

SERFF Tracking Number: AEGX-126073726 State: Arkansas  
Filing Company: Monumental Life Insurance Company State Tracking Number: 41710  
Company Tracking Number: GH AR0047355F01  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Supplemental Medical Insurance  
Project Name/Number: Supplemental Medical Insurance/GH AR0047355F01

## Filing at a Glance

Company: Monumental Life Insurance Company

Product Name: Supplemental Medical Insurance SERFF Tr Num: AEGX-126073726 State: ArkansasLH

Insurance

TOI: H21 Health - Other

SERFF Status: Closed

State Tr Num: 41710

Sub-TOI: H21.000 Health - Other

Co Tr Num: GH AR0047355F01

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: SPI ADMSLH

Disposition Date: 03/17/2009

Date Submitted: 03/13/2009

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name: Supplemental Medical Insurance

Status of Filing in Domicile: Not Filed

Project Number: GH AR0047355F01

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 03/17/2009

Explanation for Other Group Market Type:

State Status Changed: 03/17/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Monumental Life insurance Company (MLIC) and Tyson Foods, Inc., headquartered in Springdale, Arkansas, have entered into agreement where MLIC will issue a Group Supplemental Medical Insurance Policy covering applicable employees of Tyson Foods. The submitted Group Supplemental Medical Insurance Policy is intended to be used for this purpose.

This Group Supplemental Medical Insurance Policy (Form MLSM2000GP.AR) is a new form however it is very similar to

SERFF Tracking Number: AEGX-126073726 State: Arkansas  
Filing Company: Monumental Life Insurance Company State Tracking Number: 41710  
Company Tracking Number: GH AR0047355F01  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Supplemental Medical Insurance  
Project Name/Number: Supplemental Medical Insurance/GH AR0047355F01

Group Supplemental Medical Policy Form MLSM1000GP filed and approved in Arkansas on July 7, 2006 (Arkansas Insurance Department File # 32813). We wanted to file the enclosed forms as a single case filing unique to the benefit configuration requested by Tyson Foods.

This Group Supplemental Medical Insurance Policy (Form MLSM2000GP.AR) is intended to supplement applicable Tyson Foods employee base health benefit plan. The base health benefit plan will provide all required benefits and conditions required of a group health benefit plan, including any state mandated benefits. This Group Supplemental Medical Insurance Policy (Form MLSM2000GP.AR) is intended to reimburse the eligible employee's covered medical expenses not paid under the base health benefit plan. The premium for this coverage is fully paid by Tyson Foods, Inc.

This Group Supplemental Medical Insurance Policy (Form MLSM2000GP.AR) is arranged with respect to eligible classes (and eligible employees) and applicable benefit configurations as requested by Tyson Foods and accepted by MLIC.

Certificate form MLSM1000GC.AR will be issued to eligible employees and reflect the applicable benefit configuration for that employee.

The Group Policy and Certificate forms contain the required complaint Notice.

Upon approval, we will use Group Application form MLSM1000GA previously approved by your department on July 7, 2006 (Arkansas Insurance Department File # 32813).

We hope the above forms meet with your satisfaction. Should you have any questions or need additional information, please contact me direct at 410-209-5265.

## Company and Contact

### Filing Contact Information

Edward Weigand, Director  
520 Park Avenue  
Baltimore, MD 21201

eweigand@aegonusa.com  
(410) 685-5500 [Phone]  
(410) 209-5910[FAX]

SERFF Tracking Number: AEGX-126073726 State: Arkansas  
Filing Company: Monumental Life Insurance Company State Tracking Number: 41710  
Company Tracking Number: GH AR0047355F01  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Supplemental Medical Insurance  
Project Name/Number: Supplemental Medical Insurance/GH AR0047355F01

**Filing Company Information**

Monumental Life Insurance Company  
4333 Edgewood Road, N.E.  
Cedar Rapids, IA 52499  
(800) 553-5957 ext. [Phone]

CoCode: 66281  
Group Code: 468  
Group Name:  
FEIN Number: 52-0419790  
-----

State of Domicile: Iowa  
Company Type: Life and Health  
State ID Number:

SERFF Tracking Number: AEGX-126073726 State: Arkansas  
Filing Company: Monumental Life Insurance Company State Tracking Number: 41710  
Company Tracking Number: GH AR0047355F01  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Supplemental Medical Insurance  
Project Name/Number: Supplemental Medical Insurance/GH AR0047355F01

## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation: Required Filing Fee of \$50 per Form Filing  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Monumental Life Insurance Company	\$50.00	03/13/2009	26403455

SERFF Tracking Number: AEGX-126073726 State: Arkansas  
Filing Company: Monumental Life Insurance Company State Tracking Number: 41710  
Company Tracking Number: GH AR0047355F01  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Supplemental Medical Insurance  
Project Name/Number: Supplemental Medical Insurance/GH AR0047355F01

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/17/2009	03/17/2009

*SERFF Tracking Number:*      *AEGX-126073726*                      *State:*                      *Arkansas*  
*Filing Company:*              *Monumental Life Insurance Company*              *State Tracking Number:*      *41710*  
*Company Tracking Number:*      *GH AR0047355F01*  
*TOI:*                      *H21 Health - Other*                      *Sub-TOI:*                      *H21.000 Health - Other*  
*Product Name:*              *Supplemental Medical Insurance*  
*Project Name/Number:*      *Supplemental Medical Insurance/GH AR0047355F01*

## **Disposition**

Disposition Date: 03/17/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AEGX-126073726 State: Arkansas  
 Filing Company: Monumental Life Insurance Company State Tracking Number: 41710  
 Company Tracking Number: GH AR0047355F01  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: Supplemental Medical Insurance  
 Project Name/Number: Supplemental Medical Insurance/GH AR0047355F01

<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	No
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	AR - NAIC TRANSMITTAL DOC	Approved-Closed	Yes
<b>Form</b>	Group Supplemental Medical Insurance Policy	Approved-Closed	Yes
<b>Form</b>	Group Supplemental Medical Certificate of Insurance	Approved-Closed	Yes

SERFF Tracking Number: AEGX-126073726 State: Arkansas  
 Filing Company: Monumental Life Insurance Company State Tracking Number: 41710  
 Company Tracking Number: GH AR0047355F01  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: Supplemental Medical Insurance  
 Project Name/Number: Supplemental Medical Insurance/GH AR0047355F01

## Form Schedule

### Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	MLSM2000 GP.AR	Policy/Cont ract/Fraternal Certificate	Group Supplemental Medical Insurance Policy	Initial		43	MLSM2000G P_AR.PDF
Approved-Closed	MLSM2000 GC.AR	Certificate	Group Supplemental Medical Certificate of Insurance	Initial		44	MLSM2000G C_AR.PDF

# MONUMENTAL LIFE INSURANCE COMPANY

520 Park Avenue, Baltimore, Maryland 21201

---

<b>POLICYHOLDER:</b>	TYSON FOODS, INC.
<b>GROUP POLICY EFFECTIVE DATE:</b>	[June 1, 2009]
<b>GROUP POLICY ISSUE DATE:</b>	[June 1, 2009]
<b>GROUP POLICY ANNIVERSARY DATE:</b>	[January 1]
<b>PREMIUM DUE DATE:</b>	[1 <sup>ST</sup> of Each Month]
<b>STATE OF ISSUE:</b>	Arkansas

---

Monumental Life Insurance Company (herein called the Company or we, us or our), in consideration of the Group Policy Application and the timely payment of premiums, agrees, subject to the terms and conditions of this Group Policy, any attached Group Certificate and any attached Group Amendment Rider, to insure the Policyholder's eligible persons. We and the Policyholder agree to all of the terms of this Group Policy.

This Group Policy describes the terms and conditions of insurance. It goes into effect, subject to its applicable terms and conditions, at 12:01 AM on the Group Policy Effective Date shown above, at the Policyholder's address. The laws of the State of Issue shown above govern this Group Policy.

IN WITNESS WHEREOF Monumental Life Insurance Company has caused this Group Policy to be executed and to take effect on the Group Policy Effective Date.



Secretary



President

## TABLE OF CONTENTS

Policy Schedule .....	Page 2
Definitions .....	Page 4
Group Policy Effective Date Provisions.....	Page 6
Group Policy Termination Provisions.....	Page 6
Conditions of Individual Insurance .....	Page 6
Medical Expense Benefits .....	Page 8
General Exclusions and Limitations .....	Page 8
Claim Provisions.....	Page 10
Premium Provisions .....	Page 11
General Provisions .....	Page 12
COBRA Continuation Rights .....	Page 13
Notice of Complaint .....	Page 17

## GROUP POLICY SUPPLEMENTAL MEDICAL EXPENSE INSURANCE COVERAGE

**THIS POLICY PROVIDES LIMITED COVERAGE.**  
**IT DOES NOT PROVIDE MAJOR MEDICAL OR COMPREHENSIVE MEDICAL INSURANCE.**

**READ IT CAREFULLY**

**NON-PARTICIPATING**

**POLICY SCHEDULE**

**MEDICAL EXPENSE BENEFITS:**

**[PLAN A:**

**Plan A pays 100% of eligible Covered Medical Expenses**  
**Maximum Amount per Family Per Plan Year.....** **[\$30,000]**

**PLAN B:**

**Plan B pays 100% of eligible Covered Medical Expenses**  
**Maximum Amount per Family Per Plan Year.....** **[\$20,000]**

**PLAN C:**

**Plan C pays 50% of eligible Covered Medical Expenses; 100% for Executive Physical as defined by the Policyholder's Executive Physical Plan**  
**Maximum Amount per Family Per Plan Year.....** **[\$20,000]**

**PLAN D:**

**Plan D pays 50% of eligible Covered Medical Expenses**  
**Maximum Amount per Family Per Plan Year.....** **[\$20,000]**

**DESCRIPTION OF ELIGIBLE CLASSES:**

**PLAN A**

**[Eligible Class 1:** Full-time employees of the Policyholder who: are a contracted Officer Band Level 0 – 5; and are covered under the Policyholder's Base Health Plan (Premium Medical Plan or Out of Area Premium Passive Medical Plan).]

**[Eligible Class 2:** Full-time employees of the Policyholder who: are newly promoted contracted Officer Band Level 0 – 5; since the date of the promotion to such position, an Open Enrollment period has not occurred during which such employee could have enrolled in the Policyholder's Base Health Plan (Premium Medical Plan or Out of Area Premium Passive Medical Plan); and are covered under the Policyholder's Base Health Plan (Basic Medical Plan or Out of Area Premium Passive Medical Plan). (In such case, the employee must enroll in the Policyholder's Base Health Plan (Premium Medical Plan or Out of Area Premium Passive Medical Plan) during the first Open Enrollment period which occurs after the promotion. If the employee does not so enroll, membership in this Eligible Class will end on the last day of that calendar year.)]

**[Eligible Class 3:** Retired General Counsel of the Policyholder or former full-time employees of the Policyholder who are not covered under the Policyholder's Base Health Plan but are covered under Medicare Parts A and B plus a Medicare Supplement policy which meets the minimum state requirements for such plan who have been named as eligible by the Policyholder.]

**[Eligible Class 4:** Dependents of an eligible member of Eligible Class 1, 2 or 3, who are covered under the Policyholder's Base Health Plan.]

**PLAN B**

**[Eligible Class 1:** Full-time employees of the Policyholder who: are a contracted Officer Band Level 6 – 9; and are covered under the Policyholder's Base Health Plan (Premium Medical Plan or Out of Area Premium Passive Medical Plan).]

**[Eligible Class 2:** Full-time employees of the Policyholder who: are newly promoted contracted Officer Band Level 6 – 9; since the date of the promotion to such position, an Open Enrollment period has not occurred during which such employee could have enrolled in the Policyholder's Base Health Plan (Premium Medical Plan or Out of Area Premium Passive Medical Plan); and are covered under the Policyholder's Base Health Plan (Basic Medical Plan or Out of Area Premium Passive Medical Plan). (In such case, the employee must enroll in the Policyholder's Base Health Plan (Premium Medical Plan or Out of Area Premium Passive Medical Plan) during the first Open Enrollment period which occurs after the promotion. If the employee does not so enroll, membership in this Eligible Class will end on the last day of that calendar year.)]



## DEFINITIONS

Please note that certain words used in this Group Policy have specific meanings. The words defined below and capitalized within the text of this Group Policy have the meanings set forth below. The use of any personal pronoun includes both genders.

**Base Health Plan:** The Policyholder's primary major medical plan, PPO, HMO or a combination, which is not a part of the plan provided by this Group Policy. The Base Health Plan includes the insured service plan or health plan, or group health, dental, vision or prescription drug policy, or Medicare or other governmental program. The Base Health Plan must remain in effect throughout the period this Group Policy is in effect and must cover each Covered Person under this Group Policy.

**Covered Person:** A person:

1. who is eligible for coverage as the Insured or as a Dependent;
2. who is covered under the Policyholder's Base Health Plan or is covered under Medicare and a Medicare Supplement plan, as described in the Description of Eligible Classes shown in the Policy Schedule;
3. who has been named as eligible for coverage by the Policyholder;
4. who has been accepted for coverage or has been automatically added;
5. whose required premium has been paid by the Policyholder; and
6. whose coverage has become effective and has not terminated.

**Dental Treatment:** Dental services or supplies which are consistent with currently accepted dental practice. Any operation, treatment, service or supply not a valid course of treatment recognized by the American Dental Association is not considered necessary Dental Treatment.

**Dependent:** A person who resides with the Insured, is covered under the Policyholder's Base Health Plan, has been named as eligible for coverage by the Policyholder, and is the Insured's:

1. legally married spouse.
2. child who is dependent upon the Insured for support and maintenance and is under the age of 23.
3. child who is dependent upon the Insured for support and maintenance, is 23 years of age or older and is incapable of self-sustaining employment by reason of mental or physical handicap. Notice of the child's condition and dependence must be submitted to us after the date the child ceases to qualify in item 2 above.

The term child refers to the Insured's unmarried:

1. Natural child;
2. Stepchild; A stepchild is a Dependent on the date the Insured marries the child's parent.
3. Adopted child, including a child placed with the Insured for the purpose of adoption, from the moment of placement as certified by the agency making the placement.

In the event both parents of a Dependent are insured persons, such child is considered as a Dependent of either parent. The child may not be considered a Dependent of both parents.

**Durable Medical Equipment:** A device which:

1. Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of injury or sickness and is able to withstand repeated use;
2. Is used exclusively by the patient;
3. Is routinely used in a hospital but can be used effectively in a non-medical facility;
4. Can be expected to make a meaningful contribution to the patient's injury or sickness; and
5. Is prescribed by a Provider and the device is medically necessary for rehabilitation.

Durable Medical Equipment includes, but is not limited to: abdominal, back and arch supports; artificial limbs; diagnostic devices such as blood sugar test kits; elastic hosiery when prescribed by a Provider; wheelchairs and invalid chairs; splints, crutches and orthopedic shoes, oxygen and oxygen equipment, fluoridation units

and special beds when prescribed by a Provider. Durable Medical Equipment also includes wigs needed for severe hair loss due to medical treatment such as chemotherapy.

Durable Medical Equipment does **not** include: (a) comfort and convenience items; (b) equipment that can be used by Family Members other than the patient; (c) health exercise equipment; and (d) equipment that may increase the value of the patient's residence. Such items that do not qualify as Durable Medical Equipment include, but are not limited to: modifications to the patient's property or automobiles, such as spas, air conditioners and vehicle hand controls; or corrective shoes, exercise and sports equipment. Modifications to the patient's residence such as ramps and elevators will be considered Durable Medical Equipment if such modifications will allow the patient to remain at home instead of being confined to a hospital or skilled nursing facility.

**Family Member:** A person who is related to an Insured in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member includes an individual who normally lives in the Insured's household.

**Insured:** A member of an Eligible Class described in the Schedule of Benefits, who is covered under the Policyholder's Base Health Plan and has been named as eligible for coverage by the Policyholder.

**Medicare:** The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.

**Mental Disorder Treatment:** Care and treatment of nervous, emotional and mental disease, illness, syndrome or dysfunction classified in the most recent edition of the International Classification of Diseases as a Mental Disorder on the date the medical care or treatment is rendered to a Covered Person.

**Plan Year:** The period of 12 months following the Group Policy's Effective Date, and each subsequent period of 12 months after that.

**Prescription Drugs:** Drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the U.S. Food and Drug Administration (FDA). The drugs must be dispensed by a licensed pharmacy provider for out of hospital use. Coverage for a Prescription Drug will not be excluded for a particular indication on the ground that the drug has not been approved by the FDA for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies. Prescription Drug coverage shall also include medically necessary services associated with the administration of the drug.

**Preventive Care:** Care, services or treatment that is necessary and appropriate for the prevention of sickness in accordance with generally accepted standards of medical practice at the time it is provided. Preventive Care includes but is not limited to routine physical examinations, routine laboratory tests and preventive inoculations.

**Provider:** A legally qualified person licensed in the healing arts and practicing within the scope of his or her license and is not a Family Member.

**Vision Treatment:** Vision services or supplies which are consistent with currently accepted vision practice, including but not limited to examinations, lenses, frames and contact lenses.

**Wellness and Lifestyle Programs:** Care or treatment, under the direction of a Provider, that is not medically necessary but may aid in the treatment of an injury or sickness. Such programs include but are limited to acupuncture, care provided by Christian Science practitioners, diathermy, hydrotherapy, massage therapy and ultra-violet ray treatment.

## GROUP POLICY EFFECTIVE DATE PROVISIONS

### **Effective Date.**

Insurance coverage begins on the Group Policy Effective Date shown on this Group Policy's first page.

### **Eligibility.**

The Policyholder's eligible persons are those persons that meet all of the requirements of one of the Description of Eligible Classes shown in the Policy Schedule. No person may be eligible for insurance under this Group Policy as both an Insured and a Dependent at the same time.

### **Group Policy Amendment.**

We may amend or change this Group Policy by written agreement with the Policyholder. If required by law, we may amend or change this Group Policy at any time, without the consent of the Policyholder, any Covered Person or beneficiary. Any amendment shall be without prejudice to any charge incurred prior to the effective date of the amendment.

### **Group Policy Renewal.**

This Group Policy shall automatically renew on each Group Policy Anniversary Date subject to the Group Policy Termination Provisions. An eligible person's participation under this Group Policy shall automatically renew on each anniversary of the eligible person's effective date subject to the termination provisions.

## GROUP POLICY TERMINATION PROVISIONS

### **Termination by Policyholder.**

The Policyholder may terminate this Group Policy, on any Group Policy Anniversary Date, by providing us with at least 90 days prior written notice.

### **Termination by Company.**

We may terminate this Group Policy, on any Group Policy Anniversary Date, by providing the Policyholder with at least 90 days prior written notice.

This Group Policy will automatically terminate for any of the following reasons, on any premium due date:

1. Failure of the Policyholder to pay the required premium when due.
2. Fraud or misrepresentation by the Policyholder.
3. Termination of the Policyholder's Base Health Plan.

We will provide the Policyholder with 60 days prior written notice of termination.

We may terminate this Group Policy if we cease to offer coverage in such market. If this Group Policy is terminated due to our ceasing to offer coverage in a market, we will provide the Policyholder with at least 180 days prior written notice.

## CONDITIONS OF INDIVIDUAL INSURANCE

### **Individual Eligibility.**

Insured: An employee becomes eligible for coverage under this Group Policy as an Insured:

1. If the employee is included in an Eligible Class on the effective date of this Group Policy, there is no waiting period for that Insured to become eligible.
2. If the employee is not included in an Eligible Class on the effective date of this Group Policy, the Insured will become eligible as follows:
  - a. If the employee is a full-time employee but not in an Eligible Class, the employee will become eligible on the date the employee enters an Eligible Class.

- b. If the employee enters an Eligible Class on the date the employee's employment begins, the employee will become eligible on the first day of the calendar month coinciding with or following completion of 3 months of full-time service.
- c. If the employee is a former full-time employee, the employee will become eligible on the date that the employee enters an Eligible Class.

**Dependent:** When a Dependent is a member of an Eligible Class, such Dependent becomes eligible for coverage on the later of:

1. the date the Insured becomes eligible for insurance; or
2. the date such Dependent first meets the definition of Dependent.

No person may be eligible for insurance under this Group Policy as both an employee and a spouse or dependent child at the same time.

**Effective Date.**

**Insured:** Coverage becomes effective for an Insured on the latest of the following dates:

1. the effective date of this Group Policy; or
2. the date the Insured becomes eligible.

**Dependent:** Coverage becomes effective for an Insured's eligible Dependents on the latest of the following dates:

1. the effective date of this Group Policy;
2. the date the Insured becomes effective; or
3. the date such Dependent meets the definition of Dependent.

**Termination.**

A Covered Person's coverage will terminate on the earliest of:

1. the date this Group Policy terminates;
2. the date the Base Health Plan terminates;
3. the date the Insured is no longer an eligible person;
4. the date we receive the Insured's written request to terminate coverage;
5. the last day of the period for which the premium is paid;
6. the date a Dependent ceases to be a Dependent as defined;
7. the date a Covered Person enters full time active military service. Upon written request within 30 days of entering the military, we will refund any unearned pro-rata Premium with respect to such person.

Termination of coverage is subject to the Extension of Benefits provision.

**Extension of Benefits.**

In the event an Insured ceases active work and eligibility for this coverage terminates, coverage under this Group Policy may be continued as follows:

1. If the Insured is disabled due to injury or sickness, coverage may be continued during the disability resulting from that condition.
2. If the Insured is on a temporary layoff or an approved leave of absence, coverage may be continued for 3 months following the month in which the layoff or leave began.
3. If a Covered Person is entitled to continue coverage in accord with any federal or any applicable state law, coverage may continue for the period required by law.

Throughout any period of continued coverage, this Group Policy must remain in force, the Policyholder's Base Health Plan must remain in force for the Covered Person, and premium payments must continue to be made.

## MEDICAL EXPENSE BENEFITS

If a Covered Person incurs Covered Medical Expenses, during the Policyholder's Plan Year, we will pay Medical Expense Benefits equal to the amount of such Covered Medical Expenses incurred in excess of the Deductible. However, Medical Expense Benefits will not exceed the Maximum Amount for Family per Plan Year shown on the Schedule of Benefits.

**Covered Medical Expenses:** Covered Medical Expenses include the expenses incurred for a medical service or supply (unless otherwise excluded) which:

1. are performed or given under the direction of a Provider for the medically necessary treatment of an injury or sickness;
2. are incurred for the Covered Person's medical care;
3. are the Covered Person's legal obligation to pay;
4. are not payable under the Policyholder's Base Health Plan; and
5. are allowed as a medical deduction by Section 213 of the U.S. Internal Revenue Code of 1954, as amended.

Such Covered Medical Expense may include but is not limited to:

1. hospital, medical and surgical services to diagnosis or treat an injury or sickness;
2. Preventive Care;
3. Dental Treatment;
4. Vision Treatment;
5. Prescription Drugs;
6. Durable Medical Equipment;
7. the fitting and cost of hearing aids;
8. Wellness and Lifestyle Programs; and
9. transportation that is primarily for and essential to medical care.

Covered Medical Expenses will not exceed 180% of the schedule of fees under Medicare allowable charge tables or the usual and customary charge if the Covered Medical Expense is not contained in such tables. The usual and customary charge is the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The most common charge means the lesser of: the actual amount charged by the provider; the negotiated rate, if any; or the charge which would have been made by the provider of medical services for a comparable service or supply made by other providers in the same geographic area, as reasonably determined by us for the same service or supply. Geographic area means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

**Deductible:** The Deductible means any amount of benefits payable to the Covered Person for the same medical care under: the Base Health Plan; any other insured or self-insured health plan or group health, dental, vision or prescription drug policy; or workers' compensation, Medicare or other governmental program.

**Annual Maximum Amount:** The maximum amount of benefits we will pay each Plan Year for all Covered Persons under each Certificate is shown on the Schedule of Benefits.

## GENERAL EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for:

1. expenses in excess of 180% of the schedule of fees under Medicare allowable charge tables or the usual and customary charge if the Covered Medical Expense is not contained in such tables.
2. out of network coinsurance, applicable only to Plans C and D.
3. treatment, services or supplies which:

- a. are not recommended, approved or certified by a Provider as medically necessary to treat an Sickness or Injury;
  - b. are received without charge or legal obligation to pay;
  - c. would not routinely be paid in the absence of insurance;
  - d. are received from any Family Member.
4. expenses incurred as a result of loss due to war, or any action of war, declared or undeclared; service in the armed forces of any country.
  5. treatment, services or supplies which are provided by or reimbursable under Medicare or any other government program (except Medicaid).
  6. injury or sickness arising out of or in the course of employment or which is reimbursable under any workers' compensation or Occupational Disease Act or Law.
  7. expenses incurred as a result of a cosmetic surgical procedure, cosmetic dental procedure or drug or medicines prescribed for cosmetic use, except reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part or reconstructive surgery because of a congenital disease or anomaly.
    - a. cosmetic surgical procedures include but are not limited to: face lifts, dermabrasion, chemical peels and collagen injections; voluntary radial kerotomy, blepharoplasty, rhinoplasty or otoplasty; liposuction, breast augmentation or reduction; and hair transplants and electrolysis.
    - b. cosmetic dental procedures include but are not limited to tooth bleaching, facings on crowns or pontics distal to the second bicuspid, and characterization of dentures.
    - c. drugs and medicines prescribed for cosmetic use include but are not limited to wrinkle treatments and hair growth stimulants.
  8. expenses incurred, whether or not they are prescribed or recommended by a Provider, which are not allowed as a medical deduction by Section 213 of the U.S. Internal Revenue Code, as amended, including but not limited to:
    - a. baby sitting, childcare, and nursing services for a normal healthy baby;
    - b. controlled substances;
    - c. dancing or swimming lessons;
    - d. health club or business, pleasure or recreation association membership or dues;
    - e. household help or companion services;
    - f. illegal operations and treatments;
    - g. maternity clothes;
    - h. medicines and drugs brought in or ordered from other countries;
    - i. nonprescription drugs or medicines except insulin;
    - j. nutritional supplements (vitamins, minerals, enzymes, herbal or homeopathic preparations, special foods or dietary supplements) which can be obtained without a Provider's prescription;
    - k. weight loss or smoking cessation programs or medications when provided for appearance, well being or general health;
    - l. any other service or expenses not allowed as a medical deduction by Section 213 of the U.S. Internal Revenue Code, as amended.
  9. expenses incurred for the following (which are generally allowed as a medical deduction by Section 213 of the U.S. Internal Revenue Code, as amended):
    - a. non-medical modifications to a Covered Person's home, yard, motor vehicle or workplace or the purchase or rental of non-medical equipment, including but not limited to: an air conditioner, humidifier or purifier; exercise, sports or motorized transportation equipment; a ramp, lift, escalator or elevator; or a sun or heat lamp, whirlpool bath, hot tub, sauna or swimming pool;
    - b. insurance premiums, contributions or fees paid for the cost of insured medical insurance, health care plan, Medicare Part B, and long term care insurance;
    - c. lead-based paint removal from surfaces in a Covered Person's home;
    - d. legal fees paid that are necessary to authorize treatment for medical care, mental illness or substance abuse;
    - e. lifetime care advance payments, such as:
      - (i) fees for a continuing care retirement community including portions related to medical care;
      - (ii) fees for a private institution for lifetime care, treatment, and training of a physically or mentally impaired child; and
      - (iii) current payments for medical care to be provided substantially beyond the end of the year;

- f. lodging and meal expenses at a hospital or similar institution if the purpose of the trip was for personal pleasure, recreation or vacation in the travel away from home;
- g. long term care services including the cost of a nursing home facility and the services rendered;
- h. costs of keeping a mentally retarded person in a special home to help the person adjust from life in a mental hospital to community living;
- i. costs paid for a child's tutoring by a specially trained and qualified teacher working with a child who has learning disabilities caused by mental or physical impairments, including nervous system disorders;
- j. nursing services custodial in nature;
- k. costs paid for "patterning" therapy exercises consisting of coordinated physical manipulation of a mental retarded child's arms and legs to imitate crawling and other normal movements; and
- l. transportation which is not primarily for or essential to medical care.

## **CLAIM PROVISIONS**

Before we can pay any benefits for any type of Covered Medical Expenses, the Covered Person must file a claim with the Covered Person's Base Health Plan. The Base Health Plan will send the Covered Person a copy of the Explanation of Benefits form. This form will show the amount of benefits paid by the Base Health Plan. We will need a copy of this form to determine if benefits are payable under this Group Policy. In the absence of coverages not included in the Base Health Plan, such as a dental or vision coverage, the Covered Person may file the claim directly to us.

**Notice of Claim:** Written Notice of Claim must be given to us or our authorized representative within 60 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

**Claim Forms:** Upon our receipt of written Notice of Claim, we will furnish to the claimant such forms as are usually furnished by us for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Group Policy as to Proof of Loss upon submitting, within the time fixed in the Group Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

**Proof of Loss:** Written Proof of Loss for Hospital Confinement must be given to us or our authorized representative within 90 days after release from the Hospital. Proof of any other covered loss must be given to us or our authorized representative not later than 90 days after the covered loss. If Proof of Loss is not given within 90 days, the claim will not be denied or reduced for that reason if that proof was given as soon as reasonably possible.

**Time of Payment of Claims:** Benefits will be paid as soon as we receive proper Proof of Loss unless the Group Policy provides for periodic payment. When the Group Policy provides for periodic payment, the benefits will accrue and will be paid monthly subject to proper proof of loss.

**Payment of Claims:** Benefits will be payable to the Insured.

If any benefit is unpaid at the Insured's death or if we feel the Insured is not able to give a valid release for payment, we will pay such benefit as follows: to the Insured's spouse, parent, child(ren), brother(s) or sister(s), or estate. Any payment made by us in good faith pursuant to this provision shall fully discharge us to the extent of such payment.

**Physical Examination:** We, at our own expense, shall have the right and opportunity to examine the Covered Person as it may reasonably require while a claim is pending.

**Legal Actions:** A legal action may not be brought to recover on the Group Policy within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

**Subrogation:** When benefits are paid to or for a Covered Person under the terms of the Group Policy, we shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such Covered Person against any person who might be acknowledgedly liable or found legally liable by a Court of competent jurisdiction for the Injury that necessitated the hospitalization or the medical or surgical treatment for which benefits were paid. Such subrogation rights shall extend only to our recovery of the benefits we have paid for such hospitalization and treatment and we shall pay fees and costs associated with such recovery.

## **PREMIUM PROVISIONS**

### **Premiums.**

The premiums for this Group Policy will be based on the rates shown on the Policy Schedule or subsequently changed, the plan and amounts of insurance in effect for Covered Persons and the premium mode selected.

### **Premium Payment.**

All premium, charges or fees must be paid to us prior to the start of the term for which coverage is selected. In no event will coverage become effective prior to the date required premium is received at our home office or by the general agent. If a check in payment for the premium is dishonored for insufficient funds, a reasonable service charge may be charged to the Policyholder which will not exceed the maximum specified under state law. A dishonored check shall be considered a failure to pay Premium and coverage shall not take effect. If any premium is not paid when due, this Group Policy will be cancelled as of the Premium Due Date of the unpaid premiums, except as provided in the Grace Period provision.

We shall not be liable to any Covered Person for any loss of coverage due to the failure of the Policyholder to remit to us any contributory premiums that it may collect on behalf of any Covered Person. The Policyholder is not our agent for the collection of any premiums whatsoever.

### **Changes in Premium Rates.**

We have the right to change premium rates on any Group Policy Anniversary Date with at least 60 days advance written notice to the Policyholder. An increase in rates will not be made more often than once in a 12-month period. However, we reserve the right to change rates at any time if any of the following events take place:

1. the terms of this Group Policy change;
2. coverage is reinstated following failure to pay premium during the Grace Period;
3. acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 10% or more the number of eligible individuals;
4. a change in the number of eligible persons which would require a change of 10% or more in the premium rate;
5. a change in any federal or state law or regulation is enacted, adopted or amended to the extent that it affects our benefit obligations under this Group Policy; or
6. the Policyholder fails to provide sufficient information, as required by us, to confirm adequacy of premiums and rates currently being paid.

### **Grace Period.**

We allow a Grace Period of 31 days for the payment of premium after the first premium. Coverage is in force during the Grace Period. The Policyholder is liable to us for any unpaid premium for the time this Group Policy was in force. Coverage terminates on the last day for which premium has been paid.

### **Reinstatement.**

If this Group Policy terminates due to non-payment of premium, then a subsequent acceptance of premium by us or by an agent, without requiring an application for reinstatement, will reinstate the insurance under this Group Policy.

If we do require an application for reinstatement and accept premium, then we may issue a conditional premium receipt. If we approve the application, then insurance will be reinstated as of the date of our approval. If we do not approve the application, then we will notify the Policyholder in writing within 45 days after the date of the application. If we do not notify the Policyholder within 45 days, then coverage will be reinstated on the 45<sup>th</sup> day after the date of the conditional premium receipt.

The reinstated coverage will cover only losses due to conditions that begin after the date of reinstatement. In all other respects, the Policyholder's and Covered Person's rights and Ours will be the same as before insurance terminated, unless there are new provisions added due to reinstatement. The premium we accept for reinstatement may be used for the period for which premiums had not been paid. We can apply the premium for as many as 60 days before the date of reinstatement.

## **GENERAL PROVISIONS**

### **Entire Contract; Changes.**

This Group Policy, including the Group Certificate, any endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in this Group Policy will be valid until approved by one of our executive officers and endorsed on or attached to this Group Policy. No agent has authority to change this Group Policy or to waive any of its provisions.

### **Incontestability.**

All statements made by the Policyholder in the Group Application are, in the absence of fraud, representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Group Policy unless the statement is in writing, signed by the Policyholder, and furnished to the Policyholder. After two years from the Group Policy Effective Date, no such statement will cause this Group Policy to be contested except for fraud.

### **Assignment.**

The rights and benefits provided by this Group Policy may not be assigned.

### **Certificates.**

We will provide the Policyholder with certificates of insurance for delivery to the Covered Persons. Each certificate will list the benefits, conditions and limits of this Group Policy. It will state to whom benefits will be paid. If there is a conflict between this Group Policy and a certificate, this Group Policy will control.

### **Clerical Error.**

If a clerical error is made so that an otherwise eligible person's coverage does not become effective, coverage may be in effect if: (a) the Policyholder makes a written request for coverage on a form approved by us ; and (b) any premium not paid because of the error is paid in full from the effective date of coverage. We reserve the right to limit retroactive coverage to 2 months preceding the date the error was reported.

If a clerical error is made so that the coverage is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any Premium refund will be reduced by any payment made for claims. If claims paid exceed the Premium refund, the Policyholder shall reimburse us for the overpayment.

### **Conformity with Statutes.**

Any provisions in conflict with the requirements of any state or federal law that applies to this Group Policy are automatically changed to satisfy the minimum requirements of such laws.

### **Information and Records.**

The Policyholder shall provide us with information necessary to administer coverage under this Group Policy. Information is required when an eligible person becomes covered, when changes in amounts of coverage occur, and when a Covered Person's coverage terminates. We will have the right to audit books and records

of the Policyholder at its place of business and during regularly scheduled business hours, in order to determine the accuracy of premium paid.

**Non-Participating.**

The Group Policy is non-participating. It does not share in our profits or surplus earnings.

**Workers' Compensation Insurance.**

This Group Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

## **COBRA CONTINUATION RIGHTS**

**What is COBRA Continuation Coverage**

Under federal law, the Insured and/or the Insured's Dependents must be given the opportunity to continue health insurance when there is a qualifying event that would result in loss of coverage under the Plan. The Insured and/or the Insured's Dependents will be permitted to continue the same coverage under which the Insured or the Insured's Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. The Insured and/or the Insured's Dependents cannot change coverage options until the next open enrollment period.

**When is COBRA Continuation Available**

For the Insured and the Insured's Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- the Insured's termination of employment for any reason, other than
- gross misconduct; or
- the Insured's reduction in work hours.

For the Insured's Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- the Insured's death;
- the Insured's divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

**Who is Entitled to COBRA Continuation**

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: the Insured, the Insured's spouse, and the Insured's Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if the Insured declines or is not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, same sex spouses, grandchildren (unless adopted by the Insured), stepchildren (unless adopted by the Insured). Although these individuals do not have an independent right to elect COBRA continuation coverage, if the Insured elects COBRA continuation coverage for the Insured, the Insured may also cover the Insured's Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when the Insured's COBRA continuation coverage terminates. The sections below titled "Secondary Qualifying Events" and "Medicare Extension for Your Dependents" are not applicable to these individuals.

**Secondary Qualifying Events**

If, as a result of the Insured's termination of employment or reduction in work hours, the Insured's Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a

maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: the Insured's death; the Insured's divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

### **Disability Extension**

If, after electing COBRA continuation coverage due to the Insured's termination of employment or reduction in work hours, the Insured or one of the Insured's Dependents is determined by the Social Security Administration (SSA) to be totally disabled under title II or XVI of the SSA, the Insured and all of the Insured's Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, the Insured must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled. All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

### **Medicare Extension for An Insured's Dependents**

When the qualifying event is the Insured's termination of employment or reduction in work hours and the Insured became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for the Insured's Dependents will last for up to 36 months after the date the Insured became enrolled in Medicare. The Insured's COBRA continuation coverage will last for up to 18 months from the date of the Insured's termination of employment or reduction in work hours.

### **Termination of COBRA Continuation**

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with us;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a preexisting condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

### **Employer's Notification Requirements**

The Insured's Employer is required to provide the Insured and/or the Insured's Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after the Insured's (or the Insured's spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If the Insured and/or the Insured's Dependents experience a qualifying

event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.

- A COBRA continuation coverage election notice must be provided to the Insured and/or the Insured's Dependents within the following timeframes:
  - (a) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - (b) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - (c) in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

### **How to Elect COBRA Continuation Coverage**

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform the Insured of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. The Insured must notify the Plan Administrator of the Insured's election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, the Insured and the Insured's Dependents will lose the right to elect COBRA continuation coverage. If the Insured rejects COBRA continuation coverage before the due date, the Insured may change the Insured's mind as long as the Insured furnishes a completed election form before the due date. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. The insured or the Insured's spouse may elect continuation coverage on behalf of all the qualified beneficiaries. The Insured is not required to elect COBRA continuation coverage in order for the Insured's Dependents to elect COBRA continuation.

### **How Much Does COBRA Continuation Coverage Cost**

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member. For example:

- If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium.
- If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium.
- If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

### **When and How to Pay COBRA Premiums**

#### *First payment for COBRA continuation*

If the Insured elects COBRA continuation coverage, the Insured does not have to send any payment with the election form. However, the Insured must make the Insured's first payment no later than 45 calendar days after the date of the Insured's election. (This is the date the Election Notice is postmarked, if mailed.) If the Insured does not make the Insured's first payment within that 45 days, the Insured will lose all COBRA continuation rights under the Plan.

#### *Subsequent payments*

After the Insured makes the Insured's first payment for COBRA continuation coverage, the Insured will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If the Insured makes a payment on or before its due date, the Insured's coverage under the Plan will continue for that coverage period without any break.

### *Grace periods for subsequent payments*

Although subsequent payments are due by the first day of the month, the Insured will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. The Insured's COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if the Insured's payment is received after the due date, the Insured's coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, the Insured's coverage will be reinstated back to the beginning of the coverage period. This means that any claim the Insured submits for benefits while the Insured's coverage is suspended may be denied and may have to be resubmitted once the Insured's coverage is reinstated. If the Insured fails to make a payment before the end of the grace period for that coverage period, the Insured will lose all rights to COBRA continuation coverage under the Plan.

### **The Insured Must Give Notice of Certain Qualifying Events**

If the Insured or the Insured's Dependent(s) experience one of the following qualifying events, the Insured must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- The Insured's divorce or legal separation;
- The Insured's child ceases to qualify as a Dependent under the Plan; or
- The occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events" above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled "Extension of Benefits" For additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

### **Newly Acquired Dependents**

If the Insured acquires a new Dependent through marriage, birth, adoption or placement for adoption while the Insured's coverage is being continued, the Insured may cover such Dependent under the Insured's COBRA continuation coverage. However, only the Insured's newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following the Insured's early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for the Insured's Dependent spouse and any Dependent children who are not the Insured's children (e.g., stepchildren or grandchildren) will cease on the date the Insured's COBRA coverage ceases and they are not eligible for a secondary qualifying event.

### **COBRA Continuation for Retirees Following Employer's Bankruptcy**

If the Insured is covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, the Insured may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for the Insured, the Insured's Dependents or the Insured's surviving spouse within one year before or after such proceeding, the Insured and the Insured's covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. The Insured will be entitled to COBRA continuation coverage until the Insured's death. The Insured's surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following the Insured's death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

### **Trade Act of 2002**

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can

either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If the Insured has questions about these new tax provisions, the Insured may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact/2002act\\_index.asp](http://www.doleta.gov/tradeact/2002act_index.asp). In addition, if the Insured initially declined COBRA continuation coverage and, within the Insured's loss of coverage under the Plan, the Insured is deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, the Insured may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If the Insured elects COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless the Insured experiences one of the events discussed under "Termination of COBRA Continuation" above. Coverage will not be retroactive to the initial loss of coverage. If the Insured receives a determination that the Insured is TAA-eligible, the Insured must notify the Plan Administrator immediately.

#### **Interaction With Other Continuation Benefits**

The Insured may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

### **NOTICE OF COMPLAINT**

The address and telephone number of our Service Center is as follows:

Monumental Life Insurance Company  
Service Center  
520 Park Avenue  
Baltimore, Maryland 21201  
1-877-709-9290

If we fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, Arkansas 72201  
1-800-282-9134

**MONUMENTAL LIFE INSURANCE COMPANY**

520 Park Avenue, Baltimore, Maryland 21201

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule.

In this Certificate, Monumental Life Insurance Company will be called we, us or our. This Certificate is evidence of the Covered Person’s insurance under the Policy and of its benefits. Everything contained in this Certificate is subject to the provisions, definitions, and exceptions in the Policy issued to the Policyholder.

Our President and Secretary witness this Certificate.

*N Stacy Boyer*  
Secretary

*W. S. Hogan*  
President

**TABLE OF CONTENTS**

Certificate Schedule.....Page 2  
Definitions .....Page 2  
Individual Effective Date.....Page 4  
Individual Termination Provision .....Page 4  
Medical Expense Benefits .....Page 5  
General Exclusions and Limitations .....Page 6  
Claim Provisions.....Page 7  
General Provisions .....Page 8  
COBRA Continuation Rights .....Page 8  
Notice of Compliant .....Page 13

**GROUP CERTIFICATE  
SUPPLEMENTAL MEDICAL EXPENSE INSURANCE COVERAGE**

**THIS CERTIFICATE PROVIDES LIMITED COVERAGE.  
IT DOES NOT PROVIDE MAJOR MEDICAL OR COMPREHENSIVE MEDICAL INSURANCE.**

**READ IT CAREFULLY**  
**NON-PARTICIPATING**

**CERTIFICATE SCHEDULE**

---

INSURED	[John Doe]
DEPENDENT(S)	[N/A]
POLICYHOLDER	TYSON FOODS, INC.
POLICY NUMBER	[XXX123456789]
CERTIFICATE NUMBER	[234]
EFFECTIVE DATE OF COVERAGE	[6/1/09]

---

**MEDICAL EXPENSE BENEFITS**

**[PLAN A:**  
Plan A pays 100% of eligible Covered Medical Expenses  
Maximum Amount per Family Per Plan Year..... **[\$30,000]**

**PLAN B:**  
Plan B pays 100% of eligible Covered Medical Expenses  
Maximum Amount per Family Per Plan Year..... **[\$20,000]**

**PLAN C:**  
Plan C pays 50% of eligible Covered Medical Expenses; 100% for Executive Physical as defined by the Policyholder’s Executive Physical Plan  
Maximum Amount per Family Per Plan Year..... **[\$20,000]**

**PLAN D:**  
Plan D pays 50% of eligible Covered Medical Expenses  
Maximum Amount per Family Per Plan Year..... **[\$20,000]**

**PREMIUM:** The cost of this insurance is paid by the Policyholder.

**DEFINITIONS**

Please note that certain words used in this Certificate have specific meanings. The words defined below and capitalized within the text of this Certificate have the meanings set forth below. The use of any personal pronoun includes both genders.

**Base Health Plan:** The Policyholder’s primary major medical plan, PPO, HMO or a combination, which is not a part of the plan provided by the Policy. The Base Health Plan includes the insured service plan or health plan, or group health, dental, vision or prescription drug policy, or Medicare or other governmental program. The Base Health Plan must remain in effect throughout the period the Policy is in effect and must cover each Covered Person under the Policy.

**Covered Person:** A person:

1. who is eligible for coverage as the Insured (named in the Certificate Schedule) or as a Dependent;
2. who is covered under the Policyholder’s Base Health Plan or is covered under Medicare and a Medicare Supplement plan;
3. who has been named as eligible for coverage by the Policyholder;
4. who has been accepted for coverage or has been automatically added;
5. whose required premium has been paid by the Policyholder; and
6. whose coverage has become effective and has not terminated.

**Dental Treatment:** Dental services or supplies which are consistent with currently accepted dental practice. Any operation, treatment, service or supply not a valid course of treatment recognized by the American Dental Association is not considered necessary Dental Treatment.

**Dependent:** A person who resides with the Insured, is covered under the Policyholder's Base Health Plan, has been named as eligible for coverage by the Policyholder, and is the Insured's:

1. legally married spouse.
2. child who is dependent upon the Insured for support and maintenance and is under the age of 23.
3. child who is dependent upon the Insured for support and maintenance, is 23 years of age or older and is incapable of self-sustaining employment by reason of mental or physical handicap. Notice of the child's condition and dependence must be submitted to us after the date the child ceases to qualify in item 2 above.

The term child refers to the Insured's unmarried:

1. Natural child;
2. Stepchild; A stepchild is a Dependent on the date the Insured marries the child's parent.
3. Adopted child, including a child placed with the Insured for the purpose of adoption, from the moment of placement as certified by the agency making the placement.

In the event both parents of a Dependent are insured persons, such child is considered as a Dependent of either parent. The child may not be considered a Dependent of both parents. ]

**Durable Medical Equipment:** A device which:

1. Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of injury or sickness and is able to withstand repeated use;
2. Is used exclusively by the patient;
3. Is routinely used in a hospital but can be used effectively in a non-medical facility;
4. Can be expected to make a meaningful contribution to the patient's injury or sickness; and
5. Is prescribed by a Provider and the device is medically necessary for rehabilitation.

Durable Medical Equipment includes, but is not limited to: abdominal, back and arch supports; artificial limbs; diagnostic devices such as blood sugar test kits; elastic hosiery when prescribed by a Provider; wheelchairs and invalid chairs; splints, crutches and orthopedic shoes, oxygen and oxygen equipment, fluoridation units and special beds when prescribed by a Provider. Durable Medical Equipment also includes wigs needed for severe hair loss due to medical treatment such as chemotherapy.

Durable Medical Equipment does **not** include: (a) comfort and convenience items; (b) equipment that can be used by Family Members other than the patient; (c) health exercise equipment; and (d) equipment that may increase the value of the patient's residence. Such items that do not qualify as Durable Medical Equipment include, but are not limited to: modifications to the patient's property or automobiles, such as spas, air conditioners and vehicle hand controls; or corrective shoes, exercise and sports equipment. Modifications to the patient's residence such as ramps and elevators will be considered Durable Medical Equipment if such modifications will allow the patient to remain at home instead of being confined to a hospital or skilled nursing facility.

**Family Member:** A person who is related to an Insured in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member includes an individual who normally lives in the Insured's household.

**Insured:** You, an eligible employee named on the Certificate Schedule, who is covered under the Policyholder's Base Health Plan and has been named as eligible for coverage by the Policyholder.

**Medicare:** The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.

**Mental Disorder Treatment:** Care and treatment of nervous, emotional and mental disease, illness, syndrome or dysfunction classified in the most recent edition of the International Classification of Diseases as a Mental Disorder on the date the medical care or treatment is rendered to a Covered Person.

**Plan Year:** The period of 12 months following the Policy's Effective Date, and each subsequent period of 12 months after that.

**Prescription Drugs:** Drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the U.S. Food and Drug Administration (FDA). The drugs must be dispensed by a licensed pharmacy provider for out of hospital use. Coverage for a Prescription Drug will not be excluded for a particular indication on the ground that the drug has not been approved by the FDA for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies. Prescription Drug coverage shall also include medically necessary services associated with the administration of the drug.

**Preventive Care:** Care, services or treatment that is necessary and appropriate for the prevention of sickness in accordance with generally accepted standards of medical practice at the time it is provided. Preventive Care includes but is not limited to routine physical examinations, routine laboratory tests and preventive inoculations.

**Provider:** A legally qualified person licensed in the healing arts and practicing within the scope of his or her license and is not a Family Member.

**Vision Treatment:** Vision services or supplies which are consistent with currently accepted vision practice, including but not limited to examinations, lenses, frames and contact lenses.

**Wellness and Lifestyle Programs:** Care or treatment, under the direction of a Provider, that is not medically necessary but may aid in the treatment of an injury or sickness. Such programs include but are limited to acupuncture, care provided by Christian Science practitioners, diathermy, hydrotherapy, massage therapy and ultra-violet ray treatment.

### INDIVIDUAL EFFECTIVE DATE

**Insured:** The Insured's Effective Date is shown in the Certificate Schedule.

**Dependent:** Coverage becomes effective for an Insured's eligible Dependents on the latest of the following dates:

1. the Insured's Effective Date shown on the Certificate Schedule; or
2. the date such Dependent meets the definition of Dependent.

### INDIVIDUAL TERMINATION PROVISION

A Covered Person's coverage will terminate on the earliest of:

1. the date the Policy terminates;
2. the date the Base Health Plan terminates;
3. the date the Insured is no longer an eligible person;
4. the date we receive the Insured's written request to terminate coverage;
5. the last day of the period for which the premium is paid;
6. the date a Dependent ceases to be a Dependent as defined;
7. the date a Covered Person enters full time active military service. Upon written request within 30 days of entering the military, we will refund any unearned pro-rata Premium with respect to such person.

Termination of coverage is subject to the Extension of Benefits provision.

### **Extension of Benefits.**

In the event an Insured ceases active work and eligibility for this coverage terminates, coverage under the Policy may be continued as follows:

1. If the Insured is disabled due to injury or sickness, coverage may be continued during the disability resulting from that condition.
2. If the Insured is on a temporary layoff or an approved leave of absence, coverage may be continued for 3 months following the month in which the layoff or leave began.
3. If a Covered Person is entitled to continue coverage in accord with any federal or any applicable state law, coverage may continue for the period required by law.

Throughout any period of continued coverage, the Policy must remain in force, the Policyholder's Base Health Plan must remain in force for the Covered Person, and premium payments must continue to be made.

## **MEDICAL EXPENSE BENEFITS**

If a Covered Person incurs Covered Medical Expenses, during the Policyholder's Plan Year, we will pay Medical Expense Benefits equal to the amount of such Covered Medical Expenses incurred in excess of the Deductible. However, Medical Expense Benefits will not exceed the Maximum Amount for Family per Plan Year.

**Covered Medical Expenses:** Covered Medical Expenses include the expenses incurred for a medical service or supply (unless otherwise excluded) which:

1. are performed or given under the direction of a Provider for the medically necessary treatment of a injury or sickness;
2. are incurred for the Covered Person's medical care;
3. are the Covered Person's legal obligation to pay;
4. are not payable under the Policyholder's Base Health Plan; and
5. are allowed as a medical deduction by Section 213 of the U.S. Internal Revenue Code of 1954, as amended.

Such Covered Medical Expense may include but is not limited to:

1. hospital, medical and surgical services to diagnosis or treat an injury or sickness;
2. Preventive Care;
3. Dental Treatment;
4. Vision Treatment;
5. Prescription Drugs;
6. Durable Medical Equipment;
7. the fitting and cost of hearing aids;
8. Wellness and Lifestyle Programs; and
9. transportation that is primarily for and essential to medical care.

Covered Medical Expenses will not exceed 180% of the schedule of fees under Medicare allowable charge tables or the usual and customary charge if the Covered Medical Expense is not contained in such tables. The usual and customary charge is the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The most common charge means the lesser of: the actual amount charged by the provider; the negotiated rate, if any; or the charge which would have been made by the provider of medical services for a comparable service or supply made by other providers in the same geographic area, as reasonably determined by us for the same service or supply. Geographic area means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

**Deductible:** The Deductible means any amount of benefits payable to the Covered Person for the same medical care under: the Base Health Plan; any other insured or self-insured health plan or group health, dental, vision or prescription drug policy; or workers' compensation, Medicare or other governmental program.

**Annual Maximum Amount:** The maximum amount of benefits we will pay each Plan Year for all Covered Persons under each Certificate is shown on the Certificate Schedule.

## GENERAL EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for:

1. expenses in excess of 180% of the schedule of fees under Medicare allowable charge tables or the usual and customary charge if the Covered Medical Expense is not contained in such tables.
2. [out of network coinsurance.]
3. treatment, services or supplies which:
  - a. are not recommended, approved or certified by a Provider as medically necessary to treat an Sickness or Injury;
  - b. are received without charge or legal obligation to pay;
  - c. would not routinely be paid in the absence of insurance;
  - d. are received from any Family Member.
4. expenses incurred as a result of loss due to war, or any action of war, declared or undeclared; service in the armed forces of any country.
5. treatment, services or supplies which are provided by or reimbursable under Medicare or any other government program (except Medicaid).
6. injury or sickness arising out of or in the course of employment or which is reimbursable under any workers' compensation or Occupational Disease Act or Law.
7. expenses incurred as a result of a cosmetic surgical procedure, cosmetic dental procedure or drug or medicines prescribed for cosmetic use, except reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part or reconstructive surgery because of a congenital disease or anomaly.
  - a. cosmetic surgical procedures include but are not limited to: face lifts, dermabrasion, chemical peels and collagen injections; voluntary radial kerotomy, blepharoplasty, rhinoplasty or otoplasty; liposuction, breast augmentation or reduction; and hair transplants and electrolysis.
  - b. cosmetic dental procedures include but are not limited to tooth bleaching, facings on crowns or pontics distal to the second bicuspid, and characterization of dentures.
  - c. drugs and medicines prescribed for cosmetic use include but are not limited to wrinkle treatments and hair growth stimulants.
8. expenses incurred, whether or not they are prescribed or recommended by a Provider, which are not allowed as a medical deduction by Section 213 of the U.S. Internal Revenue Code, as amended, including but not limited to:
  - a. baby sitting, childcare, and nursing services for a normal healthy baby;
  - b. controlled substances;
  - c. dancing or swimming lessons;
  - d. health club or business, pleasure or recreation association membership or dues;
  - e. household help or companion services;
  - f. illegal operations and treatments;
  - g. maternity clothes;
  - h. medicines and drugs brought in or ordered from other countries;
  - i. nonprescription drugs or medicines except insulin;
  - j. nutritional supplements (vitamins, minerals, enzymes, herbal or homeopathic preparations, special foods or dietary supplements) which can be obtained without a Provider's prescription;
  - k. weight loss or smoking cessation programs or medications when provided for appearance, well being or general health;
  - l. any other service or expenses not allowed as a medical deduction by Section 213 of the U.S. Internal Revenue Code, as amended.

9. expenses incurred for the following (which are generally allowed as a medical deduction by Section 213 of the U.S. Internal Revenue Code, as amended):
  - a. non-medical modifications to a Covered Person's home, yard, motor vehicle or workplace or the purchase or rental of non-medical equipment, including but not limited to: an air conditioner, humidifier or purifier; exercise, sports or motorized transportation equipment; a ramp, lift, escalator or elevator; or a sun or heat lamp, whirlpool bath, hot tub, sauna or swimming pool;
  - b. insurance premiums, contributions or fees paid for the cost of insured medical insurance, health care plan, Medicare Part B, and long term care insurance;
  - c. lead-based paint removal from surfaces in a Covered Person's home;
  - d. legal fees paid that are necessary to authorize treatment for medical care, mental illness or substance abuse;
  - e. lifetime care advance payments, such as:
    - (i) fees for a continuing care retirement community including portions related to medical care;
    - (ii) fees for a private institution for lifetime care, treatment, and training of a physically or mentally impaired child; and
    - (iii) current payments for medical care to be provided substantially beyond the end of the year;
  - f. lodging and meal expenses at a hospital or similar institution if the purpose of the trip was for personal pleasure, recreation or vacation in the travel away from home;
  - g. long term care services including the cost of a nursing home facility and the services rendered;
  - h. costs of keeping a mentally retarded person in a special home to help the person adjust from life in a mental hospital to community living;
  - i. costs paid for a child's tutoring by a specially trained and qualified teacher working with a child who has learning disabilities caused by mental or physical impairments, including nervous system disorders;
  - j. nursing services custodial in nature;
  - k. costs paid for "patterning" therapy exercises consisting of coordinated physical manipulation of a mental retarded child's arms and legs to imitate crawling and other normal movements; and
  - l. transportation which is not primarily for or essential to medical care.

## CLAIM PROVISIONS

Before we can pay any benefits for any type of Covered Medical Expenses, the Covered Person must file a claim with the Covered Person's Base Health Plan. The Base Health Plan will send the Covered Person a copy of the Explanation of Benefits form. This form will show the amount of benefits paid by the Base Health Plan. We will need a copy of this form to determine if benefits are payable under the Policy. In the absence of coverages not included in the Base Health Plan, such as a dental or vision coverage, the Covered Person may file the claim directly to us.

**Notice of Claim:** Written Notice of Claim must be given to us or our authorized representative within 60 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

**Claim Forms:** Upon our receipt of written Notice of Claim, we will furnish to the claimant such forms as are usually furnished by us for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Group Policy as to Proof of Loss upon submitting, within the time fixed in the Group Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

**Proof of Loss:** Written Proof of Loss for Hospital Confinement must be given to us or our authorized representative within 90 days after release from the Hospital. Proof of any other covered loss must be given to us or our authorized representative not later than 90 days after the covered loss. If Proof of Loss is not given within 90 days, the claim will not be denied or reduced for that reason if that proof was given as soon as reasonably possible.

**Time of Payment of Claims:** Benefits will be paid as soon as we receive proper Proof of Loss unless the Group Policy provides for periodic payment. When the Group Policy provides for periodic payment, the benefits will accrue and will be paid monthly subject to proper proof of loss.

**Payment of Claims:** Benefits will be payable to the Insured. If any benefit is unpaid at the Insured's death or if we feel the Insured is not able to give a valid release for payment, we will pay such benefit as follows: to the Insured's spouse, parent, child(ren), brother(s) or sister(s), or estate. Any payment made by us in good faith pursuant to this provision shall fully discharge us to the extent of such payment.

**Physical Examination:** We, at our own expense, shall have the right and opportunity to examine the Covered Person as it may reasonably require while a claim is pending.

**Legal Actions:** A legal action may not be brought to recover on the Policy within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

**Subrogation:** When benefits are paid to or for a Covered Person under the terms of the Policy, we shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such Covered Person against any person who might be acknowledgedly liable or found legally liable by a Court of competent jurisdiction for the Injury that necessitated the hospitalization or the medical or surgical treatment for which benefits were paid. Such subrogation rights shall extend only to our recovery of the benefits we have paid for such hospitalization and treatment and we shall pay fees and costs associated with such recovery.

## **GENERAL PROVISIONS**

### **Incontestability.**

All statements made by the Policyholder in the Group Application are, in the absence of fraud, representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of the Policy unless the statement is in writing, signed by the Policyholder, and furnished to the Policyholder. After two years from the Policy Effective Date, no such statement will cause the Policy to be contested except for fraud.

### **Workers' Compensation Insurance.**

The Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

## **COBRA CONTINUATION RIGHTS**

### **What is COBRA Continuation Coverage**

Under federal law, the Insured and/or the Insured's Dependents must be given the opportunity to continue health insurance when there is a qualifying event that would result in loss of coverage under the Plan. The Insured and/or the Insured's Dependents will be permitted to continue the same coverage under which the Insured or the Insured's Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. The Insured and/or the Insured's Dependents cannot change coverage options until the next open enrollment period.

### **When is COBRA Continuation Available**

For the Insured and the Insured's Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- the Insured's termination of employment for any reason, other than
- gross misconduct; or
- the Insured's reduction in work hours.

For the Insured's Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- the Insured's death;
- the Insured's divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

### **Who is Entitled to COBRA Continuation**

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: the Insured, the Insured's spouse, and the Insured's Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if the Insured declines or is not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, same sex spouses, grandchildren (unless adopted by the Insured), stepchildren (unless adopted by the Insured). Although these individuals do not have an independent right to elect COBRA continuation coverage, if the Insured elects COBRA continuation coverage for the Insured, the Insured may also cover the Insured's Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when the Insured's COBRA continuation coverage terminates. The sections below titled "Secondary Qualifying Events" and "Medicare Extension for Your Dependents" are not applicable to these individuals.

### **Secondary Qualifying Events**

If, as a result of the Insured's termination of employment or reduction in work hours, the Insured's Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: the Insured's death; the Insured's divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

### **Disability Extension**

If, after electing COBRA continuation coverage due to the Insured's termination of employment or reduction in work hours, the Insured or one of the Insured's Dependents is determined by the Social Security Administration (SSA) to be totally disabled under title II or XVI of the SSA, the Insured and all of the Insured's Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, the Insured must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled. All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

### **Medicare Extension for An Insured's Dependents**

When the qualifying event is the Insured's termination of employment or reduction in work hours and the Insured became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for the Insured's Dependents will last for up to 36 months after the date the

Insured became enrolled in Medicare. The Insured's COBRA continuation coverage will last for up to 18 months from the date of the Insured's termination of employment or reduction in work hours.

### **Termination of COBRA Continuation**

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with us;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a preexisting condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

### **Employer's Notification Requirements**

The Insured's Employer is required to provide the Insured and/or the Insured's Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after the Insured's (or the Insured's spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If the Insured and/or the Insured's Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to the Insured and/or the Insured's Dependents within the following timeframes:
  - (a) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - (b) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - (c) in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

### **How to Elect COBRA Continuation Coverage**

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform the Insured of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. The Insured must notify the Plan Administrator of the Insured's election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, the Insured and the Insured's Dependents will lose the right to elect COBRA continuation coverage. If the Insured rejects COBRA continuation coverage before the due date, the Insured may change the Insured's mind as long as the Insured furnishes a completed election form before the due date. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. The insured or the Insured's spouse may elect continuation coverage on behalf of all the qualified beneficiaries. The Insured is not required to elect COBRA continuation coverage in order for the Insured's Dependents to elect COBRA continuation.

### **How Much Does COBRA Continuation Coverage Cost**

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member. For example:

- If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium.
- If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium.
- If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

### **When and How to Pay COBRA Premiums**

#### *First payment for COBRA continuation*

If the Insured elects COBRA continuation coverage, the Insured does not have to send any payment with the election form. However, the Insured must make the Insured's first payment no later than 45 calendar days after the date of the Insured's election. (This is the date the Election Notice is postmarked, if mailed.) If the Insured does not make the Insured's first payment within that 45 days, the Insured will lose all COBRA continuation rights under the Plan.

#### *Subsequent payments*

After the Insured makes the Insured's first payment for COBRA continuation coverage, the Insured will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If the Insured makes a payment on or before its due date, the Insured's coverage under the Plan will continue for that coverage period without any break.

#### *Grace periods for subsequent payments*

Although subsequent payments are due by the first day of the month, the Insured will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. The Insured's COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if the Insured's payment is received after the due date, the Insured's coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, the Insured's coverage will be reinstated back to the beginning of the coverage period. This means that any claim the Insured submits for benefits while the Insured's coverage is suspended may be denied and may have to be resubmitted once the Insured's coverage is reinstated. If the Insured fails to make a payment before the end of the grace period for that coverage period, the Insured will lose all rights to COBRA continuation coverage under the Plan.

### **The Insured Must Give Notice of Certain Qualifying Events**

If the Insured or the Insured's Dependent(s) experience one of the following qualifying events, the Insured must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- The Insured's divorce or legal separation;
- The Insured's child ceases to qualify as a Dependent under the Plan; or
- The occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events" above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled "Extension of Benefits" For additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

### **Newly Acquired Dependents**

If the Insured acquires a new Dependent through marriage, birth, adoption or placement for adoption while the Insured's coverage is being continued, the Insured may cover such Dependent under the Insured's COBRA continuation coverage. However, only the Insured's newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following the Insured's early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for the Insured's Dependent spouse and any Dependent children who are not the Insured's children (e.g., stepchildren or grandchildren) will cease on the date the Insured's COBRA coverage ceases and they are not eligible for a secondary qualifying event.

### **COBRA Continuation for Retirees Following Employer's Bankruptcy**

If the Insured is covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, the Insured may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for the Insured, the Insured's Dependents or the Insured's surviving spouse within one year before or after such proceeding, the Insured and the Insured's covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. The Insured will be entitled to COBRA continuation coverage until the Insured's death. The Insured's surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following the Insured's death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

### **Trade Act of 2002**

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If the Insured has questions about these new tax provisions, the Insured may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact/2002act\\_index.asp](http://www.doleta.gov/tradeact/2002act_index.asp). In addition, if the Insured initially declined COBRA continuation coverage and, within the Insured's loss of coverage under the Plan, the Insured is deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, the Insured may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If the Insured elects COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless the Insured experiences one of the events discussed under "Termination of COBRA Continuation" above. Coverage will not be retroactive to the initial loss of coverage. If the Insured receives a determination that the Insured is TAA-eligible, the Insured must notify the Plan Administrator immediately.

### **Interaction With Other Continuation Benefits**

The Insured may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

## **NOTICE OF COMPLAINT**

The address and telephone number of our Service Center is as follows:

Monumental Life Insurance Company  
Service Center  
520 Park Avenue  
Baltimore, Maryland 21201  
1-877-709-9290

If we fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, Arkansas 72201  
1-800-282-9134

*SERFF Tracking Number:*    *AEGX-126073726*                      *State:*                      *Arkansas*  
*Filing Company:*            *Monumental Life Insurance Company*            *State Tracking Number:*    *41710*  
*Company Tracking Number:*    *GH AR0047355F01*  
*TOI:*                      *H21 Health - Other*                      *Sub-TOI:*                      *H21.000 Health - Other*  
*Product Name:*                *Supplemental Medical Insurance*  
*Project Name/Number:*        *Supplemental Medical Insurance/GH AR0047355F01*

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: AEGX-126073726 State: Arkansas  
Filing Company: Monumental Life Insurance Company State Tracking Number: 41710  
Company Tracking Number: GH AR0047355F01  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Supplemental Medical Insurance  
Project Name/Number: Supplemental Medical Insurance/GH AR0047355F01

## Supporting Document Schedules

**Satisfied -Name:** Flesch Certification **Review Status:** Approved-Closed 03/17/2009  
**Comments:**  
**Attachment:**  
AR - READABILITY CERTIFICATION.PDF

**Bypassed -Name:** Application **Review Status:** Approved-Closed 03/17/2009  
**Bypass Reason:** We will be using Group Application form MLSM1000GA approved in AR on 7/7/2006 (AR Insurance Department File # 32813)  
**Comments:**

**Bypassed -Name:** Outline of Coverage **Review Status:** Approved-Closed 03/17/2009  
**Bypass Reason:** This is a group product and an outline of coverage is not required.  
**Comments:**

**Satisfied -Name:** AR - NAIC TRANSMITTAL DOC **Review Status:** Approved-Closed 03/17/2009  
**Comments:**  
**Attachment:**  
AR - NAIC TRANSMITTAL DOC.PDF

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

**COMPANY NAME:** Monumental Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
MLSM2000GP.AR	42.66
MLSM2000GC.AR	43.8



Signed: \_\_\_\_\_

Name: Edward G. Weigand

Title: Assistant Secretary

Date: 3/12/2009

**Life, Accident & Health, Annuity, Credit Transmittal Document**

<b>1.</b>	<b>Prepared for the State of</b>	Arkansas
-----------	----------------------------------	----------

<b>2.</b>	<b>Department Use Only</b>	
	<b>State Tracking ID</b>	

3. Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
Monumental Life Insurance Company 4333 Edgewood Road, N.E. Cedar Rapids IA 52499	IA		468	66281	52-0419790	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Edward G. Weigand 520 Park Avenue Baltimore MD 21201	800-233-4624 Ext. 5265	410-209-5910	eweigand@aegonusa.com

<b>5. Requested Filing Mode</b>	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
---------------------------------	--

<b>6. Company Tracking Number</b>	GH AR0047355F01
-----------------------------------	-----------------

<b>7.</b>	<input checked="" type="checkbox"/> <b>New Submission</b> <input type="checkbox"/> <b>Resubmission</b> Previous file # _____
-----------	--

<b>8. Market</b>	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise <input type="checkbox"/> Small <input checked="" type="checkbox"/> Large <input type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____
------------------	---

<b>9. Type of Insurance</b>	H21 Health - Other
-----------------------------	--------------------

<b>10. Product Coding Matrix Filing Code</b>	H21.000 Health - Other
--	------------------------

<b>11. Submitted Documents</b>	<input checked="" type="checkbox"/> <b>FORMS</b> <input checked="" type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input checked="" type="checkbox"/> Certificate <input type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____  <input type="checkbox"/> <b>RATES</b> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate  <input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____  <b>SUPPORTING DOCUMENTATION</b> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
--------------------------------	--

12.	<b>Filing Submission Date</b>	3/13/2009
13.	<b>Filing Fee (If required)</b>	Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No Check Number _____
14.	<b>Date of Domiciliary Approval</b>	N/A
15.	<b>Filing Description:</b>	
<p>Monumental Life insurance Company (MLIC) and Tyson Foods, Inc., headquartered in Springdale, Arkansas, have entered into agreement where MLIC will issue a Group Supplemental Medical Insurance Policy covering applicable employees of Tyson Foods. The submitted Group Supplemental Medical Insurance Policy is intended to be used for this purpose.</p> <p>This Group Supplemental Medical Insurance Policy (Form MLSM2000GP.AR) is a new form however it is very similar to Group Supplemental Medical Policy Form MLSM1000GP filed and approved in Arkansas on July 7, 2006 (Arkansas Insurance Department File # 32813). We wanted to file the enclosed forms as a single case filing unique to the benefit configuration requested by Tyson Foods.</p> <p>This Group Supplemental Medical Insurance Policy (Form MLSM2000GP.AR) is intended to supplement applicable Tyson Foods employee base health benefit plan. The base health benefit plan will provide all required benefits and conditions required of a group health benefit plan, including any state mandated benefits. This Group Supplemental Medical Insurance Policy (Form MLSM2000GP.AR) is intended to reimburse the eligible employee's covered medical expenses not paid under the base health benefit plan. The premium for this coverage is fully paid by Tyson Foods, Inc.</p> <p>This Group Supplemental Medical Insurance Policy (Form MLSM2000GP.AR) is arranged with respect to eligible classes (and eligible employees) and applicable benefit configurations as requested by Tyson Foods and accepted by MLIC.</p> <p>Certificate form MLSM1000GC.AR will be issued to eligible employees and reflect the applicable benefit configuration for that employee.</p> <p>The Group Policy and Certificate forms contain the required complaint Notice.</p> <p>Upon approval, we will use Group Application form MLSM1000GA previously approved by your department on July 7, 2006 (Arkansas Insurance Department File # 32813).</p> <p>We hope the above forms meet with your satisfaction. Should you have any questions or need additional information, please contact me direct at 410-209-5265.</p>		

16.	<b>Certification (If required)</b>	
<p><b>I HEREBY CERTIFY</b> that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p>		
<p>Print Name <u>Edward G. Weigand</u> Title <u>Director</u></p>		
<p>Signature  Date <u>3/13/2009</u></p>		