

SERFF Tracking Number: ZURC-125675974 State: Arkansas
Filing Company: Zurich American Insurance Company State Tracking Number: 39184
Company Tracking Number: AR-AH-26876
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: AR-AH-26876 Policy Form Fing to include Notice
Project Name/Number: AR-AH-26876 Policy Form Fing to include Notice/AR-AH-26876

Filing at a Glance

Company: Zurich American Insurance Company

Product Name: AR-AH-26876 Policy Form Fing SERFF Tr Num: ZURC-125675974 State: ArkansasLH
to include Notice

TOI: H21 Health - Other

SERFF Status: Closed

State Tr Num: 39184

Sub-TOI: H21.000 Health - Other

Co Tr Num: AR-AH-26876

State Status: Withdrawn

Filing Type: Form

Co Status: Not Applicable

Reviewer(s): Rosalind Minor

Author: Linda Kulpa

Disposition Date: 06/04/2008

Date Submitted: 06/02/2008

Disposition Status: Withdrawn

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: AR-AH-26876 Policy Form Fing to include Notice

Status of Filing in Domicile: Authorized

Project Number: AR-AH-26876

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Blanket

Filing Status Changed: 06/04/2008

State Status Changed: 06/04/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Based on Bulletin No. 6-2008 issued by the AR DOI on April 3, 2008, we must file the revised Stop Loss Policy as we are not required to include the Notice in the Stop Loss Application used in Arkansas until January 1, 2009 and AR has already approved the original Stop Loss Policy form.

Company and Contact

Filing Contact Information

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Linda Kulpa, Filing Analyst linda.kulpa@zurichna.com
1400 American Lane (847) 605-3763 [Phone]
Schaumburg, IL 60196 (847) 605-7768[FAX]

Filing Company Information

Zurich American Insurance Company CoCode: 16535 State of Domicile: New York
1400 American Lane Group Code: 212 Company Type:
Schaumburg, IL 60102 Group Name: State ID Number:
(847) 605-6000 ext. [Phone] FEIN Number: 36-4233459

SERFF Tracking Number: ZURC-125675974 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation: revised policy form filing
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Zurich American Insurance Company	\$20.00	06/02/2008	20619680

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Withdrawn	Rosalind Minor	06/04/2008	06/04/2008

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to Withdraw Filing	Note To Reviewer	Linda Kulpa	06/03/2008	06/03/2008

SERFF Tracking Number: *ZURC-125675974* *State:* *Arkansas*
Filing Company: *Zurich American Insurance Company* *State Tracking Number:* *39184*
Company Tracking Number: *AR-AH-26876*
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Disposition

Disposition Date: 06/04/2008

Implementation Date:

Status: Withdrawn

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ZURC-125675974 State: Arkansas
 Filing Company: Zurich American Insurance Company State Tracking Number: 39184
 Company Tracking Number: AR-AH-26876
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Withdrawn	Yes
Supporting Document	Application	Withdrawn	Yes
Supporting Document	Health - Actuarial Justification	Withdrawn	Yes
Supporting Document	Outline of Coverage	Withdrawn	Yes
Form	Stop Loss Policy Form	Withdrawn	Yes

SERFF Tracking Number: *ZURC-125675974* *State:* *Arkansas*
Filing Company: *Zurich American Insurance Company* *State Tracking Number:* *39184*
Company Tracking Number: *AR-AH-26876*
TOI: *H21 Health - Other* *Sub-TOI:* *H21.000 Health - Other*
Product Name: *AR-AH-26876 Policy Form Fing to include Notice*
Project Name/Number: *AR-AH-26876 Policy Form Fing to include Notice/AR-AH-26876*

Note To Reviewer

Created By:

Linda Kulpa on 06/03/2008 03:43 PM

Subject:

Request to Withdraw Filing

Comments:

Dear Rosalinda,

Please withdraw this filing at your earliest convenience.

Regards,

Linda Kulpa

SERFF Tracking Number: ZURC-125675974 State: Arkansas
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Form Schedule

Lead Form Number: U-MSL-500-A AR (10/07)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Withdrawn	U-MSL-500-A AR (10/07)	Policy/Cont ract/Fraternal Certificate	Stop Loss Policy	Revised	Replaced Form #: U- 42 MSL-500-A CW (10/07) Previous Filing #: CW-AH-26876		5-30-08 U-MSL-500-A AR - ZAIC Stop Loss Policy.pdf

Stop Loss Policy



Zurich American Insurance Company

This **Policy** is issued to

Policyholder: [ABC Company including the following companies]
Policy Number: [123456]
Effective Date: From: [January 1, 2001] To: [December 31, 2001]
12:01 A.M. Standard Time at the Address indicated in SECTION I

The **Company** agrees to reimburse the **Policyholder** for certain **Plan Benefits** the **Policyholder** has provided under a self-funded benefit plan (**Plan**). Such reimbursement will be subject to all the terms and conditions of this **Policy**.

This **Policy** is issued in consideration of:

- (1) the application made by the **Policyholder**; and
- (2) the payment of the initial premium on the Effective Date of this **Policy**; and
- (3) the payment of all subsequent premiums when due; and
- (4) the continual compliance by the **Policyholder** with all the terms and conditions of this **Policy**.

This **Policy** is governed by the laws of the State of Arkansas.

The **Policyholder** may cancel this coverage within [ten (10)] days after receipt of the Master **Policy** by returning it to the **Company** or the Agent. If it is returned for cancellation, the **Company** will refund any premiums paid. This coverage will be void.

In Witness Whereof, the **Company** caused this **Policy** to be executed and attested, and if required by state law, this **Policy** shall not be valid unless countersigned by its authorized representative.

The provisions on the following pages are a part of this **Policy**.

Licensed Resident Agent _____
(if required by law in this state)

A handwritten signature in cursive script that reads "Louis J. Mannello Jr.".

Louis J. Mannello, Jr.
President
Zurich American Insurance Company

A handwritten signature in cursive script that reads "David A. Bowers".

David A. Bowers
Corporate Secretary
Zurich American Insurance Company

This **Policy** is Non-Participating

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SECTION I

[RENEWAL] APPLICATION FOR STOP LOSS INSURANCE COVERAGE

Applicant (Policyholder): _____ Proposed Effective Date: _____

Address: _____ Initial Premium Deposit: \$_____

City, State, Zip Code: _____ Telephone Number: (____) _____

Coverage Applied For:

SECTION II

SCHEDULE OF STOP LOSS INSURANCE

Enrollment (Covered Units) at Effective Date: [Employees] [Single____] [Family____]

Policy Period from [January 1, 2001] through [December 31, 2001]

Minimum number of lives and/or participation: []

SPECIFIC STOP LOSS

Specific Coverage: Yes No

Specific Deductible per Covered Person: [\$100,000]

Lifetime Limit of Liability per Covered Person: [\$900,000]

- Claims Basis: Incurred and Paid [12/12]
 Run-In [15/12]
 Run-Out [12/15]
 Paid
 [Other _____]

Benefit Period: Eligible Plan Benefits Incurred from [January 1, 2001] through [December 31, 2001] and Paid from [January 1, 2001] through [December 31, 2001]

Specific Terminal Liability: Yes No

[It is hereby agreed and understood that the Specific Stop Loss Coverage selected does not provide reimbursement to the Policyholder for any Plan Benefits Incurred prior to the beginning of the Benefit Period or, for any Plan Benefits Paid after the Benefit Period has ended. Only Plan Benefits that are both Incurred and Paid by the Policyholder within the [twelve (12)] month Policy Period are reimbursable under the Specific Stop Loss Coverage selected.]

[It is hereby agreed and understood that the Specific Stop Loss Coverage selected does not provide reimbursement to the Policyholder for any Plan Benefits which are not Paid within the current Benefit Period. Only Plan Benefits that are both Incurred and Paid by the Policyholder within the Benefit Period are reimbursable under the Specific Stop Loss Coverage selected.]

Specific Percentage Reimbursable: [100%]

[Plan Benefits for treatment rendered at the Policyholder's facilities (Domestic Plan Benefits): [80%]
Plan Benefits for treatment rendered at outside facilities (Foreign Plan Benefits): [100%]]

Specific Advance Funding: Yes No

[Plan Benefits Incurred prior to the Policy Period will be limited to \$_____]

[Aggregating Specific Deductible: \$_____]

AGGREGATE STOP LOSS

Aggregate Coverage: Yes No

Claims Basis: **Incurred and Paid** [12/12]
 Run-In [15/12]
 Run-Out [12/15]
 Paid
 [Other _____]

Benefit Period: Eligible **Plan Benefits** **Incurred** from [January 1, 2001] through [December 31, 2001]
and **Paid** from [January 1, 2001] through [December 31, 2001]

Aggregate Terminal Liability: Yes No

[It is hereby agreed and understood that the Aggregate Stop Loss Coverage selected does not provide reimbursement to the **Policyholder** for any **Plan Benefits Incurred** prior to the beginning of the **Benefit Period** or, for any **Plan Benefits Paid** after the **Benefit Period** has ended. Only **Plan Benefits** that are both **Incurred** and **Paid** by the **Policyholder** within the [twelve (12)] month **Policy Period** are reimbursable under the Aggregate Stop Loss Coverage selected.]

[It is hereby agreed and understood that the Aggregate Stop Loss Coverage selected does not provide reimbursement to the **Policyholder** for any **Plan Benefits** which are not **Paid** within the current **Benefit Period**. Only **Plan Benefits** that are both **Incurred** and **Paid** by the **Policyholder** within the **Benefit Period** are reimbursable under the Aggregate Stop Loss Coverage selected.]

Aggregate **Percentage Reimbursable:** [100%]

[Plan Benefits for treatment rendered at the **Policyholder's** facilities (Domestic **Plan Benefits**): [80%]
Plan Benefits for treatment rendered at outside facilities (Foreign **Plan Benefits**): [100%]

Monthly Aggregate **Deductible** Factors: [\$275.00 Employee/Composite] [\$150.00 Single] [\$350.00 Family]

Minimum **Annual Aggregate Deductible:** [\$900,000] based on number of initial **Covered Units** multiplied by the number of months in the **Policy Period** multiplied by [90%] multiplied by the corresponding Monthly Aggregate **Deductible** Factors

Annual Aggregate Deductible for any one **Policy Period** means the greater of:

- (1) The cumulative monthly total of **Covered Units** multiplied by the Monthly Aggregate **Deductible** Factors; or
- (2) The Minimum **Annual Aggregate Deductible**

Limit of Liability for the **Policy Period:** [\$1,000,000]
Loss Limit per **Covered Person** for the **Policy Period:** [\$ 100,000]

Monthly Aggregate Accommodation: Yes No

[Plan Benefits Incurred prior to the **Policy Period** will be limited to \$ _____]

PREMIUMS

Specific: [Monthly] [\$275.00 Employee] [\$150.00 Single] [\$350.00 Family]
[Minimum Annual Specific Premium:] [\$50,000]
[Specific Terminal Liability:] [Monthly] [\$275.00 Employee] [\$150.00 Single] [\$350.00 Family]

Aggregate: [Monthly] [\$2.75 Employee] [\$5,000 Annual]
[Monthly Aggregate Accommodation:] [\$2.00 Employee]
[Aggregate Terminal Liability:] [\$1.00 Employee]

PLAN BENEFITS INCLUDED

Specific: Medical
 Free Standing Drug Program
 Other _____

Aggregate: Medical
 Free Standing Drug Program
 Dental
 Vision
 Other _____

ENDORSEMENTS INCLUDED

[Monthly Aggregate Accommodation] [Aggregate Terminal Liability] [Specific Terminal Liability] [Other]

Third Party Administrator: _____

If coverage is accepted, this SCHEDULE OF STOP LOSS INSURANCE will become a part of the **Policy**.

INSURANCE FRAUD WARNING

[Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading, is guilty of insurance fraud and is subject to criminal and/or civil penalties.]

The applicant hereby applies for Stop Loss Insurance Coverage and:

1. Represents that the answers included in this Application for Stop Loss Insurance Coverage have been reviewed and are true and complete; and
2. Understands and agrees that the insurance applied for shall not become effective until the Application for Stop Loss Insurance Coverage is approved by the **Company** and the initial premium deposit is received; and
3. Agrees that if the insurance applied for is approved by the **Company**, the applicant will pay all premiums due after the effective date of the insurance, including any premiums which may accumulate between the effective date of the insurance and the date the **Policy** is issued.

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

This Application for Stop Loss Insurance Coverage, as it may be amended, will become part of the **Policy**, if issued.

Signed at _____ this _____ day of _____ 20_____

Signed by _____ Title _____

FOR HOME OFFICE USE ONLY

Approved: Yes No By: _____ Date: _____

SECTION III
DEFINITIONS

ANNUAL AGGREGATE DEDUCTIBLE as shown in the SCHEDULE OF STOP LOSS INSURANCE for any one **Policy Period** means the greater of:

1. The cumulative monthly total of **Covered Units** multiplied by the Monthly Aggregate **Deductible** Factors; or
2. The Minimum **Annual Aggregate Deductible**.

[AGGREGATING SPECIFIC DEDUCTIBLE as shown in the SCHEDULE OF STOP LOSS INSURANCE is a **Deductible** applied in addition to the Specific **Deductible**. At the start of the **Policy Period**, **Plan Benefits** for each **Covered Person** in excess of the Specific **Deductible** will be added together until the cumulative total equals the **Aggregating Specific Deductible** amount shown in the SCHEDULE OF STOP LOSS INSURANCE. A Specific Stop Loss reimbursement will not be paid by the **Company** until the **Aggregating Specific Deductible** has been satisfied.]

BENEFIT PERIOD means the period of time in which **Plan Benefits** must be **Incurred** by the **Covered Person** and **Paid** by the **Plan** to be eligible for reimbursement under this **Policy**. This period does not alter the **Policy** effective date and **Policy Period**, nor does it waive the eligibility requirements of this **Policy**.

COMPANY means the Zurich Company issuing this **Policy**.

COVERED BENEFITS means the benefits provided for **Covered Persons** by the **Plan** as defined in the **Policy**. [Benefits for occupational accidents and illness and fees for administration purposes are not **Covered Benefits**.]

COVERED PERSON means any eligible individual entitled to benefits under the **Policyholder's Plan**.

COVERED UNIT(S) for the purposes of determining the premiums payable or the **Annual Aggregate Deductible** means the following:

1. Employee; or
2. Employee with dependents; or
3. Such other defined unit as agreed between the **Company** and the **Policyholder**.

DEDUCTIBLE(S) means the Specific **Deductible(s)**, or Aggregate **Deductible(s)** [or **Aggregating Specific Deductible**], as shown in the SCHEDULE OF STOP LOSS INSURANCE.

ELIGIBLE CLAIM EXPENSE(S) means **Plan Benefits** which are **Incurred** by a **Covered Person** under the **Plan(s)** and for which benefits have been **Paid** by the **Policyholder** in accordance with the terms of the **Plan(s)** on the Claims Basis shown in the SCHEDULE OF STOP LOSS INSURANCE. **Eligible Claim Expenses** which are covered under the terms of the **Plan(s)**, **Paid** by the **Policyholder** and not excluded under the terms of this **Policy** shall be included in the calculation of the reimbursements payable under this **Policy** after the **Deductible(s)** of this **Policy** has been satisfied.

EXPERIMENTAL OR INVESTIGATIONAL TREATMENT means a treatment, procedure, service, device, or drug (treatment) which will be considered to be experimental or investigational if:

1. The treatment has not been approved by the United States Food and Drug Administration (FDA) at the time the treatment is provided; or
2. The treatment is identified as a Phase I, II, III, or IV clinical trial or under study to determine its maximum tolerated dose, its safety, its efficacy, or its toxicity as compared with the standard means of treatment or diagnosis; or
3. The treatment is governed by a written protocol that references determinations of safety, toxicity and/or efficacy in comparison to conventional alternatives and/or has been approved or is subject to the approval by an Institutional Review Board (IRB) or the appropriate committee of the provider institution; or
4. The treatment is being provided subject to the **Covered Person's** execution of an informed consent that references determinations of safety, toxicity or efficacy in comparison to conventional alternatives; or
5. The predominant opinion of medical experts as expressed in published peer-reviewed literature is that further research is necessary in order to determine safety, toxicity, or efficacy in comparison to conventional alternatives.

Experimental or Investigational Treatment will be considered an **Eligible Claim Expense** under this **Policy** when the following criteria are met:

1. Treatment protocol identified as a Phase II, III, or IV clinical trial, or the equivalent, will be considered an **Eligible Claim Expense** when all of the following criteria are met:

- (a) There is no clearly superior, non-investigational treatment alternative and there is a reasonable expectation that the treatment will be more effective than the non-investigational alternative; and
- (b) The clinical trial is subject to review by an IRB and has been approved by the governing local IRB; and
- (c) The **Covered Person** has executed an informed consent, which has been approved by the IRB; and
- (d) The treatment protocol has been approved by one or more of the following organizations, the treatment is being provided within one of the centers designated by the clinical trial sponsor as a participating center and is being provided under the direction of the principal investigator at that center:
 - i. National Institutes of Health (NIH).
 - ii. NIH cooperative group or center.
 - iii. United States Department of Health and Human Services (HHS), which includes the Center for Medicare and Medicaid Services (CMS).
 - iv. FDA.
 - v. United States Department of Defense.
 - vi. United States Department of Veterans Affairs; or
2. Treatment utilizing drugs previously approved by the FDA for non-approved indications when all of the following criteria are met:
 - (a) There is no clearly superior, non-investigational treatment alternative and there is a reasonable expectation that the treatment will be more effective than the non-investigational alternative.
 - (b) The provider has complied with all of the IRB's requirements for providing the treatment; or
3. Treatment utilizing Investigator sponsored trials which are done in accordance with IRB approved protocols in an academic medical center that is a recipient of NIH grants and which meets all of the criteria in 1.(a) through 1.(d) above. Investigator sponsored trials will be considered on a case-by-case basis. Investigator or drug company sponsored trials in which there is no academic medical center involvement and where the principal investigator is not affiliated with an academic medical center will not be considered for coverage except by recommendation of an independent third party reviewer.

To determine if any treatment meets the standards for coverage, the **Company** reserves the right to obtain an independent third party review.

INCURRED means as follows:

1. with respect to services, the date on which the services are rendered to the **Covered Person**; or
2. with respect to supplies, the date on which the supplies are given to the **Covered Person**; or
3. with respect to disability income benefits, on the date each periodic benefit payment becomes payable to the **Covered Person**].

LIFETIME LIMIT OF LIABILITY means the amount shown in the SCHEDULE OF STOP LOSS INSURANCE and is the maximum amount the **Company** will reimburse the **Policyholder** with respect to any **Covered Person(s)** under this **Policy** issued by the **Company** but not more than the Lifetime Maximum specified in the **Plan**.

MEDICALLY NECESSARY AND APPROPRIATE means that a service, supply or drug is provided by a recognized provider, is accepted by the United States Food and Drug Administration and is generally accepted as the standard of care for the control or cure of the illness or injury being treated by physicians practicing in the same or related specialty field.

PAID means:

1. the draft or check for payment of **Plan Benefits** is issued and released by the **Policyholder** by mail or other means or funds are transmitted electronically by the plan supervisor to the payee; and
2. sufficient funds are available:
 - a. in the account from which the draft or check is issued for a non-zero balance account or from the account from which the funds are electronically transmitted; or
 - b. to permit the draft or check to be honored in a zero-balance account.

PERCENTAGE REIMBURSABLE means the percentage at which the **Company** will consider **Plan Benefits** under this **Policy**.

PLAN(S) means the **Policyholder's** self-funded benefit plan(s) as described in its **Plan(s)** document as required by either Federal or state law. A copy of the **Plan(s)** document is attached to this **Policy** for the purpose of determining the **Company's** liability under this **Policy**.

PLAN BENEFITS means **Eligible Claim Expenses** which are **Incurred** by a **Covered Person** under the **Plan(s)** and for which benefits have been **Paid** by the **Policyholder** in accordance with the terms of the **Plan(s)** on the Claim Basis shown in the SCHEDULE OF STOP LOSS INSURANCE. **Plan Benefits** which are covered under the terms of the **Plan(s)**, **Paid** by the **Policyholder** and not excluded under the terms of this **Policy** shall be included in the calculation of the reimbursements payable under this **Policy** after the **Deductible(s)** of this **Policy** has been satisfied.

POLICY means this Stop Loss Policy.

POLICYHOLDER means the applicant named in the [Renewal] Application for Stop Loss Insurance Coverage.

POLICY PERIOD means the dates shown in the SCHEDULE OF STOP LOSS INSURANCE.

PROOF OF LOSS means receipt of a complete claim form, satisfactory to the **Company**, and other supporting documentation required by the **Company**.

PROVIDER NETWORK(S) means a network(s) or similar organization consisting of selected health care providers (e.g., physicians and hospitals) that provide services or supplies to a **Covered Person** at a discounted or pre-determined price.

[REASONABLE AND CUSTOMARY CHARGE means the normal charge made to an individual without insurance and which does not exceed the general level of fees and prices normally charged for a given procedure or supply within the same geographical area in which the expense was incurred. The **Reasonable and Customary Charge** will be determined by the **Company** based upon the most current version of the reasonable and customary fee schedules [published by [Ingenix] [maintained by the **Policyholder's Third Party Administrator**]. In no event will the allowable charge exceed: 1) the amount charged to an individual without insurance; or 2) the **Provider Network** discounted or pre-determined price; or 3) the [90th] percentile of the most current version of the reasonable and customary fee schedules [published by [Ingenix] [maintained by the **Policyholder's Third Party Administrator**], whichever is less.]

THIRD PARTY ADMINISTRATOR means a firm or person which has been retained by the **Policyholder** to pay claims and/or provide other administrative services on behalf of the **Policyholder**.

WAR means expenses resulting from war or any act of war declared or undeclared, whether civil or international, and any substantial armed conflict between organized government forces of a military nature.

SECTION IV

SPECIFIC STOP LOSS

The **Company** will reimburse the **Policyholder** for the amount of any **Plan Benefits** which exceed the Specific **Deductible** as shown in the SCHEDULE OF STOP LOSS INSURANCE for a **Covered Person** and which are **Incurred** and **Paid** during the **Benefit Period** as shown in the SCHEDULE OF STOP LOSS INSURANCE.

While the determination of benefits under the **Plan** is the sole responsibility of the **Policyholder**, the **Company** reserves the right to interpret the terms and conditions of the **Plan** as it applies to this **Policy**. The **Company** has the sole authority to approve or deny reimbursements under this **Policy**.

For **Eligible Claim Expenses** for organ or tissue transplant procedures performed in an Enhanced Transplant Coverage network, the **Covered Person's** Specific **Deductible** will be reduced by \$10,000.

[If Specific Advance Funding is applicable as shown in the SCHEDULE OF STOP LOSS INSURANCE the **Company** will pay the Specific Stop Loss benefit in advance of the payment by the **Policyholder** provided:

1. the Specific Stop Loss payment exceeds the Specific **Deductible**, and
2. the **Policyholder** has submitted proof that **Plan Benefits** have satisfied the Specific **Deductible**, and
3. the **Company** has received all of the **Proof of Loss** information it requires; and
4. the above requirements are satisfied within the **Benefit Period**.

The continued availability of Specific Advance Funding is subject to:

1. the **Policyholder** providing the **Company** with a copy of the front of the check payable to the provider within [ten (10)] days of the payment from the **Company**; and
2. the **Policyholder** providing the **Company** with a copy of the front and back of the canceled check payable to the provider within [forty-five (45)] days of the receipt by the **Policyholder** of the payment from the **Company**.

If the requirements for Specific Advance Funding are met, **Plan Benefits** which qualify for Specific Advance Funding shall be considered as **Paid**.]

SECTION V

AGGREGATE STOP LOSS

The **Company** will reimburse the **Policyholder** for the amount of any **Plan Benefits** which exceed the **Annual Aggregate Deductible** as shown in the SCHEDULE OF STOP LOSS INSURANCE and which are **Incurred** and **Paid** during the **Benefit Period** as shown in the SCHEDULE OF STOP LOSS INSURANCE. **Plan Benefits** for each **Covered Person** in excess of the Loss Limit per **Covered Person** for the **Policy Period** as shown in the SCHEDULE OF STOP LOSS INSURANCE will not be included for purposes of determining the amount of the Aggregate Stop Loss reimbursement under this **Policy**.

Reimbursements to the **Policyholder** for any Aggregate Stop Loss provided under this **Policy** will be made after the end of the **Policy Period** provided:

1. the **Company** has received all of the **Proof of Loss** information it requires; and
2. the **Company** has completed any audit it may deem necessary.

While the determination of benefits under the **Plan** is the sole responsibility of the **Policyholder**, the **Company** reserves the right to interpret the terms and conditions of the **Plan** as it applies to this **Policy**. The **Company** has the sole authority to approve or deny reimbursements under this **Policy**.

If this **Policy** or the Aggregate Stop Loss Coverage is terminated prior to the end of the **Policy Period**, the **Annual Aggregate Deductible** will not be pro-rated.

SECTION VI

TERM OF POLICY

This **Policy** will be in force during the **Policy Period** shown in the SCHEDULE OF STOP LOSS INSURANCE and will automatically terminate at the end of the **Policy Period** unless it has been terminated earlier as provided in the TERMINATION provision, or unless the **Company** and the **Policyholder** have agreed upon terms to renew the **Policy**. In such event, the **Company** will issue to the **Policyholder** a new **Policy** or a renewal endorsement and SCHEDULE OF STOP LOSS INSURANCE.

SECTION VII

PREMIUMS AND AGGREGATE FACTORS

The SCHEDULE OF STOP LOSS INSURANCE shows the premium rates for each coverage and the Monthly Aggregate **Deductible** Factors for Aggregate Stop Loss Coverage. The initial premium is due on the Effective Date of this **Policy** and subsequent premiums are due on the first (1st) day of each succeeding month in the **Policy Period**. The entire amount of the applicable premium shall be paid when due. The **Company** is not obligated to accept or apply any premium paid which is less than the entire amount due for any period. Premium payments shall be credited first to any past due and unpaid premium, in the order in which due. Premiums are not considered paid until the premium payment is received by the **Company**.

A grace period of [thirty-one (31)] days is allowed for the payment of any premium except the first. The **Company** is not obligated to apply any premium which is received after the grace period and may, at its discretion, return any premium payment. The payment of any premium will not cause the insurance under this **Policy** to remain in force beyond the day before the next Premium Due Date.

The **Company** may change the premiums and Monthly **Aggregate Deductible Factors** on any of the following dates:

1. The effective date that the **Plan** is amended; or
2. The effective date that the **Policyholder** adds or deletes a subsidiary or affiliated companies or divisions; or
3. The date an increase or decrease in the number of **Covered Units** exceeds [10%] in any one month or [15%] from the number of **Covered Units** on the first (1st) day of the **Policy** effective date; or

4. The date that the **Company** is informed of a clerical error or discovers material misrepresentation of underwriting information. The **Company's** action will be in accordance with the Misstated Data Provisions under the GENERAL PROVISIONS of this **Policy**; or
5. The effective date that the **Provider Network(s)** is changed.

The **Policyholder** will furnish to the **Company** any information which the **Company** deems necessary to determine the amount of premium due under this **Policy**. The **Company** may, at its discretion, examine any records of the **Policyholder** at any reasonable time to confirm that premiums are being calculated and paid in accordance with this **Policy**. The **Company** will refund to the **Policyholder** any overpayment of premium made in error. Such refund shall be made only for the overpayments made during the **Policy Period** in which the error is uncovered and reported to the **Company**.

SECTION VIII

CLAIM PROVISIONS

The **Policyholder** warrants, upon presentation of a **Plan Benefit** for reimbursement, that all monies necessary to pay for the **Plan Benefit** have been **Paid** to the **Covered Person** or the provider of services to the **Covered Person**.

The **Policyholder** will maintain records showing the complete details concerning any and all amounts paid for benefits not provided under the terms of the **Plan**. These payments for benefits not provided under the terms of the **Plan** will not be included in determining **Plan Benefits** reimbursable under this **Policy**.

SPECIFIC STOP LOSS COVERAGE

With respect to Specific Stop Loss coverage, the **Policyholder** or **Third Party Administrator** will give written notice of claims to the **Company** on the **Company's** customary **Proof of Loss** form within [thirty (30)] days of the date the **Policyholder** or **Third Party Administrator** becomes aware [or by the exercise of reasonable due diligence should have become aware] of the existence of facts which would reasonably suggest the possibility that **Plan Benefits** will be **Incurred** which are subject to this **Policy** and will result in at least [\$50,000.00] or fifty (50%) of the Specific **Deductible**, whichever is less, or that the **Covered Person** has been diagnosed with or treated for any of the codes listed in the **Policyholder** Disclosure Statement. The **Policyholder** or **Third Party Administrator** will also comply with other claim reporting requirements, provided the **Company** sends written notice to the **Policyholder** or **Third Party Administrator** of these requirements and allows the **Policyholder** or **Third Party Administrator** [thirty (30)] days to begin complying with the new requirements. [Failure to furnish written notice will not invalidate or reduce any claim if it was not reasonably possible to provide such written notice within the time period required.] [If the **Company** determines it was reasonably possible to provide written notice in accordance with the provisions of this paragraph, the **Company** may adjust the reimbursement to reflect savings the **Company** may have obtained had the **Company** received notice within [thirty (30)] days.]

In no event will the **Company** be liable for any claims submitted for reimbursement more than [twelve (12)] months after the end of the **Benefit Period**.

AGGREGATE STOP LOSS COVERAGE

With respect to Aggregate Stop Loss Coverage, written **Proof of Loss**, in a form and content satisfactory to the **Company**, must be given within [thirty-one (31)] days after the end of the **Benefit Period**. If it is not possible to give proof within this time period, proof must be given as soon as reasonably possible. **Proof of Loss** may not be given later than [twelve (12)] months after the end of the **Benefit Period**. The **Policyholder** will also comply with other claim reporting requirements, provided that the **Company** sends written notice to the **Policyholder** of these requirements and allows the **Policyholder** [thirty (30)] days to begin complying with the new requirements.

OFFSET

The **Company** has the right to offset any benefits payable to the **Policyholder** under this **Policy** against premiums due and unpaid by the **Policyholder**. This right will not prevent the termination of this **Policy** for the non-payment of premium under the Termination Provision of this **Policy**.

SECTION IX

EXCLUSIONS AND LIMITATIONS

The following charges and/or expenses are not covered:

1. Expenses not specifically covered under the terms of the **Plan**.
2. Expenses **Incurred** by an individual who is not a **Covered Person** under the **Plan** when the expense was **Incurred**.
3. Expenses **Incurred** when the **Plan** is not in effect.
4. Expenses **Paid** by the **Policyholder** to the extent the **Policyholder** receives payments for those expenses from other insurers.
5. Charges for cosmetic surgery, unless from a congenital defect, or the **Plan** is required to provide coverage under Federal law.
6. Expenses for the cost of any **Experimental or Investigational Treatment**, procedure, service, supply, or drug. Unless all of the criteria as shown in SECTION III DEFINITIONS are met.
7. Expenses for the cost of any treatment, procedure, service, supply, or drug which is not **Medically Necessary and Appropriate**.
8. Expenses of persons who were not reported on the Policyholder Disclosure Statement who should have been disclosed in compliance with the terms of the Policyholder Disclosure Statement.
9. Expenses for benefits which the **Policyholder** is not legally liable to pay under the **Plan**.
10. Expenses also covered as benefits under Medicare or another health insurance plan. In no event will total payments on behalf of a **Covered Person** for a reimbursement otherwise payable under this **Policy** and any similar Medicare benefit or a benefit under another health insurance plan exceed one hundred percent of the **Covered Person's Eligible Claim Expenses**.
11. Expenses which are covered under Medicare or another health insurance plan for which the **Policyholder** is not liable under coordination of benefits, non duplication or other provisions in the **Plan**.
12. Expenses resulting from:
 - a. extra or non-contractual damages including compensatory, exemplary or punitive damages; or
 - b. legal fees and expenses related to the operation of the **Plan**, including the defense of claims and appeals; or
 - c. fines for statutory penalties awarded as a result of an act, omission or course of conduct committed by or for which the **Policyholder** was held responsible in connection with the **Plan**; or
 - d. cost of the administration of claim payments, consulting fees, administration fees, or other services provided on behalf of the **Policyholder** by a third party.
13. Charges for any accidental bodily injury or sickness for which the **Covered Person** would be entitled to benefits under any Workers' Compensation or Occupational Disease Law whether or not the **Covered Person** claims his or her rights to such benefits.
14. Expenses related to **War**.
15. Expenses resulting from **Provider Network** discounts and/or prompt pay or negotiated discounts that were lost as a result of the **Policyholder's** failure to pay a provider in a timely manner or for any other reason.
16. Expenses resulting from liability or obligations assumed by the **Policyholder** or **Third Party Administrator** under any contract or service agreement other than the **Policyholder's** self-funded benefit **Plan(s)**.
17. Taxes. The payment of reimbursement under this **Policy** will not include:
 - a. any taxes which might be paid or payable by the **Policyholder**; or
 - b. any tax liability, interest, or penalty imposed by any regulatory or taxing authority.

In addition, the **Policyholder** agrees to:

- 1) hold harmless the **Company** from any tax liability assessed against the **Company** on the basis of the coverage provided under the **Plan** other than any tax levied upon the **Company** for the premium due under this Policy; and

- 2) reimburse the **Company** for the amount of any such tax liability, interest, penalty, or cost incurred by the **Company** as the result of such tax assessment. Such reimbursement shall be due and payable when the **Policyholder** receives the **Company's** notification that reimbursement is due.
18. [Expenses related to drug and alcohol addiction [or mental illness] shall be limited to the lesser of the underlying **Plan** maximum or the Specific **Deductible**].
19. [Expenses relating to:
- a. non-human organ/tissue transplants; or
 - b. invitro-fertilization; or
 - c. radial keratotomy; or
 - d. reversal of voluntary sterilization; or
 - e. gene therapy; or
 - f. cloning]
20. [Charges billed by a hospital or facility, which are in excess of:
- a. [the manufacturer's invoice plus [20]% for medical/surgical supplies and devices billed under the following revenue codes, as published by the National Uniform Billing Committee, including but not limited to:
 - 1) 274 - Prosthetic/orthotic devices
 - 2) 275 - Pacemaker
 - 3) 276 - Intraocular lens
 - 4) 277 - Other implants
 - 5) 278 - Other supplies/devices
 - 6) 279 - Other supplies/devicesIf the manufacturer's invoice is not made available to the **Company**, charges billed under the above revenue codes will be limited to the manufacturer's suggested retail price plus [20].%]
 - b. [the average wholesale price (AWP) for prescription drugs billed under the following revenue codes, as published by the National Uniform Billing Committee, including but not limited to:
 - 1) 250 - General
 - 2) 251 - Generic drugs
 - 3) 252 - Nongeneric drugs
 - 4) 253 - Take-home drugs
 - 5) 259 - Other pharmacy
 - 6) 630 - General
 - 7) 631 - Single source drug
 - 8) 632 - Multiple source drug
 - 9) 633 - Restrictive prescription
 - 10) 634 - Erythropoietin (EPO) less than 10,000 units
 - 11) 635 - Erythropoietin (EPO) 10,000 or more units
 - 12) 636 - Drugs requiring detailed coding
 - 13) 637 - Self-Administrable drugsThe average wholesale price allowable will be based on the most current version of [RED BOOK by Thomson Micromedex.]
21. [Charges in excess of the **Reasonable and Customary Charge**, whether or not the service or supply was rendered by a provider participating in a **Provider Network(s)**.]

SECTION X

TERMINATION

By the Policyholder

The **Policyholder** may terminate this **Policy** on any Premium Due Date by giving the **Company** at least [thirty-one (31)] days advance written notice.

By the Company

At its option, the **Company** may terminate this **Policy** on the date that any one of the following occurs:

1. in the event that the **Policyholder** has failed to perform any of the duties or obligations under this **Policy**, the **Company** will provide the **Policyholder** with a written notice specifying such acts or omissions and will have the right to terminate the **Policy** if the **Policyholder** does not rectify such failures within [ten (10)] days of the receipt of the written notice; or
2. a petition in bankruptcy court is filed, with respect to the **Plan** or the **Policyholder**, whether voluntary or involuntary, or the **Plan** or the **Policyholder** becomes subject to liquidation, receivership or conservatorship; or
3. whenever the percentage of employees participating in one or more Health Maintenance Organizations, prepaid plans, or insurance plans exceeds [40%] of employees eligible to participate in the **Plan**, unless the **Company** has agreed in writing to continue coverage; or
4. the number of lives falls below the minimum number of lives and/or participation as shown in the SCHEDULE OF STOP LOSS INSURANCE; or
5. the date the **Plan** is found to be in violation of Federal law; however, if it is determined that the **Plan** is not in compliance with such laws, the **Company** will allow the **Policyholder** [ninety (90)] calendar days within which to achieve compliance. Failure to comply by such date will result in termination of the **Policy** as of the date the **Plan** was found to be in violation; or
6. upon giving the **Policyholder** at least [thirty (30)] days advance written notice.

Automatic

This **Policy** will automatically terminate without notification required upon the earliest of the following dates:

1. the date the **Plan** terminates; or
2. at the end of any grace period when the premium due remains unpaid as of the premium due date; or
3. the date the **Policyholder** has failed to provide funds for payment of claims under the **Plan**; or
4. delegation by the **Policyholder** of its duties under this **Policy** to a **Third Party Administrator** which has not been approved by the **Company**; or
5. [sixty (60)] days after the Effective Date if the **Policyholder** has failed to furnish the **Company** with any information or materials requested by the **Company**. Such information or materials must be of reasonable nature to allow the **Company** to determine its liability under this **Policy**. If the **Policy** is terminated under this provision, the **Company's** sole liability will be to return any monies given by the **Policyholder** as consideration for this **Policy** and less any claims or other expenses paid by the **Company** under this **Policy**. If such amounts paid by the **Company** are greater than the amount of the refund due the **Policyholder**, the **Policyholder** shall pay the amount of the deficit to the **Company** within [thirty (30)] days of notice from the **Company**. If repayment in full is not made within this [thirty (30)] day period, the **Company** will be entitled to assess monthly a late payment fee equal to [1.5%] of the outstanding balance.

Effect of Termination

In the event that this **Policy** is terminated by the **Policyholder** or by the **Company** under paragraphs (1), (2), (3), (4) or (5) of the preceding paragraph under the caption **Automatic**, the Minimum Annual Specific Premium as shown in the SCHEDULE OF STOP LOSS INSURANCE shall be due and payable to the **Company**.

The **Company** has no obligation to reimburse the **Policyholder** for any **Plan Benefits** which are **Paid** after the date this **Policy** terminated.

SECTION XI

GENERAL PROVISIONS

Entire Policy

The entire **Policy** consists of this **Policy**, the attached copy of the **Policyholder's** [Renewal] Application for Stop Loss Insurance Coverage, the Policyholder Disclosure Statement and any amendments, riders or endorsements.

Changes to the Policy

This **Policy** may be changed at any time by a written agreement between the **Policyholder** and the **Company**. The provisions of this **Policy** may be changed or waived only by the President, a Vice President, or the Secretary of the **Company** and only in writing. The **Company** will not be bound by any promise or representations made by any other person. The **Company** may change any one or more or all of the items shown in the SCHEDULE OF STOP LOSS INSURANCE by endorsement during the **Policy Period** in response to any change which is made to any applicable state or Federal law which change, in the sole opinion of the **Company**, may affect the **Company's** liability under this **Policy**.

Parties to the Policy

This **Policy** is a contract between the **Policyholder** and the **Company**. This **Policy** does not create any right or legal relationship between the **Company** and any person covered under the **Plan**. The **Company's** sole liability under this **Policy** is to the **Policyholder**. Any and all reimbursements payable under this **Policy** will be made solely to the **Policyholder**. This **Policy** will not be deemed to make the **Company** a party to any contract or agreement between the **Policyholder** and a third party.

Plan Document

The **Policyholder** will provide to the **Company** a complete copy of the **Plan** document governing the **Plan**. The **Policyholder** will submit to the **Company**, in writing, any proposed change to the provisions of the **Plan**. This must be submitted to the **Company** at least [thirty (30)] days prior to the effective date of the proposed change. The **Company** will have the right to modify premium rates and/or Monthly Aggregate **Deductible** Factors if the **Company** determines that its liability under this **Policy** has been affected by the change in the **Plan**. If the **Company** and the **Policyholder** cannot reach agreement with respect to the **Plan** changes, the **Plan** change will not affect the **Company's** liability under this **Policy** and the **Policy** will be administered as if the **Plan** had not changed. The **Company's** liability under the **Policy** will not be affected by any such charges made to the **Plan** unless and until the **Company** has sent its written approval of such charges to the **Policyholder** or its agent.

Third Party Administrator

The **Policyholder** may retain a **Third Party Administrator** to perform some or all of its duties under this **Policy**. Such **Third Party Administrator** must be named in the [Renewal] Application for Stop Loss Insurance Coverage which is attached to and made part of this **Policy**. The **Third Party Administrator** must be approved by the **Company** to perform the **Policyholder's** duties under this **Policy**. The **Policyholder** will provide to the **Company** a copy of its agreement with the **Third Party Administrator** as well as a copy of changes thereto. These documents are NOT made part of this **Policy**.

Without waiving any of its rights under this **Policy**, and without making the designated **Third Party Administrator** a party to this **Policy**, the **Company** agrees to recognize the **Third Party Administrator** as the agent for the **Policyholder**. The **Third Party Administrator** is NOT the agent of the **Company**. Notwithstanding its appointment of a **Third Party Administrator**, the **Policyholder** is still obligated to see to the timely performance of its duties and obligations under this **Policy**. Furthermore, the **Policyholder** will hold the **Company** harmless from any liability arising from or related to any negligence, error, omission, or malfeasance by the **Third Party Administrator**.

The **Policyholder** may change its **Third Party Administrator** to a **Third Party Administrator** acceptable to the **Company**. The **Policyholder** must provide written notice to the **Company** at least [sixty (60)] days prior to the effective date of change. Any changes to the designated **Third Party Administrator** without prior written approval by the **Company** will cause this **Policy** to automatically terminate as provided for in TERMINATION provision.

Reporting

The **Policyholder** will submit by the [fifteenth (15th)] day of each month all proofs, reports, and supporting documents requested by the **Company**, including but not limited to, a monthly summary of all eligible claim payments processed by the **Policyholder** and the total number of **Covered Units** covered under the **Plan** during the prior month. The **Policyholder** will be responsible for the investigation, audit, calculation, and payment of all claims incurred under the **Plan**.

The **Policyholder** will furnish the **Company** with information required by the **Company** pertaining to the risks covered under this **Policy**. Such information must be received by the **Company** in a form and during a time period satisfactory to the **Company**.

Records

The **Policyholder** will maintain records of all **Covered Persons** under the **Plan** during the **Policy Period** and for a period of [seven (7)] years after termination of the **Policy**. The **Policyholder** will make all such records available to the **Company** as needed for the **Company** to determine its liability under this **Policy**.

Audit

The **Company** or its authorized representative will have the right to audit, at its own expense, the records of the **Policyholder**, the **Third Party Administrator** or any other person who is responsible for the administration of the **Plan** pertaining to the matters which affect the **Company's** liability under this **Policy**. The **Policyholder** agrees that payment of any reimbursements under this **Policy** will be conditioned upon the results of any audit requested by the **Company**.

Clerical Error

Clerical error, whether by the **Policyholder** or the **Company**, in keeping any records pertaining to the coverage, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated. Any clerical error in data that the **Policyholder** or its agent provided to the **Company** must be corrected and promptly reported to the **Company**. The **Company** will within [fifteen (15)] days of receipt of corrected data decide the corrective course of action under the terms of the MISSTATED DATA provision below.

Concealment, Fraud

This entire **Policy** will be void:

1. if, before or after making any reimbursement, the **Company** determines that the **Policyholder** or its agent has concealed or misrepresented any material fact or circumstance concerning this **Policy**, including any losses under the **Plan**; or
2. in any case of fraud by the **Policyholder** or its agent.

Misstated Data

The **Company** has relied upon the underwriting information provided by the **Policyholder** or its agent in the issuance of this **Policy**. If the **Company** subsequently learns of information which was known but not disclosed prior to the issuance of the **Policy**, and such information would have affected the premium rates, Monthly Aggregate **Deductible** Factors, Specific or Aggregate **Deductibles**, terms, or any other conditions for coverage, the **Company** will have the right to:

1. rescind the **Policy** as of the Effective Date. In the event of **Policy** rescission, the **Company's** sole liability will be to return any monies received from the **Policyholder** as consideration for this **Policy** and less any claims or other expenses paid by the **Company** under this **Policy**. If such amounts paid by the **Company** are greater than the amount of the refund due the **Policyholder**, the **Policyholder** shall pay the amount of the deficit to the **Company** within [thirty (30)] days of notice from the **Company**. If repayment in full is not made within this [thirty (30)] day period, the **Company** will be entitled to assess monthly a late payment fee equal to [1.5%] of the outstanding balance; or
2. adjust the premium rates, Monthly Aggregate **Deductible** Factor, Specific or **Annual Aggregate Deductibles** respectively, terms or any other conditions for coverage as of the Effective Date by providing written notice to the **Policyholder**.

Insolvency

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the **Policyholder** or its **Third Party Administrator** will not impose on the **Company** any liability other than the liability defined in this **Policy**. The insolvency of the **Policyholder** will not make the **Company** liable to the creditors of the **Policyholder**, particularly the **Covered Persons** under the **Plan**.

Liability

The **Company** will not have any obligation under this **Policy** to directly pay any **Covered Person** or any provider of services or supplies to a **Covered Person**. The **Company's** sole liability is to the **Policyholder**. Nothing in this **Policy** will be construed to permit a **Covered Person** or any provider of services or supplies to a **Covered Person** to have a direct right of action against the **Company**. The **Company** is not a party to the **Plan** or to any modifications thereto. The **Policyholder** may not assign reimbursements under this **Policy** and the **Company** will not recognize any such assignments.

Provider Network(s)

The **Policyholder** or **Third Party Administrator** will provide to the **Company** a complete listing of **Provider Network(s)**. [The **Policyholder** or **Third Party Administrator** will provide the **Company** with the corresponding **Provider Network(s)** contract(s), upon request.] The **Policyholder** or **Third Party Administrator** must submit to the **Company**, in writing, any proposed change in their **Provider Network(s)**. This must be submitted to the **Company** at least [sixty (60)] days prior to the effective date of the change. The **Company** will have the right to modify premium rates and/or Monthly Aggregate **Deductible** Factors if the **Company** determines that its liability under this **Policy** has been affected by the change in the **Provider Network(s)**. The **Company's** liability under the **Policy** will not be affected by any such changes made to the **Provider Network(s)** unless and until the **Company** has sent its written approval of such changes to the **Policyholder** or its agent.

Notice

For the purpose of any notice required from the **Company** under the provisions of this **Policy**, notice to the **Third Party Administrator** will be considered notice to the **Policyholder**, and notice to the **Policyholder** will be considered notice to the **Third Party Administrator**. For the purpose of any notice requirement from the **Policyholder** under the provisions of this **Policy**, neither notice from the **Policyholder** to the **Third Party Administrator** nor notice from the **Third Party Administrator** to the **Policyholder** will be considered notice to the **Company**.

Subrogation

The **Company** has the right to recover any and all payments that the **Company** has made to the **Policyholder** under this **Policy** from any person or entity that has been found to make, or is obligated to make in the future, a First and/or Third Party payment to a **Covered Person** as the result of an accident or illness caused by the negligence of another party. If the **Policyholder** recovers any monies from any source for any loss for which the **Policyholder** received payment under this **Policy**, the **Company** will be reimbursed on a priority basis from such recovery to the extent of the **Company's** payments to the **Policyholder** before the **Policyholder** is entitled to a recovery. This obligation of the **Policyholder** to the **Company** survives the termination of this **Policy** and is applicable even if the **Policy** has expired and/or been terminated.

In the event the **Policyholder** does not pursue all available recovery sources, then the **Policyholder's** right of subrogation against a **Covered Person** transfers to the **Company** and the **Policyholder** will at all times cooperate with the **Company** in their recovery efforts. Further, there can be no deduction of the amounts due the **Company** for legal fees, or any costs associated with the recovery of these payments without the express written agreement of the **Company** prior to the matter being settled or these costs being incurred. In addition, if there is to be a settlement for any portion of the funds that is less than 100% of the amounts(s) paid to the **Policyholder** by the **Company**, any such agreement must first be approved by the **Company**, or its designated representative, before the **Policyholder** agrees to such a settlement with any other person or entity.

Other Insurance

The amounts otherwise payable under this **Policy** shall be reduced by the amount of any reimbursement or indemnity which the **Policyholder** may be entitled to receive with respect to the **Company's** liability under this **Policy**.

Waiver

Failure of the **Company** to strictly enforce its rights under this **Policy** shall not waive any such right, regardless of the frequency or similarity of the circumstances.

Conformity to Statute

Any part of this **Policy** that conflicts with state law is automatically changed to conform to that law.

Hold Harmless

The **Policyholder** agrees to indemnify and hold the **Company** harmless for any amounts paid or incurred for legal expenses, costs, reasonable settlements, or judgments arising out of any dispute involving a **Covered Person** or by any third party; provided that such legal expenses, costs, settlements, or judgments were not incurred as a result of the sole negligence or intentional wrongful acts of the **Company**.

Suit Against the Company

No suit, action or proceeding against the **Company** for the recovery of any claim will be sustained in any court of law or equity unless: the **Policyholder** has fully complied with all the provisions of this **Policy** and legal action is started within [twelve (12)] months after the end of the **Benefit Period**.

If under the insurance laws of the applicable jurisdiction such [twelve (12)] months limitation is invalid, then any such legal action needs to be started within the shortest limit of time permitted by such laws.

SERFF Tracking Number: *ZURC-125675974* *State:* *Arkansas*
Filing Company: *Zurich American Insurance Company* *State Tracking Number:* *39184*
Company Tracking Number: *AR-AH-26876*
TOI: *H21 Health - Other* *Sub-TOI:* *H21.000 Health - Other*
Product Name: *AR-AH-26876 Policy Form Fing to include Notice*
Project Name/Number: *AR-AH-26876 Policy Form Fing to include Notice/AR-AH-26876*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: ZURC-125675974 State: Arkansas
 Filing Company: Zurich American Insurance Company State Tracking Number: 39184
 Company Tracking Number: AR-AH-26876
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: AR-AH-26876 Policy Form Fing to include Notice
 Project Name/Number: AR-AH-26876 Policy Form Fing to include Notice/AR-AH-26876

Supporting Document Schedules

Satisfied -Name:	Certification/Notice	Review Status:	Withdrawn	06/04/2008
Comments:				
Attachment:				
AR Cert.pdf				
Bypassed -Name:	Application	Review Status:	Withdrawn	06/04/2008
Bypass Reason:	N/A			
Comments:				
Bypassed -Name:	Health - Actuarial Justification	Review Status:	Withdrawn	06/04/2008
Bypass Reason:	N/A			
Comments:				
Bypassed -Name:	Outline of Coverage	Review Status:	Withdrawn	06/04/2008
Bypass Reason:	N/A			
Comments:				

Arkansas Certification

This is to certify that the attached U-MSL-500-A AR (10/07) has achieved a Flesch Reading Ease Score of 55.2 and complies with the requirements of Ark. Stat. Ann. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

(Signed by Officer of Company)

Denise Goode 
Name
Secretary _____
Title