

SERFF Tracking Number: MCHX-G126689494 State: Arkansas
 Filing Company: Sterling Life Insurance Company State Tracking Number: 46025
 Company Tracking Number: GROUP POLICY (04.09)
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Group Retiree Medical Program - Sterling Life Insu
 Project Name/Number: Group Retiree Medical Program - Sterling Life Insurance Company/Group Retiree Medical Program - Sterling Life Insurance Company

Filing at a Glance

Company: Sterling Life Insurance Company

Product Name: Group Retiree Medical Program SERFF Tr Num: MCHX- G126689494 State: Arkansas
 - Sterling Life Insu

TOI: H21 Health - Other SERFF Status: Closed-Approved- State Tr Num: 46025
 Closed

Sub-TOI: H21.000 Health - Other Co Tr Num: GROUP POLICY State Status: Approved-Closed
 (04.09)

Filing Type: Form Reviewer(s): Rosalind Minor
 Author: SPI McHughConsulting Disposition Date: 07/08/2010
 Date Submitted: 06/23/2010 Disposition Status: Approved-
 Closed

Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: Group Retiree Medical Program - Sterling Life Insurance Status of Filing in Domicile: Authorized
 Company

Project Number: Group Retiree Medical Program - Sterling Life Insurance Company Date Approved in Domicile: 11/23/2009

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: 07/08/2010 Explanation for Other Group Market Type:

State Status Changed: 07/08/2010

Deemer Date: Created By: SPI McHughConsulting

Submitted By: SPI McHughConsulting Corresponding Filing Tracking Number:

PPACA: Grandfathered Immed Mkt Reforms

Filing Description:

NOT PPACA

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Sterling Life Insurance Company
NAIC # 77399 FEIN # 13-1867829

GROUP RETIREE MEDICAL INSURANCE
GROUP POLICY (4.09), et al
See attached form listing

Also Enclosed:
Explanation of Variables

Dear Commissioner Bradford:

McHugh Consulting Resources, Inc. has been requested to file the enclosed forms on behalf of Sterling Life Insurance Company. We have provided an authorization letter for your files.

We are submitting the above captioned forms for review and approval. These forms are designed to provide employer group medical coverage to retirees and their spouses. The forms are new and not intended to replace any other forms currently in use.

The policy form will be issued in your state on a direct issue basis to large (51+) employer groups. For administrative purposes, the policy is designed such that the certificate is incorporated by reference and therefore becomes a part of the policy when issued to the employer.

Please note that although this coverage is designed to coordinate with Medicare benefits, it is not Medicare Supplement insurance. Arkansas' Medicare Supplement law, 23-79-402(b) provides an exception to the Medicare Supplement requirements for employer-based group policies.

As described in the Certificate, this plan pays benefits as a secondary payor for services covered by Medicare. Some of your state's mandated benefits and offers, such as diabetes supplies and education, and routine cancer screenings are covered by Medicare. These benefits are not listed separately because as Medicare-covered services, they are paid the same as any other benefit under this retiree Medicare wrap-around Plan. State mandated benefits that are not covered by Medicare, or for which Medicare coverage is incomplete or variable, are set forth in a separate section of the Certificate and the Benefit Schedule. When Medicare fails to cover these benefits, they will be covered by this Plan as primary payor.

Please note that this plan provides benefits for retirees and their Medicare-eligible spouses/partners only. Minor children are never covered under this plan. Therefore, the certificate does not include coverage for such benefits as child preventive services, or pregnancy related benefits including infertility. In addition, certain mandated benefits may be

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non-applicable in a Plan that covers only Part A benefits.

Each employer will be offered the option of at least two benefit plans with different cost-sharing levels. For example, one Plan option may include an Annual Deductible and Provider Office Visit copay, while another Plan option may omit these cost-sharing features. Plan options may be available that cover persons who only have Medicare Part A. When a Plan covers persons who only have Part A, the Plan's Part B benefits will not apply. In such case, the Plan will primarily pay for excess hospitalization benefits, skilled nursing facility benefits and blood products as described in item 1 of the Benefit Schedule. Please refer to the enclosed Explanation of Variables for a description of the variability and available options.

Please note that this is not a network or preferred provider plan. In addition, the Company relies entirely on Medicare coverage determinations under this plan. As such, the Company does not engage in medical necessity determinations or utilization review.

When a policy is issued to an eligible employer, coverage will be provided to retirees on a guaranteed issue basis within the group. Coverage will be provided on a contributory and/or non-contributory basis, where the retiree may be responsible for all or part of the premium. Coverage will be marketed through agent/broker solicitation.

All bracketed numbers are variable to the extent allowable by your state's laws. All bracketed text is variable to the extent allowed by law. In addition, the bracketed text may or may not be included in the policy when printed. In no event will numbers or text be changed to impact compliance with your law. The enclosed Explanation of Variables provides additional information about the variable text in the forms.

The forms are in final print, subject to minor variations in formatting, duplexing, shading and fonts. While every effort is made to submit filings without mistakes, the Company reserves the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval. The Company will provide you a highlighted copy of any corrections it makes for your records.

Thank you for your attention to this filing. Please do not hesitate to contact the undersigned at 215.230.7960 if you should have any questions regarding this filing.

Sincerely,

Frankie Warhurst, FLMI, AIRC, CCP
Consultant

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Company and Contact

Filing Contact Information

Jane Neal, Compliance Project Specialist mcr@mchughconsulting.com
 McHugh Consulting Resources, Inc. 215-230-7960 [Phone]
 2005 South Easton Road, Suite 207 215-230-7961 [FAX]
 Doylestown, PA 18901

Filing Company Information

(This filing was made by a third party - McHughConsulting)

Sterling Life Insurance Company	CoCode: 77399	State of Domicile: Illinois
2219 Rimland Drive	Group Code:	Company Type:
Bellingham, WA 98226	Group Name:	State ID Number:
(360) 392-9098 ext. [Phone]	FEIN Number: 13-1867829	

Filing Fees

Fee Required? Yes
 Fee Amount: \$250.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sterling Life Insurance Company	\$250.00	06/23/2010	37445448

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/08/2010	07/08/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	06/29/2010	06/29/2010	SPI McHughConsulting	07/01/2010	07/01/2010

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Disposition

Disposition Date: 07/08/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Supporting Document	Certification of Rule 19	Approved-Closed	Yes
Supporting Document	Certification of Rule 49	Approved-Closed	Yes
Supporting Document (revised)	SOV	Approved-Closed	Yes
Supporting Document	SOV	Replaced	Yes
Supporting Document	07.01.10 Objection Response	Approved-Closed	Yes
Supporting Document	Statement of Variability - RED LINE	Approved-Closed	Yes
Supporting Document	Certificate RED LINE	Approved-Closed	Yes
Form	Group Policy	Approved-Closed	Yes
Form (revised)	Certificate of Coverage	Approved-Closed	Yes
Form	Certificate of Coverage	Replaced	Yes
Form	Master Application	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Optional Hearing Benefit	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/29/2010
Submitted Date 06/29/2010

Respond By Date

Dear Jane Neal,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certificate of Coverage, EMPLOYER COC AR (05.10) (Form)

Comment:

Your Time Payment of Claims provision is not in compliance with Rule and Regulation 43, Section 12 which states that a health carrier shall pay or deny a clean claim within 30 days after receipt by the Health Carrier if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 07/01/2010
Submitted Date 07/01/2010

Dear Rosalind Minor,

Comments:

Please find attached a response to your June 29, 2010, objection letter.

Response 1

Comments: Please find attached:

Related Objection 1

Applies To:

- Certificate of Coverage, EMPLOYER COC AR (05.10) (Form)

Comment:

Your Time Payment of Claims provision is not in compliance with Rule and Regulation 43, Section 12 which states that a health carrier shall pay or deny a clean claim within 30 days after receipt by the Health Carrier if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: SOV

Comment:

Satisfied -Name: 07.01.10 Objection Response

Comment:

Satisfied -Name: Statement of Variability - RED LINE

Comment:

Satisfied -Name: Certificate RED LINE

Comment:

Form Schedule Item Changes

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Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Certificate of Coverage	EMPLOY ER COC AR (07.10)		Certificate	Revised		46.000	AR Certificate of Coverage EMPLOY ER COC 07 10 mods for 063010 obj and APD chgs clean.PDF
Previous Version							
Certificate of Coverage	EMPLOY ER COC AR (05.10)		Certificate	Initial		46.000	AR Certificate of Coverage EMPLOY ER COC 05_10 clean.PDF

No Rate/Rule Schedule items changed.

Thank you for your continued assistance with this filing.

Sincerely,
SPI McHughConsulting

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Form Schedule

Lead Form Number: GROUP POLICY (04.09)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/08/2010	GROUP POLICY (04.09)	Policy/Contract/Fraternal Certificate	Group Policy	Initial		46.000	Group Policy GROUP POLICY 04_09.PDF
Approved-Closed 07/08/2010	EMPLOYEE COC AR (07.10)	Certificate of Coverage	Certificate of Coverage	Revised	Replaced Form #: Previous Filing #:	46.000	AR Certificate of Coverage EMPLOYER COC 07 10 mods for 063010 obj and APD chgs clean.PDF
Approved-Closed 07/08/2010	ERISA GRP APP AR (05.10)	Application/Enrollment Form	Application Enrollment Form	Initial		48.000	AR Master Application ERISA GRP APP 05_10 clean.PDF
Approved-Closed 07/08/2010	ERISA GRP ENR AR (05.10)	Application/Enrollment Form	Enrollment Form	Initial		46.000	AR Enrollment Form ERISA GRP ENR 05_10_clean.PDF
Approved-Closed 07/08/2010	HEARING BENEFIT RIDER AR	Certificate Amendment, Insert Page, Endorsement or Rider	Optional Hearing Benefit	Initial		45.000	AR Hearing Benefit clean.PDF

**Sterling Life Insurance Company
[ABC, Inc.]
Medicare-Enrolled Retiree Plan
Group Policy**

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Premium Provisions	X
Termination Provisions.....	X

Sterling Life Insurance Company, Inc.
Administrative Offices/Customer Service
[P. O. Box 5348 Bellingham, WA 98227-5348
(800) 688-0010]

GROUP INSURANCE POLICY

This Policy is entered into between Sterling Life Insurance Company, hereinafter referred to as the Company, and the Policyholder.

The Company will provide the benefits stated in this Policy subject to the provisions and limitations contained herein. We have issued this Policy in consideration of the payment of the first premium and the statements made in the Master Application, which is attached to and made part of this Policy.

This Policy is governed by the laws of the state in which it was issued, and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. The entire Policy consists of:

1. all Policy provisions and any amendments and/or attachments issued;
2. the signed Master Application; and
3. the Certificate of Coverage.

This Policy may be changed in whole or in part. Only an executive officer of the Company can approve a change. The approval must be in writing and endorsed on or attached to this Policy. No other person, including an agent, may change this Policy or waive any part of it.

This Policy shall be available for inspection at all reasonable times at the place of business or principal residence of the Policyholder where this Policy is on file, by any Covered Person or by an authorized representative of the Covered Person.

Signed by Our [President] and [Assistant Secretary].



[President]



[Assistant Secretary]

Premium Provisions

Payment Of Premium

The initial premium is due on or before the effective date of this Policy. Each premium after the initial one is due at the end of the period for which the preceding premium was paid.

Premiums are due and payable to the Company at the rates and in the manner described in the Master Application. All rates are expressed in, and all premiums are payable, in United States currency.

This Policy will lapse on the last day of the period for which the premium is paid. If the premium is not paid by that date, the grace period will begin.

Grace Period

A grace period of thirty-one (31) days is allowed for the payment of any premium except the initial premium. This Policy will continue in force during the grace period. If the premium is not paid during the grace period, this Policy will terminate at the end of the thirty-one (31) day period.

The Policyholder is liable for premium for coverage during the grace period. The Policyholder must pay all premium due for the full period this Policy is in force.

Change of Premium

The Company may change the required premiums by giving at least 31 days advance written notice to the Policyholder. The Company may also change premiums due at any time when any change agreed upon, in writing, between the Policyholder and the Company is made that affects the coverage provided by this Policy (including changes to the number of Insureds) or if it is discovered that there was a material misrepresentation in the information relied upon in establishing the premiums.

Conformity With State And Federal Laws

Any provision of this Policy which, on its effective day, is in conflict with the laws of the state in which it was issued on that date is amended to conform to the minimum requirements of such laws.

If at any time during the life of the Policy, federal or state law changes which would require a corresponding change in the coverage, the Company reserves the right, subject to regulatory approval, to change Policy language, benefits or premium rates, but only as necessary to comply with the changes in law.

Termination Provisions

This Policy shall have a term of one year from the effective date. This Policy may be terminated at the end of the term by mutual agreement between the Company and the Policyholder at least 60 days prior to the end of the term.

Cancellation by the Policyholder

This Policy may be canceled by the Policyholder at any time by giving written notice to the other of not less than 60 days prior to cancellation.

Termination by the Company

This Policy may be terminated for any of the following reasons:

1. [there is less than [25%] participation of those eligible Retirees who pay all or part of the premium for their coverage;]
2. the Policyholder does not promptly provide information that is reasonably required;
3. the Policyholder fails to perform any of its obligations that relate to this Policy;
4. fewer than [50] Retirees are insured under this Policy;
5. there is a significant change in the size, occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Policyholder; or
6. the Policyholder fails to pay premium, subject to the Grace Period provision.]

If this Policy is terminated for reasons other than the Policyholder's failure to pay premiums, written notice will be mailed to the Policyholder at least 31 days prior to the termination.

Cancellation or termination of this Policy will not affect a payable claim.

Policyholder Provisions

Entire Contract; Changes

The entire contract consists of:

1. all Policy provisions and any amendments and/or attachments issued;
2. the signed Master Application; and
3. the Certificate of coverage.

This Policy may be changed in whole or in part. Only an executive officer of the Company can approve a change. The approval must be in writing and endorsed on or attached to this Policy. No other person, including an agent, may change this Policy or waive any part of it.

Certificates

The Company will furnish to the Policyholder, for delivery to each Insured, an individual Certificate setting forth the benefits, limitations, and conditions of the Policy, and to whom benefits will be paid.

New Insureds

To the group originally insured may be added from time to time eligible new Retirees or members, in accordance with the terms of this Policy.

Time Limit On Certain Defenses (Incontestability)

In the absence of fraud, statements made by the Policyholder are deemed representations and not warranties.

After two years from the effective date of this Policy, no such statements may be used to void this Policy after the two year period.

Maintenance and Examination of Records

The Policyholder will maintain records and provide the Company with information relating to this Policy. The Company shall be permitted to request or examine records at any reasonable time or at any time for two years after the termination date of this Policy or until the final adjustments and settlement of all claims under this Policy.

Clerical Error

Inadvertent clerical errors (whether by the Policyholder or by the Company) will not void the coverage of any Covered Person if that coverage would have otherwise been in effect nor extend the coverage of any Covered Person if that coverage would have otherwise ended or been reduced as provided by this Policy. Upon discovery of any such error, all necessary information shall be furnished and an equitable adjustment of the premiums will be made, but in no event shall an adjustment be made for a period more than six months prior to the date the Policyholder or Company is notified of the error.

Certificate Part of Policy

The remainder of this Policy's provisions are contained in the individual Certificate of coverage, which is made part of this Policy.

**Sterling Life Insurance Company
[ABC Company, Inc.]
Medicare-Enrolled Retiree Plan
Certificate of Coverage**

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Sterling Life Insurance Company, Inc.
Administrative Offices/Customer Service
[P. O. Box 5348 Bellingham, WA 98227-5348
(800) 688-0010]

GROUP INSURANCE CERTIFICATE

Sterling Life Insurance Company, Inc. (Referred to in this contract as “We”, “Us”, or “Our”) will provide the coverage stated in this Certificate subject to the provisions and limitations contained herein. We have issued this Certificate in consideration of the payment of the first premium and the statements made in Your enrollment form.

The group Policy issued to the Policyholder determines all rights and benefits which are summarized in this Certificate. We or the Policyholder may end the Policy according to its terms, as described in the Termination section of this Certificate.

The group Policy shall be available for inspection at all reasonable times at the place of business or principal residence of the Policyholder where the Policy is on file, by any Covered Person or by an authorized representative of the Covered Person.

Your Right To Examine And Cancel this Certificate Within 10 Days

We want You to fully understand and be satisfied with Your Certificate. If, for any reason, You are not satisfied with Your Certificate, You may cancel it. Return the Certificate to Us or to one of this Plan’s authorized agents by midnight of the 10th day after You receive it. As soon as possible after We receive this Certificate, We will refund any premiums You have paid. The Certificate will be considered to have never been issued.

Renewability and Premium Change

You may renew Your Certificate for Yourself as long as You may live, subject to the terms of the Group Policy. To renew, just pay the renewal premiums, if necessary. They must be paid on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this Certificate or place any restrictions on it if the premiums are paid on time.

We may change the premium rates for this Certificate at renewal. The change may be due to a change in Certificate coverage or a new table of rates. We can only change Your premium rate if We change it for all policies of the same class. We will tell You in advance of any change in premium rate.

Signed by Our [President] and [Assistant Secretary].



[President]



[Assistant Secretary]

Certificate Holder Information

[Group Number:

Policyholder: [ABC, Inc.]

Certificate Number:

Certificate Effective Date:

Initial Premium Mode:

Initial Premium Amount:

First Renewal Premium:]

Schedule of Benefits

This Plan pays benefits, as secondary payor, for medical conditions and procedures covered by Medicare. There may be some additional State mandated benefits which may not be covered by Medicare but will be covered by this Plan. This Plan will be the primary payor for these benefits.

Plan Benefits – [Plan 1]

[Annual Plan Deductible]

This Plan has a [\$300] annual Deductible. You must have incurred [\$300 dollars] expense for Part A and Part B Covered Services before this Plan begins to make benefit payments. Once the Annual Plan Deductible is met, Medicare [Part A] [and] [Part B] Services are covered as described in this Schedule of Benefits.]

[Provider Office Visit Copay]

This Plan has a Primary care office visit copay of up to [\$10] and a [\$20] Specialist office visit copay of up to [\$20]. The office visit copays are not included in the Annual Plan Deductible.]

[Provider Office Visit Copay]

This Plan has a [\$10] Provider office visit copay. The office visit copays are not included in the Annual Plan Deductible.]

[Lifetime Maximum Benefit]

[\$2,000,000 - Unlimited]

1. Medicare Part A Services

Medicare (Part A) Hospital Services Per Benefit Period	A Benefit Period begins the first day You receive services as an Inpatient in a Hospital and ends after You have been out of the Hospital and have not received skilled care in any other facility for 60 days in a row. You are responsible for all other non covered charges.
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Hospitalization Semiprivate room and board, general nursing and Hospital Miscellaneous Expenses.			
SERVICES	MEDICARE PAYS	THIS RETIREE PLAN PAYS	YOU PAY
First 60 days	All but [\$1024]	[\$1024]	\$0
61 st through 90 th day	All but [\$256 a day]	[\$256 a day]	\$0
91 st day and after: While using 60 lifetime reserve days	All but [\$512 a day]	[\$512 a day]	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
Beyond the Additional 365 days	\$0	\$0	All Costs

Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a Hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the Hospital.

SERVICES	MEDICARE PAYS	THIS RETIREE PLAN PAYS	YOU PAY
First 20 days	All Approved Amounts	\$0	\$0
21 st through 100 th day	All but [\$128]	[\$128]	\$0
101 st days and after	\$0	\$0	All Costs

Blood			
SERVICES	MEDICARE PAYS	THIS RETIREE PLAN PAYS	YOU PAY
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0

Hospice Care			
SERVICES	MEDICARE PAYS	THIS RETIREE PLAN PAYS	YOU PAY
Available as long as Your Physician certifies You are terminally ill and You elect to receive these services	All but very limited Co-Insurance for Outpatient drugs and Inpatient respite care	\$0	Balance of Expenses

[2. Medicare Part B Services

If You are enrolled in [Plan 1], this Plan will not pay benefits for Part B Covered Services.

If You are enrolled in [Plan 2, Plan 3] this Plan will pay benefits for Part B Covered Services as described herein.

Medicare pays (generally) 80% of Part B Medicare approved amounts (55% for Substance Abuse and Mental Health Services) once you have met your Medicare annual Part B deductible (\$[135]). You will pay the balance based on the amounts reflected below[, up to the Plan Out-of Pocket of [\$1,000]]. (This does not include Your [\$300] Annual Plan Deductible). [Your annual Medicare Part B deductible will count towards Your [\$300] Annual Plan Deductible.]

Medicare (Part B) Medical Services – Per Calendar Year			
Medical Expenses in or out of the Hospital & Outpatient Hospital Treatment , such as Physician’s services, Inpatient and Outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, Durable Medical Equipment.			
SERVICES	MEDICARE PAYS	THIS RETIREE PLAN PAYS	YOU PAY
Provider Office Visits	0-80%	[Remaining amount after [\$10] copay.]][Remaining amount [after [\$10] Primary care office visit copay, [\$20] Specialist office visit.]	[Lessor of the remaining amount or [\$10 copay]] [Lessor of the remaining amount or the [\$10] Primary care office visit copay, [\$20] Specialist office visit copay.]

First [\$135] of Medicare Approved Amounts*	\$0	[\$0] [[[\$135] Part B Deductible]	[[[\$135] Part B Deductible] [\$0]
Remainder of Medicare Approved Amounts	Generally 80%, (or 55% for Substance Abuse and Mental Health Services)	[Generally 20% (45% for Substance Abuse and Mental Health Services)] [\$0 [until OOP Max is met, then 20%(45% for Substance Abuse and Mental Health Services)]]	[\$0] [Generally 20% (45% for Substance Abuse and Mental Health Services) [, until OOP Max is met]]
Part B Excess (Above Medicare Approved Amount)	\$0	100%	\$0

Blood			
First 3 pints	\$0	All Costs	\$0
Next [\$135] of Medicare Approved Amounts*	\$0	[\$0] [[[\$135] Part B Deductible]	[[[\$135] Part B Deductible] [\$0]
Remainder of Medicare Approved Amounts	Generally 80%	[Generally 20%] [\$0 [until OOP Max is met, then 20%]]	[\$0] [Generally 20%[, until OOP Max is met]]

Clinical Laboratory Services			
Blood Tests For Diagnostic Services	100%	\$0	\$0
Home Health Care, Medicare Approved Services Medically necessary skilled care services and medical supplies	100%	\$0	\$0

Durable Medical Equipment			
First [\$135] of Medicare Approved Amounts*	\$0	[\$0] [[[\$135] Part B Deductible]	[\$0] [Generally 20%[, until OOP Max is met]]

Remainder of Medicare Approved Amounts	Generally 80%	[Generally 20%] [\$0 [until OOP Max is met, then 20%]]	[\$0] [Generally 20%[, until OOP Max is met]]
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Annual Out of Pocket Maximum for Medicare Part B Covered Services
Once You have incurred out-of-pocket expenses of [\$1,000] (in addition to the [\$300] Annual Plan Deductible) for Medicare Part B Covered Services during the Calendar Year, this Plan will provide coverage for 100% of any additional expenses incurred for Medicare Part B Covered Services.]

]

[3.] Additional Benefits [Benefits [are/are not] subject to the [\$300 Annual Plan Deductible]

Foreign Travel - Not Covered by Medicare. Medically necessary Emergency Care services beginning during the first 60 days of each trip outside the USA.			
First [\$250] each Calendar Year	\$0	\$0	[\$250]
Remainder of Charges	\$0	[80%] to a lifetime maximum benefit of [\$50,000]	Generally 20% and amounts over the [\$50,000] lifetime maximum

4. Arkansas State Requirements

Dental Anesthesiology	The same co-payments, deductibles and benefit limits shall apply to covered anesthesia and Hospitalization for dental services as those applied to other medical or surgical benefits under this Plan.
Mastectomy-Related Services	The same co-payments, deductibles and benefit limits shall apply to mastectomy-related services as those applied to other medical or surgical benefits under this Plan.
Speech or Hearing Impairment	The same co-payments, deductibles and benefit limits shall apply to speech or hearing impairment care and treatment as those applied to other medical or surgical benefits under this Plan.

Eligibility and Enrollment

Eligibility for Coverage

Who May Receive Benefits

Benefits are provided to eligible Retirees of the Policyholder and their eligible spouses. A Retiree may be covered as a Retiree, or as a spouse of an eligible Retiree who is also a Retiree of the Policyholder, but not both. Qualifications for eligibility are as follows:

[Plan 1]

Retirees

Those who:

- § are retired from active employment with the Policyholder;
- § have completed [X years][the required number of years, as specified by the Policyholder in the Master Application,] of full time service with the Policyholder immediately before retirement;
- § are age sixty-five (65);
- § are not employed for [20 or more hours per week], either by any other employer or self-employed; and
- § are enrolled in Medicare Part A[and B]; or
- § are designated as eligible as described in an endorsement to the Policy

will be eligible for health care benefits under this Plan.

Spouse of Covered Retirees

Those who:

- § are the current spouse (husband or wife) of an eligible Retiree;
- § are age sixty-five (65);
- § are not employed for [twenty (20) or more hours per week], either by any other employer or self-employed; and
- § are enrolled in Medicare Part A[and B]; or
- § are designated as eligible as described in an endorsement to the Policy

will be eligible for health care benefits under this Plan. We may require legal proof of marriage. Common law marriages are not recognized under this Plan.

Other Dependents

With the exception of an eligible Retiree's spouse, as listed above, no other individuals or dependents are eligible for coverage under this Plan.

Enrollment

Eligible Retirees

An eligible Retiree must enroll in this Plan by completing enrollment forms within thirty (30) days of becoming eligible. These forms are provided by the Policyholder. If the enrollee's spouse is also eligible, they should also be enrolled at that time. If a Retiree does not enroll him or herself or his or her Eligible spouse, or declines coverage for them by signing a "Refusal of Coverage" card within thirty (30) days of becoming eligible, neither the Retiree nor the spouse will be

eligible for enrollment in this Plan, except in the event of a HIPAA Special Enrollment Period, as described below.

Eligible Retiree Spouses

As stated above, an eligible spouse of a Retiree may be enrolled in this Plan when the Retiree becomes eligible for coverage. If the spouse of a Retiree should become eligible for this Plan after the Retiree's enrollment, the spouse must enroll in this Plan by completing the necessary enrollment forms within 30 days of his/her eligibility.

An eligible new spouse of an eligible Retiree must be enrolled within 30 days of marriage or other eligibility, as described above. If an eligible spouse is not enrolled within 30 days of becoming eligible; he/she will not be eligible to enroll in this Plan except in the event of a HIPAA Special Enrollment Period, as described below.

Changes in Enrollment

The Policyholder must be notified if any change occurs in the status of the Retiree or spouse which could affect eligibility for coverage under this Plan.

HIPAA Special Enrollment Period

If You are declining enrollment for Yourself or Your spouse because of other health insurance coverage, You may be able to enroll Yourself or Your spouse in this Plan in the future, if You request enrollment within thirty (30) days after the other coverage ends. In addition, if You have a new spouse as a result of marriage, You may be able to enroll Your spouse if You request enrollment within thirty (30) days after the marriage.

If an individual who is eligible for this Plan does not enroll because they have coverage under another group health plan or other health insurance, then that individual is eligible for a special enrollment period under the following circumstances:

1. The individual has stated in writing that coverage under another group health plan or health insurance was the reason for declining enrollment; and
2. The individual had COBRA continuation coverage and that coverage has been exhausted or the individual was not covered under COBRA continuation and either the other coverage has been terminated as a result of loss of eligibility for coverage or employer contribution toward the other coverage has been terminated.

Loss of eligibility can be as a result of legal separation, divorce, death, termination of employment, reductions in the number of hours of employment and any other loss of eligibility under the other group health plan or health insurance coverage.

The special enrollment period lasts for thirty (30) days and begins on the day following the loss of coverage under the other plan. The required effective date of coverage for those enrolling during a special enrollment period can be no later than the first day of the month following the date on which the request for enrollment was completed.

When Coverage Begins

New Retirees and their eligible spouse will be covered on the first day of the month following enrollment. All coverage will commence at 12:01 a.m. on the date such coverage takes effect.

New spouses will be covered on the date of marriage or upon meeting the eligibility requirements described above if enrollment forms have been properly completed.

Benefits

Medical Plan

This Plan pays benefits, as secondary payor, for medical conditions and procedures covered by Medicare. There may be some additional state-mandated benefits which may not be covered by Medicare but will be covered by this Plan. This Plan will be the primary payor for these benefits.

Services which are not covered by Medicare or mandated by state law as indicated below will not be covered under this Plan.

Medical benefits are provided to eligible Retirees and their covered spouse as defined under the Eligibility for Coverage provision in the Eligibility and Enrollment section.

[Plan 1]

Deductible

[After Your [\$300 dollar] Annual Plan Deductible,]this Plan pays the Inpatient [Medicare Part A] [and] [Medicare Part B] Deductible for Covered Services. Except for Medically Necessary Emergency Care in a Foreign Country, as described in the Eligible Services and Benefits section, there are no other Deductibles associated with this Plan.

[Provider Office Visit Copay

This Plan has a Primary care office visit copay of up to [\$10] and a Specialist office visit copay of up to [\$20]. The office visit copays are not included in the Annual Plan Deductible.]

[Provider Office Visit Co-Payment

This Plan has a [\$10] Provider office visit copay. The office visit copays are not included in the Annual Plan Deductible.]

Providers Of Service

This Plan will provide benefits for Covered Services rendered by a qualified Provider of service under Medicare.

This Plan will not pay benefits for services not covered under this Plan, even if rendered by a Medicare-qualified Provider. The status of being listed as a Medicare-qualified Provider does not mean that all services rendered by that Provider will be covered under this Plan, but only those services which are specifically listed as Covered Services.

Covered Services and Benefits

Inpatient Hospital Stay – Medicare Part A

This Plan provides medical benefits for Hospital and Facility charges, as covered by Medicare. Medicare Part A covers Inpatient Hospital care, Skilled Nursing Facility care, Hospice care, and *some* home health care (including physical, occupational and speech therapy; and Durable Medical Equipment). For more details on Medicare Covered Services, please consult the most recent “Medicare & You” booklet, or contact Medicare at 1-800-MEDICARE or www.medicare.gov.

If, while this Certificate is in force, You incur facility charges covered by Medicare Part A, We will provide the coverage described below. The facility stay must be Medically Necessary and be approved by Medicare; be caused by an Injury or Sickness; and begin while You have this coverage. No benefits will be paid under this section that would duplicate benefits paid under Medicare Part B, if applicable. This Plan will limit coverage to Medicare Eligible Expenses and benefits mandated by state law. This Plan will not cover charges that Medicare deems unreasonable and/or unnecessary.

We will provide coverage for the following benefits[, subject to the Annual Plan Deductible for which You are liable]:

1. Medicare Part A Deductible: Coverage for all of the Medicare Part A Inpatient Hospital Deductible amount in a Benefit Period.
2. Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare for days 61 through 90 in any Medicare Benefit Period;
3. Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used;
4. When the Medicare Hospital Inpatient coverage, and the lifetime reserve days have exhausted, coverage for Medicare Part A Eligible Expenses for Hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days.
5. Coverage for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells) unless replaced in accordance with federal regulations, or covered under Medicare Part B, if applicable.
6. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Co-Insurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital Skilled Nursing Facility care eligible under Medicare Part A.

Hospice Care

This Plan does not pay benefits for Hospice Care beyond those paid by Medicare. Medicare generally covers all expenses for Hospice Care, with the exception of very limited Co-Insurance for Outpatient drugs and Inpatient respite care.

Medicare Part B

[The following Part B benefits apply only to [Plans 2 and 3]. This Plan's Part B benefits do not apply to [Plan 1].]

[Part B Deductible and Co-Insurance

Once You have incurred out-of-pocket expenses of [\$1,000] (in addition to the [\$300] Annual Plan Deductible) for Medicare Part B Covered Services during the Calendar Year, this Plan will provide coverage for 100% of any additional expenses incurred for Medicare Part B Covered services.]

[Provider Care – Medicare Part B

This Plan provides medical benefits for Physician, Provider, and Outpatient Hospital charges, as covered by Medicare. Medicare Part B covers Physician's services, Outpatient Hospital care, and some other medical services not covered by Part A, such as the services of physical and occupational therapists and *some* home health care. For more details on Medicare Covered Services, please consult the most recent "Medicare & You" booklet, or contact Medicare at 1-800-MEDICARE or www.medicare.gov.

If, while this Certificate is in force, You incur Provider or facility charges covered by Medicare Part B, We will provide the coverage described below. The services received must be Medically Necessary and be approved by Medicare; be caused by an Injury or Sickness; and begin while You have this coverage. No benefits will be paid under this section that would duplicate benefits paid under Medicare Part A. This Plan will limit coverage to Medicare Eligible Expenses. Medicare does not pay for charges it deems unreasonable and/or unnecessary.

We will provide coverage for the following benefits[, subject to [the Annual Plan Deductible] [and] [the Plan Out of Pocket of [\$1000] and [the Provider office visit copay/s], for which You are liable]:

1. [We will pay all of the Medicare Part B Deductible amount in a Calendar Year regardless of whether or not You were confined in a Hospital.]
2. [We will pay the Co-Insurance or, in the case of Hospital Outpatient department services under a prospective payment system, the Co-Payment amount of Medicare Eligible Expenses under Part B. We will pay this amount regardless of whether or not You were confined in a Hospital.]
3. We will pay all the difference between the actual Medicare Part B charge as billed, and the Part B charge approved by Medicare, not to exceed any charge limitation established by the Medicare program or state law.]

Medically Necessary Emergency Care in a Foreign Country

This Plan provides coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare Eligible Expenses for Medically Necessary Emergency Care, including Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a Calendar Year benefit Deductible of [\$250], and a lifetime maximum benefit of [\$50,000].

Maximum Benefit

The lifetime maximum benefit under this Plan is [\$2,000,000 – unlimited].

Arkansas State Requirements

The Covered Services listed below are provided in compliance with state law. To the extent covered by original Medicare, this Plan pays such benefits as secondary payor. To the extent not covered by original Medicare, this Plan pays such benefits as primary payor.

Dental Anesthesiology

This Plan covers general anesthesia and associated facility charges for services performed in a Hospital or ambulatory surgical center in connection with dental procedures that are Medically Necessary because the Covered Person has a serious mental or physical condition, or a significant behavioral problem that the Covered Person's Physician determines would place the Covered Person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the Covered Person's Physician.

The dental procedure itself and associated dentist's fee are not covered.

Mastectomy-Related Services

Following a mastectomy for the treatment of breast cancer, there is a minimum hospitalization benefit of 48 hours unless the decision to discharge prior to 48 hours is made by the attending Physician in consultation with the patient

This Plan covers reconstructive breast surgery following a mastectomy, including reconstruction of the breast on which surgery was performed and the other breast to produce a symmetrical appearance if the patient elects reconstruction, in the manner chosen by the patient and Physician. The Plan also covers prosthetic devices and physical complications at all stages of mastectomy, including lymphedemas.

Speech or Hearing Impairment

This Plan covers the Medically Necessary care and treatment of loss or impairment of speech or hearing, including services provided by a licensed audiologist or a licensed speech-language pathologist. This does not include coverage for hearing aids or devices.

Exclusions and Limitations

Benefits will be paid only for care given under the direct supervision of covered Providers of service as described in the Benefits section, to the extent they perform services within the scope of their license. Support professionals must be properly certified and licensed.

All facilities must be licensed in the states in which they operate. Hospitals and Skilled Nursing Facilities must meet the definitions provided in the Definitions section.

The following services, supplies and charges are **NOT** covered under this Plan and are excluded when determining benefit payments:

Not Covered By Medicare or State-Mandated

This Plan does not pay benefits for anything not eligible under Medicare and/or not specifically mandated by state law.

Acts of War

This Plan does not pay benefits for charges incurred:

- As a result of war or acts of war (declared or undeclared),
- From participating in a riot,
- While serving in the armed forces of any country, or
- While confined in a penal or correctional institution.

Acupuncture and Naturopathic

This Plan does not pay benefits for charges incurred for any acupuncture or naturopathic services.

Cosmetic Procedures or Reconstruction Surgical Treatment

This Plan does not pay benefits for services primarily intended to change one's appearance; including liposuction and breast reduction; or in connection with Cosmetic Procedures, except reconstructive surgery resulting from Injury or surgical treatment of the involved part incurred while covered under this Plan.

Court Ordered Care

This Plan does not pay benefits for non-Medically Necessary services which are ordered by court of law.

Custodial Care

This Plan does not pay benefits for Custodial Care.

Dental Care

This Plan does not pay benefits for items and services related to the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth, including periodontium, gingivae, dentogingival junction, periodontal membrane, cementum of the teeth and alveolar process, dental splints, prostheses, or any dental treatment for the teeth, gums or jaw not otherwise allowed by Medicare.

Elective or Voluntary

This Plan does not pay benefits for enhancement procedures, services, supplies, and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, anti-aging, and mental performance, unless Medically Necessary.

Experimental

This Plan does not pay benefits for medical and surgical care, services, supplies or devices and medications which are:

- Experimental or Investigational,
- Not recognized by the American Medical Association as generally accepted and Medically Necessary to the diagnosis and/or treatment of an active Sickness or Injury, or
- Charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value or are otherwise not covered by Medicare.

Foot Care and Supplies

This Plan does not pay benefits for foot care only to improve comfort or appearance. This includes care for

- Flat feet,
- Corns,
- Bunions (except capsular and bone surgery),
- Calluses or ingrown toenails;

This also includes supplies in connection with routine foot care, such as but not limited to,

- Impression casts,
- Appliances and braces, or
- Corrective shoes.

Benefits are not provided for Orthotic Appliances unless they are prescribed for necessary medical treatment of a covered Injury, or after surgery. Orthopedic shoes and supportive devices for the feet are not covered unless they are part of a leg brace and are included in the orthopedist's charge. This exclusion shall not apply to therapeutic shoes for those suffering from diabetic foot disease as allowed by Medicare.

Government Facilities and Programs

This Plan does not pay benefits for services and supplies which could have been received without charge under government programs; Charges incurred while confined in a Hospital owned or operated by the United States government or any agency thereof; and charges for services, treatments or supplies furnished by United State Government or any agency thereof.

Hearing Aids

This Plan does not pay benefits for routine hearing and hearing aids.

Illegal Act

This Plan does not pay benefits for charges resulting from or occurring during the commission of a felony by the Covered Person or while engaged in an illegal occupation or felonious act or as the instigator of assault.

Incurred Prior to Plan

This Plan does not pay benefits for charges incurred prior to the Certificate Effective Date or after coverage is terminated.

Inpatient Hospital

This Plan does not pay benefits:

- For services that are rendered during an Inpatient confinement which are primarily related to behavior, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of psychological disorders;
- For education, training and bed and board while confined to an institution which is primarily a school or other;
- For Hospitalization primarily for x-ray, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent care, Custodial Care or test care, or any medical examination or tests not connected with an actual Sickness or Injury; or
- For a private room in a Hospital, unless Medically Necessary and allowable by Medicare.

Missed Appointment

This Plan does not pay benefits for charges for missed appointment or completion of forms.

Non-Covered Provider Services

This Plan does not pay benefits:

- For any treatment which is not rendered by or under the direct supervision of a licensed Physician;
- In connection with services and supplies which are not necessary for treatment of the Injury or Sickness or not recommended and approved by a licensed Physician;
- For private duty nurses;
- For charges imposed by immediate relatives or members of Your household, whether a licensed Provider of service or not.

Not Listed as Eligible

This Plan does not pay benefits for services or supplies not listed as eligible expenses.

Not Obligated to Pay

This Plan does not pay benefits for charges incurred which the Covered Person is not, in the absence of this coverage, legally obligated to pay.

Obesity

This Plan does not pay benefits for weight reduction or treatment of obesity, unless specifically ordered by a licensed Physician as being Medically Necessary to prevent the imminent death or total permanent disability of the Covered Person.

Other Insurance Coverage

This Plan does not pay benefits for any services to the extent that benefits are available under the terms of any vehicle, homeowner's, property, or other insurance coverage. Benefits available under automobile uninsured or underinsured motorist coverage are considered an exclusion only to the extent double recovery for medical expenses. Any benefits paid by this Plan contrary to this exclusion are not provided solely to assist the Covered Person. By paying for such benefits, Sterling is not acting as a volunteer and is not waiving any right to reimbursement or subrogation (see Conditions of Coverage section).

Patient Responsibility

This Plan does not pay benefits for the portion of the charge not otherwise covered by Medicare or this Plan that is patient responsibility.

Personal Care, Comfort or Convenience

This Plan does not pay benefits for marital counseling, diversionary, recreational or educational therapies, (such as hobbies, art and crafts, dance or music) and any related testing, or biofeedback or milieu therapy primarily directed toward self enhancement or to change or control one's environment; for services or supplies which constitute personal comfort or beautification items, or in connection with education or non-occupational training; for television, telephone, personal convenience items, or expenses for any persons not covered by this Plan; homemaker services; meals delivered to Your home; nursing care on a full-time basis in Your home.

Pregnancy

This Plan does not pay benefits for any expenses related to Pregnancy; however, complications of Pregnancy are covered the same as any other Sickness.

Prescription Drugs

This Plan does not pay benefits for prescription drugs, except those covered by original Medicare.

Relatives Providing Services

This Plan does not pay benefits for charges for services rendered by a Physician, nurse or licensed therapist if such Physician, nurse or licensed therapist is a Close Relative of the Covered Person or resides in the same household as the Covered Person.

Routine and Preventive Care

This Plan does not pay benefits for routine medical examinations, screening tests or routine health check-ups, shots or vaccinations not necessary for treatment of an Injury or Sickness, except as listed under Covered Services and Benefits.

Self Inflicted

This Plan does not pay benefits for expenses incurred resulting from treatment of intentionally self-inflicted Sickness or Injury, suicide or attempted suicide, whether sane or insane.

Services in Foreign Country

This Plan does not pay benefits for charges incurred outside the United States or Canada if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies; or for services or supplies not considered legal in the United States.

Sex Change or Sexual Dysfunction

This Plan does not pay benefits for sex change operations, counseling, surgery, drugs, other services or supplies, or treatment related to sex change; penile implants including any resulting complications, services or supplies for the treatment of sexual dysfunction or inadequacies, frigidity or impotence including any expenses for psychiatric therapy, adjustment therapy, or for treatment or therapy related to inter-sex surgery not otherwise covered by Medicare.

Tele-medicine

This Plan does not pay benefits for tele-medicine provided for non-eligible services.

Vision Services / Radial Keratotomy

This Plan does not pay benefits for eye exams and for the purchase or fitting of eyeglasses except as otherwise specified. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses, following cataract surgery. Services or procedures involving Radial Keratotomy are not covered.

Vitamins and Minerals

This Plan does not pay benefits for orthomolecular testing and therapy, or nutritional supplements, even if by prescription.

Work Related Charges

This Plan does not pay benefits for charges arising out of or in the course of any work for wage or profit for which the Covered Person is entitled to receive any benefit under Workers' Compensation or Occupational Disease Law or similar law.

Conditions of Coverage

General Provisions

Assignment

This Plan's benefits are offered personally to the Retiree and eligible spouse. Neither this Plan, its services and benefits, nor its payments are assignable or transferable. We reserve the right to make benefit payment to the Covered Person, the Provider, or jointly to both for Covered Services.

Determination of Benefits

The fact that a Physician or other licensed health care Provider may prescribe, order, recommend or approve a service or supply does not mean it is covered under this Plan. The Benefit Administrator will determine whether expenses qualify for benefits and are eligible for payment.

Right of Recovery

When payments have been made in excess of the amount necessary to satisfy a Plan Benefit, We will have the right to recover these excess payments. If We elect to recover the excess payment from any Covered Person; We may recover the excess payment by deduction from any future benefits due to or on behalf of the Covered Person.

Time Limit on Certain Defenses (Incontestability)

In the absence of fraud, statements made by any Covered Person are deemed representations and not warranties. No written statement made by any Covered Person shall be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary, if any.

After two years from the Certificate Effective Date, only fraudulent misstatements on Your enrollment form may be used to void this Certificate or deny any claim for loss incurred or disability that starts after the two year period.

Misstatement of Age

If Your age is misstated on the application for this coverage, the coverage provided will be that which the premium submitted would have purchased at Your correct age. If Your correct age as of the Certificate Effective Date would have caused Us to refuse coverage to You, We will only be responsible for the return of all premiums paid, less the amount of any claims paid.

Payment Of Benefits

Benefits will be paid to You or Your designated beneficiary or beneficiaries, or to Your estate, except that if the person insured is a minor or otherwise not competent to give a valid release, such benefits may be made payable to his parent, guardian, or other person actually supporting him. A portion of any indemnities provided by this Certificate on account of Hospital, nursing, medical, or surgical services, may at Our option, and unless You request otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such services provided, further, that authorization for any such payments has been obtained from You. We will be discharged to the extent of any such payment made in good faith.

Legal Action

No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of 3 years after the time

written proof of loss is required to be furnished.

Conformity with State and Federal Laws

Any provision of the Certificate which, on its effective day, is in conflict with the laws of the state in which the Policy was issued on that date is amended to conform to the minimum requirements of such laws.

If at any time during the life of the Certificate, federal or state law changes which would require a corresponding change in the coverage, We reserve the right, subject to regulatory approval, to change Certificate language, benefits or premium rates, but only as necessary to comply with the changes in law.

Physical Examinations and Autopsy

We at Our own expense have the right to have any Covered Person examined as often as reasonably necessary by a Physician of Our choice while a claim is pending. We may also have an autopsy made unless prohibited by law.

Subrogation

The benefits of this Certificate will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this Certificate for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to Us to the extent of all payment made by Us for such benefits. You or Your representative agrees to cooperate fully with Us to secure these rights of subrogation. You also agree to otherwise help Us recover benefits We have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

Premiums

We may change the premium for this Certificate due to a change in benefits or a new table of rates. We will tell You in advance of any change in premium on a timely basis.

Payment Of Premium

The initial premium is due on or before the Certificate Effective Date. Each premium after the initial one is due at the end of the period for which the preceding premium was paid.

If the premium is not paid by that date, the grace period will begin.

Grace Period

A grace period of 31 days is allowed for the payment of any premium except the initial premium. The coverage will continue in force during the grace period. If the premium is not paid during the grace period, the coverage will terminate at the end of the 31 day period.

Reinstatement

If the premium is not paid before the grace period ends, Your coverage under the Policy will lapse. If We (or any agent authorized to accept payment) later accept Your premium, without requiring an application for reinstatement, Your coverage will be reinstated.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, We will reinstate Your coverage as of the approval date. Lacking such approval, Your coverage will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated coverage will cover only loss that results from an Injury or Sickness sustained after the date of reinstatement. In all other respects Your rights and Our rights will remain the same.

Claims and Appeals

Claims Payment

Allowed by Medicare

If a billed charge is allowed by Medicare, it will be processed by this Plan as secondary, based on the original Medicare allowable amount.

[Excess Charges

[Plan 2 and Plan 3] will allow Medicare Part B excess charges and pay the amount between the actual Medicare Part B charge as billed and the Medicare-approved Part B charge, not to exceed any charge limitation established by the Medicare program or state law.]

Usual, Customary And Reasonable Fees

Benefit payments made under this Plan for services are based on usual, reasonable and customary charges. This means the amount generally accepted by the majority of Hospitals and licensed Physicians for like services and supplies at the time such services were rendered; in the geographic area where the Provider resides, as determined by this Plan. This Plan will take into consideration the fees and prices generally accepted and the services generally furnished in the geographic area concerned.

If a state mandated benefit is not also allowed by Medicare, the claim will be processed subject to usual and customary fees, and the remaining balance will be the responsibility of the patient.

Policyholder Optional Benefits

If the Policyholder elected to offer optional benefits as part of this Retiree Benefits Plan (i.e. Extended foreign travel benefits, vision, hearing, and/or prescription), the charges will be processed subject to usual and customary fees.

Claims Procedures

How To File A Claim

When You have a Claim, You or Your Provider must first file Your claim with Medicare. Once You receive a copy of this Plan's Explanation of Medicare Benefits ("EOMB"), submit a copy and an itemized billing to Us for processing.

Doctors, Hospitals, laboratories or other Providers may submit fully itemized bills by mail or electronic submission.

If the Covered Person has paid the bill, a copy of the paid receipt must be attached to the itemized claim in order for the Covered Person to receive reimbursement for the claim payment.

Late Claims

Claims submitted more than twelve (12) months after services and supplies were received will be considered late and will not be eligible for payment. Such expenses shall be considered to have occurred at the time the service or supply was actually provided.

What Happens When A Claim Is Filed

After a medical claim is submitted to Us, it will be processed according to the provisions of this Plan.

When the claim has been approved and paid, the Covered Person will receive a written Explanation of Benefits (EOB) showing the amount of submitted charges, the amount of those charges eligible for benefit payment, the amount of benefits actually paid by this Plan and any remaining balance owed by the Covered Person.

If the claim is incomplete or additional information is needed from the claimant or the attending Physician, the claim will be held pending further clarification and the Covered Person will receive a written explanation within 30 days after receipt of the claim of the reason for the delay in processing the claim and a description of the additional information required. Once the necessary information is received by Us, the processing of the claim will be completed.

How Claims Are Paid

Payment will be made directly to the Physician, Hospital, laboratory or other Provider. If, however, the Covered Person has paid the bill and notified Us, payment will be sent to the employee. (See "How to File a Claim").

Time of Payment Of Claims

Benefits for any loss covered by this Certificate will be paid immediately upon receipt of proper written proof of loss. A clean claim will be paid or denied within 30 days after receipt if submitted electronically or within 45 days after receipt if the claim was submitted by other means. If We do not pay within 60 of receipt, We shall pay interest at the rate of 12 percent per annum from the 61st day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid.

Disputed Claims

If the Covered Person believes a claim has been incorrectly paid or denied, he or she may request a second review from Us. The request must:

1. Be in writing within sixty (60) days of receiving the Explanation of Benefits (EOB) or notice of denial;
2. Describe the claim or claims being questioned;
3. State the reasons for disputing the action taken; and
4. Include any information requested by Us.

We will respond in writing within sixty (60) days.

Coordination of Benefits and Services

If a Covered Person is covered by more than one Plan, this provision allows Sterling to coordinate what Sterling pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Retiree is covered.

The words shown below have special meanings when used in this provision. Please read these definitions carefully.

“Allowable Expense” means a Medically Necessary, Reasonable and Customary item of expense for health care; when the item of expense is covered at least in part by one or more Plans covering the person for whom claim is made.

The difference between the cost of a private Hospital room and the cost of a Semi-Private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in this Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because an insured person does not comply with that Plan's provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions or pre-certification of admissions or services.

“Plan” means any coverage with which coordination of benefits is allowed. Plan includes:

1. Any group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage.
2. Any federal, state or local governmental programs, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

“Primary Plan/Secondary Plan” The Order of Benefit Determination rules state whether this is a Primary Plan or a Secondary Plan. When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering a person, this Plan may be a Primary Plan as to one or more other Plan's benefits, and may be a Secondary Plan as to a different Plan.

Order of Benefit Determination

Sterling considers each Plan separately when coordinating payments. This Plan determines its order of benefits using the first of the following rules which applies:

1. A Plan that does not have a coordination of benefits provision will always be a Primary Plan.
2. The benefits of a Plan which covers the person on whose expenses the claim is based as other than a dependent will be determined before the benefits of a Plan which covers the person as a dependent.
3. The benefits of a Plan that covers a person as a primary insured who is neither laid off nor retired, or as that primary insured's dependent, are determined before those of a Plan that covers that person as a laid off or retired primary insured or as that primary insured's dependent. This rule will not apply if the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits.
4. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is covered under another Plan, the following will be the order of benefit determination:
 - A. First, the benefits of a Plan covering the person as an employee, member, or subscriber (or as that person's dependent);
 - B. Second, the benefits under the continuation coverage. If the other Plan does not have the rule described above and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
5. When rules 2 through 4 do not establish an order of benefit determination the benefits of a Plan which has covered the person on whose expenses the claim is based for the longer period of time will be determined before the benefits of a Plan which has covered the person the shorter period of time.

Facility of Payment

If another Plan makes a benefit payment that should have been made by Us We have the right to pay the other Plan any amount We deem necessary to satisfy our obligation under these COB rules.

Right of Recovery

If the amount of Our benefit payment is more than the amount needed to satisfy Our obligation under these COB rules, We have the right to recover the excess amount from: (A) any persons to or for whom, or with respect to whom, the payments were made; (B) any insurance companies; or (C) any other organizations.

Right to Receive and Release Necessary Information

In order to carry out these COB rules:

1. We have the right, without the consent of or notice to any person, to exchange information with any person, insurance company or organization, as We deem necessary; and
2. Any person claiming benefits under this Plan must give Us any information necessary to carry out this provision.

Termination

When Coverage Stops

Coverage of an eligible Retiree and covered spouse will cease, subject to continuation provisions below, on the last day of the month in which:

1. The Retiree and/or spouse ceases to meet eligibility requirements, as defined under the Eligibility for Coverage provision in the Eligibility and Enrollment section;
2. The Retiree dies;
3. The Retiree and/or spouse fails to make any required contribution; or
4. The Policy is terminated by the Policyholder.

Benefit ID Cards must be returned to the Policyholder's personnel office if a Retiree or spouse is no longer covered.

If We accept a premium for a time period after coverage is to cease, the premium will be refunded.

Extension of Benefits

If Your coverage ends, for reasons other than discontinuance of the group contract, while You are Totally Disabled, benefits will be extended for the disabling condition until the earlier of the following dates:

1. The date You are no longer Totally Disabled; or
2. The date that You exhaust Your benefit or reach any coverage maximum or limit.

If Your coverage ends due to discontinuance of the group contract while You are Totally Disabled, benefits will be extended for the disabling condition until the earlier of the following dates:

1. The date You are no longer Totally Disabled;
2. The date that You exhaust Your benefit or reach any coverage maximum or limit; or
3. Twelve months from the date of discontinuance

Continuation for Covered Spouse

Subject to timely payment of premium, coverage will continue for an enrolled spouse who would otherwise become ineligible due divorce or death of the Retiree. The spouse must notify the Policyholder of the Retiree's death or divorce. The Policyholder will provide written notice to the spouse of the right to continue coverage and will send instructions for premium payment.

Definitions

This section provides a list of certain terms and their meaning as used in this Certificate. Defined terms are capitalized wherever they occur in the Certificate.

Accident

An event inflicting personal bodily Injury to the Covered Person solely through external violent, unintentional and unforeseen causes.

[Annual Plan Deductible

The dollar amount, specified in the Schedule of Benefits, of covered eligible expenses incurred under this Plan during a Benefit Period which must be paid by the Covered Person before this Plan is obligated to pay its portion of any further eligible expenses incurred in that Benefit Period.]

Benefit Period

A period of consecutive days that begins with the first day (not included in the previous spell of Sickness) on which You are furnished Inpatient Hospital, skilled nursing, or rehabilitation services by a qualified Provider in a month for which You are entitled to Medicare Part A benefits. A Benefit Period ends when You have been out of a Hospital or other facility primarily providing skilled nursing or rehabilitation services for sixty (60) days in a row (including the day of discharge), or the day the Covered Person ceases to be covered for benefits under this Plan.

Calendar Year

The twelve-month period that begins on January 1st and ends with December 31st. When You first become covered under this Certificate, the first Calendar Year begins for You on the Certificate Effective Date and ends on the following December 31st.

Close Relative

A parent, spouse, spouse's parent, brother, sister, or child of the Covered Person.

Complications of Pregnancy

The following will be considered Complications of Pregnancy:

Hospital confinement required to treat conditions, such as the following, in a pregnant female: (1) acute nephritis; (2) nephrosis; (3) cardiac decompensation; (4) HELLP syndrome; (5) uterine rupture; (6) amniotic fluid embolism; (7) chorioamnionitis; (8) fatty liver in pregnancy; (9) septic abortion; (10) placenta accreta; (11) gestational hypertension; (12) puerperal sepsis; (13) peripartum cardiomyopathy; (14) cholestasis in pregnancy; (15) thrombocytopenia in pregnancy; (16) placenta previa; (17) placental abruption; (18) acute cholecystitis and pancreatitis in pregnancy; (19) postpartum hemorrhage; (20) septic pelvic thrombophlebitis; (21) retained placenta; (22) venous air embolus associated with pregnancy; (23) miscarriage; or (24) an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of descent or dilatation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy.

A C-section delivery is not considered to be an emergency C-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous C-section.

Treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: (1) hyperthyroidism, (2) hepatitis B or C, (3) HIV, (4) Human papilloma virus, (5) abnormal PAP, (6) syphilis, (7) chlamydia, (8) herpes, (9) urinary tract infections, (10) thromboembolism, (11) appendicitis, (12) hypothyroidism, (13) pulmonary embolism, (14) sickle cell disease, (15) tuberculosis, (16) migraine headaches, (17) depression, (18) acute myocarditis, (19) asthma, (20) maternal cytomegalovirus, (21) urolithiasis, (22) DVT prophylaxis, (23) ovarian dermoid tumors, (24) biliary atresia and/or cirrhosis, (25) first trimester adnexal mass, (26) hydatidiform mole, or (27) ectopic pregnancy.

Coordination of Benefits

The order of benefit determination rules state whether this Plan is a Primary Plan or Secondary Plan covering the person.

Co-Payment or Co-Insurance

That portion of expenses which must be paid by You.

Cosmetic Procedure

A procedure performed primarily for the improvement of a Covered Person's appearance rather than for the treatment of an Injury or and Sickness.

Covered Services

Any Medically Necessary treatment, services or supplies that are not specifically excluded from coverage by the Plan.

Covered Person

An eligible Retiree or spouse who has met the eligibility requirements described in Eligibility and Enrollment section, and who is eligible to receive benefits.

Custodial Care

Care that assists in the activities of daily living or meeting personal needs, such as walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets; and supervision of medication that is usually self-administered, or other care or treatment in an institution that is a rest home, place of rest, a place for the aged, a nursing home, convalescent home or similar institution.

Dental Care Services

Any services furnished to any person for the purpose of preventing, alleviating, curing, or healing human dental Sickness or Injury.

Durable Medical Equipment

Equipment which is:

1. Intended for repeated use;
2. Primarily and customarily used to service a medical purpose; and
3. Not generally useful to a person in the absence of the Sickness or Injury for which it is prescribed.

Emergency Care

Bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Experimental or Investigational

A drug, device or medical treatment or procedure is Experimental or Investigational if:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
3. Reliable evidence shows that the consensus among experts regarding the drug, device or medical treatment procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Family

A covered Retiree and his or her covered spouse.

HIPAA

The Health Insurance Portability And Accountability Act of 1996, Public Law 104-191, August 21, 1996, as amended, or any provision or section thereof.

Hospice

A health care program providing a coordinated set of services rendered in a patient's home, in Outpatient settings or in institutional settings, for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an inter-disciplinary group of personnel which includes at least one Physician and one Registered Nurse (RN), and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital

An institution which meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient or Outpatient basis at the patient's expense;
2. It is constituted, licensed, and operated in accordance with the laws of the state in which it is located;

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical or surgical treatment of any Sickness or Injury;
4. Treatment is provided for compensation by or under the supervision of licensed Physicians with continuous twenty-four (24) hour nursing services by Registered Nurses (RNs); and
5. It qualifies as a Provider of services under Medicare, and is accredited as a Hospital by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association. The term Hospital will not include an institution which is, other than incidentally a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

Convalescent and extended care facilities are not Hospitals.

Hospital Miscellaneous Expenses

The actual charges made by a Hospital on its own behalf for services and supplies rendered to the Covered Person which are Medical Necessary for the treatment of such Covered Person. These expenses do not include charges for room and board or of professional services other than general nursing services regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Injury

Bodily Injury sustained by a Covered Person caused by an Accident which is the direct cause of loss, independent of disease or bodily infirmity. All Injuries sustained in connection with one Accident will be considered one Injury. Injury does not include ptomaine poisoning, disease or infection (except pyogenic infection occurring through an Accidental cut or wound).

Inpatient

The classification of a Covered Person when that person is admitted to a Hospital, Hospice, or convalescent facility for treatment, and charges are made for room and board to the Covered Person as a result of such treatment.

Inpatient Lifetime Reserve Days

The additional non-renewable sixty (60) days of Hospital coverage provided under Medicare Part A for an admission which exceeds ninety (90) days. **Important Note:** Once You use an Inpatient Lifetime Reserve Day, it is not replaced. Inpatient Lifetime Reserve Days are non-renewable.

Medically Necessary

Health care services, supplies or treatment which, in the judgment of the attending Physician, is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

Medicare

The programs established by Title 1 of Public Law 89-98 (79 Statutes 291) as amended entitled Health Insurance for the Aged Act, and which includes both Parts A and B and Title XVIII of the Social Security Act (as amended by Public Law 89-97, 79) as amended from time to time.

Medicare Deductible

A specified dollar amount of Medicare Eligible Expenses incurred during a Benefit Period which must be paid by the Covered Person before Medicare is obligated to pay its portion of any further eligible expenses incurred in that Benefit Period.

Medicare Eligible Expenses

Expenses which are of the kind covered by Medicare, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part A

Insurance to cover Hospital expenses, such as Room and Board and other Inpatient Hospital services.

Medicare Part B

Insurance to cover medical expenses, such as Physicians' services, Outpatient Hospital services and a number of other non-Hospital medical services and supplies.

Mental Illness

Any condition classified as a mental disorders as shown in the International Classification of Diseases (ICD).

Orthotic Appliance

A rigid or semi-rigid supportive device which limits or stops the motion of a weak or diseased body part.

Outpatient

The status of a Covered Person who receives medical care, treatment, services or supplies other than as an admitted Hospital bed-patient, usually in a clinic, Physician's office, or an Outpatient surgical facility.

Physician

A person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise shall not be covered by this Certificate. "Physician" does not include You or any Close Relative.

Plan

This Retiree benefit Plan.

Plan Benefit

That portion of eligible expenses to be paid by this Plan as specified in the Schedule of Benefits. It is the basis used to determine any out-of-pocket expenses in excess of any Deductibles or Co-Payments which are to be paid by the Covered Person.

Provider

As covered under this Plan, this term means a qualified provider of services under Medicare.

Registered Nurse (RN)

An individual who has:

1. Specialized knowledge and training beyond that of a licensed practical nurse (LPN) for the observation, assessment and diagnosis of Sickness and Injury
2. Graduated from an accredited school of nursing with an RN degree

3. Served the requisite internship, and is
4. Duly licensed to perform such nursing services by the regulatory agency responsible for such licensing in the state in which that individual performs such services.

Retiree

A retired employee of the Policyholder who meets the eligibility criteria as described in the Eligibility and Enrollment section.

Semi-Private

A two, three, or four bed room in a Hospital or other treatment facility.

Sickness

Physical illness or disease of a Covered Person. Sickness includes Substance Abuse and Mental Illness when services provided are a Medicare Eligible Expense.

Skilled Nursing Facility

A place which, by law, provides care and treatment to persons who are convalescing as resident bed patients from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare; or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the facility; and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Substance Abuse

Abuse of, addiction to, or dependence on drugs, chemicals or alcohol.

Substance Abuse and/or Mental Health Services

Services for the diagnosis and treatment of Mental Illness or Substance Abuse.

Total Disability/Totally Disabled

A disability resulting from bodily Injury or Sickness which prevents the retiree or spouse from performing the normal activities of a person of like age and sex.

We, Us, Our

Sterling Life Insurance Company, Inc.

You

The Retiree to whom this Certificate is issued.

STERLING LIFE INSURANCE COMPANY

Administration/Customer Service
 [P.O. Box 5348, Bellingham, WA 98227
 (800) 688-0010]

APPLICATION FOR GROUP RETIREE INSURANCE

Applications must be accompanied by the initial premium for projected enrollees. Eligible retirees and their eligible spouses will be enrolled on the Group Policy, and premium will be forwarded by the Group to Sterling on their behalf, according to the terms of this agreement.

The Group hereby assumes full responsibility for collecting and forwarding the premium to Sterling along with a list of any enrolled members who are no longer covered under the plan. Sterling will bill the Group according to the billing option selected. The Group is fully responsible for the contribution amount as listed in this application.

IT IS UNDERSTOOD THAT INFORMATION CONTAINED ON AN INDIVIDUAL ENROLLEE'S APPLICATION IS CONFIDENTIAL AND PROTECTED BY STATE AND FEDERAL LAW. IMPROPER DISCLOSURE FOR SUCH INFORMATION MAY GIVE RISE TO CRIMINAL AND CIVIL CHARGES. AS SUCH, THE GROUP SPONSOR AGREES TO TAKE ALL NECESSARY STEPS TO GUARANTEE THE CONFIDENTIALITY OF SUCH INFORMATION, AND TO USE THE MINIMUM INFORMATION NECESSARY TO PROCESS THIS TRANSACTION.

In no way is this Group Application an appointment of the Group as an agent of Sterling for any purpose.

I. Group Applicant Name (Name of Company, Employer Group, or Retiree Association) [ABC Corporation]				
Corporation <input checked="" type="checkbox"/>		Partnership <input type="checkbox"/>		Association <input type="checkbox"/> SIC#
Tax I.D. # [12345]		Group Contact Name/Title [Jan Smith, Benefits Coordinator]		
Home Office Address Street [123 Any St., Anytown USA]		City		
County [Camden]	State [XX]	Zip [12345]	Telephone [(555) 555-1212]	
Website: www. [www.Abccorporation.com]		E-mail Address [info@abccorp.com]	Fax [(555) 555-1213]	
Billing Information: <i>If different from Home Office Address</i>		Billing Contact Name/Title [see above]		
Billing Address Street		City		
State	Zip	Telephone	E-mail	Fax
II. Requested Effective Date: [01/01/2010]		[Plan Selection: <input checked="" type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4]		
III. Participation Rate: [75%]	Total # of Medicare Eligible Retirees and Medicare Eligible Spouses: [200]	Number of Participants: [150]	Percentage of Participation: [75%]	
IV. Contribution Level - per member, per month [\$xx]		Percentage % [25%]	Dollar Amount \$ [\$xx]	

V. Please read this section carefully before signing. Please review your application for errors or omissions.

The Group Applicant and/or authorized representative hereby request that it be approved for Group Retiree coverage offered by Sterling Life Insurance Company and to be bound by Sterling's rules and regulations pertaining to coverage under the insurance contract, as may be adopted an/or revised and agreed to by both parties. Group applicant understands and agrees to the following:

1. To comply with all terms and provisions of the Group contract.
2. To make the coverage available to all Medicare Eligible Retirees and Medicare Eligible spouses according to the terms of the contract and to distribute information and documents to enrolled employees as needed.
3. To maintain records and furnish to Sterling or their designated agent any information required in connection with administration of the coverage.
4. To pay Sterling or its authorized representative by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership, to assume responsibility for handling the state-mandated continued group coverage and/or conversion process, if applicable.
5. That claims filed by or on behalf of members may, at Sterling's option, be suspended if premiums are not timely received.
6. If applicable, Employer will receive on behalf of members, all notices delivered by Sterling, and immediately forward such notices to persons involved, at their last know address.
7. The advance premium check does not create temporary or interim coverage and that receipt and deposit of that payment does not guarantee issuance of coverage. Rather, issuance of coverage is expressly conditioned on Sterling's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Sterling except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees.
8. That in order for Sterling to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Sterling, or its designated agent, is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Sterling may be different than the coverage applied for herein. In that event, Sterling shall notify the employer of such differences, and by payment of the appropriate premiums, the employer may accept or reject the coverage as issued.
9. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Sterling by the employer. Sterling reserves the right to review such rates upon receipt of all individual applications for employers' employees and to modify the rates, if the enrollment information so warrants. Any misstatements on employees' applications or failure to report new medical information prior to the employees' effective dates may result in a material change to the groups' coverage or premium rates as of the effective date of coverage.
10. The entire application for Group coverage has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.
11. The requested coverage is not in effect unless and until this application is approved by Sterling, that approval of coverage shall be evidenced by issuing Group contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Sterling.

APPLICATION IS NOT A GUARANTEE OF ELIGIBILITY FOR COVERAGE

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

Dated at City [Anytown] State [XX] Zip [12345]

Group Responsible Party Signature: [Jan Smith] Date [12/01/2009]

Broker Certification: I have reviewed this application for completeness and accuracy. I have not completed any of the information contained in the applications except with the permission of the applicant and as noted by my initials on the application. I have advised the group that failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the group's premium retroactive to the effective date and that coverage shall not be effective until Sterling reviews and approves the application and the group receives a contract from Sterling indicating said effective date.

Signature of Licensed Agent/Broker: [John Deer] Date: [12/01/2009]

Address: [123 Street Rd., Anytown, USA 12345]

Broker ID No#: [12345] Federal Tax ID Number: [12-3456789]

FOR OFFICE USE ONLY:

GROUP NUMBER#:

Application Received Date: _____

APPROVED YES NO

Underwriting Waived for Initial Enrollment? YES NO

Approved/Declined by: _____ Date: _____

Group Application Entered by: _____ Date: _____

STERLING LIFE INSURANCE COMPANY

Administration/Customer Service
[P.O. Box 5348, Bellingham, WA 98227
(800) 688-0010]

ENROLLMENT FORM FOR GROUP RETIREE INSURANCE

1. Enrollee Information. Print Enrollee's Full Name (Last, First & Middle Initial): [John Doe]			
Medicare I.D. # [12345]	Group Name: [ABC Company]		
Social Sec. # [111-11-1111]	Age [68]	Gender [M]	Date of Birth [08/17/1941]

Eligibility Status: Retiree Spouse of Retiree

Enrollment Period: Initial Enrollment Period Within 31 days of attaining Medicare eligibility

[Plan Selection: [Plan 1 Plan 2 Plan 3 Plan 4]]

Yes, I am insured under Medicare Part A and/or B

Effective date for Part B

[08/17/2006]

Permanent Residence:

123 Any St.

Anytown

Street	City	Telephone
[Camden County	12345	(555) 555-1212]
County	State	Zip
	XX	

Billing Address: If different from permanent residence

[N/A]

2. Replacement of Coverage Information. To the best of your knowledge:

a. Do you have a Medicare supplement policy or certificate in force? If so, with which company? Yes No

b. Do you have any other health insurance coverage that provides benefits similar to this retiree medical certificate? If so, with which company and what kind of policy? Yes No

c. If the answer to a) or b) is yes, do you intend to replace your current Medicare supplemental policy or health insurance coverage with this certificate? Yes No

d. Are you covered for medical assistance through the state Medicaid program:
 Yes No **If Yes** As a "Specified Low-Income Medicare Beneficiary" (SLMB)?
 As a "Qualified Medicare Beneficiary" (QMB)?
 For other Medicaid medical benefits?

Insurer and Policy Number
Company Name and Type of Policy

3. Acknowledgments. The Enrollee, to the best of his/her knowledge and belief, represents and agrees as follows:

1. That the statements contained in the enrollment form are complete, true and correct.
 2. No other person is authorized to accept risks, pass upon insurability, make or modify contracts or waive any of the Company's rights or requirements.
 3. Insurance issued as a result of this enrollment form will take effect as specified in the Receipt.
 4. Plan provisions concerning exceptions, exclusions, limitations and renewal, which have been applied for, have been explained and are understood.
- 4. Representation.** The undersigned enrollee acknowledges that the enrollee has read or had read to him/her the completed enrollment form and that he/she realized that any false statements or misrepresentation therein may result in loss of coverage under the certificate.
- 5. Payment of Premium.** Read the receipt before signing. This is to acknowledge that I have read the receipt and fully understand its conditions and limitations. I understand that no agent can waive or change the conditions and limitations of this receipt
- 6. Authorization.** In connection with an application for insurance currently made to Sterling, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or any of the members of my family named in said application or of my health, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. This authorization shall be valid for a period of two years and six months from the date signed.

I further authorize Sterling, at its option, to pay providers directly for services rendered. In addition, I hereby authorize the Health Care Financing Administration, or its duly appointed Part A or Part B carriers, or intermediaries, to release to Sterling information they may require in the processing of my supplement insurance or other insurance coverage I may have through them. This information may include EOMBs, "deduct-not-met" or denial letter, Part B billing forms, and information date of enrollment in Part B of Medicare. I further authorize ongoing release of this information to Sterling for as long as I am enrolled under the supplement coverage. I understand I may revoke this authorization for release of Title XVIII (Medicare) information for supplement insurance coverage at any time by notifying Sterling in writing. I understand that if I do rescind my authorization for the release of Title XVIII information, that I will need to fill out claims forms and some records could be released before the rescission has time to take effect.

Sterling does not consider any information obtained from genetic screening or testing in processing an application for coverage for health care services under an individual or group policy, contract, or agreement or in determining insurability under such a policy, contract, or agreement. Sterling does not inquire, directly or indirectly, into the results of genetic screening or testing or use such information, in whole or in part, to cancel, refuse to issue or renew, or limit benefits under, an individual or group policy, contract, or agreement. As used in this section, "genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies, and not an indirect manifestation of genetic disorders.

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

Dated at City [Anytown, USA] State [XX] Zip [12345]

Enrollee's Signature: [John Doe] Date [1/1/2010]

Sterling Life Insurance Company, Inc.
Administrative Offices/Customer Service
[P. O. Box 5348 Bellingham, WA 98227-5348
(800) 688-0010]

OPTIONAL HEARING BENEFIT

The consideration for this Rider is the additional premium shown in your billing statement. The Certificate to which this Rider is attached is amended to include the benefits described below, as elected by the Policyholder in the space provided at the end of this Rider. These benefits are applicable to Illinois residents only, and are subject to all other Certificate terms, limits, and conditions, except to the extent specifically modified by this Rider. These benefits are applicable only if this Rider is elected by the Policyholder as indicated in the Benefit Election section below.

Hearing Benefit

This Plan will provide coverage for services described below: [

1. Routine Hearing Examinations: Plan will provide coverage at 100% after the Calendar Year Deductible has been satisfied. This is separate from diagnostic hearing tests and related charges as covered by Medicare.
2.]Hearing Aids: The Plan will provide coverage for the cost of hearing aids at 100% up to \$1,400 per ear every 36 months.

"Hearing aid" means an instrument or device, including repair and replacement parts, that:

1. Is designed and offered for the purpose of aiding persons with or compensating for impaired hearing;
2. Is worn in or on the body; and
3. Is generally not useful to a person in the absence of a hearing impairment.

Rider Election

The optional benefits provided by this Rider are effective only to the extent elected by the Policyholder as indicated below.

The Policyholder hereby elects the optional coverage provided by this Rider.

The Policyholder hereby declines the optional coverage provided by this Rider.

Policyholder's Signature

Date

Nothing contained in this Rider will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Policy or Certificate other than as stated above. If elected, the Effective Date of this Rider is the Effective Date of the Policy or Certificate to which it is attached.

Signed by Our [President] and [Assistant Secretary].

[]
President

[]
Assistant Secretary

SERFF Tracking Number: MCHX-G126689494 State: Arkansas
 Filing Company: Sterling Life Insurance Company State Tracking Number: 46025
 Company Tracking Number: GROUP POLICY (04.09)
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Group Retiree Medical Program - Sterling Life Insu
 Project Name/Number: Group Retiree Medical Program - Sterling Life Insurance Company/Group Retiree Medical Program - Sterling Life Insurance Company

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	07/08/2010
Comments:			
Attachment:			
	AR Readability cert.PDF		
Satisfied - Item:	Application	Approved-Closed	07/08/2010
Comments:	see forms tab		
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	07/08/2010
Bypass Reason:	n/a		
Comments:			
Bypassed - Item:	Outline of Coverage	Approved-Closed	07/08/2010
Bypass Reason:	n/a		
Comments:			
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	07/08/2010
Bypass Reason:	n/a not PPACA		
Comments:			

SERFF Tracking Number: MCHX-G126689494 State: Arkansas
 Filing Company: Sterling Life Insurance Company State Tracking Number: 46025
 Company Tracking Number: GROUP POLICY (04.09)
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Group Retiree Medical Program - Sterling Life Insu
 Project Name/Number: Group Retiree Medical Program - Sterling Life Insurance Company/Group Retiree Medical Program - Sterling Life Insurance Company

Item Status: Approved-Closed
Status Date: 07/08/2010
Satisfied - Item: Authorization Letter
Comments:
Attachment:
 STERLING Authorization for McHugh Consulting - Michael 02_02_10.PDF

Item Status: Approved-Closed
Status Date: 07/08/2010
Satisfied - Item: Certification of Rule 19
Comments:
Attachment:
 AR Cert of Compliance with Rule 19.PDF

Item Status: Approved-Closed
Status Date: 07/08/2010
Satisfied - Item: Certification of Rule 49
Comments:
Attachment:
 AR Certificate of Compliance 23-79-138 and RR 49.PDF

Item Status: Approved-Closed
Status Date: 07/08/2010
Satisfied - Item: SOV
Comments:
Attachment:
 AR EOv 4_7_09 with APD chgs clean.PDF

Item Status: Approved-Closed
Status Date: 07/08/2010
Satisfied - Item: 07.01.10 Objection Response
Comments:

SERFF Tracking Number: MCHX-G126689494 State: Arkansas
 Filing Company: Sterling Life Insurance Company State Tracking Number: 46025
 Company Tracking Number: GROUP POLICY (04.09)
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Group Retiree Medical Program - Sterling Life Insu
 Project Name/Number: Group Retiree Medical Program - Sterling Life Insurance Company/Group Retiree Medical Program - Sterling Life Insurance Company

Attachment:

AR Sterling - Grp Ret Med - Resp to 06_29_10 obj.PDF

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability - RED LINE	Approved-Closed	07/08/2010

Comments:

Attachment:

AR EOVS 4_7_09 redlined with APD chgs.PDF

	Item Status:	Status Date:
Satisfied - Item: Certificate RED LINE	Approved-Closed	07/08/2010

Comments:

Attachment:

AR COC EMPLOYER COC 07 10 mods for 063010 obj and APD chgs Redlined for DOI.PDF

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Sterling 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
GROUP POLICY (04.09)	46
EMPLOYER COC AR (05.10)	46
ERISA GRP APP AR (05.10)	48
ERISA GRP ENR AR (05.10)	46
HEARING BENEFIT RIDER AR	45



Name: Craig Bodway
Title: Assistant Secretary

Date 6/23/10

STERLING Life Insurance Company

Real People. Wise Choices.®

February 2, 2010

NAIC Company Code: 77399

Re: Attached Filing Submission

Please accept this letter as authorization from Sterling Life Insurance Company for McHugh Consulting Resources, Inc. to file any or all policy forms and/or rates as referenced in the corresponding SERFF filing on behalf of Sterling Life Insurance Company.

Sincerely,



Michael Muchnicki
President
Sterling Life Insurance Company

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: Sterling Life Insurance Company

Form Number(s): GROUP POLICY (04.09)
EMPLOYER COC AR (05.10)
ERISA GRP APP AR (05.10)
ERISA GRP ENR AR (05.10)
HEARING BENEFIT RIDER AR

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Craig Bodway

Name

Assistant Secretary

Title

6/23/10

Date

CERTIFICATE OF COMPLIANCE

Insurer: Sterling Life Insurance Company

Form Numbers:

GROUP POLICY (04.09)
EMPLOYER COC AR (05.10)
ERISA GRP APP AR (05.10)
ERISA GRP ENR AR (05.10)
HEARING BENEFIT RIDER AR

I hereby certify that the filing above meets all applicable Arkansas requirements including Regulation 49 (Life and Health Guaranty Fund Notice) and Ark. Code Ann. 23-79-138 and Bulletin 11-88 (Consumer Information Notice).



Signature of Company Officer

Name

Craig Bodway

Title

Assistant Secretary

Date 6/23/10

STERLING LIFE INSURANCE COMPANY EXPLANATION OF VARIABLES

The following will be a listing of items that relate to the use of brackets within the policy forms.

- Brackets around numbers or alphas in a listing and punctuation or words such as “and”/”or” in a listing will be included or deleted as needed in order to make the statement read correctly.
- Numeric variables within the Policy (including the Schedule and Eligibility sections) will always comply with the minimum statutory requirements of the state in which the Policy is delivered.
- All names, locations, dates, amounts and other numbers, such as percents, time periods, page numbers, are illustrative and will vary from case to case.
- No changes will be made to the forms which are outside the parameters of the variability described herein.
- The term “Employee” may be replaced by “Member,” “Associate” or other similar descriptive term.
- The Company reserves the right to amend the forms to fix any minor typographical errors.

MASTER APPLICATION

- The Master Application will list Policyholder-specific data.
- The Employer will generally be given a choice of two or more Plan options, with distinct cost-sharing features, within the parameters described in this Explanation of Variables.

ENROLLMENT FORM

- The Enrollment Form will list Retiree-specific data.
- Depending on the selections made by the Policyholder, the Retiree may be offered a choice of two or more Plan options, with distinct cost-sharing features, within the parameters described in this Explanation of Variables.

GROUP POLICY

Face Page

- The Policyholder/Employer name is bracketed on the face page to allow inclusion of Policyholder-specific data.

Policy Termination Provision

- Item 1 (participation percentage requirement) may be included or omitted in its entirety, as agreed upon by the Policyholder and the Company.
- The minimum participation requirements in items 1 and 4 will be as agreed upon by the Company and the Policyholder.

GROUP CERTIFICATE

Face Page

- The Policyholder/Employer name is bracketed on the face page to allow inclusion of Policyholder-specific data.
- The Certificateholder information is bracketed to allow inclusion of personal data as listed.

Schedule of Benefits:

- The lifetime maximum benefit under the Plan may vary from \$2,000,000 to unlimited.
- The Annual Plan Deductible, Office Visit Copay, and Part B Out of Pocket Maximum are each optional and may be included or omitted depending on the plan options selected by the policyholder. All references to these features are bracketed throughout the Certificate to allow them to be omitted when any of these options is not part of the selected Plan of benefits.
- Annual Plan Deductible, if included, may vary from \$100 to \$1,000, in increments of \$50. Based on the options selected, the Annual Plan Deductible may apply to Part A or Part B expenses or both.
- The Office Visit Copay, if included, may vary from \$5 to \$20, in increments of \$5.
- The Office Visit Copay can include separate copay amounts for the Primary Care and Specialist, or the same copay can apply to all office visits.
- All amounts covered by Medicare are shown in brackets to accommodate future changes to Medicare benefits. The plan benefits that are based on Medicare benefits are also bracketed. These plan benefits will vary only to coincide with changes in Medicare.
- When one of the Plan options covers persons who are covered only by Medicare Part A, the Plan's Part B benefits will not be applicable. In such case, the Plan will cover only the Part A benefits in item 1 of the schedule, and the foreign travel benefits in item 3 of the schedule.
- The Annual Plan Deductible may or may not apply to item 3 Additional Benefits.
- Some state mandated benefits in item 4 of the schedule may be bracketed in order to be removed from a Plan that covers only Medicare Part A expenses.
- For Part B Medicare services, the Plan includes the option to pay the insured's Part B deductible, or to begin paying benefits only after the Part B deductible is paid by the insured.
- For Part B Medicare services, the Plan includes the option to pay the insured's Part B coinsurance (generally 20%). Language that describes coverage of Part B coinsurance is bracketed to allow it to be removed when the Part B coinsurance is the insured's responsibility.
- Part B Out-of Pocket Maximum, if included, will vary from \$500 to \$5,000, in increments of \$500.
- Foreign Travel deductible will vary from \$250 to \$500, in increments of \$50.
- Foreign Travel coinsurance (amount paid by the Company) will vary from 50% to 80%.
- Foreign Travel lifetime maximum will vary from \$25,000 to \$100,000, in increments of \$25,000.

Eligibility for Coverage

- The minimum years of employment service for eligible retirees will be the amount required by the employer's internal requirements.
- The outside employment limitation (whereby retirees or spouses actively employed elsewhere during their retirement become ineligible for coverage) will be as determined by the employer's internal requirements.

Benefits Section:

- The Annual Plan Deductible, Office Visit Copay, and Part B Out of Pocket Maximum are each optional and may be included or omitted depending on the plan options selected by the policyholder. All references to these features are bracketed throughout the Certificate to allow them to be omitted when any of these options is not part of the selected Plan of benefits.
- For Part B Medicare services, the Plan includes the option to pay the insured's Part B deductible, or to begin paying benefits only after the Part B deductible is paid by the insured. Language that describes coverage of the Part B deductible is bracketed to allow it to be removed when the Part B deductible is the insured's responsibility.
- For Part B Medicare services, the Plan includes the option to pay the insured's Part B coinsurance (generally 20%). Language that describes coverage of Part B coinsurance is bracketed to allow it to be removed when the Part B coinsurance is the insured's responsibility.

OPTIONAL HEARING BENEFIT**Hearing Benefit:**

- The Routine Hearing Examinations benefit may be removed.

.....

McHugh Consulting Resources, Inc.

July 1, 2010

Rosalind Minor
Arkansas Department of Insurance
Compliance - Life and Health
1200 West Third Street
Little Rock, AR 72201-1904

Sent via SERFF

RE: RESUBMISSION
Sterling Life Insurance Company
NAIC # 77399 FEIN # 13-1867829
Form Number: GROUP POLICY (4.09), et al
Group Retiree Medical Insurance
Objection Date: June 29, 2010
State Tracking Number: 46025
SERFF Tracking # MCHX- G126689494

Dear Rosalind:

This is in response to your objection dated June 29, 2010.

Objection 1

EMPLOYER COC AR (07.10) - Certificate of Coverage

Your Comments: Your Time Payment of Claims provision is not in compliance with Rule and Regulation 43, Section 12 which states that a health carrier shall pay or deny a clean claim within 30 days after receipt by the Health Carrier if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means

Response: We have revised the Time of Payment of Claims provision to include the required wording.

In addition, since our original submission we have made some slight changes to the Certificate and the Explanation of Variables to denote some additional variability in the benefits. We are submitting redlined versions of these forms, as well as clean versions, so that you can easily find the changes we made. In the Certificate, the additional changes are on pages: 5, 6, 8, 11, and 13. They are on page 2 of the Explanation of Variables.

Thank you for your continued attention to this filing. If you should have further questions or concerns regarding this submission, please do not hesitate to contact the undersigned at 215.230.7960.

Sincerely,



Frankie Warhurst, FLMI, AIRC, CCP
Consultant

STERLING LIFE INSURANCE COMPANY EXPLANATION OF VARIABLES

The following will be a listing of items that relate to the use of brackets within the policy forms.

- Brackets around numbers or alphas in a listing and punctuation or words such as “and”/”or” in a listing will be included or deleted as needed in order to make the statement read correctly.
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- All names, locations, dates, amounts and other numbers, such as percents, time periods, page numbers, are illustrative and will vary from case to case.
- No changes will be made to the forms which are outside the parameters of the variability described herein.
- The term “Employee” may be replaced by “Member,” “Associate” or other similar descriptive term.
- The Company reserves the right to amend the forms to fix any minor typographical errors.

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- The Master Application will list Policyholder-specific data.
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ENROLLMENT FORM

- The Enrollment Form will list Retiree-specific data.
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GROUP POLICY

Face Page

- The Policyholder/Employer name is bracketed on the face page to allow inclusion of Policyholder-specific data.

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- Item 1 (participation percentage requirement) may be included or omitted in its entirety, as agreed upon by the Policyholder and the Company.
- The minimum participation requirements in items 1 and 4 will be as agreed upon by the Company and the Policyholder.

GROUP CERTIFICATE

Face Page

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- The lifetime maximum benefit under the Plan may vary from \$2,000,000 to unlimited.
- The Annual Plan Deductible, Office Visit Copay, and Part B Out of Pocket Maximum are each optional and may be included or omitted depending on the plan options selected by the policyholder. All references to these features are bracketed throughout the Certificate to allow them to be omitted when any of these options is not part of the selected Plan of benefits.
- Annual Plan Deductible, if included, may vary from \$100 to \$1,000, in increments of \$50. Based on the options selected, the Annual Plan Deductible may apply to Part A or Part B expenses or both.
- The Office Visit Copay, if included, may vary from \$5 to \$20, in increments of \$5.
- The Office Visit Copay can include separate copay amounts for the Primary Care and Specialist, or the same copay can apply to all office visits.
- All amounts covered by Medicare are shown in brackets to accommodate future changes to Medicare benefits. The plan benefits that are based on Medicare benefits are also bracketed. These plan benefits will vary only to coincide with changes in Medicare.
- When one of the Plan options covers persons who are covered only by Medicare Part A, the Plan's Part B benefits will not be applicable. In such case, the Plan will cover only the Part A benefits in item 1 of the schedule, and the foreign travel benefits in item 3 of the schedule.
- The Annual Plan Deductible may or may not apply to item 3 Additional Benefits.
- Some state mandated benefits in item 4 of the schedule may be bracketed in order to be removed from a Plan that covers only Medicare Part A expenses.
- For Part B Medicare services, the Plan includes the option to pay the insured's Part B deductible, or to begin paying benefits only after the Part B deductible is paid by the insured.
- For Part B Medicare services, the Plan includes the option to pay the insured's Part B coinsurance (generally 20%). Language that describes coverage of Part B coinsurance is bracketed to allow it to be removed when the Part B coinsurance is the insured's responsibility.
- Part B Out-of Pocket Maximum, if included, will vary from \$500 to \$5,000, in increments of \$500.
- Foreign Travel deductible will vary from \$250 to \$500, in increments of \$50.
- Foreign Travel coinsurance (amount paid by the Company) will vary from 50% to 80%.
- Foreign Travel lifetime maximum will vary from \$25,000 to \$100,000, in increments of \$25,000.

Eligibility for Coverage

- The minimum years of employment service for eligible retirees will be the amount required by the employer's internal requirements.
- The outside employment limitation (whereby retirees or spouses actively employed elsewhere during their retirement become ineligible for coverage) will be as determined by the employer's internal requirements.

Benefits Section:

- The Annual Plan Deductible, Office Visit Copay, and Part B Out of Pocket Maximum are each optional and may be included or omitted depending on the plan options selected by the policyholder. All references to these features are bracketed throughout the Certificate to allow them to be omitted when any of these options is not part of the selected Plan of benefits.
- For Part B Medicare services, the Plan includes the option to pay the insured's Part B deductible, or to begin paying benefits only after the Part B deductible is paid by the insured. Language that describes coverage of the Part B deductible is bracketed to allow it to be removed when the Part B deductible is the insured's responsibility.
- For Part B Medicare services, the Plan includes the option to pay the insured's Part B coinsurance (generally 20%). Language that describes coverage of Part B coinsurance is bracketed to allow it to be removed when the Part B coinsurance is the insured's responsibility.

OPTIONAL HEARING BENEFIT**Hearing Benefit:**

- The Routine Hearing Examinations benefit may be removed.

Sterling Life Insurance Company
[ABC Company, Inc.]
Medicare-Enrolled Retiree Plan
Certificate of Coverage

| EMPLOYER COC AR (07.10)

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Table of Contents

Policy Face Page	X
Toll Free Number and Information	X
Schedule of Benefits	X
Eligibility and Enrollment	X
Benefits	X
Exclusions and Limitations	X
Conditions of Coverage	X
General Provisions.....	X
Premiums	X
Claims and Appeals	X
Claims Payment.....	X
Claims Procedures.....	X
Coordination of Benefits	X
Termination	X
Definitions	X

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Sterling Life Insurance Company, Inc.
Administrative Offices/Customer Service
[P. O. Box 5348 Bellingham, WA 98227-5348
(800) 688-0010]

GROUP INSURANCE CERTIFICATE

Sterling Life Insurance Company, Inc. (Referred to in this contract as “We”, “Us”, or “Our”) will provide the coverage stated in this Certificate subject to the provisions and limitations contained herein. We have issued this Certificate in consideration of the payment of the first premium and the statements made in Your enrollment form.

The group Policy issued to the Policyholder determines all rights and benefits which are summarized in this Certificate. We or the Policyholder may end the Policy according to its terms, as described in the Termination section of this Certificate.

The group Policy shall be available for inspection at all reasonable times at the place of business or principal residence of the Policyholder where the Policy is on file, by any Covered Person or by an authorized representative of the Covered Person.

Your Right To Examine And Cancel this Certificate Within 10 Days

We want You to fully understand and be satisfied with Your Certificate. If, for any reason, You are not satisfied with Your Certificate, You may cancel it. Return the Certificate to Us or to one of this Plan’s authorized agents by midnight of the 10th day after You receive it. As soon as possible after We receive this Certificate, We will refund any premiums You have paid. The Certificate will be considered to have never been issued.

Renewability and Premium Change

You may renew Your Certificate for Yourself as long as You may live, subject to the terms of the Group Policy. To renew, just pay the renewal premiums, if necessary. They must be paid on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this Certificate or place any restrictions on it if the premiums are paid on time.

We may change the premium rates for this Certificate at renewal. The change may be due to a change in Certificate coverage or a new table of rates. We can only change Your premium rate if We change it for all policies of the same class. We will tell You in advance of any change in premium rate.

Signed by Our [President] and [Assistant Secretary].



[President]



[Assistant Secretary]

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Certificate Holder Information

[Group Number:

Policyholder: [ABC, Inc.]

Certificate Number:

Certificate Effective Date:

Initial Premium Mode:

Initial Premium Amount:

First Renewal Premium:]

| EMPLOYER COC AR (07.10)

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Schedule of Benefits

This Plan pays benefits, as secondary payor, for medical conditions and procedures covered by Medicare. There may be some additional State mandated benefits which may not be covered by Medicare but will be covered by this Plan. This Plan will be the primary payor for these benefits.

Plan Benefits – [Plan 1]

[Annual Plan Deductible

This Plan has a [\$300] annual Deductible. You must have incurred [\$300 dollars] expense for [Part A and Part B](#) Covered Services before this Plan begins to make benefit payments. Once the Annual Plan Deductible is met, Medicare [Part A] [and] [Part B] Services are covered as described in this Schedule of Benefits.]

[Provider Office Visit Copay

[This Plan has a Primary care office visit copay of up to \[\\$10\] and a \[\\$20\] Specialist office visit copay of up to \[\\$20\]. The office visit copays are not included in the Annual Plan Deductible.\]](#)

[Provider Office Visit Copay

This Plan has a [\$10] Provider office visit copay. The office visit copays are not included in the Annual Plan Deductible.]

[Lifetime Maximum Benefit

[\$2,000,000 - Unlimited]

1. Medicare Part A Services

Medicare (Part A) Hospital Services Per Benefit Period	A Benefit Period begins the first day You receive services as an Inpatient in a Hospital and ends after You have been out of the Hospital and have not received skilled care in any other facility for 60 days in a row. You are responsible for all other non covered charges.
---	--

Hospitalization Semiprivate room and board, general nursing and Hospital Miscellaneous Expenses.			
SERVICES	MEDICARE PAYS	THIS RETIREE PLAN PAYS	YOU PAY
First 60 days	All but [\$1024]	[\$1024]	\$0
61 st through 90 th day	All but [\$256 a day]	[\$256 a day]	\$0
91 st day and after: While using 60 lifetime reserve days	All but [\$512 a day]	[\$512 a day]	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
Beyond the Additional 365 days	\$0	\$0	All Costs

Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a Hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the Hospital.

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SERVICES	MEDICARE PAYS	THIS RETIREE PLAN PAYS	YOU PAY
First 20 days	All Approved Amounts	\$0	\$0
21 st through 100 th day	All but [\$128]	[\$128]	\$0
101 st days and after	\$0	\$0	All Costs

Blood			
SERVICES	MEDICARE PAYS	THIS RETIREE PLAN PAYS	YOU PAY
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0

Hospice Care			
SERVICES	MEDICARE PAYS	THIS RETIREE PLAN PAYS	YOU PAY
Available as long as Your Physician certifies You are terminally ill and You elect to receive these services	All but very limited Co-Insurance for Outpatient drugs and Inpatient respite care	\$0	Balance of Expenses

[2. Medicare Part B Services

If You are enrolled in [Plan 1], this Plan will not pay benefits for Part B Covered Services.

If You are enrolled in [Plan 2, Plan 3] this Plan will pay benefits for Part B Covered Services as described herein.

Medicare pays (generally) 80% of Part B Medicare approved amounts (55% for Substance Abuse and Mental Health Services) once you have met your Medicare annual Part B deductible (\$[135]). You will pay the balance based on the amounts reflected below[, up to the Plan Out-of-Pocket of [\$1,000]]. (This does not include Your [\$300] Annual Plan Deductible). [Your annual Medicare Part B deductible will count towards Your [\$300] Annual Plan Deductible.]

Medicare (Part B) Medical Services – Per Calendar Year			
Medical Expenses in or out of the Hospital & Outpatient Hospital Treatment , such as Physician's services, Inpatient and Outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, Durable Medical Equipment.			
SERVICES	MEDICARE PAYS	THIS RETIREE PLAN PAYS	YOU PAY
Provider Office Visits	0-80%	[Remaining amount after [\$10] copay.] [[Remaining amount after [\$10] Primary care office visit copay, [\$20] Specialist office visit.]	[Lessor of the remaining amount or [\$10 copay]] [Lessor of the remaining amount or the [\$10] Primary care office visit copay, [\$20] Specialist office visit copay.]

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First [\$135] of Medicare Approved Amounts*	\$0	[\$0] [[[\$135] Part B Deductible]	[[[\$135] Part B Deductible] [\$0]
Remainder of Medicare Approved Amounts	Generally 80%, (or 55% for Substance Abuse and Mental Health Services)	[Generally 20% (45% for Substance Abuse and Mental Health Services)] [\$0 [until OOP Max is met, then 20%(45% for Substance Abuse and Mental Health Services)]]	[\$0] [Generally 20% (45% for Substance Abuse and Mental Health Services) [, until OOP Max is met]]
Part B Excess (Above Medicare Approved Amount)	\$0	100%	\$0

Blood			
First 3 pints	\$0	All Costs	\$0
Next [\$135] of Medicare Approved Amounts*	\$0	[\$0] [[[\$135] Part B Deductible]	[[[\$135] Part B Deductible] [\$0]
Remainder of Medicare Approved Amounts	Generally 80%	[Generally 20%] [\$0 [until OOP Max is met, then 20%]]	[\$0] [Generally 20%[, until OOP Max is met]]

Clinical Laboratory Services			
Blood Tests For Diagnostic Services	100%	\$0	\$0
Home Health Care, Medicare Approved Services Medically necessary skilled care services and medical supplies	100%	\$0	\$0

Durable Medical Equipment			
First [\$135] of Medicare Approved Amounts*	\$0	[\$0] [[[\$135] Part B Deductible]	[\$0] [Generally 20%[, until OOP Max is met]]

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Remainder of Medicare Approved Amounts	Generally 80%	[Generally 20%] [\$0 [until OOP Max is met, then 20%]]	[\$0] [Generally 20%[, until OOP Max is met]]
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[Annual Out of Pocket Maximum for Medicare Part B Covered Services]
 Once You have incurred out-of-pocket expenses of [\$1,000] (in addition to the [\$300] Annual Plan Deductible) for Medicare Part B Covered Services during the Calendar Year, this Plan will provide coverage for 100% of any additional expenses incurred for Medicare Part B Covered Services.]

[3.] Additional Benefits [Benefits [are/are not] subject to the [\$300 Annual Plan Deductible]

Foreign Travel - Not Covered by Medicare. Medically necessary Emergency Care services beginning during the first 60 days of each trip outside the USA.			
First [\$250] each Calendar Year	\$0	\$0	[\$250]
Remainder of Charges	\$0	[80%] to a lifetime maximum benefit of [\$50,000]	Generally 20% and amounts over the [\$50,000] lifetime maximum

4. Arkansas State Requirements

Dental Anesthesiology	The same co-payments, deductibles and benefit limits shall apply to covered anesthesia and Hospitalization for dental services as those applied to other medical or surgical benefits under this Plan.
Mastectomy-Related Services	The same co-payments, deductibles and benefit limits shall apply to mastectomy-related services as those applied to other medical or surgical benefits under this Plan.
Speech or Hearing Impairment	The same co-payments, deductibles and benefit limits shall apply to speech or hearing impairment care and treatment as those applied to other medical or surgical benefits under this Plan.

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Eligibility and Enrollment

Eligibility for Coverage

Who May Receive Benefits

Benefits are provided to eligible Retirees of the Policyholder and their eligible spouses. A Retiree may be covered as a Retiree, or as a spouse of an eligible Retiree who is also a Retiree of the Policyholder, but not both. Qualifications for eligibility are as follows:

[Plan 1]

Retirees

Those who:

- § are retired from active employment with the Policyholder;
- § have completed [X years][the required number of years, as specified by the Policyholder in the Master Application,] of full time service with the Policyholder immediately before retirement;
- § are age sixty-five (65);
- § are not employed for [20 or more hours per week], either by any other employer or self-employed; and
- § are enrolled in Medicare Part A[and B]; or
- § are designated as eligible as described in an endorsement to the Policy

will be eligible for health care benefits under this Plan.

Spouse of Covered Retirees

Those who:

- § are the current spouse (husband or wife) of an eligible Retiree;
- § are age sixty-five (65);
- § are not employed for [twenty (20) or more hours per week], either by any other employer or self-employed; and
- § are enrolled in Medicare Part A[and B]; or
- § are designated as eligible as described in an endorsement to the Policy

will be eligible for health care benefits under this Plan. We may require legal proof of marriage. Common law marriages are not recognized under this Plan.

Other Dependents

With the exception of an eligible Retiree's spouse, as listed above, no other individuals or dependents are eligible for coverage under this Plan.

Enrollment

Eligible Retirees

An eligible Retiree must enroll in this Plan by completing enrollment forms within thirty (30) days of becoming eligible. These forms are provided by the Policyholder. If the enrollee's spouse is also eligible, they should also be enrolled at that time. If a Retiree does not enroll him or herself or his or her Eligible spouse, or declines coverage for them by signing a "Refusal of Coverage" card within thirty (30) days of becoming eligible, neither the Retiree nor the spouse will be

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eligible for enrollment in this Plan, except in the event of a HIPAA Special Enrollment Period, as described below.

Eligible Retiree Spouses

As stated above, an eligible spouse of a Retiree may be enrolled in this Plan when the Retiree becomes eligible for coverage. If the spouse of a Retiree should become eligible for this Plan after the Retiree's enrollment, the spouse must enroll in this Plan by completing the necessary enrollment forms within 30 days of his/her eligibility.

An eligible new spouse of an eligible Retiree must be enrolled within 30 days of marriage or other eligibility, as described above. If an eligible spouse is not enrolled within 30 days of becoming eligible; he/she will not be eligible to enroll in this Plan except in the event of a HIPAA Special Enrollment Period, as described below.

Changes in Enrollment

The Policyholder must be notified if any change occurs in the status of the Retiree or spouse which could affect eligibility for coverage under this Plan.

HIPAA Special Enrollment Period

If You are declining enrollment for Yourself or Your spouse because of other health insurance coverage, You may be able to enroll Yourself or Your spouse in this Plan in the future, if You request enrollment within thirty (30) days after the other coverage ends. In addition, if You have a new spouse as a result of marriage, You may be able to enroll Your spouse if You request enrollment within thirty (30) days after the marriage.

If an individual who is eligible for this Plan does not enroll because they have coverage under another group health plan or other health insurance, then that individual is eligible for a special enrollment period under the following circumstances:

1. The individual has stated in writing that coverage under another group health plan or health insurance was the reason for declining enrollment; and
2. The individual had COBRA continuation coverage and that coverage has been exhausted or the individual was not covered under COBRA continuation and either the other coverage has been terminated as a result of loss of eligibility for coverage or employer contribution toward the other coverage has been terminated.

Loss of eligibility can be as a result of legal separation, divorce, death, termination of employment, reductions in the number of hours of employment and any other loss of eligibility under the other group health plan or health insurance coverage.

The special enrollment period lasts for thirty (30) days and begins on the day following the loss of coverage under the other plan. The required effective date of coverage for those enrolling during a special enrollment period can be no later than the first day of the month following the date on which the request for enrollment was completed.

When Coverage Begins

New Retirees and their eligible spouse will be covered on the first day of the month following enrollment. All coverage will commence at 12:01 a.m. on the date such coverage takes effect.

New spouses will be covered on the date of marriage or upon meeting the eligibility requirements described above if enrollment forms have been properly completed.

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Benefits

Medical Plan

This Plan pays benefits, as secondary payor, for medical conditions and procedures covered by Medicare. There may be some additional state-mandated benefits which may not be covered by Medicare but will be covered by this Plan. This Plan will be the primary payor for these benefits.

Services which are not covered by Medicare or mandated by state law as indicated below will not be covered under this Plan.

Medical benefits are provided to eligible Retirees and their covered spouse as defined under the Eligibility for Coverage provision in the Eligibility and Enrollment section.

[Plan 1]

Deductible

[After Your [\$300 dollar] Annual Plan Deductible,]this Plan pays the Inpatient [Medicare Part A] [and] [Medicare Part B] Deductible for Covered Services. Except for Medically Necessary Emergency Care in a Foreign Country, as described in the Eligible Services and Benefits section, there are no other Deductibles associated with this Plan.

[Provider Office Visit Copay

This Plan has a Primary care office visit copay of up to [\$10] and a Specialist office visit copay of up to [\$20]. The office visit copays are not included in the Annual Plan Deductible.]

[Provider Office Visit Co-Payment

This Plan has a [\$10] Provider office visit copay. The office visit copays are not included in the Annual Plan Deductible.]

Providers Of Service

This Plan will provide benefits for Covered Services rendered by a qualified Provider of service under Medicare.

This Plan will not pay benefits for services not covered under this Plan, even if rendered by a Medicare-qualified Provider. The status of being listed as a Medicare-qualified Provider does not mean that all services rendered by that Provider will be covered under this Plan, but only those services which are specifically listed as Covered Services.

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Covered Services and Benefits

Inpatient Hospital Stay – Medicare Part A

This Plan provides medical benefits for Hospital and Facility charges, as covered by Medicare. Medicare Part A covers Inpatient Hospital care, Skilled Nursing Facility care, Hospice care, and *some* home health care (including physical, occupational and speech therapy; and Durable Medical Equipment). For more details on Medicare Covered Services, please consult the most recent “Medicare & You” booklet, or contact Medicare at 1-800-MEDICARE or www.medicare.gov.

If, while this Certificate is in force, You incur facility charges covered by Medicare Part A, We will provide the coverage described below. The facility stay must be Medically Necessary and be approved by Medicare; be caused by an Injury or Sickness; and begin while You have this coverage. No benefits will be paid under this section that would duplicate benefits paid under Medicare Part B, if applicable. This Plan will limit coverage to Medicare Eligible Expenses and benefits mandated by state law. This Plan will not cover charges that Medicare deems unreasonable and/or unnecessary.

We will provide coverage for the following benefits[, subject to the Annual Plan Deductible for which You are liable]:

1. Medicare Part A Deductible: Coverage for all of the Medicare Part A Inpatient Hospital Deductible amount in a Benefit Period.
2. Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare for days 61 through 90 in any Medicare Benefit Period;
3. Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used;
4. When the Medicare Hospital Inpatient coverage, and the lifetime reserve days have exhausted, coverage for Medicare Part A Eligible Expenses for Hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days.
5. Coverage for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells) unless replaced in accordance with federal regulations, or covered under Medicare Part B, if applicable.
6. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Co-Insurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital Skilled Nursing Facility care eligible under Medicare Part A.

Hospice Care

This Plan does not pay benefits for Hospice Care beyond those paid by Medicare. Medicare generally covers all expenses for Hospice Care, with the exception of very limited Co-Insurance for Outpatient drugs and Inpatient respite care.

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Medicare Part B

[The following Part B benefits apply only to [Plans 2 and 3]. This Plan's Part B benefits do not apply to [Plan 1].]

[Part B Deductible and Co-Insurance

Once You have incurred out-of-pocket expenses of [\$1,000] (in addition to the [\$300] Annual Plan Deductible) for Medicare Part B Covered Services during the Calendar Year, this Plan will provide coverage for 100% of any additional expenses incurred for Medicare Part B Covered services.]

[Provider Care – Medicare Part B

This Plan provides medical benefits for Physician, Provider, and Outpatient Hospital charges, as covered by Medicare. Medicare Part B covers Physician's services, Outpatient Hospital care, and some other medical services not covered by Part A, such as the services of physical and occupational therapists and *some* home health care. For more details on Medicare Covered Services, please consult the most recent "Medicare & You" booklet, or contact Medicare at 1-800-MEDICARE or www.medicare.gov.

If, while this Certificate is in force, You incur Provider or facility charges covered by Medicare Part B, We will provide the coverage described below. The services received must be Medically Necessary and be approved by Medicare; be caused by an Injury or Sickness; and begin while You have this coverage. No benefits will be paid under this section that would duplicate benefits paid under Medicare Part A. This Plan will limit coverage to Medicare Eligible Expenses. Medicare does not pay for charges it deems unreasonable and/or unnecessary.

We will provide coverage for the following benefits[, subject to [the Annual Plan Deductible] [and] [the Plan Out of Pocket of [\$1000] and [the Provider office visit copay/s], for which You are liable]:

1. [We will pay all of the Medicare Part B Deductible amount in a Calendar Year regardless of whether or not You were confined in a Hospital.]
2. [We will pay the Co-Insurance or, in the case of Hospital Outpatient department services under a prospective payment system, the Co-Payment amount of Medicare Eligible Expenses under Part B. We will pay this amount regardless of whether or not You were confined in a Hospital.]
3. We will pay all the difference between the actual Medicare Part B charge as billed, and the Part B charge approved by Medicare, not to exceed any charge limitation established by the Medicare program or state law.]

Medically Necessary Emergency Care in a Foreign Country

This Plan provides coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare Eligible Expenses for Medically Necessary Emergency Care, including Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a Calendar Year benefit Deductible of [\$250], and a lifetime maximum benefit of [\$50,000].

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Maximum Benefit

The lifetime maximum benefit under this Plan is [\$2,000,000 – unlimited].

Arkansas State Requirements

The Covered Services listed below are provided in compliance with state law. To the extent covered by original Medicare, this Plan pays such benefits as secondary payor. To the extent not covered by original Medicare, this Plan pays such benefits as primary payor.

Dental Anesthesiology

This Plan covers general anesthesia and associated facility charges for services performed in a Hospital or ambulatory surgical center in connection with dental procedures that are Medically Necessary because the Covered Person has a serious mental or physical condition, or a significant behavioral problem that the Covered Person's Physician determines would place the Covered Person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the Covered Person's Physician.

The dental procedure itself and associated dentist's fee are not covered.

Mastectomy-Related Services

Following a mastectomy for the treatment of breast cancer, there is a minimum hospitalization benefit of 48 hours unless the decision to discharge prior to 48 hours is made by the attending Physician in consultation with the patient

This Plan covers reconstructive breast surgery following a mastectomy, including reconstruction of the breast on which surgery was performed and the other breast to produce a symmetrical appearance if the patient elects reconstruction, in the manner chosen by the patient and Physician. The Plan also covers prosthetic devices and physical complications at all stages of mastectomy, including lymphedemas.

Speech or Hearing Impairment

This Plan covers the Medically Necessary care and treatment of loss or impairment of speech or hearing, including services provided by a licensed audiologist or a licensed speech-language pathologist. This does not include coverage for hearing aids or devices.

Exclusions and Limitations

Benefits will be paid only for care given under the direct supervision of covered Providers of service as described in the Benefits section, to the extent they perform services within the scope of their license. Support professionals must be properly certified and licensed.

All facilities must be licensed in the states in which they operate. Hospitals and Skilled Nursing Facilities must meet the definitions provided in the Definitions section.

The following services, supplies and charges are **NOT** covered under this Plan and are excluded when determining benefit payments:

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Not Covered By Medicare or State-Mandated

This Plan does not pay benefits for anything not eligible under Medicare and/or not specifically mandated by state law.

Acts of War

This Plan does not pay benefits for charges incurred:

- As a result of war or acts of war (declared or undeclared),
- From participating in a riot,
- While serving in the armed forces of any country, or
- While confined in a penal or correctional institution.

Acupuncture and Naturopathic

This Plan does not pay benefits for charges incurred for any acupuncture or naturopathic services.

Cosmetic Procedures or Reconstruction Surgical Treatment

This Plan does not pay benefits for services primarily intended to change one’s appearance; including liposuction and breast reduction; or in connection with Cosmetic Procedures, except reconstructive surgery resulting from Injury or surgical treatment of the involved part incurred while covered under this Plan.

Court Ordered Care

This Plan does not pay benefits for non-Medically Necessary services which are ordered by court of law.

Custodial Care

This Plan does not pay benefits for Custodial Care.

Dental Care

This Plan does not pay benefits for items and services related to the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth, including periodontium, gingivae, dentogingival junction, periodontal membrane, cementum of the teeth and alveolar process, dental splints, prostheses, or any dental treatment for the teeth, gums or jaw not otherwise allowed by Medicare.

Elective or Voluntary

This Plan does not pay benefits for enhancement procedures, services, supplies, and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, anti-aging, and mental performance, unless Medically Necessary.

Experimental

This Plan does not pay benefits for medical and surgical care, services, supplies or devices and medications which are:

- Experimental or Investigational,
- Not recognized by the American Medical Association as generally accepted and Medically Necessary to the diagnosis and/or treatment of an active Sickness or Injury, or
- Charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value or are otherwise not covered by Medicare.

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Foot Care and Supplies

This Plan does not pay benefits for foot care only to improve comfort or appearance. This includes care for

- Flat feet,
- Corns,
- Bunions (except capsular and bone surgery),
- Calluses or ingrown toenails;

This also includes supplies in connection with routine foot care, such as but not limited to,

- Impression casts,
- Appliances and braces, or
- Corrective shoes.

Benefits are not provided for Orthotic Appliances unless they are prescribed for necessary medical treatment of a covered Injury, or after surgery. Orthopedic shoes and supportive devices for the feet are not covered unless they are part of a leg brace and are included in the orthopedist's charge. This exclusion shall not apply to therapeutic shoes for those suffering from diabetic foot disease as allowed by Medicare.

Government Facilities and Programs

This Plan does not pay benefits for services and supplies which could have been received without charge under government programs; Charges incurred while confined in a Hospital owned or operated by the United States government or any agency thereof; and charges for services, treatments or supplies furnished by United State Government or any agency thereof.

Hearing Aids

This Plan does not pay benefits for routine hearing and hearing aids.

Illegal Act

This Plan does not pay benefits for charges resulting from or occurring during the commission of a felony by the Covered Person or while engaged in an illegal occupation or felonious act or as the instigator of assault.

Incurred Prior to Plan

This Plan does not pay benefits for charges incurred prior to the Certificate Effective Date or after coverage is terminated.

Inpatient Hospital

This Plan does not pay benefits:

- For services that are rendered during an Inpatient confinement which are primarily related to behavior, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of psychological disorders;
- For education, training and bed and board while confined to an institution which is primarily a school or other;
- For Hospitalization primarily for x-ray, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent care, Custodial Care or test care, or any medical examination or tests not connected with an actual Sickness or Injury; or
- For a private room in a Hospital, unless Medically Necessary and allowable by Medicare.

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Missed Appointment

This Plan does not pay benefits for charges for missed appointment or completion of forms.

Non-Covered Provider Services

This Plan does not pay benefits:

- For any treatment which is not rendered by or under the direct supervision of a licensed Physician;
- In connection with services and supplies which are not necessary for treatment of the Injury or Sickness or not recommended and approved by a licensed Physician;
- For private duty nurses;
- For charges imposed by immediate relatives or members of Your household, whether a licensed Provider of service or not.

Not Listed as Eligible

This Plan does not pay benefits for services or supplies not listed as eligible expenses.

Not Obligated to Pay

This Plan does not pay benefits for charges incurred which the Covered Person is not, in the absence of this coverage, legally obligated to pay.

Obesity

This Plan does not pay benefits for weight reduction or treatment of obesity, unless specifically ordered by a licensed Physician as being Medically Necessary to prevent the imminent death or total permanent disability of the Covered Person.

Other Insurance Coverage

This Plan does not pay benefits for any services to the extent that benefits are available under the terms of any vehicle, homeowner's, property, or other insurance coverage. Benefits available under automobile uninsured or underinsured motorist coverage are considered an exclusion only to the extent double recovery for medical expenses. Any benefits paid by this Plan contrary to this exclusion are not provided solely to assist the Covered Person. By paying for such benefits, Sterling is not acting as a volunteer and is not waiving any right to reimbursement or subrogation (see Conditions of Coverage section).

Patient Responsibility

This Plan does not pay benefits for the portion of the charge not otherwise covered by Medicare or this Plan that is patient responsibility.

Personal Care, Comfort or Convenience

This Plan does not pay benefits for marital counseling, diversionary, recreational or educational therapies, (such as hobbies, art and crafts, dance or music) and any related testing, or biofeedback or milieu therapy primarily directed toward self enhancement or to change or control one's environment; for services or supplies which constitute personal comfort or beautification items, or in connection with education or non-occupational training; for television, telephone, personal convenience items, or expenses for any persons not covered by this Plan; homemaker services; meals delivered to Your home; nursing care on a full-time basis in Your home.

Pregnancy

This Plan does not pay benefits for any expenses related to Pregnancy; however, complications of Pregnancy are covered the same as any other Sickness.

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Prescription Drugs

This Plan does not pay benefits for prescription drugs, except those covered by original Medicare.

Relatives Providing Services

This Plan does not pay benefits for charges for services rendered by a Physician, nurse or licensed therapist if such Physician, nurse or licensed therapist is a Close Relative of the Covered Person or resides in the same household as the Covered Person.

Routine and Preventive Care

This Plan does not pay benefits for routine medical examinations, screening tests or routine health check-ups, shots or vaccinations not necessary for treatment of an Injury or Sickness, except as listed under Covered Services and Benefits.

Self Inflicted

This Plan does not pay benefits for expenses incurred resulting from treatment of intentionally self-inflicted Sickness or Injury, suicide or attempted suicide, whether sane or insane.

Services in Foreign Country

This Plan does not pay benefits for charges incurred outside the United States or Canada if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies; or for services or supplies not considered legal in the United States.

Sex Change or Sexual Dysfunction

This Plan does not pay benefits for sex change operations, counseling, surgery, drugs, other services or supplies, or treatment related to sex change; penile implants including any resulting complications, services or supplies for the treatment of sexual dysfunction or inadequacies, frigidity or impotence including any expenses for psychiatric therapy, adjustment therapy, or for treatment or therapy related to inter-sex surgery not otherwise covered by Medicare.

Tele-medicine

This Plan does not pay benefits for tele-medicine provided for non-eligible services.

Vision Services / Radial Keratotomy

This Plan does not pay benefits for eye exams and for the purchase or fitting of eyeglasses except as otherwise specified. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses, following cataract surgery. Services or procedures involving Radial Keratotomy are not covered.

Vitamins and Minerals

This Plan does not pay benefits for orthomolecular testing and therapy, or nutritional supplements, even if by prescription.

Work Related Charges

This Plan does not pay benefits for charges arising out of or in the course of any work for wage or profit for which the Covered Person is entitled to receive any benefit under Workers' Compensation or Occupational Disease Law or similar law.

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Conditions of Coverage

General Provisions

Assignment

This Plan's benefits are offered personally to the Retiree and eligible spouse. Neither this Plan, its services and benefits, nor its payments are assignable or transferable. We reserve the right to make benefit payment to the Covered Person, the Provider, or jointly to both for Covered Services.

Determination of Benefits

The fact that a Physician or other licensed health care Provider may prescribe, order, recommend or approve a service or supply does not mean it is covered under this Plan. The Benefit Administrator will determine whether expenses qualify for benefits and are eligible for payment.

Right of Recovery

When payments have been made in excess of the amount necessary to satisfy a Plan Benefit, We will have the right to recover these excess payments. If We elect to recover the excess payment from any Covered Person; We may recover the excess payment by deduction from any future benefits due to or on behalf of the Covered Person.

Time Limit on Certain Defenses (Incontestability)

In the absence of fraud, statements made by any Covered Person are deemed representations and not warranties. No written statement made by any Covered Person shall be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary, if any.

After two years from the Certificate Effective Date, only fraudulent misstatements on Your enrollment form may be used to void this Certificate or deny any claim for loss incurred or disability that starts after the two year period.

Misstatement of Age

If Your age is misstated on the application for this coverage, the coverage provided will be that which the premium submitted would have purchased at Your correct age. If Your correct age as of the Certificate Effective Date would have caused Us to refuse coverage to You, We will only be responsible for the return of all premiums paid, less the amount of any claims paid.

Payment Of Benefits

Benefits will be paid to You or Your designated beneficiary or beneficiaries, or to Your estate, except that if the person insured is a minor or otherwise not competent to give a valid release, such benefits may be made payable to his parent, guardian, or other person actually supporting him. A portion of any indemnities provided by this Certificate on account of Hospital, nursing, medical, or surgical services, may at Our option, and unless You request otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such services provided, further, that authorization for any such payments has been obtained from You. We will be discharged to the extent of any such payment made in good faith.

Legal Action

No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of 3 years after the time

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written proof of loss is required to be furnished.

Conformity with State and Federal Laws

Any provision of the Certificate which, on its effective day, is in conflict with the laws of the state in which the Policy was issued on that date is amended to conform to the minimum requirements of such laws.

If at any time during the life of the Certificate, federal or state law changes which would require a corresponding change in the coverage, We reserve the right, subject to regulatory approval, to change Certificate language, benefits or premium rates, but only as necessary to comply with the changes in law.

Physical Examinations and Autopsy

We at Our own expense have the right to have any Covered Person examined as often as reasonably necessary by a Physician of Our choice while a claim is pending. We may also have an autopsy made unless prohibited by law.

Subrogation

The benefits of this Certificate will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this Certificate for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to Us to the extent of all payment made by Us for such benefits. You or Your representative agrees to cooperate fully with Us to secure these rights of subrogation. You also agree to otherwise help Us recover benefits We have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

Premiums

We may change the premium for this Certificate due to a change in benefits or a new table of rates. We will tell You in advance of any change in premium on a timely basis.

Payment Of Premium

The initial premium is due on or before the Certificate Effective Date. Each premium after the initial one is due at the end of the period for which the preceding premium was paid.

If the premium is not paid by that date, the grace period will begin.

Grace Period

A grace period of 31 days is allowed for the payment of any premium except the initial premium. The coverage will continue in force during the grace period. If the premium is not paid during the grace period, the coverage will terminate at the end of the 31 day period.

Reinstatement

If the premium is not paid before the grace period ends, Your coverage under the Policy will lapse. If We (or any agent authorized to accept payment) later accept Your premium, without requiring an application for reinstatement, Your coverage will be reinstated.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, We will reinstate Your coverage as of the approval date. Lacking such approval, Your coverage will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

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The reinstated coverage will cover only loss that results from an Injury or Sickness sustained after the date of reinstatement. In all other respects Your rights and Our rights will remain the same.

Claims and Appeals

Claims Payment

Allowed by Medicare

If a billed charge is allowed by Medicare, it will be processed by this Plan as secondary, based on the original Medicare allowable amount.

[Excess Charges

[Plan 2 and Plan 3] will allow Medicare Part B excess charges and pay the amount between the actual Medicare Part B charge as billed and the Medicare-approved Part B charge, not to exceed any charge limitation established by the Medicare program or state law.]

Usual, Customary And Reasonable Fees

Benefit payments made under this Plan for services are based on usual, reasonable and customary charges. This means the amount generally accepted by the majority of Hospitals and licensed Physicians for like services and supplies at the time such services were rendered; in the geographic area where the Provider resides, as determined by this Plan. This Plan will take into consideration the fees and prices generally accepted and the services generally furnished in the geographic area concerned.

If a state mandated benefit is not also allowed by Medicare, the claim will be processed subject to usual and customary fees, and the remaining balance will be the responsibility of the patient.

Policyholder Optional Benefits

If the Policyholder elected to offer optional benefits as part of this Retiree Benefits Plan (i.e. Extended foreign travel benefits, vision, hearing, and/or prescription), the charges will be processed subject to usual and customary fees.

Claims Procedures

How To File A Claim

When You have a Claim, You or Your Provider must first file Your claim with Medicare. Once You receive a copy of this Plan's Explanation of Medicare Benefits ("EOMB"), submit a copy and an itemized billing to Us for processing.

Doctors, Hospitals, laboratories or other Providers may submit fully itemized bills by mail or electronic submission.

If the Covered Person has paid the bill, a copy of the paid receipt must be attached to the itemized claim in order for the Covered Person to receive reimbursement for the claim payment.

Late Claims

Claims submitted more than twelve (12) months after services and supplies were received will be considered late and will not be eligible for payment. Such expenses shall be considered to have occurred at the time the service or supply was actually provided.

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What Happens When A Claim Is Filed

After a medical claim is submitted to Us, it will be processed according to the provisions of this Plan.

When the claim has been approved and paid, the Covered Person will receive a written Explanation of Benefits (EOB) showing the amount of submitted charges, the amount of those charges eligible for benefit payment, the amount of benefits actually paid by this Plan and any remaining balance owed by the Covered Person.

If the claim is incomplete or additional information is needed from the claimant or the attending Physician, the claim will be held pending further clarification and the Covered Person will receive a written explanation within 30 days after receipt of the claim of the reason for the delay in processing the claim and a description of the additional information required. Once the necessary information is received by Us, the processing of the claim will be completed.

How Claims Are Paid

Payment will be made directly to the Physician, Hospital, laboratory or other Provider. If, however, the Covered Person has paid the bill and notified Us, payment will be sent to the employee. (See "How to File a Claim").

Time of Payment Of Claims

Benefits for any loss covered by this Certificate will be paid immediately upon receipt of proper written proof of loss. A clean claim will be paid or denied within 30 days after receipt if submitted electronically or within 45 days after receipt if the claim was submitted by other means. If We do not pay within 60 of receipt, We shall pay interest at the rate of 12 percent per annum from the 61st day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid.

Disputed Claims

If the Covered Person believes a claim has been incorrectly paid or denied, he or she may request a second review from Us. The request must:

1. Be in writing within sixty (60) days of receiving the Explanation of Benefits (EOB) or notice of denial;
2. Describe the claim or claims being questioned;
3. State the reasons for disputing the action taken; and
4. Include any information requested by Us.

We will respond in writing within sixty (60) days.

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Coordination of Benefits and Services

If a Covered Person is covered by more than one Plan, this provision allows Sterling to coordinate what Sterling pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Retiree is covered.

The words shown below have special meanings when used in this provision. Please read these definitions carefully.

“Allowable Expense” means a Medically Necessary, Reasonable and Customary item of expense for health care; when the item of expense is covered at least in part by one or more Plans covering the person for whom claim is made.

The difference between the cost of a private Hospital room and the cost of a Semi-Private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in this Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because an insured person does not comply with that Plan's provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions or pre-certification of admissions or services.

“Plan” means any coverage with which coordination of benefits is allowed. Plan includes:

1. Any group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage.
2. Any federal, state or local governmental programs, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

“Primary Plan/Secondary Plan” The Order of Benefit Determination rules state whether this is a Primary Plan or a Secondary Plan. When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering a person, this Plan may be a Primary Plan as to one or more other Plan's benefits, and may be a Secondary Plan as to a different Plan.

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Order of Benefit Determination

Sterling considers each Plan separately when coordinating payments. This Plan determines its order of benefits using the first of the following rules which applies:

1. A Plan that does not have a coordination of benefits provision will always be a Primary Plan.
2. The benefits of a Plan which covers the person on whose expenses the claim is based as other than a dependent will be determined before the benefits of a Plan which covers the person as a dependent.
3. The benefits of a Plan that covers a person as a primary insured who is neither laid off nor retired, or as that primary insured's dependent, are determined before those of a Plan that covers that person as a laid off or retired primary insured or as that primary insured's dependent. This rule will not apply if the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits.
4. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is covered under another Plan, the following will be the order of benefit determination:
 - A. First, the benefits of a Plan covering the person as an employee, member, or subscriber (or as that person's dependent);
 - B. Second, the benefits under the continuation coverage. If the other Plan does not have the rule described above and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
5. When rules 2 through 4 do not establish an order of benefit determination the benefits of a Plan which has covered the person on whose expenses the claim is based for the longer period of time will be determined before the benefits of a Plan which has covered the person the shorter period of time.

Facility of Payment

If another Plan makes a benefit payment that should have been made by Us We have the right to pay the other Plan any amount We deem necessary to satisfy our obligation under these COB rules.

Right of Recovery

If the amount of Our benefit payment is more than the amount needed to satisfy Our obligation under these COB rules, We have the right to recover the excess amount from: (A) any persons to or for whom, or with respect to whom, the payments were made; (B) any insurance companies; or (C) any other organizations.

Right to Receive and Release Necessary Information

In order to carry out these COB rules:

1. We have the right, without the consent of or notice to any person, to exchange information with any person, insurance company or organization, as We deem necessary; and
2. Any person claiming benefits under this Plan must give Us any information necessary to carry out this provision.

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Termination

When Coverage Stops

Coverage of an eligible Retiree and covered spouse will cease, subject to continuation provisions below, on the last day of the month in which:

1. The Retiree and/or spouse ceases to meet eligibility requirements, as defined under the Eligibility for Coverage provision in the Eligibility and Enrollment section;
2. The Retiree dies;
3. The Retiree and/or spouse fails to make any required contribution; or
4. The Policy is terminated by the Policyholder.

Benefit ID Cards must be returned to the Policyholder's personnel office if a Retiree or spouse is no longer covered.

If We accept a premium for a time period after coverage is to cease, the premium will be refunded.

Extension of Benefits

If Your coverage ends, for reasons other than discontinuance of the group contract, while You are Totally Disabled, benefits will be extended for the disabling condition until the earlier of the following dates:

1. The date You are no longer Totally Disabled; or
2. The date that You exhaust Your benefit or reach any coverage maximum or limit.

If Your coverage ends due to discontinuance of the group contract while You are Totally Disabled, benefits will be extended for the disabling condition until the earlier of the following dates:

1. The date You are no longer Totally Disabled;
2. The date that You exhaust Your benefit or reach any coverage maximum or limit; or
3. Twelve months from the date of discontinuance

Continuation for Covered Spouse

Subject to timely payment of premium, coverage will continue for an enrolled spouse who would otherwise become ineligible due divorce or death of the Retiree. The spouse must notify the Policyholder of the Retiree's death or divorce. The Policyholder will provide written notice to the spouse of the right to continue coverage and will send instructions for premium payment.

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Definitions

This section provides a list of certain terms and their meaning as used in this Certificate. Defined terms are capitalized wherever they occur in the Certificate.

Accident

An event inflicting personal bodily Injury to the Covered Person solely through external violent, unintentional and unforeseen causes.

[Annual Plan Deductible

The dollar amount, specified in the Schedule of Benefits, of covered eligible expenses incurred under this Plan during a Benefit Period which must be paid by the Covered Person before this Plan is obligated to pay its portion of any further eligible expenses incurred in that Benefit Period.]

Benefit Period

A period of consecutive days that begins with the first day (not included in the previous spell of Sickness) on which You are furnished Inpatient Hospital, skilled nursing, or rehabilitation services by a qualified Provider in a month for which You are entitled to Medicare Part A benefits. A Benefit Period ends when You have been out of a Hospital or other facility primarily providing skilled nursing or rehabilitation services for sixty (60) days in a row (including the day of discharge), or the day the Covered Person ceases to be covered for benefits under this Plan.

Calendar Year

The twelve-month period that begins on January 1st and ends with December 31st. When You first become covered under this Certificate, the first Calendar Year begins for You on the Certificate Effective Date and ends on the following December 31st.

Close Relative

A parent, spouse, spouse's parent, brother, sister, or child of the Covered Person.

Complications of Pregnancy

The following will be considered Complications of Pregnancy:

Hospital confinement required to treat conditions, such as the following, in a pregnant female: (1) acute nephritis; (2) nephrosis; (3) cardiac decompensation; (4) HELLP syndrome; (5) uterine rupture; (6) amniotic fluid embolism; (7) chorioamnionitis; (8) fatty liver in pregnancy; (9) septic abortion; (10) placenta accreta; (11) gestational hypertension; (12) puerperal sepsis; (13) peripartum cardiomyopathy; (14) cholestasis in pregnancy; (15) thrombocytopenia in pregnancy; (16) placenta previa; (17) placental abruption; (18) acute cholecystitis and pancreatitis in pregnancy; (19) postpartum hemorrhage; (20) septic pelvic thrombophlebitis; (21) retained placenta; (22) venous air embolus associated with pregnancy; (23) miscarriage; or (24) an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of descent or dilatation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy.

A C-section delivery is not considered to be an emergency C-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous C-section.

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Treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: (1) hyperthyroidism, (2) hepatitis B or C, (3) HIV, (4) Human papilloma virus, (5) abnormal PAP, (6) syphilis, (7) chlamydia, (8) herpes, (9) urinary tract infections, (10) thromboembolism, (11) appendicitis, (12) hypothyroidism, (13) pulmonary embolism, (14) sickle cell disease, (15) tuberculosis, (16) migraine headaches, (17) depression, (18) acute myocarditis, (19) asthma, (20) maternal cytomegalovirus, (21) urolithiasis, (22) DVT prophylaxis, (23) ovarian dermoid tumors, (24) biliary atresia and/or cirrhosis, (25) first trimester adnexal mass, (26) hydatidiform mole, or (27) ectopic pregnancy.

Coordination of Benefits

The order of benefit determination rules state whether this Plan is a Primary Plan or Secondary Plan covering the person.

Co-Payment or Co-Insurance

That portion of expenses which must be paid by You.

Cosmetic Procedure

A procedure performed primarily for the improvement of a Covered Person's appearance rather than for the treatment of an Injury or and Sickness.

Covered Services

Any Medically Necessary treatment, services or supplies that are not specifically excluded from coverage by the Plan.

Covered Person

An eligible Retiree or spouse who has met the eligibility requirements described in Eligibility and Enrollment section, and who is eligible to receive benefits.

Custodial Care

Care that assists in the activities of daily living or meeting personal needs, such as walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets; and supervision of medication that is usually self-administered, or other care or treatment in an institution that is a rest home, place of rest, a place for the aged, a nursing home, convalescent home or similar institution.

Dental Care Services

Any services furnished to any person for the purpose of preventing, alleviating, curing, or healing human dental Sickness or Injury.

Durable Medical Equipment

Equipment which is:

1. Intended for repeated use;
2. Primarily and customarily used to service a medical purpose; and
3. Not generally useful to a person in the absence of the Sickness or Injury for which it is prescribed.

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Emergency Care

Bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

- 1. Placing the patient’s health in serious jeopardy;
- 2. Serious impairment to bodily functions; or
- 3. Serious dysfunction of any bodily organ or part.

Experimental or Investigational

A drug, device or medical treatment or procedure is Experimental or Investigational if:

- 1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- 2. Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means. of treatment or diagnosis; or
- 3. Reliable evidence shows that the consensus among experts regarding the drug, device or medical treatment procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means. of treatment or diagnosis. Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Family

A covered Retiree and his or her covered spouse.

HIPAA

The Health Insurance Portability And Accountability Act of 1996, Public Law 104-191, August 21, 1996, as amended, or any provision or section thereof.

Hospice

A health care program providing a coordinated set of services rendered in a patient’s home, in Outpatient settings or in institutional settings, for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an inter-disciplinary group of personnel which includes at least one Physician and one Registered Nurse (RN), and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital

An institution which meets all of the following conditions:

- 1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient or Outpatient basis at the patient’s expense;
- 2. It is constituted, licensed, and operated in accordance with the laws of the state in which it is located;

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3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical or surgical treatment of any Sickness or Injury;
4. Treatment is provided for compensation by or under the supervision of licensed Physicians with continuous twenty-four (24) hour nursing services by Registered Nurses (RNs); and
5. It qualifies as a Provider of services under Medicare, and is accredited as a Hospital by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association. The term Hospital will not include an institution which is, other than incidentally a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

Convalescent and extended care facilities are not Hospitals.

Hospital Miscellaneous Expenses

The actual charges made by a Hospital on its own behalf for services and supplies rendered to the Covered Person which are Medical Necessary for the treatment of such Covered Person. These expenses do not include charges for room and board or of professional services other than general nursing services regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Injury

Bodily Injury sustained by a Covered Person caused by an Accident which is the direct cause of loss, independent of disease or bodily infirmity. All Injuries sustained in connection with one Accident will be considered one Injury. Injury does not include ptomaine poisoning, disease or infection (except pyogenic infection occurring through an Accidental cut or wound).

Inpatient

The classification of a Covered Person when that person is admitted to a Hospital, Hospice, or convalescent facility for treatment, and charges are made for room and board to the Covered Person as a result of such treatment.

Inpatient Lifetime Reserve Days

The additional non-renewable sixty (60) days of Hospital coverage provided under Medicare Part A for an admission which exceeds ninety (90) days. **Important Note:** Once You use an Inpatient Lifetime Reserve Day, it is not replaced. Inpatient Lifetime Reserve Days are non-renewable.

Medically Necessary

Health care services, supplies or treatment which, in the judgment of the attending Physician, is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

Medicare

The programs established by Title 1 of Public Law 89-98 (79 Statutes 291) as amended entitled Health Insurance for the Aged Act, and which includes both Parts A and B and Title XVIII of the Social Security Act (as amended by Public Law 89-97, 79) as amended from time to time.

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Medicare Deductible

A specified dollar amount of Medicare Eligible Expenses incurred during a Benefit Period which must be paid by the Covered Person before Medicare is obligated to pay its portion of any further eligible expenses incurred in that Benefit Period.

Medicare Eligible Expenses

Expenses which are of the kind covered by Medicare, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part A

Insurance to cover Hospital expenses, such as Room and Board and other Inpatient Hospital services.

Medicare Part B

Insurance to cover medical expenses, such as Physicians' services, Outpatient Hospital services and a number of other non-Hospital medical services and supplies.

Mental Illness

Any condition classified as a mental disorders as shown in the International Classification of Diseases (ICD).

Orthotic Appliance

A rigid or semi-rigid supportive device which limits or stops the motion of a weak or diseased body part.

Outpatient

The status of a Covered Person who receives medical care, treatment, services or supplies other than as an admitted Hospital bed-patient, usually in a clinic, Physician's office, or an Outpatient surgical facility.

Physician

A person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise shall not be covered by this Certificate. "Physician" does not include You or any Close Relative.

Plan

This Retiree benefit Plan.

Plan Benefit

That portion of eligible expenses to be paid by this Plan as specified in the Schedule of Benefits. It is the basis used to determine any out-of-pocket expenses in excess of any Deductibles or Co-Payments which are to be paid by the Covered Person.

Provider

As covered under this Plan, this term means a qualified provider of services under Medicare.

Registered Nurse (RN)

An individual who has:

- 1. Specialized knowledge and training beyond that of a licensed practical nurse (LPN) for the observation, assessment and diagnosis of Sickness and Injury
- 2. Graduated from an accredited school of nursing with an RN degree

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3. Served the requisite internship, and is
4. Duly licensed to perform such nursing services by the regulatory agency responsible for such licensing in the state in which that individual performs such services.

Retiree

A retired employee of the Policyholder who meets the eligibility criteria as described in the Eligibility and Enrollment section.

Semi-Private

A two, three, or four bed room in a Hospital or other treatment facility.

Sickness

Physical illness or disease of a Covered Person. Sickness includes Substance Abuse and Mental Illness when services provided are a Medicare Eligible Expense.

Skilled Nursing Facility

A place which, by law, provides care and treatment to persons who are convalescing as resident bed patients from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare; or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the facility; and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Substance Abuse

Abuse of, addiction to, or dependence on drugs, chemicals or alcohol.

Substance Abuse and/or Mental Health Services

Services for the diagnosis and treatment of Mental Illness or Substance Abuse.

Total Disability/Totally Disabled

A disability resulting from bodily Injury or Sickness which prevents the retiree or spouse from performing the normal activities of a person of like age and sex.

We, Us, Our

Sterling Life Insurance Company, Inc.

You

The Retiree to whom this Certificate is issued.

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SERFF Tracking Number: MCHX-G126689494 State: Arkansas
 Filing Company: Sterling Life Insurance Company State Tracking Number: 46025
 Company Tracking Number: GROUP POLICY (04.09)
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Group Retiree Medical Program - Sterling Life Insu
 Project Name/Number: Group Retiree Medical Program - Sterling Life Insurance Company/Group Retiree Medical Program - Sterling Life Insurance Company

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
06/23/2010	Form	Certificate of Coverage	07/01/2010	AR Certificate of Coverage EMPLOYER COC 05_10 clean.PDF (Superseded)
06/23/2010	Supporting Document	SOV	07/01/2010	AR EOV 4_7_09 clean copy.PDF (Superseded)

**Sterling Life Insurance Company
[ABC Company, Inc.]
Medicare-Enrolled Retiree Plan
Certificate of Coverage**

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Sterling Life Insurance Company, Inc.
Administrative Offices/Customer Service
[P. O. Box 5348 Bellingham, WA 98227-5348
(800) 688-0010]

GROUP INSURANCE CERTIFICATE

Sterling Life Insurance Company, Inc. (Referred to in this contract as “We”, “Us”, or “Our”) will provide the coverage stated in this Certificate subject to the provisions and limitations contained herein. We have issued this Certificate in consideration of the payment of the first premium and the statements made in Your enrollment form.

The group Policy issued to the Policyholder determines all rights and benefits which are summarized in this Certificate. We or the Policyholder may end the Policy according to its terms, as described in the Termination section of this Certificate.

The group Policy shall be available for inspection at all reasonable times at the place of business or principal residence of the Policyholder where the Policy is on file, by any Covered Person or by an authorized representative of the Covered Person.

Your Right To Examine And Cancel this Certificate Within 10 Days

We want You to fully understand and be satisfied with Your Certificate. If, for any reason, You are not satisfied with Your Certificate, You may cancel it. Return the Certificate to Us or to one of this Plan’s authorized agents by midnight of the 10th day after You receive it. As soon as possible after We receive this Certificate, We will refund any premiums You have paid. The Certificate will be considered to have never been issued.

Renewability and Premium Change

You may renew Your Certificate for Yourself as long as You may live, subject to the terms of the Group Policy. To renew, just pay the renewal premiums, if necessary. They must be paid on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this Certificate or place any restrictions on it if the premiums are paid on time.

We may change the premium rates for this Certificate at renewal. The change may be due to a change in Certificate coverage or a new table of rates. We can only change Your premium rate if We change it for all policies of the same class. We will tell You in advance of any change in premium rate.

Signed by Our [President] and [Assistant Secretary].



[President]



[Assistant Secretary]

Certificate Holder Information

[Group Number:

Policyholder: [ABC, Inc.]

Certificate Number:

Certificate Effective Date:

Initial Premium Mode:

Initial Premium Amount:

First Renewal Premium:]

Schedule of Benefits

This Plan pays benefits, as secondary payor, for medical conditions and procedures covered by Medicare. There may be some additional State mandated benefits which may not be covered by Medicare but will be covered by this Plan. This Plan will be the primary payor for these benefits.

Plan Benefits – [Plan 1]

[Annual Plan Deductible

This Plan has a [\$300] annual Deductible. You must have incurred [\$300 dollars] expense for Covered Services before this Plan begins to make benefit payments. Once the Annual Plan Deductible is met, Medicare Part A [and Part B] Services are covered as described in this Schedule of Benefits.]

[Provider Office Visit Copay

This Plan has a [\$10] Provider office visit copay. The office visit copays are not included in the Annual Plan Deductible.]

[Lifetime Maximum Benefit

[\$2,000,000 - Unlimited]

1. Medicare Part A Services

Medicare (Part A) Hospital Services Per Benefit Period	A Benefit Period begins the first day You receive services as an Inpatient in a Hospital and ends after You have been out of the Hospital and have not received skilled care in any other facility for 60 days in a row. You are responsible for all other non covered charges.
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Hospitalization Semiprivate room and board, general nursing and Hospital Miscellaneous Expenses.			
SERVICES	MEDICARE PAYS	THIS RETIREE PLAN PAYS	YOU PAY
First 60 days	All but [\$1024]	[\$1024]	\$0
61 st through 90 th day	All but [\$256 a day]	[\$256 a day]	\$0
91 st day and after: While using 60 lifetime reserve days	All but [\$512 a day]	[\$512 a day]	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
Beyond the Additional 365 days	\$0	\$0	All Costs

Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a Hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the Hospital.			
SERVICES	MEDICARE PAYS	THIS RETIREE PLAN PAYS	YOU PAY
First 20 days	All Approved Amounts	\$0	\$0

21 st through 100 th day	All but [\$128]	[\$128]	\$0
101 st days and after	\$0	\$0	All Costs

Blood			
SERVICES	MEDICARE PAYS	THIS RETIREE PLAN PAYS	YOU PAY
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
Hospice Care			
SERVICES	MEDICARE PAYS	THIS RETIREE PLAN PAYS	YOU PAY
Available as long as Your Physician certifies You are terminally ill and You elect to receive these services	All but very limited Co-Insurance for Outpatient drugs and Inpatient respite care	\$0	Balance of Expenses

[2. Medicare Part B Services

If You are enrolled in [Plan 1], this Plan will not pay benefits for Part B Covered Services.

If You are enrolled in [Plan 2, Plan 3] this Plan will pay benefits for Part B Covered Services as described herein.

Medicare pays (generally) 80% of Part B Medicare approved amounts (55% for Substance Abuse and Mental Health Services) once you have met your Medicare annual Part B deductible (\$[135]). You will pay the balance based on the amounts reflected below[, up to the Plan Out-of Pocket of [\$1,000]]. (This does not include Your [\$300] Annual Plan Deductible). [Your annual Medicare Part B deductible will count towards Your [\$300] Annual Plan Deductible.]

Medicare (Part B) Medical Services – Per Calendar Year			
Medical Expenses in or out of the Hospital & Outpatient Hospital Treatment , such as Physician's services, Inpatient and Outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, Durable Medical Equipment.			
SERVICES	MEDICARE PAYS	THIS RETIREE PLAN PAYS	YOU PAY
Provider Office Visits	0-80%	Remaining amount after [\$10 copay]	[\$10 copay]
First [\$135] of Medicare Approved Amounts*	\$0	[\$0] [[[\$135] Part B Deductible]	[[[\$135] Part B Deductible] [\$0]

Remainder of Medicare Approved Amounts	Generally 80%, (or 55% for Substance Abuse and Mental Health Services)	[Generally 20% (45% for Substance Abuse and Mental Health Services)] [\$0 [until OOP Max is met, then 20%(45% for Substance Abuse and Mental Health Services)]]	[\$0] [Generally 20% (45% for Substance Abuse and Mental Health Services) [, until OOP Max is met]]
Part B Excess (Above Medicare Approved Amount)	\$0	100%	\$0

Blood			
First 3 pints	\$0	All Costs	\$0
Next [\$135] of Medicare Approved Amounts*	\$0	[\$0] [[\$135] Part B Deductible]	[[[\$135] Part B Deductible] [\$0]
Remainder of Medicare Approved Amounts	Generally 80%	[Generally 20%] [\$0 [until OOP Max is met, then 20%]]	[\$0] [Generally 20%[, until OOP Max is met]]

Clinical Laboratory Services			
Blood Tests For Diagnostic Services	100%	\$0	\$0
Home Health Care, Medicare Approved Services Medically necessary skilled care services and medical supplies	100%	\$0	\$0

Durable Medical Equipment			
First [\$135] of Medicare Approved Amounts*	\$0	[\$0] [[\$135] Part B Deductible]	[\$0] [Generally 20%[, until OOP Max is met]]
Remainder of Medicare Approved Amounts	Generally 80%	[Generally 20%] [\$0 [until OOP Max is met, then 20%]]	[\$0] [Generally 20%[, until OOP Max is met]]

[Annual Out of Pocket Maximum for Medicare Part B Covered Services]

Once You have incurred out-of-pocket expenses of [\$1,000] (in addition to the [\$300] Annual Plan Deductible) for Medicare Part B Covered Services during the Calendar Year, this Plan will provide coverage for 100% of any additional expenses incurred for Medicare Part B Covered Services.]

]

[3.] Additional Benefits

Foreign Travel - Not Covered by Medicare. Medically necessary Emergency Care services beginning during the first 60 days of each trip outside the USA.

First [\$250] each Calendar Year	\$0	\$0	[\$250]
Remainder of Charges	\$0	[80%] to a lifetime maximum benefit of [\$50,000]	Generally 20% and amounts over the [\$50,000] lifetime maximum

4. Arkansas State Requirements

Dental Anesthesiology	The same co-payments, deductibles and benefit limits shall apply to covered anesthesia and Hospitalization for dental services as those applied to other medical or surgical benefits under this Plan.
Mastectomy-Related Services	The same co-payments, deductibles and benefit limits shall apply to mastectomy-related services as those applied to other medical or surgical benefits under this Plan.
Speech or Hearing Impairment	The same co-payments, deductibles and benefit limits shall apply to speech or hearing impairment care and treatment as those applied to other medical or surgical benefits under this Plan.

Eligibility and Enrollment

Eligibility for Coverage

Who May Receive Benefits

Benefits are provided to eligible Retirees of the Policyholder and their eligible spouses. A Retiree may be covered as a Retiree, or as a spouse of an eligible Retiree who is also a Retiree of the Policyholder, but not both. Qualifications for eligibility are as follows:

[Plan 1]

Retirees

Those who:

- § are retired from active employment with the Policyholder;
- § have completed [X years][the required number of years, as specified by the Policyholder in the Master Application,] of full time service with the Policyholder immediately before retirement;
- § are age sixty-five (65);
- § are not employed for [20 or more hours per week], either by any other employer or self-employed; and
- § are enrolled in Medicare Part A[and B]; or
- § are designated as eligible as described in an endorsement to the Policy

will be eligible for health care benefits under this Plan.

Spouse of Covered Retirees

Those who:

- § are the current spouse (husband or wife) of an eligible Retiree;
- § are age sixty-five (65);
- § are not employed for [twenty (20) or more hours per week], either by any other employer or self-employed; and
- § are enrolled in Medicare Part A[and B]; or
- § are designated as eligible as described in an endorsement to the Policy

will be eligible for health care benefits under this Plan. We may require legal proof of marriage. Common law marriages are not recognized under this Plan.

Other Dependents

With the exception of an eligible Retiree's spouse, as listed above, no other individuals or dependents are eligible for coverage under this Plan.

Enrollment

Eligible Retirees

An eligible Retiree must enroll in this Plan by completing enrollment forms within thirty (30) days of becoming eligible. These forms are provided by the Policyholder. If the enrollee's spouse is also eligible, they should also be enrolled at that time. If a Retiree does not enroll him or herself or his or her Eligible spouse, or declines coverage for them by signing a "Refusal of Coverage" card within thirty (30) days of becoming eligible, neither the Retiree nor the spouse will be

eligible for enrollment in this Plan, except in the event of a HIPAA Special Enrollment Period, as described below.

Eligible Retiree Spouses

As stated above, an eligible spouse of a Retiree may be enrolled in this Plan when the Retiree becomes eligible for coverage. If the spouse of a Retiree should become eligible for this Plan after the Retiree's enrollment, the spouse must enroll in this Plan by completing the necessary enrollment forms within 30 days of his/her eligibility.

An eligible new spouse of an eligible Retiree must be enrolled within 30 days of marriage or other eligibility, as described above. If an eligible spouse is not enrolled within 30 days of becoming eligible; he/she will not be eligible to enroll in this Plan except in the event of a HIPAA Special Enrollment Period, as described below.

Changes in Enrollment

The Policyholder must be notified if any change occurs in the status of the Retiree or spouse which could affect eligibility for coverage under this Plan.

HIPAA Special Enrollment Period

If You are declining enrollment for Yourself or Your spouse because of other health insurance coverage, You may be able to enroll Yourself or Your spouse in this Plan in the future, if You request enrollment within thirty (30) days after the other coverage ends. In addition, if You have a new spouse as a result of marriage, You may be able to enroll Your spouse if You request enrollment within thirty (30) days after the marriage.

If an individual who is eligible for this Plan does not enroll because they have coverage under another group health plan or other health insurance, then that individual is eligible for a special enrollment period under the following circumstances:

1. The individual has stated in writing that coverage under another group health plan or health insurance was the reason for declining enrollment; and
2. The individual had COBRA continuation coverage and that coverage has been exhausted or the individual was not covered under COBRA continuation and either the other coverage has been terminated as a result of loss of eligibility for coverage or employer contribution toward the other coverage has been terminated.

Loss of eligibility can be as a result of legal separation, divorce, death, termination of employment, reductions in the number of hours of employment and any other loss of eligibility under the other group health plan or health insurance coverage.

The special enrollment period lasts for thirty (30) days and begins on the day following the loss of coverage under the other plan. The required effective date of coverage for those enrolling during a special enrollment period can be no later than the first day of the month following the date on which the request for enrollment was completed.

When Coverage Begins

New Retirees and their eligible spouse will be covered on the first day of the month following enrollment. All coverage will commence at 12:01 a.m. on the date such coverage takes effect.

New spouses will be covered on the date of marriage or upon meeting the eligibility requirements described above if enrollment forms have been properly completed.

Benefits

Medical Plan

This Plan pays benefits, as secondary payor, for medical conditions and procedures covered by Medicare. There may be some additional state-mandated benefits which may not be covered by Medicare but will be covered by this Plan. This Plan will be the primary payor for these benefits.

Services which are not covered by Medicare or mandated by state law as indicated below will not be covered under this Plan.

Medical benefits are provided to eligible Retirees and their covered spouse as defined under the Eligibility for Coverage provision in the Eligibility and Enrollment section.

[Plan 1]

Deductible

[After Your [\$300 dollar] Annual Plan Deductible,]this Plan pays the Inpatient Medicare Part A [and Medicare Part B] Deductible for Covered Services. Except for Medically Necessary Emergency Care in a Foreign Country, as described in the Eligible Services and Benefits section, there are no other Deductibles associated with this Plan.

[Provider Office Visit Co-Payment

This Plan has a [\$10] Provider office visit copay. The office visit copays are not included in the Annual Plan Deductible.]

Providers Of Service

This Plan will provide benefits for Covered Services rendered by a qualified Provider of service under Medicare.

This Plan will not pay benefits for services not covered under this Plan, even if rendered by a Medicare-qualified Provider. The status of being listed as a Medicare-qualified Provider does not mean that all services rendered by that Provider will be covered under this Plan, but only those services which are specifically listed as Covered Services.

Covered Services and Benefits

Inpatient Hospital Stay – Medicare Part A

This Plan provides medical benefits for Hospital and Facility charges, as covered by Medicare. Medicare Part A covers Inpatient Hospital care, Skilled Nursing Facility care, Hospice care, and *some* home health care (including physical, occupational and speech therapy; and Durable Medical Equipment). For more details on Medicare Covered Services, please consult the most recent “Medicare & You” booklet, or contact Medicare at 1-800-MEDICARE or www.medicare.gov.

If, while this Certificate is in force, You incur facility charges covered by Medicare Part A, We will provide the coverage described below. The facility stay must be Medically Necessary and be approved by Medicare; be caused by an Injury or Sickness; and begin while You have this coverage. No benefits will be paid under this section that would duplicate benefits paid under Medicare Part B, if applicable. This Plan will limit coverage to Medicare Eligible Expenses and benefits mandated by state law. This Plan will not cover charges that Medicare deems unreasonable and/or unnecessary.

We will provide coverage for the following benefits[, subject to the Annual Plan Deductible for which You are liable]:

1. Medicare Part A Deductible: Coverage for all of the Medicare Part A Inpatient Hospital Deductible amount in a Benefit Period.
2. Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare for days 61 through 90 in any Medicare Benefit Period;
3. Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used;
4. When the Medicare Hospital Inpatient coverage, and the lifetime reserve days have exhausted, coverage for Medicare Part A Eligible Expenses for Hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days.
5. Coverage for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells) unless replaced in accordance with federal regulations, or covered under Medicare Part B, if applicable.
6. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the Co-Insurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital Skilled Nursing Facility care eligible under Medicare Part A.

Hospice Care

This Plan does not pay benefits for Hospice Care beyond those paid by Medicare. Medicare generally covers all expenses for Hospice Care, with the exception of very limited Co-Insurance for Outpatient drugs and Inpatient respite care.

Medicare Part B

[The following Part B benefits apply only to [Plans 2 and 3]. This Plan's Part B benefits do not apply to [Plan 1].]

[Part B Deductible and Co-Insurance

Once You have incurred out-of-pocket expenses of [\$1,000] (in addition to the [\$300] Annual Plan Deductible) for Medicare Part B Covered Services during the Calendar Year, this Plan will provide coverage for 100% of any additional expenses incurred for Medicare Part B Covered services.]

[Provider Care – Medicare Part B

This Plan provides medical benefits for Physician, Provider, and Outpatient Hospital charges, as covered by Medicare. Medicare Part B covers Physician's services, Outpatient Hospital care, and some other medical services not covered by Part A, such as the services of physical and occupational therapists and *some* home health care. For more details on Medicare Covered Services, please consult the most recent "Medicare & You" booklet, or contact Medicare at 1-800-MEDICARE or www.medicare.gov.

If, while this Certificate is in force, You incur Provider or facility charges covered by Medicare Part B, We will provide the coverage described below. The services received must be Medically Necessary and be approved by Medicare; be caused by an Injury or Sickness; and begin while You have this coverage. No benefits will be paid under this section that would duplicate benefits paid under Medicare Part A. This Plan will limit coverage to Medicare Eligible Expenses. Medicare does not pay for charges it deems unreasonable and/or unnecessary.

We will provide coverage for the following benefits[, subject to [the Annual Plan Deductible] [and] [the Plan Out of Pocket of [\$1000] and [the Provider office visit copay], for which You are liable]:

1. [We will pay all of the Medicare Part B Deductible amount in a Calendar Year regardless of whether or not You were confined in a Hospital.]
2. [We will pay the Co-Insurance or, in the case of Hospital Outpatient department services under a prospective payment system, the Co-Payment amount of Medicare Eligible Expenses under Part B. We will pay this amount regardless of whether or not You were confined in a Hospital.]
3. We will pay all the difference between the actual Medicare Part B charge as billed, and the Part B charge approved by Medicare, not to exceed any charge limitation established by the Medicare program or state law.]

Medically Necessary Emergency Care in a Foreign Country

This Plan provides coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare Eligible Expenses for Medically Necessary Emergency Care, including Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a Calendar Year benefit Deductible of [\$250], and a lifetime maximum benefit of [\$50,000].

Maximum Benefit

The lifetime maximum benefit under this Plan is [\$2,000,000 – unlimited].

Arkansas State Requirements

The Covered Services listed below are provided in compliance with state law. To the extent covered by original Medicare, this Plan pays such benefits as secondary payor. To the extent not covered by original Medicare, this Plan pays such benefits as primary payor.

Dental Anesthesiology

This Plan covers general anesthesia and associated facility charges for services performed in a Hospital or ambulatory surgical center in connection with dental procedures that are Medically Necessary because the Covered Person has a serious mental or physical condition, or a significant behavioral problem that the Covered Person's Physician determines would place the Covered Person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the Covered Person's Physician.

The dental procedure itself and associated dentist's fee are not covered.

Mastectomy-Related Services

Following a mastectomy for the treatment of breast cancer, there is a minimum hospitalization benefit of 48 hours unless the decision to discharge prior to 48 hours is made by the attending Physician in consultation with the patient

This Plan covers reconstructive breast surgery following a mastectomy, including reconstruction of the breast on which surgery was performed and the other breast to produce a symmetrical appearance if the patient elects reconstruction, in the manner chosen by the patient and Physician. The Plan also covers prosthetic devices and physical complications at all stages of mastectomy, including lymphedemas.

Speech or Hearing Impairment

This Plan covers the Medically Necessary care and treatment of loss or impairment of speech or hearing, including services provided by a licensed audiologist or a licensed speech-language pathologist. This does not include coverage for hearing aids or devices.

Exclusions and Limitations

Benefits will be paid only for care given under the direct supervision of covered Providers of service as described in the Benefits section, to the extent they perform services within the scope of their license. Support professionals must be properly certified and licensed.

All facilities must be licensed in the states in which they operate. Hospitals and Skilled Nursing Facilities must meet the definitions provided in the Definitions section.

The following services, supplies and charges are **NOT** covered under this Plan and are excluded when determining benefit payments:

Not Covered By Medicare or State-Mandated

This Plan does not pay benefits for anything not eligible under Medicare and/or not specifically mandated by state law.

Acts of War

This Plan does not pay benefits for charges incurred:

- As a result of war or acts of war (declared or undeclared),
- From participating in a riot,
- While serving in the armed forces of any country, or
- While confined in a penal or correctional institution.

Acupuncture and Naturopathic

This Plan does not pay benefits for charges incurred for any acupuncture or naturopathic services.

Cosmetic Procedures or Reconstruction Surgical Treatment

This Plan does not pay benefits for services primarily intended to change one's appearance; including liposuction and breast reduction; or in connection with Cosmetic Procedures, except reconstructive surgery resulting from Injury or surgical treatment of the involved part incurred while covered under this Plan.

Court Ordered Care

This Plan does not pay benefits for non-Medically Necessary services which are ordered by court of law.

Custodial Care

This Plan does not pay benefits for Custodial Care.

Dental Care

This Plan does not pay benefits for items and services related to the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth, including periodontium, gingivae, dentogingival junction, periodontal membrane, cementum of the teeth and alveolar process, dental splints, prostheses, or any dental treatment for the teeth, gums or jaw not otherwise allowed by Medicare.

Elective or Voluntary

This Plan does not pay benefits for enhancement procedures, services, supplies, and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, anti-aging, and mental performance, unless Medically Necessary.

Experimental

This Plan does not pay benefits for medical and surgical care, services, supplies or devices and medications which are:

- Experimental or Investigational,
- Not recognized by the American Medical Association as generally accepted and Medically Necessary to the diagnosis and/or treatment of an active Sickness or Injury, or
- Charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value or are otherwise not covered by Medicare.

Foot Care and Supplies

This Plan does not pay benefits for foot care only to improve comfort or appearance. This includes care for

- Flat feet,
- Corns,
- Bunions (except capsular and bone surgery),
- Calluses or ingrown toenails;

This also includes supplies in connection with routine foot care, such as but not limited to,

- Impression casts,
- Appliances and braces, or
- Corrective shoes.

Benefits are not provided for Orthotic Appliances unless they are prescribed for necessary medical treatment of a covered Injury, or after surgery. Orthopedic shoes and supportive devices for the feet are not covered unless they are part of a leg brace and are included in the orthopedist's charge. This exclusion shall not apply to therapeutic shoes for those suffering from diabetic foot disease as allowed by Medicare.

Government Facilities and Programs

This Plan does not pay benefits for services and supplies which could have been received without charge under government programs; Charges incurred while confined in a Hospital owned or operated by the United States government or any agency thereof; and charges for services, treatments or supplies furnished by United State Government or any agency thereof.

Hearing Aids

This Plan does not pay benefits for routine hearing and hearing aids.

Illegal Act

This Plan does not pay benefits for charges resulting from or occurring during the commission of a felony by the Covered Person or while engaged in an illegal occupation or felonious act or as the instigator of assault.

Incurred Prior to Plan

This Plan does not pay benefits for charges incurred prior to the Certificate Effective Date or after coverage is terminated.

Inpatient Hospital

This Plan does not pay benefits:

- For services that are rendered during an Inpatient confinement which are primarily related to behavior, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of psychological disorders;
- For education, training and bed and board while confined to an institution which is primarily a school or other;
- For Hospitalization primarily for x-ray, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent care, Custodial Care or test care, or any medical examination or tests not connected with an actual Sickness or Injury; or
- For a private room in a Hospital, unless Medically Necessary and allowable by Medicare.

Missed Appointment

This Plan does not pay benefits for charges for missed appointment or completion of forms.

Non-Covered Provider Services

This Plan does not pay benefits:

- For any treatment which is not rendered by or under the direct supervision of a licensed Physician;
- In connection with services and supplies which are not necessary for treatment of the Injury or Sickness or not recommended and approved by a licensed Physician;
- For private duty nurses;
- For charges imposed by immediate relatives or members of Your household, whether a licensed Provider of service or not.

Not Listed as Eligible

This Plan does not pay benefits for services or supplies not listed as eligible expenses.

Not Obligated to Pay

This Plan does not pay benefits for charges incurred which the Covered Person is not, in the absence of this coverage, legally obligated to pay.

Obesity

This Plan does not pay benefits for weight reduction or treatment of obesity, unless specifically ordered by a licensed Physician as being Medically Necessary to prevent the imminent death or total permanent disability of the Covered Person.

Other Insurance Coverage

This Plan does not pay benefits for any services to the extent that benefits are available under the terms of any vehicle, homeowner's, property, or other insurance coverage. Benefits available under automobile uninsured or underinsured motorist coverage are considered an exclusion only to the extent double recovery for medical expenses. Any benefits paid by this Plan contrary to this exclusion are not provided solely to assist the Covered Person. By paying for such benefits, Sterling is not acting as a volunteer and is not waiving any right to reimbursement or subrogation (see Conditions of Coverage section).

Patient Responsibility

This Plan does not pay benefits for the portion of the charge not otherwise covered by Medicare or this Plan that is patient responsibility.

Personal Care, Comfort or Convenience

This Plan does not pay benefits for marital counseling, diversionary, recreational or educational therapies, (such as hobbies, art and crafts, dance or music) and any related testing, or biofeedback or milieu therapy primarily directed toward self enhancement or to change or control one's environment; for services or supplies which constitute personal comfort or beautification items, or in connection with education or non-occupational training; for television, telephone, personal convenience items, or expenses for any persons not covered by this Plan; homemaker services; meals delivered to Your home; nursing care on a full-time basis in Your home.

Pregnancy

This Plan does not pay benefits for any expenses related to Pregnancy; however, complications of Pregnancy are covered the same as any other Sickness.

Prescription Drugs

This Plan does not pay benefits for prescription drugs, except those covered by original Medicare.

Relatives Providing Services

This Plan does not pay benefits for charges for services rendered by a Physician, nurse or licensed therapist if such Physician, nurse or licensed therapist is a Close Relative of the Covered Person or resides in the same household as the Covered Person.

Routine and Preventive Care

This Plan does not pay benefits for routine medical examinations, screening tests or routine health check-ups, shots or vaccinations not necessary for treatment of an Injury or Sickness, except as listed under Covered Services and Benefits.

Self Inflicted

This Plan does not pay benefits for expenses incurred resulting from treatment of intentionally self-inflicted Sickness or Injury, suicide or attempted suicide, whether sane or insane.

Services in Foreign Country

This Plan does not pay benefits for charges incurred outside the United States or Canada if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies; or for services or supplies not considered legal in the United States.

Sex Change or Sexual Dysfunction

This Plan does not pay benefits for sex change operations, counseling, surgery, drugs, other services or supplies, or treatment related to sex change; penile implants including any resulting complications, services or supplies for the treatment of sexual dysfunction or inadequacies, frigidity or impotence including any expenses for psychiatric therapy, adjustment therapy, or for treatment or therapy related to inter-sex surgery not otherwise covered by Medicare.

Tele-medicine

This Plan does not pay benefits for tele-medicine provided for non-eligible services.

Vision Services / Radial Keratotomy

This Plan does not pay benefits for eye exams and for the purchase or fitting of eyeglasses except as otherwise specified. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses, following cataract surgery. Services or procedures involving Radial Keratotomy are not covered.

Vitamins and Minerals

This Plan does not pay benefits for orthomolecular testing and therapy, or nutritional supplements, even if by prescription.

Work Related Charges

This Plan does not pay benefits for charges arising out of or in the course of any work for wage or profit for which the Covered Person is entitled to receive any benefit under Workers' Compensation or Occupational Disease Law or similar law.

Conditions of Coverage

General Provisions

Assignment

This Plan's benefits are offered personally to the Retiree and eligible spouse. Neither this Plan, its services and benefits, nor its payments are assignable or transferable. We reserve the right to make benefit payment to the Covered Person, the Provider, or jointly to both for Covered Services.

Determination of Benefits

The fact that a Physician or other licensed health care Provider may prescribe, order, recommend or approve a service or supply does not mean it is covered under this Plan. The Benefit Administrator will determine whether expenses qualify for benefits and are eligible for payment.

Right of Recovery

When payments have been made in excess of the amount necessary to satisfy a Plan Benefit, We will have the right to recover these excess payments. If We elect to recover the excess payment from any Covered Person; We may recover the excess payment by deduction from any future benefits due to or on behalf of the Covered Person.

Time Limit on Certain Defenses (Incontestability)

In the absence of fraud, statements made by any Covered Person are deemed representations and not warranties. No written statement made by any Covered Person shall be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary, if any.

After two years from the Certificate Effective Date, only fraudulent misstatements on Your enrollment form may be used to void this Certificate or deny any claim for loss incurred or disability that starts after the two year period.

Misstatement of Age

If Your age is misstated on the application for this coverage, the coverage provided will be that which the premium submitted would have purchased at Your correct age. If Your correct age as of the Certificate Effective Date would have caused Us to refuse coverage to You, We will only be responsible for the return of all premiums paid, less the amount of any claims paid.

Payment Of Benefits

Benefits will be paid to You or Your designated beneficiary or beneficiaries, or to Your estate, except that if the person insured is a minor or otherwise not competent to give a valid release, such benefits may be made payable to his parent, guardian, or other person actually supporting him. A portion of any indemnities provided by this Certificate on account of Hospital, nursing, medical, or surgical services, may at Our option, and unless You request otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such services provided, further, that authorization for any such payments has been obtained from You. We will be discharged to the extent of any such payment made in good faith.

Legal Action

No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of 3 years after the time

written proof of loss is required to be furnished.

Conformity with State and Federal Laws

Any provision of the Certificate which, on its effective day, is in conflict with the laws of the state in which the Policy was issued on that date is amended to conform to the minimum requirements of such laws.

If at any time during the life of the Certificate, federal or state law changes which would require a corresponding change in the coverage, We reserve the right, subject to regulatory approval, to change Certificate language, benefits or premium rates, but only as necessary to comply with the changes in law.

Physical Examinations and Autopsy

We at Our own expense have the right to have any Covered Person examined as often as reasonably necessary by a Physician of Our choice while a claim is pending. We may also have an autopsy made unless prohibited by law.

Subrogation

The benefits of this Certificate will be available to You if You are injured by the act or omission of another person, firm, or corporation. If You receive benefits under this Certificate for treatment of such injuries, You, or Your personal representative in the event of Your death, shall subrogate Your rights to Us to the extent of all payment made by Us for such benefits. You or Your representative agrees to cooperate fully with Us to secure these rights of subrogation. You also agree to otherwise help Us recover benefits We have paid to the extent that such sums exceed the amount required to fully compensate You, including an equitable apportionment of collection costs and legal expenses.

Premiums

We may change the premium for this Certificate due to a change in benefits or a new table of rates. We will tell You in advance of any change in premium on a timely basis.

Payment Of Premium

The initial premium is due on or before the Certificate Effective Date. Each premium after the initial one is due at the end of the period for which the preceding premium was paid.

If the premium is not paid by that date, the grace period will begin.

Grace Period

A grace period of 31 days is allowed for the payment of any premium except the initial premium. The coverage will continue in force during the grace period. If the premium is not paid during the grace period, the coverage will terminate at the end of the 31 day period.

Reinstatement

If the premium is not paid before the grace period ends, Your coverage under the Policy will lapse. If We (or any agent authorized to accept payment) later accept Your premium, without requiring an application for reinstatement, Your coverage will be reinstated.

If We require an application, You will be given a conditional receipt for the premium. If the application is approved, We will reinstate Your coverage as of the approval date. Lacking such approval, Your coverage will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated coverage will cover only loss that results from an Injury or Sickness sustained after the date of reinstatement. In all other respects Your rights and Our rights will remain the same.

Claims and Appeals

Claims Payment

Allowed by Medicare

If a billed charge is allowed by Medicare, it will be processed by this Plan as secondary, based on the original Medicare allowable amount.

[Excess Charges

[Plan 2 and Plan 3] will allow Medicare Part B excess charges and pay the amount between the actual Medicare Part B charge as billed and the Medicare-approved Part B charge, not to exceed any charge limitation established by the Medicare program or state law.]

Usual, Customary And Reasonable Fees

Benefit payments made under this Plan for services are based on usual, reasonable and customary charges. This means the amount generally accepted by the majority of Hospitals and licensed Physicians for like services and supplies at the time such services were rendered; in the geographic area where the Provider resides, as determined by this Plan. This Plan will take into consideration the fees and prices generally accepted and the services generally furnished in the geographic area concerned.

If a state mandated benefit is not also allowed by Medicare, the claim will be processed subject to usual and customary fees, and the remaining balance will be the responsibility of the patient.

Policyholder Optional Benefits

If the Policyholder elected to offer optional benefits as part of this Retiree Benefits Plan (i.e. Extended foreign travel benefits, vision, hearing, and/or prescription), the charges will be processed subject to usual and customary fees.

Claims Procedures

How To File A Claim

When You have a Claim, You or Your Provider must first file Your claim with Medicare. Once You receive a copy of this Plan's Explanation of Medicare Benefits ("EOMB"), submit a copy and an itemized billing to Us for processing.

Doctors, Hospitals, laboratories or other Providers may submit fully itemized bills by mail or electronic submission.

If the Covered Person has paid the bill, a copy of the paid receipt must be attached to the itemized claim in order for the Covered Person to receive reimbursement for the claim payment.

Late Claims

Claims submitted more than twelve (12) months after services and supplies were received will be considered late and will not be eligible for payment. Such expenses shall be considered to have occurred at the time the service or supply was actually provided.

What Happens When A Claim Is Filed

After a medical claim is submitted to Us, it will be processed according to the provisions of this Plan.

When the claim has been approved and paid, the Covered Person will receive a written Explanation of Benefits (EOB) showing the amount of submitted charges, the amount of those charges eligible for benefit payment, the amount of benefits actually paid by this Plan and any remaining balance owed by the Covered Person.

If the claim is incomplete or additional information is needed from the claimant or the attending Physician, the claim will be held pending further clarification and the Covered Person will receive a written explanation within 30 days after receipt of the claim of the reason for the delay in processing the claim and a description of the additional information required. Once the necessary information is received by Us, the processing of the claim will be completed.

How Claims Are Paid

Payment will be made directly to the Physician, Hospital, laboratory or other Provider. If, however, the Covered Person has paid the bill and notified Us, payment will be sent to the employee. (See "How to File a Claim").

Time of Payment Of Claims

Benefits for any loss covered by this Certificate will be paid immediately upon receipt of proper written proof of loss. If We do not pay within 60 of receipt, We shall pay interest at the rate of 12 percent per annum from the 61st day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid.

Disputed Claims

If the Covered Person believes a claim has been incorrectly paid or denied, he or she may request a second review from Us. The request must:

1. Be in writing within sixty (60) days of receiving the Explanation of Benefits (EOB) or notice of denial;
2. Describe the claim or claims being questioned;
3. State the reasons for disputing the action taken; and
4. Include any information requested by Us.

We will respond in writing within sixty (60) days.

Coordination of Benefits and Services

If a Covered Person is covered by more than one Plan, this provision allows Sterling to coordinate what Sterling pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Retiree is covered.

The words shown below have special meanings when used in this provision. Please read these definitions carefully.

“Allowable Expense” means a Medically Necessary, Reasonable and Customary item of expense for health care; when the item of expense is covered at least in part by one or more Plans covering the person for whom claim is made.

The difference between the cost of a private Hospital room and the cost of a Semi-Private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in this Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because an insured person does not comply with that Plan's provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions or pre-certification of admissions or services.

“Plan” means any coverage with which coordination of benefits is allowed. Plan includes:

1. Any group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage.
2. Any federal, state or local governmental programs, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

“Primary Plan/Secondary Plan” The Order of Benefit Determination rules state whether this is a Primary Plan or a Secondary Plan. When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering a person, this Plan may be a Primary Plan as to one or more other Plan's benefits, and may be a Secondary Plan as to a different Plan.

Order of Benefit Determination

Sterling considers each Plan separately when coordinating payments. This Plan determines its order of benefits using the first of the following rules which applies:

1. A Plan that does not have a coordination of benefits provision will always be a Primary Plan.
2. The benefits of a Plan which covers the person on whose expenses the claim is based as other than a dependent will be determined before the benefits of a Plan which covers the person as a dependent.
3. The benefits of a Plan that covers a person as a primary insured who is neither laid off nor retired, or as that primary insured's dependent, are determined before those of a Plan that covers that person as a laid off or retired primary insured or as that primary insured's dependent. This rule will not apply if the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits.
4. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is covered under another Plan, the following will be the order of benefit determination:
 - A. First, the benefits of a Plan covering the person as an employee, member, or subscriber (or as that person's dependent);
 - B. Second, the benefits under the continuation coverage. If the other Plan does not have the rule described above and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
5. When rules 2 through 4 do not establish an order of benefit determination the benefits of a Plan which has covered the person on whose expenses the claim is based for the longer period of time will be determined before the benefits of a Plan which has covered the person the shorter period of time.

Facility of Payment

If another Plan makes a benefit payment that should have been made by Us We have the right to pay the other Plan any amount We deem necessary to satisfy our obligation under these COB rules.

Right of Recovery

If the amount of Our benefit payment is more than the amount needed to satisfy Our obligation under these COB rules, We have the right to recover the excess amount from: (A) any persons to or for whom, or with respect to whom, the payments were made; (B) any insurance companies; or (C) any other organizations.

Right to Receive and Release Necessary Information

In order to carry out these COB rules:

1. We have the right, without the consent of or notice to any person, to exchange information with any person, insurance company or organization, as We deem necessary; and
2. Any person claiming benefits under this Plan must give Us any information necessary to carry out this provision.

Termination

When Coverage Stops

Coverage of an eligible Retiree and covered spouse will cease, subject to continuation provisions below, on the last day of the month in which:

1. The Retiree and/or spouse ceases to meet eligibility requirements, as defined under the Eligibility for Coverage provision in the Eligibility and Enrollment section;
2. The Retiree dies;
3. The Retiree and/or spouse fails to make any required contribution; or
4. The Policy is terminated by the Policyholder.

Benefit ID Cards must be returned to the Policyholder's personnel office if a Retiree or spouse is no longer covered.

If We accept a premium for a time period after coverage is to cease, the premium will be refunded.

Extension of Benefits

If Your coverage ends, for reasons other than discontinuance of the group contract, while You are Totally Disabled, benefits will be extended for the disabling condition until the earlier of the following dates:

1. The date You are no longer Totally Disabled; or
2. The date that You exhaust Your benefit or reach any coverage maximum or limit.

If Your coverage ends due to discontinuance of the group contract while You are Totally Disabled, benefits will be extended for the disabling condition until the earlier of the following dates:

1. The date You are no longer Totally Disabled;
2. The date that You exhaust Your benefit or reach any coverage maximum or limit; or
3. Twelve months from the date of discontinuance

Continuation for Covered Spouse

Subject to timely payment of premium, coverage will continue for an enrolled spouse who would otherwise become ineligible due divorce or death of the Retiree. The spouse must notify the Policyholder of the Retiree's death or divorce. The Policyholder will provide written notice to the spouse of the right to continue coverage and will send instructions for premium payment.

Definitions

This section provides a list of certain terms and their meaning as used in this Certificate. Defined terms are capitalized wherever they occur in the Certificate.

Accident

An event inflicting personal bodily Injury to the Covered Person solely through external violent, unintentional and unforeseen causes.

[Annual Plan Deductible

The dollar amount, specified in the Schedule of Benefits, of covered eligible expenses incurred under this Plan during a Benefit Period which must be paid by the Covered Person before this Plan is obligated to pay its portion of any further eligible expenses incurred in that Benefit Period.]

Benefit Period

A period of consecutive days that begins with the first day (not included in the previous spell of Sickness) on which You are furnished Inpatient Hospital, skilled nursing, or rehabilitation services by a qualified Provider in a month for which You are entitled to Medicare Part A benefits. A Benefit Period ends when You have been out of a Hospital or other facility primarily providing skilled nursing or rehabilitation services for sixty (60) days in a row (including the day of discharge), or the day the Covered Person ceases to be covered for benefits under this Plan.

Calendar Year

The twelve-month period that begins on January 1st and ends with December 31st. When You first become covered under this Certificate, the first Calendar Year begins for You on the Certificate Effective Date and ends on the following December 31st.

Close Relative

A parent, spouse, spouse's parent, brother, sister, or child of the Covered Person.

Complications of Pregnancy

The following will be considered Complications of Pregnancy:

Hospital confinement required to treat conditions, such as the following, in a pregnant female: (1) acute nephritis; (2) nephrosis; (3) cardiac decompensation; (4) HELLP syndrome; (5) uterine rupture; (6) amniotic fluid embolism; (7) chorioamnionitis; (8) fatty liver in pregnancy; (9) septic abortion; (10) placenta accreta; (11) gestational hypertension; (12) puerperal sepsis; (13) peripartum cardiomyopathy; (14) cholestasis in pregnancy; (15) thrombocytopenia in pregnancy; (16) placenta previa; (17) placental abruption; (18) acute cholecystitis and pancreatitis in pregnancy; (19) postpartum hemorrhage; (20) septic pelvic thrombophlebitis; (21) retained placenta; (22) venous air embolus associated with pregnancy; (23) miscarriage; or (24) an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of descent or dilatation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy.

A C-section delivery is not considered to be an emergency C-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous C-section.

Treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: (1) hyperthyroidism, (2) hepatitis B or C, (3) HIV, (4) Human papilloma virus, (5) abnormal PAP, (6) syphilis, (7) chlamydia, (8) herpes, (9) urinary tract infections, (10) thromboembolism, (11) appendicitis, (12) hypothyroidism, (13) pulmonary embolism, (14) sickle cell disease, (15) tuberculosis, (16) migraine headaches, (17) depression, (18) acute myocarditis, (19) asthma, (20) maternal cytomegalovirus, (21) urolithiasis, (22) DVT prophylaxis, (23) ovarian dermoid tumors, (24) biliary atresia and/or cirrhosis, (25) first trimester adnexal mass, (26) hydatidiform mole, or (27) ectopic pregnancy.

Coordination of Benefits

The order of benefit determination rules state whether this Plan is a Primary Plan or Secondary Plan covering the person.

Co-Payment or Co-Insurance

That portion of expenses which must be paid by You.

Cosmetic Procedure

A procedure performed primarily for the improvement of a Covered Person's appearance rather than for the treatment of an Injury or and Sickness.

Covered Services

Any Medically Necessary treatment, services or supplies that are not specifically excluded from coverage by the Plan.

Covered Person

An eligible Retiree or spouse who has met the eligibility requirements described in Eligibility and Enrollment section, and who is eligible to receive benefits.

Custodial Care

Care that assists in the activities of daily living or meeting personal needs, such as walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets; and supervision of medication that is usually self-administered, or other care or treatment in an institution that is a rest home, place of rest, a place for the aged, a nursing home, convalescent home or similar institution.

Dental Care Services

Any services furnished to any person for the purpose of preventing, alleviating, curing, or healing human dental Sickness or Injury.

Durable Medical Equipment

Equipment which is:

1. Intended for repeated use;
2. Primarily and customarily used to service a medical purpose; and
3. Not generally useful to a person in the absence of the Sickness or Injury for which it is prescribed.

Emergency Care

Bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Experimental or Investigational

A drug, device or medical treatment or procedure is Experimental or Investigational if:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
3. Reliable evidence shows that the consensus among experts regarding the drug, device or medical treatment procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Family

A covered Retiree and his or her covered spouse.

HIPAA

The Health Insurance Portability And Accountability Act of 1996, Public Law 104-191, August 21, 1996, as amended, or any provision or section thereof.

Hospice

A health care program providing a coordinated set of services rendered in a patient's home, in Outpatient settings or in institutional settings, for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an inter-disciplinary group of personnel which includes at least one Physician and one Registered Nurse (RN), and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital

An institution which meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient or Outpatient basis at the patient's expense;
2. It is constituted, licensed, and operated in accordance with the laws of the state in which it is located;

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical or surgical treatment of any Sickness or Injury;
4. Treatment is provided for compensation by or under the supervision of licensed Physicians with continuous twenty-four (24) hour nursing services by Registered Nurses (RNs); and
5. It qualifies as a Provider of services under Medicare, and is accredited as a Hospital by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association. The term Hospital will not include an institution which is, other than incidentally a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

Convalescent and extended care facilities are not Hospitals.

Hospital Miscellaneous Expenses

The actual charges made by a Hospital on its own behalf for services and supplies rendered to the Covered Person which are Medical Necessary for the treatment of such Covered Person. These expenses do not include charges for room and board or of professional services other than general nursing services regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Injury

Bodily Injury sustained by a Covered Person caused by an Accident which is the direct cause of loss, independent of disease or bodily infirmity. All Injuries sustained in connection with one Accident will be considered one Injury. Injury does not include ptomaine poisoning, disease or infection (except pyogenic infection occurring through an Accidental cut or wound).

Inpatient

The classification of a Covered Person when that person is admitted to a Hospital, Hospice, or convalescent facility for treatment, and charges are made for room and board to the Covered Person as a result of such treatment.

Inpatient Lifetime Reserve Days

The additional non-renewable sixty (60) days of Hospital coverage provided under Medicare Part A for an admission which exceeds ninety (90) days. **Important Note:** Once You use an Inpatient Lifetime Reserve Day, it is not replaced. Inpatient Lifetime Reserve Days are non-renewable.

Medically Necessary

Health care services, supplies or treatment which, in the judgment of the attending Physician, is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

Medicare

The programs established by Title 1 of Public Law 89-98 (79 Statutes 291) as amended entitled Health Insurance for the Aged Act, and which includes both Parts A and B and Title XVIII of the Social Security Act (as amended by Public Law 89-97, 79) as amended from time to time.

Medicare Deductible

A specified dollar amount of Medicare Eligible Expenses incurred during a Benefit Period which must be paid by the Covered Person before Medicare is obligated to pay its portion of any further eligible expenses incurred in that Benefit Period.

Medicare Eligible Expenses

Expenses which are of the kind covered by Medicare, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part A

Insurance to cover Hospital expenses, such as Room and Board and other Inpatient Hospital services.

Medicare Part B

Insurance to cover medical expenses, such as Physicians' services, Outpatient Hospital services and a number of other non-Hospital medical services and supplies.

Mental Illness

Any condition classified as a mental disorders as shown in the International Classification of Diseases (ICD).

Orthotic Appliance

A rigid or semi-rigid supportive device which limits or stops the motion of a weak or diseased body part.

Outpatient

The status of a Covered Person who receives medical care, treatment, services or supplies other than as an admitted Hospital bed-patient, usually in a clinic, Physician's office, or an Outpatient surgical facility.

Physician

A person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Services rendered otherwise shall not be covered by this Certificate. "Physician" does not include You or any Close Relative.

Plan

This Retiree benefit Plan.

Plan Benefit

That portion of eligible expenses to be paid by this Plan as specified in the Schedule of Benefits. It is the basis used to determine any out-of-pocket expenses in excess of any Deductibles or Co-Payments which are to be paid by the Covered Person.

Provider

As covered under this Plan, this term means a qualified provider of services under Medicare.

Registered Nurse (RN)

An individual who has:

1. Specialized knowledge and training beyond that of a licensed practical nurse (LPN) for the observation, assessment and diagnosis of Sickness and Injury
2. Graduated from an accredited school of nursing with an RN degree

3. Served the requisite internship, and is
4. Duly licensed to perform such nursing services by the regulatory agency responsible for such licensing in the state in which that individual performs such services.

Retiree

A retired employee of the Policyholder who meets the eligibility criteria as described in the Eligibility and Enrollment section.

Semi-Private

A two, three, or four bed room in a Hospital or other treatment facility.

Sickness

Physical illness or disease of a Covered Person. Sickness includes Substance Abuse and Mental Illness when services provided are a Medicare Eligible Expense.

Skilled Nursing Facility

A place which, by law, provides care and treatment to persons who are convalescing as resident bed patients from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare; or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the facility; and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Substance Abuse

Abuse of, addiction to, or dependence on drugs, chemicals or alcohol.

Substance Abuse and/or Mental Health Services

Services for the diagnosis and treatment of Mental Illness or Substance Abuse.

Total Disability/Totally Disabled

A disability resulting from bodily Injury or Sickness which prevents the retiree or spouse from performing the normal activities of a person of like age and sex.

We, Us, Our

Sterling Life Insurance Company, Inc.

You

The Retiree to whom this Certificate is issued.

STERLING LIFE INSURANCE COMPANY EXPLANATION OF VARIABLES

The following will be a listing of items that relate to the use of brackets within the policy forms.

- Brackets around numbers or alphas in a listing and punctuation or words such as “and”/”or” in a listing will be included or deleted as needed in order to make the statement read correctly.
- Numeric variables within the Policy (including the Schedule and Eligibility sections) will always comply with the minimum statutory requirements of the state in which the Policy is delivered.
- All names, locations, dates, amounts and other numbers, such as percents, time periods, page numbers, are illustrative and will vary from case to case.
- No changes will be made to the forms which are outside the parameters of the variability described herein.
- The term “Employee” may be replaced by “Member,” “Associate” or other similar descriptive term.
- The Company reserves the right to amend the forms to fix any minor typographical errors.

MASTER APPLICATION

- The Master Application will list Policyholder-specific data.
- The Employer will generally be given a choice of two or more Plan options, with distinct cost-sharing features, within the parameters described in this Explanation of Variables.

ENROLLMENT FORM

- The Enrollment Form will list Retiree-specific data.
- Depending on the selections made by the Policyholder, the Retiree may be offered a choice of two or more Plan options, with distinct cost-sharing features, within the parameters described in this Explanation of Variables.

GROUP POLICY

Face Page

- The Policyholder/Employer name is bracketed on the face page to allow inclusion of Policyholder-specific data.

Policy Termination Provision

- Item 1 (participation percentage requirement) may be included or omitted in its entirety, as agreed upon by the Policyholder and the Company.
- The minimum participation requirements in items 1 and 4 will be as agreed upon by the Company and the Policyholder.

GROUP CERTIFICATE

Face Page

- The Policyholder/Employer name is bracketed on the face page to allow inclusion of Policyholder-specific data.
- The Certificateholder information is bracketed to allow inclusion of personal data as listed.

Schedule of Benefits:

- The lifetime maximum benefit under the Plan may vary from \$2,000,000 to unlimited.
- The Annual Plan Deductible, Office Visit Copay, and Part B Out of Pocket Maximum are each optional and may be included or omitted depending on the plan options selected by the policyholder. All references to these features are bracketed throughout the Certificate to allow them to be omitted when any of these options is not part of the selected Plan of benefits.
- Annual Plan Deductible, if included, may vary from \$100 to \$1,000, in increments of \$50.
- The Office Visit Copay, if included, may vary from \$5 to \$20, in increments of \$5.
- All amounts covered by Medicare are shown in brackets to accommodate future changes to Medicare benefits. The plan benefits that are based on Medicare benefits are also bracketed. These plan benefits will vary only to coincide with changes in Medicare.
- When one of the Plan options covers persons who are covered only by Medicare Part A, the Plan's Part B benefits will not be applicable. In such case, the Plan will cover only the Part A benefits in item 1 of the schedule, and the foreign travel benefits in item 3 of the schedule.
- Some state mandated benefits in item 4 of the schedule may be bracketed in order to be removed from a Plan that covers only Medicare Part A expenses.
- For Part B Medicare services, the Plan includes the option to pay the insured's Part B deductible, or to begin paying benefits only after the Part B deductible is paid by the insured.
- For Part B Medicare services, the Plan includes the option to pay the insured's Part B coinsurance (generally 20%). Language that describes coverage of Part B coinsurance is bracketed to allow it to be removed when the Part B coinsurance is the insured's responsibility.
- Part B Out-of Pocket Maximum, if included, will vary from \$500 to \$5,000, in increments of \$500.
- Foreign Travel deductible will vary from \$250 to \$500, in increments of \$50.
- Foreign Travel coinsurance (amount paid by the Company) will vary from 50% to 80%.
- Foreign Travel lifetime maximum will vary from \$25,000 to \$100,000, in increments of \$25,000.

Eligibility for Coverage

- The minimum years of employment service for eligible retirees will be the amount required by the employer's internal requirements.
- The outside employment limitation (whereby retirees or spouses actively

employed elsewhere during their retirement become ineligible for coverage) will be as determined by the employer's internal requirements.

Benefits Section:

- The Annual Plan Deductible, Office Visit Copay, and Part B Out of Pocket Maximum are each optional and may be included or omitted depending on the plan options selected by the policyholder. All references to these features are bracketed throughout the Certificate to allow them to be omitted when any of these options is not part of the selected Plan of benefits.
- For Part B Medicare services, the Plan includes the option to pay the insured's Part B deductible, or to begin paying benefits only after the Part B deductible is paid by the insured. Language that describes coverage of the Part B deductible is bracketed to allow it to be removed when the Part B deductible is the insured's responsibility.
- For Part B Medicare services, the Plan includes the option to pay the insured's Part B coinsurance (generally 20%). Language that describes coverage of Part B coinsurance is bracketed to allow it to be removed when the Part B coinsurance is the insured's responsibility.

OPTIONAL HEARING BENEFIT

Hearing Benefit:

- The Routine Hearing Examinations benefit may be removed.