

SERFF Tracking Number: MRKC-125742396 State: Arkansas
Filing Company: Markel Insurance Company State Tracking Number: 39776
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Stop Loss
Project Name/Number: /

Filing at a Glance

Company: Markel Insurance Company

Product Name: Stop Loss

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: MRKC-125742396 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 39776

Co Tr Num:

State Status: Approved-Closed

Co Status:

Reviewer(s): Rosalind Minor

Authors: Carol Depuy, Holly Pratt

Disposition Date: 08/16/2008

Date Submitted: 07/29/2008

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments: This product is exempt from filing in our domicile state of Illinois.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 08/16/2008

State Status Changed: 08/16/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

This excess loss coverage is designed to be offered to employer groups who self fund their employee medical plan. This coverage is purchased by the employer to protect itself from catastrophic losses. Benefits are payable to the employer and not to individual employees. While the benefits covered under the plan will parallel the employer's underlying plan, this excess loss coverage is not medical coverage for employees. As excess/stop loss coverage is not "health insurance coverage" as defined under the federal Health Insurance Portability and Accountability Act (HIPAA), it is not subject to

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the requirements in the HIPAA law. Benefits will be offered on a specific or aggregate basis, or both. The exact benefits will vary depending on the options chosen by the employer. Marketing for this product will be done through licensed agents and brokers.

Company and Contact

Filing Contact Information

Carol DePuy, Accident & Health Compliance Manager
 cdepuy@markelcorp.com
 4600 Cox Road
 Glen Allen, VA 23060
 (800) 431-1270 [Phone]
 (804) 527-7915[FAX]

Filing Company Information

Markel Insurance Company
 4600 Cox Road
 Glen Allen, VA 23060
 (800) 431-1270 ext. [Phone]

CoCode: 38970
 Group Code: 785
 Group Name:
 FEIN Number: 36-3101262

State of Domicile: Illinois
 Company Type: Property & Casualty
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: Filing or review of policy/contract, endorsements or certificates, riders, applications, or annuity forms, per submission (not per form) - \$ 50

Rule and Regulation 57 s 5

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Markel Insurance Company	\$50.00	07/29/2008	21644083

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/16/2008	08/16/2008

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Disposition

Disposition Date: 08/16/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Readability Certification	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	AR Forms List	Approved-Closed	Yes
Form	Excess Loss Insurance Policy	Approved-Closed	Yes
Form	Group Stop Loss Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	MSL100 (02/07)	Policy/Cont Excess Loss ract/Fratern Insurance Policy al Certificate	Initial		51	MSL100 0207.pdf
Approved-Closed	MSL123-AR (07/08)	Policy/Cont Group Stop Loss ract/Fratern Application al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			MSL123-AR (07-08).pdf



Deerfield, IL

**EXCESS LOSS INSURANCE POLICY
Non-Participating**

POLICY NUMBER:

POLICYHOLDER:

POLICY PERIOD:

EFFECTIVE DATE:

EXPIRATION DATE:

ANNIVERSARY DATE: _____, and on the same day each year after.

PREMIUM DUE DATE: _____, and on the same day each month.

STATE OF DELIVERY:

This Policy is a legal contract. We issue it in consideration of: (1) Your Application, (2) Your Disclosure Statement, and (3) Your payment of premiums when due. This Policy, Your Application, Your Disclosure Statement, and a copy of the Plan form the entire agreement between Us.

In issuing this Policy, We have relied upon the information (including, without limitation, information in the Disclosure Statement, Your Application, and the Plan) provided to Us by: (1) You, (2) Your Administrator, and (3) Your agent or broker. We have also relied on this information being both complete and accurate. If the information was incomplete or incorrect, We shall have the immediate right: (1) to modify the Policy to reflect the complete or correct information, or (2) to terminate the Policy upon written notice.

We agree to make payments in accordance with the provisions of this Policy.

In this Policy, "You" and "Your" refer to the Policyholder, and "We", "Us", and "Our" refer to Markel Insurance Company.

This Policy is issued and governed by the laws of the state of delivery as indicated above.

Signed for Markel Insurance Company as of the Effective Date.

A handwritten signature in black ink, appearing to read "Brett L. M.", written over a horizontal line.

President

A handwritten signature in black ink, appearing to read "Linda S. Roth", written over a horizontal line.

Secretary

Service Address:
P.O. Box 3870
Glen Allen, VA 23058-3870
Telephone (800) 431-1270

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SECTION 1-SCHEDULE OF EXCESS LOSS INSURANCE
(hereinafter referred to as the "Schedule")

POLICYHOLDER:

ADDRESS:

ADMINISTRATOR:

ADDRESS:

ALL AMOUNTS AND NUMBERS SHOWN IN THIS SCHEDULE APPLY ONLY TO THE POLICY PERIOD IN EFFECT. A NEW SCHEDULE WILL BE ISSUED FOR EACH NEW POLICY PERIOD.

A. [] AGGREGATE EXCESS LOSS INSURANCE:

1. BENEFITS COVERED:

Medical Dental Weekly Income Vision
 Prescription Drug Card

2. POLICY BASIS/BENEFIT PERIOD:

Eligible Expenses Incurred from _____ through _____; and

Eligible Expenses Paid from _____ through _____

If this Policy terminates prior to the Expiration Date, no Aggregate Excess Loss Benefits will be payable and premium paid will not be refundable.

3. INITIAL AGGREGATE ATTACHMENT POINT: _____

4. MINIMUM AGGREGATE ATTACHMENT POINT: _____

5. BENEFIT PERCENTAGE PAYABLE IN ACCORDANCE WITH SECTION 3: _____

6. MAXIMUM AGGREGATE BENEFIT (WHILE COVERED, AND WHILE THIS POLICY IS IN FORCE): _____

7. AGGREGATE MONTHLY FACTOR(S): Single: _____ Family: _____
Composite: _____
Covered Units/enrollment:
Single: _____ Family: _____
Composite: _____

8. AGGREGATE MONTHLY PREMIUM (PER EMPLOYEE): _____

9. AGGREGATE LOSS LIMIT: _____

10. PAYMENT MODE: _____

B. [] SPECIFIC/INDIVIDUAL EXCESS LOSS INSURANCE:

1. **BENEFITS COVERED:** [Medical Only] [RX]

2. **POLICY BASIS/BENEFIT PERIOD:**

Eligible Expenses Incurred from _____ through _____; and

Eligible Expenses Paid from _____ through _____.

If this Policy terminates prior to the Expiration Date, the Benefit Period will not extend past the date of termination. In addition, the deductible per Covered Person will apply as if the Policy were in force for the entire Policy Year.

3. **DEDUCTIBLE PER COVERED PERSON:** _____

4. **BENEFIT PERCENTAGE PAYABLE IN EXCESS OF THE SPECIFIC DEDUCTIBLE:** _____

5. **MAXIMUM SPECIFIC BENEFIT PAYABLE MINUS THE SPECIFIC DEDUCTIBLE (PER LIFETIME PER COVERED PERSON), WHILE THIS POLICY IS IN FORCE:** _____

6. **SPECIFIC MONTHLY PREMIUM RATE:** Single: _____ Family: _____
Composite: _____
Covered Units/enrollment:
Single: _____ Family: _____
Composite: _____

[] **OPTIONAL RIDERS ELECTED:**

[] **WAIVER OF ACTIVELY AT WORK ELECTED:**

SECTION 2 - DEFINITIONS

ADMINISTRATOR means an organization which has been retained by You and approved by Us to provide claim and administrative services for You.

AGGREGATE MONTHLY FACTOR means the amount applicable to each Covered Person as shown in the Schedule.

ANNUAL AGGREGATE ATTACHMENT POINT which is determined at the end of the Policy Year and is an amount equal to the product of the Aggregate Monthly Factor times the number of Covered Units for each applicable month during the Policy Year. The Annual Aggregate Attachment Point is stated in the Schedule and is described in Section 3. This amount is that portion of the Eligible Expenses not covered by this Policy and entirely retained by You for the total Number of Covered Units in each Policy Year.

APPLICATION means the application for excess loss insurance submitted by You to Us in connection with the issuance of this Policy.

BENEFIT PERCENTAGE PAYABLE means the factor that determines the amount of the Maximum Benefit payable to You as shown in the Schedule. Separate benefit percentages may apply to either the Aggregate Excess Loss or to the Specific Excess Loss.

BENEFIT PERIOD means the period of time, as shown in the Schedule, during which a covered expense must be Incurred, and/or Paid to be eligible for reimbursement under this Policy.

COVERED MONTH is determined from the Effective Date. Each new Covered Month will begin on the date which corresponds with the Effective Date. If there is no such date in any applicable month, then the last date of that month will be used.

COVERED PERSON means an eligible employee or eligible dependent(s) .

COVERED UNIT includes an eligible employee, eligible employees and their dependents or such other defined individuals as specifically agreed upon between You and Us.

DISCLOSURE STATEMENT means the disclosure statement submitted by You to Us in connection with the issuance of this Policy.

ELIGIBLE EXPENSES means the reasonable and customary charges covered by the Plan and incurred by a Covered Person while insured under the Plan for medically necessary treatment, services and/or supplies prescribed by an attending physician.

EFFECTIVE DATE means the date the coverage begins as stated in the Schedule.

EXPERIMENTAL or **INVESTIGATIVE** means care, procedures, treatments, or technology that are not widely recognized and accepted as effective, safe and appropriate for the injury or illness by the medical profession in the U.S., that are in research or Investigative stage, or conducted for research or similar purposes; or for which the patient has been asked to give, or has signed, a release or other document, indicating that the treatment is Experimental or Investigative or other similar term.

In determining any of the criteria stated above We will rely on recognized medical sources such as, but not limited to the American Medical Association, the Council of Technology Assistance Program and the Council on Medical Special Services, the National Institute of Health, Medicare, the Food and Drug Administration; and other accepted medical authorities and sources.

INCURRED means the date on which an Eligible Expense was rendered to a Covered Person.

INITIAL AGGREGATE ATTACHMENT POINT means the annual aggregate attachment point as calculated on the Effective Date based upon the number of Covered Units at that time multiplied by the corresponding attachment factors and multiplied by twelve.

LATE ENROLLEE means any individual who makes a written application for coverage under the Plan more than a specified number of days (as indicated in the Plan) after first becoming eligible for coverage under the Plan.

LOSS OR LOSSES mean amounts Paid, in accordance with the Policy Basis/Benefit Period shown on the Schedule, by You or the Administrator on Your behalf for benefits under the Plan, in settlement of claims for benefits under the Plan; or in satisfaction of judgments for benefits under the Plan.

LOSS OR LOSSES, HOWEVER, DOES NOT INCLUDE:

1. any payment which does not strictly comply with the provisions of the Plan; or
2. any payment for which there is any other insurance, reinsurance or plan established pursuant to federal, state or local law or any other indemnity against Loss which would, except for the existence of this Policy, indemnify the Insured; or
3. extra-contractual damages of any nature, compensatory damages, exemplary and punitive damages or liabilities of any kind whatsoever, including but not limited to those resulting from negligence, intentional wrongs, fraud, bad faith or strict liability on the part of You, Your Administrator or Your agent or broker; or
4. salaries paid to Your employees as well as Your claim and administrative expenses; or
5. litigation costs and expenses.

MAXIMUM AGGREGATE BENEFIT means the amount stated in the Schedule.

MAXIMUM SPECIFIC BENEFIT means the amount stated in the Schedule.

MINIMUM AGGREGATE ATTACHMENT POINT means an amount equal to 95% of the product of the Initial Enrollment of the first Covered Month of the Policy multiplied by the corresponding Aggregate Monthly Factor multiplied by twelve.

MONTHLY AGGREGATE ATTACHMENT POINT means an amount equal to the product of the total Number of Covered Units per Covered Month of a Policy Year multiplied by the corresponding Aggregate Monthly Factor.

NUMBER OF COVERED UNITS means the total Covered Units existing in any one Covered Month and will be determined on a monthly basis in accordance with the definition of Covered Units; and the eligibility requirements of the Plan.

PAID (Payment) means that a claim has been adjudicated by the Administrator and the funds are actually disbursed by the Plan prior to the end of the Benefit Period. Payment of a claim must be unconditional and directly made to a Covered Person or their health care provider(s). Payment will be deemed made on the date that both You or Your Administrator directly tenders payment by mailing (or by other form of delivery) a draft or check; and the account upon which the payment is drawn contains, and continues to contain, sufficient funds to permit the check or draft to be honored by the institution upon which it is drawn.

PLAN means the employee benefit plan You provide Your eligible employees and their eligible dependents, as defined in this Policy, which has been received and accepted by Us. Plan does not include

life insurance, accidental death and dismemberment insurance, long and short-term disability insurance coverages, or fully insured major medical insurance coverages.

POLICY YEAR means the specified period of time during which the coverage provided under this Policy is in effect, as stated in the Schedule.

SPECIFIC DEDUCTIBLE AMOUNT means the amount shown in the Schedule.

SECTION 3 - AGGREGATE EXCESS LOSS INSURANCE

If at the end of a Policy Year, Losses exceed the Annual Aggregate Attachment Point or the Minimum Aggregate Attachment Point shown in the Schedule, We will pay You an amount equal to:

1. the amount by which Losses Paid during the Policy Year exceed the applicable Annual Aggregate Attachment Point or the Minimum Attachment Point, whichever is greater, multiplied by,
2. the Benefit Percentage Payable and shown in the Schedule, subject to
3. the Maximum Aggregate Benefit as shown in the Schedule.

Payment of Policy benefits is:

1. subject to all terms, conditions, limitations and exclusions in this Policy, and
2. contingent upon Our receipt of satisfactory proof of Loss (including, without limitation, an on-site audit), and Your request for reimbursement.

Losses Paid under this Section 3 during any Policy Year will be determined according to the Policy Basis/Benefit Period, and will not include any amount paid or payable by Us to You for the applicable Policy Year for Specific Excess Loss Insurance according to the terms in Section 4 of this Policy.

If this Policy terminates prior to the Expiration Date as shown in the Schedule no Aggregate Excess Loss Benefits will be payable.

SECTION 4 - SPECIFIC EXCESS LOSS INSURANCE

If during the Policy Year, or any fraction of a Policy Year, Losses for any Covered Person exceed the Specific Deductible Amount shown in the applicable Schedule, We will pay a benefit for such Covered Person in an amount equal to:

1. the amount by which Losses Paid during the Policy Year exceed the Specific Deductible Amount as shown in the Schedule multiplied by:
2. the Benefit Percentage Payable, subject to
3. the Maximum Specific Benefit as shown in the Schedule.

Payment of Policy benefits is:

1. subject to all terms, conditions, limitations and exclusions in the Policy and the Plan, and
2. contingent upon our receipt of satisfactory proof of Loss and Your request for reimbursement, and
3. determined, for any Covered Person during the Policy Year, according to the Policy Basis/Benefit Period.

Payment will not include any amounts paid or payable by Us to You for Aggregate Excess Loss Insurance according to the terms in Section 3 of this Policy.

If this Policy terminates prior to the Expiration Date, the Benefit Period will not extend past the date of termination. In addition, the deductible per Covered Person will apply as if the Policy were in force for the entire Policy Year.

SECTION 5 - EXCLUSIONS AND LIMITATIONS

Our liability under this Policy will not be increased if the Plan provides more liberal exclusions and limitations provisions.

In addition to the exclusions and limitations provided under the Plan, this Policy will not cover any of the following (unless such exclusion or limitation is specifically waived by rider or endorsement):

1. Deductibles, co-payment amounts, or any other charges which are not payable under the terms of the Plan or charges which are payable by the Plan, or to You from any other source.
2. Charges for Experimental or Investigative services, treatments or supplies; or drugs which have not been approved by the Food and Drug Administration.
3. Any conditions for which benefits of any kind are paid or payable, by judgment or settlement, under any Worker's Compensation or Occupational Law, even if the Covered Person fails to claim his or her rights to such benefits.
4. Claims for a Covered Person who, on the date that coverage under this Policy would otherwise begin, is an employee who is not actively at work at his or her normal job or is a retired employee or dependent of an employee who is unable to perform the normal activities of a person of like age or sex.

No benefits will be provided for any charges Incurred until the day after the date that such Covered Person if an employee returns to active work on a full-time basis or if a retired employee or eligible dependent of an employee is able to perform the normal activities of a person of like age and sex.

5. Charges resulting from any extra or non-contractual damages or legal fees and expenses for the defense thereof, or any fines or statutory penalties.
6. Any procedure or treatment to change physical characteristics to those of the opposite sex, or any other treatment or studies related to a sex change or treatment of sexual disorders.
7. Any services furnished by an institution which is primarily a rest home, a place for the aged, a nursing home, a convalescent home, a place for custodial care, or any other place of like character.
8. Services or expenses for charges Incurred as a result of suicide or attempted suicide, whether sane or insane; or intentional self-inflicted injury or illness.
9. Injury or illness which occurs due to a Covered Person's commission of, or attempt to commit a criminal act or while a Covered Person is engaged in an illegal activity.
10. Legal expenses of any kind or description, including legal expenses related to or Incurred for the confinement of a Covered Person or any compulsory process to adopt, abstain from, or cease to continue a particular mode of treatment, care or therapy.
11. Services done for cosmetic purposes, unless performed to correct functional disorders or congenital anomalies; or due to accidental injury occurring while that individual is a Covered Person.
12. Expenses for hearing aids.
13. Treatment for obesity and/or eating disorders.

14. Expenses for artificial insemination, invitro fertilization, gamete or zygote intrafallopian transfer, or reversal of voluntary sterilization.
15. Transplants of non-human, mechanical or artificial organs or tissue.
16. Expenses arising out of, caused by, contributed to or in consequence of war, declared or undeclared, civil war, hostilities, or invasion.
17. Expenses for any COBRA continuee or retiree whose continuation of coverage was not offered in a timely manner or according to COBRA regulations.
18. Expenses incurred as a result of any lost savings or discounts offered by a facility or provider due to untimely payment of the bill by You or Your Administrator.
19. Expenses for which benefits are not payable under the Plan because of an exclusion for expenses incurred due to a pre-existing condition as defined in the Plan.

SECTION 6 - TERMINATION

This Policy and all Policy benefits will terminate upon the earliest of:

1. on any premium due date, if the premium due on that date is not paid in full by the end of the Grace Period;
2. the premium due date following Our receipt of Your written notice to cancel or terminate this Policy;
3. on any premium due date We specify if We give You at least thirty-one days advance written notice to cancel or terminate this Policy;
4. the end of the Policy Year as shown in the Schedule;
5. the date of termination of the Plan or the Policy;
6. the date that You suspend active business operations or become insolvent or a bankruptcy action is commenced (whether voluntary or involuntary) or You are in liquidation or receivership;
7. the date that You do not pay claims or make funds available to pay claims as required by the Plan;
or
8. the date on which Your employees are covered under another employee benefit plan or fully insured medical program.

In addition, this Policy shall automatically terminate upon the cancellation of the agreement between You and the Administrator, unless We have, prior to such cancellation, agreed in writing to Your designation of a successor Administrator.

SECTION 7 - PREMIUMS

PAYMENT OF PREMIUMS

No coverage under this Policy shall be in effect until the first premium for the Policy is paid. For coverage to remain in effect, each subsequent premium must be paid on or before its due date. You are responsible for paying premiums when they become due. Premium due dates are determined from the Effective Date. Each premium due date is the same day of each month corresponding with the Effective Date. If there is no such date in any applicable month, the last day of that month shall be used.

GRACE PERIOD

We will allow a thirty-one day Grace Period for the payment of each premium due after the payment of the first premium. During this Grace Period, this coverage shall remain in effect. If any premium is not paid within this thirty-one day period, coverage under this Policy will automatically terminate without further notice. Such termination will be effective as of the premium due date immediately following the end of the last period for which the minimum monthly premium has been paid.

PREMIUM RATE CHANGE

We have the right to modify Aggregate Monthly Factor(s) or Specific Monthly Premium Rates on any of the following dates:

1. the effective date of any change in benefits or other amendment to the Plan; or
2. the date that You acquire or dispose of any subsidiary, affiliated company, corporate division or assets relating thereto; or
3. any Anniversary Date as shown on the cover page of this Policy; or
4. any premium due date, when there is a ten percent or more change in the number of Covered Persons during a Policy Period; or
5. at such time as We determine that the last two months of claims in the preceding Policy Period vary by more than ten percent from the average monthly paid claims for the prior ten months.

SECTION 8 - YOUR DUTIES

You shall be responsible for the investigating, auditing, calculating, and paying of all claims, and the defense of any legal action instituted against You.

You shall maintain and make available to Us, at all times, such information and records as We may reasonably require evidencing Your proof of payment of amounts which qualify for coverage under this Policy.

You shall maintain a record of any and all amounts paid in excess of payments required by the Plan.

You shall prepare and submit to Us the following:

1. a monthly report of the total claims paid during the month,
2. a monthly report of the total number of Covered Units under the Plan during the month,
3. any other report as required by Us, and
4. any notice of claim as required under this Policy.

You shall maintain records reasonably required by Us and shall furnish to Us upon Our request, all pertinent data with respect to Covered Persons.

You shall immediately notify us if You acquire or dispose of any subsidiary, affiliated company, corporate division or assets relating thereto.

You shall immediately notify Us of the date that You suspend active business operations or become insolvent or a bankruptcy action is commenced (whether voluntary or involuntary) or You are in liquidation or receivership.

You shall immediately notify Us if the Plan is amended or terminated.

If You do not give Us notice of amendment of the Plan Our liability is limited to the lesser of the benefits payable: a) under the Plan as revised; or b) as if the Plan had not been amended.

You may retain an Administrator as Your agent to perform any or all of the duties listed in this Section. We are not liable under this Policy for any charges or expenses that may be incurred by You and/or Your Administrator for the performance of these duties.

You and the Plan acknowledge that:

1. The Administrator is not Our agent.
2. Payments by or notices from Us to the Administrator are deemed received by You upon receipt by the Administrator. Payments from You to the Administrator are not deemed received by Us. We act only as a provider of excess loss insurance coverage to the Plan. We do not act as a fiduciary. We do not assume any duty to perform any of the functions or provide any of the reports required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.
3. We must approve a change in Administrator prior to its occurrence.

SECTION 9 - GENERAL PROVISIONS

ENTIRE CONTRACT

This Policy, Your Application, Your Disclosure Statement and a copy of the Plan constitute the entire contract between the parties.

No change in the Plan, made after the Effective Date, shall have any effect on benefits payable under this Policy, unless a copy of such change has been submitted to and approved in writing by one of Our officers or Our authorized representative.

This Policy does not create any right or legal relationship whatsoever between Us and a Covered Person or beneficiaries under the Plan. We shall not have any responsibility or obligation under this Policy to directly reimburse any Covered Person, or provider of professional or medical services for any benefits which are provided under the terms of the Plan. Our only liability under this Policy is to You. Only one of Our officers may change this Policy. No change shall be valid unless the change is agreed to by Our President, Vice President or Secretary in writing.

OTHER INSURANCE

The insurance coverage provided by this Policy shall be excess over any other valid group health, excess insurance, or group indemnity coverage unless such other coverage is specifically issued to be in excess of the insurance provided by this Policy.

NOTICE

For the purpose of any notice required under this Policy, notice to the Administrator is notice to You, and conversely, notice to You is notice to the Administrator.

EXAMINATION OF RECORDS

Your books and records, and the books and records of all of Your agents and representatives pertaining to the Plan and/or insurance provided by this Policy shall be available to Us and Our representatives during Your regular business hours for inspection and audit.

AMENDMENTS TO THE PLAN

Amendments to the Plan are not covered under this Policy unless We have approved the proposed change in writing; and You have agreed to pay any additional premium or to accept a higher Aggregate Monthly Factor(s) as a result of the Plan change.

CLERICAL ERROR

Clerical error will not invalidate insurance otherwise in effect nor continue insurance validly terminated. A clerical error does not include intentional acts or the failure to comply with the Plan or this Policy. If an error is discovered, an equitable adjustment in premium will be made. If a premium and/or factor(s) adjustment involves the return of unearned premium, the amount of the return will be limited to the premium for the twelve month period which precedes the date that We receive proof that such an adjustment should be made.

CONFORMITY WITH STATE STATUTES

If any provision of this Policy or its Effective Date conflicts with any applicable law, the provision will be deemed to conform with the minimum requirements of such law.

ASSIGNMENT

Your interest under this Policy is not assignable and any attempt to assign Your interest shall be null and void.

NON-PARTICIPATING

You are not entitled to share in Our surplus earnings.

NOTICE OF POTENTIAL CLAIM

You shall give Us a written notice of any potential claim within thirty days of the date You become aware of the existence of facts which would reasonably suggest the possibility that expenses covered under the Plan will be Incurred for which benefits may be payable under this Policy, and is equivalent to or exceeds fifty percent of the Specific Deductible Amount.

This notice shall include:

1. name of the Covered Person;
2. date of accident or onset of sickness;
3. nature of injury or sickness; and
4. estimated total cost of claim.

Your failure to furnish written notice of a potential claim within thirty days shall not invalidate or reduce the claim if it was not reasonably possible to give such notice within such time; provided that written notice is furnished to Us as soon as reasonably possible.

CLAIMS

We shall have the sole authority to pay or deny claims which exceed any Aggregate Attachment Point or Specific Deductible Amount. Claims shall be administered by Us or Our authorized representative. Claims must be submitted within thirty days after You have paid Eligible Expenses on behalf of any Covered Person. We are not obligated to reimburse a claim submitted after such period. However, We will reimburse such claim in the event You show that timely submission was not possible, and You made the submission as soon as possible.

In no event will We reimburse claims submitted more than one year after proof of the claim was otherwise due. All benefits will be paid to You as they become payable under this Policy.

Any objection, notice of legal action, or complaint, which is received on a claim processed by You or Your Administrator and on which it reasonably appears that benefits will be payable under this Policy, shall be brought to Our immediate attention.

CASH LOSS LIMIT

When a claim has been submitted to Us which is in compliance with all other terms and conditions of this Policy and, provided that You have Paid to the providers of services or supplies to which the claim relates

all amounts equal to the Specific Deductible Amount, You may request in writing and We will consider advancing to You the remaining eligible unpaid balance of the claim.]

LEGAL ACTION

No legal action to recover any benefits may be brought until sixty days after the date that written claim for benefits has been given to Us. No legal action may be brought more than three years after the Incurred date of the Loss for which benefits are claimed.

RENEWAL

At the end of a Policy Year, a subsequent Policy Year may be agreed to by You and Us. The Schedule in Section 1 will be amended to show the coverage and terms in effect during each subsequent Policy Year.

SUBROGATION

You shall pursue any and all valid claims against third parties arising out of any occurrence resulting in a Loss payment under the Plan in accordance with applicable law. You shall account for any amounts recovered. Should You fail to pursue any valid claims against third parties for good cause and We then become liable to make payment to You under the terms and conditions of the Policy, then We shall be subrogated to all of Your rights to the proceeds of a third party settlement or satisfied judgment; but only to the extent that said settlement or judgment specifically allocates a portion thereof to Eligible Expenses Incurred by a Covered Person prior to the date of settlement or judgment. You shall take such action, furnish such information and assistance, and execute such papers as We may require to facilitate enforcement of Our rights, and shall take no action prejudicing Our rights and interests under this Policy.

Any amounts that We recover shall be used to pay Our expenses of collection; and reimbursement for any amount that We may have paid or become liable to pay, to You under the terms of this Policy. All remaining amounts shall be paid to You.

MEDICARE

This Policy does not provide benefits for any Loss for which payment has been made or would have been made, if application has been made or eligibility maintained, under Part A or Part B of Medicare on behalf of a Covered Person. However, if a Covered Person is eligible for Medicare but has a right to be enrolled under the Plan, such exclusion shall not apply.

REINSTATEMENT

We may agree at Our sole option and without prejudice to Our rights under this Policy to reinstate coverage as of the effective date of cancellation, on receipt and approval of written application for reinstatement and any and all other material and/or information as We may request, including but not limited to all outstanding premiums plus interest due from the effective date of reinstatement at a rate of not less than 1.5% per month compounded monthly. No insurance shall be reinstated until We confirm such reinstatement to You in writing and any premiums have been paid.

LIABILITY AND INDEMNIFICATION

Except as specifically provided in any rider or endorsement, attached to and forming part of the Policy, We have no obligation to any third party. Our liability under this Policy is limited to reimbursing You for payments You make on behalf of Covered Persons for expenses covered under the Plan. You hold Us harmless for damages, of any kind, which are not caused by Our own acts or omissions. We are not responsible for any liability You assume under any contract of agreement other than the Plan.



MARKEL INSURANCE COMPANY

GROUP STOP LOSS APPLICATION

1. Policyholder Name _____
 Contact Person _____
 Address _____

 Telephone Number (____) _____ Ext. _____
2. Names and addresses of all subsidiaries or affiliated companies whose employees will be covered.

3. Number of employees at all locations listed above:
 Single: _____
 Composite: _____
 Family: _____
 COBRA Continuees: _____
 Retirees: _____
4. Name of Plan Administrator: _____
 Address: _____
 (City) (State) (Zip)
5. Effective date: 12:01 am on _____
6. Benefits provided: Medical and Prescription Drugs
7. Optional benefits provided by rider:
 Dental Weekly Income Vision Other _____

AGGREGATE EXCESS LOSS INSURANCE

This section must be completed.

8. Benefits Included: Medical and Prescription Drugs
9. Optional benefits provided by rider

<u>BENEFIT</u>	<u>YES</u>	<u>NO</u>
Dental	θ	θ
Weekly Income	θ	θ
Vision	θ	θ
Other _____	θ	θ
10. Maximum aggregate benefit: _____
11. Benefit percentage payable: _____

12. Policy basis/Benefit period (check one):

Covered expenses incurred during the policy year and paid during the policy year.

Covered expenses paid during the policy year.

Covered expenses incurred within _____ month(s) prior to coverage effective date and paid during the policy year.

Covered expenses incurred during the policy year and paid within _____ month(s) after the policy year.

The applicant agrees and acknowledges that, depending upon the coverage selected and the terms of any expiring coverage or coverage the applicant may elect in the future, the applicant may experience losses that are not covered under the policy, when issued, or under any such prior or subsequent coverage.

13. Annual aggregate premium: _____

14. Monthly aggregate premium per employee: _____

15. Aggregate monthly factors

Single: \$ _____

Family: \$ _____

Composite: \$ _____

16. Covered units/Enrollees

Single: _____

Family: _____

Composite: _____

17. Initial Attachment Point: _____

18. Minimum Attachment Point: _____

SPECIFIC EXCESS LOSS INSURANCE: YES NO

Complete this section ONLY if Specific Excess Loss Insurance is selected as an option.

19. Deductible per covered person: _____

20. Maximum specific benefit minus the deductible: _____

21. Benefit percentage payable: _____

22. Expense eligibility claim basis (check one):

Covered expenses incurred during the policy year and paid during the policy year.

Covered expenses paid during the policy year.

Covered expenses incurred within _____ month(s) prior to coverage effective date and paid during the policy year.

Covered expenses incurred during the policy year and paid within _____ month(s) after the policy year.

The applicant agrees and acknowledges that, depending upon the coverage selected and the terms of any expiring coverage or coverage the applicant may elect in the future, the applicant may experience losses that are not covered under the policy, when issued, or under any such prior or

subsequent coverage.

23. Specific premium rates:

Single: \$ _____

Family: \$ _____

Composite: \$ _____

20. A deposit of \$_____ is enclosed to apply to the first payment under the policy, if issued, subject to the requirements below. If the application is not accepted, the deposit will be returned.

It is understood and agreed that:

1. Any Excess Loss Insurance resulting from this application shall be as described in and shall be subject to the terms and provisions of the policy, when issued. Such policy shall become effective on the date specified in this application; provided that, including, without limitation:
 - a. a true and correct Disclosure Statement has been received;
 - b. the underwriting requirements have been satisfied;
 - c. the required premiums have been paid;
 - d. a copy of the executed Plan is received and acceptable to the Company pursuant to paragraph b below; and
 - e. the policy has been issued.
2. Within 90 days from the date of this application, the applicant shall furnish to Markel insurance Company, for approval, a copy of the executed employee benefit plan (the Plan) describing the benefits provided by the Plan. The Plan shall be kept on file in the office of the approved third party administrator or the Company. No Policy will be released nor claim reimbursed until a Plan is received and accepted by the Company. If we do not receive a copy of the Plan within 90 days of the date of this application, all premium will be refunded and coverage will be null and void retroactive to the proposed effective date. If in the sole judgment of the Company there is a material variance between the provisions of the Plan received by the Company, and the Plan provisions upon which the terms and rates of the aggregate and specific excess coverage were based, the Company may, at its option, notify the applicant of such variances and decline to release the policy until an amended Plan is received and accepted. In the event an amended Plan is not received and accepted by the Company within 30 days of such notice, all premium will be refunded and coverage will be null and void retroactive to the proposed effective date.
3. The applicant will provide or employ supervision and claim administration facilities acceptable to the Company to administer the Plan and to process and pay claims according to the Plan.
4. Receipt by the Company of the initial premium and the deposit of any check drawn in connection with this application shall not constitute an acceptance of liability. In the event that the Company does not approve this application, its sole obligation shall be to refund the deposit premium to the applicant.
5. The applicant represents that the statements and declarations made in this application, the Disclosure Statement, and in the Plan referred to in this application are true and complete and that the policy will be issued in reliance upon the truth and completeness of such statements and declarations. The Disclosure Statement, this application and the Plan shall form a part of the policy, and the policy shall embody all agreements existing between the applicant or its authorized agent and the Company relating to the excess loss insurance for which application is being made.

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

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.

The applicant represents that it, directly or through its authorized agent, has read this application in its entirety and has been given the opportunity to ask any questions it may have. The applicant further understands that the insurance requested does not start unless this application is approved and accepted by the Company.

Dated _____

Signature of Employer _____

Name _____

Title _____

Dated _____

Signature of Producer _____

Name _____

Producer's Address _____

MARKEL INSURANCE COMPANY

4600 Cox Road
Glen Allen, VA 23060

SERFF Tracking Number: MRKC-125742396

State: Arkansas

Filing Company: Markel Insurance Company

State Tracking Number: 39776

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: Stop Loss

Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: MRKC-125742396

State: Arkansas

Filing Company: Markel Insurance Company

State Tracking Number: 39776

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: Stop Loss

Project Name/Number: /

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 08/16/2008
Comments:
Attachment:
Rule 19 Certification - Signed.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 08/16/2008
Comments:
Application can be found under form schedule tab.

Bypassed -Name: Health - Actuarial Justification **Review Status:** Approved-Closed 08/16/2008
Bypass Reason: Not applicable
Comments:

Bypassed -Name: Outline of Coverage **Review Status:** Approved-Closed 08/16/2008
Bypass Reason: Not applicable
Comments:

Satisfied -Name: Readability Certification **Review Status:** Approved-Closed 08/16/2008
Comments:
Attachment:
READABILITY CERTIFICATION - MSL100.pdf

Satisfied -Name: Cover Letter **Review Status:** Approved-Closed 08/16/2008
Comments:
Attachment:
AR Cover Letter (07-22-08).pdf

SERFF Tracking Number: MRKC-125742396

State: Arkansas

Filing Company: Markel Insurance Company

State Tracking Number: 39776

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: Stop Loss

Project Name/Number: /

Satisfied -Name: AR Forms List

Review Status:

Approved-Closed

08/16/2008

Comments:

Attachment:

AR Forms List Stop Loss.pdf



MARKEL INSURANCE COMPANY

4600 Cox Road Glen Allen, Virginia 23060-9817 P.O. Box 3870, Glen Allen, Virginia 23058-3870
(804) 527-2700 (800) 431-1270 Fax (804) 527-7915

Markel Insurance Company certifies that this Stop Loss submission is in compliance with Arkansas Rule 19 as well as all applicable requirements of the Arkansas Department of Insurance.

Mark Nichols, A&H Vice President and Business Unit Manager
Officer of the Company



Signature

7/24/08
Date

READABILITY CERTIFICATION

The undersigned hereby certifies that he has reviewed the enclosed form(s) and certifies to the best of his knowledge and belief, the form(s) meet(s) the minimum Flesch reading ease test score requirement of 51.

Form number

Description

MSL100 (02/07)

Excess Risk Insurance Policy



By: _____
Signature

Name: Mark Nichols
Title: Vice President
Date: February 1, 2008



MARKEL INSURANCE COMPANY

4600 Cox Road Glen Allen, Virginia 23060-9817 P.O. Box 3870, Glen Allen, Virginia 23058-3870
(804) 527-2700 (800) 431-1270 Fax (804) 527-7915

July 22, 2008

Sent via SERFF

Ms. Julie Benafield Bowman, Commissioner
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

RE: **MARKEL INSURANCE COMPANY**
NAIC No. 38970 FEIN No. 363101262

Excess Loss Insurance Program

MSL100 (02/07) Excess Loss Insurance Policy
MSL123-AR (07/08) Group Stop Loss Application

- Rates are Exempt From Filing -

(See Attached Forms Listing)

Dear Commissioner Bowman:

The above referenced forms are attached for your review and approval. These forms are new and do not replace any forms previously approved by your Department.

PRODUCT DESCRIPTION

This excess loss coverage is designed to be offered to employer groups who self fund their employee medical plan. This coverage is purchased by the employer to protect itself from catastrophic losses. Benefits are payable to the employer and not to individual employees. While the benefits covered under the plan will parallel the employer's underlying plan, this excess loss coverage is not medical coverage for employees. As excess/stop loss coverage is not "health insurance coverage" as defined under the federal Health Insurance Portability and Accountability Act (HIPAA), it is not subject to the requirements in the HIPAA law. Benefits will be offered on a specific or aggregate basis, or both. The exact benefits will vary depending on the options chosen by the employer. Marketing for this product will be done through licensed agents and brokers.

As a point of information, this excess loss program is exempt from the filing requirements of the Company's state of domicile, Illinois.

Please be advised that the above mentioned forms comply with Arkansas's readability requirements, scoring a 51 on the Flesch reading ease test. Our filing in SERFF includes a readability certification as well as a certification attesting that we will comply with Arkansas Rule 19. These forms are exempt from filing in our domicile state of Illinois and have not been previously filed with the state of Arkansas. Included in this filing is a filing fee of \$50, which is not retaliatory.

The forms are in final printed form subject only to changes in font style, margins, page numbers, ink, and paper stock. Printing standards will never be less than those required by law. Once approved, the Company reserves the right to use the forms in their approved format in a variety of media, including the Internet, with the understanding that there may be slight accommodations made for electronic viewing.

Attached please find any applicable state required fees, transmittal forms and a readability certification. If there are any questions or comments which you feel could best be handled by phone, please feel free to contact us. We would be most pleased to discuss this filing with you over the phone.

Markel Insurance Company will deem these forms approved, if upon the expiration of the initial review period, your Department has not extended the review period or otherwise has not responded to this submission.

Thank you in advance for your immediate attention.

Sincerely,

A handwritten signature in black ink that reads "Carol F. DePuy". The signature is written in a cursive, flowing style.

Carol F. DePuy
Regulatory Compliance Manager, Accident & Health
cdepuy@markelcorp.com

MARKEL INSURANCE COMPANY

**Excess Loss
Arkansas Form Listing**

Form Name	Form Number
Excess Loss Insurance Policy	MSL100 (02/07)
Group Stop Loss Application	MSL123-AR (07/08)