

State: Arkansas **Filing Company:** Stonebridge Life Insurance Company
TOI/Sub-TOI: H17G Group Health - Prescription Drug/H17G.000 Health - Prescription Drug
Product Name: Prescription Drug Part D Wrap Product
Project Name/Number: Prescription Drug/

Filing at a Glance

Company: Stonebridge Life Insurance Company
Product Name: Prescription Drug Part D Wrap Product
State: Arkansas
TOI: H17G Group Health - Prescription Drug
Sub-TOI: H17G.000 Health - Prescription Drug
Filing Type: Form
Date Submitted: 11/14/2012
SERFF Tr Num: CLTR-128764295
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: SLRX1000GP (11/12)
Implementation: On Approval
Date Requested:
Author(s): Susan Coulter, Dana Suter, Natanella Har-Sinay, Erica Ruggley, Eve Indradat
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 11/15/2012
Disposition Status: Approved-Closed
Implementation Date:
State Filing Description:

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General Information

Project Name: Prescription Drug Status of Filing in Domicile: Not Filed
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: Will be filed asap
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Large
Group Market Type: Employer Overall Rate Impact:
Filing Status Changed: 11/15/2012 Deemer Date:
State Status Changed: 11/15/2012 Submitted By: Dana Suter
Created By: Dana Suter
Corresponding Filing Tracking Number:

Filing Description:

The purpose of this cover letter is to summarize the changes made to the Employer Group Waiver Plan (EGWP) wrap pharmacy product for Stonebridge Life Insurance Company (Stonebridge). The original product filing was filed in the fall of 2011 in select states. Following is a summary of the product changes.

In early 2012, CMS issued a regulation titled CMS-4157-FC. The health insurance industry generally interpreted this, along with other guidance, to mean that combined EGWP and secondary wrap arrangements were no longer necessary to receive the full brand coverage gap discount program amounts beginning in 2013. However, CMS recently clarified that it intended the guidance to mean that no EGWP coverage beyond the Basic Medicare Part D benefit is permitted to be considered a Medicare benefit in any way. CMS intends to require plans to offer any benefit that is in excess of the Basic Medicare Part D benefit as commercial insurance through a wrap product. We expect this to impact many carriers in the Part D market.

Therefore, this filing revision is intended to allow the Medicare wrap product to encompass all benefits and reduced cost sharing associated with pharmacy coverage richer than the Medicare Part D Basic Coverage. This includes, but is not limited to, coverage for non-Part D covered drugs and the differential between the net member cost sharing (copays, coinsurance, and / or deductibles) and the cost sharing required under Medicare Part D Basic Coverage. This cost sharing differential will vary depending on a drug's formulary tier placement and on what phase of the Medicare Part D benefit the member is in (which is dependent on cumulative annual prescription costs).

A similar filing was previously approved on 9/9/11 under serff tracking number CLTR-127378757. The only changes to these forms are those mentioned above and I have attached merged copies of the forms on the supporting docs tab so that you are able to easily see any changes from the previous filing.

Please feel free to contact me with any questions at dana@coulter-and-associates.com or by phone at 609-443-7540. Thank you.

Company and Contact

Filing Contact Information

Dana Suter, consultant dana@coulter-and-associates.com
379 Princeton-Hightstown Road 609-443-7540 [Phone]
Suite 15
Cranbury, NJ 08512

State: Arkansas **Filing Company:** Stonebridge Life Insurance Company
TOI/Sub-TOI: H17G Group Health - Prescription Drug/H17G.000 Health - Prescription Drug
Product Name: Prescription Drug Part D Wrap Product
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Filing Company Information

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

Stonebridge Life Insurance Company	CoCode: 65021	State of Domicile: Vermont
4333 Edgewood Road NE	Group Code:	Company Type:
Cedar Rapids, IA 52499	Group Name:	State ID Number:
(319) 355-8511 ext. [Phone]	FEIN Number: 03-0164230	

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? Yes
 Fee Explanation: Fee is \$50.00 per form and there are 2 forms.
 Per Company: No

Company	Amount	Date Processed	Transaction #
Stonebridge Life Insurance Company	\$100.00	11/14/2012	64905229

State: Arkansas Filing Company: Stonebridge Life Insurance Company
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/15/2012	11/15/2012

State: Arkansas **Filing Company:** Stonebridge Life Insurance Company
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Disposition

Disposition Date: 11/15/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Authorization to File	Approved-Closed	Yes
Supporting Document	Merged documents	Approved-Closed	Yes
Form	Group Prescription Drug Policy	Approved-Closed	Yes
Form	Group Prescription Drug Certificate	Approved-Closed	Yes

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Form Schedule

Lead Form Number: SLRX1000GP (11/12)								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/15/2012	Group Prescription Drug Policy	SLRX1000G P (11/12)	POL	Initial			SLRX1000GP 11-14-12 Final.pdf
2	Approved-Closed 11/15/2012	Group Prescription Drug Certificate	SLRX1000G C (11/12)	CER	Initial			SLRX1000GC - 11-14-12 Final.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

Stonebridge Life Insurance Company

A Stock Company

Home Office: Rutland, Vermont
Administrative Office: [520 Park Avenue, Baltimore, Maryland 21201]

This is a contract between us, **STONEBRIDGE LIFE INSURANCE COMPANY**, and **The ABC Company**, (the Contract Holder).

Policy Number: [012345]

Policy Effective Date: [01/01/11]

Policy Anniversary Date: [01/01]

Policy Term: This policy will go into effect on the Policy Effective Date. All periods of insurance for a Coverage Person begin and end at 12:01 A.M. Standard Time at the Contract Holder's address. Unless this policy is ended by the Contract Holder or us (see "Termination of Policy" in GENERAL PROVISIONS), it may be renewed by payment of the required premiums, at the rates in effect on each premium due date.

Scope of Coverage: In exchange for the payment of premiums, as described in PREMIUMS, we agree to pay benefits to all eligible persons covered for benefits described in PRESCRIPTION DRUG EXPENSE BENEFIT.

This coverage is subject to the exclusions, and to all other terms of this policy. This policy will be governed by the laws of the state in which it is delivered {and, to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any of its amendments}.

IN WITNESS WHEREOF, we have signed this policy at Rutland, Vermont.


Craig D. Vermie
Secretary


PRESIDENT

This is not a standardized Medicare Supplement Plan.

**GROUP SUPPLEMENTAL PRESCRIPTION DRUG BENEFIT POLICY
THIS POLICY PROVIDES LIMITED PRESCRIPTION DRUG BENEFITS.
READ IT CAREFULLY.**

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SCHEDULE OF BENEFITS

1. **ELIGIBILITY:** The following persons are eligible for insurance under this Policy if enrolled for the [Plan Name] Medicare Part D Plan and eligible based on Employer's classification or guidelines.
 - a) Medicare eligible [by reason of age] Retirees;
 - b) [Medicare eligible [by reason of age] Retiree's legal spouses;]
 - c) [All Retirees who are covered under this Contract Holder's group health plan and who are under age 65. Retirees in this class are NOT eligible for coverage under this policy but may enroll their eligible spouse;]
 - d) [All widow/widowers of a deceased spouse who was an active employee or Retiree of the Contract Holder and who is entitled to Medicare [by reason of age];]
 - e) [A Retiree's child who is chiefly dependent upon the Retiree for support and maintenance and who is eligible for Medicare [by reason of age].]

2. **COVERAGE YEAR:** Begins on each [JANUARY 1ST] and continues for the next [12] consecutive months, and ends on [DECEMBER 31ST] of the [same] year.

3. **COVERAGE AND BENEFIT AMOUNTS:**

We will pay the amount of Total Allowed Costs incurred for Prescription Drugs, reduced by the amount paid by the underlying Medicare Part D plan, any pharmaceutical manufacturer discounts, and subject to:

	Tier	Retail [(31-day supply)]	Mail [(90-day supply)]	Retail [(90-day supply)]
[Deductible]	[\$0-325]]			
[Initial Coverage Limit]	Generic	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Preferred Brand	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Non-Preferred Brand	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Specialty	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
[Coverage Gap]	Generic	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Preferred Brand	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Non-Preferred Brand	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Specialty	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
[Catastrophic Phase]	Generic	Greater of [5% or [\$2.65]]		
	Brand	Greater of [5% or [\$6.60]]		

4. INSURED EFFECTIVE DATE: [The first of the month the Insured is effective for the [Plan Name] Part D Plan.]

5. PREMIUMS:

Premium Payable: Monthly Annual
 Contributory Non-Contributory]

Premium Amount: Employee Only \$ XX.XX
 Spouse Only \$ XX.XX]

GENERAL DEFINITIONS

“Brand” means a prescription drug that has no generic equivalent or a prescription drug that is the innovator or original formulation for which a generic drug equivalent exists.

“Catastrophic Phase” means the final layer of a Medicare Part D prescription drug plan where the True Out of Pocket Threshold has been met, as determined by Medicare each year, and Medicare and the Medicare Part D prescription drug plan provide enhanced coverage to the beneficiary.

{“Co-insurance” means a specified percentage (%) that an Insured is responsible for paying, each time the person has a prescription for covered drugs newly filled or renewed by a Provider, before benefits are payable under the policy.}

{“Co-pay” means a specified amount that an Insured is responsible for paying, each time the person has a prescription for covered drugs newly filled or renewed by a Provider, before benefits are payable under the policy. If the Total Allowed Cost less any pharmaceutical manufacturer discount for the Prescription Drug is less than the Co-pay, then the Insured will pay the lesser of the Total Allowed Cost less any pharmaceutical discount or the Co-pay for the drug.}

“Coverage Gap” means second layer of a Medicare Part D prescription drug plan that begins when you have incurred Medicare eligible expenses for prescription drugs equal to the Initial Coverage Limit and ends when the True Out-of-Pocket Threshold amount has been met.

{“Coverage Year” means a consecutive 12-month period described on the Schedule of Benefits.}

[“Deductible” means the deductible on this plan which is based on the standard Medicare Part D Deductible as adjusted annually.]

“Formulary” means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary includes Generic, Preferred Brand, Non-preferred Brand and Specialty Formulary Drugs.

“Generic Drug” means a drug that is identical or bioequivalent to a brand drug in dosage form, safety, strength, route of administration, quality, performance characteristics, intended use and is not protected by a patent. Not all Generic Drugs will be Formulary drugs.

“Initial Coverage Limit” means the initial layer of a Medicare Part D prescription drug plan, including satisfaction of the Deductible, if any. You pay a set amount until Your payments and the plan payments reach a certain total as determined by Medicare each year. Once this limit is reached, you enter the Coverage Gap.

“Insured” means the person for whom coverage is in effect under the policy.

“Medicare” means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

“Medicare Part D” is a Medicare program that partially subsidizes the costs of prescription drugs.

[“Non Part D Covered Prescription Drugs” means drugs that are defined by Medicare as ineligible under Medicare Part D and are optionally included in the Formulary (e.g. sexual dysfunction drugs).]

[“Non-Preferred Brand Drug” means a drug that is not listed as a Preferred Brand Drug on the Formulary drug list.]

[“Non-Preferred Generic Drug” means a drug that is not listed as a Preferred Generic Drug on the Formulary drug list.]

“Part D Covered Prescription Drugs” means drugs that are defined by Medicare as eligible under Medicare Part D and are included in the Formulary.

[“Preferred Brand Drug” means a Formulary drug that is within a select subset of Therapeutic Classes, which make up the Formulary drug list.]

[“Preferred Generic Drug” means a Formulary drug that is within a select subset of Therapeutic Classes, which make up the Formulary drug list.]

“Provider” means a person trained and licensed in the art of preparing and dispensing drugs.}

“Retiree” means a former employee of the Contract Holder who meets the employer’s eligibility classifications.

[“Specialty Drug” means certain a Formulary drug Drugs that is identified as a Specialty Drug due to its composition, storage requirements, methods of administration and/or cost.]

“Total Allowed Cost” means the ingredient cost plus dispensing fee plus sales tax.

“True Out-of-Pocket” means the drug costs that can be used to calculate an Insured’s coverage under Medicare Part D that count toward an Insured’s Medicare drug plan True Out-of-Pocket Threshold, as determined by Medicare each year. True Out-of-Pocket costs determine when an Insured exits the Coverage Gap and enters into the Catastrophic Coverage state of Medicare Part D prescription drug plan. It includes all payments for drugs listed on Insured’s plan’s Formulary.

“True Out-of Pocket Threshold” means the upper limit of the Coverage Gap as determined by Medicare. When the upper limit is reached, the Catastrophic Phase Begins.

INDIVIDUAL EFFECTIVE DATES

Insured – Individual insurance will become effective as indicated on the Schedule of Benefits.

An eligible person may [enroll or be enrolled] only [within 31 days after becoming eligible] [during an open enrollment period], unless otherwise indicated by the policy. Open enrollment period means a pre-determined term during which any eligible person who previously did not enroll for coverage under the policy, may enroll for coverage.

INDIVIDUAL TERMINATION DATES

Insured – Coverage for an Insured will end on the earliest of:

- a) the date the Insured is no longer eligible {unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid}; or
- b) any premium due date, if full payment for the Insured's coverage is not made within 31 days following the premium due date; or
- c) the date the policy terminates.

Termination will not affect a claim for benefits for covered charges that were incurred while the person was covered under this policy.

PRESCRIPTION DRUG EXPENSE BENEFITS

After satisfaction of any Deductible, we will pay the expense incurred by the Insured for Part D Covered Prescription Drugs [and Non-Part D Covered Prescription Drugs] newly filled or renewed by a Provider and subject to an other exclusions or limitations in the Policy.

Benefit will be paid up to the [applicable maximum], as shown on the Schedule of Benefits.

OTHER PROVISIONS APPLICABLE TO PRESCRIPTION DRUG EXPENSE BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare Part D program.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare Part D.

EXCLUSIONS

The Policy does not cover:

- a) any drug expense that is:
 - 1. not a Medicare Part D eligible drug expense; or
 - 2. beyond the limits imposed by Medicare for such expense; or
 - 3. excluded by name or specific description by Medicare; except as specifically provided under the Policy;
- b) any portion of a covered expense to the extent paid by Medicare;
- c) covered expenses incurred after coverage under the Policy terminates;
- d) {expenses used to meet any Co-pay or Co-insurance;}
- e) {expenses in excess of the percentages payable;}
- f) {any drugs prescribed or dispensed by a member of the Insured's immediate family or by the Contract Holder;}
- g) {drugs not requiring a prescription;}
- h) {drugs covered under a medical insurance plan}
- i) {drugs covered under a Workers' compensation plan;}
- j) {drugs not deemed to be medically necessary.}

PREMIUMS

Premiums are shown on the Schedule of Benefits. A person's coverage will not be affected by the Contract Holder's failure, due to clerical error, to remit premiums to us on time.

Rates are provided on a group basis. Premiums may be changed on any premium due date, on or after the first Policy Anniversary Date, within 31 days' advance notice in writing to the Contract Holder.

Grace Period: The Contract Holder has a 31-day grace period after each ensuing premium due date once the first premium has been paid. If a subsequent premium is not paid by the end of the grace period, coverage will end as of the premium due date. {If this happens, the Contract Holder will still owe us all premiums then due, including any premium due for the grace period or for any part of the grace period.}

CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within 31 days after a covered loss begins, or as soon as reasonably possible. Notice should include information that identifies the claimant and this policy.

Claim Forms: When we receive notice of claim, we will send forms for filing proof of loss to the claimant. If these forms are not sent within 15 day, the claimant will meet the proof of loss requirements if we are given, within 90 days, written proof of the nature and extent of the loss.

Proof of Loss: Written proof of loss must be given to us within 90 days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to us within 1 year after it is due, unless the Insured is legally incapable of doing so.

Time of Payment of Claim: Benefits for loss covered by the policy will be paid as soon as we receive proper written proof of such loss.

Payment of Claims: All benefits will be paid to the Insured, unless an Assignment of Benefits has been requested by the Insured. Any other benefits due and unpaid at the Insured's death will be paid to the Insured's estate. Any payment made by us in good faith pursuant to this provision will fully release us to the extent of such payment.

Legal Action: No legal action may be brought to recover on the policy before 60 days after written proof of loss has been furnished as required by the policy. No such action may be brought after 3 years from the time written proof of loss is required to be furnished.

GENERAL PROVISIONS

Entire Contract; Changes: The policy (including the application, endorsements and attached papers) is the entire contract. The enrollments of eligible persons for coverage (if any), are not a part of the policy; we may not use any statement contained in them to contest the policy or deny a claim. No change in the policy is valid unless it has been approved by one of our executive officers. Their approval must be attached to or endorsed on the policy. No agent may change the policy or waive any provision.

Conformity With State Law: If any part of the policy conflicts with the law of the state of delivery on the date the policy goes into effect, the policy is amended to meet the minimum requirements of such law.

Records Maintained; Examination and Audit: The Contract Holder or its agent will keep records showing essential facts of each person's coverage. We may examine these records at any time that the policy is in force, within 3 years after the policy expires, and later if claims are still pending.

Not in Lieu of Workers' Compensation: The policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

Termination of Policy: The Contract Holder may terminate the policy at any time on or after the first Policy Anniversary Date, by sending us written notice. The policy will be terminated on the date that we receive the notice or later if specified in the notice. We may terminate the policy at any time on or after the first Policy Anniversary Date, by sending the Contract Holder at least 31 days' prior written notice to its most recent address in our records. We will return pro-rata the unearned portion of the premiums, if any, that were paid. Termination will be without prejudice to a claim for covered drug expenses that are incurred while the policy is in force.

Certificate for the Insured: We will issue to the Contract Holder, for delivery to Insureds, a certificate of insurance containing the principal terms of the policy.

Stonebridge Life Insurance Company

A Stock Company

Home Office: Rutland, Vermont

Administrative Office: [520 Park Avenue, Baltimore, Maryland 21201]

Your insurance is issued under a contract between us, **STONEBRIDGE LIFE INSURANCE COMPANY**, and **The ABC Company**, (the Contract Holder).

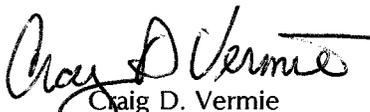
This is a Certificate of Insurance that explains your Prescription Drug Insurance under Group Policy Number [123456]. The Group Policy is issued to the Contract Holder named above. This is not the insurance contract. It does not waive or alter any terms of the Policy. The Group Policy is a legal contract. It may be inspected during business hours at the office of the Contract Holder.

EFFECTIVE DATE: This Certificate and the insurance provided by it become effective 12:01 A.M. Standard Time at the Contract Holder's address on the Effective Date shown on the Schedule.

This Certificate takes the place of any other Certificate previously issued to you under this Policy. This Certificate itself sets forth the rights and obligations of both you and the insurance company. It is therefore important that you **READ YOUR CERTIFICATE** carefully.

This coverage is subject to the exclusions, and to all other terms of this policy. This policy will be governed by the laws of the state in which it is delivered {and, to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any of its amendments}.

IN WITNESS WHEREOF, we have signed this policy at Rutland, Vermont.


Craig D. Vermie
Secretary


PRESIDENT

This is not a standardized Medicare Supplement Plan.

**GROUP SUPPLEMENTAL PRESCRIPTION DRUG BENEFIT POLICY
THIS CERTIFICATE PROVIDES LIMITED PRESCRIPTION DRUG BENEFITS.
READ IT CAREFULLY.**

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SCHEDULE OF BENEFITS

1. INSURED: [John Doe]

2. COVERAGE YEAR: Begins on each [JANUARY 1ST] and continues for the next [12] consecutive months, and ends on [DECEMBER 31ST] of the [same] year.

3. COVERAGE AND BENEFIT AMOUNTS:

We will pay the amount of Total Allowed Costs incurred for Prescription Drugs, reduced by the amount paid by the underlying Medicare Part D plan, any pharmaceutical manufacturer discounts, and subject to:

	Tier	Retail [(31-day supply)]	Mail [(90-day supply)]	Retail [(90-day supply)]
[Deductible]		[\$0-325]		
[Initial Coverage Limit]	Generic	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Preferred Brand	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Non-Preferred Brand	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Specialty	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
[Coverage Gap]	Generic	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Preferred Brand	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
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	Specialty	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
[Catastrophic Phase]	Generic	Greater of [5% or [\$2.65]]		
	Brand	Greater of [5% or [\$6.60]]		

4. INSURED EFFECTIVE DATE: [The first of the month You are effective for the [Plan Name] Part D Plan.]

5. PREMIUMS:

Premium Payable: Monthly Annual
 Contributory Non-Contributory]

Insured: Premium Amount:

GENERAL DEFINITIONS

“Brand” means a prescription drug that has no generic equivalent or a prescription drug that is the innovator or original formulation for which a generic drug equivalent exists.

“Catastrophic Phase” means the final layer of a Medicare Part D prescription drug plan where the True Out of Pocket Threshold has been met, as determined by Medicare each year, and Medicare and the Medicare Part D prescription drug plan provide enhanced coverage to the beneficiary.

{“Co-insurance” means a specified percentage (%) that you are responsible for paying, each time you have a prescription for covered drugs newly filled or renewed by a Provider, before benefits are payable under the policy.}

{“Co-pay” means a specified amount that you are responsible for paying, each time you have a prescription for covered drugs newly filled or renewed by a Provider, before benefits are payable under the policy. If the Total Allowed Cost less any pharmaceutical manufacturer discount for the Prescription Drug is less than the Co-pay, then You will pay the lesser of the Total Allowed Cost less any pharmaceutical discount or the Co-pay for the drug.}

“Coverage Gap” means second layer of a Medicare Part D prescription drug plan that begins when you have incurred Medicare eligible expenses for prescription drugs equal to the Initial Coverage Limit and ends when the True Out-of-Pocket Threshold amount has been met.

{“Coverage Year” means a consecutive 12-month period described on the Schedule of Benefits.}

[“Deductible” means the deductible on this plan which is based on the standard Medicare Part D Deductible as adjusted annually.]

“Formulary” means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary includes Generic, Preferred Brand, Non-preferred Brand and Specialty Formulary Drugs.

“Generic Drug” means a drug that is identical or bioequivalent to a brand drug in dosage form, safety, strength, route of administration, quality, performance characteristics, intended use and is not protected by a patent. Not all Generic Drugs will be Formulary drugs.

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“Medicare” means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

“Medicare Part D” is a Medicare program that partially subsidizes the costs of prescription drugs.

[“Non Part D Covered Prescription Drugs” means drugs that are defined by Medicare as ineligible under Medicare Part D and are optionally included in the Formulary (e.g. sexual dysfunction drugs).]

[“Non-Preferred Brand Drug” means a drug that is not listed as a Preferred Brand Drug on the Formulary drug list.]

[“Non-Preferred Generic Drug” means a drug that is not listed as a Preferred Generic Drug on the Formulary drug list.]

“Part D Covered Prescription Drugs” means drugs that are defined by Medicare as eligible under Medicare Part D and are included in the Formulary.

[“Preferred Brand Drug” means a Formulary drug that is within a select subset of Therapeutic Classes, which make up the Formulary drug list.]

[“Preferred Generic Drug” means a Formulary drug that is within a select subset of Therapeutic Classes, which make up the Formulary drug list.]

“Provider” means a person trained and licensed in the art of preparing and dispensing drugs.}

“Retiree” means a former employee of the Contract Holder who meets the employer’s eligibility classifications.

[“Specialty Drug” means certain a Formulary drug Drugs that is identified as a Specialty Drug due to its composition, storage requirements, methods of administration and/or cost.]

“Total Allowed Cost” means the ingredient cost plus dispensing fee plus sales tax.

“True Out-of-Pocket” means the drug costs that can be used to calculate Your coverage under Medicare Part D that count toward Your Medicare drug plan out-of-pocket threshold, as determined by Medicare each year. True Out-of-Pocket costs determine when you exit the Coverage Gap and enter into the Catastrophic Coverage state of Medicare Part D prescription drug plan. It includes all payments for drugs listed on your plan's Formulary.

“True Out-of Pocket Threshold” means the upper limit of the Coverage Gap as determined by Medicare. When the upper limit is reached, the Catastrophic Phase begins.

INDIVIDUAL EFFECTIVE DATES

Your insurance will become effective as indicated on the Schedule of Benefits.

INDIVIDUAL TERMINATION DATES

Your coverage will end on the earliest of:

- a) the date You are no longer eligible {unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid}; or
- b) any premium due date, if full payment for Your coverage is not made within 31 days following the premium due date; or
- c) the date the policy terminates.

Termination will not affect a claim for benefits for covered charges that were incurred while the person was covered under this policy.

PRESCRIPTION DRUG EXPENSE BENEFITS

After satisfaction of any Deductible, we will pay the expense incurred by You for Part D Covered Prescription Drugs [and Non-Part D Covered Prescription Drugs] newly filled or renewed by a Provider and subject to an other exclusions or limitations in the Policy.

Benefit will be paid up to the [applicable maximum], as shown on the Schedule of Benefits.

OTHER PROVISIONS APPLICABLE TO PRESCRIPTION DRUG EXPENSE BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare Part D program.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare Part D.

EXCLUSIONS

The Policy does not cover:

- a) any drug expense that is:
 1. not a Medicare Part D eligible drug expense; or
 2. beyond the limits imposed by Medicare for such expense; or
 3. excluded by name or specific description by Medicare; except as specifically provided under the Policy;
- b) any portion of a covered expense to the extent paid by Medicare;
- c) covered expenses incurred after coverage under the Policy terminates;
- d) {expenses used to meet any Co-pay or Coinsurance;}
- e) {expenses in excess of the percentages payable;}
- f) {any drugs prescribed or dispensed by a member of your immediate family or by the Contract Holder;}
- g) {drugs not requiring a prescription;}
- h) {drugs covered under a medical insurance plan}
- i) {drugs covered under a Workers' compensation plan;}
- j) {drugs not deemed to be medically necessary.}

PREMIUMS

Premiums are shown on the Schedule of Benefits and remitted by the Contract holder. Your coverage will not be affected by the Contract Holder's failure, due to clerical error, to remit premiums to us on time.

Rates are provided on a group basis. Premiums may be changed on any premium due date, on or after the first Policy Anniversary Date, within 31 days' advance notice in writing to the Contract Holder.

Grace Period: The Contract Holder has a 31-day grace period after each ensuing premium due date once the first premium has been paid. If a subsequent premium is not paid by the end of the grace period, coverage will end as of the premium due date. {If this happens, the Contract Holder will still owe us all premiums then due, including any premium due for the grace period or for any part of the grace period.}

CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within 31 days after a covered loss begins, or as soon as reasonably possible. Notice should include information that identifies the claimant and this policy.

Claim Forms: When we receive notice of claim, we will send forms for filing proof of loss to the claimant. If these forms are not sent within 15 day, the claimant will meet the proof of loss requirements if we are given, within 90 days, written proof of the nature and extent of the loss.

Proof of Loss: Written proof of loss must be given to us within 90 days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to us within 1 year after it is due, unless You are legally incapable of doing so.

Time of Payment of Claim: Benefits for loss covered by the policy will be paid as soon as we receive proper written proof of such loss.

Payment of Claims: All benefits will be paid to you, unless you have requested an Assignment of Benefits. Any other benefits due and unpaid at your death will be paid to Your estate. Any payment made by us in good faith pursuant to this provision will fully release us to the extent of such payment.

Legal Action: No legal action may be brought to recover on the policy before 60 days after written proof of loss has been furnished as required by the policy. No such action may be brought after 3 years form the time written proof of loss is required to be furnished.

GENERAL PROVISIONS

Conformity With State Law: If any part of the policy conflicts with the law of the state of delivery on the date the policy goes into effect, the policy is amended to meet the minimum requirements of such law.

Not in Lieu of Workers' Compensation: The policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

SERFF Tracking #:

CLTR-128764295

State Tracking #:**Company Tracking #:**

SLRX1000GP (11/12)

State:

Arkansas

Filing Company:

Stonebridge Life Insurance Company

TOI/Sub-TOI:

H17G Group Health - Prescription Drug/H17G.000 Health - Prescription Drug

Product Name:

Prescription Drug Part D Wrap Product

Project Name/Number:

Prescription Drug/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/15/2012
Comments:			
Attachment(s):			
Flesch Cert_signed by Morrow_11-13-12.pdf			
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/15/2012
Bypass Reason:	An application is not used, but rather a proposal.		
		Item Status:	Status Date:
Satisfied - Item:	Authorization to File	Approved-Closed	11/15/2012
Comments:			
Attachment(s):			
Authorization to File 2012.pdf			
		Item Status:	Status Date:
Satisfied - Item:	Merged documents	Approved-Closed	11/15/2012
Comments:			
Attachment(s):			
Merged Certificate.pdf Merged Policy.pdf			

FLESCH CERTIFICATION

I, Robert D. Morrow, Assistant Vice President, for Stonebridge Life Insurance Company, certify that the forms listed below satisfy the NAIC Model Bill standards of policy language simplification legislation.

Form Number	Form Title	Flesch Score
SLRX1000GP (11/12)	GROUP PRESCRIPTION DRUG BENEFIT POLICY	50.4
SLRX1000GC (11/12)	GROUP PRESCRIPTION DRUG BENEFIT CERFTIFICATE	51.6

Signature:  _____

Title: Assistant Vice President

Date: 11/13/12

Stonebridge Life Insurance Company
A Stock Company

Date: November 9, 2012
To: State Insurance Departments
Subject: Filing Authority for Coulter & Associates, Inc.
Re: Medicare Part D Wrap Product

Stonebridge Life Insurance Company has authorized Coulter & Associates, Inc., acting as our Contracts Consultants, to file products and correspond with your Department on our behalf.

Signature: _____



Printed Name: Robert D. Morrow, Jr. _____

Title: Assistant V.P. _____

Date: 11/9/12 _____

Stonebridge Life Insurance Company

A Stock Company

Home Office: Rutland, Vermont

Administrative Office: [520 Park Avenue, Baltimore, Maryland 21201]

~~You~~Your insurance is issued under a contract between us, **STONEBRIDGE LIFE INSURANCE COMPANY**, and **The ABC Company**, (the Contract Holder).

This is a Certificate of Insurance that explains your Prescription Drug Insurance under Group Policy Number [123456]. The Group Policy is issued to the Contract Holder named above. This is not the insurance contract. It does not waive or alter any terms of the Policy. The Group Policy is a legal contract. It may be inspected during business hours at the office of the Contract Holder.

EFFECTIVE DATE: This Certificate and the insurance provided by it become effective 12:01 A.M. Standard Time at the Contract Holder's address on the Effective Date shown on the Schedule.

This Certificate takes the place of any other Certificate previously issued to you under this Policy. This Certificate itself sets forth the rights and obligations of both you and the insurance company. It is therefore important that you READ YOUR CERTIFICATE carefully.

This coverage is subject to the exclusions, and to all other terms of this policy. This policy will be governed by the laws of the state in which it is delivered {and, to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any of its amendments}.

IN WITNESS WHEREOF, we have signed this policy at Rutland, Vermont.


Craig D. Vermie
Secretary


PRESIDENT

This is not a standardized Medicare Supplement Plan.

GROUP SUPPLEMENTAL PRESCRIPTION DRUG BENEFIT POLICY
THIS CERTIFICATE PROVIDES LIMITED PRESCRIPTION DRUG BENEFITS.
READ IT CAREFULLY.

SLRX1000GC (11/12)

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SCHEDULE OF BENEFITS

1. INSURED: [John Doe]

2. COVERAGE YEAR: Begins on each [JANUARY 1ST] and continues for the next [12] consecutive months, and ends on [DECEMBER 31ST] of the [same] year.

3. COVERAGE AND BENEFIT AMOUNTS:

~~Prescription Drug Expense Benefit~~

~~For Total Allowed Costs within the Coverage Gap, We will pay the amount we will pay for of Total Allowed Costs incurred for Prescription Drugs, reduced by the amount paid under by the underlying Prescription Drug Plan, if Medicare Part D plan, any, and pharmaceutical manufacturer discounts, if any, and subject to:~~

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- ~~• [the following Coinsurance of the Total Allowed Cost:~~
 - ~~Per Formulary Branded Prescription~~
 - ~~Preferred Formulary~~ ~~XX%~~
 - ~~Non-preferred Formulary~~ ~~XX%~~
 - ~~Per Non-Formulary Branded Prescription~~ ~~XX%~~
 - ~~Per Specialty Drug~~ ~~XX%~~
- ~~• [the following Co-payment of:~~
 - ~~Per Formulary Branded Prescription~~
 - ~~Preferred Formulary~~ ~~\$XX~~
 - ~~Non-preferred Formulary~~ ~~\$XX~~
 - ~~Per Non-Formulary Branded Prescription Co-pay~~ ~~\$XX~~
 - ~~Per Specialty Drug~~ ~~\$XX~~

-	Tier	Retail [(31-day supply)]	Mail [(90-day supply)]	Retail [(90-day supply)]
[Deductible]		[\$0-325]		
[Initial Coverage Limit]	Generic	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Preferred Brand	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Non-Preferred Brand	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Specialty	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
[Coverage Gap]	Generic	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Preferred Brand	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Non-Preferred Brand	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Specialty	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]

<u>Catastrophic Phase</u>	<u>Generic</u>	<u>Greater of [5% or [\$2.65]]</u>
	<u>Brand</u>	<u>Greater of [5% or [\$6.60]]</u>

4. INSURED EFFECTIVE DATE: [The first of the month You are effective for the ~~Medicare Generation Rx~~[Plan Name] Part D Plan.]

5. PREMIUMS:

Premium Payable: Monthly Annual

Contributory Non-Contributory]

Insured: Premium Amount:

GENERAL DEFINITIONS

~~“Brand Prescription Drug” means a prescription drug that has no generic drug equivalent or a prescription drug that is the innovator or original formulation for which a generic drug equivalent exists.~~

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~~“Catastrophic Phase” means the final layer of a Medicare Part D prescription drug plan where the True Out of Pocket Threshold has been met, as determined by Medicare each year, and Medicare and the Medicare Part D prescription drug plan provide enhanced coverage to the beneficiary.~~

~~{“Co-insurance” means a specified percentage (%) that you are responsible for paying, each time you have a prescription for covered drugs newly filled or renewed by a Provider, before benefits are payable under the policy.}~~

{“Co-pay” means a specified amount that you are responsible for paying, each time you have a prescription for covered drugs newly filled or renewed by a ~~Pharmacist~~Provider, before benefits are payable under the policy. If the Total Allowed Cost less any pharmaceutical manufacturer discount for the Prescription Drug is less than the Co-pay, then You will pay the lesser of the Total Allowed Cost less any pharmaceutical discount or the Co-pay for the drug.}

~~{“Co-insurance” means a specified percentage (%) that you are responsible for paying, each time you have a prescription for covered drugs newly filled or renewed by a Pharmacist, before benefits are payable under the policy.}~~

“Coverage Gap” means ~~the period~~second layer of ~~time under a~~ Medicare Part D prescription drug plan that begins when you have incurred Medicare eligible expenses for prescription drugs equal to the Initial Coverage Limit and ends when the True Out-of-Pocket Threshold amount has been met. ~~Once the True Out-of-Pocket Threshold amount is reached, you are no longer in the Coverage Gap and no further benefits are payable until the start of a new Coverage Year.~~

{“Coverage Year” means a consecutive 12-month period described on the Schedule of Benefits.}

~~“Prescriber” means any duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to perform the service for which claim is made.~~

~~{“Deductible” means the deductible on this plan which is based on the standard Medicare Part D Deductible as adjusted annually.}~~

“Formulary” means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary includes Generic, Preferred Brand, Non-preferred Brand and ~~non-preferred~~Specialty Formulary Drugs.}

~~“Generic Drug” means a drug that is identical or bioequivalent to a brand drug in dosage form, safety, strength, route of administration, quality, performance characteristics, intended use and is not protected by a patent. Not all Generic Drugs will be Formulary drugs.~~

“Initial Coverage Limit” means the ~~first part~~initial layer of a Medicare Part D prescription drug plan, including satisfaction of the Deductible, if any. You pay a set amount until Your payments -and the plan payments reach a certain total as determined by Medicare each year. Once this limit is reached, you enter the Coverage Gap.

~~{“In-Network Pharmacy” means a pharmacy that is a part of [the XYZ network of participating pharmacies].}~~

“Insured” means the person for whom coverage is in effect under the policy. You and Your refer to the Insured.

"Medicare" means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

"Medicare Part D" is a Medicare program that partially subsidizes the costs of prescription drugs.

~~("Out-of-Network Pharmacy" means a pharmacy that is not a part of [the XYZ network of participating pharmacies].)~~

~~"Pharmacist["Non Part D Covered Prescription Drugs" means drugs that are defined by Medicare as ineligible under Medicare Part D and are optionally included in the Formulary (e.g. sexual dysfunction drugs).]~~

~~["Non-Preferred Brand Drug" means a drug that is not listed as a Preferred Brand Drug on the Formulary drug list.]~~

~~["Non-Preferred Generic Drug" means a drug that is not listed as a Preferred Generic Drug on the Formulary drug list.]~~

~~"Part D Covered Prescription Drugs" means drugs that are defined by Medicare as eligible under Medicare Part D and are included in the Formulary.~~

~~["Preferred Brand Drug" means a Formulary drug that is within a select subset of Therapeutic Classes, which make up the Formulary drug list.]~~

~~["Preferred Generic Drug" means a Formulary drug that is within a select subset of Therapeutic Classes, which make up the Formulary drug list.]~~

~~"Provider" means a person trained and licensed in the art of preparing and dispensing drugs.)~~

"Retiree" means a former employee of the Contract Holder who meets the employer's eligibility classifications.

~~["Specialty Drug" means certain a Formulary drug Drugs that is identified as a Specialty Drug due to its composition, storage requirements, methods of administration and/or cost.]~~

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"Total Allowed Cost" means the ingredient cost plus dispensing fee plus sales tax.

"True Out-of-Pocket" means the drug costs that can be used to calculate Your coverage under Medicare Part D that count toward Your Medicare drug plan out-of-pocket threshold, as determined by Medicare each year. True Out-of-Pocket costs determine when you exit the Coverage Gap and enter into the Catastrophic Coverage state of Medicare Part D prescription drug plan. It includes all payments for drugs listed on your plan's Formulary ~~and purchased at an In-Network Pharmacy.~~

"True Out-of Pocket Threshold" means the upper limit of the Coverage Gap as determined by Medicare. When the upper limit is reached, ~~no further benefits are payable until the start of a new Coverage Year~~Catastrophic Phase begins.

INDIVIDUAL EFFECTIVE DATES

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Your insurance will become effective as indicated on the Schedule of Benefits.

INDIVIDUAL TERMINATION DATES

Your coverage will end on the earliest of:

- a) the date You are no longer eligible (unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid); or
- b) any premium due date, if full payment for Your coverage is not made within 31 days following the premium due date; or
- c) the date the policy terminates.

Termination will not affect a claim for benefits for covered charges that were incurred while the person was covered under this policy.

PRESCRIPTION DRUG EXPENSE BENEFITS

~~Once you enter After satisfaction of any Deductible, we will pay the Coverage Gap under Medicare Part D, we will pay~~ expense incurred by You for ~~Branded~~Part D Covered Prescription Drugs ~~[and Non-Part D Covered Prescription Drugs]~~ newly filled or renewed by a ~~Pharmacist~~Provider and subject to the amounts shown in the Schedule of Benefits. ~~Subject to any an~~ other exclusions or limitations in the Policy, ~~in order to be covered, the drug must be:~~

- ~~a) a drug covered under Medicare Part D unless otherwise specifically covered herein;~~
- ~~b) listed in the Formulary as utilized by [the XYZ network]; and~~
- ~~c) prescribed by a Prescriber.~~

Benefit will be paid up to the [applicable maximum], as shown on the Schedule of Benefits.

OTHER PROVISIONS APPLICABLE TO PRESCRIPTION DRUG EXPENSE BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare Part D program.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare Part D.

EXCLUSIONS

The Policy does not cover:

- a) any drug expense that is:
 - 1. not a Medicare Part D eligible drug expense; or
 - 2. beyond the limits imposed by Medicare for such expense; or
 - ~~3.~~ excluded by name or specific description by Medicare;
 - 3. except as specifically provided under the Policy;
- b) any portion of a covered expense to the extent paid by Medicare;
- c) covered expenses incurred after coverage under the Policy terminates;
- d) {expenses used to meet any Co-pay or Coinsurance;}
- e) {expenses in excess of the percentages payable;}

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- f) {any drugs prescribed or dispensed by a member of your immediate family or by the Contract Holder;}
- g) {drugs not requiring a prescription;}
- h) {drugs covered under a medical insurance plan}
- i) {drugs covered under a Workers' compensation plan;}
- j) {drugs not deemed to be medically necessary.}

PREMIUMS

Premiums are shown on the Schedule of Benefits and remitted by the Contract holder. Your coverage will not be affected by the Contract Holder's failure, due to clerical error, to remit premiums to us on time.

Rates are provided on a group basis. Premiums may be changed on any premium due date, on or after the first Policy Anniversary Date, within 31 days' advance notice in writing to the Contract Holder.

Grace Period: The Contract Holder has a 31-day grace period after each ensuing premium due date once the first premium has been paid. If a subsequent premium is not paid by the end of the grace period, coverage will end as of the premium due date. {If this happens, the Contract Holder will still owe us all premiums then due, including any premium due for the grace period or for any part of the grace period.}

CLAIM PROVISIONS

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Notice of Claim: Written notice of claim must be given within 31 days after a covered loss begins, or as soon as reasonably possible. Notice should include information that identifies the claimant and this policy.

Claim Forms: When we receive notice of claim, we will send forms for filing proof of loss to the claimant. If these forms are not sent within 15 day, the claimant will meet the proof of loss requirements if we are given, within 90 days, written proof of the nature and extent of the loss.

Proof of Loss: Written proof of loss must be given to us within 90 days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to us within 1 year after it is due, unless You are legally incapable of doing so.

Time of Payment of Claim: Benefits for loss covered by the policy will be paid as soon as we receive proper written proof of such loss.

Payment of Claims: All benefits will be paid to you, unless you have requested an Assignment of Benefits. Any other benefits due and unpaid at your death will be paid to Your estate. Any payment made by us in good faith pursuant to this provision will fully release us to the extent of such payment.

Legal Action: No legal action may be brought to recover on the policy before 60 days after written proof of loss has been furnished as required by the policy. No such action may be brought after 3 years form the time written proof of loss is required to be furnished.

GENERAL PROVISIONS

Conformity With State Law: If any part of the policy conflicts with the law of the state of delivery on the date the policy goes into effect, the policy is amended to meet the minimum requirements of such law.

Not in Lieu of Workers' Compensation: The policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

Stonebridge Life Insurance Company

A Stock Company

Home Office: Rutland, Vermont

Administrative Office: [520 Park Avenue, Baltimore, Maryland 21201]

This is a contract between us, **STONEBRIDGE LIFE INSURANCE COMPANY**, and **The ABC Company**, (the Contract Holder).

Policy Number: [012345]

Policy Effective Date: [01/01/11]

Policy Anniversary Date: [01/01]

Policy Term: This policy will go into effect on the Policy Effective Date. All periods of insurance for a Coverage Person begin and end at 12:01 A.M. Standard Time at the Contract Holder's address. Unless this policy is ended by the Contract Holder or us (see "Termination of Policy" in GENERAL PROVISIONS), it may be renewed by payment of the required premiums, at the rates in effect on each premium due date.

Scope of Coverage: In exchange for the payment of premiums, as described in PREMIUMS, we agree to pay benefits to all eligible persons covered for benefits described in PRESCRIPTION DRUG EXPENSE BENEFIT.

This coverage is subject to the exclusions, and to all other terms of this policy. This policy will be governed by the laws of the state in which it is delivered {and, to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any of its amendments}.

IN WITNESS WHEREOF, we have signed this policy at Rutland, Vermont.


Craig D. Vermie
Secretary


PRESIDENT

This is not a standardized Medicare Supplement Plan.

GROUP SUPPLEMENTAL PRESCRIPTION DRUG BENEFIT POLICY
THIS POLICY PROVIDES LIMITED PRESCRIPTION DRUG BENEFITS.
READ IT CAREFULLY.

| **SLRX1000GP (11/12)**

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SCHEDULE OF BENEFITS

1. ELIGIBILITY: The following persons are eligible for insurance under this Policy if enrolled for the ~~[Plan Name] Medicare - Generation - RX~~ Medicare Part D Plan and eligible based on Employer's classification or guidelines.
- a) Medicare eligible [by reason of age] Retirees;
 - b) [Medicare eligible [by reason of age] Retiree's legal spouses;]
 - c) [All Retirees who are covered under this Contract Holder's group health plan and who are under age 65. Retirees in this class are NOT eligible for coverage under this policy but may enroll their eligible spouse;]
 - d) [All widow/widowers of a deceased spouse who was an active employee or Retiree of the Contract Holder and who is entitled to Medicare [by reason of age];]
 - e) [A Retiree's child who is chiefly dependent upon the Retiree for support and maintenance and who is eligible for Medicare [by reason of age].]
2. COVERAGE YEAR: Begins on each [JANUARY 1ST] and continues for the next [12] consecutive months, and ends on [DECEMBER 31ST] of the [same] year.}
3. COVERAGE AND BENEFIT AMOUNTS:

~~We will pay — [— Prescription Drug Expense Benefit~~

~~For Total Allowed Costs within the Coverage Gap, the amount of we will pay for Total Allowed Costs incurred for Prescription Drugs, reduced by the amount paid by under the underlying Medicare Part D plan, Prescription Drug Plan, if any, and pharmaceutical manufacturer discounts, if any, and subject to:~~

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-	Tier	Retail [(31-day supply)]	Mail [(90-day supply)]	Retail [(90-day supply)]
[Deductible]		[\$0-325]		
[Initial Coverage Limit]	Generic	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Preferred Brand	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Non-Preferred Brand	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Specialty	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
[Coverage Gap]	Generic	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Preferred Brand	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Non-Preferred Brand	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]
	Specialty	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]	[\$XX co-pay or XX% co-insurance]

<u>Catastrophic Phase</u>	<u>Generic</u>	<u>Greater of [5% or [\$2.65]]</u>
	<u>Brand</u>	<u>Greater of [5% or [\$6.60]]</u>

- ~~[the following Co-insurance of the Total Allowed Cost:~~
 - ~~Per Formulary Branded Prescription~~
 - ~~Preferred Formulary~~ ~~XX%~~
 - ~~Non-preferred Formulary~~ ~~XX%~~
 - ~~Per Non-Formulary Branded Prescription~~ ~~XX%~~
 - ~~Per Specialty Drug~~ ~~XX%~~
- ~~[the following Co-payment of:~~
 - ~~Per Formulary Branded Prescription~~
 - ~~Preferred Formulary~~ ~~\$XX~~
 - ~~Non-preferred Formulary~~ ~~\$XX~~
 - ~~Per Non-Formulary Branded Prescription Co-pay~~ ~~\$XX~~
 - ~~Per Specialty Drug~~ ~~\$XX]~~

4. INSURED EFFECTIVE DATE: [The first of the month the Insured is effective for the Plan Name Medicare Generation Rx Part D Plan.]

5. PREMIUMS:

Premium Payable: Monthly Annual
 Contributory Non-Contributory]

Premium Amount: Employee Only \$ XX.XX
 Spouse Only \$ XX.XX]

GENERAL DEFINITIONS

~~“Branded Prescription Drug” means a prescription drug that has no generic drug equivalent or a prescription drug that is the innovator or original formulation for which a generic drug equivalent exists.~~

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~~“Catastrophic Phase” means the final layer of a Medicare Part D prescription drug plan where the True Out of Pocket Threshold has been met, as determined by Medicare each year, and Medicare and the Medicare Part D prescription drug plan provide enhanced coverage to the beneficiary.~~

~~“Co-insurance” means a specified percentage (%) that an Insured is responsible for paying, each time the person has a prescription for covered drugs newly filled or renewed by a Provider, before benefits are payable under the policy.~~

“Co-pay” means a specified amount that an Insured is responsible for paying, each time the person has a prescription for covered drugs newly filled or renewed by a ~~Provider~~Pharmacist, before benefits are payable under the policy. If the Total Allowed Cost less any pharmaceutical manufacturer discount for the Prescription Drug is less than the Co-pay, then the Insured will pay the lesser of the Total Allowed Cost less any pharmaceutical discount or the Co-pay for the drug.

~~“Co-insurance” means a specified percentage (%) that an Insured is responsible for paying, each time the person has a prescription for covered drugs newly filled or renewed by a Pharmacist, before benefits are payable under the policy.~~

“Coverage Gap” means ~~second layer~~the period of ~~atime under~~ Medicare Part D ~~prescription drug plan~~ that begins when ~~you have an Insured has~~ incurred Medicare eligible expenses for prescription drugs equal to the Initial Coverage Limit and ends when the True Out-of-Pocket Threshold amount has been met. ~~Once the True Out-of-Pocket Threshold amount is reached, the Insured is no longer in the Coverage Gap and no further benefits are payable until the start of a new Coverage Year.~~

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“Coverage Year” means a consecutive 12-month period described on the Schedule of Benefits.”

~~“Deductible” means the deductible on this plan which is based on the standard Medicare Part D Deductible as adjusted annually.” “Prescriber” means any duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to perform the service for which claim is made.~~

“Formulary” means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary includes ~~Generic, Preferred Brand, Non-preferred Brand and Specialty~~and ~~non-preferred~~ Formulary Drugs.

~~“Generic Drug” means a drug that is identical~~“Initial Coverage Limit” means the first part of a Medicare prescription drug plan. The Insured pays a set amount until his or ~~bioequivalent to a brand drug in dosage form, safety, strength, route of administration, quality, performance characteristics, intended use and is not protected by a patent. Not all Generic Drugs will be Formulary drugs.~~

“Initial Coverage Limit” means the initial layer of a Medicare Part D prescription drug plan, including ~~satisfaction of the Deductible, if any. You pay a set amount until Your~~her payments -and the plan payments reach a certain total as determined by Medicare each year. Once this limit is reached, ~~you enter~~the Insured enters the Coverage Gap.

~~“In-Network Pharmacy” means a pharmacy that is a part of [the XYZ network of participating pharmacies].~~

“Insured” means the person for whom coverage is in effect under the policy.

“Medicare” means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

"Medicare Part D" is a Medicare program that partially subsidizes the costs of prescription drugs.

["Non Part D Covered Prescription Drugs" means drugs that are defined by Medicare as ineligible under Medicare Part D and are optionally included in the Formulary (e.g. sexual dysfunction drugs).]

["Non-Preferred Brand Drug" means a drug that is not listed as a Preferred Brand Drug on the Formulary drug list.]

["Non-Preferred Generic Drug" means a drug that is not listed as a Preferred Generic Drug on the Formulary drug list.]

"Part D Covered Prescription Drugs" means drugs that are defined by Medicare as eligible under Medicare Part D and are included in the Formulary.

["Preferred Brand Drug" means a Formulary drug that is within a select subset of Therapeutic Classes, which make up the Formulary drug list.]

["Preferred Generic Drug" means a Formulary drug that is within a select subset of Therapeutic Classes, which make up the Formulary drug list.]

~~["Provider{"Out-of-Network Pharmacy" means a pharmacy that is not a part of [the XYZ network of participating pharmacies].}~~

~~"Pharmacist" means a person trained and licensed in the art of preparing and dispensing drugs.)~~

"Retiree" means a former employee of the Contract Holder who meets the employer's eligibility classifications.

["Specialty Drug" means certain a Formulary drug Drugs that is identified as a Specialty Drug due to its composition, storage requirements, methods of administration and/or cost.]

"Total Allowed Cost" means the ingredient cost plus dispensing fee plus sales tax.

"True Out-of-Pocket" means the drug costs that can be used to calculate an Insured's coverage under Medicare Part D that count toward an Insured's Medicare drug plan True Out-of-Pocket Threshold, as determined by Medicare each year. True Out-of-Pocket costs determine when an Insured exits the Coverage Gap and enters into the Catastrophic Coverage state of Medicare Part D prescription drug plan. It includes all payments for drugs listed on Insured's plan's Formulary ~~and purchased at an In-Network Pharmacy.~~

"True Out-of Pocket Threshold" means the upper limit of the Coverage Gap as determined by Medicare. When the upper limit is reached, ~~no further benefits are payable until the Catastrophic Phase Begins start of a new Coverage Year.~~

INDIVIDUAL EFFECTIVE DATES

Insured – Individual insurance will become effective as indicated on the Schedule of Benefits.

An eligible person may [enroll or be enrolled] only [within {31 days after becoming eligible}] ~~[or during an open enrollment period]~~, unless otherwise indicated by the policy. Open enrollment period means a pre-determined term during which any eligible person who previously did not enroll for coverage under the policy, may enroll for coverage.

INDIVIDUAL TERMINATION DATES

Insured – Coverage for an Insured will end on the earliest of:

- a) the date the Insured is no longer eligible {unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid}; or
- b) any premium due date, if full payment for the Insured's coverage is not made within 31 days following the premium due date; or
- c) the date the policy terminates.

Termination will not affect a claim for benefits for covered charges that were incurred while the person was covered under this policy.

PRESCRIPTION DRUG EXPENSE BENEFITS

~~After satisfaction of any Deductible, we will pay~~ ~~Once an Insured enters the Coverage Gap under Medicare Part D, we will pay~~ expense incurred by the Insured for ~~Part D Covered~~**Branded** Prescription Drugs ~~[and Non-Part D Covered Prescription Drugs]~~ newly filled or renewed by a ~~Provider and~~**Pharmacist** subject to ~~an the amounts shown in the Schedule of Benefits.~~ ~~Subject to any other exclusions or limitations in the Policy,~~ **in order to be covered, the drug must be:**

- ~~a) a drug covered under Medicare Part D unless otherwise specifically covered herein;~~
- ~~b) listed in the Formulary as utilized by [the XYZ network]; and~~
- ~~c) prescribed by a Prescriber.~~

Benefit will be paid up to the [applicable maximum], as shown on the Schedule of Benefits.

OTHER PROVISIONS APPLICABLE TO PRESCRIPTION DRUG EXPENSE BENEFITS

~~The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare Part D program.~~

~~Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare Part D.~~

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EXCLUSIONS

The Policy does not cover:

- a) any drug expense that is:
 - 1. not a Medicare Part D eligible drug expense; or
 - 2. beyond the limits imposed by Medicare for such expense; or
 - 3. excluded by name or specific description by Medicare;

 except as specifically provided under the Policy;
- b) any portion of a covered expense to the extent paid by Medicare;
- c) covered expenses incurred after coverage under the Policy terminates;
- d) {expenses used to meet any Co-pay or Co-insurance;}
- e) {expenses in excess of the percentages payable;}
- f) {any drugs prescribed or dispensed by a member of the Insured's immediate family or by the Contract Holder;}
- g) {drugs not requiring a prescription;}

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- h) {drugs covered under a medical insurance plan}
- i) {drugs covered under a Workers' compensation plan;}
- j) {drugs not deemed to be medically necessary.}

PREMIUMS

Premiums are shown on the Schedule of Benefits. ~~Premium must be paid to us on or before the premium due date (and not more than [31 days] after the effective date of the eligible person's coverage).~~ A person's coverage will not be affected by the Contract Holder's failure, due to clerical error, to remit premiums to us on time.

Rates are provided on a group basis. Premiums may be changed on any premium due date, on or after the first Policy Anniversary Date, within 31 days' advance notice in writing to the Contract Holder.

Grace Period: The Contract Holder has a 31-day grace period after each ensuing premium due date once the first premium has been paid. If a subsequent premium is not paid by the end of the grace period, coverage will end as of the premium due date. {If this happens, the Contract Holder will still owe us all premiums then due, including any premium due for the grace period or for any part of the grace period.}

CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within 31 days after a covered loss begins, or as soon as reasonably possible. Notice should include information that identifies the claimant and this policy.

Claim Forms: When we receive notice of claim, we will send forms for filing proof of loss to the claimant. If these forms are not sent within 15 day, the claimant will meet the proof of loss requirements if we are given, within 90 days, written proof of the nature and extent of the loss.

Proof of Loss: Written proof of loss must be given to us within 90 days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to us within 1 year after it is due, unless the Insured is legally incapable of doing so.

Time of Payment of Claim: Benefits for loss covered by the policy will be paid as soon as we receive proper written proof of such loss.

Payment of Claims: All benefits will be paid to the Insured, unless an Assignment of Benefits has been requested by the Insured. Any other benefits due and unpaid at the Insured's death will be paid to the Insured's estate. Any payment made by us in good faith pursuant to this provision will fully release us to the extent of such payment.

Legal Action: No legal action may be brought to recover on the policy before 60 days after written proof of loss has been furnished as required by the policy. No such action may be brought after 3 years form the time written proof of loss is required to be furnished.

GENERAL PROVISIONS

Entire Contract; Changes: The policy (including the application, endorsements and attached papers) is the entire contract. The enrollments of eligible persons for coverage (if any), are not a part of the policy; we may not use any statement contained in them to contest the policy or deny a claim. No change in the

policy is valid unless it has been approved by one of our executive officers. Their approval must be attached to or endorsed on the policy. No agent may change the policy or waive any provision.

Conformity With State Law: If any part of the policy conflicts with the law of the state of delivery on the date the policy goes into effect, the policy is amended to meet the minimum requirements of such law.

Records Maintained; Examination and Audit: The Contract Holder or its agent will keep records showing essential facts of each person's coverage. We may examine these records at any time that the policy is in force, within 3 years after the policy expires, and later if claims are still pending.

Not in Lieu of Workers' Compensation: The policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

Termination of Policy: The Contract Holder may terminate the policy at any time on or after the first Policy Anniversary Date, by sending us written notice. The policy will be terminated on the date that we receive the notice or later if specified in the notice. We may terminate the policy at any time on or after the first Policy Anniversary Date, by sending the Contract Holder at least 31 days' prior written notice to its most recent address in our records. We will return pro-rata the unearned portion of the premiums, if any, that were paid. Termination will be without prejudice to a claim for covered drug expenses that are incurred while the policy is in force.

Certificate for the Insured: We will issue to the Contract Holder, for delivery to Insureds, a certificate of insurance containing the principal terms of the policy.