

SERFF Tracking Number: HCCH-126234283 State: Arkansas
Filing Company: HCC Life Insurance Company State Tracking Number: 42932
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Provider Excess Loss - A&H
Project Name/Number: PEX 4 Filing/

Filing at a Glance

Company: HCC Life Insurance Company
Product Name: Provider Excess Loss - A&H SERFF Tr Num: HCCH-126234283 State: Arkansas
TOI: H21 Health - Other SERFF Status: Closed-Withdrawn State Tr Num: 42932
Sub-TOI: H21.000 Health - Other Co Tr Num: State Status: Withdrawn
Filing Type: Form Reviewer(s): Rosalind Minor
Authors: Brad Long, Misty Pagelsen Disposition Date: 07/22/2009
Date Submitted: 07/20/2009 Disposition Status: Withdrawn
Implementation Date Requested: 09/01/2009 Implementation Date:
State Filing Description:

General Information

Project Name: PEX 4 Filing Status of Filing in Domicile: Authorized
Project Number: Date Approved in Domicile: 07/10/2009
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small and Large
Overall Rate Impact: Group Market Type: Other
Filing Status Changed: 07/22/2009 Explanation for Other Group Market Type:
Excess Loss
State Status Changed: 07/22/2009
Deemer Date: Created By: Misty Pagelsen
Submitted By: Misty Pagelsen Corresponding Filing Tracking Number:

Filing Description:
HCCL PEX 4 - Provider Excess Loss Policy
HCCL PEX 4 SOI - Schedule of Insurance/ Application
HCCL PEX 4 AR - Amendment AR
HCCL PEX 4 AMEND - Amendment Form

HCC Life Insurance is filing the above-referenced forms for approval in your state. These forms were submitted to the state of domicile, IN, on July 7, 2009 and were approved on July 10, 2009. For this policy the form HCCL PEX 4 SOI will serve as the application. These forms are intended to replace any forms currently on file with your department. We anticipate using these forms for effective dates beginning September 1, 2009.

This product will be marketed to health-care providers that accept risk from managed care organizations (i.e., physician

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hospital organizations, health maintenance organizations, prepaid health plans, insurance companies, preferred provider organizations, self-funded employer groups, or physician services organizations) for the services and supplies they provide. When issued, the Provider Excess Insurance Policy ("Policy") will reflect the risk that the health-care providers have accepted from the managed care organizations.

Variable material is indicated by brackets. These areas are considered variable to the extent of the deletion of, addition of, or change in the specifics of a provision filed as variable. For example, on the schedule page reimbursement may include multiple variations of the same method of reimbursement or specific services and this reimbursement may be grouped or separated based on risk. In addition, the list of excluded services on the application are examples only and actual exclusions will be based upon the health care services and supplies that the provider is at risk for. We intend to work with all variable materials within the confines of the explanation of variables submitted with this filing, the risk of the health-care provider and the coverage for that risk, and the laws of your state. We also consider page numbers and numbers at the beginning of items on a list to be variable.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

Company and Contact

Filing Contact Information

Misty Pagelsen, mpagelsen@hcclife.com
 225 TownPark Drive 770-693-6455 [Phone]
 Suite 145
 Kennesaw, GA 30144

Filing Company Information

HCC Life Insurance Company CoCode: 92711 State of Domicile: Indiana
 225 TownPark Dr., NW Group Code: Company Type:
 Suite 145 Group Name: State ID Number:
 Kennesaw, GA 30144-5885 FEIN Number: 35-1817054
 (770) 693-6441 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: Normal fees are \$50.00 for each policy including all forms associated with the policy and filed

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with the policy.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
HCC Life Insurance Company	\$50.00	07/20/2009	29308582

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Withdrawn	Rosalind Minor	07/22/2009	07/22/2009

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending	Rosalind Minor	07/21/2009	07/21/2009

Industry Response

Response Letters

Responded By	Created On	Date Submitted
Misty Pagelsen	07/21/2009	07/21/2009

SERFF Tracking Number: *HCCH-126234283* *State:* *Arkansas*
Filing Company: *HCC Life Insurance Company* *State Tracking Number:* *42932*
Company Tracking Number:
TOI: *H21 Health - Other* *Sub-TOI:* *H21.000 Health - Other*
Product Name: *Provider Excess Loss - A&H*
Project Name/Number: *PEX 4 Filing/*

Disposition

Disposition Date: 07/22/2009

Implementation Date:

Status: Withdrawn

Comment:

As discussed in our telephone conversation on this date, this filing is being withdrawn and being filed under the Property & Casualty division.

I assume that the policy will be filed under HCC Insurance Company which is the P&C company. HCC Life Insurance Company does not have P&C authority.

Also, as discussed in our telephone conversation, please do not submit a filing fee when filing with P&C. I discussed this with our P&C division.

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Withdrawn	Yes
Supporting Document	Application	Withdrawn	Yes
Supporting Document	Health - Actuarial Justification	Withdrawn	Yes
Supporting Document	Outline of Coverage	Withdrawn	Yes
Supporting Document	AR Cover Letter	Withdrawn	Yes
Supporting Document	AR Transmittal Doc	Withdrawn	Yes
Supporting Document	Compliance Certification	Withdrawn	Yes
Supporting Document	Note	Withdrawn	Yes
Form	Provider Excess Loss Policy	Withdrawn	Yes
Form	Schedule of Insurance	Withdrawn	Yes
Form	Amendment Form	Withdrawn	Yes
Form	Amendment AR	Withdrawn	Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 07/21/2009

Submitted Date 07/21/2009

Respond By Date

Dear Misty Pagelsen,

This will acknowledge receipt of the captioned filing.

Objection 1

- Provider Excess Loss Policy, HCCL PEX 4 (Form)

Comment:

A Provider Excess Loss is a P&C product. Do you want to withdraw this filing and submit it through P&C? I cannot reassign it to the P&C Division.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 07/21/2009
Submitted Date 07/21/2009

Dear Rosalind Minor,

Comments:

Currently HCC Life Insurance Company has Provider Excess Loss forms on file with your state under A&H. Recently this policy and associated forms underwent substantial changes which is why it is now necessary to re-file the forms with your state.

Response 1

Comments: When this product was originally filed in 2006 it was filed as an A&H product. State tracking number 33658. Our company thought you might have changed this to a P&C product, so when the new forms were filed on 07/13/2009, state tracking number HCCH-126226991, they were filed under P&C. On July 17, 2009 the reviewer Llyweyia Rawlins, rejected the filing as a P&C product and asked me to withdraw the forms as P&C and re-file as A&H. On July 20, 2009 these forms were withdrawn under P&C and re-filed under A&H.

Related Objection 1

Applies To:

- Provider Excess Loss Policy, HCCL PEX 4 (Form)

Comment:

A Provider Excess Loss is a P&C product. Do you want to withdraw this filing and submit it through P&C? I cannot reassign it to the P&C Division.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Can you please advise if this should remain an A&H product as I have submitted these forms and fees twice. If this is to be submitted under P&C will I have to submit the fee again as well? Please advise.

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Sincerely,

Brad Long, Misty Pagelsen

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Form Schedule

Lead Form Number: HCCL PEX 4

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Withdrawn 07/22/2009	HCCL PEX 4	Policy/Cont ract/Fratern al Certificate	Provider Excess Loss Policy	Revised	Replaced Form #: HCCL PEX 2 AR Previous Filing #: 33658		HCCL PEX 4 - final.pdf
Withdrawn 07/22/2009	HCCL PEX 4 SOI	Application/ Enrollment Form	Schedule of Insurance	Initial			HCCL PEX 4 SOI - final.pdf
Withdrawn 07/22/2009	HCCL PEX 4 AMEND	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Amendment Form	Revised	Replaced Form #: HCCL PEX 2 AMEND Previous Filing #: 33658		HCCL PEX 4 AMEND - Generic - Final.pdf
Withdrawn 07/22/2009	HCCL PEX 4 AR	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Amendment AR	Initial			HCCL PEX 4 AR - final.pdf

HCC Life Insurance Company
225 TownPark Drive, Suite 145
Kennesaw, GA 30144

Policyholder Service Office
11100 Wayzata Blvd. Suite 350
Minnetonka, MN 55305
Phone: 877-843-5743

PROVIDER EXCESS INSURANCE POLICY - NONPARTICIPATING

INSURED PROVIDER: [XYZ Hospital ("Insured Provider")]

POLICY NUMBER: [1234-000]

EFFECTIVE DATE: [Effective Date] 12:01 AM at the address of Insured Provider

This Provider Excess Insurance Policy ("Policy") is delivered in [STATE].

This Policy is issued in consideration of HCC Life Insurance Company's ("Company") receipt of a completed Provider Excess Schedule of Insurance ("Schedule of Insurance") and the first month's premium from Insured Provider. The first premium is due and payable on the effective date and subsequent premiums are due and payable according to the premium provisions, as long as the Policy remains in force.

IN WITNESS WHEREOF, COMPANY has executed this Policy at Kennesaw, Georgia on [Month _____, Year].

[

]

[

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[President]

[Secretary]

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8	Material Change
9	General Provisions

ARTICLE 1

Insuring Clause

Subject to all the terms of this Policy, Company will reimburse Insured Provider the Percentage Payable of Eligible Expenses that exceed the applicable Specific Retention up to any applicable maximums.

ARTICLE 2

Definitions

The following terms have the following meaning. Inclusion of a definition below does not indicate coverage for same. Only those Eligible Expenses shown on the Coverage Summary in the Schedule of Insurance will be covered.

- 2.01 Ambulance:** Transportation for an emergency or from one facility to another facility
- 2.02 Average Daily Maximum (“ADM”):** The average allowed per day for each period of continuous confinement during the Contract Period, as shown in the Schedule of Insurance.
- 2.03 Blood Products:** Blood products, including blood clotting factors, derived from blood or recombinant (synthetic) sources and used to treat serious conditions, including blood clotting disorders. Blood clotting factors include, but are not limited to, Factor VIIa (recombinant), Factor VIII (human, porcine, recombinant), Factor IX (nonrecombinant and recombinant).
- 2.04 Capitated Provider Agreement:** The agreement between Insured Provider and a Managed Care Organization under which Insured Provider is responsible to provide health care services and supplies to Covered Persons in exchange for the Managed Care Organization’s payment of a monthly fee.
- 2.05 Chemotherapy:** Chemotherapy drugs (as indicated in HCPCS book for codes J9000-J9999 or any replacement codes or an equivalent NDC code) and any medications used to treat cancer or the side effects of chemotherapy.
- 2.06 Contract Period:** The period that begins on the contract period beginning date shown in the Schedule of Insurance and ends upon the last Incurred Date of Service shown in the Section entitled Claims Basis of the Schedule of Insurance or the date of termination, whichever is earlier.
- 2.07 Contract Period Maximum:** The maximum liability of Company for all Covered Persons under this Policy per Contract Period, as indicated by the amount specified in the Schedule of Insurance.
- 2.08 Covered Person:** Any individual, including dependent, who is enrolled in and eligible for coverage under a Covered Plan while this Policy is in force.
- 2.09 Covered Plan:** The plan of health care services and supplies described in a document issued to a Covered Person by a Managed Care Organization. Covered Plans are listed in the Section entitled Line of Business in the Schedule of Insurance.
- 2.10 Custodial Care:** Services and supplies provided to a Covered Person that is for maintenance, not mainly rehabilitative or restorative, or mainly to assist in activities of daily living (such as help in eating, getting out of bed, bathing, dressing, toileting, or taking drugs). Custodial Care does not include Hospice Care.
- 2.11 Dentist:** A person licensed to practice dentistry by the state in which the person has a dental practice and who is practicing within the scope of this license at said dental practice.

- 2.12 Durable Medical Equipment (“DME”):** Medical equipment ordered by a health care provider including, but not limited to orthotics and prosthetics.
- 2.13 Eligible Expense:** The Allowable Charges as shown in the Schedule of Insurance for Medically Necessary expenses incurred by a Covered Person for health care services and supplies that are specified in the Capitated Provider Agreement as the sole responsibility of Insured Provider; and
- a. are provided under the Covered Plan; and
 - b. have an Incurred Date of Service during the Contract Period; and
 - c. are not excluded on the Coverage Summary; and
 - d. are not excluded elsewhere under this Policy.

Eligible Expense also includes transplant network access fees only when approved through an HCC Life transplant access agreement. Eligible Expense does not include Sub-Capitated Services, subcapitation, surcharges, taxes, loss adjustment expenses, care coordination and related administrative services or vendor fees.

- 2.14 Emergency Out-of-Area Care:** Care provided to a Covered Person that, due to an emergency, are provided outside the Managed Care Organization’s service area. An emergency exists when there is a sudden onset of illness or accidental injury occurring while the Covered Person is outside the service area requiring such immediate treatment that the life or health of the Covered Person might be jeopardized if taken to a hospital, physician, or surgeon within the service area or when the Covered Person is incapable of making the decision on treatment.

- 2.15 Experimental or Investigational.** A medical procedure, treatment, service, supply, equipment, drug, or device that:

- a. Cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- b. Is the subject of ongoing Phase I, II or III clinical trials (other than a Qualified Clinical Trial) or under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis; or
- c. Reliable Evidence shows that the consensus among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis.

Reliable Evidence means: 1) published reports and articles in the authoritative peer reviewed medical and scientific literature; 2) the written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, device, or medical treatment or procedure; or 3) the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

- 2.16 Fixed Fee:** The DRG rate, per diem or per case rate the Insured Provider pays a Hospital for health care services and supplies. Fixed Fee **does not include:**

- a. The DRG rate, per diem or case rate if the entire payment reverts to a discounted rate once an outlier or stoploss level was reached; or
- b. all amounts if any part of the payment includes amounts that exceed an outlier or stop-loss level to be paid at a discounted rate; or
- c. any payment that included billed charges as part of its calculation.

- 2.17 Home Health Care:** Part-time or intermittent health care services and supplies that are mainly rehabilitative or restorative in nature and are for treatment of a Covered Person in a home setting. Home Health Care must be ordered by a physician and provided by a certified home health agency. Home Health Care does not include Hospice, DME, Custodial Care, Inpatient Hospital Services or Physician Services.

2.18 Hospice: Care and services in the home or other facility for the care of a Covered Person with a terminal illness who is expected to live 6 months or less, as certified by a physician. Hospice Care includes inpatient respite care up to 5 days for each period of respite care.

2.19 Hospital: an institution which:

- a. is licensed and operated as a Hospital under the laws of the jurisdiction in which it is located;
- b. provides, as its primary function, for pay, on an inpatient basis treatment and care for the sick and injured;
- c. is under the direction of a staff of Physicians; and
- d. provides 24-hour-a-day nursing services by registered nurses (R.N.).

Hospital will not include an institution used solely as a facility for any one or more of the following:

- a. rest;
- b. custodial care;
- c. nursing;
- d. care for the aged; or
- e. care for substance abuse.

2.20 Implants: An object or material inserted or grafted into a structure of the body or body cavity for prosthetic, therapeutic, diagnostic or experimental purposes. The implant may be of tissue, such as in a blood vessel graft, or of an artificial substance, such as in a hip prosthesis, a cardiac pacemaker, or a container of radioactive material.

2.21 Incurred Date of Service: The date the service or treatment is provided to the Covered Person.

2.22 Individual Contract Period Maximum: The maximum liability of Company per Covered Person per Contract Period, as indicated by the amount specified in the Schedule of Insurance.

2.23 Individual Lifetime Maximum: The maximum liability of Company per Covered Person combined for this Policy and all policies issued to Insured Provider by Company previous to this Policy, as indicated by the amount specified in the Schedule of Insurance.

2.24 Infusion: The introduction of a substance, such as a fluid, electrolyte, nutrient or drug, directly into a vein or interstitially by means of gravity flow. Infusion includes the supplies to administer the infusion. Infusion does not include Chemotherapy.

2.25 Injectables: Drugs other than oral medications (as indicated in HCPCS book for codes J0001-J8999 and Q codes or any replacement codes or any NDC equivalent codes) for non-chemotherapy medications. Injectables will include the supplies to administer the injectable. Injectables do not include clotting factors (J7190-J7199) and Blood Products.

2.26 Inpatient Hospital Services: Services, supplies and Pharmaceuticals provided by a Hospital to a Covered Person who is a registered inpatient in that Hospital. Inpatient Hospital Services do not include Physician Services, Outpatient or Home Health Care.

2.27 Long Term Acute Care Facility: A Hospital licensed as a specialty or acute care hospital. The facility is considered long term acute care if the Covered Person requires specialized complex services and is stable enough to move from a short term acute hospital. These facilities provide daily physician monitoring and intensive nursing care, generally with an anticipated length of stay in excess of 25 days and include, but are not limited to, ventilator dependent patients, patients requiring wound care management, IV therapy, dialysis or telemetry. A Long Term Acute Care Facility does not include a Skilled Nursing Facility, Rehabilitation Facility, Short Term Hospital or Hospice.

2.28 Managed Care Organization: Those organizations listed in the Schedule of Insurance for whom Insured Provider has agreed to provide or arrange to provide those services and supplies described in the Capitated Provider Agreement.

2.29 Medicare: Title XVIII of the Social Security Act of 1965, as amended.

2.30 Medicare Allowable: Reimbursement parameters established by Medicare. When applicable, reimbursement is based on the location of the Covered Plan and/or the date the Eligible Expenses were Incurred.

2.31 Medicaid: Title XIX of the Social Security Act of 1965, as amended.

2.32 Medicaid Fee Schedule: Reimbursement parameters established by the state in which the care occurs for Covered Persons enrolled in the state-funded medical assistance program.

2.33 Medically Necessary:

A medical procedure, treatment, service, supply, equipment, drug or device that is:

- a. Deemed appropriate, essential and is recommended for the diagnosis or treatment of the Covered Person's symptoms by a licensed physician who is practicing within the scope of his or her license and specialty or primary area of practice, and
- b. Within the scope, duration and intensity of that level of care which is required to provide safe, adequate and appropriate diagnosis or treatment, and
- c. Prescribed in accordance with the generally accepted, current professional medical practice and is not considered Experimental or Investigational.

The fact that a licensed physician may prescribe, order, recommend or approve a procedure, medical treatment, service, supply, equipment, drug or device does not make it Medically Necessary.

2.34 Outpatient Hospital Services: Services and supplies provided by a Hospital to a Covered Person who is NOT a registered inpatient in that Hospital. Outpatient services do not include, Inpatient Facility Services, Physician Services, Custodial Care, Outpatient, DME or Home Health Care.

2.35 Paid: The charges for an Eligible Expense for which the Insured Provider tenders a draft or payment, or in the event services are provided under a Capitated Provider Agreement, where the Insured Provider records the financial transaction in the books and records maintained for these purposes.

2.36 Pharmaceuticals: Means:

- a. Blood Products;
- b. Chemotherapy;
- c. Injectables;
- d. Infusion;
- e. Specialty Drugs; and

Over the counter medications and prescription medication dispensed by a retail pharmacy are NOT considered Pharmaceuticals.

2.37 Percentage Payable: The percentage shown in the Schedule of Insurance that applies to Eligible Expenses in excess of the Specific Retention.

2.38 Physician Services: Services and supplies, including medical, surgical, diagnostic, therapeutic, and preventative services, provided to a Covered Person by a physician. Physician Services do not include services provided by a Dentist.

- 2.39 Qualified Clinical Trial.** A clinical trial in Phase III or IV that meets all the following conditions:
- a. The clinical trial is intended to treat cancer in a Member who has been so diagnosed; and
 - b. The clinical trial has been peer reviewed and is approved by at least one of the following:
 1. One of the United States National Institutes of Health,
 2. A cooperative group or center of the National Institutes of Health,
 3. A qualified nongovernmental research entity identified in guidelines issued by the National Institutes of Health for center support grants,
 4. The United States Food and Drug Administration pursuant to an investigational new drug exemption,
 5. The United States Departments of Defense or Veterans Affairs,
 6. a qualified institutional review board, and
 - c. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise, and
 - d. The Member meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial, and
 - e. The Member has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards, and
 - f. The available clinical or pre-clinical data provide a reasonable expectation that the Member's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial, and
 - g. The clinical trial does not unjustifiably duplicate existing studies, and
 - h. The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the Member.
- 2.40 Rehabilitation Facility:** A Hospital licensed as a Rehabilitation Hospital by the laws of the state where it is located, or in lieu thereof, is a participating Rehabilitation Facility under Medicare, and which provides rehabilitation care to Covered Persons and has the services of a physician available at all times under an established agreement.
- 2.41 Short Term Hospital:** A Hospital that provides care to Covered Persons for a brief but severe episode of illness for conditions that are the result of disease, trauma or during recovery from surgery. It must have facilities on the premises for major surgery, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries.
- 2.42 Skilled Nursing Facility:** A Hospital that provides restorative services to Covered Persons in need of rehabilitation and medical care that is of a lesser intensity than in a Short Term Hospital or Rehabilitation Facility. A Skilled Nursing Facility must provide 24-hour skilled nursing services under the supervision of a physician.
- 2.43 Specialty Drugs:** Outpatient clinically administered or prescribed medications that are not retail pharmacy, including but not limited to DME supply drugs, immunosuppressive therapy drugs, hemophilia clotting factors, oral anti-cancer drugs, oral anti-emetic drugs, pneumococcal vaccine, hepatitis B vaccine, influenza vaccine, antigens, erythropoietin, parenteral nutrition and intravenous immune globulin.
- 2.44 Specific Retention:** The amount shown in the Schedule of Insurance that applies per Covered Person per Contract Period, which is wholly retained by the Insured Provider.
- 2.45 Sub-Capitated Services:** Services specified in the Capitated Provider Agreement when the Insured Provider capitates a third party to manage and assume the risk.
- 2.46 Transplant:** A surgical procedure in which a dysfunctional organ is replaced by a functional human organ from either a deceased or living donor or the infusion of bone marrow or peripheral blood stem cells to reconstitute the immune system following preparative regimens of chemotherapy administered to treat disease.

- 2.47 Transplant Acquisition Expense:** Search fees and expenses to remove (from either a deceased or living donor), preserve, and transport a donated organ, bone marrow, or peripheral stem cells.
- 2.48 Transplant Confinement:** The period of time:
- a. for which there is a negotiated case rate for a defined number of days; or
 - b. if there is no negotiated case rate, that begins one day prior to the Transplant and ends upon hospital discharge or for outpatient bone marrow and peripheral stem cell transplants, that begins on the date of the Transplant and ends XX days later.
- 2.49 Travel Expense:** Commercial transportation to and from the site of a Transplant and lodging and meals costs of the Covered Person receiving the Transplant and his/her companions when the Covered Person resides more than 50 miles from the Transplant site and when the covered Person receives a Transplant during the Contract Year.

ARTICLE 3

Limitations and Exclusions

- 3.1 Company's Obligation.** This Policy is solely for the benefit of Insured Provider and Company. The parties intend no benefit by this Policy to creditors, Covered Persons, or health care providers. Insured Provider is responsible for all health care and health care expenses for Covered Persons. Company has no obligation, directly or indirectly, to provide any services or payment to anyone but Insured Provider.
- 3.2 Reduction of Benefits.** If Insured Provider receives or will receive any payment or reduction in expense by reason of a coordination of benefits provision in the Covered Plan, by any right of subrogation, or otherwise, that payment or reduction is a reduction in Eligible Expenses. If Company has already paid a claim that included these Eligible Expenses, Insured Provider will reimburse Company the amount of this reduction.
- 3.3 Multiple Policies.** If Insured Provider has another policy insuring the same risk assumed under this Policy for these same lines of business, Company will pay only the pro rata portion of the amount otherwise payable under this Policy, subject to the Policy maximums and limitations.
- 3.4 Additional Exclusions.** This Policy excludes the following:
- a. expenses that the Insured Provider has not Paid or Sub-Capitated Services;
 - b. treatment and supplies shown as Not Covered on the Schedule of Insurance;
 - c. amounts in excess of the Allowable Charges Per Covered Person shown in the Schedule of Insurance;
 - d. amounts in excess of the maximums shown in the Schedule of Insurance;
 - e. any claim not received in compliance with the Loss of Coverage or the Proof of Claim sections in Article 5;
 - f. amounts payable from any other source, unless from multiple policies, as described in this article;
 - g. services and supplies not eligible under the Covered Plan;
 - h. expenses due to war or act of war;
 - i. expenses for which Insured Provider has released any persons or entity from a legal liability;
 - j. additional liability of Company caused by a Material Change, unless Company expressly accepts the Material Change or Insured Provider agrees to accept changes in premiums, terms or provisions of the policy to accept the Material Change; and
 - k. Experimental or Investigational procedures.
 - l. any procedure or treatment to change physical characteristics to those of the opposite sex and any other treatment or studies related to sex change.

ARTICLE 4

Effective Date, Duration and Termination

- 4.1 Effective Date/Termination Date.** This Policy is effective on the effective date shown on the face page and will continue until terminated at the earliest of the following:
- a. nonpayment of premium as set forth in the premium provisions;
 - b. the date a petition is made for a declaration of receivership or rehabilitation of a party, or the date a party ceases operation;
 - c. the end of a Contract Period unless Insured Provider accepts in writing Company's terms for renewal of this Policy before the end of the Contract Period;
 - d. the date of any Material Change when Insured Provider is unwilling to accept modified premiums, terms or provisions to the Policy offered by the Company to expand the coverage under the Policy for a Material Change.
 - e. upon the date of a material breach of this Policy. The party terminating for this reason must give the other party notice of the actions or inactions that constitute the breach and 5 business days to cure the breach to the satisfaction of the notifying party.
- 4.2 Policy Not Renewed.** This Policy is for excess risk coverage for one Contract Period. Additional Contract Periods may apply upon Company's acceptance and issuance of a new Schedule of Insurance from Insured Provider. This Policy is not guaranteed renewable. We may elect to non-renew this Policy at the end of the Contract Period by giving you 31 days written notice of such non-renewal.
- 4.3 Survival of Termination.** Termination of this Policy does not terminate the rights or liabilities of either party arising during any period this Policy was in force. However, this does not extend Company's liability under this Policy to any Eligible Expense Incurred on or after the date of termination of this Policy.
- 4.4 Insolvency.** In the event of the insolvency of the Insured Provider, all insurance will be payable directly to the liquidator, receiver, or statutory successor of the Insured Provider, on the basis of the liability of Insured Provider in this Policy without diminution due to the insolvency of the Insured Provider.

ARTICLE 5

Claim Provisions

- 5.1 Written Notice of Potential Claim.** Insured Provider will give Company written notice by completing an Early Notification Form or any other form, electronic file, or format designated and approved by Company that contains the same fields as the Early Notification Form, including medical management contact information, within 30 days of the Insured Provider's knowledge of any claim or potential claim that exceeds or is expected to exceed 50% of the Specific Retention during the Contract Period. The Insured Provider will also submit a monthly update to Company of changes to potential claims.

If an acceptable written notice is not received within 90 days of the payment that causes a claim to exceed the Specific Retention, the Company will reduce by one-half the Percentage Payable as shown on the Schedule for such claim and any subsequent claims on the Covered Person.

5.2 Proof of Claim. In order to consider a claim submission for processing, the Insured Provider must file completed and itemized proof of loss by sending to the Company information related to the Eligible Expense prior to the Received by the Company date as shown in the Section entitled Claim Basis in the Schedule of Insurance. Proof of Claim includes the following:

- a. completed claim form;
- b. enrollment documents including eligibility verification on each submission, including, but not limited to:
 - 1. Copies of enrollment screens;
 - 2. Copies of enrollment forms;
 - 3. Member eligibility history screen-prints;
 - 4. Standard computer reports/data utilized by the Insured Provider that have been reviewed and accepted by the Company
 - 5. Other documentation as determined by Company;
- c. claim detail report in the format required by Company (with all the required data elements, including, but not limited to: billed and paid amounts, dates of service, diagnoses, claim service codes (Rev, CPT, HCPC), including modifiers and place of service, in CMS standard coding, proof of payment, provider name and identifier;
- d. any other documentation Company reasonably deems necessary to properly determine the amount payable. This includes, but is not limited to, copies of the completed CMS-1450 or CMS-1500 with itemized detail.

5.3 Loss of Coverage. There is no coverage of an Eligible Expense when:

- a. Company receives a completed Early Notification Form or any other form, electronic file, or format after the Reported date shown in the Section entitled Claim Basis in the Schedule of Insurance;
- b. The expense is incurred, or paid, outside of the dates shown in the Section entitled Claim Basis in the Schedule of Insurance;
- c. Company receives the Proof of Claim documentation after the Received by the Company date shown in the Section entitled Claim Basis in the Schedule of Insurance. However, this limitation does not apply to Eligible Expenses if prior to this time the Insured Provider has, in writing, pursued their right of coordination of benefits, subrogation or otherwise initiated a right to recover or reduce such expenses, and has notified Company within 30 days of such action.

5.4 Claim Forms. Company will send Insured Provider claim forms for filing a claim upon request.

5.5 Appeal of Claim Determination. Insured Provider must submit a written request for appeal of any claim processed under this Policy within 60 days after receipt of a claim determination. This appeal must include the specific reason for the review.

ARTICLE 6

Premium Provisions

6.1 Premium Rate. The premium rate in the Schedule of Insurance is payable monthly and is based on the number of Covered Persons enrolled during the month. Additional Premium may be charged based on a Material Change.

6.2 Due Date. Premiums are due on the first day of each month of the Contract Period at Company's office in Kennesaw, Georgia.

6.3 Grace Period. There is a grace period of 31 days after the due date to pay the premium. Company will provide Insured Provider with written notice of nonpayment of premium. If premium is not received before the end of the grace period, this Policy automatically terminates as of the end of the period for which the last premium has been received.

- 6.4 Reinstatement.** The Company may, at its sole discretion, reinstate this Policy upon receipt of all outstanding and current month's premium after the grace period along with any claim information determined by the Company. Payment of overdue premiums will not guarantee reinstatement of the Policy. Premium rates, terms and provisions of the Policy are subject to change as a condition of reinstatement. The parties agree that past reinstatements create no right of presumption of future reinstatement.
- 6.5 Signed Statement.** Each premium payment must be accompanied by a statement signed by an authorized representative of Insured Provider giving the number of Covered Persons for that month by Line of Business and Managed Care Organization and any adjustments from previous statements.

ARTICLE 7

Reports, Records and Audits

- 7.1 Monthly Enrollment.** Insured Provider will keep a record of the monthly enrollment of Covered Persons by Capitated Provider Agreement and the Eligible Expenses for each Covered Person. Insured Provider will keep this record for at least three years after termination of this Policy or for the period during which claims are pending, whichever is longer.
- 7.2 Books and Records.** Insured Provider will make its books and records available to Company for inspection and audit at any time during normal business hours during the time this Policy is in effect and for three years after its termination.

ARTICLE 8

Material Change

- 8.1 Material Change.** Material Change is a change or combination of changes that represent a change in the risk assumed by the Company, as solely determined by the Company. Material Changes include:
- a. a change in any Capitated Provider Agreement or provider contract that Company determines would increase our risk under this Policy;
 - b. a change or increase in liability due to the acquisition of, merger with, or sale to another company or provider group;
 - c. a change in Insured Provider's service management or vendor contracts;
 - d. a change in majority ownership of Insured Provider;
 - e. a change in the tertiary capabilities of the Insured Provider or its affiliates; or
 - f. if the number of Covered Persons increases or decreases in any Line of Business by more than 10%.
- 8.2 Notice.** Insured Provider must give Company 31 days advance written notice of any Material Change. Upon notice of such change, Company may exclude the expanded obligations from coverage under this Policy, charge additional premium, modify the terms or provisions of coverage under this Policy to represent the change in risk due to the material change. Should the Insured Provider refuse to accept the Company's modifications for the Material Change, Company reserves the right to exclude Eligible Expenses that result from the Material Change or terminate the policy in its entirety as of the date of the Material Change.

ARTICLE 9

General Provisions

- 9.1 Assignment.** Neither party may assign this Policy without the written consent of the other party.
- 9.2 Clerical Error.** If either party fails to comply with a provision of this Policy because of a clerical error, the underlying status of this Policy will not be changed so long as the error is rectified within 30 days of discovery. Then both parties will be restored to the position they would have occupied had such error not occurred. An error is an inadvertent clerical mistake. It does not include errors in judgment, errors that expand the definition of Eligible Expenses or reduce the effect of the limits in this Policy, negligent acts, and repetitive errors in administration, or other errors. Neither party may invoke a right to rectify its error after 12 months beyond the end of the Contract Period.
- 9.3 Conflict of Law.** Any provision of this Policy that conflicts with applicable federal or state laws and regulations is amended to conform to the minimum requirements of those laws and regulations.
- 9.4 Entire Contract.** The Policy, the Schedule of Insurance and any amendments thereto constitute the entire contract of insurance. No change in this Policy is valid until approved by an officer of Company and Insured Provider. No agent has authority to change this Policy or to waive any of its provisions. In the event that any Insured Provider signature is delivered by electronic means or facsimile transmission, such signature shall create a valid and binding obligation on the party executing the same with the same force and effect as if such electronic or facsimile signature page were an original thereof.
- 9.5 Legal Actions.** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of claim has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of claim is required to be furnished.
- 9.6 Misstated Data.** If information material to the underwriting of this Policy is misstated or omitted, Company may retroactively adjust the premiums or coverage in accordance with the correct data.
- 9.7 Personal Information.** Personal Information means nonpublic personal information as described in Title V of the Gramm-Leach-Bliley Act and protected health information as described in privacy regulations of the Department of Health and Human Service ("HHS") that may be identified with a Covered Person and that Company obtains.

Company may use Personal Information to underwrite and perform terms of this Policy and in other ways permitted by applicable privacy laws. Company will:

- a. use safeguards to prevent nonpermitted use or disclosure; and
- b. restrict access to only those employees involved in the permitted uses; and
- c. report to Insured Provider any nonpermitted use or disclosure that it becomes aware of; and
- d. make Personal Information and related records available as described in privacy regulations of HHS.

Company may disclose Personal Information to a person assisting in permitted uses if that person agrees in writing to be bound to terms similar to this Article 9.7. This Article 9.7 does not apply if:

- a. the Personal Information is available to the public other than as a result of any disclosure by Company or its representatives; or
- b. the Personal Information was available to Company or its representatives on a nonconfidential basis before it was obtained for uses permitted in this article; or
- c. Insured Provider and the Covered Person consent in writing to the disclosure; or
- d. the law requires disclosure.

Company will destroy Personal Information, if feasible, after seven years after this Policy terminates.

9.8 Right of Offset. Amounts owed by the Insured Provider to Company with respect to this Policy, or any previous Policy provided to Insured Provider by Company, may be offset against claims made under this policy up to the balance owed. The right of offset will not be affected or diminished because of the insolvency of either party.

9.9 Binding Arbitration. If any dispute arises out of or relates to this Policy or its breach, termination, interpretation, or validity, both parties agree that they will try in good faith to settle the dispute. If they do not reach a solution within 90 days, then the parties agree that the dispute will be resolved not through litigation but instead through binding arbitration administered by the American Arbitration Association according to its Commercial Arbitration Rules. Each party will pay the costs of its expenses for counsel, witnesses, proofs, and experts. Both parties will share the cost of the arbitration administration. The arbitrator may award specific performance, rescission, or monetary damages in an amount that does not include punitive or other damages in excess of contractual damages. Binding arbitration shall be considered an action at law or in equity and, as such, is subject to the time limits set forth in Article 9.5, Legal Actions.

9.10 Waiver. Waiver of any provision of this Policy is not a waiver of that provision or other provisions at a later date.

HCC Life Insurance Company
225 TownPark Drive, Suite 145
Kennesaw, GA 30144

Policyholder Service Office
11100 Wayzata Blvd. Suite 350
Minnetonka, MN 55305
Phone: 877-843-5743

SCHEDULE OF INSURANCE

FOR CONTRACT PERIOD BEGINNING [_____]

Attaching to and forming a part of the

PROVIDER EXCESS INSURANCE POLICY

FOR

[XYZ PROVIDER GROUP]

[

LINE OF BUSINESS:**Commercial**

Commercial HMO	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included
Commercial POS	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included
Commercial PPO	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included
Commercial Indemnity	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included

Medicaid

Medicaid AFDC/TANF	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included
Medicaid ABD/SSI	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included
Medicaid Chip (ages 0-19)	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included
Medicaid Chip (ages 1-19)	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included
Medicaid FHP	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included
_____	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included

Medicare

Medicare Advantage

Medicare HMO	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included
Medicare PPO	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included
Medicare PFFS	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included
Medicare SNP	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included
_____	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included

Medicare PACE	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included
Medicare Dual Eligible	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included

PREMIUM:

Insured Provider will pay Company the following premium per Covered Person for coverage of the lines of business specified below:

HMO X	
Commercial/HMO	\$X.XX
Commercial/POS	\$X.XX
Medicare	\$X.XX
Medicaid	\$X.XX
Medicaid	\$X.XX
Other	\$X.XX
Other	\$X.XX
HMO Y	
Commercial/HMO	\$X.XX
Commercial/POS	\$X.XX
Medicare	\$X.XX
Medicaid	\$X.XX
Medicaid	\$X.XX
Other	\$X.XX
Other	\$X.XX
HMO Z	
Commercial/HMO	\$X.XX
Commercial/POS	\$X.XX
Medicare	\$X.XX
Medicaid	\$X.XX
Medicaid	\$X.XX
Other	\$X.XX
Other	\$X.XX

If the Loss Ratio for this Contract Period is XX% or less, the above monthly premium will not increase for the XX/XX/XXXX Contract Period (exclusive of any Material Changes). If the three-year Loss Ratio for the XX/XX/XXXX, XX/XX/XXXX and XX/XX/XXXX Contract Periods is XX% or less, the above monthly premium will not increase by more than XX% for the XX/XX/XXXX Contract Period (exclusive of any Material Change).

Loss Ratio: The ratio of Claims to premiums paid, net of any experience refund, under this Policy and Policy #HCLXXXXX-XXX for XXXXXXXXXXXXXXXXXXXXXXXX.

Claims: The sum of all claims paid by Company and all fees paid by Company for access to medical providers and/or any unaffiliated company or person to investigate, manage or audit a claim under this Policy and Policy #XXXXXX-XXX for XXXXXXXXXXXXXXXXXXXXXXXX .

The minimum premium under this Policy is \$X,XXX,XXX per Contract Period.

SPECIFIC RETENTION:

The Specific Retention for Eligible Expenses is as follows:

Line of Business	Specific Retention	
	Hospital	Physician
Commercial/HMO	\$XX,XXX	\$XX,XXX
Commercial/POS	\$XX,XXX	\$XX,XXX
Medicare	\$XX,XXX	\$XX,XXX
Medicaid	\$XX,XXX	\$XX,XXX
Medicaid	\$XX,XXX	\$XX,XXX
Other	\$XX,XXX	\$XX,XXX
Other	\$XX,XXX	\$XX,XXX

If a Covered Person undergoes a transplant and the entire transplant event is paid at a Fixed Fee, the Covered Person's Specific Retention is \$XX,XXX for [MCO Name] for all Eligible Expenses in the Contract Period in which the transplant takes place.

See Coverage Summary for Eligible Expenses and the Specific Retention to which such expenses apply.

AGGREGATING SPECIFIC RETENTION:

The percentage payable of Eligible Expenses that exceed the applicable specific retention above, up to any applicable maximums, will be applied toward an aggregating specific retention.

Aggregating Specific Retention		
Line of Business	Hospital	Physician
Commercial/HMO	\$XX,XXX	\$XX,XXX
Commercial/POS	\$XX,XXX	\$XX,XXX
Medicare	\$XX,XXX	\$XX,XXX
Medicaid	\$XX,XXX	\$XX,XXX
Medicaid	\$XX,XXX	\$XX,XXX
Other	\$XX,XXX	\$XX,XXX
Other	\$XX,XXX	\$XX,XXX

The aggregating specific retention is calculated by first determining the number of Covered Persons enrolled during each month by line of business, summing these monthly totals over the entire Contract Period, and then multiplying the resulting sums by the corresponding aggregating specific retention per Covered Person per month factor. In no event will the aggregating specific retention be less than the minimum aggregating specific retention listed below.

Aggregating Specific Retention			
Line of Business	Per Covered Person Per Month Factor		Minimum Aggregating Specific Retention
	Hospital	Physician	
Commercial/HMO	\$XX,XXX	\$XX,XXX	\$XX,XXX
Commercial/POS	\$XX,XXX	\$XX,XXX	\$XX,XXX
Medicare	\$XX,XXX	\$XX,XXX	\$XX,XXX
Medicaid	\$XX,XXX	\$XX,XXX	\$XX,XXX
Medicaid	\$XX,XXX	\$XX,XXX	\$XX,XXX
Other	\$XX,XXX	\$XX,XXX	\$XX,XXX

RETAINED CORRIDOR:

Definitions: For purposes of this article, the following terms are defined as such:

- a. **Loss Ratio:** The ratio of Policy Claims as of the date of claim adjudication to annual premium paid under this Policy and Policy #XXXXXXX.
- b. **Corridor Ceiling:** XXX% of annual premium paid under this Policy and Policy #XXXXXXXXXX as of the date of claim adjudication.
- c. **Policy Claims:** The percentage payable of Eligible Expenses that exceed the applicable specific retention under this Policy and Policy #XXXXXXXXXX, up to any applicable maximums.

Calculation: If the Loss Ratio reaches XXX%, Insured Provider will retain the risk for all Eligible Expenses in excess of this Loss Ratio up to the Corridor Ceiling. Once the Corridor Ceiling has been reached, Company will resume payment of Policy Claims in excess of the Corridor Ceiling. The annual premium shall be calculated as year to date premium plus the most recent month's premium as an estimate for the remaining months. At the end of the Contract Period, a 'true up' calculation will be performed based on the actual annual premiums paid and the duration of the Policy for that Contract Period. Additional amounts owed Insured Provider will be paid within 60 days from the end of the Contract Period. Additional amounts owed Company will be used to offset claims, until the proof of claim period has expired, at which time, any amounts still owed Company will be paid within 60 days.

PERCENTAGE PAYABLE 90%

This Percentage Payable will be reduced by one-half if Written Notice of Potential Claim is not received within 90 days of the payment that causes the claim to exceed the Specific Retention and any subsequent claims as required by Article 5.1.

Transplants	
Transplants during the Transplant Confinement and Transplant Acquisition Expenses will be reimbursed at:	
If paid at a fixed fee	80%
If paid at (state's) Medicaid fee schedule for Transplants listed on Exhibit X	80%
If paid at any other Transplant rate	50%
If provided by (facilities in the state of XX) for Transplants listed on Exhibit X	90%
Care provided outside the Transplant Confinement will be reimbursed at:	XX%

COVERAGE SUMMARY:

Eligible Expenses for services and supplies that are marked with an "X" under "Physician Specific Retention" or "Hospital Specific Retention" are Eligible Expenses provided the expenses otherwise meet the definition of Eligible Expenses. Services marked with an "X" under "Not Covered" are not Eligible Expenses.			
List of Services	Eligible Expense		Not Covered
	Physician Specific Retention	Hospital Specific Retention	
Inpatient Hospital Services (other than Transplants)			
Burn unit			X
Cardiac unit			X
Neonatal unit			X
Out of network care			X
All other Inpatient Hospital Services		X	
Transplants during the Transplant Confinement			
Inpatient Hospital Services		X	
Physician Services	X		
Transplant Acquisition Expense			X
Travel Expense			X
Other Inpatient Facilities			
Long Term Acute Care Facility			
All other Long Term Acute Care			X
Skilled Nursing Facility			
All other Skilled Nursing Care		X	
Rehabilitation Facility			
All other Rehabilitation Facility Care		X	
Emergency Out of Area Care			
Inpatient Hospital Services		X	
Outpatient Hospital Services		X	
Physician Services	X		
Outpatient Hospital Services			
Dialysis			X
Diagnostic			X
Nuclear medicine			X
All other Outpatient Hospital Services			X

Eligible Expenses for services and supplies which are marked with an "X" under "Physician Specific Retention" or "Hospital Specific Retention" are Eligible Expenses provided the expenses otherwise meet the definition of Eligible Expenses. Services marked with an "X" under "Not Covered" are not Eligible Expenses.

List of Services	Eligible Expense		Not Covered
	Physician Specific Retention	Hospital Specific Retention	
Physician Services			
All other Physician Services	X		
Home Health Care			
Dialysis			X
Parenteral and Enteral Nutrition			X
All other Home Health Care	X		
Hospice			
Parenteral and Enteral nutrition			X
All other Hospice Care	X		
Ambulance			
Emergency transportation services		X	
Air ambulance			X
Nonemergency transportation services			X
Durable Medical Equipment (DME)			
Orthotics			X
Prosthetics			X
All other DME		X	
Implants			
		X	
Pharmaceuticals			
Blood Products			
Administered and billed by a facility while receiving Inpatient Hospital Services		X	
Administered and billed by a facility while receiving care in Other Inpatient Facilities		X	
Administered and billed by a facility while receiving Outpatient Care		X	
Administered while receiving Home Health Care	X		
Self-administered	X		
Administered by a physician	X		

Eligible Expenses for services and supplies which are marked with an "X" under "Physician Specific Retention" or "Hospital Specific Retention" are Eligible Expenses provided the expenses otherwise meet the definition of Eligible Expenses. Services marked with an "X" under "Not Covered" are not Eligible Expenses.			
List of Services	Eligible Expense		Not Covered
	Physician Specific Retention	Hospital Specific Retention	
Chemotherapy Drugs and all related medications			
Administered and billed by a facility while receiving Inpatient Hospital Services		X	
Administered and billed by a facility while receiving care in Other Inpatient Facilities		X	
Administered and billed by a facility while receiving Outpatient Hospital Services		X	
Administered while receiving Home Health Care	X		
Self-administered	X		
Administered by a physician	X		
Injectables			
Administered and billed by a facility while receiving Inpatient Hospital Services		X	
Administered and billed by a facility while receiving care in Other Inpatient Facilities		X	
Administered and billed by a facility while receiving Outpatient Hospital Services		X	
Administered while receiving Home Health Care	X		
Self-administered	X		
Administered by a physician	X		
Infusion			
Administered and billed by a facility while receiving Inpatient Hospital Services		X	
Administered and billed by a facility while receiving care in Other Inpatient Facilities		X	
Administered and billed by a facility while receiving Outpatient Hospital Services		X	
Administered while receiving Home Health Care	X		
Self-administered	X		
Administered by a physician	X		
Specialty Drugs	X	X	
Prescription medications dispensed by a retail pharmacy or mail order company			X
Custodial Care			X

ALLOWABLE CHARGES PER COVERED PERSON:

A. Inpatient Hospital Services at:

Short Term Hospitals:

ABC Provider:

The lesser of:

1. XX% of billed charges (unless paid at a Medicare or Medicaid DRG rate);
2. the amount Paid; or
3. \$X,XXX per day/per case rate.

All other Short Term Hospitals:

The lesser of:

1. billed charges (unless paid at a Medicare or Medicaid DRG rate);
2. the amount Paid;
3. XX% of Medicare Allowable or XX% of billed charges if no Medicare Allowable; or
4. Average Daily Maximums (ADMs) of:

All days	\$X,XXX	Days X – XX	\$X,XXX
Days XX – XX.....	\$X,XXX		
Days XXX – XXX....	\$X,XXX		

The ADM is waived when the entire stay is paid at a Fixed Fee.

Long Term Acute Care Facilities

The lesser of:

1. billed charges (unless paid at a Medicare or Medicaid DRG rate);
2. the amount Paid; or
3. \$X,XXX per day up to a maximum of XX days per Contract Period.

Skilled Nursing Facilities

The lesser of:

1. billed charges (unless paid at a Medicare or Medicaid DRG rate);
2. the amount Paid; or
3. \$X,XXX per day up to a maximum of XX days per Contract Period.

Rehabilitation Facilities

The lesser of:

1. billed charges (unless paid at a Medicare or Medicaid DRG rate);
2. the amount Paid; or
3. \$X,XXX per day up to a maximum of XX days per Contract Period.

B. Transplants during the Transplant Confinement

The lesser of:

1. billed charges;
2. the amount Paid; or
3. the amounts shown below:
 - Inpatient Hospital Services at an HCC Approved Transplant Network Amounts shown on Exhibit X
 - All other Inpatient Hospital Services.... Refer to A above
 - Physician Services Amounts shown on Exhibit X
 - Transplant Acquisition Expense \$X,XXX per Contract Period
 - Travel Expense..... \$X,XXX per Contract Period.

C. Emergency Out-of-Area Care:

The lesser of:

1. billed charges;
2. the amount Paid; or
3. \$X,XXX per Contract Period.

D. Outpatient Hospital Services:

The lesser of:

1. the amount Paid; or
2. XX% of billed charges; or
3. \$X,XXX per day; or
4. \$XXX,XXX per Contract Period.

E. Physician Services

The lesser of:

1. the amount Paid; or
2. XX% of Medicare Allowable or XX% of billed charges if no Medicare Allowable.

F. Home Health Care

The lesser of:

1. billed charges;
2. the amount Paid; or
3. \$X,XXX per day to a maximum of XX days per Contract Period; or
4. \$XXX,XXX per Contract Period.

G. Hospice

The lesser of:

1. billed charges;
2. the amount Paid; or
3. \$X,XXX per day to a maximum of XX days per Contract Period; or
4. \$XXX,XXX per Contract Period.

H. Ambulance

The lesser of:

1. billed charges;
2. the amount Paid; or
3. \$X,XXX per Contract Period.

I. Durable Medical Equipment (DME), other than Inpatient Hospital Services:

The lesser of:

1. billed charges;
2. the amount Paid; or
3. \$X,XXX per Contract Period.

J. Implants, other than Inpatient Hospital Services:

The lesser of:

1. billed charges;
2. the amount Paid; or
3. \$X,XXX per Contract Period.

K. Pharmaceuticals ,other than Inpatient Hospital Services:

The lesser of:

1. the amount Paid; or
2. XX% of Medicare Allowable, or XX% of billed charges if no Medicare Allowable; or
3. \$XXX,XXX per Contract Period

INDIVIDUAL CONTRACT PERIOD MAXIMUM: \$X,XXX,XXX

INDIVIDUAL LIFETIME MAXIMUM: \$X,XXX,XXX

CARRYFORWARD:

Eligible Expenses may include expenses by a Covered Person in the last 31 days of a policy issued to Insured Provider by Company immediately preceding this Policy if the applicable Specific Retention was not reached with respect to that Covered Person under that preceding policy.

CLAIM BASIS:

All expenses must meet all of the following criteria to be considered an Eligible Expense:

Incurred Date of Service: _____ through _____ and,
Paid: _____ through _____ and,
Reported: _____ through _____ and,
Received by the Company on or before: _____.

OPTIONAL FUNDING PROVISIONS:

Experience Refund

If Company issues all of the following parties a Policy subsequent to this Policy that provides coverage for an additional Contract Period and coverage is continuous from the effective date of their respective Policy through the entire Contract Period of the subsequent policy, the premium for these Policies provides for an experience refund of XX% of Company's net profit for these Policies will be available. When applicable, all experience refunds are subject to any Net Profit deficits carried forward from Policies issued to Insured Provider by Company during the previous XX years.

Parties:

- a. xxx
- b. xxx
- c. xxx

Net Profit. Net Profit is calculated as:

- a. The sum of all premiums paid by the above listed parties for coverage under the respective Policies, minus
- b. The sum of all expenses incurred by the Company that are equal to XX% of the combined premium paid by these parties, minus
- c. The sum of all claims paid by the Company under each of these Policies, minus
- d. The sum of all fees paid by the Company under these Policies for access to medical providers and/or to any unaffiliated company or person to investigate, manage or audit claims.

Calculation of Refund. Company will calculate and distribute to Insured Provider any experience refund XX months after the end of the Contract Period.

Retrospective Premium Adjustment

Calculation. XX months after the termination of this Policy, Company will calculate premiums paid and net loss for this Policy and provide Insured Provider with a copy of this calculation and any supporting documentation.

Net Loss. For purposes of this calculation, net loss is calculated as:

- a. the sum of all expenses incurred by Company that are equal to XX% of premium paid by Insured Provider for this Policy; plus
- b. the sum of all claims paid by Company under this Policy; plus
- c. the sum of all fees paid by Company under this Policy for access to medical providers and/or to any unaffiliated company or person to investigate, manage or audit a claim; plus
- d. any deficit calculated from Policies issued to Insured Provider previous to this Policy.

Additional Premium. Insured Provider shall pay Company an additional premium equal to any amount of net loss that is greater than premiums paid for this Policy but less than XX% of premium paid. Any amount of net loss that is more than XX% of premium paid shall be considered a deficit and be carried over to any subsequent Policy issued to Insured Provider and added to the net loss of that Policy.

Premium Refund. Company shall pay Insured Provider an amount equal to any net loss that is less than premiums paid but greater than XX% of premiums paid. If net loss is less than XX% of premium paid, Insured Provider will receive a premium refund equal to XX% of premiums paid.

Payments. Any additional premium owed by Insured Provider or any premium refund owed by Company shall be paid within XX days of the date of the calculation. Any payment made after XX days shall accrue interest at the XX-day T-bill rate plus XX percent, calculated on a monthly basis.

Revised Statement. Company shall provide Insured Provider with a revised statement that accurately reflects premiums paid and net profit based on the payment of additional premium or a premium refund.

]

I agree to the terms as stated above and hereby apply for insurance with HCC Life Insurance Company.

It is understood and agreed by the Applicant that:

1. All documentation requested by the Company must be received with 90 days of the Policy Effective Date, and is subject to approval by the Company and may require adjustment of rates or limits; and
2. The Provider Excess Insurance applied for herein will not become effective until accepted by the Company; and
3. This Schedule of Insurance will be attached to and made a part of the Policy issued by the Company; and
4. After diligent and complete review, the representations made in this Application/Schedule of Insurance, the disclosures made, and all of the information provided for underwriters to evaluate the risk, are true and complete.

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Full Legal Name of Applicant:

Signature: _____

Title: _____

Date: _____

HCC Life Insurance Company
225 TownPark Drive, Suite 145
Kennesaw, GA 30144

Policyholder Service Office
11100 Wayzata Blvd. Suite 350
Minnetonka, MN 55305
Phone: 877-843-5743

AMENDMENT NO. [X]

This Amendment is attached to and made a part of Provider Excess Insurance Policy No. [XXXXXXX] ("Policy") issued by HCC Life Insurance Company ("Company") to [XYZ Hospital] ("Insured Provider").

It is agreed by and between Company and Insured Provider that effective [date], the Policy is amended as follows: [

]

Except as stated herein, all other terms and conditions of the Policy remain in effect.

Date: _____

President

Secretary

HCC Life Insurance Company
225 TownPark Drive, Suite 145
Kennesaw, GA 30144

Policyholder Service Office
11100 Wayzata Blvd. Suite 350
Minnetonka, MN 55305
Phone: 877-843-5743

**AMENDMENT TO A POLICY
ISSUED IN THE STATE OF ARKANSAS**

Amendment of Policy Number [HCL XXXXX-XXX] ("Policy") between HCC Life Insurance Company ("Company") and [Generic Health Plan] ("Insured Provider").

The Company and the Insured Provider agree that the Provider Excess Insurance Policy is amended as follows:

Article 9 – **General Provisions** is hereby amended as follows:

Section 9.9 - **Binding Arbitration** is deleted in its entirety.

Except as herein stated, all terms and conditions of the Agreement remain unchanged.

The Effective Date of this Amendment is [_____].

[

President

]

[

Secretary

]

SERFF Tracking Number: HCCH-126234283

State: Arkansas

Filing Company: HCC Life Insurance Company

State Tracking Number: 42932

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: Provider Excess Loss - A&H

Project Name/Number: PEX 4 Filing/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: AR Readability Certification.pdf	Withdrawn	07/22/2009

	Item Status:	Status Date:
Satisfied - Item: Application Comments: For this policy the Schedule of Insurance, form HCCL PEX 4 SOI, will be used as the application. This is attached under the Forms Schedule.	Withdrawn	07/22/2009

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage Bypass Reason: Not applicable to this filing. Comments:	Withdrawn	07/22/2009

	Item Status:	Status Date:
Satisfied - Item: AR Cover Letter Comments: Attachment: AR Cover Letter-HCCL.pdf	Withdrawn	07/22/2009

	Item Status:	Status Date:
Satisfied - Item: AR Transmittal Doc Comments: Attachment:	Withdrawn	07/22/2009

SERFF Tracking Number: HCCH-126234283 State: Arkansas
 Filing Company: HCC Life Insurance Company State Tracking Number: 42932
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Provider Excess Loss - A&H
 Project Name/Number: PEX 4 Filing/
 AR Transmittal Doc_2009-A&H.pdf

		Item Status:	Status
			Date:
Satisfied - Item:	Compliance Certification	Withdrawn	07/22/2009
Comments:			
Attachment:			
	AR Certification of Compliance.pdf		

		Item Status:	Status
			Date:
Satisfied - Item:	Note	Withdrawn	07/22/2009
Comments:			
	This is the note from the P&C filing advising the Company to refile as an A&H product.		
Attachment:			
	AR- Note from reviewer - HCCH-126226991.pdf		

HCC LIFE INSURANCE COMPANY



225 TownPark Drive, Suite 145, Kennesaw, Georgia 30144 Telephone: (770) 973-9851 Facsimile: (770) 973-9854

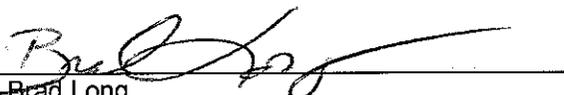
July 20, 2009

STATE OF ARKANSAS READABILITY CERTIFICATION

COMPANY NAME: HCC Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
HCCL PEX 4	51.5
HCCL PEX 4 SOI	55.4
HCCL PEX 4 AMEND	62.5
HCCL PEX 4 AR	49.4


Brad Long
Assistant Vice President, Compliance

7-20-09
Date

HCC LIFE INSURANCE COMPANY



225 TownPark Drive, Suite 145, Kennesaw, Georgia 30144 Telephone: (770) 973-9851 Facsimile: (770) 973-9854

July 20, 2009

Compliance – Life and Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201

RE:	HCC Life Insurance Company			
	NAIC #	0984-92711	FEIN #	35-1817054
	Form:	HCCL PEX 4	-	Provider Excess Loss Policy
		HCCL PEX 4 SOI	-	Schedule of Insurance/ Application
		HCCL PEX 4 AR	-	Amendment AR
		HCCL PEX 4 AMEND	-	Amendment Form

Dear Sir or Madam:

HCC Life Insurance is filing the above-referenced forms for approval in your state. These forms were submitted to the state of domicile, IN, on July 7, 2009 and were approved on July 10, 2009. For this policy the form HCCL PEX 4 SOI will serve as the application.

This filing was submitted as a P&C product on 07/13/2009 and withdrawn as a P&C product on 07/20/2009. The reviewer Llyweyia Rawlins has advised that this should be filed as an A&H product. Substantial changes have been made from the forms that were previously approved for HCC Life Insurance Company. (Please refer to SERFF Tracking Number SERT-6T5RXN058/00-00/00-00/00, which was approved by your state on 09/28/06). The Company needs to have the captioned forms approved by September 1, 2009 since we will be issuing renewals on existing business as of then.

We enclose the following for your consideration:

- One copy of this submission letter
- One copy of the above referenced forms
- One copy of the certification of compliance
- One copy of the explanation of variables
- One copy of the transmittal document
- One copy of the readability certification
- One copy of the actuarial memorandum and rates

Our fee of \$50.00 has been sent EFT, on this same date.

These forms are intended to replace any forms currently on file with your department. We anticipate using these forms for effective dates beginning September 1, 2009.

This product will be marketed to health-care providers that accept risk from managed care organizations (i.e., physician hospital organizations, health maintenance organizations, prepaid health plans, insurance companies, preferred provider organizations, self-funded employer groups, or physician services organizations) for the services and supplies they provide. When issued, the Provider Excess Insurance Policy ("Policy") will reflect the risk that the health-care providers have accepted from the managed care organizations.



Variable material is indicated by brackets. These areas are considered variable to the extent of the deletion of, addition of, or change in the specifics of a provision filed as variable. For example, on the schedule page reimbursement may include multiple variations of the same method of reimbursement or specific services and this reimbursement may be grouped or separated based on risk. In addition, the list of excluded services on the application are examples only and actual exclusions will be based upon the health care services and supplies that the provider is at risk for. We intend to work with all variable materials within the confines of the explanation of variables submitted with this filing, the risk of the health-care provider and the coverage for that risk, and the laws of your state. We also consider page numbers and numbers at the beginning of items on a list to be variable.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

If you have any questions or need additional information, please call toll-free 1-800-447-0460. Thank you for your assistance.

Respectfully,

A handwritten signature in blue ink that reads "Misty Pagelsen".

Misty Pagelsen
Compliance Assistant
770-693-6455
mpagelsen@hcclife.com

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	
-----------	----------------------------------	--

2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address

5.	Requested Filing Mode	<input type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
-----------	------------------------------	---

6.	Company Tracking Number	
-----------	--------------------------------	--

7.	<input type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
-----------	---	-----------------------

8.	Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise	
		Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

9.	Type of Insurance	
-----------	--------------------------	--

10.	Product Coding Matrix Filing Code	
------------	--	--

11.	Submitted Documents	<p><input type="checkbox"/> FORMS</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Policy</td> <td><input type="checkbox"/> Outline of Coverage</td> <td><input type="checkbox"/> Certificate</td> </tr> <tr> <td><input type="checkbox"/> Application/Enrollment</td> <td><input type="checkbox"/> Rider/Endorsement</td> <td><input type="checkbox"/> Advertising</td> </tr> <tr> <td><input type="checkbox"/> Schedule of Benefits</td> <td><input type="checkbox"/> Other</td> <td></td> </tr> </table> <p>Rates</p> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate	<input type="checkbox"/> Policy	<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate	<input type="checkbox"/> Application/Enrollment	<input type="checkbox"/> Rider/Endorsement	<input type="checkbox"/> Advertising	<input type="checkbox"/> Schedule of Benefits	<input type="checkbox"/> Other		
<input type="checkbox"/> Policy	<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate										
<input type="checkbox"/> Application/Enrollment	<input type="checkbox"/> Rider/Endorsement	<input type="checkbox"/> Advertising										
<input type="checkbox"/> Schedule of Benefits	<input type="checkbox"/> Other											
		<input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____										
		<p>SUPPORTING DOCUMENTATION</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Articles of Incorporation</td> <td><input type="checkbox"/> Third Party Authorization</td> </tr> <tr> <td><input type="checkbox"/> Association Bylaws</td> <td><input type="checkbox"/> Trust Agreements</td> </tr> <tr> <td><input type="checkbox"/> Statement of Variability</td> <td><input type="checkbox"/> Certifications</td> </tr> <tr> <td><input type="checkbox"/> Actuarial Memorandum</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Articles of Incorporation	<input type="checkbox"/> Third Party Authorization	<input type="checkbox"/> Association Bylaws	<input type="checkbox"/> Trust Agreements	<input type="checkbox"/> Statement of Variability	<input type="checkbox"/> Certifications	<input type="checkbox"/> Actuarial Memorandum		<input type="checkbox"/> Other _____	
<input type="checkbox"/> Articles of Incorporation	<input type="checkbox"/> Third Party Authorization											
<input type="checkbox"/> Association Bylaws	<input type="checkbox"/> Trust Agreements											
<input type="checkbox"/> Statement of Variability	<input type="checkbox"/> Certifications											
<input type="checkbox"/> Actuarial Memorandum												
<input type="checkbox"/> Other _____												

12.	Filing Submission Date		
13.	Filing Fee (If required)	Amount _____	Check Date _____
		Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No	Check Number _____
14.	Date of Domiciliary Approval		
15.	Filing Description:		

16.	Certification (If required)		
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of _____.</p>			
Print Name _____		Title _____	
Signature _____		Date: _____	

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	
This filing corresponds to rate filing company tracking number	

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	

LH RFA-1



HCC LIFE INSURANCE COMPANY

225 TownPark Drive, Suite 145, Kennesaw, Georgia 30144 Telephone: (770) 973-9851 Facsimile: (770) 973-9854

July 20, 2009

STATE OF ARKANSAS CERTIFICATION OF COMPLIANCE

Company Name: HCC Life Insurance Company

Form Title(s): Provider Excess Loss Policy, Provider Excess Insurance Application/Schedule of Insurance, Amendment Form

Form Number(s): HCCL PEX 4, HCCL PEX 4 SOI, HCCL PEX 4 AMEND, HCCL PEX 4 AR

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.

Brad Long
Assistant Vice President, Compliance

7-20-09
Date

<i>SERFF Tracking Number:</i>	<i>HCCH-126226991</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>US Specialty Insurance Company</i>	<i>State Tracking Number:</i>	<i>EFT \$50</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>33.0 Other Lines of Business</i>	<i>Sub-TOI:</i>	<i>33.0002 Other Commercial Lines</i>
<i>Product Name:</i>	<i>Provider Excess Loss Policy - P&C</i>		
<i>Project Name/Number:</i>	<i>PEX 4 Filing 2009/</i>		

SERFF Tracking Number: HCCH-126226991 State: Arkansas
 Filing Company: US Specialty Insurance Company State Tracking Number: EFT \$50
 Company Tracking Number:
 TOI: 33.0 Other Lines of Business Sub-TOI: 33.0002 Other Commercial Lines
 Product Name: Provider Excess Loss Policy - P&C
 Project Name/Number: PEX 4 Filing 2009/

Amendment Letter

Amendment Date:
 Submitted Date: 07/20/2009

Comments:

In response to your filing problem we hereby withdraw said forms for consideration as a P&C product in the state of Arkansas.

USSIC PEX 4
 USSIC PEX 4 SOI
 USSIC PEX 4 AMEND
 USSIC PEX 4 AR

Changed Items:

Form Schedule Item Changes:

Form Name	Form Number	Edition Date	Form Type	Action	Replaced Form #	Previous Filing #	Readability Score	Attachments
Provider Excess Loss 4 Policy	USSIC PEX 4	2009	Policy/C overage Form	Withdrawn	USSIC PEX 2 AR	33658		USSIC PEX 4 - final.pdf
Schedule of Insurance	USSIC PEX 4 SOI	2009	Declarati ons/Schedule	Withdrawn				USSIC PEX 4 SOI - final.pdf
Amendment Form	USSIC PEX 4 AMEND	2009	Endorse ment/Am endment /Conditio ns	Withdrawn	USSIC PEX 2 AMEND	33658		USSIC PEX 4 AMEND - generic - final.pdf
Amendment Form AR	USSIC PEX 4 AR	2009	Endorse ment/Am endment /Conditio	Withdrawn				USSIC PEX 4 AR - final.pdf

SERFF Tracking Number: *HCCH-126226991* *State:* *Arkansas*
Filing Company: *US Specialty Insurance Company* *State Tracking Number:* *EFT \$50*
Company Tracking Number:
TOI: *33.0 Other Lines of Business* *Sub-TOI:* *33.0002 Other Commercial Lines*
Product Name: *Provider Excess Loss Policy - P&C*
Project Name/Number: *PEX 4 Filing 2009/*

ns

SERFF Tracking Number: *HCCH-126226991* *State:* *Arkansas*
Filing Company: *US Specialty Insurance Company* *State Tracking Number:* *EFT \$50*
Company Tracking Number:
TOI: *33.0 Other Lines of Business* *Sub-TOI:* *33.0002 Other Commercial Lines*
Product Name: *Provider Excess Loss Policy - P&C*
Project Name/Number: *PEX 4 Filing 2009/*

Note To Filer

Created By:

Llyweyia Rawlins on 07/17/2009 03:53 PM

Last Edited By:

Llyweyia Rawlins

Submitted On:

07/17/2009 03:53 PM

Subject:

Filing Problem

Comments:

Hello Misty

After reviewing some of the forms and the transmittal document. I feel this filing should be filed under Life and Health instead of Commercial Filing.

Please withdraw this filing under the Commercial and refile with Life and Health Dept.

Sincerely,

Llyweyia Rawlins