

SERFF Tracking Number: ICCI-126246296 State: Arkansas  
 Filing Company: Virginia Surety Company, Inc. State Tracking Number: 43080  
 Company Tracking Number: EM-INDF (12.08)  
 TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only  
 Product Name: Individual Emergency Medical filing EM-INDF (12.08) A&H  
 Project Name/Number: Individual Emergency Medical filing EM-INDF (12.08) A&H/Individual Emergency Medical filing EM-INDF (12.08) A&H

## Filing at a Glance

Company: Virginia Surety Company, Inc.

Product Name: Individual Emergency Medical SERFF Tr Num: ICCI-126246296 State: ArkansasLH  
 filing EM-INDF (12.08) A&H

|   |                            |                                     |
|---|----------------------------|-------------------------------------|
| TOI: H02I Individual Health - Accident Only | SERFF Status: Closed       | State Tr Num: 43080                 |
| Sub-TOI: H02I.000 Health - Accident Only    | Co Tr Num: EM-INDF (12.08) | State Status: Approved-Closed       |
| Filing Type: Form/Rate                      | Co Status:                 | Reviewer(s): Rosalind Minor         |
|   | Author: Brenda Dawson      | Disposition Date: 08/05/2009        |
|   | Date Submitted: 07/29/2009 | Disposition Status: Approved-Closed |

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Individual Emergency Medical filing EM-INDF (12.08) A&H Status of Filing in Domicile:

Project Number: Individual Emergency Medical filing EM-INDF (12.08) A&H Date Approved in Domicile:

Requested Filing Mode: Domicile Status Comments:

Explanation for Combination/Other: Market Type: Individual

Submission Type: New Submission Group Market Size:

Overall Rate Impact: Group Market Type:

Filing Status Changed: 08/05/2009 Explanation for Other Group Market Type:

State Status Changed: 08/05/2009

Deemer Date: Corresponding Filing Tracking Number:

Filing Description:

Enclosed for review and approval for use in your state are the forms attached to the form schedule tab. These forms are new and are not intended to replace any forms previously approved by your Department.

Insurance Compliance Consultants, Inc., is making this filing on behalf of Virginia Surety Company, Inc. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc., at

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the address shown above.

Individual Policy form EM-INDF (12.08) (for family coverage) and Individual Policy Form, EM-INDI (12.08) (for individual coverage) will provide Emergency Medical Insurance for accidents only. Form EM-SCH (12.08) is the schedule of benefits. Application form IND-APP-AH (12.08) will be used to apply for coverage.

Amendatory Endorsement END-IND-AR-AH (12.08) will be attached to all Policies issued in Arkansas.

The documents were prepared on a personal computer and will ultimately be printed from another data processing system that may cause some print style, formatting and/or page spacing changes. However, there will not be any changes to the actual text of the contract other than listed or bracketed variables, or to the general print size.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions.

## Company and Contact

### Filing Contact Information

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

Brenda Dawson, Authorized Representative      Brendadawson@inscompliance.com  
3925 East State Street, Suite 200              (815) 316-6714 [Phone]  
Rockford, IL 61108                              (815) 986-2355[FAX]

### Filing Company Information

Virginia Surety Company, Inc.                      CoCode: 40827                      State of Domicile: Illinois  
175 West Jackson Blvd, 11th Floor              Group Code:                      Company Type:  
Chicago, IL 60604                              Group Name:                      State ID Number:  
(312) 356-3000 ext. [Phone]                      FEIN Number: 36-3186541

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## Filing Fees

Fee Required?              Yes  
Fee Amount:                \$50.00  
Retaliatory?                No



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| COMPANY                       | AMOUNT  | DATE PROCESSED | TRANSACTION # |
|-------------------------------|---------|----------------|---------------|
| Virginia Surety Company, Inc. | \$50.00 | 07/29/2009     | 29503324      |

SERFF Tracking Number: ICCI-126246296 State: Arkansas  
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Company Tracking Number: EM-INDF (12.08)  
TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only  
Product Name: Individual Emergency Medical filing EM-INDF (12.08) A&H  
Project Name/Number: Individual Emergency Medical filing EM-INDF (12.08) A&H/Individual Emergency Medical filing EM-INDF (12.08) A&H

## Correspondence Summary

### Dispositions

| Status          | Created By     | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 08/05/2009 | 08/05/2009     |



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| <b>Item Type</b>           | <b>Item Name</b>                 | <b>Item Status</b> | <b>Public Access</b> |
|----------------------------|----------------------------------|--------------------|----------------------|
| <b>Supporting Document</b> | Flesch Certification             | Approved-Closed    | Yes                  |
| <b>Supporting Document</b> | Application                      | Approved-Closed    | Yes                  |
| <b>Supporting Document</b> | Health - Actuarial Justification | Approved-Closed    | No                   |
| <b>Supporting Document</b> | Outline of Coverage              | Approved-Closed    | Yes                  |
| <b>Supporting Document</b> | Actuarial memorandum             | Approved-Closed    | Yes                  |
| <b>Supporting Document</b> | Rate and Rule manual             | Approved-Closed    | Yes                  |
| <b>Form</b>                | Emergency Medical Policy         | Approved-Closed    | Yes                  |
| <b>Form</b>                | Emergency Medical Policy         | Approved-Closed    | Yes                  |
| <b>Form</b>                | Schedule                         | Approved-Closed    | Yes                  |
| <b>Form</b>                | Application                      | Approved-Closed    | Yes                  |
| <b>Form</b>                | Amendatory Endorsement           | Approved-Closed    | Yes                  |

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## Form Schedule

**Lead Form Number:** EM-INDF (12.08)

| Review Status   | Form Number           | Form Type    | Form Name  | Action  | Action Specific Data | Readability | Attachment                         |
|-----------------|-----------------------|--------------|--|---------|----------------------|-------------|------------------------------------|
| Approved-Closed | EM-INDF (12.08)       | Policy/Cont  | Emergency Medical<br>ract/Fratern Policy<br>al<br>Certificate  | Initial |                      |             | EM-INDF (12<br>08) 6-2-09.pdf      |
| Approved-Closed | EM-INDI (12.08)       | Policy/Cont  | Emergency Medical<br>ract/Fratern Policy<br>al<br>Certificate  | Initial |                      |             | EM-INDI (12<br>08) 6-2-09.pdf      |
| Approved-Closed | EM-SCH (12.08)        | Schedule     | Schedule<br>Pages  | Initial |                      |             | EM-SCH<br>(12.08).pdf              |
| Approved-Closed | IND-APP-AH (12.08)    | Application/ | Application<br>Enrollment<br>Form  | Initial |                      |             | A&H IND-<br>APP-A&H (12<br>08).pdf |
| Approved-Closed | END-IND-AR-AH (12.08) | Policy/Cont  | Amendatory<br>ract/Fratern Endorsement<br>al<br>Certificate:<br>Amendmen<br>t, Insert<br>Page,<br>Endorseme<br>nt or Rider | Initial |                      |             | END-IND-AR-<br>AH<br>(12.08).pdf   |

**Emergency Medical  
Insurance Policy**

**This is Accident Only Coverage.**

**PLEASE READ THIS POLICY CAREFULLY**

This **Policy** is a legal contract between You and Virginia Surety Company, Inc.

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**A. DEFINITIONS**

Throughout this document, You and Your refer to the Policyholder indicated on the **Schedule**. We, Us, Our, and VSC refer to Virginia Surety Company, Inc. In addition, when in bold certain words and phrases are defined as follows:

**Accident** means an unintentional and unexpected event.

**Administrator** means [Insert Administrator Name]. You may contact the **Administrator** if You have questions regarding this coverage or would like to make a claim. The **Administrator** can be reached by [phone at [Insert Administrator Phone Number]] [or] [mail at [Insert Administrator Address]] [or] [email at [Insert Administrator e-mail Address]].

[**Auto Related Accident** means an **Accident** which occurs:

- 1) While as a pedestrian, You or Your **Family Member** are struck by a **Private Passenger Automobile**.
- 2) While You or Your **Family Member** are riding in, entering, or exiting a **Private Passenger Automobile** (excluding an automobile used for a commercial purpose.)

[**Covered Health Deductible** means the amount of the deductible in Your [or Your **Family Member’s**] health insurance coverage (including, but not limited to, a PPO or HMO), that You [or Your **Family Member**] are required to pay.]

**Covered Individual** means Your **Family Member** [and includes a **Home Visitor** in a **Home Related Accident**].

**Domestic Partner** means an unmarried person in an intimate, committed relationship of mutual caring. That person must share responsibility for basic living expenses with You. That person must also be at least eighteen (18) years old and not currently married or committed to another person.

[**Emergency Treatment Expenses** means the charge You or a **Covered Individual** are required to pay for **Outpatient Treatment** at a **Medical Facility** for:

- 1) Diagnosis, treatment or surgery performed by a **Physician, Surgeon, or Dentist**.
- 2) Laboratory tests and X-ray exams that are made by or at the request of the **Physician, Surgeon, or Dentist**.
- 3) Casts, splints and medication.

- 4) Any other reasonable and necessary emergency services and supplies.]

**Family Member** means Your spouse or **Domestic Partner**. **Family Member** also includes You or Your spouse or Domestic Partner's:

- a) Unmarried children (including those who You are their legal guardian) under twenty-one (21) years of age.
- b) Unmarried children (including those who You are their legal guardian) under twenty-three (23) years of age if a full-time student at an accredited college or university.
- c) Any dependent with documented disabilities who has the same **Home** as You and who relies on You for maintenance and support.

Any **Family Member** who does not reside at Your **Home** is not eligible for coverage.

[**Home** means either a single-family dwelling or a multiple-family dwelling (e.g. condominium, townhome, mobile home on a permanent foundation, or apartment unit) that is normally inhabited by You.]

[**Home Related Accident** means an **Accident** which occurs at Your **Home**.]

[**Home Visitor** means a person visiting You or Your **Family Member** who does not reside at Your **Home**.]

**Injury** means bodily injury resulting from an **Accident** that occurs during the **Coverage Period**.

[**Inpatient Treatment** means treatment that takes place in a controlled environment that requires being admitted into a **Medical Facility** for a period of time of at least twenty-four (24) hours.]

[**Medical Facility** means a hospital, walk-in medical center, or outpatient clinic which meets all of the following requirements:

- 1) Is licensed by a state, federal, or provincial regulatory entity.
- 2) Is operated primarily for the reception, care, and treatment of sick, ailing or injured persons.
- 3) Has a staff of one or more licensed **Physicians** available at all times when patients are present.
- 4) Provides facilities for diagnosis and surgery.

**Medical Facility** does not include nursing, rest, or convalescent homes.]

[**Outpatient Treatment** means treatment that takes place in a controlled environment that does not require being admitted into a **Medical Facility** for a period of time more than twenty-four (24) hours.]

**Physician, Surgeon, or Dentist** means a licensed or certified practitioner of the healing arts. The **Physician, Surgeon, or Dentist** must perform a covered service within the scope of the practitioner's license or certificate. The treating **Physician, Surgeon, or Dentist** may not be You, a **Covered Individual**, or related to You or a **Covered Individual**.

**Policy** means this document, which describes the terms, conditions, and exclusions of this coverage. The **Policy** sets forth the entire agreement between You and Us. Representations or promises made by any person that are not contained in this document are not a part of this coverage.

[**Private Passenger Automobile** means a vehicle designed and licensed for use on public roads. **Private Passenger Automobiles** include private passenger cars, station wagons, jeep-type vehicles, SUV's, trucks, and pick-ups. **Private Passenger Automobile** does not include motor homes, RVs campers, trailers, ATVs, motorcycles, or vehicles designed to seat more than eight (8) passengers.]

**Program** means [Insert Program].

**Schedule** means the attached document listing the named insured, benefit(s), term, and limit.

## B. COVERAGES

You or a **Covered Individual** may only receive coverage for the same expenses under one of the following benefits.

### 1. **EMERGENCY MEDICAL EXPENSE BENEFIT**

We will reimburse You for **Emergency Treatment Expenses** (for **Outpatient Treatment**), if You or a **Covered Individual** require emergency treatment in a **Medical Facility** as a result of an **Injury** received in [a **Home Related Accident**] [or] [an **Auto Related Accident**]. The emergency treatment must be received within forty-eight (48) hours after the **Accident**.

Reimbursement is limited to the lesser of the following:

- 1) **Emergency Treatment Expenses** actually incurred.
- 2) Up to the limit per **Accident** indicated on the **Schedule**.

### 2. **AMBULANCE AND PARAMEDIC EXPENSE BENEFIT**

We will reimburse You for ambulance and/or paramedic expenses incurred, if You or a **Covered Individual** require ambulance transportation and/or paramedic service as the result of an **Injury** caused by [a **Home Related Accident**] [or] [an **Auto Related Accident**]. The ambulance service transportation must be furnished by a licensed ambulance provider within forty-eight hours of the **Accident** and must be for urgent medical attention. The paramedic service(s) must be provided by a certified emergency medical technician.

Reimbursement is limited to the lesser of the following:

- 1) Expenses for ambulance transportation and/or paramedic service actually incurred.
- 2) Up to the limit per **Accident** indicated on the **Schedule**.

### 3. **HEALTH INSURANCE DEDUCTIBLE REIMBURSEMENT BENEFIT**

We will reimburse You the **Covered Health Deductible** on Your or Your **Family Member's** health insurance coverage, if You or Your **Family Member** receive [**Outpatient Treatment**] [or] [**Inpatient Treatment**] as a result of the **Injury**.

To be eligible for coverage:

- 1) You or Your **Family Member** must be insured by health insurance coverage.
- 2) You or a **Family Member** must have submitted a claim which was paid by Your or Your **Family Member's** health insurance company which included a **Covered Health Deductible**.

Coverage is limited to the **Covered Health Deductible** up to up to the limit per **Accident** indicated on the **Schedule**.

### 4. **CHILD'S ACCIDENT EXPENSE BENEFIT**

We will reimburse You for medical expenses incurred, if a child (who is a **Family Member**) suffers an **Injury** received in an **Accident** and incurs:

- 1) **Emergency Treatment Expenses** (for **Outpatient Treatment**); or
- 2) Ambulance transportation services and/or paramedic treatment within [forty-eight (48)] hours after an **Accident**. The ambulance service transportation must be furnished by a licensed ambulance provider and must be for urgent medical attention. The paramedic service(s) must be provided by a certified emergency medical technician.

Reimbursement is limited to the lesser of the following:

- 1) **Emergency Treatment Expenses** actually incurred and expenses for ambulance transportation and/or paramedic services actually incurred.
- 2) Up to the limit per **Accident** indicated on the **Schedule**.

## C. EXCLUSIONS

The following exclusions apply to [Emergency Medical Expense Benefit] [,] [and] [Ambulance and Paramedic Expense Benefit] [,] [and] [Health Insurance Deductible Reimbursement] [,] [and] [Child's Accident Expense Benefit]:

Any loss caused by or resulting from:

- Suicide, attempted suicide, or any self-inflicted injury while sane or insane.
- War, including undeclared war; civil war; insurrection; rebellion; warlike act by military force or military personnel; destruction, seizure, or use for a military purpose, including any consequence of these. Discharge of a nuclear weapon shall be deemed a warlike act even if accidental.
- Nuclear hazard, meaning any weapon employing atomic fission, fusion, or other radioactive force or nuclear reaction, radiation, or radioactive contamination from any other cause except that direct loss by fire resulting from the nuclear hazard is covered.
- Bacterial infection, except pus-forming infections resulting from **Injury**.
- Participation in or attempting to commit a felony.
- Illness, disease or allergic reaction.
- Being under the influence of narcotics, unless they are taken in accordance with the advice of a **Physician, Surgeon, or Dentist**.
- Being under the influence of any intoxicating liquor. (An intoxicating liquor is that which is defined as or determined to be such by the laws of the jurisdiction where the loss or cause of loss occurred.)
- **Injury** occurring while You or a **Covered Individual** are using Your **Home** or accompanying structures and grounds for commercial purposes.
- Any **Injury** caused by or resulting from operating, riding in, entering or exiting any vehicle which is (a) being tested or time tested; or (b) participating in races, speed contests, or exhibitions of any kind.
- An **Injury** resulting from domestic violence.
- An **Injury** that occurred outside the United States or Canada.

[[The following exclusions apply to Health Insurance Deductible Reimbursement:]]

- Any co-pays or co-insurance.
- Any **Injury** where You or Your **Family Member** are not insured under any health insurance coverage.
- Any **Injury** if the expenses incurred are not covered by Your or Your **Family Member's** health insurance coverage.]

## D. HOW TO FILE A CLAIM

Call the **Administrator** at [Insert Administrator Phone Number] to request a claim form. You must report the claim within forty-five (45) days of the **Accident**.

The following required items, must sent to the **Administrator** at [Insert Administrator Address] and be postmarked within ninety (90) days of **Accident**.

1. The completed claim form.
2. Signed HIPPA authorization form from You or the **Covered Individual** (if applicable).
3. A copy of the declaration page from Your or the **Covered Individual's** health insurance company.
4. A copy of the claim from Your or the **Covered Individual's** health insurance company showing the claim was approved, with the amount paid and the deductible of the health insurance policy.
5. Any other documentation the **Administrator** may reasonably request.

All benefits will be payable to You or, in the case of death, to Your estate. If any benefits are payable to Your estate, We may pay such benefit up to \$1,000 to any of Your relatives by blood or marriage who We deem to be equitably entitled. Any equitable payment made in good faith will release Us from liability to the extent of payment.

## E. CANCELLATION AND NON-RENEWAL

Coverage can be:

- a) Cancelled by You at any time by sending written notification to the **Administrator**. If You cancel Your coverage, We will refund any unearned premium.
- b) Cancelled by Us or Our designated representative for the following reasons:
  - i. Non payment of premium at any time by sending You written notification by certified mail, at Your last known address, at least twenty (20) days before the effective date of cancellations.
  - ii. Within sixty (60) days of the effective date of this **Policy**, unless the **Policy** was renewed by Us, for any reason. If we cancel this Policy, We will send You written notification by certified mail, at Your last known address, at least twenty (20) days before the effective date of cancellations. The notice of cancellation will include the reason and effective date of cancellation.
  - iii. After this **Policy** has been in effect for more than sixty (60) days or at any time if this is a renewal **Policy**, for the following reasons:
    1. Non payment of premium;
    2. Misrepresentation and Fraud (see below);
    3. The Department of Insurance determines that the **Policy** would result in a violation of their law.

If We cancel this Policy, We will send You written notification by certified mail, at Your last known address, at least thirty (30) days before the effective date of cancellations. The notice of cancellation will include the reason and effective date of cancellation.

If We cancel this **Policy**, we will refund any unearned premium.

- c) Non-renewed by Us. We will send You written notification by certified mail, at Your last known address, at least thirty (30) days in advance of the expiration of coverage.

## F. GENERAL PROVISIONS

**Assignment of Benefits:** All benefits will be paid to You unless You authorize Us in writing to make payment to the medical services provider.

**Conformity of Statute:** Any parts of this **Policy** that are in conflict with the state laws where this **Policy** is issued are automatically changed to conform to the minimum requirements of such laws.

**Dispute Resolution – Arbitration:** The **Policy** requires binding arbitration if there is an unresolved dispute between You and VSC concerning the **Policy**. Under this Arbitration provision, You give up your right to resolve any dispute arising from the **Policy** by a judge and/or a jury. You also agree not to participate as a class representative or class member in any class action litigation, any class arbitration or any consolidation of individual arbitrations. In arbitration, a group of three (3) arbitrators (each of whom is an independent, neutral third party) will give a decision after hearing Your and Our positions. The decision of a majority of the arbitrators will determine the outcome of the arbitration and the decision of the arbitrators shall be final and binding and cannot be reviewed or changed by, or appealed to, a court of law.

To start arbitration, either You or VSC must make a written demand to the other party for arbitration. This demand must be made within one (1) year of the earlier of the date the loss occurred or the dispute arose. You and VSC will each separately select an arbitrator. The two arbitrators will select a third arbitrator called an "umpire." Each party will each pay the expense of the arbitrator selected by that party. The expense of the umpire will be shared equally by You and VSC. Unless otherwise agreed to by You and VSC, the arbitration will take place in the county and state in which You live. The arbitration shall be governed by the Federal Arbitration Act (9 U.S.C.A. § 1 et. seq.) and not by any state law concerning arbitration. The rules of the American Arbitration Association ([www.adr.org](http://www.adr.org)) will apply to any arbitration under the **Policy**. The laws of the state of Illinois (without giving effect to its conflict of law principles) govern all matters arising out of or relating to the **Policy** and all transactions contemplated by the **Policy**, including, without limitation, the validity, interpretation, construction, performance and enforcement of the **Policy**.

**Legal Actions:** No action at law or in equity shall be brought to recover under the **Policy** prior to the expiration of sixty (60) days after proof of loss has been furnished in accordance with the requirements of this coverage.

**Misrepresentation and Fraud:** Coverage may be cancelled if, whether before or after a loss, any party or person whom coverage is provided has concealed or misrepresented any material fact or circumstance concerning this coverage or the subject thereof, or the interests therein. Coverage may also be cancelled if fraud or false is committed swearing in connection with any of the above.

**Subrogation:** If payment is made under the **Policy**, We are entitled to recover such amounts from other parties or persons. Any party or person to or for whom We make payment must transfer to Us his or her rights to recovery against any other party or person and must do everything necessary to secure these rights and must do nothing that would jeopardize them, or these rights will be recovered from that person.

**Emergency Medical  
Insurance Policy**

**This is Accident Only Coverage.**

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**Accident** means an unintentional and unexpected event.

**Administrator** means [Insert Administrator Name]. You may contact the **Administrator** if You have questions regarding this coverage or would like to make a claim. The **Administrator** can be reached by [phone at [Insert Administrator Phone Number]] [or] [mail at [Insert Administrator Address]] [or] [email at [Insert Administrator e-mail Address]].

[**Auto Related Accident** means an **Accident** which occurs:

- 1) While as a pedestrian, You are struck by a **Private Passenger Automobile**.
- 2) While You are riding in, entering, or exiting a **Private Passenger Automobile** (excluding an automobile used for a commercial purpose).]

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[**Emergency Treatment Expenses** means the charge You are required to pay for **Outpatient Treatment** at a **Medical Facility** for:

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[**Home** means either a single-family dwelling or a multiple-family dwelling (e.g. condominium, townhome, mobile home on a permanent foundation, or apartment unit) that is normally inhabited by You.]

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- 1) Is licensed by a state, federal, or provincial regulatory entity.
- 2) Is operated primarily for the reception, care, and treatment of sick, ailing or injured persons.
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**Physician, Surgeon, or Dentist** means a licensed or certified practitioner of the healing arts. The **Physician, Surgeon, or Dentist** must perform a covered service within the scope of the practitioner's license or certificate. The treating **Physician, Surgeon, or Dentist** may not be You or related to You.

**Policy** means this document, which describes the terms, conditions, and exclusions of this coverage. The **Policy** sets forth the entire agreement between You and Us. Representations or promises made by any person that are not contained in this document are not a part of this coverage.

**Private Passenger Automobile** means a vehicle designed and licensed for use on public roads. **Private Passenger Automobiles** include private passenger cars, station wagons, jeep-type vehicles, SUV's, trucks, and pick-ups. **Private Passenger Automobile** does not include motor homes, RVs campers, trailers, ATVs, motorcycles, or vehicles designed to seat more than eight (8) passengers.]

**Program** means [Insert Program].

**Schedule** means the attached document listing the named insured, benefit(s), term, and limit.

## B. COVERAGES

You may only receive coverage for the same expenses under one of the following benefits.

### 1. **EMERGENCY MEDICAL EXPENSE BENEFIT**

We will reimburse You for **Emergency Treatment Expenses** (for **Outpatient Treatment**), if You require emergency treatment in a **Medical Facility** as a result of an **Injury** received in [a **Home Related Accident**] [or] [an **Auto Related Accident**]. The emergency treatment must be received within forty-eight (48) hours after the **Accident**.

Reimbursement is limited to the lesser of the following:

- 1) **Emergency Treatment Expenses** actually incurred.
- 2) Up to the limit per **Accident** indicated on the **Schedule**.

### 2. **AMBULANCE AND PARAMEDIC EXPENSE BENEFIT**

We will reimburse You for ambulance and/or paramedic expenses incurred, if You require ambulance transportation and/or paramedic service as the result of an **Injury** caused by [a **Home Related Accident**] [or] [an **Auto Related Accident**]. The ambulance service transportation must be furnished by a licensed ambulance provider within forty-eight hours of the **Accident** and must be for urgent medical attention. The paramedic service(s) must be provided by a certified emergency medical technician.

Reimbursement is limited to the lesser of the following:

- 1) Expenses for ambulance transportation and/or paramedic service actually incurred.
- 2) Up to the limit per **Accident** indicated on the **Schedule**.

**3. HEALTH INSURANCE DEDUCTIBLE REIMBURSEMENT BENEFIT**

We will reimburse You the **Covered Health Deductible** on Your health insurance coverage, if You receive **[Outpatient Treatment]** [or] **[Inpatient Treatment]** as a result of the **Injury**.

To be eligible for coverage:

- 1) You must be insured by health insurance coverage.
- 2) You must have submitted a claim which was paid by Your health insurance company which included a **Covered Health Deductible**.

Coverage is limited to the **Covered Health Deductible** up to up to the limit per **Accident** indicated on the **Schedule**.

**C. EXCLUSIONS**

The following exclusions apply to [Emergency Medical Expense Benefit] [,] [and] [Ambulance and Paramedic Expense Benefit] [,] [and] [Health Insurance Deductible Reimbursement] [,] [and] [Child's Accident Expense Benefit]:

Any loss caused by or resulting from:

- Suicide, attempted suicide, or any self-inflicted injury while sane or insane.
- War, including undeclared war; civil war; insurrection; rebellion; warlike act by military force or military personnel; destruction, seizure, or use for a military purpose, including any consequence of these. Discharge of a nuclear weapon shall be deemed a warlike act even if accidental.
- Nuclear hazard, meaning any weapon employing atomic fission, fusion, or other radioactive force or nuclear reaction, radiation, or radioactive contamination from any other cause except that direct loss by fire resulting from the nuclear hazard is covered.
- Bacterial infection, except pus-forming infections resulting from **Injury**.
- Participation in or attempting to commit a felony.
- Illness, disease or allergic reaction.
- Being under the influence of narcotics, unless they are taken in accordance with the advice of a **Physician, Surgeon, or Dentist**.
- Being under the influence of any intoxicating liquor. (An intoxicating liquor is that which is defined as or determined to be such by the laws of the jurisdiction where the loss or cause of loss occurred.)
- **Injury** occurring while You are using Your **Home** or accompanying structures and grounds for commercial purposes.
- Any **Injury** caused by or resulting from operating, riding in, entering or exiting any vehicle which is (a) being tested or time tested; or (b) participating in races, speed contests, or exhibitions of any kind.
- An **Injury** resulting from domestic violence.
- An **Injury** that occurred outside the United States or Canada.

[[The following exclusions apply to Health Insurance Deductible Reimbursement:]

- Any co-pays or co-insurance.
- Any **Injury** where You are not insured under any health insurance coverage.
- Any **Injury** if the expenses incurred are not covered by Your health insurance coverage.]

## D. HOW TO FILE A CLAIM

Call the **Administrator** at [Insert Administrator Phone Number] to request a claim form. You must report the claim within forty-five (45) days of the **Accident**.

The following required items, must sent to the **Administrator** at [Insert Administrator Address] and be postmarked within ninety (90) days of **Accident**.

1. The completed claim form.
2. Signed HIPPA authorization form from You.
3. A copy of the declaration page from Your health insurance company.
4. A copy of the claim from Your health insurance company showing the claim was approved, with the amount paid and the deductible of the health insurance policy.
5. Any other documentation the **Administrator** may reasonably request.

All benefits will be payable to You or, in the case of death, to Your estate. If any benefits are payable to Your estate, We may pay such benefit up to \$1,000 to any of Your relatives by blood or marriage who We deem to be equitably entitled. Any equitable payment made in good faith will release Us from liability to the extent of payment.

## E. CANCELLATION AND NON-RENEWAL

Coverage can be:

- a) Cancelled by You at any time by sending written notification to the **Administrator**. If You cancel Your coverage, We will refund any unearned premium.
- b) Cancelled by Us or Our designated representative for the following reasons:
  - i. Non payment of premium at any time by sending You written notification by certified mail, at Your last known address, at least twenty (20) days before the effective date of cancellations.
  - ii. Within sixty (60) days of the effective date of this **Policy**, unless the **Policy** was renewed by Us, for any reason. If we cancel this **Policy**, We will send You written notification by certified mail, at Your last known address, at least twenty (20) days before the effective date of cancellations. The notice of cancellation will include the reason and effective date of cancellation.
  - iii. After this **Policy** has been in effect for more than sixty (60) days or at any time if this is a renewal **Policy**, for the following reasons:
    1. Non payment of premium;
    2. Misrepresentation and Fraud (see below);
    3. The Department of Insurance determines that the **Policy** would result in a violation of their law.

If We cancel this **Policy**, We will send You written notification by certified mail, at Your last known address, at least thirty (30) days before the effective date of cancellations. The notice of cancellation will include the reason and effective date of cancellation.

If We cancel this **Policy**, we will refund any unearned premium.

- c) Non-renewed by Us. We will send You written notification by certified mail, at Your last known address, at least thirty (30) days in advance of the expiration of coverage.

## F. GENERAL PROVISIONS

**Assignment of Benefits:** All benefits will be paid to You unless You authorize Us in writing to make payment to the medical services provider.

**Conformity of Statute:** Any parts of this **Policy** that are in conflict with the state laws where this **Policy** is issued are automatically changed to conform to the minimum requirements of such laws.

**Dispute Resolution – Arbitration:** The **Policy** requires binding arbitration if there is an unresolved dispute between You and VSC concerning the **Policy**. Under this Arbitration provision, You give up your right to resolve any dispute arising from the **Policy** by a judge and/or a jury. You also agree not to participate as a class representative or class member in any class action litigation, any class arbitration or any consolidation of individual arbitrations. In arbitration, a group of three (3) arbitrators (each of whom is an independent, neutral third party) will give a decision after hearing Your and Our positions. The decision of a majority of the arbitrators will determine the outcome of the arbitration and the decision of the arbitrators shall be final and binding and cannot be reviewed or changed by, or appealed to, a court of law.

To start arbitration, either You or VSC must make a written demand to the other party for arbitration. This demand must be made within one (1) year of the earlier of the date the loss occurred or the dispute arose. You and VSC will each separately select an arbitrator. The two arbitrators will select a third arbitrator called an "umpire." Each party will each pay the expense of the arbitrator selected by that party. The expense of the umpire will be shared equally by You and VSC. Unless otherwise agreed to by You and VSC, the arbitration will take place in the county and state in which You live. The arbitration shall be governed by the Federal Arbitration Act (9 U.S.C.A. § 1 et. seq.) and not by any state law concerning arbitration. The rules of the American Arbitration Association ([www.adr.org](http://www.adr.org)) will apply to any arbitration under the **Policy**. The laws of the state of Illinois (without giving effect to its conflict of law principles) govern all matters arising out of or relating to the **Policy** and all transactions contemplated by the **Policy**, including, without limitation, the validity, interpretation, construction, performance and enforcement of the **Policy**.

**Legal Actions:** No action at law or in equity shall be brought to recover under the **Policy** prior to the expiration of sixty (60) days after proof of loss has been furnished in accordance with the requirements of this coverage.

**Misrepresentation and Fraud:** Coverage may be cancelled if, whether before or after a loss, any party or person whom coverage is provided has concealed or misrepresented any material fact or circumstance concerning this coverage or the subject thereof, or the interests therein. Coverage may also be cancelled if fraud or false is committed swearing in connection with any of the above.

**Subrogation:** If payment is made under the **Policy**, We are entitled to recover such amounts from other parties or persons. Any party or person to or for whom We make payment must transfer to Us his or her rights to recovery against any other party or person and must do everything necessary to secure these rights and must do nothing that would jeopardize them, or these rights will be recovered from that person.

**Virginia Surety Company, Inc.**  
A Stock Company  
175 West Jackson Blvd., Chicago, IL 60604

**Emergency Medical  
Schedule**

Policy Number:  
[000-00-0000]

Policyholder:  
[insert policyholder name]  
[insert policyholder's address]

**PLEASE KEEP THIS POLICY IN A SAFE PLACE**

TO REPORT A CLAIM UNDER THIS POLICY CALL [(XXX) XXX-XXXX]

**Term:** [Insert Term]

**Policy Effective Date:** [XX/XX/XXXX] at 12:01 a.m.

**Policy Expiration Date:** [XX/XX/XXXX] at 12:01 a.m.

**Coverage:**

1. [Emergency Medical Expense  
Limit per Loss: [Insert Dollar Limit]]
2. [Ambulance and Paramedic Expense  
Limit for Living Expenses per Event: [Insert Dollar Limit]]
3. [Health Insurance Deductible Reimbursement  
Limit: [Insert Dollar Limit]]
4. [Child's Accident Expense  
Limit per Loss: [Insert Dollar Limit]]

**Coverage Premium:** \$[XX.XX]

---

[Joe Smith]  
Authorized Representative

---

[John Smith]  
Secretary

---

[Jane Smith]  
President

**Virginia Surety Company, Inc.**  
A Stock Company  
175 West Jackson Blvd., Chicago, Illinois 60604

**APPLICATION**

I \_\_\_\_\_ apply for the following coverage(s):

- [Emergency Medical Expense Benefit]
- [Ambulance and Paramedic Expense Benefit]
- [Health Insurance Deductible Reimbursement Benefit]
- [Child's Accident Expense Benefit]
- [Insert Benefit]

I have read, understand and agree to all Terms and Conditions for the coverage(s) selected. I understand that once my application is processed, coverage becomes effective on the effective date stated on the Declaration Page, provided the premium is paid. Please see the fraud warning notice below.

\_\_\_\_\_  
Signature/Date

**General Fraud Notice:** Any person who knowingly and with 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 may be a crime and may subject such person to criminal and civil penalties.

**[Residents of [Arkansas], [New Mexico], [and] [Ohio]:** Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

**[Residents of Colorado:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from the insurance proceeds shall be reported to the Colorado Division of Insurance.]

**[Residents of the [District of Columbia] [and] [Tennessee]:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.]

**[Residents of Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

**[Residents of Kentucky:** Any person who knowingly and with intent to defraud any insurance company, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.]

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

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

**[Residents of New Jersey:** Any person who includes any false or misleading information on an application for an insurance contract is subject to criminal or civil penalties.]

**[Residents of New York:** Any person who knowingly and with 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 shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

**[Residents of Oklahoma:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

**[Residents of Pennsylvania:** Any person who knowingly and with 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 subject such person to criminal and civil penalties.]

**[Residents of Washington:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.]

**Virginia Surety Company, Inc.**  
A Stock Company  
175 West Jackson Blvd., Chicago, IL 60604

**AMENDATORY ENDORSEMENT**

**THIS ENDORSEMENT CHANGES THE POLICY, PLEASE READ IT CAREFULLY**

---

Policy Number: [Insert Policy Number]

Effective Date of this Endorsement: [Insert Endorsement Effective Date]

---

It is agreed that the following revisions are made to the above captioned policy:

**GENERAL PROVISIONS “Dispute Resolution – Arbitration” is deleted in its entirety:**

**GENERAL PROVISIONS “Legal Action” is replaced with the following:**

**Legal Actions:** No action at law or in equity shall be brought to recover under the **Policy** prior to the expiration of five (5) years after proof of loss has been furnished in accordance with the requirements of this coverage.

**GENERAL PROVISIONS “Subrogation” is replaced with the following:**

**Subrogation:** When You have been fully compensated for Your **Loss** and there has been payment by Us under this **Policy** for that **Loss**, then We are entitled to recover those amounts that have exceeded the amount of Your **Loss**. In order to accomplish this, You agree that You will transfer Your rights to recovery against any other party or person for the amount of the excess over the amount of Your **Loss**. With respect to the excess amount, You agree to everything necessary for Us to secure these rights and to do nothing that would jeopardize these rights to recovery from any other party or person.

All other provisions remain unchanged.

**VIRGINIA SURETY COMPANY, INC.**

[John Smith]  
President

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SERFF Tracking Number: ICCI-126246296 State: Arkansas  
 Filing Company: Virginia Surety Company, Inc. State Tracking Number: 43080  
 Company Tracking Number: EM-INDF (12.08)  
 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only  
 Product Name: Individual Emergency Medical filing EM-INDF (12.08) A&H  
 Project Name/Number: Individual Emergency Medical filing EM-INDF (12.08) A&H/Individual Emergency Medical filing EM-INDF (12.08) A&H

## Supporting Document Schedules

|                         |   |                       |                 |            |
|-------------------------|---|-----------------------|-----------------|------------|
| <b>Satisfied -Name:</b> | Flesch Certification                              | <b>Review Status:</b> | Approved-Closed | 08/05/2009 |
| <b>Comments:</b>        |   |                       |                 |            |
| <b>Attachment:</b>      | AR readability certification Ind EM-INDF 6-24.pdf |                       |                 |            |
| <b>Satisfied -Name:</b> | Application                                       | <b>Review Status:</b> | Approved-Closed | 08/05/2009 |
| <b>Comments:</b>        | The form schedule tab                             |                       |                 |            |
| <b>Bypassed -Name:</b>  | Outline of Coverage                               | <b>Review Status:</b> | Approved-Closed | 08/05/2009 |
| <b>Bypass Reason:</b>   | NA  |                       |                 |            |
| <b>Comments:</b>        |   |                       |                 |            |
| <b>Satisfied -Name:</b> | Actuarial memorandum                              | <b>Review Status:</b> | Approved-Closed | 08/05/2009 |
| <b>Comments:</b>        |   |                       |                 |            |
| <b>Attachment:</b>      | Actuarial Memo.pdf                                |                       |                 |            |
| <b>Satisfied -Name:</b> | Rate and Rule manual                              | <b>Review Status:</b> | Approved-Closed | 08/05/2009 |
| <b>Comments:</b>        |   |                       |                 |            |
| <b>Attachment:</b>      | EM-I-RRM (12.08).pdf                              |                       |                 |            |

## FLESCH READING EASE TEST CERTIFICATION

This is to certify that the forms listed below are in compliance with readability requirements of the Flesch Reading Ease Test, and the requirements of your state.

The Flesch Test was applied to the forms in their entirety, except that company name and address, form numbers, titles, captions, subcaptions, schedules, tables, defined words, and text required by law or regulation were excluded.

The Flesch Reading Ease scores are as follows:

FORM NUMBERS

**EM-INDF (12.08)**

**EM-INDI (12.08)**

**EM-SOC (12.08)**

FLESCH SCORE

**41.615**

**41.615**

**combined with certificate**

### VIRGINIA SURETY COMPANY, INC.

June 24, 2009

Date

Joseph D. Fagan  
Signature of Officer

Joseph D. Fagan, Vice President and Senior Counsel  
Name & Title of signer

**Virginia Surety Company, Inc.**  
**ACTUARIAL MEMORANDUM**  
**Emergency Medical Insurance Expense Program**

This filing is for six different emergency medical insurance products each providing reimbursement of medically necessary expenses resulting from accidental injuries to the insured, and/or the insureds family or guests. Historically marketed as either individual or family coverage, each of these products is considered to be either "Auto" or "Home" coverage with discounts previously provided when the insured purchased a combination of at least one product from each category.

Using historical experience, this filing:

1. Revises the overall rate level
2. Eliminates the coverage discount for home & Auto when purchased together
3. Establishes a common rate relativity for the family class vs. the individual class

Data on 918,500 contracts written from 12-2004 to 05-2005 with terms of 12-120 months were used to review the program. Policy level premiums totaling \$6.23 million in written premium were allocated to the six underlying coverages. On-level factors were derived from a comparison of current annual term premiums to historical annual equivalents. On-level written and earned premiums were converted to base class (individual and non-discounted) levels using rate relativities. Paid to earned experience loss ratios were calculated after the loss experience of 1,728 claims totaling \$1.28 million dollars was mapped by coverage, class, and term. Experience by coverage is not uniform across the coverages. Of 1,728 claims, 1,434 are concentrated in Home Emergency Medical and Home Child Expense. The remaining 294 are spread across the remaining four coverages. As a result, we are only (i) revising the overall rate level, (ii) revising the family/individual relativity, and (iii) eliminating the combination discount. The overall rate level was achieved by off-balancing to the expected loss ratio (53.4%). The combination discount was removed through on-leveling to the base class level. The 'Family/Individual' relativities were revised using paid to earned loss ratios. No specific adjustments were made for IBNR, loss development, or trend. Increased limits factors were derived using a limits factor analysis.

The review resulted in material changes to the existing rate relativities. Original individual rate levels prior to off balancing were reduced 28.0%, off balancing increased this reduction and additional 44.7% for a total reduction of 72.7%. Family rates, previously twice the magnitude of Individual rates, are now 453.8% of individual but still 37% lower than prior levels.

**VIRGINIA  
SURETY**  
COMPANY, INC.

175 West Jackson Blvd.  
Chicago, IL 60604

**Emergency Medical**

**Manual of Rules and Rates**

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## I. Description of Coverage

Emergency Medical is a combination of reimbursement benefits that are included within a membership. Below is a description of the different benefits:

### 1. Ambulance and Paramedic Expense

Coverage in the event you require ambulance transportation and/or paramedic service as the result of an Injury caused by a home or auto related accident.

### 2. Child Accident Expense

Coverage in the event that a child suffers an injury and incurs: (a) Emergency treatment expenses in an outpatient facility or (b) Requires ambulance transportation services and/or paramedic treatment after suffering the injury.

### 3. Emergency Medical Expenses

Coverage in the event you require emergency treatment in an outpatient facility as a result of an injury received in a home or Auto related accident.

### 4. Health Insurance Deductible Reimbursement

Coverage in the event you are hospitalized as a result of an injury received from a home related accident.

Types of accidents:

- **A**  
**uto** related accident means an accident which occurs: (1) while the member is riding in, entering or exiting a private passenger automobile; (2) in the event a private passenger automobile strikes member.
- **H**  
**ome** related accident means an accident which occurs at the member's principal residence

## II. Premiums and Computations

### 1. Ambulance and Paramedic Expense

- A. Premium Determination - Insurance premiums are determined by multiplying the premium by the premium variability factors. Premium for options not shown below shall be determined through interpolation. Below is an example of the base coverage and the relative premium.

#### Auto Related Accident

|                          |            |
|--------------------------|------------|
| <b>Who is Covered</b>    | Individual |
| <b>Limit per claim</b>   | \$5,000    |
| <b>Term</b>              | 12 Months  |
| <b>Insurance Premium</b> | \$0.016    |

#### Home Related Accident

|                          |            |
|--------------------------|------------|
| <b>Who is Covered</b>    | Individual |
| <b>Limit per claim</b>   | \$5,000    |
| <b>Term</b>              | 12 Months  |
| <b>Insurance Premium</b> | \$0.008    |

- B. Premium Variation Tables - Premium variation factors for options not shown below shall be determined through interpolation

- a. Who is Covered - Apply the following factors to adjust the premium for who is covered:

| <b>Who is Covered</b> | <b>Factor</b> |
|-----------------------|---------------|
| Individual            | 1.00          |
| Family                | 4.563         |

- b. Limit per Claim - Apply the following factors to adjust the premium for different limits per claim:

| <b>Limit</b> | <b>Factor</b> |
|--------------|---------------|
| \$250        | 0.348         |
| \$500        | 0.578         |
| \$1,000      | 0.781         |
| \$2,000      | 0.908         |
| \$5,000      | 1.00          |

c. Term - Apply the following factors to adjust the premium for the policy term:

| <b>Term</b> | <b>Factor</b> |
|-------------|---------------|
| 1 Month     | .083          |
| 12 Months   | 1.00          |
| 24 Months   | 2.00          |
| 36 Months   | 3.00          |
| 60 Months   | 5.00          |
| 120 Months  | 10.00         |

2. Child Accident Expense

A. Premium Determination - Insurance premiums are determined by multiplying the premium by the premium variability factors. Premium for options not shown below shall be determined through interpolation. Below is an example of the base coverage and the relative premium.

|                          |           |
|--------------------------|-----------|
| <b>Limit per claim</b>   | \$5,000   |
| <b>Term</b>              | 12 Months |
| <b>Insurance Premium</b> | \$0.150   |

B. Premium Variation Tables - Premium variation factors for options not shown below shall be determined through interpolation

a. Limit per Claim - Apply the following factors to adjust the premium for different limits per claim:

| <b>Limit</b> | <b>Factor</b> |
|--------------|---------------|
| \$250        | 0.318         |
| \$500        | 0.511         |
| \$1,000      | 0.727         |
| \$2,000      | 0.911         |
| \$5,000      | 1.00          |

b. Term - Apply the following factors to adjust the premium for the policy term:

| <b>Term</b> | <b>Factor</b> |
|-------------|---------------|
| 1 Month     | .083          |
| 12 Months   | 1.00          |
| 24 Months   | 2.00          |
| 36 Months   | 3.00          |
| 60 Months   | 5.00          |
| 120 Months  | 10.00         |

3. Emergency Medical Expenses

A. Premium Determination - Insurance premiums are determined by multiplying the premium by the premium variability factors. Premium for options not shown below shall be determined through interpolation. Below is an example of the base coverage and the relative premium.

**Auto Related Accident**

|                          |            |
|--------------------------|------------|
| <b>Who is Covered</b>    | Individual |
| <b>Limit per claim</b>   | \$5,000    |
| <b>Term</b>              | 12 Months  |
| <b>Insurance Premium</b> | \$0.298    |

**Home Related Accident**

|                          |            |
|--------------------------|------------|
| <b>Who is Covered</b>    | Individual |
| <b>Limit per claim</b>   | \$5,000    |
| <b>Term</b>              | 12 Months  |
| <b>Insurance Premium</b> | \$0.164    |

a. Who is Covered - Apply the following factors to adjust the premium for who is covered:

| <b>Who is Covered</b> | <b>Factor</b> |
|-----------------------|---------------|
| Individual            | 1.00          |
| Family                | 4.563         |

a. Limit per Claim - Apply the following factors to adjust the premium for different limits per claim:

**Auto Related Accident**

| <b>Limit</b> | <b>Factor</b> |
|--------------|---------------|
| \$250        | 0.129         |
| \$500        | 0.259         |
| \$1,000      | 0.470         |
| \$2,000      | 0.720         |
| \$5,000      | 1.00          |

**Home Related Accident**

| <b>Limit</b> | <b>Factor</b> |
|--------------|---------------|
| \$250        | 0.231         |
| \$500        | 0.401         |
| \$1,000      | 0.620         |
| \$2,000      | 0.810         |
| \$5,000      | 1.00          |

b. Term - Apply the following factors to adjust the premium for the policy term:

| <b>Term</b> | <b>Factor</b> |
|-------------|---------------|
| 1 Month     | .083          |
| 12 Months   | 1.00          |
| 24 Months   | 2.00          |
| 36 Months   | 3.00          |
| 60 Months   | 5.00          |
| 120 Months  | 10.00         |

4. Health Insurance Deductible Reimbursement

A. Premium Determination - Insurance premiums are determined by multiplying the premium by the premium variability factors. Premium for options not shown below shall be determined through interpolation. Below is an example of the base coverage and the relative premium.

|                          |            |
|--------------------------|------------|
| <b>Who is Covered</b>    | Individual |
| <b>Limit per claim</b>   | \$500      |
| <b>Term</b>              | 12 Months  |
| <b>Insurance Premium</b> | \$0.005    |

a. Who is Covered - Apply the following factors to adjust the premium for who is covered:

| <b>Who is Covered</b> | <b>Factor</b> |
|-----------------------|---------------|
| Individual            | 1.00          |
| Family                | 4.563         |

b. Limit per Claim - Apply the following factors to adjust the premium for different limits per claim:

| <b>Limit</b> | <b>Factor</b> |
|--------------|---------------|
| \$250        | 0.569         |
| \$500        | 1.000         |

c. Term - Apply the following factors to adjust the premium for the policy term:

| <b>Term</b> | <b>Factor</b> |
|-------------|---------------|
| 1 Month     | .083          |
| 12 Months   | 1.00          |
| 24 Months   | 2.00          |
| 36 Months   | 3.00          |
| 60 Months   | 5.00          |
| 120 Months  | 10.00         |

### III. Experience Rating

Experience rating recognizes the differences in the expected loss ratio among the different eligible groups. The expected loss ratio may be different between groups due to several factors but not limited to their marketing methods, make-up of the group, or demographics.

To qualify for experience rating the following eligibility requirements need to be achieved:

- Need minimum of 2 prior years. Most current year is not eligible.
- Experience modifications will be computed as of the anniversary the Group Policy.
- Applies to all risks meeting eligibility requirements.

The Experience modification is based on the experience from the most recent three year period, using the following model:

Adjusted Premium = Manual Premium \* Experience Modifier, where

Manual Premium = The Insurance Premium determined in section II “Premiums and Computations.”

Experience Modifier =  $(1-Z) + Z (\text{Experience Factor}) / (\text{Target Loss Ratio})$  if experience is available, otherwise =1.00

Experience Factor =  $(\text{IL1} + \text{IL2} + \text{IL3}) / (\text{CP1} + \text{CP2} + \text{CP3})$

IL1, IL2, and IL3 are incurred losses in years 1, 2, 3

CP1, CP2, and CP3 are earned premium for years 1, 2, and 3 converted to the current manual level.

Z = Credibility factor, determined for the following table, where “Members” is the average number of members over the past three years.

| Member Range |    |         | Z    |
|--------------|----|---------|------|
| 0            | to | 100,000 | 0.00 |
| 100,001      | to | 200,000 | 0.30 |
| 200,001      | to | 300,000 | 0.50 |
| 300,001      | to | 400,000 | 0.70 |
| 400,001      | to | 500,000 | 0.90 |
| 500,001      | to | +       | 1.00 |

**IV. Interpolation Formula and Example**

Formula:

$$f = f_1 + \frac{(f_2 - f_1)}{(l_2 - l_1)} \times (l_2 - l_1)$$

Example:

|                                | Term  |
|--------------------------------|-------|
| l = desired Term               | 72    |
| l <sub>1</sub> = lower Term    | 60    |
| l <sub>2</sub> = higher Term   | 120   |
| f = desired factor             | 6.00  |
| f <sub>1</sub> = lower factor  | 5.00  |
| f <sub>2</sub> = higher factor | 10.00 |

**V. Scheduled Premium Modification**

The premiums in the manual can be modified by a maximum modification of plus or minus 25%, to reflect such characteristics of the risk which are not otherwise reflected in the premium computation.