Filing at a Glance

Company: Companion Life Insurance Company

Product Name: HOEM01GR11	SERFF Tr Num: CMLX-G127045199	State: Arkansas
TOI: H21 Health - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 48035
Sub-TOI: H21.000 Health - Other	Co Tr Num: AR001520100004	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: SPI CompanionLife	Disposition Date: 03/01/2011
	Date Submitted: 02/21/2011	Disposition Status: Approved-Closed
Implementation Date Requested: 02/21/2011		Implementation Date:

State Filing Description:

General Information

Project Name: HOEM01GR11
Project Number: AR001520100004
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 03/01/2011
State Status Changed: 03/01/2011
Created By: SPI CompanionLife
Corresponding Filing Tracking Number:
PPACA: Not PPACA-Related
PPACA Notes: null

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:

Deemer Date:
Submitted By: SPI CompanionLife

Filing Description:

Companion Life Insurance Company hereby files the attached Group Accident and Health insurance policy, certificate, master application, and enrollment form.

The forms are new and will not replace any forms that have been previously approved in your state. The policy will be issued to employer-employee groups and will be marketed through a network of independent licensed agents.

These forms were submitted to South Carolina, our domiciliary state, on February 9, 2011, and are still pending.

Company and Contact

Filing Contact Information

Vivian Frederic, Contracts Compliance Specialist
vivian.frederic@companiongroup.com
7909 Parklane Rd
803-735-1251 [Phone] 46777 [Ext]
Columbia, SC 29223-5666
800-836-5433 [FAX]

Filing Company Information

Companion Life Insurance Company	CoCode: 77828	State of Domicile: South Carolina
7909 Parklane Rd, Suite 200	Group Code: 661	Company Type:
Columbia, SC 29223-5666	Group Name: Companion Life Insurance Company	State ID Number:
(803) 735-1251 ext. [Phone]	FEIN Number: 57-0523959	

Filing Fees

Fee Required?	Yes
Fee Amount:	$200.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Companion Life Insurance Company	$200.00	02/21/2011	44905751

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/01/2011	03/01/2011

Disposition

Disposition Date: 03/01/2011

Implementation Date:

Status: Approved-Closed

HHS Status: Not Reported

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMLX-G127045199*	*State:*	*Arkansas*
Filing Company:	*Companion Life Insurance Company*	*State Tracking Number:*	*48035*
Company Tracking Number:	*AR001520100004*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*HOEM01GR11*		
Project Name/Number:	*HOEM01GR11/AR001520100004*		

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
Form	Group Medicare-Enrolled Retiree Plan Policy	Approved-Closed	Yes
Form	Group Medicare-Enrolled Retiree Plan Certificate	Approved-Closed	Yes
Form	Master Application	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes

Form Schedule

Lead Form Number: MERP 4000

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/01/2011	MERP 4000	Policy/Contract/Fraternal Certificate	Group Medicare-Enrolled Retiree Plan Policy	Initial		46.300	MERP 4000 - Generic Group Policy.PDF
Approved-Closed 03/01/2011	MERC 4100 AR	Certificate	Group Medicare-Enrolled Retiree Plan Certificate	Initial		45.600	MERC 4100 AR - Certificate.PDF
Approved-Closed 03/01/2011	MER APP 4200	Application/Enrollment Form	Master Application	Initial		47.900	MER APP 4200 - Master Application.PDF
Approved-Closed 03/01/2011	MER ENR 4300	Application/Enrollment Form	Enrollment Form	Initial		50.900	MER ENR 4300 - Enrollment Form.PDF

COMPANION LIFE INSURANCE COMPANY
(Herein called the Company)
7909 Parklane Road, Suite 200
Columbia, SC 29223

GROUP INSURANCE POLICY

POLICYHOLDER:	[ABC, Inc]
GROUP POLICY NUMBER:	[123456]
POLICY EFFECTIVE DATE:	[January 1, 2011]
POLICY ISSUE DATE:	[January 1, 2011]
STATE OF ISSUE:	[Any State]

This Policy is entered into between Companion 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.

Trescott N. Hinton, Jr.
President

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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.

COMPANION LIFE INSURANCE COMPANY
(Herein called the Company)
7909 Parklane Road, Suite 200
Columbia, SC 29223

GROUP INSURANCE CERTIFICATE

Companion Life Insurance Company (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.

Trescott N. Hinton, Jr.
President

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Schedule of Benefits

[Group Number:

Policyholder: [ABC, Inc.]

Certificate Number:

Certificate Effective Date:

Initial Premium Mode:

Initial Premium Amount:

First Renewal Premium:]

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 a [$300] 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.**

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
61st through 90th day	All but [$256 a day]	[$256 a day]	$0
91st 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
21st through 100th day	All but [$128]	[$128]	$0
101st 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 (50% 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 50% for Substance Abuse and Mental Health Services)	[Generally 20% (50% for Substance Abuse and Mental Health Services)] [$0 [until Out Of Pocket Max is met, then 20% (50% for Substance Abuse and Mental Health Services)]]	[$0] [Generally 20% (50% for Substance Abuse and Mental Health Services) [, until Out Of Pocket 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 Out Of Pocket Max is met, then 20%]]	[$0] [Generally 20%[, until Out Of Pocket 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 Out Of Pocket Max is met]]
Remainder of Medicare Approved Amounts	Generally 80%	[Generally 20%] [$0 [until Out Of Pocket Max is met, then 20%]]	[$0] [Generally 20%[, until Out Of Pocket 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

Women's Health Care Services	The same co-payments, deductibles and benefit limits shall apply to covered women's health care services, as described in the Covered Benefits and Services section, as those applied to other medical or surgical benefits under this Plan.
Colorectal Cancer Screening	The same co-payments, deductibles and benefit limits shall apply to colorectal cancer screening as those applied to other medical or surgical benefits under this Plan.
Diabetes Self-Management	The same co-payments, deductibles and benefit limits shall apply to covered equipment, supplies and training for diabetes self-management as those applied to other medical or surgical benefits under this Plan.
Prostate Specific Antigen Tests	The same co-payments, deductibles and benefit limits shall apply to prostate-specific antigen testing as those applied to other medical or surgical benefits under this Plan.
Loss or Impairment of Speech or Hearing	The same co-payments, deductibles and benefit limits shall apply to loss or impairment of speech or hearing 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

Women's Health Care Services

This Plan covers annual screening by low-dose mammography on the same basis as other radiological examinations, and an annual Clinical Breast Exam, as covered by Medicare.

This Plan covers treatment for breast cancer as follows:

- Coverage for Inpatient care following a mastectomy for a length of time determined by the attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and upon evaluation of the patient; and
- Coverage for post-discharge Physician office visit or in-home nurse visit to verify the condition of the patient within the first 48 hours after discharge.

This Plan covers reconstructive surgery and associated procedures following a mastectomy, including, but no limited to:

- Reconstructive surgery on the non-diseased breast to produce a symmetrical appearance.
- Necessary internal and permanent external breast prostheses.
- Physical complications of all stages of mastectomy, including lymphedemas.

This Plan also covers an annual cervical Pap smear test.

Colorectal Cancer Screening

Regular medical benefits will be provided under this Plan for colorectal cancer screening, to include fecal occult blood testing, flexible sigmoidoscopy, and colonoscopy, as covered by Medicare.

Diabetes Self-Management

Regular medical benefits will be provided under this Plan, as covered by Medicare, for diabetes self-management training, and for the necessary equipment, supplies, and services for the treatment of diabetes, when prescribed by a licensed Physician.

Prostate-Specific Antigen Tests

Regular medical benefits will be provided under this Plan for an annual digital rectal examination and a prostate-specific antigen test, as covered by Medicare.

Loss or Impairment of Speech or Hearing

Regular medical benefits will be provided under this Plan for the necessary care and treatment of loss or impairment of speech or hearing, as covered by Medicare.

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. Reconstructive breast surgery incident to mastectomy is covered regardless of whether the mastectomy occurred while this Plan was in force.

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, Companion 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's 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 or complications of Pregnancy.

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.

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 along with a Claim Form 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 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 within thirty (30) days after We receive proper written proof of loss. If We do not pay within such period, We shall pay interest at the rate of 9 percent per annum from the 30th 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 Companion to coordinate what Companion 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 health care expense, including deductibles, coinsurance and copayments, that 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 of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts:

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

"Primary Plan/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 so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

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

1. 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.
2. 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.
3. 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.
4. 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.
5. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans. This Plan will not pay more than it would have paid had it been the Primary Plan.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of 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 to 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.

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 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 the 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 devise 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 Medically 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 disorder 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.

Pregnancy
The physical state which results in childbirth, abortion or miscarriage. This definition includes medical complications arising out of or resulting from the physical state of pregnancy.

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
Companion Life Insurance Company.

You
The Retiree to whom this Certificate is issued.

RETIREE MEDICAL APPLICATION

Underwritten by Companion Life Insurance Company

Group Policy: [XXXXX]

Policyholder: [ABC Employer]

Address:

Plan Elected: [• Plan 1 • Plan 2 • Plan 3]

The Policyholder hereby applies to Companion Life Insurance Company for the insurance provided by the Medicare-Enrolled Retiree Group Health Plan and approves and accepts the Group Policy with the signature shown below. The Group Policy takes effect on the date specified on the face page of the Group Policy.

Dated at: _____

On: _____

Signed for the Policyholder

By: _____
(Signature and Title)

Agent: _____
(Must be a Resident Licensed Agent where required by law)

RETIREE MEDICAL ENROLLMENT FORM

Underwritten by Companion Life Insurance Company

Please Print

Retiree Information (Please Print)		
Name	Date of Birth	Sex • Male • Female
Address		
City	State	Zip Code
Social Security Number	HIC # (from Medicare ID card)	
Phone Number	Email Address	

Employer Information		
Name of Employer	Address	
City	State	Zip Code

Please Choose Type of Coverage

• Retiree • Retiree and Spouse • Spouse Only

Spouse Information (if to be covered)		
Name	Date of Birth	Sex • Male • Female
Social Security Number	HIC # (from Medicare ID card)	

I hereby enroll in the Medicare-Enrolled Retiree Group Health Plan issued by Companion Life Insurance Company. I and my spouse (if to be covered) are age 65 or over and covered by Medicare Parts A & B. I understand that this insurance will be effective on the date shown on the certificate schedule.

Applicant's Signature:_____ **Date:** _____

Spouse's Signature: _____ **Date:** _____
(If to be Covered)

SERFF Tracking Number:	*CMLX-G127045199*	*State:*	*Arkansas*
Filing Company:	*Companion Life Insurance Company*	*State Tracking Number:*	*48035*
Company Tracking Number:	*AR001520100004*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*HOEM01GR11*		
Project Name/Number:	*HOEM01GR11/AR001520100004*		

Rate data does NOT apply to filing.

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	03/01/2011

Comments:

Attachment:

AR - READABILITY CERTIFICATION.PDF

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	03/01/2011

Bypass Reason: Application submitted in this filing for approval

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	03/01/2011

Bypass Reason: Not applicable

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	03/01/2011

Bypass Reason: Not applicable

Comments:

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	03/01/2011

Bypass Reason: Not applicable

Comments:

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **Companion 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
MERP 4000	46.3
MERC 4100 AR	45.6
MER APP 4200	47.9
MER ENR 4300	50.9

Signed: _____

Name: Karl Kemmerlin

Title: Vice President and CFO

Date: February 21, 2011