

SERFF Tracking Number: BKAH-126222715 State: Arkansas
Filing Company: StarNet Insurance Company State Tracking Number: 42912
Company Tracking Number: AH52041
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Provider Excess Loss
Project Name/Number: Provider Excess Loss/AH52041

Filing at a Glance

Company: StarNet Insurance Company

Product Name: Provider Excess Loss

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: BKAH-126222715 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 42912

Co Tr Num: AH52041

State Status: Approved-Closed

Co Status:

Reviewer(s): Rosalind Minor

Authors: Barbara Glowatsky, Susan Disposition Date: 07/17/2009

Bradbury, Denise Beck, Diana

Mandile, Caren Alvarado

Date Submitted: 07/10/2009

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Provider Excess Loss

Project Number: AH52041

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 07/17/2009

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: These forms are not available in our home state of Delaware.

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Other

Explanation for Other Group Market Type:

Provider

State Status Changed: 07/17/2009

Corresponding Filing Tracking Number:

Deemer Date:

Filing Description:

The above referenced forms are submitted for your review and approval. These forms are new and do not replace any forms previously approved by your department. It is not required to be filed in our state of domicile Delaware.

This medical provider excess loss program is intended to provide coverage for catastrophic losses. More specifically, it

<i>SERFF Tracking Number:</i>	<i>BKAH-126222715</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>StarNet Insurance Company</i>	<i>State Tracking Number:</i>	<i>42912</i>
<i>Company Tracking Number:</i>	<i>AH52041</i>		
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is a type of stop loss protection against catastrophic claims for medical provider organizations that assume financial risk through the use of capitated payment agreements. It has been designed to mitigate the unanticipated financial loss that may be incurred by a capitated medical provider in treating a catastrophic illness or injury. The coverage offers eligible medical provider groups; e.g., physician groups, hospitals, physician hospital organizations and preferred provider organizations, the opportunity to insure their capitation arrangements with stop loss insurance. It will be marketed via licensed agents and brokers.

Variable data is bracketed and may vary from case to case. Amounts may vary or provisions may be modified to fit a specific Policyholder's request. Variable data will never exclude or limit provisions required by your state. The enclosed Explanation of Variables provides more detailed information about the variable text.

Company and Contact

Filing Contact Information

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

Susan Bradbury, Director of Compliance	sbradbury@berkleyah.com
3655 North Point Parkway	(770) 751-8930 [Phone]
Alpharetta, GA 30005	(866) 790-2179[FAX]

Filing Company Information

StarNet Insurance Company	CoCode: 40045	State of Domicile: Delaware
475 Steamboat Road	Group Code:	Company Type:
Greenwich, CT 06830	Group Name:	State ID Number:
(203) 542-3800 ext. [Phone]	FEIN Number: 22-3590451	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$150.00
Retaliatory?	Yes
Fee Explanation:	Delaware has a \$50.00 per form filing fee. 3 forms = \$150.00
Per Company:	No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
StarNet Insurance Company	\$150.00	07/10/2009	29116390

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/17/2009	07/17/2009

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Disposition

Disposition Date: 07/17/2009

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	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Explanation of Variables	Approved-Closed	Yes
Form	Provider Excess Loss Policy	Approved-Closed	Yes
Form	Provider Excess Loss Application	Approved-Closed	Yes
Form	Provider Excess Loss Policy AE	Approved-Closed	Yes

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Form Schedule

Lead Form Number: AH52041

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AH52041	Policy/Cont Provider Excess ract/Fratern Loss Policy al Certificate	Initial		51	SIC AH52041_PO LICY.pdf
Approved-Closed	AH52042	Application/ Provider Excess Enrollment Loss Application Form	Initial			SIC AH52042_Ap p.pdf
Approved-Closed	AH52043	Policy/Cont Provider Excess ract/Fratern Loss Policy AE al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			SIC AH52043_Pol icy_Endt.pdf

StarNet Insurance Company

Wilmington, Delaware

[Administrative Office: 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690]

A Berkley Company

PROVIDER EXCESS LOSS INSURANCE POLICY

Policyholder: [ABC Company]

Policy Number: [12345]

Effective Date: [May 1, 2008]

StarNet Insurance Company (“the Company”) agrees to reimburse the Policyholder as outlined under the provisions of this Excess Loss Insurance Policy (“this Policy”), subject to all the terms and conditions of this Policy.

This Policy is legally binding between the Policyholder and the Company. This Policy is issued in consideration of the application and the payment of premiums as provided hereinafter.

The first premium is due on the first day of the Policy Period. Subsequent monthly premiums are due on the first day of each month thereafter. The premium is not considered paid until the premium payment is received by the Company.

All periods of coverage will begin and end 12:01 a.m. Standard Time at the principal office of the Policyholder.

This Policy is governed by the laws of the state of delivery as stated in the Schedule of Insurance. The Policyholder and the Company further agree to the following terms and conditions of the Policy.

Signed for the Company:



President



Secretary

**PLEASE READ THIS POLICY CAREFULLY
THIS IS A POLICY OF EXCESS INSURANCE
ISSUED TO THE POLICYHOLDER IDENTIFIED ON THE SCHEDULE OF INSURANCE
NON-PARTICIPATING**

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StarNet Insurance Company

Urbandale, Iowa

[Administrative Office: 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690]

A Berkley Company

SCHEDULE OF INSURANCE

Policyholder: [ABC Provider]

Subsidiary of Affiliated Entities included in the Policy:

Full legal name: [CDE Provider]

Principal address: [Place, City, State, Zip]

State of Delivery: [Any State]

Policy Number: [XYZ1234]

Policy Period: **Effective Date:** [MM/DD/YYYY] **Expiration Date:** [MM/DD/YYYY]

Managed Care Organizations included for the purposes of this Policy:

Full legal name: [CDE MCO]

Principal address: [Place, City, State, Zip]

Covered Plan(s) [HMO, Commercial, Medicare, Medicaid]

Specific Excess Loss Insurance:

Specific Deductible: [\$XXX,XXX]

Maximum Benefit Per Covered Person: [\$XXX,XXX]

[Maximum Aggregate Limit of Company's Liability: [\$XXX,XXX]

[The Specific Deductible will be reduced by [\$5,000-\$75,000] for Members who undergo a Transplant paid at a fixed fee (case rate) or paid at a fixed fee with outlier per diems. This reduction in the Specific Deductible will not apply to Transplants paid at a percentage of charge basis or if the fixed fee reverts to a percentage of charge basis once an outlier or stop-loss level is reached.]

Percentage payable in Excess of the Specific Deductible

[Hospital Services	XX %	Chemical Dependency Treatment Facility	XX %
Referral Hospital	XX %	Transplant Services:	
Out-of-Service-Area Emergency Hospital	XX %	Contracted Transplant Facilities	XX%
Extended Care Facility	XX %	Non Contracted Transplant Facilities	XX%
Home Health Care	XX %	Physician Services	XX %
Rehabilitation Facility	XX %	[All eligible services	XX%]]

Claims Basis:

Losses that are:

Incurred from: [MM/DD/YYYY to MM/DD/YYYY]

Paid by: [MM/DD/YYYY]

Reported by: [MM/DD/YYYY]

Received by Us by: [MM/DD/YYYY]

In the event that this Policy is terminated for any reason prior to the expiration date claims for Eligible Services must be received by the Company within six (6) months after the termination date of the Policy.

Eligible Services

[Inpatient Hospital]	[Durable Medical Equipment]
[Outpatient Services]	[Prescription Pharmaceuticals [not retail]]
[Inpatient Rehabilitation Facility]	[Transplant Network Access Fees]
[Long Term Acute Care Facility (LTAC)]	[Skilled Nursing Facility]
[Extended Care Facility]	[Referral Hospital]
[Hospice]	[Home Health Care]
[Physician Professional Care [in connection with Transplants]]	

Premium Rate Per Member per Month: [\$0]

Minimum Premium: [\$0]

[Aggregate Claims Retained Amount per Member per month [\$0]]

[Annual Minimum Aggregate Claims Retained Amount [\$0]]

[Minimum Premium Rate per Member per month [\$0]]

[Maximum Premium Rate per Member per month [\$0]]

Carryover Period [0, 30, 90] days

[EXPERIENCE REFUND:

The Company may refund to the Policyholder a portion of the premium paid for the Policy effective [xx/xx/xx] and ending [xx/xx/xx] if the following conditions are satisfied:

- 1) The Company issues the Policyholder a renewal Policy for the [12] month period immediately subsequent to this policy; and
- 2) The Policyholder accepts the renewal Policy with the Company; and
- 3) The Policyholder's coverage is continuous from the effective date of this policy for the entire 12 month Policy Period of the subsequent policy with the Company; and
- 4) The minimum gross annual premium for the current Policy is [\$250,000 - \$1,000,000]; and
- 5) The refund calculation below results in a positive balance. If the calculation results in a negative balance, no refund will be paid

The amount of the refund will be [10% to 100%] of the result of the following refund calculation:

- 1) The sum of all gross premium paid to and collected by the Company for the Policy Period; minus
- 2) The sum of all expenses incurred by the Company [that are equal to [0% to 100%] of paid and collected premium for the Policy Period]; minus
- 3) The sum of all Company liability for the Policy Period. Company liability means the total amount paid by the Company under this Policy, including claims, paid under the Policy, loss adjustment expenses, administrative fees or charges, and loss reserves established by the Company; minus
- 4) [The sum of all deficits incurred under the [three] policy periods immediately preceding this Policy Period].

The Company will calculate and distribute to the Policyholder any experience refund [3 to 36] months after the end of the Policy Period.]

[LOSS CORRIDOR

Loss Corridor means the Policyholder agrees to self-insure a certain portion of Claim Payments as follows. In the event that the Loss Ratio under the Policy reaches [40-75%], the Policyholder will self-insure (and, therefore pay) the full amount of all Claim Payments in excess of such [40%-75%] Loss Ratio up to the Maximum Self-Insured Amount. In the event that Claim Payments by the Policyholder reach the Maximum Self-Insured Amount, the Policyholder's obligation to make Claim Payments ends and the Company's obligation to make Claim Payment's resumes, subject to the limits of liability and the other terms and conditions of the Policy.

"Claim Payments" mean the sum of (i) all amounts payable under the Policy plus (ii) any costs incurred by the Company in processing such Claims.

"Loss Ratio" means the percentage arrived at by dividing Claim Payments by the full amount of annual premium payable by the Policyholder under the Policy.

"Maximum Self-Insured Amount means an amount equal to the sum of \$x.xx per Member per month multiplied by the number of annual Members months covered under the Policy.]

[SWING RATE PROVISION

1. After the Policyholder has completed its [three (3) – twenty-four (24)] months payment period immediately following the Policy Period, the Company shall compute the following:
 - a) Reimbursements made to the Policyholder for Eligible Services during the Policy Period in accordance with the terms of the Policy;
 - b) Reimbursements to be made to the Policyholder for Eligible Services during the Policy Period in accordance with the terms of the Policy;
 - c) The Minimum Premium Rate (shown in the Schedule of Insurance) paid by the Policyholder to the Company during the Policy Period;
 - d) The sum of a) and b) above divided by [%]; then further divided by the cumulative number of Covered Persons insured during the Policy Period.
2. In order to calculate the total premium payable by the Policyholder, subtract the rate computed in 1.d) above from the rate computed in 1.c) above.
3. If the amount computed in 1.d) above is less than or equal to the amount computed in c) above, the Minimum Premium payable per Member per month is considered the premium payment for the Policy Period and no further computations will be made.
4. If the amount computed in 1.d) above is greater then the amount computed in 1.c) above, the difference payable per Member per month will be the additional premium due from the Policyholder. However, in no event will the amount paid by the Policyholder exceed the Maximum Rate shown in the Schedule of Insurance.]

DEFINITIONS

The following definitions apply to this Policy. In the event of conflict in the meaning of terms or the content of provisions between the Policy and the Subscriber Agreement(s), Capitated Provider Agreement(s) or Covered Plan(s), these definitions and the provisions of this Policy will govern.

The inclusion of a definition of a Facility, Service, Hospital or Provider in this section or anywhere else in this Policy, does not automatically mean that coverage is provided for that Facility, Service, Hospital or Provider. Only those Eligible Services and Facilities shown on the Schedule will be considered covered.

AGREEMENT CHANGE means any amendment, revision, change or other alteration to the Subscriber Agreement(s), Capitated Provider Agreement(s) or to the Covered Plan(s), which is made after our review and acceptance of all the terms and provisions of such Agreement(s).

[ANNUAL AGGREGATE CLAIMS RETAINED AMOUNT per Policy Period means the amount wholly retained by the Policyholder in addition to the Specific Deductible per covered Member per Policy Period shown in the Schedule. The Annual Aggregate Claims Retained Amount per Policy Period shall be the Claims Retained per Covered Person per Policy month amount shown in the Schedule multiplied by the total number of Covered Persons for the Policy Period, or the minimum Annual Aggregate Claims Retained Amount shown in the Schedule, whichever is greater.]

AVERAGE DAILY MAXIMUM (ADM) means [the average expense per day for each period of continuous confinement for Inpatient care during the Policy Period.] [The average expense per day over all confinements for Inpatient care during the Policy Period.] [The number of days used to determine the tiering for the ADM is the cumulative number of days of inpatient confinements per Covered Person occurring during any one Policy Period.]

BLOOD PRODUCTS means blood products, including blood clotting factors, derived from blood or recombinant (synthetic) sources and used to treat serious conditions, including but not limited to Factor VIIa (recombinant), Factor VIII (human, porcine, recombinant), Factor IX (non-recombinant and recombinant), and von Willebrand Disease.

CAPITATED PROVIDER AGREEMENT means the written and executed agreement or contract, including any and all amendments and additions thereto, between the Policyholder and the Managed Care Organization through which the Policyholder agrees to provide Eligible Services to Covered Persons in exchange for a fixed monthly fee per Covered Person. The terms and conditions of the Capitated Provider Agreement must be reviewed by the Company.

CARRYOVER PERIOD means the period of time prior to the Effective Date as shown in the Schedule of Insurance. Eligible Services incurred by a Covered Person during this period will be included as Eligible Services under this Policy if the Annual Deductible was not met by the Covered Person during the prior Policy year [under a Policy issued by the Company.]

CHEMICAL DEPENDENCY TREATMENT FACILITY means an institution licensed by the laws of the state where it is located and operating as a facility for the treatment of Chemical Dependency. Such facilities must:

1. operate within the scope of its license;
2. provide 24-hour-a-day nursing care furnished or supervised by graduate Registered Nurses;
3. maintain daily clinical records on each patient;
4. have the services of a Physician available at all times under an established agreement;
5. use appropriate methods to dispense and administer drugs and medicines;
6. have transfer arrangements with at least one hospital;
7. have a utilization review plan in effect; and

8. have treatment policies developed with the advice of, and reviewed by, a group of professionals who are specialists in the care and treatment of chemical dependency.

CHEMOTHERAPY means antineoplastic drugs used to treat cancer or the combination of these drugs into a standardized treatment regimen.

[**CLAIMS RETAINED** means those claims in excess of the Specific Deductible per Covered Person per Policy Period shown in the Schedule retained or assumed by the Policyholder which would otherwise be payable by Us under the terms and conditions of the Policy.]

COMPANY, WE, US and OUR means [StarNet Insurance Company](#).

[**CONTRACTED TRANSPLANT FACILITY** means:

1. any first tiered participating facility for any one of the following transplant network programs: Interlink Health Services; LifeTrac; Strategic Health Development Corporation; United Resource Network (URN) and/or Cigna LifeSource
2. any non-first tiered participating facility for any one of the following transplant network programs: Interlink Health Services; LifeTrac; Strategic Health Development Corporation; United Resource Network (URN) and/or Cigna LifeSource which has a negotiated a rate for transplant services which ultimately results in a paid amount which is less than or equal to the total length of stay for Transplant Services times [\$1,000 - \$10,000] per day; or
3. any facility at which the Policyholder has negotiated a rate for transplant services which ultimately results in a paid amount which is less than or equal to the total length of stay for Transplant Services times [\$1,000 - \$10,000] per day

Additionally, prior to the transplant event, the Policyholder is responsible for complying with all guidelines established by Interlink, LifeTrac, Strategic Health Development Corporation, United Resource Network or Cigna LifeSource and signing all agreements, letters of agreement, and/or memoranda of understanding required by Interlink, LifeTrac, Strategic Health Development Corporation, United Resource Network or Cigna LifeSource. The Policyholder shall not rely on this Policy to provide access to negotiated rates at any Interlink, LifeTrac, Strategic Health Development Corporation, United Resource Network or Cigna LifeSource participating facility. Rather, the Policyholder will obtain access to Interlink, LifeTrac, Strategic Health Development Corporation, United Resource Network or Cigna LifeSource negotiated rates only when they receive an agreement(s) signed by an authorized representative of Interlink, LifeTrac, Strategic Health Development Corporation, United Resource Network or Cigna LifeSource which specifies the terms and conditions for a specific Member at a specific facility.]

COVERED PERSON means any individual person, including any dependent of a subscriber, member, or insured, who:

1. is enrolled in or who subscribes to the Covered Plan(s) shown in the Schedule; and
2. is eligible to receive Eligible Services within the terms and provisions of the Subscriber Agreement while this Policy is in force; [and] [or]
3. is assigned to the Policyholder under a Capitated Provider Agreement.

COVERED PLAN(s) means the health benefits and medical services provided or made available to Covered Persons through the Managed Care Organization within the terms and provisions of the Subscriber Agreement. and the Covered Plan(s) are shown in the Schedule.

EFFECTIVE DATE means the date set forth on the cover page of the Policy.

ELIGIBLE SERVICE means any Medically Necessary service, treatment, or supply which is:

1. specified in the Capitated Provider Agreement as being the sole responsibility of the Policyholder to provide to a Covered Person; and
2. shown in the Schedule as an Eligible Service.

EXPERIMENTAL OR INVESTIGATIVE SERVICES, medical treatments, procedures, technology, supplies or drugs which:

1. have not been approved by the Federal Food and Drug Administration for the particular condition at the time the service, medical treatment, procedure, technology, supply or drug is provided; or
2. is the subject of ongoing Phase I, II, or III clinical trial as defined by the National Institute of Health, National Cancer Institute or the FDA; or
3. there is documentation in published U.S. peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine the safety, toxicity or efficacy of the service, medical treatment, procedure, technology, supply or drug ; or
4. the patient has been asked to sign or has signed a release or other document indicating that the treatment is experimental or investigative or other term of similar meaning.

In determining any of the above, the Company will rely on recognized medical sources such as, but not limited to, the American Medical Association, including 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.

EXTENDED CARE FACILITY means:

1. an institution owned, operated by or affiliated with a Hospital (by written agreement); or
2. a separate and distinct part of a Hospital; or
3. any other institution or part of an institution meeting the requirements established for approved operation under Medicare.

Such institution must be operated and licensed in accordance with the laws of the state and locality where located. It must maintain daily medical records for each patient and be primarily engaged in providing:

1. room and board; and
2. 24-hour-a-day inpatient skilled nursing services by, or under the supervision of, a full-time Registered Nurse; and
3. other necessary medical services under the supervision of a Physician or staff of Physicians whose services are available at all times.

HOSPICE means a comprehensive package of services that are:

1. Provided by health-care providers who are Medicare certified and have a current state Hospice license.
2. Offered as palliative care support to an individual who has a medical prognosis with a life expectancy of 6 months or less and his/her family.
3. Provided in the home or a Facility.
4. Focused on holistic support and relieving pain and other symptoms during the terminal illness.

HOME HEALTH CARE means part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services (excluding general housekeeping services) under the supervision of a registered nurse (R.N.); physical, occupational, and speech therapy provided by a registered therapist or under the supervision of a registered therapist; medical supplies; and laboratory services provided through a federally certified and state licensed home health agency.

HOSPITAL means an institution which:

1. is licensed and operated as a Hospital under the laws of the jurisdiction where it is located; and
2. provides, as its primary function, for pay on an inpatient basis:
 - a. facilities for medical and surgical diagnosis and therapy; and
 - b. treatment and care of the sick and injured; and
3. is under the direction of a staff of Physicians; and
4. provides 24-hour-a-day nursing services by Registered Nurses; and
5. has facilities on premises for major surgery [and

6. meets the required standards of the Joint Commission on Accreditation of Healthcare Organizations and is approved by Medicare.]

An institution that lacks surgical facilities may still be considered a Hospital if it has a written contractual arrangement with an accredited Hospital for the performance of major surgery.

Hospital will not include an institution used as a facility for:

1. rest; or
2. custodial care; or
3. nursing; or
4. care for the aged; or
5. care for alcoholics or drug addicts.

ILLNESS means a bodily, emotional or nervous disorder, or mental infirmity. Illness includes pregnancy (including childbirth, non-elective therapeutic abortion, when Medically Necessary, miscarriage or complications.)

INCURRED means the date an Eligible Service is performed or provided.

INJECTABLES means drugs other than oral medications (as indicated in HCPCS books) for non-chemotherapy medication, excluding Blood Products.

INJURY means an accidental bodily trauma which is caused directly and independently of all other causes by an accident.

INTENSIVE CARE UNIT means a type of Hospital accommodation to provide the level of services necessary for:

1. the care of critically ill patients who require constant audio-visual observation that is prescribed by a Physician under the supervision of a graduate Registered Nurse; and
2. the provision of all necessary life saving equipment, drugs, and supplies for immediate use.

LIFETIME MAXIMUM AMOUNT PER COVERED PERSON means the maximum amount payable to the Policyholder by the Company with respect to any one Covered Person under all Policies issued by the Company.

LONG TERM ACUTE CARE “(LTAC)” FACILITY means a licensed acute care Hospital that provides extended medical and rehabilitative care of Covered Persons who suffer from multiple acute or chronic conditions and require specialized, complex care. Services include comprehensive rehabilitation, respiratory therapy, head trauma treatment and pain management.

MANAGED CARE ORGANIZATION means an organization, as shown in the Schedule, which has contracted with the Policyholder to provide or arrange to provide Eligible Services to Covered Persons under a covered Capitated Provider Agreement with the Policyholder.

MATERIAL CHANGE means a change or combination of changes in:

1. any provider agreement or contract that Company determines would increase expected aggregate insurance claims under this Policy by [5-20%] or more
2. The assets of the Policyholder due to the acquisition of, merger with or sale to another company.
3. Senior operating management
4. Policyholders management service contracts
5. Majority ownership of Policyholder
6. If the number of [Commercial, Medicare, Medicaid] Covered Persons increases or decreases by more than [5 to 100%].

Material Changes must be advised to Us, and may be excluded, or result in premium changes or termination of this agreement.

MAXIMUM BENEFIT PER COVERED PERSON means the maximum amount payable to the Policyholder per Policy Period under the Policy with respect to any one Covered Person.

MAXIMUM COVERED AMOUNT means the highest dollar amount for the Eligible Services specified in the Schedule that will both count toward the Specific Deductible and be payable to the Policyholder at the percentage payable shown in the Schedule after satisfaction of the Specific Deductible.

MEDICALLY NECESSARY AND MEDICAL NECESSITY means a treatment, service, supply or medicine that:

1. is appropriate and essential for the diagnosis or treatment of the Covered Person's symptoms;
2. falls within the scope, duration or intensity of the level of care needed to provide safe, adequate and appropriate diagnosis or treatment;
3. is in accordance with generally-accepted current professional medical practice, based on consultation with health care providers in the appropriate medical specialty; and
4. allows the inclusion only of those drugs or substances formally approved by the United States Food and Drug Administration.
5. is defined by established National Medical Necessity Criteria guidelines.

A treatment, service, supply or medicine will not be considered Medically Necessary if:

1. it is part of a treatment plan that is considered to be experimental or for research purposes; or
2. it is provided primarily as a convenience to the patient, the patient's family or the provider of care.

The fact that a Physician may prescribe, order, recommend, or approve a treatment, service, supply or medicine does not, of itself, make it Medically Necessary.

MEDICAID means Title XIX of the Social Security Act of 1965, as amended.

MEDICARE means Title XIII of the Social Security Act of 1965, as amended.

MEDICARE ALLOWABLE means fees set by Medicare.

NON-PARTICIPATING PROVIDER means a provider of healthcare services who does not meet the definition of a Participating Provider.

OUT OF AREA EMERGENCY means that due to accidental bodily injury or other emergency medical condition, a Covered Person receives immediate medical treatment or services in a location other than the Service Area of the Plan. In such event, You will make the appropriate arrangements for the Covered Person's earliest possible discharge, or transfer to a Participating Provider within Your Service Area.

OUTPATIENT CARE means services and supplies provided by a facility to a Covered Person who is NOT a registered inpatient in that facility.

OUTPATIENT SERVICES means services and supplies provided and used at a Hospital under the direction of a Physician to a Covered Person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory, x-ray facility, dialysis center or an ambulatory surgical center.

PAID means the date the Policyholder tenders a draft or check in payment of or renders a billing in respect of charges for Eligible Services incurred by a Covered Person or otherwise settles any such amount due.

PARTICIPATING PROVIDER means any Hospital, Physician, or other health care or medical service provider or entity which has entered into a written agreement with You or the Managed Care Organization(s) shown in the Schedule to provide health care services or treatment to Covered Persons in exchange for pre-determined pricing. It also means any Provider in which or in whom You have an ownership interest, or which has an ownership interest in You. A list of the Policyholder's Participating Providers has been advised to and is on file with Us.

PHARMACEUTICALS means Blood products, chemotherapy, injectables and prescription medication.

PHYSICIAN means a person duly licensed or certified to treat the type of Injury or Illness for which claim is made, and one who is practicing within the scope of his or her license.

PHYSICIAN SERVICES means services or treatments rendered to a Covered Person by a Physician who has a contract or agreement with the Policyholder for the provision of services specified in the Capitated Provider Agreement.

PROFESSIONAL CARE means treatment or services provided by a Physician or other healthcare professional who is duly licensed or certified to perform services within the scope of his or her license.

POLICY PERIOD means the period of time as stated in the Schedule.

POLICYHOLDER, YOU, YOUR means the legal entity, named on the face page, to whom the Company has issued this Policy.

POLICYHOLDER CHANGE means that the Policyholder acquires or disposes of its assets or assumes liabilities of another corporation, company or foundation, or becomes subject to administration, operation, management or control of another company, corporation or foundation.

REASONABLE AND CUSTOMARY means the usual charge made by the provider of care for a service not to exceed the usual charge made by the majority of like providers for same or like services in the same geographical area in which the service or treatment is performed.

REFERRAL SERVICES means those Eligible Services which, due to the specialized nature of the services required, are not available in and cannot be provided by You. These services must be specifically authorized under the provisions of the Capitation Agreement before the services are rendered.

REHABILITATION FACILITY means a free standing institution or separate and distinct part of a Hospital which is licensed as a "Rehabilitation Hospital" by the laws of the state where it is located, and which:

1. is operated within the scope of its license; and
2. provides 24 hour a day nursing care furnished or supervised by registered nurses (RNs); and
3. maintain daily clinical records on each patient; and
4. has the services of a Physician available at all times under an established agreement; and
5. uses appropriate methods to dispense and administer drugs and medicines; and
6. has transfer arrangements with at least one Hospital; and
7. has a utilization review plan in effect.

A Rehabilitation Facility is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care or care of mental disorders.

SCHEDULE means the "Schedule of Insurance" of this Policy.

SERVICE AREA means the geographic area, as defined in the Capitation Agreement, within which Covered Plan benefits are provided to a Covered Person on a regular basis through You as of the Effective Date of this Policy. If during the Policy Period, the service area changes to a new geographic area, then such are will be deemed to be the Service Area.

SPECIFIC DEDUCTIBLE is the amount shown in the Schedule, and applies separately per Covered Person per Policy Period.

SUBSCRIBER AGREEMENT means those formally written understandings or agreements under which a Managed Care Organization agrees to provide or to have provided the services described in the certificate of coverage issued to a Covered Person.

TOTALLY DISABLED means that, due to Illness or Injury, a Covered Person is confined in a Hospital, Extended Care Facility or such other institution, or due to Illness or Injury, is unable to perform the normal and routine activities of a person of like age and sex who is in good health.

TRANSPLANT means the surgical removal from one person (deceased or living) to another person of a healthy human organ or tissue, or the surgical transfer of bone marrow or hemopoietic stem cells from one person to another or from self to self.

TRANSPLANT ACQUISITION FEES: Fees associated with the acquisition of donated solid organ, bone marrow, or peripheral stem cell from either a deceased or living donor for the purpose of transplant. The transplant acquisition fees include search fees, the expenses to remove (including the hospital inpatient costs associated with the donor), preserve and transport the donated organ, bone marrow or peripheral stem cell.

LIMITATIONS

This Policy is subject to the following limitations:

1. This Policy is a legal contract between the Policyholder and the Company. Nothing contained herein reflects any right, obligation or contractual relationship between the Managed Care Organization or any Covered Person and the Company. The Company's sole liability herein is to the Policyholder, subject to the terms and provisions of this Policy.
2. Treatment, services or supplies rendered in an Extended Care Facility, Chemical Dependency Treatment Facility or Rehabilitation Facility, or by a Home Health Care Agency will be considered Eligible Services only if the following treatments are met:
 - a. referral to such facility is approved by the Managed Care Organization; and
 - b. the Policyholder is solely responsible for the charges incurred in such facility; and
 - c. treatment, services or supplies rendered in or by any such facility are in lieu of inpatient confinement in a Hospital; and
 - d. treatment, services or supplies rendered in or by any such facility are listed as Eligible Services on the Schedule.
3. Treatment, services or supplies rendered in a Referral Hospital or Out-Of-Service-Area Emergency Hospital will be considered Eligible Services only if the following requirements are met:
 - a. referral to or confinement in such facility is approved by the Managed Care Organization;
 - b. the Policyholder is solely responsible for the charges incurred in such Hospital facility; and
 - c. treatment, services or supplies rendered in such Hospital are listed as Eligible Services on the Schedule.

4. [If a Covered Person is Totally Disabled, as defined herein, on the Effective Date of this Policy, any charges incurred prior to the date such Covered Person ceases to be Totally Disabled will be excluded from the definition of Eligible Services and will not be used to satisfy the Specific Deductible; nor will such charge serve as the basis of any benefit payable under this Policy.]

EXCLUSIONS

This Policy shall not cover any charge which:

1. results from any treatment, service or supply that is not Medically Necessary;
2. results from complications caused by non-covered services;
3. is assumed by the Policyholder in excess of the liability under the Capitated Provider Agreement or which is assumed by reason of any contract or agreement other than the Capitated Provider Agreement;
4. is in excess of Reasonable And Customary charges, or which is in excess of any amount that would have been charged the Policyholder in the absence of the Capitated Provider Agreement;
5. additional liability of Company caused by a Material Change.
6. are losses resulting from any professional or general liability claims arising from services rendered by the Policyholder or any employee or affiliated organization or individual;
7. results from any extra-contractual or non-contractual damages, or legal fees and expenses for the defense thereof, or fines or statutory penalties;
8. is incurred for Injury or Illness for which the Covered Person is entitled to benefits under a Worker's Compensation, occupational disease, or similar law;
9. is payable to the Policyholder from any other source;
10. results from any procedure or treatment to change physical characteristics to those of the opposite sex, and any other treatment or studies related to sex change;
11. results from war, whether declared or undeclared, hostilities, invasion or civil war;
12. is the result of an Injury or Illness that is the result of a nuclear or radioactive accident;
13. is excluded from or not covered by the Capitated Provider Agreement, Subscriber Agreement, or Covered Plan;
14. is incurred for Experimental Procedures, as defined, or for research or studies, or for any services or supplies not considered legal in the United States of America, unless required by state mandate;
15. are services done for cosmetic purposes; unless:
 - a. performed to correct functional disorders or congenital anomalies; or
 - b. due to accidental injury occurring while the individual is a Covered Person;
- [16. results from any Transplant or transfer of any tissue or organ from one body part to another or from one body, including a corpse, to another, unless specifically covered by endorsement. This exclusion includes, but is not limited to, heart, heart-lung, liver, pancreas and bone marrow Transplants;]
- [17. is incurred by a live organ donor and the donor is a Covered Person, unless specifically covered by endorsement.]

POLICYHOLDER CHANGE OR AGREEMENT CHANGE

The Policyholder shall give the Company written notice at least [45] days in advance of any Policyholder Change or Agreement Change, as defined herein.

Upon receipt of the written notice of a Policyholder Change or an Agreement Change, the Company shall have the right to terminate this Policy by giving written notice by registered mail which shall set forth the date and time of such termination which shall not be sooner than 31 days after the date of delivery of such notice.

If the Company does not terminate this Policy pursuant to its rights stated herein, the Company shall have the right to change the premium for or provisions of the Policy, such change to be effective concurrent with the effective date of any Policyholder Change or Agreement Change.

PREMIUMS

PREMIUM AMOUNT: The premium rates and due dates for the insurance coverage provided herein are as stated in the Schedule or any later modification of this Policy as provided in the RENEWAL section.

PAYMENT OF PREMIUMS: For coverage under this Policy to remain in effect, each premium must be paid on or before its due date. The Policyholder is responsible for paying premiums as they become due.

GRACE PERIOD: A Grace Period of [31-90] days from the premium due date(s) will be allowed for the payment of each premium due after the first. If any premium is not paid before the end of the Grace Period, the insurance will automatically terminate at the end of the period for which premiums have been paid.

PREMIUM CHANGE: We have the right to change the premium as a result of: (1) a change in the insurance provided herein; (2) a Policyholder Change; or (3) an Agreement Change. We will notify the Policyholder with 31 days written notice of such premium change.

RENEWAL AND TERMINATION

RENEWAL: This Policy and all coverage hereunder will terminate at the end of the Policy Period shown in the Schedule. Should the Policyholder wish to continue the coverage, complete and satisfactory information must be submitted to Us. Payment of premium after the end of the Policy Period by the Policyholder for a new Policy Period will not be construed as an agreement by Us to offer coverage for a new Policy Period.

TERMINATION: This Policy and all insurance provided hereunder will terminate upon the earliest of:

1. the due date of any premium not paid if that premium is not paid within the Grace Period;
2. the premium due date next following our receipt of written notice from the Policyholder that this Policy is to be terminated;
3. the end of the Policy Period, as shown in the Schedule;
4. the date of termination of any applicable Subscriber Agreement, Capitated Provider Agreement or the Covered Plan;
5. the date the Policyholder suspends or ceases active business operation or is placed in bankruptcy or receivership;
6. the date the Policyholder's business is dissolved; or
7. the date of Our Insolvency or cessation of operations; or
8. the Cancellation Date as explained under the terms of the Cancellation provision of this Policy.

CANCELLATION: This Policy may be cancelled by the Policyholder by mailing to Us written notice which states when thereafter such cancellation shall be elected. This Policy may be cancelled by Us by mailing to the Policyholder at the address of record, a written notice which states when, not less than 30 days thereafter, such cancellation shall be effective for any of the following reasons:

1. fraud, misrepresentation, or failure to comply with the terms and conditions of this Policy by the Policyholder;
2. a Material Change;
3. a Policyholder Change or Agreement Change as defined in the POLICYHOLDER CHANGE or AGREEMENT CHANGE section of this Policy.

Termination or cancellation of this Policy shall not terminate the rights or liabilities of either the Policyholder or the Company which arise during any period this Policy was in force, provided that nothing herein shall be construed to extend our liability for payments under this Policy for any losses incurred by the Policyholder on or after the date of termination or cancellation of this Policy.

CLAIMS PROVISIONS

LIABILITY: The Company will have neither the right nor the obligation under this Policy to directly pay any Covered Person, provider of professional or medical services, or other third party. The Company's sole liability is to the Policyholder, subject to the terms and conditions of this Policy. Nothing in this Policy shall be construed to permit a Covered Person to have a direct right of action against the Company. The Company will not be considered a party to the Plan or to any supplement or amendment to it. The Policyholder may not assign reimbursement under this Policy, and the Company will not recognize any such assignment.

NOTICE OF CLAIM: The Policyholder shall give written notice to the Company of a Covered Person receiving Eligible Services where the eligible paid claims are expected to exceed or have exceeded [50%- 75%] of the Specific deductible within 30 days (or as soon thereafter as reasonably possible) of the date incurred or the date the Policyholder becomes aware of the potential/actual claim. Written notice must include: Covered Person's first and last name, date of birth, identification number, managed care affiliation, plan type, claims paid and pending amount, primary diagnosis, date of onset, prognosis and anticipated liability for the Policy Period. The Policyholder must report to the Company any Covered Person who is a potential or actual Transplant recipient (excluding corneal and cochlear transplants). Notification for potential or actual Transplant recipients must include the details provided above and the type of Transplant, donor type, date of evaluation, date of listing, facility name, transplantation network contract provider name. The Policyholder must provide a minimum of quarterly updates to an initial notification or more frequently if a salient change from the initial reported notice of claim has occurred or upon request of the Company.

OFFSET: Any payment or overpayment of a claim made to the Policyholder due to error or mistake must be promptly refunded to the Company upon notice to the Policyholder of such error or mistake. The Company may offset any refund owed to the Company for such payment or overpayment or any premium owed to the Company against any reimbursement due the Policyholder.

RECOVERY FROM THIRD PARTY: You may be entitled to recover from third parties for payments made to or on behalf of persons covered under Your Policy. If You recover from a third party, the recovered amount cannot be used to meet a deductible amount or attachment point under this Policy.

1. If the third party does not make payment before the Company makes payment the Company will pay any benefits due under this Policy;
2. When payment is later made by the third party, the Company is entitled to be repaid first less reasonable prorated expenses, such as lawyer's fees and court costs that You incurred in seeking the third party payment;
3. Your obligation to repay the Company will be binding regardless of whether:
 - a. The payment received from the third party, or its insurer, is the result of a court judgement, arbitration award, compromise settlement, or any other arrangement; or
 - b. The third party or its insurer admits liability; or
 - c. The expenses are itemized in the third party payment; or
 - d. You have been paid by the third party for all losses sustained or alleged.

PAYMENT OF CLAIMS: Amounts payable under this Policy will be paid to the Policyholder upon receipt and acceptance by the Company of complete Proof of Loss.

PROOF OF LOSS: The Policyholder must provide written proof of loss within 30 days of the Policyholder's payment that exceeds the Specific Deductible. If such proof is not given in the required time period the claim will not be denied or reduced if the proof of loss is given as soon as reasonably possible. However, in no event will the Company be liable for a claim where complete proof of loss is submitted more than [3-12] months after the end of the Policy Period during which the charge is incurred.

Complete Proof of Loss means:

- a) Fully completed claim form;

- b) Copies of itemized bills or paid claims report;
- c) Proof of payment; and
- d) Confirmation of Covered Persons eligibility under this Policy.

The Policyholder must cooperate with the Company in a timely manner in the investigation and the settlement of any claim payable under this Policy.

A claim will not be deemed to have been received by or reported to the Company until such information is received by the Company. Further, the notice of claim report shall not constitute receipt of or report of a claim by the Company.

[SUBROGATION: The Policyholder is required to investigate and prosecute all valid claims that it may have against third parties arising out of any claim for which benefits were paid by this Policy. The Policyholder shall account to the Company for all amounts recovered. If the Policyholder fails to pursue any action against a third party and the Company has made benefit payments under this Policy, the Company will be subrogated to all of the Policyholder's rights to make recoveries. However, the Company's Subrogation right is secondary to the Policyholder's right to be fully compensated for its damages. The Policyholder is required to cooperate fully and do all things necessary and required for the Company to pursue any action to recover against the third party; the scope of the Policyholder's cooperation shall include, without limitation, the execution of a Subrogation receipt or assignment in favor of the Company and the granting of authorization to the Company to commence litigation or other legal proceedings in the name of the Policyholder to seek recoveries from third parties. The Company agrees to pay its portion of the Policyholder's attorneys' fees or other costs associated with a claim or lawsuit to the extent that the Company recovers any portion of the benefits paid under this Policy pursuant to its Subrogation right.]

GENERAL PROVISIONS

[ARBITRATION: All disputes between the Policyholder and the Company shall be settled by arbitration in accordance with the Commercial Rules of the American Arbitration Association, except with regard to rules governing the selection of arbitrators. It is further stipulated that the arbitrator(s) shall, when adjudicating any dispute under this Policy, consider the terms and conditions of this Policy, applicable substantive law, and may, in the arbitrators' discretion, consider applicable custom and practice in the Accident and Health industry [and the Managed Care or Employer Stop Loss sectors.] All matters shall be decided by a panel of three (3) arbitrators, all of whom must be either current or former officers or directors of Life, Health and Accident insurers or current or former insurance brokers or administrators with substantial experience in the [Managed Care or Employer Stop Loss sectors.] Each party shall select its own party arbitrator and the parties' chosen arbitrators shall jointly select the third; in the event that the two party-arbitrators cannot agree on the third arbitrator, each party shall appoint three candidates, two of whom shall be stricken by the other party, and the third arbitrator shall thereafter be chosen from the remaining two candidates by the drawing of lots. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction. This provision shall survive the termination or expiration of this Policy. The arbitrators shall have no power or authority to award punitive or exemplary damages. Any arbitration shall be confidential, and except as required by law, neither party may disclose the existence, content or results of any arbitration hereunder without the prior written consent of the other parties, except that disclosure is permitted to a party's auditors and legal advisors. The parties hereto may alter any of the terms of this provision only by express written agreement, although such alteration may be before or after any rights or obligations arise under this provision. This provision will survive the termination or expiration of this Policy.]

AUDIT: The Company shall have the right to inspect and audit all records and procedures of the Policyholder and their agents and representatives relating to this insurance and any claims under this Policy and to require proof of records satisfactory to the Company that Eligible Services have been provided. Such books and records shall be opened to the Company and its representatives during usual business hours. The Company reserves the right to request an annual reconciliation of membership, considering all retroactive additions and deletions. The Company reserves the right to appoint an independent claim auditor to investigate any claim submitted by the Policyholder for reimbursement.

CLERICAL ERROR: Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

ENTIRE CONTRACT: This Policy, including the Schedule, riders and endorsements, exhibits, signed disclosure statement, disclosure documents and the Policyholder's application which are attached hereto, constitute the entire contract between the Company and the Policyholder. In the absence of fraud, any statements made by the Policyholder are representations and not warranties. No statement will void this insurance or reduce benefits under the Policy unless the statement is contained in a written instrument signed by the Policyholder, and a copy of that written statement has been furnished to the Policyholder.

This Policy can be altered only with the consent of the Company and then only in writing. No such alteration of this Policy shall be valid unless endorsed on or attached to this Policy. No agent, broker, or Third Party Administrator has the authority to alter this Policy or to waive any of its provisions, including premiums shown in the Schedule of Insurance.

INSOLVENCY: The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon 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, including Covered Persons under the Plan.

LEGAL ACTION: No legal action may be brought against the Company until there has been full compliance with all the terms of this Policy. All Policy terms will be interpreted under the laws of the state where this Policy was issued. No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

MISREPRESENTATION, CONCEALMENT, FRAUD: This entire Policy will be void and subject to rescission if the Company determines that the Policyholder or its agent has concealed or misrepresented any material fact or circumstance concerning this Policy, including without limitation material facts contained within the Policy application, the Disclosure Statement, any other material facts provided by the Policyholder to the Company prior to the Policy Effective Date, or regarding any claim or any case of fraud by the Policyholder or its Third Party Administrator or other agent relating to this Policy.

MISSTATED DATA: The Company has relied upon the underwriting information provided by the Policyholder and its Agent in the issuance of this Policy. Should subsequent information become known which, if known prior to issuance of this Policy, would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms or conditions as of the Effective Date of issuance, by providing written notice to the Policyholder or the Policyholder's Agent. Nothing contained within this provision shall be deemed to in any way, affect the Company's right to rescind the Policy in the event of a material misrepresentation by the Policyholder or the Policyholder's Agent.

NOTICE: For the purpose of any notice required from the Company under the provisions of this Policy, notice to the Policyholder's Agent shall be considered notice to the Policyholder. Notice from the Policyholder to the Policyholder's Agent and notice from the Policyholder's Agent to the Policyholder shall not be considered notice to the Company.

OTHER COVERAGE: The reimbursement provided by this Policy is in excess of other coverages such as group insurance, excess insurance, reinsurance, plan benefits including insurance or benefits established by any federal, state or local law.

PARTIES TO THE POLICY: The parties to this Policy are exclusively the Policyholder and the Company. The Company's sole liability under this Policy is to the Policyholder. This Policy does not create any right or legal relation between the Company and a Covered Person under the Plan. This Policy will not be deemed to make the Company a party to any agreement between the Policyholder and any third party.

RECORDS: The Policyholder will maintain records of all Covered Persons under the Plan during the Policy Period and for a period of seven years after the termination of this Policy. The Policyholder shall make such records available to the Company as needed to evaluate its liability under this Policy.

REINSTATEMENT: If any premium that is due and owing to the Company is paid after the expiration of the Grace Period, the Company may at its option elect to reinstate the Policy on the terms and conditions that the Company elects at that time.

RENEWAL: At the end of the Policy Period, but only by mutual agreement of the Policyholder and the Company, this Policy may be renewed for another Policy Period. The renewal may be subject to new premium rates, new underwriting terms, a new Benefit Period and new Policy terms.

TAXES: In the event any taxing authority which has jurisdiction over either of the parties finds that additional taxes or other assessments, other than premium taxes paid by the Company with respect to this Policy, must be paid in respect of this Policy, the Plan, or related matters, the Policyholder shall be responsible for such additional taxes and the Company shall be held harmless from any such tax liability.

TIME LIMIT ON CERTAIN DEFENSES: In the absence of fraud, all statements made by the Policyholder shall be deemed representations and not warranties. No statement made by the Policyholder for the purpose of effecting insurance shall be used to contest this Policy or reduce benefits unless contained in a signed, written application, a copy of which has been provided to the Policyholder. No such statement will be used to contest this Policy after this Policy has been in force for two years..

WAIVER: Failure of the Company to strictly enforce its rights under this Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

StarNet Insurance Company

Wilmington, Delaware

[Administrative Office: 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690]

A Berkley Company

APPLICATION

Application is hereby made for Provider Excess Loss Insurance based on the following statements and representations. In addition to the information supplied in this form, all information and documents supplied to the Company for use in underwriting shall be considered a part of this Application.

1. **POLICYHOLDER:** ABC Hospital
ADDRESS: 12345 Main Street, Anytown, PA 22222
2. **POLICY NUMBER:** 12345
3. **MANAGED CARE ORGANIZATION(S)** (included for the purposes of this Policy):
NAME: XXX, Inc.
ADDRESS: 789 Main Street, Anywhere, PA 33333
Type of Managed Care Organization: XYZ Health Maintenance Organization

4. **COVERED PLAN(S):** HMO1, Commercial and Medicare

5. **COVERAGE:** xxxxxxxxxx

SPECIFIC EXCESS LOSS INSURANCE:

- A. Specific Deductible: \$XX,XXX
- B. Maximum Benefit per Covered Person: \$X,XXX,XXX
- C. Maximum Aggregate Limit of Company's Liability: \$X,XXX,XXX

6. **PREMIUM RATES:** \$XXXX Per Covered Person for Hospital Services
\$XXXX Per Covered Person for Physician Services

CLAIMS BASIS:

- A. Eligible Services Incurred from 01/01/2008 to 01/01/2009
- B. Eligible Services Paid from 01/01/2008 to 07/01/2009

However, in no event will the Company be liable for a claim(s) where complete proof of loss is submitted more than [3 – 24] months after the end of the Policy Period during which the change is incurred.

8. **ELIGIBLE SERVICES:** xxxxxxxxxxxxxxxx

MAXIMUM COVERED AMOUNT:

In no event shall the MAXIMUM COVERED AMOUNT be more than the maximum amount for which the Insured is liable.

10. **ENDORSEMENTS:** _____ Yes _____ No
If Yes, Please Specify:

11. **PROPOSED EFFECTIVE DATE:** 01/01/2008 (subject to the Company's acceptance)

12. **DEPOSIT:** \$XXXX is enclosed to apply to the first payment under the Policy if issued.

This Application is executed in duplicate. One copy is to be attached to said Policy, and the other is to be returned to the Company.

The Policyholder warrants that a true and accurate copy of the Subscriber Agreement(s) and Capitated Provider Agreement(s) in force on the effective date of this Policy have been provided to the Company. The Policyholder undertakes to comply with the POLICYHOLDER CHANGE OR AGREEMENT CHANGE sections herein.

It is agreed that this Application replaces any prior application made for the same said Policy.

For _____
(Full or Corporate Name of Applicant)

Date at _____

By _____
(President or CEO Signature)

Title _____

On _____, 20____

(Witness)

NOTE: This Application must be signed by the President or Chief Executive Officer of the Applicant acting as the authorized agent of the entity(ies) proposed for this insurance.

StarNet Insurance Company

Wilmington, Delaware

[Administrative Office: 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690]

A Berkley Company

POLICY ENDORSEMENT

This endorsement forms a part of Policy Number [XXXXXX] to which it is attached and is subject to all the terms and conditions of the Policy not in conflict with this endorsement. This endorsement takes effect on [01/01/06].

It is hereby understood and agreed that the SCHEDULE OF INSURANCE of the Policy, Item [1] is amended as follows: []

IN WITNESS WHEREOF, this Policy has been signed on behalf of **StarNet Insurance Company** by its Authorized Representatives.

EFFECTIVE DATE OF AMENDMENT: XXXXXXXX

Signed for the Company:



President



Secretary

SERFF Tracking Number: BKAH-126222715

State: Arkansas

Filing Company: StarNet Insurance Company

State Tracking Number: 42912

Company Tracking Number: AH52041

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: Provider Excess Loss

Project Name/Number: Provider Excess Loss/AH52041

Rate Information

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>BKAH-126222715</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>StarNet Insurance Company</i>	<i>State Tracking Number:</i>	<i>42912</i>
<i>Company Tracking Number:</i>	<i>AH52041</i>		
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>Provider Excess Loss</i>		
<i>Project Name/Number:</i>	<i>Provider Excess Loss/AH52041</i>		

Supporting Document Schedules

Satisfied -Name:	Flesch Certification	Review Status:	Approved-Closed	07/17/2009
Comments:	The Flesch Certification is attached. In review of the remainder of these requirements, it appears that none of the rest would apply to this type of product. There is no solicitation or issue to any individual insured. This product is marketed only to capitated providers.			
Attachment:	AR-READ.pdf			
Satisfied -Name:	Application	Review Status:	Approved-Closed	07/17/2009
Comments:	The application is submitted for approval on the forms schedule tab.			
Satisfied -Name:	Health - Actuarial Justification	Review Status:	Approved-Closed	07/17/2009
Comments:	This is group provider excess policy forms.			
Satisfied -Name:	Outline of Coverage	Review Status:	Approved-Closed	07/17/2009
Comments:	This is group provider excess policy forms.			
Satisfied -Name:	Explanation of Variables	Review Status:	Approved-Closed	07/17/2009
Comments:	Attached.			
Attachment:	SIC EOVS PSL.pdf			

CERTIFICATE OF COMPLIANCE
FOR ARKANSAS

This is to certify the attached form has achieved the Flesch Reading Ease Score given below and complies with the requirements of Arkansas Stat. Ann, ACA 23-80-206, cited as the Life and Accident and Health Policy Language Simplification Act.

Form Name: Provider Excess Loss Policy forms

Form Number: AH52041 etal.

Flesch Reading Ease Score: 51.3

Susan Bradbury

Susan E. Bradbury, Director of Compliance

July 10, 2009

Date

StarNet Insurance Company

Wilmington, Delaware

[Administrative Office: 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690]

EXPLANATION OF VARIABLES PROVIDER EXCESS INSURANCE FORMS

Purpose and Use of Forms

- Brackets around numbers or alphas in a listing and punctuation or words such as “and”/”or” in a listing will be included or deleted as needed in order to make the statement read correctly.
- Numeric variables within the Policy will always comply with the minimum statutory requirements of the state in which the Policy is delivered.
- All names, dates, amounts and other numbers, such as percents, time periods, page numbers, are illustrative and will vary from case to case.
- No changes will be made to the forms which are in conflict with state law or are outside the parameters of the variability described herein.

Note that the above variables will not be explained everywhere they appear.

PROVIDER EXCESS APPLICATION, FORM # AH52042

- The Application is considered to be variable in its entirety. It contains sample language for filing purposes. Numeric variables are shown as typical ranges. In all cases of ranges both the minimum and maximum limits will comply with any applicable state mandates.

PROVIDER EXCESS POLICY ENDORSEMENT, FORM # AH52043

- This Amendment will be used for a variety of administrative and coverage changes. Changes that may be made by way of this Amendment include, but are not limited to, the following:

Administrative Changes. The Amendment may be used to make changes to administrative information, for example name changes, address changes, Policy number changes, Plan name changes, or change of TPA.

Policy Reissue. The Amendment may be used to reissue the Schedule as of the Policy termination date, with the new Schedule reflecting the new Policy Period and any other changes agreed to by the Company and the Policyholder.

Change of Schedule Items and Coverage Amounts. The Amendment may be used to change variable Schedule information as agreed to by the Company and the Policyholder.

PROVIDER EXCESS SCHEDULE OF INSURANCE

- The Schedule is considered to be variable in its entirety. It contains sample language for filing purposes. Numeric variables are shown as typical ranges. In all cases of ranges both the minimum and maximum limits will comply with any applicable state mandates.