this rider, *covered expenses* under this rider are subject to all the terms, conditions, exclusions, and limitations of the *policy,* including any [applicable *deductible amounts, copayment amounts,* coinsurance provisions, {notification/prior authorization} requirements, or maximum dollar limits].

[This rider applies only to *covered persons* who reside in the state of Arkansas.]

This rider will not change, waive, or extend any part of the *policy*, other than as stated herein.

American Medical Security Life Insurance Company

President

MTI00361-03

American Medical Security Life Insurance Company

AMENDMENT TO
APPLICATION FOR INSURANCE

[3100 AMS Boulevard
P.O. Box 19032
Green Bay, WI 54307-9032
Telephone (800) 232-5432]

RE: [POLICY NUMBER]

The application of _____, dated _____
is hereby amended as follows:

[ ]

I hereby represent that the above answers and statements are true, complete, and correctly recorded and that they are to be considered as a part of the original application for insurance. I further represent that the answers and statements contained in the original application, except to the extent they are amended by the above, are still true, complete, and correctly recorded.

Signature of Applicant_____ Date _____

Rate Information

Rate data applies to filing.

Filing Method:	SERFF
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:	Company Rate Change:	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):
American Medical Security Life Insurance Company	New Product	%	%				%	%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:								
Policy Holders:								

Rate Review Details

COMPANY:

Company Name:	American Medical Security Life Insurance Company
HHS Issuer Id:	00000
Product Names:	Individual Gen 28
Trend Factors:	

FORMS:

New Policy Forms:	GIP28-P-AMS
Affected Forms:	
Other Affected Forms:	

REQUESTED RATE CHANGE INFORMATION:

Change Period:	Quarterly
Member Months:	0
Benefit Change:	None
Percent Change Requested:	Min: 0.0 Max: 0.0 Avg: 0.0

PRIOR RATE:

Total Earned Premium:	0.00
Total Incurred Claims:	0.00
Annual $:	Min: 0.00 Max: 0.00 Avg: 0.00

REQUESTED RATE:

Projected Earned Premium:	0.00
Projected Incurred Claims:	0.00
Annual $:	Min: 134.00 Max: 4,971.00 Avg: 391.00

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved-Closed 06/12/2012	Arkansas GIP28-AMS Actuarial Memorandum		New		AR GIP28-AMS Actuarial Memo.PDF
Approved-Closed 06/12/2012	Arkansas GIP-28-AMS Rate Manual		New		AR GIP28-AMS Rate Manual.PDF

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Health - Actuarial Justification	Approved-Closed	06/12/2012

Comments:

Attachment:

AR GIP28-AMS Actuarial Memo.PDF

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	06/12/2012

Comments:

Attachments:

Readability Cert GIP28-P-AMS.pdf

Readability Cert GIP28-P-AMS-OC.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	06/12/2012

Comments:

Attachment:

GIP-AP-144-AMS-03 022412 FV.pdf

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	06/12/2012

Comments:

Attachment:

GIP28-P-AMS-OC PPO Outline.pdf

		Item Status:	Status

			Date:
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved-Closed	06/12/2012

Comments:

Attachment:

GIP28-P-AMS PPACA Uniform Compliance Summary.pdf

		Item Status:	**Status Date:**
Bypassed - Item:	Rate Summary Worksheet	Approved-Closed	06/12/2012

Bypass Reason: This worksheet is for: "reporting of rate increases in the individual and small group markets." There are no rate increases subject to this filing. This is a new rate filing.

Comments:

		Item Status:	**Status Date:**
Bypassed - Item:	Consumer Disclosure Form	Approved-Closed	06/12/2012

Bypass Reason: This is an initial submission.

Comments:

		Item Status:	**Status Date:**
Satisfied - Item:	Forms List GIP28 Arkansas	Approved-Closed	06/12/2012

Comments:

Attachment:

Forms List GIP28 AR for AMS .pdf

Certification of Reading Ease

RE: Forms(s) GIP28-P-AMS

Golden Rule Insurance Company, by Michael L. Corne, its Vice President, does hereby certify to the best of our knowledge and belief that:

1. **The Flesch reading ease test score of the above is:** 53.7.

2. **The above is printed (except for: specification pages, schedules, tables, and, with regard to any application, minor instructions concerning preparation) in not less than ten point type, one point leaded.**

3. **All text has been included in arriving at the above score(s) except for the following:** headings, italicized words, form numbers, company name and address, title of policy, table of contents, schedule pages, and medical terminology

4. **The entire text of the forms(s) was analyzed in arriving at the above score(s), except as follows:** See #3 above.

5. **The readability of the above form(s) complies with the statutory and/or regulatory requirements of the following states:** _____

6. **The above form(s) will be used in:**

   ☒ **individual health insurance** ☐ **individual life insurance**

   ☐ **group health insurance** ☐ **group life insurance**

05/04/2012

Date

Michael L. Corne
Vice President, Health Products

CRE

Certification of Reading Ease

RE: Forms(s) GIP28-P-AMS-OC

Golden Rule Insurance Company, by Michael L. Corne, its Vice President, does hereby certify to the best of our knowledge and belief that:

1. **The Flesch reading ease test score of the above is:** 43.4.

2. **The above is printed (except for: specification pages, schedules, tables, and, with regard to any application, minor instructions concerning preparation) in not less than ten point type, one point leaded.**

3. **All text has been included in arriving at the above score(s) except for the following:** headings, italicized words, form numbers, company name and address, title of policy, table of contents, schedule pages, and medical terminology

4. **The entire text of the forms(s) was analyzed in arriving at the above score(s), except as follows:** See #3 above.

5. **The readability of the above form(s) complies with the statutory and/or regulatory requirements of the following states:** _____

6. **The above form(s) will be used in:**

☒ **individual health insurance** ☐ **individual life insurance**

☐ **group health insurance** ☐ **group life insurance**

05/04/2012

Date

Michael L. Corne
Vice President, Health Products

CRE

AMERICAN MEDICAL SECURITY LIFE INSURANCE COMPANY
APPLICATION FOR INSURANCE

[MUST BE COMPLETED BY THE APPLICANT(S)] **[PLEASE PRINT IN BLACK INK]**

A. APPLICANT(S) INFORMATION

[1. **REASON FOR APPLICATION:** ❍ New Application ❍ Add a dependent ❍ Reinstatement ❍ Change deductible ID Number _____
(for additions, reinstatements, or deductible changes)]

[2.] **PRIMARY APPLICANT'S INFORMATION:**

a. Name (Last, First, M.I.): _____

b. Mailing Address _____
Street (Include Apt.)
_____ _____ _____
City State ZIP

c. **A physical address is required if different than your mailing address. P.O. Boxes are not accepted as a physical address.**

Physical Address _____
Street (Include Apt.)
_____ _____ _____
City State ZIP

d. Phone Numbers: ( ) ( ) _____
Home Other Best number and time to call [Email Address]

e. Payor (If not You): Name [Email Address] _____
_____
Street City State ZIP

f. Your Beneficiary: _____ You will be the beneficiary for your spouse.
Name Relationship Age

[g. Marital Status: ❍ Married ❍ Single]

[3.] **APPLICANTS FOR COVERAGE:** Please list only those persons needing coverage.

Gender	Name (Last, First, M.I.)	Social Security No.	Birth Date	Age	MUST BE ACCURATE Height	Weight
❍ Male ❍ Female	a. Primary (You)					
❍ Male ❍ Female	b. Spouse					
❍ Male ❍ Female	c. Child					
❍ Male ❍ Female	d. Child					
❍ Male ❍ Female	e. Child					
❍ Male ❍ Female	f. Child					
❍ Male ❍ Female	g. Child					

If you need to list additional dependents, please use lined paper, sign and date it, and check here. ❍

[4.] Do all applicants, other than dependent children, read, write, speak, and understand the English language? ..... ❍ Yes ❍ No

B. COVERAGE INFORMATION — Must complete for all new applications.

5. Requested Effective Date: __ __/__ __ / __ __ __ __

6. All plans include a preferred network. Network Name:_____

7. Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? (If yes, indicate who below.) ..... ❍ Yes ❍ No

a. Primary	b. Spouse	c. Child	d. Child	e. Child	f. Child	g. Child
❍ Yes	❍ Yes	❍ Yes	❍ Yes	❍ Yes	❍ Yes	❍ Yes

C. PRODUCT SELECTION & BILLING (or attach a health insurance quote)
For additions and reinstatements, complete only if changing the deductible for all insureds.

❍ Plan A
❍ Deductible 1 ❍ Deductible 2 ❍ Deductible 3
❍ Deductible 4 ❍ Deductible 5 ❍ Deductible 6
Coinsurance Choices
❍ xx% ❍ xx% ❍ xx%
❍ Plan B
❍ Plan C
❍ Deductible 1 ❍ Deductible 2 ❍ Deductible 3
❍ Deductible 4 ❍ Deductible 5 ❍ Deductible 6
❍ Plan D
❍ Plan E
❍ Deductible 1 ❍ Deductible 2 ❍ Deductible 3
❍ Deductible 4 ❍ Deductible 5 ❍ Deductible 6

Base Premium Amount $ _____

OPTIONAL BENEFITS — See current brochure and inserts for availability

❍ Benefit 1 + $_____ Optional
❍ Benefit 2
❍ Benefit 3
❍ Benefit 4
❍ Benefit 5
❍ Treatment of Temporomandibular Joint Disorder and Craniomandibular Disorder
(Note: Rejection of this optional benefit means the policy will not include coverage of these disorders.)

Total Monthly Payment = $_____

Initial Monthly Payment (Payable to ["American Medical Security"]) = $ _____

If Quarterly, Total Monthly Payment x 3 = $_____

Initial Quarterly Payment (Payable to ["American Medical Security"]) = $ _____

8. **Initial Payment With Application:** ❍ Check ❍ EFT ❍ Credit Card
Ongoing Payments: Monthly ❍ EFT (no billing fee) ❍ Direct Bill ($10 monthly billing fee)
Quarterly ❍ Direct Bill ($10 quarterly billing fee)

Premium will be verified and may be adjusted up or down during the processing of your application.
Electronic Funds Transfer (EFT) and Credit Card payments will only be collected upon approval of your application.
Checks are deposited upon receipt.

D. PREVIOUS OR CURRENT HEALTH INSURANCE COVERAGE [(Completing this section may make you eligible for an earlier effective date for illnesses.)]

Yes No

[9.] Within the last [63] days, has any applicant **been covered by** any type of **medical** insurance? ..... ❍ ❍
If yes, complete chart below. Your signature on this application indicates your agreement to terminate any existing coverage listed below as being replaced.

Applicant's Name	Company Name	Policy/Certificate Number	Type (Individual, Employer Group, Short Term, COBRA, Medicaid, Other)	Is this to be replaced?	Termination Date

D. PREVIOUS OR CURRENT HEALTH INSURANCE COVERAGE — Continued
[(Completing this section may make you eligible for an earlier effective date for illnesses.)]

	Yes	No
[10. Will the term life benefit replace any existing **life** insurance?	❍	❍

Company Name_____ Policy Number _____]

[11.] Has any applicant ever had an application or policy voided, declined, rated, or had coverage modified (including medical exclusion riders) by any health or life insurer? (If yes, list name and give details.)	❍	❍

Person: Company: Action Taken:

Date: Reason for Action:

E. MEDICAL HISTORY — FOR ALL APPLICANTS

IMPORTANT! YOU MUST PROVIDE DETAILS OF EACH YES ANSWER IN "MEDICAL HISTORY DETAILS."

	Yes	No
[12.] Are you, or is any family member (whether or not named in this application), pregnant or an expectant mother or father, or in the process of surrogate pregnancy, or do you or any family member have an adoption pending?	❍	❍
[13.] Has any applicant had or been advised to have: (a) any testing (other than routine testing, such as pap or mammogram); or (b) any treatment that has not yet been completed?	❍	❍
[14.] In the last 6 months, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind?	❍	❍
[15.] In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more?	❍	❍
[16.] In the last 5 years, has any applicant:		
a. Filed a claim and/or received benefits from disability insurance or Worker's Compensation?	❍	❍
b. Used an illegal drug; had any diagnosis or treatment of an alcohol or drug dependency, problem, or abuse; been advised to reduce alcohol intake; or had any alcohol- or drug-related moving violation, arrest, or driver's license suspension?	❍	❍
c. Been a user of alcoholic beverages in excess of 14 drinks* per week? (*One drink equals 12 oz. of beer, 4 oz. of wine, or 1 oz. of hard liquor.) If yes, show who and how many drinks* per week in "Medical History Details"	❍	❍
[17.] In the last 10 years, has any applicant:		
a. Consulted a health care provider for any condition or symptom(s) for which a diagnosis has not been established?	❍	❍
b. Had any, signs, symptoms, diagnosis, or treatment of Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness, or tested positive for antibodies to the HIV virus?	❍	❍
c. Had any abnormal physical exam, X-ray, EKG, MRI, CT scan, or any adverse or abnormal laboratory or other test results?	❍	❍
d. Been confined in a hospital?	❍	❍
e. Had surgery?	❍	❍
f. Had placement, treatment, or maintenance of an internal or external implant or prosthetic device?	❍	❍
[18.] **In the last 10 years, has any applicant had testing or additional tests recommended for, or had any, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of, any of the following:**	Yes	No
a. **Digestive System** (gallbladder; pancreas; liver; ulcers; rectal bleeding; or other disorder or condition)?	❍	❍
b. **Urinary System** (kidney; or other disorder or condition)?	❍	❍
c. **Eyes, Ears, Nose** (ear or sinus infections {more than two in the past 12 months}; or other disorder or condition)?	❍	❍
d. **Mouth, Throat, or Jaw**?	❍	❍
e. **Skin Disorders**?	❍	❍
f. **Heart or Circulatory System** (chest pain; high or low blood pressure; elevated cholesterol; stroke; shunts, stents, or pacemaker; or other disorder or condition)?	❍	❍
g. **Male or Female Reproductive System** (infertility or erectile dysfunction; sexually transmitted disease; abnormal mammogram or Pap smear; or other disorder or condition)?	❍	❍
h. **Blood, Gland, Endocrine, or Metabolic** (thyroid, breast, or other glands; diabetes or sugar in the blood or urine; anemia; immune system disorder, other than AIDS or HIV; or other disorder or condition)?	❍	❍
i. **Brain and Nervous System** (migraines or chronic or severe headache; seizures or epilepsy; mental, emotional, or behavioral disorder, including anorexia or bulimia; multiple sclerosis or paralysis; or other disorder or condition)?	❍	❍
j. **Muscular or Skeletal System** (joints, bones, spine, or back; arthritis or fibromyalgia; amputation; or other disorder or condition)?	❍	❍
k. **Respiratory System** (asthma or allergies; sleep apnea; or other disorder or condition)?	❍	❍
l. **Cancer, Cyst, or Tumor** (or polyp, lump, or growth of any kind)?	❍	❍
m. **Birth Defects or Congenital Abnormalities** (Down's syndrome; cerebral palsy; or other birth defect or congenital anomaly?	❍	❍

E. MEDICAL HISTORY — Continued

[19.] In the last 5 years, has any applicant had any signs, symptoms, diagnosis, or treatment for any other disease, disorder, injury, or condition (excluding childbirth) that is not listed on this application? ❍ ❍

[20.] **List in "Medical History Details" any additional doctors or other health care professionals that any applicant has consulted with or been treated by in the last 5 years, and give full details.**

F. MEDICAL HISTORY DETAILS — FOR ALL APPLICANTS

Question Number: _____ Person: _____ Dates: _____

Symptoms or Conditions: _____

Prescriptions (include dose, how often taken, dates taken): _____

Treatment, Advice Given, Results, and Other Details: _____

Name, Address, Phone of Doctors, Hospitals, etc.: _____

Question Number: _____ Person: _____ Dates: _____

Symptoms or Conditions: _____

Prescriptions (include dose, how often taken, dates taken): _____

Treatment, Advice Given, Results, and Other Details: _____

Name, Address, Phone of Doctors, Hospitals, etc.: _____

Question Number: _____ Person: _____ Dates: _____

Symptoms or Conditions: _____

Prescriptions (include dose, how often taken, dates taken): _____

Treatment, Advice Given, Results, and Other Details: _____

Name, Address, Phone of Doctors, Hospitals, etc.: _____

If you need more space to provide complete and accurate information, please use lined paper, sign and date it, and check here. ❍

G. SPECIAL INSTRUCTIONS

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

H. STATEMENT OF UNDERSTANDING — Review the completed application and read the section below carefully before signing.

I personally completed this application. I represent that the answers and statements on it are true, complete, and correctly recorded. **I understand and agree that:**

(1) This application and the initial payment do not give me immediate coverage.

(2) I should not terminate existing coverage until I have accepted the American Medical Security coverage.

[(3) With regard to medical coverage, unless American Medical Security agrees to an earlier date, coverage for illness begins on the 15th day after a person becomes insured for injury.]

(4) **Incorrect or incomplete information on this application may result in voidance of coverage and claim denial.**

(5) This completed application, and any supplements or amendments, will be a part of any policy, if issued.

(6) The broker may only submit the application and initial payment, and may not promise me coverage, modify American Medical Security's underwriting policy or terms of coverage, or change or waive any right or requirement.

(7) The broker may receive copies of any correspondence about my medical history when correspondence is required.

(8) **If I continue other coverage existing on the American Medical Security effective date for more than [90] days after that date, the American Medical Security coverage will be void.**

(9) I must notify American Medical Security of any medical conditions or treatment arising between the date of this application and the effective date of my coverage.

(10) I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding all listed dependents.

(11) If American Medical Security rejects this application, under no circumstances will any benefits be payable. Receipt of money, cashing of my check, or charging my credit card by American Medical Security does not constitute approval of my application or create American Medical Security coverage.

(12) American Medical Security may request additional information, and this may delay the processing of this application. If the health care provider charges a fee for these services, American Medical Security will determine its payment, and I will be responsible for any difference.

(13) American Medical Security has the right to rely upon the answers and statements in this application, without requesting medical records from any provider listed.

I have received a Notice of Information Practices [a Summary of Benefits and Coverage,] and a Conditions Prior to Coverage.

X _____
Primary Applicant (You)

X _____
Spouse (if to be covered)

X _____
Parent/Guardian (if You are a minor) Relationship

_____/_____/_____
Date

American Medical Security Life Insurance Company
3100 AMS Boulevard
P.O. Box 19032
Green Bay, WI 54307-9032
For Inquiries: [(800) 232-5432]

In this outline, "you" or "your" will refer to the person for whom this outline has been prepared, and "we," "our," or "us" will refer to American Medical Security Life Insurance Company.

Medical Expense Coverage
Outline of Coverage for Policy Form GIP28-P-AMS
(Please retain this outline for your records)

Read Your Policy Carefully -- This outline sets forth a brief description of the important aspects of your policy. This is not the insurance contract. Only the actual policy will control. The policy sets forth in detail your and our rights and obligations. For this reason, it is important that you READ YOUR POLICY CAREFULLY!

Medical Expense Coverage -- Plans of this type are designed to provide covered persons with coverage for the major costs of hospital, medical, and surgical care. The cost must be due to a covered illness or injury. Coverage is provided for daily hospital room and board, other hospital services, surgical services, anesthesia services, inpatient medical services, and out-of-hospital care. Coverage is subject to any deductible amounts, copayment provisions, or other limitations that may be set forth in the policy.

State Mandates -- Some provisions addressed in this outline of coverage may change according to the laws of the state where you reside. Please see the state mandates rider attached to your policy.

Amount Payable

Definitions:

"Coinsurance percentage" means the percentage of covered expenses that are payable by us, as shown on the policy Data Page.

"Deductible amount" means the amount of covered expenses that must be paid by [each/all][i] covered person[s] before any benefits are payable. The deductible amount does not include any copayment amount.

"Eligible expense" means a covered expense that is determined as follows:

(A) For network providers (excluding Transplant Benefits), the eligible expense is the contracted fee with that provider.

(B) For non-network providers:

(1) The eligible expense is the lesser of the billed charge or a lower amount negotiated with the provider [or authorized by state law] for covered expenses that are:

(a) Received as a result of an emergency or otherwise approved by us; or

(b) For a service or supply that is not of a type provided by any network provider.

(2) Except as provided under (1) above, when a covered expense (excluding Transplant Benefits) is received from a non-network provider, the eligible expense is determined based on [the lesser of]:

(a) [The fee that has been negotiated with the provider;

(b) [110%] of the fee Medicare allows for the same or similar services provided in the same geographical area;

(c) 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 geographical area determined by us;

(d) The fee charged by the provider for the services; or

(e) A fee schedule that we develop.]

The "variable deductible" is equal to the amount of benefits payable for covered expenses by any other plan.

Amount Payable: The deductible amount is the larger of the stated deductible or a variable deductible. The stated deductible varies according to the type of plan and amount selected by the insured. (Please see the policy Data Page for more information.) We may apply the variable deductible even though the stated deductible has been satisfied.

If payment is calculated using the variable deductible, the coinsurance percentage will be 100 percent. The effect of the variable deductible is to pay 100 percent of the covered person's out-of-pocket expenses.

We will pay the applicable coinsurance percentage in excess of the applicable deductible amount(s) and copayment amount(s) for a service or supply that qualifies as a covered expense and is received while the covered person's coverage is in force under the policy, if the charge for the service or supply qualifies as an eligible expense.

The amount payable will be subject to any specific benefit limits stated in the policy, a determination of eligible expenses, and any reduction for expenses incurred at a non-network provider.

The deductible amount(s), coinsurance percentage, and copayment amount(s) are shown in the policy Data Page.

Non-emergency non-network eligible expenses will be reduced by [25%] before application of any applicable deductible amount(s), coinsurance provisions, and/or copayment amounts.

Note: The bill you receive for services or supplies from a non-network provider may be significantly higher than the eligible expenses for those services or supplies. In addition to the deductible amount, coinsurance, and copayment, you are responsible for the difference between the eligible expense and the amount the provider bills you for the services or supplies. Any amount you must pay to the provider in excess of the eligible expenses will not apply to your deductible amount or maximum out-of-pocket expenses.

[**Primary Care Physician:** In order to obtain benefits, you must designate a network primary care physician for each covered person. If you do not select a network primary care physician for each covered person, one will be assigned. You may obtain a list of network primary care physicians at our website or by calling the telephone number shown on the front page of your policy.

Specialist Physician: For network specialist physicians, a referral from your primary care physician is required in order to be eligible for [maximum] benefits. A referral is not required for emergencies or for care received from an obstetrician or gynecologist.][ii]

Deductible Credit: A covered person will be eligible for a deductible credit if, in any given calendar year, he or she did not meet the applicable stated deductible and has been a covered person for at least 6 consecutive months. The deductible credit will apply to the stated deductible in the following calendar year.

Medical Benefits

Covered expenses set forth in the policy include the charges:

(A) Made by a hospital for:

(1) Daily room and board and nursing services at the most common semi-private room rate.

(2) Daily room and board and nursing services while confined in an intensive care unit, not to exceed the eligible expense.

(3) Inpatient use of an operating, treatment, or recovery room.

(4) Outpatient use of an operating, treatment, or recovery room for surgery.

(5) Other routine services and supplies provided to an inpatient.

(6) Emergency treatment of an illness or injury. [However, charges for use of the emergency room itself for treatment of an illness will be reduced by $100 unless the covered person is directly admitted to the hospital for further treatment of that illness.][iii]

(B) For surgery in a doctor's office or at an outpatient surgical facility.

(C) Made by a doctor for professional services, including surgery.

(D) Made by an assistant surgeon, limited to [20] percent of the eligible expense for the surgical procedure.

(E) Made by a medical practitioner who is not a doctor and who is acting as a surgical assistant surgeon, limited to [14] percent of the eligible expense for the surgical procedure.

(F) Made by a medical practitioner for professional services.

(G) For dressings, crutches, orthopedic braces, splints, casts, or other necessary medical supplies.

(H) For diagnostic testing using radiologic, ultrasonographic, or laboratory services, but not including psychometric, behavioral, and educational testing.

(I) For chemotherapy and radiation therapy or treatment.

(J) For hemodialysis and the charges by a hospital for processing and administration of blood or blood components.

(K) For the cost and administration of oxygen or an anesthetic.

(L) For dental expenses when a covered person suffers an injury, after the effective date of coverage, that results in: (1) damage to the person's natural teeth; and (2) expenses that are incurred within six months of the accident.

(M) For surgery, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint, limited to a combined [$10,000] lifetime maximum per person.

(N) For artificial eyes or larynx, breast prostheses, or basic artificial limbs (but not replacement, unless required by a physical change in the person and the item cannot be modified).

(O) For one pair of foot orthotics per covered person.

(P) For medically necessary genetic blood tests.

(Q) For medically necessary immunizations to prevent respiratory syncytial virus (RSV).

(R) For two mastectomy bras per year if the covered person has undergone a covered mastectomy.

(S) For the rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.

(T) For the cost of one Continuous Passive Motion machine per person following a covered joint surgery.

(U) For the cost of one wig per person, up to [$500], that is necessitated by hair loss due to cancer treatments or traumatic burns.

(V) For occupational therapy following a covered treatment for traumatic hand injuries.

(W) For one pair of eyeglasses or contact lenses per person, up to [$200], following a covered cataract surgery.

(X) For routine annual digital rectal examinations, prostate specific antigen tests, and human papillomavirus (HPV) tests or screenings.

(Y) For surveillance tests for ovarian cancer for females who are at risk for ovarian cancer.

(Z) For breast reconstruction following a mastectomy, prostheses, and treatment for physical complications of mastectomy, including lymphedemas.

(AA) For emergency ground or air ambulance service to the nearest hospital, or the nearest neonatal special care unit for newborns.

(BB) For other benefits as required by the laws of the state where you reside. Please see the state mandates rider attached to your policy.

[**Preventive Care:** Covered expenses include the charges for the following preventive health services if appropriate per the guidelines [in effect as of March 23, 2010]:

(A) Evidence based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force.

(B) Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(C) Preventive care and screenings for children in accordance with guidelines supported by the Health Resources and Services Administration.

(D) Additional preventive care and screenings not included in (A) above, in accordance with guidelines supported by the Health Resources and Services Administration for women.

Benefits for the preventive health services listed above[, except under the administration of reasonable medical management techniques as discussed in the policy,] are exempt from any [stated deductibles, coinsurance provisions, and copayment amounts] when the services are provided by a network provider.

Covered expenses incurred at a non-network provider will be reduced by 25%, then subject to the applicable deductible amount and coinsurance percentage.]

Limitation on Spine and Back Disorders: If the diagnosis or treatment of a spine or back disorder is rendered to a covered person while an outpatient, covered expenses for the medical practitioner's fees and all services and supplies will be limited to [15 visits] per person per calendar year.

Transplant Expense Benefits: The following types of tissue transplants are covered expenses: cornea transplants, artery or vein grafts, heart valve grafts, prosthetic tissue replacement (including joint replacement), and implantable prosthetic lenses in connection with cataracts. The policy also provides coverage for listed transplants, which include heart, lung, heart/lung, kidney, and liver transplants, and bone marrow transplants as listed in the policy. The amount of benefits under the policy for a listed transplant depends upon whether it is performed in one of our Centers of Excellence.

Home Health Care Expense Benefits: The policy provides benefits for home health care. Benefits for home health aide services are limited to [7] visits per week and a lifetime maximum of [365] visits. Benefits for outpatient private duty registered nurse services are limited to a lifetime maximum of [1,000 hours]. Benefits for intermittent private duty registered nurse services are limited to [$75] per visit.

Hospice Care Expense Benefits: The policy provides benefits for hospice care for a terminally ill covered person who receives medically necessary care under a hospice care program, limited to 180 days in a covered person's lifetime.

Rehabilitation and Extended Care Facility Expense Benefits: The policy provides benefits for rehabilitation services or an inpatient stay in a rehabilitation facility or extended care facility that begins within [14 days] of a hospital stay of at least [3 days] and is for treatment of, or rehabilitation related to, the same illness or injury that required the hospital stay. Covered expenses are limited to [60 days per calendar year for each covered person].

Outpatient Prescription Drug Expense Benefits: The policy provides benefits for outpatient prescription drugs that must be prescribed by a doctor, limited to a 34-day supply for each prescription or refill (excludes drugs for addiction to, or dependency on, tobacco or foods).

[Notification

You must notify us on or before the day a covered person begins the 4th day of an inpatient hospitalization or is evaluated for an organ or tissue transplant. If you fail to notify us, benefits will be reduced to 80% of the regular policy benefits, up to a maximum reduction of $1,000. This does not apply to an inpatient hospital admission for emergency treatment.]

[Prior Authorization

Some covered expenses require prior authorization. In general, network providers must obtain authorization from us prior to providing a service or supply to a covered person. However, there are some network eligible expenses for which you must obtain the prior authorization. A list of which services require prior authorization, and who must obtain the prior authorization, is shown in the policy Data Page. Failure to obtain prior authorization will result in benefits being reduced, except in the case of an emergency. Please see the policy Data Page for details.][iv]

What Is Not Covered

No benefits will be paid for:

(A) Loss for which no charge would be made in the absence of insurance;

(B) Charges that are actually the responsibility of the provider to pay;

(C) Any services performed by a member of a covered person's immediate family; or

(D) Services not identified as covered expenses under the policy.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

(A) For services and supplies provided prior to the effective date or after the termination date of the policy.

(B) For any portion of the charges that are in excess of the eligible expense.

(C) For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.

(D) For breast reduction or augmentation.

(E) For modification of the physical body to improve the psychological, mental, or emotional well-being of the covered person, such as sex-change surgery.

(F) For any drug, treatment, or procedure that promotes conception or prevents childbirth, including but not limited to, artificial insemination or treatment for infertility or impotency; for sterilization or reversal of sterilization; or for abortion (unless a pregnancy carried to term would endanger the mother's life).

(G) For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders[, except as described in the policy].

(H) For routine well-baby care of a newborn infant, except as specifically provided by the policy.

(I) For television, telephone, or expenses for other persons.

(J) For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.

(K) For telephone consultations or failure to keep a scheduled appointment.

(L) For hospital room and board and nursing services for the first Friday or Saturday of an inpatient stay that begins on one of those days, unless it is an emergency or medically necessary inpatient surgery is scheduled for the date after the date of admission.

(M) For stand-by availability of a medical practitioner when no treatment is rendered.

(N) For dental expenses, including braces, or surgery and treatment for oral surgery[, except as described in the policy].

(O) For cosmetic treatment, except reconstructive surgery that is incidental to or follows surgery or an injury that was covered under the policy or is performed to correct a birth defect in a child who has been covered under the policy since birth.

(P) For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.

(Q) For diagnosis or treatment of nicotine addiction, [except as otherwise covered under the Preventive Care Expense Benefits provision of the policy].

(R) For charges related to, or in preparation for, tissue or organ transplants[, except as expressly provided for by the policy].

(S) For high dose chemotherapy prior to, in conjunction with, or supported by bone marrow transplant[, except as specifically provided by the policy].

(T) For eye refractive surgery when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

(U) While confined primarily to receive rehabilitation, custodial care, educational care, or nursing services [(unless expressly provided for by the policy)].

(V) For vocational or recreational therapy, vocational rehabilitation, occupational therapy, or outpatient speech therapy[, except as provided by the policy].

(W) For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.

(X) For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any related examinations or fittings.

(Y) For pregnancy (except for complications of pregnancy)[, unless the optional Pregnancy Expense Benefits Rider is attached to the policy,] or for confinement primarily for well-baby care.

(Z) For treatment of mental disorders, substance abuse, or for court ordered treatment programs for substance abuse, [unless the Optional Mental Disorders Benefits rider or the Optional Biologically-Based Mental Illness Benefits rider is attached to the policy].

(AA) For preventive care or prophylactic care, including routine physical examinations, premarital examinations, and educational

programs[, except as required by law or as provided by the policy].

(BB) For experimental or investigational treatment or for unproven services, as defined in the policy.

(CC) For expenses incurred outside of the United States, except for emergency treatment.

(DD) For injury or illness caused by employment[, except as may be covered by the policy].

(EE) As a result of intentionally self-inflicted bodily harm (whether sane or insane); an injury or illness caused by an act of war; from taking part in a riot; or from the commission of a felony, whether or not charged.

(FF) For durable medical equipment, except as expressly provided for by the policy.

(GG) For any illness or injury that occurs as a result of the covered person being intoxicated or under the influence of illegal narcotics or controlled substance, unless administered or prescribed by a doctor.

(HH) For or related to surrogate parenting.

(II) For or related to treatment of hyperhidrosis (excessive sweating).

(JJ) For fetal reduction surgery.

(KK) Except as expressly provided for by the policy, expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

(LL) [As a result of any injury sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: [operating or riding on a motorcycle;] professional or semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; [racing or speed testing any non-motorized vehicle or conveyance (if the covered person is paid to participate or to instruct);] scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; [horseback riding (if the covered person is paid to participate or to instruct);] rock or mountain climbing (if the covered person is paid to participate or to instruct); or skiing (if the covered person is paid to participate or to instruct).]

(MM) [As a result of any injury sustained while operating, riding in, or descending from any type of aircraft if the covered person is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.]

(NN) While at a residential treatment facility.

(OO) [For prescription drugs for a person who enrolls in Medicare Part D.]

In no event will we pay for charges that are: (A) not made or ordered by a doctor; or (B) not medically necessary to the diagnosis or treatment of an illness or injury.

[Coverage for illness will begin 14 days after coverage for injury. There is a 6-month waiting period for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, and disorders of the reproductive organs, unless provided on an emergency basis or for treatment of cancer.]

Term of Coverage and Renewability

The policy term begins as of the effective date of the policy. You may keep the policy in force by paying us the required premium as it comes due. However, we may cancel the policy or deny a claim if a covered person commits fraud or makes a material misrepresentation in the application.

We may refuse to renew the policy if:

(A) We refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where you then live; or

(B) There is fraud or a material misrepresentation made by or with the knowledge of a covered person in filing a claim for policy benefits.

Benefits will continue to be paid for an illness or injury after a person's coverage terminates, provided the illness or injury causes a period of extended loss that begins while the covered person is still covered by the policy.

[i] NTR: The phrase "each covered person" prints in plans that are not high deductible health plans for use with a health savings account, and the phrase "all covered persons" prints in high deductible health plans for use with a health savings account.
[ii] The Primary Care Physician and Specialist Physician provisions are bracketed so that they may be included or omitted.
[iii] The bracketed portion does not print in high deductible health plans for use with a health savings account.
[iv] Either the Notification provision or the Prior Authorization provision will be included.

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☑ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☐ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
American Medical Security Life Insurance Company	97179	AMMS-128344640	GIP28-P-AMS	☑ Yes ☐ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: The form does not exclude coverage for preexisting conditions.			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: The form does not contain any annual dollar limits on essential benefits.			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: The form does not contain any lifetime dollar limits on essential benefits.			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number: 30, Rescissions provision			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: 16, Preventive Care Expense Benefits subsection			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: 6, definition of "eligible child"			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: The appeals/grievance forms are filed separately.			
	Page Number:			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number: 22, Notification section, and Prior Authorization section of the data page.			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: 10, definition of "primary care physician"			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: 13, Primary Care Physician and Referral Required provisions.			

Reset Form

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes**◊ ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

◊ For plan years beginning before January 1, 2010, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

Forms for Arkansas GIP28

	AMS PPO	FORM DESCRIPTION
1.	GIP28-P-AMS	Individual Health PPO Policy
2.	GIP28-P-AMS-OC	Individual Health PPO Outline of Coverage
3.	SA-S-9N-AMS	Administrative Rider
4.	SA-S-10N-AMS	Administrative Rider
5.	SA-S-1356RN-AMS	Vision Benefit Rider
6.	SA-S-1366RN-AMS	Term Life Insurance Rider
7.	SA-S-1367RN-AMS	Accidental Death Insurance Rider
8.	SA-S-1417R-AMS	Copayment Amount Rider
9.	SA-S-1418R-AMS	Copayment Amount Rider (w4OVs)
10.	SA-S-1451N-AMS	Supplemental Accident Benefits Rider
11.	SA-S-1505-AMS	Pregnancy Benefits Rider
12.	SA-S-1528-P-AMS	Outpatient Prescription Drug Expense Benefits Rider
13.	SA-S-1542-P-AMS	Outpatient Generic Prescription Drug Expense Benefits Rider
14.	SA-S-1547-AMS	Prior Authorization Rider
15.	SA-S-1559-P-AMS	Copayment Amount Rider (for HSA)
16.	SA-S-1560-P-AMS	Copayment Amount Rider (for HSA w4OVs)
17.	SA-S-1561-P-AMS	Outpatient Prescription Drug Expense Benefits Rider (for HSA)
18.	SA-S-1562-P-AMS	Outpatient Generic Prescription Drug Expense Benefits Rider (for HSA)
19.	SA-S-1499N-AMS	[Optional] Mental Disorder Benefits Rider
20.	SA-S-1570-AMS	[Optional] Biologically-Based Mental Illness Benefits Rider
21.	SA-S-1457N-AMS	AR Optional Hearing Aids Rider
22.	SA-S-1574-AMS	AR Optional Musculoskeletal Disorders Rider
23.	GIP-AP-144-AMS-03	Application
24.	SA-AP-1.1-AMS	Amendment to Application
25.	MTI00123-03	Reimbursement provision
26.	MTI00359	Endorsement opening
27.	MTI00361-03	Endorsement closing
28.	MTI00363-03	Benefit for diabetes
29.	MTI00364-03	Benefit for speech and hearing disorders
30.	MTI00366-03	Benefit for metabolic disorders
31.	MTI00367-03	Benefit for newborn screenings and tests
32.	MTI00368-03	Definition of "complications of pregnancy"
33.	MTI00393-03	Adding a Newborn Child provision
34.	MTI00394-03	Adding an Adopted Child provision
35.	MTI00395	Coordination of Benefits provision
36.	MTI00396	Prior to Legal Action provision
37.	MTI00408-03	Definition of "medical practitioner"
38.	MTI00410	Remove the variable deductible
39.	MTI00427-03	Benefit for in vitro fertilization

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/08/2012	Supporting Document	Forms List GIP28 Arkansas	06/06/2012	Forms List GIP28 AR for AMS.pdf (Superceded)
05/08/2012	Form	Individual Health PPO Policy	06/11/2012	GIP28-P-AMS PPO Policy.pdf (Superceded)
05/08/2012	Form	Individual Health PPO Outline of Coverage	06/08/2012	GIP28-P-AMS-OC PPO Outline.pdf (Superceded)
05/08/2012	Form	Administrative Rider	06/06/2012	SA-S-9-AMS Rdr.pdf (Superceded)
05/08/2012	Form	Administrative Rider	06/06/2012	SA-S-10-AMS Rdr.pdf (Superceded)

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32.	MTI00368-03	Definition of "complications of pregnancy"
33.	MTI00393-03	Adding a Newborn Child provision
34.	MTI00394-03	Adding an Adopted Child provision
35.	MTI00395	Coordination of Benefits provision
36.	MTI00396	Prior to Legal Action provision
37.	MTI00408-03	Definition of "medical practitioner"
38.	MTI00410	Remove the variable deductible
39.	MTI00427-03	Benefit for in vitro fertilization

American Medical Security Life Insurance Company
3100 AMS Boulevard
P.O. Box 19032
Green Bay, WI 54307-9032
For Inquiries: [(800) 232-5432]

In this *policy, "you"* or *"your"* will refer to the Insured named on page 3, and *"we," "our,"* or *"us"* will refer to American Medical Security Life Insurance Company, a stock company.

Section 1

AGREEMENT AND CONSIDERATION

We will pay benefits for a *loss* as set forth in this *policy.* This *policy* is issued in exchange for and on the basis of the statements made on *your* application and payment of the first premium. It takes effect on the applicable *effective date* shown on the Data Page. It will remain in force until the first premium due date, and for such further periods for which premium payment is received by *us* when due, subject to the renewal provision below. All periods will begin and end at 12:01 A.M., Standard Time, where *you* live.

GUARANTEED RENEWABLE SUBJECT TO LISTED CONDITIONS

You may keep this *policy* in force by timely payment of the required premiums. However, *we* may refuse renewal as of the anniversary of the *policy effective date* if: (A) *we* refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* then live[, as explained under the Discontinuance clause]; or (B) there is fraud or a material misrepresentation made by or with the knowledge of a *covered person* in filing a claim for *policy* benefits.

From time to time, *we* will change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The policy plan, age and sex of *covered persons,* type and level of benefits, time the *policy* has been in force, and place of residence on the premium due date are some of the factors used in determining *your* premium rates. Premium rates are expected to increase over time.

At least [31] days notice of any plan to take an action or make a change permitted by this clause will be mailed to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *policy* or a change in a *covered person's* health. While this *policy* is in force, *we* will not restrict coverage already in force.

10-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this *policy.* If *you* are not satisfied, *you* may notify *us* within 10 days after *you* received it. Any premium paid will be refunded, less claims paid. This *policy* will then be void from its start.

Check the attached application. If it is not complete or has an error, please let *us* know. An intentional misrepresentation of a material fact or a fraudulent misstatement in the application may cause *your policy* to be voided, or a claim to be reduced or denied.

This *policy* is signed for *us* as of the *effective date* for *injuries* as shown on the Data Page.

President

Medical Expense Insurance Policy

This policy is renewable, subject only to the two conditions set forth in the renewal clause. We have the right to change premiums as set forth above.

As a cost containment feature, this policy contains [notification/prior authorization] requirements. Benefits are reduced if the requirements are not met. Please refer to [the Notification and Predetermination section/the Prior Authorization Rider].

Table of Contents

Section	
[1	Policy Face Page
	Agreement and Consideration
	Guaranteed Renewable Subject to Listed Conditions
	10-Day Right to Examine and Return This Policy
2	Data Page
3	General Definitions
4	Premiums
5	Dependent Coverage
6	Continuing Eligibility
7	Amount Payable
8	Medical Benefits
	Preventive Care Expense Benefits
	Transplant Expense Benefits
	Home Health Care Expense Benefits
	Hospice Care Expense Benefits
	Rehabilitation and Extended Care Facility Expense Benefits
	Outpatient Prescription Drug Expense Benefits
9	Notification and Predetermination
10	General Exclusions and Limitations
11	Reimbursement
12	Termination
13	Claims
14	General Provisions]

Important Notice

This *policy* is a legal contract between *you* and *us*.

READ *YOUR POLICY* CAREFULLY.

Section 2
Data Page

[**Policy Number -** 999-999-999
Insured - John Doe
Plan - Individual/Husband-Wife/All Family/One-Parent Family
Total Premium - $XXXX.XX

Premium Mode - Monthly/Quarterly
Effective Date:
For Injuries - Month Day, Year
For Illnesses - Month Day, Year]

[**Premiums for Optional Benefits** (These are already included in the Total Premium above.)

Vision ..... $XX.XX
Supplemental Accident ..... $XX.XX
Lower Copayment Amount for Doctor Office Visits ..... $XX.XX
Prescription Drug Copay Card ..... $XX.XX
Lower Prescription Drug Deductible ..... $XX.XX
24-Month Rate Guarantee ..... $XX.XX
Term Life (initial premium*) ..... $XX.XX
Accidental Death (initial premium*) ..... $XX.XX

*Please see the Term Life and Accidental Death sections of the Data Page for renewal premium amounts.]

[**See rider-amendment(s) attached to policy.**]

[**IMPORTANT: If covered expenses are incurred at a non-network provider, benefits for non-network eligible expenses will be less than the amount that would have otherwise been payable for the services of a network provider. Please refer to the Amount Payable section of this policy and the information listed below.**]

[**DEDUCTIBLE AMOUNT -- Stated Deductible,** per *covered person,* per calendar year

Inpatient

Network Provider .....[Range = $1,000 - $10,000]

Maximum number of *covered persons* required to meet the *inpatient network provider* stated deductible per family, per calendar year ..... Two

Unless otherwise stated, the *network provider* stated deductible will not apply to *covered expenses* subject to a *copayment amount*.

Non-Network Provider (including *covered expenses* credited to the *network provider* stated deductible) .....[Range = $2,000 - $20,000]

Outpatient

Network Provider .....[Range = $1,000 - $10,000]

Maximum number of *covered persons* required to meet the outpatient *network provider* stated deductible per family, per calendar year ..... Two

Unless otherwise stated, the *network provider* stated deductible will not apply to *covered expenses* subject to a *copayment amount*.

Non-Network Provider (including *covered expenses* credited to the *network provider* stated deductible) .....[Range = $2,000 - $20,000]

Variable Deductible is equal to the amount of *covered expenses* payable under any *other plan*. The *variable deductible* will be applied even if the stated deductible has been satisfied.][1]

[1] Note to Reviewer (NTR): This provision will print in plans that are not intended to be used with a qualified health savings account.

[**DEDUCTIBLE AMOUNT**

Stated Deductible, per calendar year

Individual Plan

Network Provider ..... [Range = $1,250 - $6,000[2]]

Non-Network Provider ..... [Range = $2,500 - $12,000]

Family Plan

Network Provider ..... [Range = $2,500 - $12,000[3]]

Non-Network Provider ..... [Range = $5,000 - $24,000]

Variable Deductible is equal to the amount of *covered expenses* payable under any *other plan*. The *variable deductible* will be applied even if the stated deductible has been satisfied.

Your stated deductible is likely to increase each year. If *you* have chosen the maximum stated deductible, the increase will be based on the cost-of-living adjustment (COLA) levels set annually by the Internal Revenue Service (IRS) with regard to the maximum deduction allowed by law for Health Savings Accounts (HSAs). If *you* have chosen a lower stated deductible, the increase will be based on COLA levels set annually by the IRS for the minimum deductible required of an HSA high deductible health plan. The increase is currently calculated as a percentage rounded to the nearest $50. All stated deductibles may be adjusted, even if not required to maintain tax-qualified status.][4]

[**DEDUCTIBLE CREDIT**

Qualified covered person for 1 year ..... 20% of the *network provider* stated deductible

Qualified covered person for 2 consecutive years ..... 40% of the *network provider* stated deductible

Qualified covered person for 3+ consecutive years ..... 50% of the *network provider* stated deductible]

[**COINSURANCE PERCENTAGE**

Inpatient

For *covered expenses* in excess of the applicable stated deductible [Range=60%-100%]

Outpatient

For *covered expenses* in excess of the applicable stated deductible [Range=60%-100%]

{(Not applicable to *covered expenses* subject to a *copayment amount*, unless otherwise specifically stated)}[5]

COINSURANCE OUT-OF-POCKET MAXIMUM

Per *covered person*, per calendar year ..... [Range = $0-$10,000]

If payment is calculated using the *variable deductible*, the *coinsurance percentage* will be 100 percent. The effect of the *variable deductible* is to pay 100 percent of the *covered person's out-of-pocket* expenses, excluding any *copayment amounts*.][6]

[**COINSURANCE PERCENTAGE**

Inpatient

For *covered expenses* in excess of the applicable stated deductible [Range=70%-100%]

Outpatient

For *covered expenses* in excess of the applicable stated deductible [Range=70%-100%]

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[2] NTR: Or the IRS limit for high deductible health plans.

[3] NTR: Or the IRS limit for high deductible health plans.

[4] NTR: This provision will print in high deductible health plans used with a qualified health savings account.

[5] NTR: This sentence will print in plans with a copayment amount.

[6] NTR: This provision will print in plans that are not intended for use with a qualified health savings account.

If payment is calculated using the *variable deductible*, the *coinsurance percentage* will be 100 percent. The effect of the *variable deductible* is to pay 100 percent of the *covered person's out-of-pocket* expenses, excluding any *copayment amounts*.][7]

[**OUT-OF-POCKET MAXIMUM**

Individual Plan .....[Range = $1,250-$6,000]

Family Plan.....[Range = $2,500-$12,000]

The out-of-pocket maximum includes applicable stated deductibles, *copayment amounts,* and coinsurance amounts.][8]

[**NON-NETWORK PROVIDER BENEFITS**

Covered expenses do not include amounts in excess of the *eligible expense*. Non-*emergency non-network eligible expenses* will be reduced by 25% before application of any applicable *deductible amounts* and coinsurance provisions. This means, for example, $100 of *non-network eligible expenses* will be considered as $75 in *eligible expenses* for purposes of determining benefits. These reduced *non-network eligible expenses* will then be subject to any applicable *deductible amounts* and coinsurance provisions.]

[**BENEFIT LIMITS/SPECIFICS**]

[**EMERGENCY ROOM DEDUCTIBLE** (for each visit for *illness* to an *emergency* room

when the *covered person* is not directly admitted to the *hospital*) .....[Range = $100-$1,000]

Note: After satisfaction of the *emergency* room deductible, *covered expenses* are subject to any applicable *deductible amounts* and coinsurance provisions.][9]

[**BENEFIT REDUCTION FOR FAILURE TO OBTAIN REFERRAL: Failure to obtain a referral from your primary care physician will result in a benefit reduction. Reduced benefits will be 80% of regular policy benefits.**][10]

[**NETWORK PROVIDER COPAYMENT AMOUNTS***

Office Visits for Injury or Illness: *Copayment amount* per office visit (excluding *surgery*) performed by a *doctor*, limited to the charge for the office visit (history and exam only)

Network Primary Care Physician (PCP).....[Range = $25-$50]

Network Specialist Physician

With PCP Referral.....[Range = $25-$100]

Without Referral .....[2 x Specialist Copay / $50-$200]

Hospital Inpatient

{*Copayment amount* per *inpatient* stay in a *hospital*..... [Range = $500-$1,000]}

{*Copayment amount* per *inpatient* day in a *hospital* .....[Range = $250-$750]}

Urgent Care Center

Copayment amount per visit to an *urgent care center* .....[Range = $75-$100]

MRI/CT Scan/PET Scan

Copayment amount per service** .....[Range = $150-$250]

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[7] NTR: This provision will print in high deductible health plans for use with a qualified health savings account.

[8] NTR: This provision will print in high deductible health plans for use with a qualified health savings account.

[9] NTR: This provision will print in plans that are not intended to be used with a qualified health savings account.

[10] NTR: This provision will print in non-copay plans.

{The *copayment amount* will be applied after the *deductible amount* has been met. After the *copayment amount,* benefits will then be subject to the applicable *coinsurance percentage*.}[11]

Covered expenses incurred at a non-*network provider* will be reduced by 25%. Benefits will then be subject to the non-*network provider deductible amount* and the applicable *coinsurance percentage*.

**Benefits will then be subject to the *network provider deductible amount*.][12]

[**NETWORK PROVIDER COPAYMENT AMOUNTS***

Office Visits 1-4 (per *covered person,* per calendar year)**

Copayment amount per office visit (excluding *surgery*) performed by a *doctor,* limited to the charge for the office visit (history and exam only)

Network Primary Care Physician (PCP).....[Range = $25-$50]

Network Specialist Physician

With PCP Referral.....[Range = $25-$100]

Without Referral .....[2 x Specialist Copay / $50-$200]

Hospital Inpatient

{*Copayment amount* per *inpatient* stay in a *hospital*..... [Range = $500-$1,000]}

{*Copayment amount* per *inpatient* day in a *hospital* .....[Range = $250-$750]}

Urgent Care Center

Copayment amount per visit to an *urgent care center*.....[Range = $75-$100]

MRI/CT Scan/PET Scan

Copayment amount per service***.....[Range = $150-$250]

{The *copayment amount* will be applied after the *deductible amount* has been met. After the *copayment amount,* benefits will then be subject to the applicable *coinsurance percentage*.}[13]

Covered expenses incurred at a non-*network provider* will be reduced by 25%. Benefits will then be subject to the non-*network provider deductible amount* and the applicable *coinsurance percentage.*

**Additional office visits will be subject to the applicable *deductible amount* and *coinsurance percentage.*

***Benefits will then be subject to the *network provider deductible amount*.][14]

[**PRESCRIPTION DRUGS**

Tier 1, *prescription drug copayment amount* per *prescription order* or refill.....{$15-$30}

Tier 2, *prescription drug copayment amount* per *prescription order* or refill
{after satisfaction of a [Range = $500 - $1,000] calendar year *prescription drug deductible amount*,}[15] per *covered person*.....{$35-$50}

Tier 3, *prescription drug copayment amount* per *prescription order* or refill
{after satisfaction of a [Range = $500 - $1,000] calendar year *prescription drug deductible amount,*}[16] per *covered person*.....{$65-$80}

Tier 4, *prescription drug copayment amount* per *prescription order* or refill
{after satisfaction of a [Range = $500 - $1,000] calendar year *prescription drug deductible amount*,}[17] per *covered person*

[11] NTR: This statement will print in high deductible health plans for use with a qualified health savings account.
[12] NTR: This copayment provision will print if the optional four office visits benefit is not selected.
[13] NTR: This statement will print in high deductible health plans for use with a qualified health savings account.
[14] NTR: This copayment provision will print when the optional four office visits benefit is selected.
[15] NTR: This phrase will not print in high deductible health plans for use with a health savings account.
[16] NTR: This phrase will not print in high deductible health plans for use with a health savings account.
[17] NTR: This phrase will not print in high deductible health plans for use with a health savings account.

At *member pharmacies* ..... {25%-35%} of negotiated rate
At non-*member pharmacies* ..... {25%-35%} of *predominant reimbursement rate*

NOTE: Tier status for a *prescription drug* may be determined by accessing *your prescription drug* benefits via *our* website or by calling the telephone number on *your* identification card. The tier to which a *prescription drug* is assigned may change as detailed in the *policy*.

{The *copayment amount* will be applied after the *deductible amount* has been met. After the *copayment amount,* benefits will then be subject to the applicable *coinsurance percentage*.}[18]

No benefits are payable for expenses in excess of the cost of the *generic drug* when a name brand drug is purchased and the *generic drug* is available.

"*Generic drug*" means a prescription drug product that: (1) is chemically equivalent to a brand-name drug; or (2) *we* identify as a generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. *You* should know that all products identified as a "generic" by the manufacturer, pharmacy or *your* physician may not be classified as a *generic drug* by *us*.][19]

[**NETWORK PROVIDER COPAYMENT AMOUNTS**

Outpatient Generic Prescription Drugs, per *prescription order* or refill ..... {$15-$30}

"Generic drug" means a prescription drug product that: (1) is chemically equivalent to a brand-name drug; or (2) *we* identify as a generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. *You* should know that all products identified as a "generic" by the manufacturer, pharmacy, or *your* physician may not be classified as a *generic drug* by *us*.][20]

[**Spine and Back Disorders Benefits**

Maximum number of outpatient visits, per *covered person,* per calendar year ..... 15]

[**Supplemental Accident Expense Benefits** (Benefits are not subject to the stated deductible, but benefits paid will be credited to any *network provider* stated deductible and *coinsurance percentage*.)

Maximum Benefit.....[Range = $250 - $10,000]
Benefit Period ..... Within 90 days of an accidental *injury*][21]

[**This policy is intended to be and will be administered to qualify as a high deductible health plan for purposes of tax qualified Health Savings Account plans.**][22]

[**24-MONTH INITIAL RATE GUARANTEE**
(Not applicable to dependent eligibility changes, address changes, or benefit changes requested by the insured or mandated by law.)
The rate guarantee expires 24 calendar months after the *effective date* shown on the Data Page.][23]

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[18] NTR: This statement will print in high deductible health plans for use with a qualified health savings account.
[19] NTR: Included in some plans. An optional benefit for other plans.
[20] NTR: This provision will print if the optional generic prescription drugs only benefit is selected.
[21] NTR: This provision will print if the optional supplemental accident benefit is selected.
[22] NTR: This provision will print in high deductible health plans used with a qualified health savings account.
[23] NTR: This provision will print only if the optional 24-month rate guarantee benefit is selected.

[**NOTIFICATION REQUIREMENTS**

You must notify *us* at the phone number listed on *your* ID card when a *covered person's hospital* stay exceeds three days, or when a *covered person* is evaluated for an organ or tissue transplant. Failure to notify *us* will result in a benefit reduction. Notification does not guarantee payment.]

[PRIOR AUTHORIZATION REQUIREMENTS

We require prior authorization for certain *covered expenses.* In general, when services or supplies are received from a *network provider,* the *network provider* is responsible for obtaining the prior authorization, and when services or supplies are received from a non-*network provider, you* are responsible for obtaining the prior authorization. However, there are exceptions. Services and supplies for which *you* are responsible for obtaining prior authorization are listed below.

Failure to obtain prior authorization will result in a reduction of benefits. Reduced benefits will be 80% of regular *policy* benefits that would have otherwise been payable.

Obtaining prior authorization does not guarantee payment. Please see the Prior Authorization Rider for more information.

SERVICES AND SUPPLIES FOR WHICH YOU MUST OBTAIN PRIOR AUTHORIZATION

[**Ambulance, non-emergency**

You must obtain authorization for non-*emergency* ambulance transportation as soon as possible prior to transport.

Clinical Trials

You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises.

Congenital Heart Disease Surgery

For *network* and non-*network* benefits, *you* must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) *surgery* arises.

Dental Expenses - Injuries Only

For *network* and non-*network* benefits, *you* must obtain prior authorization 5 business days before follow-up (post-*emergency*) treatment begins. *You* do not have to obtain prior authorization before the initial *emergency* treatment.

Diabetes Services

For non-*network* benefits, *you* must obtain prior authorization before obtaining any equipment, for the management and treatment of diabetes, [that exceeds {Range = $1,000-$5,000} in cost (either retail purchase cost or cumulative retail rental cost of a single item)].

Durable Medical Equipment

For non-*network* benefits, *you* must obtain prior authorization before obtaining any *durable medical equipment* [that exceeds {Range = $1,000-$5,000} in cost (either retail purchase cost or cumulative retail rental cost of a single item)].

Home Health Care

For non-*network* benefits, *you* must obtain prior authorization 5 business days before receiving *home health care* services, or as soon as reasonably possible.

Hospice Care

For non-*network* benefits, *you* must obtain prior authorization 5 business days before admission for an *inpatient* stay in a *hospice*, or as soon as reasonably possible.

Hospital Inpatient Stay

For non-*network* benefits, *you* must obtain prior authorization:

5 business days before a scheduled admission; or

As soon as is reasonably possible for a non-scheduled admission, including *emergency* admissions.

Lab, X-Ray, and Major Diagnostics - CT, PET, MRI, MRA, and Nuclear Medicine

For non-*network* benefits, *you* must obtain prior authorization:

5 business days before scheduled services are received; or

For non-scheduled services, within one business day or as soon as is reasonably possible.

{**Mental Health and Substance Abuse Services**

For non-*network* benefits for treatment of a [*biologically-based mental illness/mental disorder*] or *substance abuse, you* must obtain authorization:

5 business days before a scheduled admission;

As soon as is reasonably possible for a non-scheduled admission, including *emergency* admissions; or

Prior to receiving services on an outpatient basis.}[24]

Outpatient Prescription Drugs

For non-*network* benefits for intravenous infusions, *you* must obtain prior authorization:

5 business days before receiving scheduled services; or

For non-scheduled services, within one business day or as soon as is reasonably possible.

For non-*network* benefits for other outpatient *prescription drugs, you* must obtain prior authorization 5 business days before certain *prescription drugs* are received, or as soon as is reasonably possible. *You* may determine whether a particular *prescription drug* requires prior authorization by calling *us* at the telephone number listed on *your* health insurance identification card.

Outpatient Surgery

For non-*network* benefits for *outpatient surgery, you* must obtain prior authorization:

5 business days before receiving scheduled services; or

For non-scheduled services, within one business day or as soon as is reasonably possible.

Prosthetic Devices

For non-*network* benefits, *you* must obtain prior authorization before obtaining prosthetic devices [that exceed {range = $1,000-$5,000} in cost per device].

Reconstructive Surgery

For non-*network* benefits, *you* must obtain prior authorization:

5 business days before a scheduled *reconstructive surgery* is performed; or

For a non-scheduled *reconstructive surgery*, within one business day or as soon as is reasonably possible.

Rehabilitation and Extended Care Facility Services

For non-*network* benefits for *rehabilitation therapy* services, *you* must obtain prior authorization 5 business days before receiving *rehabilitation* services, or as soon as is reasonably possible.

For non-*network* benefits for *inpatient rehabilitation* or confinement in an *extended care facility, you* must obtain prior authorization:

5 business days before a scheduled admission; or

As soon as is reasonably possible for a non-scheduled admission.

Sleep Studies

For non-*network benefits, you* must obtain prior authorization 5 business days before scheduled services are received.

Temporomandibular Joint (TMJ) Services

For non-*network* benefits, *you* must obtain prior authorization 5 business days before TMJ services are performed during an *inpatient* stay in a *hospital.*

Therapeutic Treatments

For non-*network* benefits, *you* must obtain prior authorization for dialysis, chemotherapy, radiation therapy:

5 business days before scheduled services are received; or

For non-scheduled services, within one business day or as soon as is reasonably possible.

Transplants

For *network* and non-*network* benefits, *you* must obtain prior authorization as soon as the possibility of a transplant arises and before the time a pre-transplant evaluation is performed at a transplant center.]**]**

[24] NTR: This paragraph will print only if optional rider SA-S-1499N or SA-S-1570 is attached to the policy.

[**We may from time to time negotiate fee discounts with health care professionals and facilities. Benefit calculations will be based upon the discounted price, if any. We share discounts with you in proportion to payment. Discounts taken by us contribute to lower future rate increases.**]

[**TERM LIFE INSURANCE BENEFIT**

Term Life Proceeds

Attained Age*	**Primary Insured Term Life Proceeds**	**Spouse Term Life Proceeds**
18-64	$50,000/$100,000/$150,000	$50,000/$100,000/$150,000
65 and older	$ 0	$ 0

*For purposes of determining the term life proceeds, *attained age* means the age of the primary insured or *spouse* at the start of the *premium period* in which death occurs.

Annual Renewal Premiums

Attained Age**	**Primary Insured Gender Tobacco/Non-Tbco**	**Spouse Gender Tobacco/NonTbco**
18-29	PrimaryPremium1	SpousePremium1
30-34	PrimaryPremium2	SpousePremium2
35-39	PrimaryPremium3	SpousePremium3
40-44	PrimaryPremium4	SpousePremium4
45-49	PrimaryPremium5	SpousePremium5
50-54	PrimaryPremium6	SpousePremium6
55-59	PrimaryPremium7	SpousePremium7
60-64	PrimaryPremium8	SpousePremium8

**For purposes of calculating renewal premiums, *attained age* means the age of the primary insured or *spouse* at the beginning of any *premium period*.

Quarterly - .25 x Annual **Monthly - .08333 x Annual**

Covered Persons: Primary Insured and Spouse Only][25]

[**ACCIDENTAL DEATH BENEFIT**

Accidental Death Proceeds

Attained Age*	**Primary Insured Accidental Death Proceeds**	**Spouse Accidental Death Proceeds**
18-64	$ 50,000	$ 50,000
65 and older	$ 0	$ 0

*For purposes of determining the accidental death proceeds, *attained age* means the age of the primary insured or *spouse* at the start of the *premium period* in which death occurs.

[25] NTR: This provision will print only if the optional term life benefit is selected.

Annual Renewal Premiums

Primary Insured	**Spouse**
PrimaryPremium1	SpousePremium1

Quarterly - .25 x Annual **Monthly - .08333 x Annual**

Covered Persons: Primary Insured and Spouse Only][26]

[**VISION BENEFIT**

Eye Exam .....[$10 copay then 100%]
Eye Exam *Vision Benefit Non-Preferred Provider* .....[up to $40 allowance]
Frames[C] ..... [$25[A] copay then 100%]
Frames *Vision Benefit Non-Preferred Provider*.....[up to $45 allowance]
Standard Single Vision Lenses ..... [$25[A] copay then 100%]
Single Vision Lenses *Vision Benefit Non-Preferred Provider* .....[up to $40 allowance]
Standard Bifocal Lenses ..... [$25[A] copay then 100%]
Bifocal Lenses *Vision Benefit Non-Preferred Provider* .....[up to $60 allowance]
Standard Trifocal Lenses ..... [$25[A] copay then 100%]
Trifocal Lenses *Vision Benefit Non-Preferred Provider* .....[up to $80 allowance]
Standard Lenticular Lenses ..... [$25[A] copay then 100%]
Lenticular Lenses *Vision Benefit Non-Preferred Provider* .....[up to $80 allowance]
Covered-in-Full Elective Contacts[B] ..... [$25 copay then 100%[D]]
Contacts *Vision Benefit Non-Preferred Provider*.....[up to $105 allowance]
Necessary Contacts ..... [$25 copay then 100%[D]]
Contacts *Vision Benefit Non-Preferred Provider*.....[up to $210 allowance]

[A] If you purchase eyeglass lenses and eyeglass frames at the same time from the same *vision benefit preferred provider*, only one copayment will apply to those eyeglass lenses and eyeglass frames together.

[B] You are eligible to select only one of either eyeglasses (eyeglass lenses and/or eyeglass frames) or contact lenses. If you select more than one of these services, only one service will be covered.

[C] You may purchase from your *vision benefit preferred provider* eyeglass frames that are outside of the covered eyeglass frames selection. Non-selection eyeglass frames will receive an allowance. The eyeglass frame allowance will be [$50] wholesale or [$130] retail, depending upon the type of *vision benefit preferred provider* selected. No copayment will apply to non-selection eyeglass frames.

[D] You may purchase from your *vision benefit preferred provider* contact lenses that are outside of the covered contact lens selection. Non-selection contact lenses will receive an allowance of [$105] for elective contacts and [$210] for necessary contacts. No copayment will apply to non-selection contact lenses.][27]

[26] NTR: This provision will print only if the optional accidental death benefit is selected.
[27] NTR: This provision will print only if the optional vision benefit is selected.

Section 3
GENERAL DEFINITIONS

In this *policy, italicized* words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this *policy*:

- *"Acute rehabilitation"* means two or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for three or more hours per day, five to seven days per week, while the *covered person* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *extended care facility*.

- *"At risk for ovarian cancer"* means:

  (A) A female *covered person* having a family history of:

    (1) One or more first-degree relatives with ovarian cancer;

    (2) Two or more female relatives with breast cancer; or

    (3) Nonpolyposis colorectal cancer; or

  (B) A female *covered person* testing positive for BRCA1 or BRCA2 mutations.

- *"Coinsurance percentage"* means the percentage of *covered expenses* that are payable by *us*.

If payment is calculated using the *variable deductible,* the *coinsurance percentage* will be 100 percent.

- *"Complications of pregnancy"* means:

  (A) Conditions whose diagnoses are distinct from *pregnancy,* but are adversely affected by *pregnancy* or are caused by *pregnancy* and not, from a medical viewpoint, associated with a normal *pregnancy.* This includes: ectopic *pregnancy,* spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, *doctor* prescribed rest during the period of *pregnancy,* morning sickness, and conditions of comparable severity associated with management of a difficult *pregnancy,* and not constituting a medically classifiable distinct complication of *pregnancy*.

  (B) An *emergency* caesarean section or a *non-elective caesarean section*.

- *"Copayment amount"* means the amount of *covered expenses* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Data Page), before [benefits are payable for remaining *covered expenses* for that service under the *policy*][i] [application of any *coinsurance percentage*][ii].

- *"Cosmetic treatment"* means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an *injury*, *illness*, or congenital anomaly.

- *"Covered expense"* means an expense that is:

  (A) Incurred while *your* or *your dependent's* insurance is in force under this *policy*;

  (B) Covered by a specific benefit provision of this *policy*; and

  (C) Not excluded anywhere in this *policy*.

- *"Covered person"* means *you*, *your* lawful *spouse* and each *eligible child*:

  (A) Named in the application; or

  (B) Whom *we* agree in writing to add as a *covered person*.

- *"Custodial care"* means care that is administered for assistance (rather than for training or education) of the patient in performing the activities of daily living. *Custodial care* also includes nonacute care for the comatose, semicomatose, paralyzed, or mentally incompetent patient.

- *"Deductible amount"* means the amount of *covered expenses*, shown in the Data Page, that must actually be paid by [each/all][iii] *covered person[s]* during any calendar year before any benefits are payable. The *deductible amount* does not include any *copayment amount.* The *deductible amount* is the larger of the stated deductible shown in the Data Page or the *variable deductible*.

A new stated deductible must be met each calendar year.

[The maximum number of *covered persons* in a family that must meet the stated deductible in a calendar year is shown in the Data Page.][iv]

- *"Deductible credit"* means the amounts shown on the Data Page that may be offset against a

qualified covered person's [individual/family] stated deductible for the following calendar year.

- *"Dental expenses"* means *surgery* or services provided to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue and any related supplies or oral appliances. Expenses for such treatment are considered *dental expenses* regardless of the reason for the services.

- *"Dependent"* means *your* lawful *spouse* and/or an *eligible child*.

- *"Doctor"* means a duly licensed practitioner of the medical arts, limited to a physician holding an M.D. or D.O. degree, optometrist, dentist, podiatrist, chiropractor, or clinical psychologist. With regard to medical services provided to a *covered person*, a *doctor* must be currently licensed by the state in which the services are provided, and the services must be provided within the scope of that license. With regard to consulting services provided to *us*, a *doctor* must be currently licensed by the state in which the consulting services are provided.

- *"Durable medical equipment"* means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an *illness* or *injury*, can withstand repeated use, are generally not useful to a person in the absence of *illness* or *injury*, and are appropriate for use in the patient's home.

- *"Effective date"* means the applicable date a *covered person* becomes insured for *illness* or *injury*. The applicable *effective date* is shown:

  (A) In the Data Page of this *policy* for initial *covered persons*; and

  (B) On the rider adding any new *covered person*.

[The *effective date* for *illness* will always be on the 15th day after the *effective date* for *injury*.]

- *"Eligible child"* means *your* or *your spouse's* child, if that child is less than 26 years of age.

As used in this definition, "child" means: (A) a natural child; (B) a legally adopted child; (C) a child placed with *you* for adoption; or (D) a child for whom legal guardianship has been awarded to *you* or *your spouse*.

It is *your* responsibility to notify *us* if *your* child ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* pay for a child at a time when the child did not qualify as an *eligible child*.

- *"Eligible expense"* means a *covered expense* as determined below.

  (A) For *network providers* (excluding Transplant Benefits): When a *covered expense* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.

  (B) For non-*network providers*:

    (1) When a *covered expense* is received from a non-*network provider* as a result of an *emergency* or as otherwise approved by *us*, the *eligible expense* is the lesser of the billed charge or a lower amount negotiated with the provider [or authorized by state law].

    (2) When a *covered expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible expense* is the lesser of the billed charge or a lower amount negotiated with the provider [or authorized by state law].

    (3) Except as provided under (1) and (2) above, when a *covered expense* (excluding Transplant Benefits) is received from a non-*network provider*, the *eligible expense* is determined based on [the lesser of/the first of the following rules that can be applied in the order shown below]:

      (a) [The fee that has been negotiated with the provider; or

      (b) [110%] of the fee Medicare allows for the same or similar services provided in the same geographical area; or

      (c) 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 geographical area determined by *us*; or

      (d) The fee charged by the provider for the services; or

      (e) A fee schedule that *we* develop.]

- *"Emergency"* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(A) Placing the health of the *covered person* (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

- *"Experimental or investigational treatment"* means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

(A) Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"USFDA"*) regulation, regardless of whether the trial is subject to *USFDA* oversight.

(B) An *unproven service.*

(C) Subject to *USFDA* approval, and:

(1) It does not have *USFDA* approval;

(2) It has *USFDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or

(3) It has *USFDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *USFDA*-approved drug is a use that is determined by *us* to be:

(a) Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;

(b) Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or

(c) Not an *unproven service;* or

(4) It has *USFDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *USFDA* or has not been determined through peer-reviewed medical literature to treat the medical condition of the *covered person.*

(D) Experimental or investigational according to the provider's research protocols.

Items (C) and (D) above do not apply to phase III or IV *USFDA* clinical trials.

- *"Extended care facility"* means an institution, or a distinct part of an institution, that:

(A) Is licensed as a *hospital*, *extended care facility*, or *rehabilitation facility* by the state in which it operates;

(B) Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *doctor* and the direct supervision of a registered nurse;

(C) Maintains a daily record on each patient;

(D) Has an effective utilization review plan;

(E) Provides each patient with a planned program of observation prescribed by a *doctor;* and

(F) Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing standards of medical practice for that condition.

Extended care facility does not include a facility primarily for rest, the aged, treatment of *substance abuse, custodial care,* nursing care, or for care of *mental disorders* or the mentally incompetent.

- *"Generally accepted standards of medical practice"* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered expense* under the *policy*. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

- *"Hospital"* means an institution that:

(A) Operates as a *hospital* pursuant to law;

(B) Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients*;

(C) Provides 24-hour nursing service by registered nurses on duty or call;

(D) Has staff of one or more *doctors* available at all times;

(E) Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and

(F) Is not primarily a long-term care facility; an *extended care facility*, nursing, rest, *custodial care*, or convalescent home; a halfway house, transitional facility, or *residential treatment facility;* a place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *covered person* will be deemed not to be confined in a *hospital* for purposes of this *policy*.

- *"Illness"* means a sickness, disease, disorder, or abnormal condition of a *covered person*. *Illness* does not include *pregnancy*, learning disabilities, attitudinal disorders, or disciplinary problems. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

- *"Immediate family"* means the parents, *spouse*, children, or siblings of any *covered person*, or any person residing with a *covered person*.

- *"Injury"* means accidental bodily damage sustained by a *covered person* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

- *"Inpatient"* means that medical services, supplies, or treatment are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

- *"Intensive care unit"* means a Cardiac Care Unit, or other unit or area of a *hospital*, that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

- *"Intensive day rehabilitation"* means two or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for three or more hours per day, five to seven days per week.

- *"Loss"* means an event for which benefits are payable under this *policy*. A *loss* must occur while the *covered person* is insured under this *policy*.

- *"Maximum therapeutic benefit"* means the point in the course of treatment where no further improvement in a *covered person's* medical condition can be expected, even though there may be fluctuations in levels of pain and function.

- *"Medical practitioner"* means a *doctor*, nurse anesthetist, physician's assistant, [physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* acupuncturist, speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, *emergency* medical technician, social worker, family counselor, marriage counselor, child counselor, naturopath, perfusionist, massage therapist or sociologist.] With regard to medical services provided to a *covered person*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification. With regard to consulting services provided to *us*, a *medical practitioner* must be licensed or certified by the state in which the consulting services are provided.

- *"Medically necessary"* means a health care service, supply, or drug provided for the purpose of preventing, evaluating, diagnosing, or treating an *illness, injury,* condition, disease, or its symptoms, that is determined by *us* or in consultation with an appropriate medical professional to be:

(A) In accordance with *generally accepted standards of medical practice*.

(B) Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the *covered person's illness, injury,* condition, disease, or its symptoms.

(C) Not provided mainly for the *covered person's* convenience or that of the *covered person's doctor* or other health care provider.

(D) Not furnished solely to promote athletic achievement, a desired lifestyle, or to improve the *covered person's* environmental or personal comfort.

(E) As cost effective as any established alternative service, supply, or drug that is as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the *covered person's illness, injury,* condition, disease, or its symptoms.

A health care service, supply, or drug will not meet this definition based solely on the fact that a *doctor* or health care provider of a *covered person* performs, provides, prescribes, orders, recommends, or approves that service, supply, or drug.

- *"Medically stabilized"* means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*.

- *"Medicare opt-out practitioner"* means a *medical practitioner* who:

(A) Has filed an affidavit with the Department of Health and Human Services stating that he, she, or it will not submit any claims to Medicare during a two-year period; and

(B) Has been designated by the Secretary of that Department as a *Medicare opt-out practitioner*.

- *"Medicare-participating practitioner"* means a *medical practitioner* who is eligible to receive reimbursement from Medicare for treating Medicare-eligible individuals.

- *"Mental disorder"* means a mental or emotional disease or disorder that is:

(A) A disease of the brain with predominant behavioral symptoms;

(B) A disease of the mind or personality, evidenced by abnormal behavior; or

(C) A disorder of conduct evidenced by socially deviant behavior.

Mental disorder includes psychiatric *illnesses* listed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders of the American Psychiatric Association.

- *"Necessary medical supplies"* means medical supplies that are:

(A) Necessary to the care or treatment of an *injury* or *illness*;

(B) Not reusable or *durable medical equipment*; and

(C) Not able to be used by others.

Necessary medical supplies do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

- "*Network*" means a group of *doctors* and providers who have contracts that include an agreed upon price for health care expenses.

- "*Network eligible expense*" means the *eligible expense* for services or supplies that are provided by a *network provider*. For facility services, this is the *eligible expense* that is provided at and billed by a *network* facility for the services of either a *network* or non-*network provider*. *Network eligible expense* includes benefits for *emergency* health services even if provided by a non-*network provider*.

- *"Network provider"* means a *doctor* or provider who is identified [in the most current list for the *network* shown on *your* identification card.]

- *"Non-elective caesarean section"* means:

(A) A caesarean section where vaginal delivery is not a medically viable option; or

(B) A repeat caesarean section.

- *"Non-network eligible expense"* means the *eligible expense* for services or supplies that are provided and billed by a non-*network provider.*

- *"Other plan"* means any plan or policy that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, health maintenance organization subscriber contracts, self-insured group plans, prepayment plans, and Medicare when the *covered person* is enrolled in Medicare. *Other plan* will not include Medicaid.

- *"Out-of-pocket expenses"* means those expenses that a *covered person* is required to pay that: (A) qualify as *covered expenses*; and (B) are not paid or payable if a claim were made under any *other plan*.

- *"Outpatient surgical facility"* means any facility with a medical staff of *doctors* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics,

free-standing emergency facilities, and *doctor* offices.

- *"Pain management program"* means a program using interdisciplinary teams providing coordinated, goal-oriented services to a *covered person* who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and decreasing dependence on the health care system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

- *"Policy"* when *italicized,* means this *policy* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

- *"Pregnancy"* means the physical condition of being pregnant, but does not include *complications of pregnancy*.

- [*"Primary care physician"* means a *doctor* who is a family practitioner, general practitioner, pediatrician, or internist.]

- *"Proof of loss"* means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, and *network* repricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.

- *"Qualified covered person"* means a *covered person* who, for any given calendar year:

  (A) Did not[, individually or when combined with all *covered persons* under the *policy*,] incur sufficient *covered expenses* to meet the [individual/family] applicable stated deductible [after applying any applicable *deductible credit*]; and

  (B) Has been a *covered person* for at least 6 consecutive months.

- *"Reconstructive surgery"* means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient's appearance, to the extent possible.

- *"Rehabilitation"* means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation*, *subacute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and *pain management programs*. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment under a *pain management program*.

- *"Rehabilitation facility"* means an institution or a separate identifiable *hospital* unit, section, or ward that:

  (A) Is licensed by the state as a *rehabilitation facility*; and

  (B) Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care,* nursing care*,* or for care of the mentally incompetent.

- *"Rehabilitation medical practitioner"* means a *doctor*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

- *"Rehabilitation therapy"* means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

- *"Residence"* means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address (not a P.O. Box) shown on *your* United States income tax return as *your* residence will be deemed to be *your* place of residence. If *you* do not file a United States income tax return, the *residence* where *you* spend the greatest amount of time will be deemed to be *your* place of *residence*.

- *"Residential treatment facility"* means a facility that provides (with or without charge) sleeping accommodations, and:

  (A) Is not a *hospital, extended care facility,* or *rehabilitation facility;* or

  (B) Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

- [*"Specialist physician"* means a *doctor* who is not a *primary care physician*.]

- *"Spouse"* means *your* lawful wife or husband.

- *"Subacute rehabilitation"* means one or more different types of therapy provided by one or more

rehabilitation medical practitioners and performed for one-half hour to two hours per day, five to seven days per week, while the *covered person* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *extended care facility*.

- *"Substance abuse"* means alcohol, drug or chemical abuse, overuse, or dependency.

- *"Surgery"* or *"surgical procedure"* means:

  (A) An invasive diagnostic procedure; or

  (B) The treatment of a *covered person's illness* or *injury* by manual or instrumental operations, performed by a *doctor* while the *covered person* is under general or local anesthesia.

- *"Surveillance tests for ovarian cancer"* means annual screening using: (A) CA-125 serum tumor marker testing; (B) transvaginal ultrasound; or (C) pelvic examination.

- *"Terminally ill"* means a *doctor* has given a prognosis that a *covered person* has six months or less to live.

- *"Unproven service(s)"* means services, including medications, that are determined not to be effective for treatment of the medical condition, and/or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from *well-conducted randomized controlled trials* or *well-conducted cohort studies* in the prevailing published peer-reviewed medical literature.

  (A) *"Well-conducted randomized controlled trials"* means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.

  (B) *"Well-conducted cohort studies"* means patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

- *"Urgent care center"* means a facility, not including a *hospital emergency* room or a *doctor's* office, that provides treatment or services that are required:

  (A) To prevent serious deterioration of a *covered person's* health; and

  (B) As a result of an unforeseen *illness, injury,* or the onset of acute or severe symptoms.

- *"Variable deductible"* means an amount equal to the amount of benefits payable for *covered expenses* by any *other plan*.

We may apply the *variable deductible* even though the stated deductible has been satisfied. The effect of the *variable deductible* is to pay 100 percent of the *covered person's out-of-pocket expenses*, excluding any copayment amounts as shown on the Data Page.

Section 4
PREMIUMS

PREMIUM PAYMENT: Each premium is to be paid to *us* on or before its due date. A due date is the last day of the period for which the preceding premium was paid.

GRACE PERIOD: *You* have until the 31st day following each premium due date to pay all premiums due. *We* may pay benefits for *your covered expenses* incurred during this 31-day grace period. Any such benefit payment is made in reliance on the receipt of the full premium due from *you* by the end of the grace period.

However, if *we* pay benefits for any claims during the grace period, and the full premium is not paid by the end of the grace period, *we* will require repayment of all benefits paid from *you* or any other person or organization that received payment on those claims. If repayment is due from another person or organization, *you* agree to assist and cooperate with *us* in obtaining repayment. *You* are responsible for repaying *us* if *we* are unsuccessful in recovering *our* benefits from these other sources.

MISSTATEMENT OF AGE OR SEX: If a *covered person's* age or sex has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age or sex.

CHANGE OR MISSTATEMENT OF RESIDENCE: If *you* change *your residence*, *you* must notify *us* of *your* new *residence* within 60 days of the change. *Your* premium will be based on *your* new *residence* beginning on the [first premium due date/first day of the next calendar month] after the change. If *your residence* is misstated on *your* application, or *you* fail to notify *us* of a change of *residence*, *we* will apply the correct premium amount beginning on the [first premium due date/first day of the first full calendar month] *you* resided at that place of *residence*. If the change results in a lower premium,

we will refund any excess premium. If the change results in a higher premium, *you* will owe *us* the additional premium.

BILLING/ADMINISTRATIVE FEES: Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* will charge a [$20] fee for any check or automatic payment deduction that is returned unpaid.

Section 5
DEPENDENT COVERAGE

DEPENDENT ELIGIBILITY: *Your dependents* become eligible for insurance on the latter of: (A) the date *you* became insured under this *policy;* or (B) the first day of the [premium period/first full calendar month] after the date of becoming *your dependent*.

EFFECTIVE DATE FOR INITIAL DEPENDENTS: The *effective date* for *your* initial *dependents,* if any, is shown on the Data Page. Only *dependents* included in the application for this *policy* will be covered on *your effective date*.

ADDING A NEWBORN CHILD: An *eligible child* born to *you* or *your spouse* will be covered from the time of birth until [the 31st day] after its birth. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond [the 31st day] after the date of birth of the child. The required premium will be calculated from the child's date of birth. Coverage of the child will terminate on [the 31st day] after its birth, unless *we* have received both: (A) written notice of the child's birth; and (B) the required premium within [90 days] of the child's birth.

ADDING AN ADOPTED CHILD: An *eligible child* legally placed for adoption with *you* or *your spouse* will be covered from the date of *placement* until [the 31st day] after *placement,* unless the *placement* is disrupted prior to legal adoption and the child is removed from *your* or *your spouse's* custody.

The child will be covered for *loss* due to *injury* and *illness*, including *medically necessary* care and treatment of conditions existing prior to the date of *placement.*

Additional premium will be required to continue coverage beyond [the 31st day] following *placement* of the child. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on [the 31st day] following *placement*, unless *we* have received both: (A) written notice of *your* or *your spouse's* intent to adopt the child; and (B) any additional premium required for the addition of the child within [90 days] of the date of *placement.*

As used in this provision, *"placement"* means the earlier of:

(A) The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or

(B) The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption.

ADDING OTHER DEPENDENTS: If *you* apply in writing for insurance on a *dependent* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent* is insured.

Section 6
CONTINUING ELIGIBILITY

[**FOR ALL COVERED PERSONS:** A *covered person's* eligibility for insurance under this *policy*] will cease on the earlier of:

(A) The date that a *covered person* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *policy*; or

(B) The date a *covered person's* employer and a *covered person* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes.

FOR DEPENDENTS: A *dependent* will cease to be a *covered person* at the end of the premium period in which he or she ceases to be *your dependent* due to divorce or if a child ceases to be an *eligible child*.

We must receive notification within 90 days of the date an insured ceases to be an eligible *dependent*. If notice is received by *us* more than 90 days from this date, any unearned premium will be credited only from the first day of the [*policy*/calendar] month in which *we* receive the notice.

A *covered person* will not cease to be a *dependent eligible child* solely because of age if the *eligible child* is:

(A) Not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and

(B) Mainly dependent on *you* for support.

Section 7
AMOUNT PAYABLE

AMOUNT PAYABLE: The *deductible amount* is the larger of the stated deductible shown in the Data Page or the *variable deductible*. *We* may apply the *variable deductible* even though the stated deductible has been satisfied. A new stated deductible must be met each calendar year.

If payment is calculated using the *variable deductible,* the *coinsurance percentage* will be 100 percent. The effect of the *variable deductible* is to pay 100 percent of the *covered person's out-of-pocket expenses,* excluding any *copayment amounts* as shown in the Data Page.

We will pay the applicable *coinsurance percentage* in excess of the applicable *deductible amount(s)* and *copayment amount(s)* for a service or supply that:

(A) Qualifies as a *covered expense* under one or more benefit provisions; and

(B) Is received while the *covered person's* insurance is in force under the *policy* if the charge for the service or supply qualifies as an *eligible expense*.

[When the out-of-pocket maximum has been met, additional *covered expenses* will be payable at 100%.][v]

The amount payable will be subject to:

(A) Any specific benefit limits stated in the *policy*;

(B) A determination of *eligible expenses*; and

(C) Any reduction for expenses incurred at a non-*network provider*. (Please refer to the information on the Data Page.)

The applicable *deductible amount(s), coinsurance percentage,* and *copayment amounts* are shown on the Data Page.

Note: The bill *you* receive for services or supplies from a non-*network provider* may be significantly higher than the *eligible expenses* for those services or supplies. In addition to the *deductible amount*, [copayment, and coinsurance,] *you* are responsible for the difference between the *eligible expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible expense* will <u>not</u> apply to *your deductible amount* or maximum out-of-pocket expenses.

[**PRIMARY CARE PHYSICIAN:** In order to obtain benefits, *you* must designate a *network primary care physician* for each *covered person. You* may select any *network primary care physician* who is accepting new patients. If *you* do not select a *network primary care physician* for each *covered person,* one will be assigned. *You* may obtain a list of *network primary care physicians* at *our* website or by calling the telephone number shown on the front page of *your policy.*

Your network primary care physician will be responsible for coordinating all covered health services and making referrals for services from other *network providers. You* do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* must obtain a referral from *your network primary care physician* in order to be eligible for [maximum] benefits under *your policy.*

You may change *your network primary care physician* by submitting a written request, [online at *our* website], or by contacting *our* office at the number shown on *your* identification card. The change to *your network primary care physician* of record will be effective no later than 30 days from the date *we* receive *your* request.]

[**REFERRAL REQUIRED** {**FOR MAXIMUM BENEFITS**}**:** *You* do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* must obtain a referral from *your network primary care physician* {for benefits to be payable under *your policy.*}{or benefits payable under *your policy* will be reduced. Please refer to the Data Page.}]

NETWORK AVAILABILITY: *Your network* is subject to change upon advance written notice. A *network* may not be available in all areas. If *you* move to an area where *we* are not offering access

to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible expense*[, subject to the *deductible amount* for *network providers*]. *You* will be notified of any increase in premium.

DEDUCTIBLE CREDIT: A *qualified covered person* will be eligible for a *deductible credit*. The *deductible credit*, if any, will be determined on a specific date, the *"determination date,"* by the end of the [first month of the calendar year] to which it applies. The *deductible credit* will be based on the [individual/family] applicable stated deductible as of the *determination date*. The *deductible credit* will not be affected by any changes to the [individual/family] applicable stated deductible stated in a rider to the *policy* and required as a condition of issuance of a *covered person's* coverage under the *policy*.

If a *covered person* is a *qualified covered person* for consecutive years, that *covered person* will be eligible for an increased *deductible credit* as shown on the Data Page.

NOTE: If the *policy* was issued to meet the requirements for a tax-qualified status for a health savings account, the *deductible credit* will never reduce the [individual/family] applicable stated deductible below the minimum *deductible amount* required to maintain that tax-qualified status.

CHANGING THE STATED DEDUCTIBLE: *You* may increase the stated deductible to an amount currently available.

An increase in the stated deductible will become effective as of the [next premium due date/first day of the calendar month] after *we* receive *your* request. *Your* premium will then be adjusted to reflect this change.

COVERAGE UNDER OTHER POLICY PROVISIONS: Charges for services and supplies that qualify as *covered expenses* under one benefit provision will not qualify as *covered expenses* under any other benefit provision of this *policy.*

Section 8
MEDICAL BENEFITS

Standard medical *covered expenses* are limited to charges:

(A) Made by a *hospital* for:

(1) Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.

(2) Daily room and board and nursing services while confined in an *intensive care unit*.

(3) *Inpatient* use of an operating, treatment, or recovery room.

(4) Outpatient use of an operating, treatment, or recovery room for *surgery.*

(5) Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients.*

(6) *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. [However, charges for use of the emergency room itself for treatment of an *illness* will be reduced by $100 unless the *covered person* is directly admitted to the *hospital* for further treatment of that *illness*.][vi]

(B) For *surgery* in a *doctor's* office or at an *outpatient surgical facility,* including services and supplies.

(C) Made by a *doctor* for professional services, including *surgery.*

(D) Made by an assistant surgeon, limited to [20] percent of the *eligible expense* for the *surgical procedure.*

(E) Made by a *medical practitioner* who is not a *doctor* and who is acting as a surgical assistant, limited to [14] percent of the *eligible expense* for the *surgical procedure.*

(F) For the professional services of a *medical practitioner.*

(G) For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*

(H) For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).

(I) For chemotherapy and radiation therapy or treatment.

(J) For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.

(K) For the cost and administration of an anesthetic.

(L) For oxygen and its administration.

(M) For *dental expenses* when a *covered person* suffers an *injury,* after the *covered person's effective date* of coverage, that results in:

(1) Damage to his or her natural teeth; and

(2) Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *doctor* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.

(N) For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint, limited to a combined [$10,000] lifetime maximum for each *covered person.*

(O) For artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not the replacement thereof, unless required by a physical change in the *covered person* and the item cannot be modified). If more than one prosthetic device can meet a *covered person's* functional needs, only the charge for the most cost effective prosthetic device will be considered a *covered expense*.

(P) For one pair of foot orthotics per *covered person*.

(Q) For *medically necessary* genetic blood tests.

(R) For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).

(S) For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.

(T) For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.

(U) For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.

(V) For the cost of one wig per *covered person*, up to [$500], necessitated by hair loss due to cancer treatments or traumatic burns.

(W) For occupational therapy following a covered treatment for traumatic hand injuries.

(X) For one pair of eyeglasses or contact lenses per *covered person,* up to [$200], following a covered cataract surgery.

(Y) For one digital rectal examination and one prostate specific antigen test each calendar year for male *covered persons.*

(Z) For *surveillance tests for ovarian cancer* for female *covered persons* who are *at risk for ovarian cancer.*

(AA) For one annual FDA-approved test or screening for the detection of the human papillomavirus.

(BB) For the following, when provided to a *covered person* who is receiving benefits for *covered expenses* in connection with a mastectomy and who elects breast reconstruction:

(1) All stages of reconstruction of the breast on which the mastectomy has been performed.

(2) *Surgery* and reconstruction of the other breast to produce a symmetrical appearance.

(3) Prostheses and treatment for physical complications of mastectomy, including lymphedemas.

LIMITATION ON SPINE AND BACK DISORDERS: If the diagnosis or treatment of a spine or back disorder is rendered to a *covered person* on an outpatient basis, *covered expenses* will be limited. The *covered expenses* for professional fees of a *medical practitioner,* and all services and supplies provided in the *medical practitioner's* office, are limited to [15 visits] per *covered person,* per calendar year. *Covered expenses* are also limited to *eligible expenses* and all other terms and conditions of the *policy,* including deductible and coinsurance provisions. This limitation does not apply to MRI and CAT scan expenses.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT STATEMENT OF RIGHTS: If expenses for *hospital* confinement in connection with childbirth are otherwise included as *covered expenses*, *we* will not limit the number of days for these expenses to less than that stated in this provision.

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, *we* may provide benefits for *covered expenses* incurred for a shorter stay if the attending provider (e.g., *your* physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

The level of benefits and out-of-pocket costs for any later part of the 48-hour (or 96-hour) stay will not be less favorable to the mother or newborn than any earlier part of the stay. *We* do not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Note: This provision does not amend the *policy* to include *pregnancy* expense benefits as *covered expenses* or to restrict any other terms, limits, or conditions that may otherwise apply to *covered expenses* for childbirth.

AMBULANCE SERVICE BENEFITS: *Covered expenses* will include ambulance services for local transportation:

(A) To the nearest *hospital* that can provide services appropriate to the *covered person's illness* or *injury*.

(B) To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

Benefits for air ambulance services are limited to:

(A) Services requested by police or medical authorities at the site of an *emergency*.

(B) Those situations in which the *covered person* is in a location that cannot be reached by ground ambulance.

Exclusions: No benefits will be paid for:

(A) Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law.

(B) Non-*emergency* air ambulance.

(C) Air ambulance:

(1) Outside of the 50 United States and the District of Columbia;

(2) From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or

(3) From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.

(D) Ambulance services provided for a *covered person's* comfort or convenience.

Preventive Care Expense Benefits

[**PREVENTIVE CARE EXPENSE BENEFITS:** *Covered expenses* are expanded to include the charges incurred by a *covered person* for the following preventive health services if appropriate for that *covered person* in accordance with the following recommendations and guidelines [in effect as of March 23, 2010]:

(A) Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.

(B) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.

(C) Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.

(D) Additional preventive care and screenings not included in (C) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.

Benefits for preventive health services listed in this provision[, except under the administration of reasonable medical management techniques discussed in the next paragraph,] are exempt from any [stated deductibles, coinsurance provisions, and *copayment amounts*] under the *policy* when the services are provided by a *network provider.*

[Benefits for *covered expenses* for preventive care expense benefits may include the use of reasonable medical management techniques authorized by federal law to promote the use of high value preventive services from *network providers*. Reasonable medical management techniques may result in the application of stated deductibles, coinsurance provisions, or *copayment amounts* to services when a *covered person* chooses not to use a high value service (as identified on myuhone.com) that is otherwise exempt from deductibles, coinsurance provisions, and *copayment amounts*, when received from a *network provider*.]

As new recommendations and guidelines are issued, those services will be considered *covered expenses* when required by [the United States Secretary of Health and Human Services], but not earlier than one year after the recommendation or guideline is issued.]

[**SERVICES OF NON-NETWORK PROVIDERS:** *Covered expenses* incurred at a non-*network provider* will be reduced by 25%, then subject to the applicable *deductible amount* and *coinsurance percentage*.]

Transplant Expense Benefits

TRANSPLANT EXPENSES COVERED UNDER MEDICAL EXPENSE BENEFITS: The following types of tissue transplants are *covered expenses* under the Medical Benefits provision:

(A) Cornea transplants.

(B) Artery or vein grafts.

(C) Heart valve grafts.

(D) Prosthetic tissue replacement, including joint replacements.

(E) Implantable prosthetic lenses, in connection with cataracts.

ALL OTHER COVERED EXPENSES FOR TRANSPLANT EXPENSES: If *we* determine that a *covered person* is an appropriate candidate for a *listed transplant,* Medical Benefits *covered expenses* will be provided for:

(A) Pre-transplant evaluation.

(B) Pre-transplant harvesting.

(C) Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *covered person* to prepare for a later transplant, whether or not the transplant occurs.

(D) High dose chemotherapy.

(E) Peripheral stem cell collection.

(F) The transplant itself, not including the acquisition cost for the organ or bone marrow (except at a *Center of Excellence*).

(G) Post transplant follow-up.

TRANSPLANT DONOR EXPENSES: *We* will cover the medical expenses incurred by a live donor as if they were medical expenses of the *covered person* if:

(A) They would otherwise be considered *covered expenses* under the *policy;*

(B) The *covered person* received an organ or bone marrow of the live donor; and

(C) The transplant was a *listed transplant.*

ANCILLARY "CENTER OF EXCELLENCE" BENEFITS: A *covered person* may obtain services in connection with a *listed transplant* from any willing provider of such services. However, if a *listed transplant* is performed in a *Center of Excellence:*

(A) *Covered expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.

(B) *We* will pay a maximum of [$5,000 per transplant] for the following services:

(1) Transportation for the *covered person,* any live donor, and the *immediate family* to accompany the *covered person* to and from the *Center of Excellence.*

(2) Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *covered person* while the *covered person* is confined in the *Center of Excellence.*

We must make the arrangements and pay the costs directly for transportation and lodging.

DEFINITIONS: As used in this provision, the following terms have the meanings indicated:

- *"Allogeneic bone marrow transplant"* or *"BMT"* means a procedure in which bone marrow from a related or non-related donor is infused into the

transplant recipient and includes peripheral blood stem cell transplants.

- *"Autologous bone marrow transplant"* or *"ABMT"* means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

- *"Center of Excellence"* means a *hospital* that:

  (A) Specializes in a specific type or types of *listed transplants*; and

  (B) Has agreed with *us* or an entity designated by *us* to meet quality of care criteria on a cost efficient basis.

The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence.*

- *"Listed transplant"* means one of the following procedures and no others:

  (A) Heart transplants.

  (B) Lung transplants.

  (C) Heart/lung transplants.

  (D) Kidney transplants.

  (E) Liver transplants.

  (F) Bone marrow transplants for the following conditions:

    (1) [*BMT* or *ABMT* for Non-Hodgkin's Lymphoma.

    (2) *BMT* or *ABMT* for Hodgkin's Lymphoma.

    (3) *BMT* for Severe Aplastic Anemia.

    (4) *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.

    (5) *BMT* for Chronic Myelogenous Leukemia.

    (6) *ABMT* for Testicular Cancer.

    (7) *BMT* for Severe Combined Immunodeficiency.

    (8) *BMT* or *ABMT* for Stage III or IV Neuroblastoma.

    (9) *BMT* for Myelodysplastic Syndrome.

    (10) *BMT* for Wiskott-Aldrich Syndrome.

    (11) *BMT* for Thalassemia Major.

    (12) *BMT* or *ABMT* for Multiple Myeloma.

    (13) *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.

    (14) *BMT* for Fanconi's anemia.

    (15) *BMT* for malignant histiocytic disorders.

    (16) *BMT* for juvenile myelo-monocytic leukemia.]

EXCLUSIONS: No benefits will be paid under these Transplant Expense Benefits for charges:

(A) For search and testing in order to locate a suitable donor.

(B) For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.

(C) For animal to human transplants.

(D) For artificial or mechanical devices designed to replace a human organ temporarily or permanently.

(E) For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.

(F) To keep a donor alive for the transplant operation.

(G) For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.

(H) Related to transplants not included under this provision as a *listed transplant.*

(I) For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"USFDA"*) regulation, regardless of whether the trial is subject to *USFDA* oversight.

LIMITATIONS ON TRANSPLANT EXPENSE BENEFITS: In addition to the exclusions and limitations specified elsewhere in this section:

(A) *Covered expenses* for *listed transplants* will be limited to [two transplants during any 10-year period] for each *covered person*.

(B) If a designated *Center of Excellence* is not used, *covered expenses* for a *listed transplant* will be limited to a maximum of

[one transplant in any twelve-month period, and a maximum benefit limit of $100,000] for all expenses associated with the transplant.

(C) If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Home Health Care Expense Benefits

HOME HEALTH CARE EXPENSES: *Covered expenses* for *home health care* are limited to the following charges:

(A) *Home health aide services*.

(B) Services of a private duty registered nurse rendered on an outpatient basis.

(C) Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*

(D) I.V. medication and pain medication.

(E) Hemodialysis, and for the processing and administration of blood or blood components.

(F) *Necessary medical supplies*.

(G) Rental of the *durable medical equipment* set forth below:

(1) I.V. stand and I.V. tubing.

(2) Infusion pump or cassette.

(3) Portable commode.

(4) Patient lift.

(5) Bili-lights.

(6) Suction machine and suction catheters.

Charges under (D) and (G) are *covered expenses* to the extent they would have been *covered expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase. If the equipment is purchased, the *covered person* must return the equipment to *us* when it is no longer in use.

DEFINITIONS: As used in this provision, the following terms have the meanings indicated:

- *"Home health aide services"* means those services provided by a home health aide employed by a *home health care agency* and supervised by a registered nurse, which are directed toward the personal care of a *covered person.*

- "*Home health care*" means care or treatment of an *illness* or *injury* at the *covered person's* home that is:

(A) Provided by a *home health care agency*; and

(B) Prescribed and supervised by a *doctor*.

- *"Home health care agency"* means a public or private agency, or one of its subdivisions, that:

(A) Operates pursuant to law as a *home health care agency*;

(B) Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;

(C) Maintains a daily medical record on each patient; and

(D) Provides each patient with a planned program of observation and treatment by a *doctor,* in accordance with existing standards of medical practice for the *injury* or *illness* requiring the *home health care.*

An agency that is approved to provide *home health care* to those receiving Medicare benefits will be deemed to be a *home health care agency*.

- *"Respite care"* means home health care services provided temporarily to a *covered person* in order to provide relief to the *covered person's immediate family* or other caregiver.

LIMITATIONS: *Covered expenses* for *home health aide services* will be limited to:

(A) [Seven] visits per week; and

(B) A lifetime maximum of [365] visits.

Each [eight-hour] period of *home health aide services* will be counted as one visit.

Covered expenses for outpatient private duty registered nurse services will be limited as follows:

(A) Outpatient private duty registered nurse services will be limited to a lifetime maximum of [1,000 hours].

(B) Intermittent private duty registered nurse visits (not to exceed [4 hours] each) will be:

(1) Limited to [$75] per visit.

(2) Deemed to be [2 hours] applied towards the lifetime maximum above.

EXCLUSION: No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

Hospice Care Expense Benefits

HOSPICE CARE EXPENSES: This provision only applies to a *terminally ill covered person* receiving *medically necessary* care under a *hospice care program*.

The list of *covered expenses* in the Medical Benefits provision is expanded to include:

(A) Room and board in a *hospice* while the *covered person* is an *inpatient.*

(B) Occupational therapy.

(C) Speech-language therapy.

(D) The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *policy* if the *covered person* had been confined in a *hospital.*

(E) Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.

(F) Counseling the *covered person* regarding his or her *terminal illness.*

(G) *Terminal illness counseling* of members of the *covered person's immediate family.*

(H) Up to [$250] for *bereavement counseling*.

EXCLUSIONS AND LIMITATIONS: Any exclusion or limitation contained in the *policy* regarding:

(A) An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;

(B) Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program;* or

(C) Expenses for other persons,

to the extent those expenses are described above, will not be applied to this provision.

Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person* for one continuous period up to [180 days in a *covered person's* lifetime]. For each day the *covered person* is confined in a *hospice,* benefits for room and board will not exceed:

(A) For a *hospice* that is associated with a *hospital* or nursing home, the most common semiprivate room rate of the *hospital* or nursing home with which the *hospice* is associated.

(B) For any other *hospice,* the lesser of the billed charge or [$200] per day.

DEFINITIONS: As used in this provision, the following terms have the meanings indicated:

- *"Bereavement counseling"* means counseling of members of a deceased person's *immediate family* that is designed to aid them in adjusting to the person's death.

- *"Hospice"* means an institution that:

(A) Provides a *hospice care program*;

(B) Is separated from or operated as a separate unit of a *hospital, hospital*-related institution, *home health care agency,* mental health facility, *extended care facility,* or any other licensed health care institution;

(C) Provides care for the *terminally ill;* and

(D) Is licensed by the state in which it operates.

- *"Hospice care program"* means a coordinated, interdisciplinary program prescribed and supervised by a *doctor* to meet the special physical, psychological, and social needs of a *terminally ill covered person* and those of his or her *immediate family.*

- *"Terminal illness counseling"* means counseling of the *immediate family* of a *terminally ill* person for the purpose of teaching the *immediate family* to care for and adjust to the *illness* and impending death of the *terminally ill* person.

Rehabilitation and Extended Care Facility Expense Benefits

COVERED EXPENSES: *Covered expenses* include expenses incurred for *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

(A) *Covered expenses* available to a *covered person* while confined primarily to receive *rehabilitation* are limited to those specified in this provision.

(B) *Rehabilitation services* or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.

(C) *Covered expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:

(1) Daily room and board and nursing services.

(2) Diagnostic testing.

(3) Drugs and medicines that are prescribed by a *doctor*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.

(D) *Covered expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

MAXIMUM BENEFITS: Subject to the limitations otherwise stated in this Rehabilitation and Extended Care Facility Expense Benefits provision, benefits for *covered expenses* under this provision are limited to [60 days per calendar year for each *covered person*.]

Care ceases to be *rehabilitation* upon *our* determination of any of the following:

(A) The *covered person* has reached *maximum therapeutic benefit*.

(B) Further treatment cannot restore bodily function beyond the level the *covered person* already possesses.

(C) There is no measurable progress toward documented goals.

(D) Care is primarily *custodial care*.

EXCLUSION: No benefits will be paid under these Rehabilitation and Extended Care Facility Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

DEFINITION: As used in this provision, *"provider facility"* means a *hospital, rehabilitation facility*, or *extended care facility*.

Outpatient Prescription Drug Expense Benefits

COVERED EXPENSES: *Covered expenses* in this benefit subsection are limited to charges from a licensed *pharmacy* for:

(A) A *prescription drug.*

(B) Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *doctor.*

The appropriate drug choice for a *covered person* is a determination that is best made by the *covered person* and his or her *doctor.*

NOTICE AND PROOF OF LOSS: In order to obtain payment for *covered expenses* incurred at a *pharmacy* for *prescription orders,* a notice of claim and *proof of loss* must be submitted directly to *us.*

DEFINITIONS: As used in this benefit subsection, the following terms have the meanings indicated:

- *"Managed drug limitations"* means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.
- *"Prescription drug"* means any medicinal substance whose label is required to bear the legend "RX only."
- *"Prescription order"* means the request for each separate drug or medication by a *doctor* or each authorized refill or such requests.

EXCLUSIONS AND LIMITATIONS: No benefits will be paid under this benefit subsection for expenses incurred:

(A) For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance.

(B) For immunization agents, blood, or blood plasma.

(C) For medication that is to be taken by the *covered person,* in whole or in part, at the place where it is dispensed.

(D) For medication received while the *covered person* is a patient at an institution that has a facility for dispensing pharmaceuticals.

(E) For a refill dispensed more than 12 months from the date of a *doctor's* order.

(F) Due to a *covered person's* addiction to, or dependency on, tobacco or foods.

(G) For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.

(H) For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent.

(I) For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.

(J) [For a *prescription drug* that contains (an) active ingredient(s) that is/are:

(1) Available in and *therapeutically equivalent* to another covered *prescription drug;* or

(2) A modified version of and *therapeutically equivalent* to another covered *prescription drug.*

Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.]

(K) For more than a 34-day supply when dispensed in any one prescription or refill [(a 90-day supply when dispensed by mail order)].

(L) [In excess of the cost of the generic equivalent, if any, regardless of whether the *doctor* specifies name brand on the written prescription.]

(M) [For *prescription drugs* for any *covered person* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.]

Section 9
NOTIFICATION AND PREDETERMINATION

NOTIFICATION REQUIRED: *You* must notify *us* by phone **at the phone number listed on *your* health insurance identification card** on or before the day a *covered person:*

(A) Begins the 4th day of an *inpatient* hospitalization; or

(B) Is evaluated for an organ or tissue transplant.

BENEFIT REDUCTION FOR FAILURE TO NOTIFY: Failure to comply with notification requirements will result in a benefit reduction. Reduced benefits will be 80% of regular *policy* benefits that would have otherwise been payable. When there is a failure to notify, benefit reduction of an expense requiring notification will be a maximum of $1,000.

Benefits will not be reduced for failure to comply with notification requirements in any case in which:

(A) An *inpatient hospital* admission is for *emergency* treatment of an *illness* or *injury*; and

(B) It is impossible for *you* to notify *us* by the 4th day after *emergency inpatient hospital* admission.

In such a case, *you* must contact *us* as soon as reasonably possible after the *emergency inpatient hospital* admission.

NOTIFICATION DOES NOT GUARANTEE BENEFITS: *Our* receipt of notification does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *policy*.

REQUESTS FOR PREDETERMINATIONS: *You* may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause us to reverse the predetermination:

(A) The predetermination was based on incomplete or inaccurate information initially received by *us.*

(B) The medical expense has already been paid by someone else.

(C) Another party is responsible for payment of the medical expense.

We will make all benefit determinations after a *loss* in good faith. All benefit determinations are subject to *our* receipt of proper *proof of loss*.

Section 10
GENERAL EXCLUSIONS AND LIMITATIONS

No benefits will be paid for:

(A) Any service or supply that would be provided without cost to *you* or *your* covered *dependent* in the absence of insurance covering the charge.

(B) Expenses/surcharges imposed on *you* or *your* covered *dependent* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.

(C) Any services performed by a member of a *covered person's immediate family.*

(D) Any services not identified and included as *covered expenses* under the *policy*. *You* will be fully responsible for payment for any services that are not *covered expenses.*

Even if not specifically excluded by this *policy,* no benefit will be paid for a service or supply unless it is:

(A) Administered or ordered by a *doctor;* and

(B) *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

(A) For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*[, except as expressly provided for under the Benefits After Coverage Terminates clause in this *policy's* Termination section].

(B) For any portion of the charges that are in excess of the *eligible expense.*

(C) For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*.

(D) For breast reduction or augmentation.

(E) For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *covered person,* such as sex-change *surgery*.

(F) For any drug, treatment, or procedure that promotes conception or prevents childbirth, including but not limited to artificial insemination or treatment for infertility or impotency.

(G) For sterilization or reversal of sterilization.

(H) For abortion (unless the life of the mother would be endangered if the fetus were carried to term).

(I) For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered expenses* of the Medical Benefits provision.

(J) For routine well-baby care of a newborn infant, except as specifically provided by this *policy.*

(K) For expenses for television, telephone, or expenses for other persons.

(L) For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.

(M) For telephone consultations or for failure to keep a scheduled appointment.

(N) For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.

(O) For stand-by availability of a *medical practitioner* when no treatment is rendered.

(P) For *dental expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*[, except as expressly provided for under Medical Benefits].

(Q) For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child who has been a *covered person* from its birth until the date *surgery* is performed.

(R) For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.

(S) For diagnosis or treatment of nicotine addiction, [except as otherwise covered under the Preventive Care Expense Benefits provision of this *policy*].

(T) For charges related to, or in preparation for, tissue or organ transplants[, except as expressly provided for under the Transplant Expense Benefits].

(U) For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*[, except as specifically provided under the Transplant Expense Benefits].

(V) For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

(W) While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services [(unless expressly provided for by the *policy)*].

(X) For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy[, except as expressly provided for in this *policy*].

(Y) For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.

(Z) For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices[, except as specifically provided under the *policy*].

(AA) Due to *pregnancy* (except for *complications of pregnancy*)[, unless the optional Pregnancy Expense Benefits Rider is attached to this *policy*].

(BB) For any expenses, including expenses for diagnostic testing, incurred while confined primarily for well-baby care.

(CC) For treatment of *mental disorders, substance abuse,* or for court ordered treatment programs for *substance abuse*, [unless the Optional Mental Disorders Benefits rider or the Optional Biologically-Based Mental Illness Benefits rider is attached to this *policy*].

(DD) For preventive or prophylactic care, including routine physical examinations, premarital examinations, and educational programs[, except as required under applicable state and federal law or as expressly provided for in this *policy*].

(EE) For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.

(FF) For expenses incurred outside of the United States, except for expenses incurred for *emergency* treatment of a *covered person*.

(GG) As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *covered person* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *covered person's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *covered person's* workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.

(HH) As a result of:

(1) Intentionally self-inflicted bodily harm [(whether the *covered person* is sane or insane)].

(2) An *injury* or *illness* caused by any act of declared or undeclared war.

(3) The *covered person* taking part in a riot.

(4) The *covered person's* commission of a felony, whether or not charged.

(II) For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications therefrom[, except as expressly provided for under the Medical Benefits].

(JJ) For any *illness* or *injury* incurred as a result of the *covered person* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *doctor*.

(KK) For or related to surrogate parenting.

(LL) For or related to treatment of hyperhidrosis (excessive sweating).

(MM) For fetal reduction surgery.

(NN) Except as specifically identified as a *covered expense* under the *policy*, for expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

(OO) [As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: [operating or riding on a motorcycle;] professional or semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; [racing or speed testing any non-motorized vehicle or conveyance (if the *covered person* is paid to participate or to instruct);] scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; [horseback riding (if the *covered person* is paid to participate or to instruct);] rock or mountain climbing (if the *covered person* is paid to participate or to instruct); or skiing (if the *covered person* is paid to participate or to instruct).]

(PP) [As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *covered person* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.]

(QQ) While at a *residential treatment facility.*

(RR) [For prescription drugs for any *covered person* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date.]

[**WAITING PERIODS:** Coverage for all *illnesses* will begin 14 days after the *effective date* for *injuries,* unless otherwise excluded under this *policy*. However, there is a six-month waiting period for certain conditions.

Expenses incurred by a *covered person* for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs will not be covered during the *covered person's* first six months of coverage under this *policy.* This exclusion will not apply if the treatment is provided on an *emergency* basis or for treatment for cancer.

After the six-month period, the condition will be subject to all the terms of this *policy,* just like any other condition.]

LIMITATION ON BENEFITS FOR SERVICES PROVIDED BY MEDICARE OPT-OUT PRACTITIONERS: Benefits for *covered expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare-participating practitioner*. (Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare-participating practitioner*.)

Section 11
REIMBURSEMENT

If a *covered person's illness* or *injury* is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*. However, if payment by or for the *third party* has not been made by the time *we* receive acceptable *proof of loss, we* will pay regular *policy* benefits for the *covered person's loss*. *We* will have the right to be reimbursed to the extent of benefits *we* paid for the *illness* or *injury* if the *covered person* subsequently receives any payment from any *third party*. The *covered person* (or the guardian, legal representatives, estate, or heirs of the *covered person*) shall promptly reimburse *us* from the settlement, judgment, or any payment received from any *third party*.

As a condition for *our* payment, the *covered person* or anyone acting on his or her behalf (including, but not limited to, the guardian, legal representatives, estate, or heirs) agrees:

(A) To fully cooperate with *us* in order to obtain information about the *loss* and its cause.

(B) To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *covered person* in connection with the *loss*.

(C) To include the amount of benefits paid by *us* on behalf of a *covered person* in any claim made against any *third party*.

(D) That *we*:

(1) Will have a lien on all money received by a *covered person* in connection with the *loss* equal to the amount *we* have paid.

(2) May give notice of that lien to any *third party* or *third party's* agent or representative.

(3) Will have the right to intervene in any suit or legal action to protect *our* rights.

(4) Are subrogated to all of the rights of the *covered person* against any *third party* to the extent of the benefits paid on the *covered person's* behalf.

(5) May assert that subrogation right independently of the *covered person*.

(E) To take no action that prejudices *our* reimbursement and subrogation rights.

(F) To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.

(G) To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.

(H) To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.

(I) That *we* may reduce other benefits under the *policy* by the amounts a *covered person* has agreed to reimburse *us*.

Furthermore, as a condition of *our* payment, *we* may require the *covered person* or the *covered person's* guardian (if the *covered person* is a minor or legally incompetent) to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

We have a right to be reimbursed in full regardless of whether or not the *covered person* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

We will not pay attorney fees or costs associated with the *covered person's* claim or lawsuit unless *we* previously agreed in writing to do so.

If a dispute arises as to the amount a *covered person* must reimburse *us*, the *covered person* (or the guardian, legal representatives, estate, or heirs of the *covered person*) agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by *us* until the dispute is resolved.

Definition: As used in this provision, the following term has the meaning indicated:

- *"Third party"* means a person or other entity that is or may be obligated or liable to the *covered person* for payment of any of the *covered person's* expenses for *illness* or *injury*. The term *"third party"* includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term *"third party"* will not include any insurance company with a policy under which the *covered person* is entitled to benefits as a named insured person or an insured *dependent* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

Section 12
TERMINATION

TERMINATION OF POLICY: All insurance will cease on termination of this *policy.* This *policy* will terminate on the earliest of:

(A) Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*.

(B) The date *we* receive a request from *you* to terminate this *policy,* or any later date stated in *your* request.

(C) The date *we* decline to renew this *policy,* as stated in the Guaranteed Renewable provision or as explained in the Discontinuance provision.

(D) The date of *your* death, if this *policy* is an Individual Plan.

(E) [The date that a *covered person* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *policy,* or the date a *covered person's* employer and a *covered person* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes.]

(F) The date a *covered person's* eligibility for insurance under this *policy* ceases due to any of the reasons stated in [the Continuing Eligibility section in this *policy*].

We will refund any premium paid and not earned due to *policy* termination.

If this *policy* is other than an Individual Plan, it may be continued after *your* death:

(A) By *your spouse*, if a *covered person;* otherwise,

(B) By the youngest child who is a *covered person.*

This *policy* will be changed to a plan appropriate, as determined by *us,* to the *covered person(s)* that continue to be covered under it. *Your spouse* or youngest child will replace *you* as the insured. A proper adjustment will be made in the premium required for this *policy* to be continued. *We* will also refund any premium paid and not earned due to *your* death. The refund will be based on the number of full months that remain to the next premium due date.

DISCONTINUANCE:

[90]-Day Notice: If *we* discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where *you* reside, *we* will provide a written notice to *you* at least [90] days prior to the date that *we* discontinue coverage. *You* will be offered an option to purchase any other coverage in the individual market *we* offer in *your* state at the time of discontinuance of this *policy*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

[180]-Day Notice: If *we* discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where *you* reside, *we* will provide a written notice to [*you* and the Commissioner of Insurance] at least [180] days prior to the date that *we* stop offering and terminate all existing individual policies/certificates in the individual market in the state where *you* reside.

PORTABILITY OF COVERAGE: If a person ceases to be a *covered person* due to the fact that the person no longer meets the definition of *dependent* under the *policy*, the person will be eligible for continuation of coverage. [If elected,] *we* will continue the person's coverage under the *policy* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the residence of the person continuing coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this *policy*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts*, waiting periods and maximum benefit limits will be satisfied under the new policy to the extent satisfied under this *policy* at the time that the continuation of coverage is issued. (If the original coverage contains a family deductible which must be met by all *covered persons* combined, only those expenses incurred by the *covered person* continuing coverage under the new policy will be applied toward the satisfaction of the *deductible amount* under the new policy.)

Notification Requirements: It is the responsibility of *you* or *your* former *dependent* to notify *us* within 31 days of *your* legal divorce or *your dependent's* marriage. *You* must notify *us* of the address at which their continuation of coverage should be issued.

Continuation of Coverage: *We* will issue the continuation of coverage:

(A) [No less than 30 days] prior to a *covered person's* 26th birthday; or

(B) Within [30 days] after the date *we* receive timely notice of *your* legal divorce or *dependent's* marriage.

Your former *dependent* must pay the required premium within [31 days] following notice from *us* or the new *policy* will be void from its beginning.

REINSTATEMENT: If *your policy* lapses due to nonpayment of premium, it may be reinstated provided:

(A) *We* receive from *you* a written application for reinstatement within one year after the date coverage lapsed; and

(B) The written application for reinstatement is accompanied by the required premium payment.

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than 60 days before the date of reinstatement.

The Rescissions provision will apply to statements made on the reinstatement application, based on the date of reinstatement.

Changes may be made in *your policy* in connection with the reinstatement. These changes will be sent to *you* for *you* to attach to *your policy.* In all other respects, *you* and *we* will have the same rights as before *your policy* lapsed.

BENEFITS AFTER COVERAGE TERMINATES: Benefits for *covered expenses* incurred after a *covered person* ceases to be insured are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *policy* is terminated because of:

(A) A request by *you*;

(B) Fraud or material misrepresentation on *your* part; or

(C) *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before insurance of the *covered person* ceases under this *policy*. No benefits are provided for *covered expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *policy* is terminated because *we* refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* live, termination of this *policy* will not prejudice a claim for a *continuous loss* that begins before insurance of the *covered person* ceases under this *policy.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

(A) The date the *continuous loss* ends; or

(B) [12] months after the date renewal is declined.

During coverage for a *period of extended loss* or a *continuous loss,* as described above, the terms and conditions of this *policy,* including those stated in the Premiums section of this *policy,* will apply as though insurance had remained in force for that *illness* or *injury*.

Definitions: As used in this provision, the following terms have the meanings indicated:

- *"Continuous loss"* means that *covered expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered expense* for the *illness* or *injury* must have been incurred before insurance of the *covered person* ceased under this *policy*. Whether or not *covered expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

- *"Period of extended loss"* means a period of consecutive days:

(A) Beginning with the first day on which a *covered person* is a *hospital inpatient;* and

(B) Ending with the 30th consecutive day for which he or she is not a *hospital inpatient*.

Section 13
CLAIMS

CLAIM FORMS: *We* will furnish claim forms after *we* receive notice of a claim. If *our* usual claim forms are not furnished within 15 days, *you* or *your* covered *dependent* may file a claim without them. The claim must contain written *proof of loss.*

NOTICE OF CLAIM: *We* must receive notice of claim within 30 days of the date the *loss* began or as soon as reasonably possible.

PROOF OF LOSS: *You* or *your* covered *dependent* must give *us* written *proof of loss* within [90 days] of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than [one year late] will not be accepted, unless *you* or *your* covered *dependent* had no legal capacity in that year.

COOPERATION PROVISION: Each *covered person*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *policy* and, as often as may be reasonably necessary:

(A) Sign, date and deliver to *us* authorizations to obtain any medical or other information, records or documents *we* deem relevant from any person or entity.

(B) Obtain and furnish to *us*, or *our* representatives, any medical or other

information, records or documents *we* deem relevant.

(C) Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask.

(D) Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*).

If any *covered person*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *policy*.

In addition, failure on the part of any *covered person*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of claims of all *covered persons*.

TIME FOR PAYMENT OF CLAIMS: Benefits will be paid as soon as *we* receive proper *proof of loss*.

PAYMENT OF CLAIMS: Except as set forth in this provision, all benefits are payable to *you.* Any accrued benefits unpaid at *your* death, or *your dependent's* death may, at *our* option, be paid either to the beneficiary or to the estate. If any benefit is payable to *your* or *your dependent's* estate, or to a beneficiary who is a minor or is otherwise not competent to give valid release, *we* may pay up to [$1,000] to any relative who, in *our* opinion, is entitled to it.

We may pay all or any part of the benefits provided by this *policy* for *hospital,* surgical, nursing, or medical services, directly to the *hospital* or other person rendering such services.

Any payment made by *us* in good faith under this provision shall fully discharge *our* obligation to the extent of the payment. [*We* reserve the right to deduct any overpayment made under this *policy* from any future benefits under this *policy*.]

FOREIGN CLAIMS INCURRED FOR EMERGENCY CARE: Claims incurred outside of the United States for *emergency* care and treatment of a *covered person* must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper *proof of loss*.

[**ASSIGNMENT:** The life insurance provided under this *policy,* if any, is not assignable. *We* will reimburse a *hospital* or health care provider if:

(A) *Your* health insurance benefits are assigned by *you* in writing; and

(B) *We* approve the assignment.

Any assignment to a *hospital* or person providing the treatment, whether with or without *our* approval, shall not confer upon such *hospital* or person, any right or privilege granted to *you* under the *policy* except for the right to receive benefits, if any, that *we* have determined to be due and payable.]

MEDICAID REIMBURSEMENT: The amount payable under this *policy* will not be changed or limited for reason of a *covered person* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *policy* to the state if:

(A) A *covered person* is eligible for coverage under his or her state's Medicaid program; and

(B) *We* receive proper *proof of loss* and notice that payment has been made for *covered expenses* under that program.

Our payment to the state will be limited to the amount payable under this *policy* for the *covered expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

CUSTODIAL PARENT: This provision applies if the parents of a covered *eligible child* are divorced or legally separated and both the custodial parent and the non-custodial parent are subject to the same court or administrative order establishing custody. The custodial parent, who is not a *covered person*, will have the rights stated below if *we* receive a copy of the order establishing custody.

Upon request by the custodial parent, *we* will:

(A) Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the *policy*;

(B) Accept claim forms and requests for claim payment from the custodial parent; and

(C) Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge *our* obligations.

A custodial parent may, with *our* approval, assign claim payments to the *hospital* or *medical practitioner* providing treatment to an *eligible child*.

PHYSICAL EXAMINATION: *We* shall have the right and opportunity to examine a *covered person* while a claim is pending or while a dispute over the claim is pending. These examinations are made at *our* expense and as often as *we* may reasonably require.

LEGAL ACTIONS: No suit may be brought by *you* on a claim sooner than [60 days] after the required *proof of loss* is given. No suit may be brought more than three years after the date *proof of loss* is required.

No action at law or in equity may be brought against *us* under the *policy* for any reason unless the *covered person* first completes all the steps in [the complaint/grievance procedures made available to resolve disputes in *your* state under the *policy*]. After completing that complaint/grievance procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date [*we* notified *you* of the final decision on *your* complaint/grievance].

Section 14
GENERAL PROVISIONS

ENTIRE CONTRACT: This *policy,* with the application and any rider-amendments is the entire contract between *you* and *us.* No change in this *policy* will be valid unless it is approved by one of *our* officers and noted on or attached to this *policy.* No agent may:

(A) Change this *policy*;

(B) Waive any of the provisions of this *policy*;

(C) Extend the time for payment of premiums; or

(D) Waive any of *our* rights or requirements.

NON-WAIVER: If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *policy*, that will not be considered a waiver of any rights under the *policy*. A past failure to strictly enforce the *policy* will not be a waiver of any rights in the future, even in the same situation or set of facts.

RESCISSIONS: No misrepresentation of fact made regarding a *covered person* during the application process that relates to insurability will be used to void/rescind the insurance coverage or deny a claim unless:

(A) The misrepresented fact is contained in a written application, including amendments, signed by a *covered person;*

(B) A copy of the application, and any amendments, has been furnished to the *covered person(s),* or to their beneficiary; and

(C) The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *covered person.*

A *covered person's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud.

REPAYMENT FOR FRAUD, MISREPRESENTATION OR FALSE INFORMATION: During the first two years a *covered person* is insured under the *policy*, if a *covered person* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *covered person* under this *policy* or in filing a claim for *policy* benefits, *we* have the right to demand that *covered person* pay back to *us* all benefits that *we* paid during the time the *covered person* was insured under the *policy*.

MISSTATEMENT OF TOBACCO USE: The answer to the tobacco question on the application is material to *our* correct underwriting. If a *covered person's* use of tobacco has been misstated on the *covered person's* application for coverage under this *policy, we* have the right to rescind that person's coverage, subject to the Rescissions provision in this *policy*.

CONFORMITY WITH STATE LAWS: Any part of this *policy* in conflict with the laws of the state where *you* reside on this *policy's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

CONDITIONS PRIOR TO LEGAL ACTION: On occasion, *we* may have a disagreement related to coverage, benefits, premiums, or other provisions under this *policy*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, *you* must give written notice to *us* of *your* intent to sue *us* as a condition prior to bringing any legal action. *Your* notice must:

(A) Identify the coverage, benefit, premium, or other disagreement;

(B) Refer to the specific *policy* provision(s) at issue; and

(C) Include all relevant facts and information that support *your* position.

Unless prohibited by law, *you* agree that *you* waive any action for statutory or common law extra-contractual or punitive damages that *you* may have if the specified contractual claims are paid, or the issues giving rise to the disagreement are resolved or corrected, within [30 days] after *we* receive *your* notice of intention to sue *us*.

[i] Note to Reviewer (NTR): Prints in plans that are not high deductible health plans for use with a health savings account.
[ii] NTR: Prints in high deductible health plans for use with a health savings account.
[iii] NTR: The phrase "each covered person" prints in plans that are not high deductible health plans for use with a health savings account, and the phrase "all covered persons" prints in high deductible health plans for use with a health savings account.
[iv] NTR: Does not print in high deductible health plans for use with a health savings account.
[v] NTR: Prints in high deductible health plans for use with a health savings account.
[vi] NTR: Does not print in high deductible health plans for use with a health savings account.

American Medical Security Life Insurance Company
3100 AMS Boulevard
P.O. Box 19032
Green Bay, WI 54307-9032
For Inquiries: [(800) 232-5432]

In this outline, "you" or "your" will refer to the person for whom this outline has been prepared, and "we," "our," or "us" will refer to American Medical Security Life Insurance Company.

Medical Expense Coverage
Outline of Coverage for Policy Form GIP28-P-AMS
(Please retain this outline for your records)

Read Your Policy Carefully -- This outline sets forth a brief description of the important aspects of your policy. This is not the insurance contract. Only the actual policy will control. The policy sets forth in detail your and our rights and obligations. For this reason, it is important that you READ YOUR POLICY CAREFULLY!

Medical Expense Coverage -- Plans of this type are designed to provide covered persons with coverage for the major costs of hospital, medical, and surgical care. The cost must be due to a covered illness or injury. Coverage is provided for daily hospital room and board, other hospital services, surgical services, anesthesia services, inpatient medical services, and out-of-hospital care. Coverage is subject to any deductible amounts, copayment provisions, or other limitations that may be set forth in the policy.

State Mandates -- Some provisions addressed in this outline of coverage may change according to the laws of the state where you reside. Please see the state mandates rider attached to your policy.

Amount Payable

Definitions:

"Coinsurance percentage" means the percentage of covered expenses that are payable by us, as shown on the policy Data Page.

"Deductible amount" means the amount of covered expenses that must be paid by [each/all][i] covered person[s] before any benefits are payable. The deductible amount does not include any copayment amount.

"Eligible expense" means a covered expense that is determined as follows:

(A) For network providers (excluding Transplant Benefits), the eligible expense is the contracted fee with that provider.

(B) For non-network providers:

(1) The eligible expense is the lesser of the billed charge or a lower amount negotiated with the provider [or authorized by state law] for covered expenses that are:

(a) Received as a result of an emergency or otherwise approved by us; or

(b) For a service or supply that is not of a type provided by any network provider.

(2) Except as provided under (1) above, when a covered expense (excluding Transplant Benefits) is received from a non-network provider, the eligible expense is determined based on [the lesser of]:

(a) [The fee that has been negotiated with the provider;

(b) [110%] of the fee Medicare allows for the same or similar services provided in the same geographical area;

(c) 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 geographical area determined by us;

(d) The fee charged by the provider for the services; or

(e) A fee schedule that we develop.]

The "variable deductible" is equal to the amount of benefits payable for covered expenses by any other plan.

Amount Payable: The deductible amount is the larger of the stated deductible or a variable deductible. The stated deductible varies according to the type of plan and amount selected by the insured. (Please see the policy Data Page for more information.) We may apply the variable deductible even though the stated deductible has been satisfied.

If payment is calculated using the variable deductible, the coinsurance percentage will be 100 percent. The effect of the variable deductible is to pay 100 percent of the covered person's out-of-pocket expenses.

We will pay the applicable coinsurance percentage in excess of the applicable deductible amount(s) and copayment amount(s) for a service or supply that qualifies as a covered expense and is received while the covered person's coverage is in force under the policy, if the charge for the service or supply qualifies as an eligible expense.

The amount payable will be subject to any specific benefit limits stated in the policy, a determination of eligible expenses, and any reduction for expenses incurred at a non-network provider.

The deductible amount(s), coinsurance percentage, and copayment amount(s) are shown in the policy Data Page.

Non-emergency non-network eligible expenses will be reduced by [25%] before application of any applicable deductible amount(s), coinsurance provisions, and/or copayment amounts.

Note: The bill you receive for services or supplies from a non-network provider may be significantly higher than the eligible expenses for those services or supplies. In addition to the deductible amount, coinsurance, and copayment, you are responsible for the difference between the eligible expense and the amount the provider bills you for the services or supplies. Any amount you must pay to the provider in excess of the eligible expenses will not apply to your deductible amount or maximum out-of-pocket expenses.

[**Primary Care Physician:** In order to obtain benefits, you must designate a network primary care physician for each covered person. If you do not select a network primary care physician for each covered person, one will be assigned. You may obtain a list of network primary care physicians at our website or by calling the telephone number shown on the front page of your policy.

Specialist Physician: For network specialist physicians, a referral from your primary care physician is required in order to be eligible for [maximum] benefits. A referral is not required for emergencies or for care received from an obstetrician or gynecologist.][ii]

Deductible Credit: A covered person will be eligible for a deductible credit if, in any given calendar year, he or she did not meet the applicable stated deductible and has been a covered person for at least 6 consecutive months. The deductible credit will apply to the stated deductible in the following calendar year.

Medical Benefits

Covered expenses set forth in the policy include the charges:

(A) Made by a hospital for:

(1) Daily room and board and nursing services at the most common semi-private room rate.

(2) Daily room and board and nursing services while confined in an intensive care unit, not to exceed the eligible expense.

(3) Inpatient use of an operating, treatment, or recovery room.

(4) Outpatient use of an operating, treatment, or recovery room for surgery.

(5) Other routine services and supplies provided to an inpatient.

(6) Emergency treatment of an illness or injury. [However, charges for use of the emergency room itself for treatment of an illness will be reduced by $100 unless the covered person is directly admitted to the hospital for further treatment of that illness.][iii]

(B) For surgery in a doctor's office or at an outpatient surgical facility.

(C) Made by a doctor for professional services, including surgery.

(D) Made by an assistant surgeon, limited to [20] percent of the eligible expense for the surgical procedure.

(E) Made by a medical practitioner who is not a doctor and who is acting as a surgical assistant surgeon, limited to [14] percent of the eligible expense for the surgical procedure.

(F) Made by a medical practitioner for professional services.

(G) For dressings, crutches, orthopedic braces, splints, casts, or other necessary medical supplies.

(H) For diagnostic testing using radiologic, ultrasonographic, or laboratory services, but not including psychometric, behavioral, and educational testing.

(I) For chemotherapy and radiation therapy or treatment.

(J) For hemodialysis and the charges by a hospital for processing and administration of blood or blood components.

(K) For the cost and administration of oxygen or an anesthetic.

(L) For dental expenses when a covered person suffers an injury, after the effective date of coverage, that results in: (1) damage to the person's natural teeth; and (2) expenses that are incurred within six months of the accident.

(M) For surgery, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint, limited to a combined [$10,000] lifetime maximum per person.

(N) For artificial eyes or larynx, breast prostheses, or basic artificial limbs (but not replacement, unless required by a physical change in the person and the item cannot be modified).

(O) For one pair of foot orthotics per covered person.

(P) For medically necessary genetic blood tests.

(Q) For medically necessary immunizations to prevent respiratory syncytial virus (RSV).

(R) For two mastectomy bras per year if the covered person has undergone a covered mastectomy.

(S) For the rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.

(T) For the cost of one Continuous Passive Motion machine per person following a covered joint surgery.

(U) For the cost of one wig per person, up to [$500], that is necessitated by hair loss due to cancer treatments or traumatic burns.

(V) For occupational therapy following a covered treatment for traumatic hand injuries.

(W) For one pair of eyeglasses or contact lenses per person, up to [$200], following a covered cataract surgery.

(X) For routine annual digital rectal examinations, prostate specific antigen tests, and human papillomavirus (HPV) tests or screenings.

(Y) For surveillance tests for ovarian cancer for females who are at risk for ovarian cancer.

(Z) For breast reconstruction following a mastectomy, prostheses, and treatment for physical complications of mastectomy, including lymphedemas.

(AA) For emergency ground or air ambulance service to the nearest hospital, or the nearest neonatal special care unit for newborns.

(BB) For other benefits as required by the laws of the state where you reside. Please see the state mandates rider attached to your policy.

[**Preventive Care:** Covered expenses include the charges for the following preventive health services if appropriate per the guidelines [in effect as of March 23, 2010]:

(A) Evidence based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force.

(B) Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(C) Preventive care and screenings for children in accordance with guidelines supported by the Health Resources and Services Administration.

(D) Additional preventive care and screenings not included in (A) above, in accordance with guidelines supported by the Health Resources and Services Administration for women.

Benefits for the preventive health services listed above[, except under the administration of reasonable medical management techniques as discussed in the policy,] are exempt from any [stated deductibles, coinsurance provisions, and copayment amounts] when the services are provided by a network provider.

Covered expenses incurred at a non-network provider will be reduced by 25%, then subject to the applicable deductible amount and coinsurance percentage.]

Limitation on Spine and Back Disorders: If the diagnosis or treatment of a spine or back disorder is rendered to a covered person while an outpatient, covered expenses for the medical practitioner's fees and all services and supplies will be limited to [15 visits] per person per calendar year.

Transplant Expense Benefits: The following types of tissue transplants are covered expenses: cornea transplants, artery or vein grafts, heart valve grafts, prosthetic tissue replacement (including joint replacement), and implantable prosthetic lenses in connection with cataracts. The policy also provides coverage for listed transplants, which include heart, lung, heart/lung, kidney, and liver transplants, and bone marrow transplants as listed in the policy. The amount of benefits under the policy for a listed transplant depends upon whether it is performed in one of our Centers of Excellence.

Home Health Care Expense Benefits: The policy provides benefits for home health care. Benefits for home health aide services are limited to [7] visits per week and a lifetime maximum of [365] visits. Benefits for outpatient private duty registered nurse services are limited to a lifetime maximum of [1,000 hours]. Benefits for intermittent private duty registered nurse services are limited to [$75] per visit.

Hospice Care Expense Benefits: The policy provides benefits for hospice care for a terminally ill covered person who receives medically necessary care under a hospice care program, limited to 180 days in a covered person's lifetime.

Rehabilitation and Extended Care Facility Expense Benefits: The policy provides benefits for rehabilitation services or an inpatient stay in a rehabilitation facility or extended care facility that begins within [14 days] of a hospital stay of at least [3 days] and is for treatment of, or rehabilitation related to, the same illness or injury that required the hospital stay. Covered expenses are limited to [60 days per calendar year for each covered person].

Outpatient Prescription Drug Expense Benefits: The policy provides benefits for outpatient prescription drugs that must be prescribed by a doctor, limited to a 34-day supply for each prescription or refill (excludes drugs for addiction to, or dependency on, tobacco or foods).

[Notification

You must notify us on or before the day a covered person begins the 4th day of an inpatient hospitalization or is evaluated for an organ or tissue transplant. If you fail to notify us, benefits will be reduced to 80% of the regular policy benefits, up to a maximum reduction of $1,000. This does not apply to an inpatient hospital admission for emergency treatment.]

[Prior Authorization

Some covered expenses require prior authorization. In general, network providers must obtain authorization from us prior to providing a service or supply to a covered person. However, there are some network eligible expenses for which you must obtain the prior authorization. A list of which services require prior authorization, and who must obtain the prior authorization, is shown in the policy Data Page. Failure to obtain prior authorization will result in benefits being reduced, except in the case of an emergency. Please see the policy Data Page for details.][iv]

What Is Not Covered

No benefits will be paid for:

(A) Loss for which no charge would be made in the absence of insurance;

(B) Charges that are actually the responsibility of the provider to pay;

(C) Any services performed by a member of a covered person's immediate family; or

(D) Services not identified as covered expenses under the policy.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

(A) For services and supplies provided prior to the effective date or after the termination date of the policy.

(B) For any portion of the charges that are in excess of the eligible expense.

(C) For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.

(D) For breast reduction or augmentation.

(E) For modification of the physical body to improve the psychological, mental, or emotional well-being of the covered person, such as sex-change surgery.

(F) For any drug, treatment, or procedure that promotes conception or prevents childbirth, including but not limited to, artificial insemination or treatment for infertility or impotency; for sterilization or reversal of sterilization; or for abortion (unless a pregnancy carried to term would endanger the mother's life).

(G) For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders[, except as described in the policy].

(H) For routine well-baby care of a newborn infant, except as specifically provided by the policy.

(I) For television, telephone, or expenses for other persons.

(J) For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.

(K) For telephone consultations or failure to keep a scheduled appointment.

(L) For hospital room and board and nursing services for the first Friday or Saturday of an inpatient stay that begins on one of those days, unless it is an emergency or medically necessary inpatient surgery is scheduled for the date after the date of admission.

(M) For stand-by availability of a medical practitioner when no treatment is rendered.

(N) For dental expenses, including braces, or surgery and treatment for oral surgery[, except as described in the policy].

(O) For cosmetic treatment, except reconstructive surgery that is incidental to or follows surgery or an injury that was covered under the policy or is performed to correct a birth defect in a child who has been covered under the policy since birth.

(P) For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.

(Q) For diagnosis or treatment of nicotine addiction, [except as otherwise covered under the Preventive Care Expense Benefits provision of the policy].

(R) For charges related to, or in preparation for, tissue or organ transplants[, except as expressly provided for by the policy].

(S) For high dose chemotherapy prior to, in conjunction with, or supported by bone marrow transplant[, except as specifically provided by the policy].

(T) For eye refractive surgery when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

(U) While confined primarily to receive rehabilitation, custodial care, educational care, or nursing services [(unless expressly provided for by the policy)].

(V) For vocational or recreational therapy, vocational rehabilitation, occupational therapy, or outpatient speech therapy[, except as provided by the policy].

(W) For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.

(X) For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any related examinations or fittings.

(Y) For pregnancy (except for complications of pregnancy)[, unless the optional Pregnancy Expense Benefits Rider is attached to the policy,] or for confinement primarily for well-baby care.

(Z) For treatment of mental disorders, substance abuse, or for court ordered treatment programs for substance abuse, [unless the Optional Mental Disorders Benefits rider or the Optional Biologically-Based Mental Illness Benefits rider is attached to the policy].

(AA) For preventive care or prophylactic care, including routine physical examinations, premarital examinations, and educational

programs[, except as required by law or as provided by the policy].

(BB) For experimental or investigational treatment or for unproven services, as defined in the policy.

(CC) For expenses incurred outside of the United States, except for emergency treatment.

(DD) For injury or illness caused by employment[, except as may be covered by the policy].

(EE) As a result of intentionally self-inflicted bodily harm (whether sane or insane); an injury or illness caused by an act of war; from taking part in a riot; or from the commission of a felony, whether or not charged.

(FF) For durable medical equipment, except as expressly provided for by the policy.

(GG) For any illness or injury that occurs as a result of the covered person being intoxicated or under the influence of illegal narcotics or controlled substance, unless administered or prescribed by a doctor.

(HH) For or related to surrogate parenting.

(II) For or related to treatment of hyperhidrosis (excessive sweating).

(JJ) For fetal reduction surgery.

(KK) Except as expressly provided for by the policy, expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

(LL) [As a result of any injury sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: [operating or riding on a motorcycle;] professional or semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; [racing or speed testing any non-motorized vehicle or conveyance (if the covered person is paid to participate or to instruct);] scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; [horseback riding (if the covered person is paid to participate or to instruct);] rock or mountain climbing (if the covered person is paid to participate or to instruct); or skiing (if the covered person is paid to participate or to instruct).]

(MM) [As a result of any injury sustained while operating, riding in, or descending from any type of aircraft if the covered person is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.]

(NN) While at a residential treatment facility.

(OO) [For prescription drugs for a person who enrolls in Medicare Part D.]

In no event will we pay for charges that are: (A) not made or ordered by a doctor; or (B) not medically necessary to the diagnosis or treatment of an illness or injury.

[Coverage for illness will begin 14 days after coverage for injury. There is a 6-month waiting period for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, and disorders of the reproductive organs, unless provided on an emergency basis or for treatment of cancer.]

Term of Coverage and Renewability

The policy term begins as of the effective date of the policy. You may keep the policy in force by paying us the required premium as it comes due. However, we may cancel the policy or deny a claim if a covered person commits fraud or makes a material misrepresentation in the application.

We may refuse to renew the policy if:

(A) We refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where you then live; or

(B) There is fraud or a material misrepresentation made by or with the knowledge of a covered person in filing a claim for policy benefits.

Benefits will continue to be paid for an illness or injury after a person's coverage terminates, provided the illness or injury causes a period of extended loss that begins while the covered person is still covered by the policy.

[i] NTR: The phrase "each covered person" prints in plans that are not high deductible health plans for use with a health savings account, and the phrase "all covered persons" prints in high deductible health plans for use with a health savings account.
[ii] The Primary Care Physician and Specialist Physician provisions are bracketed so that they may be included or omitted.
[iii] The bracketed portion does not print in high deductible health plans for use with a health savings account.
[iv] Either the Notification provision or the Prior Authorization provision will be included.

Rider-Amendment to Policy

American Medical Security Life Insurance Company, Green Bay, Wisconsin

To be attached to and form a part of Policy Number [XXX-XXX-XXX]

Issued to [Policyholder Name]

By the attachment of this rider it is understood and agreed that the insurance under this policy is amended as follows:

[ ]

* * * * * * * * * * * * * *

Nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, provisions or limitations of this Policy, other than as herein provided. [This Rider-Amendment to Policy is not applicable to any life insurance.]

This Rider is effective as of [DATE].

Countersigned by [signature]
Authorized Representative

[signature]
President

Rider-Amendment to Policy

American Medical Security Life Insurance Company, Green Bay, Wisconsin

To be attached to and form a part of Policy Number [XXX-XXX-XXX]

Issued to [Insured Name]

By the attachment of this rider it is understood and agreed that the insurance under this policy is amended as follows:

[ ]

* * * * * * * * * * * * * *

Nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, provisions or limitations of this Policy, other than as herein provided. [This Rider-Amendment to Policy is not applicable to any life insurance.]

This Rider is effective as of [DATE].

Accepted _____
Insured

Countersigned by [signature]
Authorized Representative

[signature]
President