

SERFF Tracking Number: ERCB-127633272 State: Arkansas
 Filing Company: Westport Insurance Corporation State Tracking Number: 49864
 Company Tracking Number: WIC-ESL-AR-11-06144-1-F
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
 Product Name: AR - ESL - Enhanced Stop Loss Program - Form Filing
 Project Name/Number: AR - ESL - Enhanced Stop Loss Program - Form Filing/WIC-ESL-AR-11-06144-1-F

Filing at a Glance

Company: Westport Insurance Corporation

Product Name: AR - ESL - Enhanced Stop LossSERFF Tr Num: ERCB-127633272 State: Arkansas

Program - Form Filing

TOI: H12 Health - Excess/Stop Loss SERFF Status: Closed-Approved- State Tr Num: 49864
 Closed

Sub-TOI: H12.004 Self-Funded Health Plan Co Tr Num: WIC-ESL-AR-11- State Status: Approved-Closed
 06144-1-F

Filing Type: Form

Author: Robin Bromell

Reviewer(s): Rosalind Minor

Date Submitted: 09/23/2011

Disposition Date: 10/03/2011

Disposition Status: Approved-
 Closed

Implementation Date Requested: 01/01/2012

Implementation Date:

State Filing Description:

General Information

Project Name: AR - ESL - Enhanced Stop Loss Program - Form Filing

Status of Filing in Domicile: Pending

Project Number: WIC-ESL-AR-11-06144-1-F

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 10/03/2011

Deemer Date:

State Status Changed: 10/03/2011

Submitted By: Robin Bromell

Created By: Robin Bromell

Corresponding Filing Tracking Number:

Filing Description:

Westport Insurance Corporation is filing a new Enhanced Excess Stop Loss Program. This new program provides excess coverage over self-funded employee benefit plans apart from the existing Excess Stop Loss Program by providing enhanced coverage through form changes.

The policy provides excess coverage at a specific retention level chosen by the self-insured employer. The coverage is for benefits provided under the Self-Insured Employee Benefit Plan. The maximum coverage is typically \$1 million per member per year, less the employer's specific retention. Aggregate coverage is also available with policy limits of at

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least \$1 million. This product is available for employers with more than 50 employees. The Westport Insurance Corporation targets employers with 200+ employees.

These forms have been developed to fit the excess coverage needs of specific employee benefit plans and will not replace any forms that are currently on file or in use by Westport.

The filing is being submitted under the Prior Approval provisions. We respectfully request an effective date of January 1, 2012.

Please let me know if you have any questions or concerns. Thank you for your consideration of this filing.

Company and Contact

Filing Contact Information

Robin Bromell, Compliance Specialist robin_bromell@swissre.com
 5200 Metcalf 800-255-6931 [Phone] 5503 [Ext]
 Overland Park, KS 66201

Filing Company Information

Westport Insurance Corporation CoCode: 39845 State of Domicile: Missouri
 5200 Metcalf Group Code: 181 Company Type:
 Overland Park, KS 66201 Group Name: Swiss Re State ID Number:
 (800) 255-6931 ext. [Phone] FEIN Number: 48-0921045

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Westport Insurance Corporation	\$50.00	09/23/2011	52065605
Westport Insurance Corporation	\$1,700.00	09/27/2011	52198353

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/03/2011	10/03/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	09/27/2011	09/27/2011	Robin Bromell	09/27/2011	09/27/2011

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Project Name/Number: *AR - ESL - Enhanced Stop Loss Program - Form Filing/WIC-ESL-AR-11-06144-1-F*

Disposition

Disposition Date: 10/03/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Forms Memo	Approved-Closed	Yes
Form	Excess Medical Indemnity Policy Form (Enhanced)	Approved-Closed	Yes
Form	Specific No Laser Rate Cap (NLRC) Endorsement	Approved-Closed	Yes
Form	Add Plan Endorsement	Approved-Closed	Yes
Form	Address Endorsement	Approved-Closed	Yes
Form	Administrator Endorsement	Approved-Closed	Yes
Form	Aggregate Indemnity Limit Endorsement	Approved-Closed	Yes
Form	Aggregate Indemnity Percentage Endorsement	Approved-Closed	Yes
Form	Aggregate Liability Basis Endorsement	Approved-Closed	Yes
Form	Aggregate Monthly Premium Rate Endorsement	Approved-Closed	Yes
Form	Aggregating Specific Retention Option Endorsement	Approved-Closed	Yes
Form	Annual Payment of Premium Endorsement	Approved-Closed	Yes
Form	Attachment Point Endorsement	Approved-Closed	Yes
Form	Covered Unit(s) Specific and Aggregate Excess Endorsement	Approved-Closed	Yes
Form	Covered Unit(s) Specific Excess Endorsement	Approved-Closed	Yes
Form	Delete Plan Endorsement	Approved-Closed	Yes
Form	Insured Endorsement	Approved-Closed	Yes
Form	Aggregate Loss Limit Per Person Endorsement	Approved-Closed	Yes
Form	Monthly Aggregate Reimbursement Endorsement	Approved-Closed	Yes
Form	Non-Medical Benefits Covered Specific and Aggregate Excess Endorsement	Approved-Closed	Yes
Form	Non-Medical Benefits Covered Specific Excess Endorsement	Approved-Closed	Yes
Form	Participant Endorsement	Approved-Closed	Yes

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Form	Plan Name Endorsement	Approved-Closed	Yes
Form	Policy Period Endorsement	Approved-Closed	Yes
Form	Quarterly Payment of Premium Endorsement	Approved-Closed	Yes
Form	Specific Retention Each Person Endorsement	Approved-Closed	Yes
Form	Specific Excess Premium Endorsement	Approved-Closed	Yes
Form	Specific Indemnity Percentage Endorsement	Approved-Closed	Yes
Form	Specific Liability Basis Endorsement	Approved-Closed	Yes
Form	Major Diagnosis Endorsement	Approved-Closed	Yes
Form	Specific Terminal Liability Option Endorsement	Approved-Closed	Yes
Form	Aggregate Terminal Liability Option Endorsement	Approved-Closed	Yes
Form	International Trade Controls Amendatory Endorsement	Approved-Closed	Yes
Form	Medicare Benefits Exclusion Endorsement	Approved-Closed	Yes
Form	Other Carrier Transplant Coverage	Approved-Closed	Yes
Form	Specific Policy Period Limit Endorsement	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 09/27/2011

Submitted Date 09/27/2011

Respond By Date

Dear Robin Bromell,

This will acknowledge receipt of the captioned filing.

Objection 1

- Excess Medical Indemnity Policy Form (Enhanced), SP 5 117 0911 (Form)
- Specific No Laser Rate Cap (NLRC) Endorsement, SP 5 149 0911 (Form)
- Add Plan Endorsement, SP 5 150 0911 (Form)
- Address Endorsement, SP 5 151 0911 (Form)
- Administrator Endorsement, SP 5 152 0911 (Form)
- Aggregate Indemnity Limit Endorsement, SP 5 153 0911 (Form)
- Aggregate Indemnity Percentage Endorsement, SP 5 154 0911 (Form)
- Aggregate Liability Basis Endorsement, SP 5 155 0911 (Form)
- Aggregate Monthly Premium Rate Endorsement, SP 5 156 0911 (Form)
- Aggregating Specific Retention Option Endorsement, SP 5 157 0911 (Form)
- Annual Payment of Premium Endorsement, SP 5 158 0911 (Form)
- Attachment Point Endorsement, SP 5 159 0911 (Form)
- Covered Unit(s) Specific and Aggregate Excess Endorsement, SP 5 160 0911 (Form)
- Covered Unit(s) Specific Excess Endorsement, SP 5 161 0911 (Form)
- Delete Plan Endorsement, SP 5 162 0911 (Form)
- Insured Endorsement, SP 5 163 0911 (Form)
- Aggregate Loss Limit Per Person Endorsement, SP 5 164 0911 (Form)
- Monthly Aggregate Reimbursement Endorsement, SP 5 165 0911 (Form)
- Non-Medical Benefits Covered Specific and Aggregate Excess Endorsement, SP 5 167 0911 (Form)
- Non-Medical Benefits Covered Specific Excess Endorsement, SP 5 168 0911 (Form)
- Participant Endorsement, SP 5 169 0911 (Form)
- Plan Name Endorsement, SP 5 170 0911 (Form)
- Policy Period Endorsement, SP 5 172 0911 (Form)
- Quarterly Payment of Premium Endorsement, SP 5 173 0911 (Form)
- Specific Retention Each Person Endorsement, SP 5 174 0911 (Form)
- Specific Excess Premium Endorsement, SP 5 175 0911 (Form)

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- Specific Indemnity Percentage Endorsement, SP 5 176 0911 (Form)
- Specific Liability Basis Endorsement, SP 5 177 0911 (Form)
- Major Diagnosis Endorsement, SP 5 337 0911 (Form)
- Specific Terminal Liability Option Endorsement, SP 5 338 0911 (Form)
- Aggregate Terminal Liability Option Endorsement, SP 5 340 0911 (Form)
- International Trade Controls Amendatory Endorsement, SP 5 341 0911 (Form)
- Medicare Benefits Exclusion Endorsement, SP 5 342 0911 (Form)
- Other Carrier Transplant Coverage, SP 5 343 0911 (Form)
- Specific Policy Period Limit Endorsement, SP 5 344 0911 (Form)

Comment: Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$1,750.00. Please submit an additional \$1,700.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

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 09/27/2011
Submitted Date 09/27/2011

Dear Rosalind Minor,

Comments:

This is in response to your 09/27/2011 Objection Letter.

Response 1

Comments: I have submitted an additional filing fee of \$1700.00 as required. I apologize for any inconvenience that this may have caused.

Related Objection 1

Applies To:

- Excess Medical Indemnity Policy Form (Enhanced), SP 5 117 0911 (Form)
- Specific No Laser Rate Cap (NLRC) Endorsement, SP 5 149 0911 (Form)
- Add Plan Endorsement, SP 5 150 0911 (Form)
- Address Endorsement, SP 5 151 0911 (Form)
- Administrator Endorsement, SP 5 152 0911 (Form)
- Aggregate Indemnity Limit Endorsement, SP 5 153 0911 (Form)
- Aggregate Indemnity Percentage Endorsement, SP 5 154 0911 (Form)
- Aggregate Liability Basis Endorsement, SP 5 155 0911 (Form)
- Aggregate Monthly Premium Rate Endorsement, SP 5 156 0911 (Form)
- Aggregating Specific Retention Option Endorsement, SP 5 157 0911 (Form)
- Annual Payment of Premium Endorsement, SP 5 158 0911 (Form)
- Attachment Point Endorsement, SP 5 159 0911 (Form)
- Covered Unit(s) Specific and Aggregate Excess Endorsement, SP 5 160 0911 (Form)
- Covered Unit(s) Specific Excess Endorsement, SP 5 161 0911 (Form)
- Delete Plan Endorsement, SP 5 162 0911 (Form)
- Insured Endorsement, SP 5 163 0911 (Form)
- Aggregate Loss Limit Per Person Endorsement, SP 5 164 0911 (Form)
- Monthly Aggregate Reimbursement Endorsement, SP 5 165 0911 (Form)
- Non-Medical Benefits Covered Specific and Aggregate Excess Endorsement, SP 5 167 0911 (Form)
- Non-Medical Benefits Covered Specific Excess Endorsement, SP 5 168 0911 (Form)
- Participant Endorsement, SP 5 169 0911 (Form)

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- Plan Name Endorsement, SP 5 170 0911 (Form)
- Policy Period Endorsement, SP 5 172 0911 (Form)
- Quarterly Payment of Premium Endorsement, SP 5 173 0911 (Form)
- Specific Retention Each Person Endorsement, SP 5 174 0911 (Form)
- Specific Excess Premium Endorsement, SP 5 175 0911 (Form)
- Specific Indemnity Percentage Endorsement, SP 5 176 0911 (Form)
- Specific Liability Basis Endorsement, SP 5 177 0911 (Form)
- Major Diagnosis Endorsement, SP 5 337 0911 (Form)
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- Aggregate Terminal Liability Option Endorsement, SP 5 340 0911 (Form)
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- Medicare Benefits Exclusion Endorsement, SP 5 342 0911 (Form)
- Other Carrier Transplant Coverage, SP 5 343 0911 (Form)
- Specific Policy Period Limit Endorsement, SP 5 344 0911 (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$1,750.00. Please submit an additional \$1,700.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Please let me know if you have additional questions or concerns. Thank you for your continued consideration of this filing.

Sincerely,
Robin Bromell

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Robin Bromell

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/03/2011	SP 5 117 0911	Policy/Cont	Excess Medical ract/Fratern Indemnity Policy al Form (Enhanced) Certificate	Initial		0.000	SP 5 117 0911.pdf
Approved-Closed 10/03/2011	SP 5 149 0911	Policy/Cont	Specific No Laser ract/Fratern Rate Cap (NLRC) al Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0.000	SP 5 149 0911.pdf
Approved-Closed 10/03/2011	SP 5 150 0911	Policy/Cont	Add Plan ract/Fratern Endorsement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0.000	SP 5 150 0911.pdf
Approved-Closed 10/03/2011	SP 5 151 0911	Policy/Cont	Address ract/Fratern Endorsement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0.000	SP 5 151 0911.pdf

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<i>Product Name:</i>	<i>AR - ESL - Enhanced Stop Loss Program - Form Filing</i>			
<i>Project Name/Number:</i>	<i>AR - ESL - Enhanced Stop Loss Program - Form Filing/WIC-ESL-AR-11-06144-1-F</i>			
Approved- SP 5 152	Policy/Cont Administrator	Initial	0.000	SP 5 152
Closed 0911	ract/Fratern Endorsement			0911.pdf
10/03/2011	al			
	Certificate:			
	Amendmen			
	t, Insert			
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	Endorseme			
	nt or Rider			
Approved- SP 5 153	Policy/Cont Aggregate Indemnity Initial		0.000	SP 5 153
Closed 0911	ract/Fratern Limit Endorsement			0911.pdf
10/03/2011	al			
	Certificate:			
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Approved- SP 5 154	Policy/Cont Aggregate Indemnity Initial		0.000	SP 5 154
Closed 0911	ract/Fratern Percentage			0911.pdf
10/03/2011	al Endorsement			
	Certificate:			
	Amendmen			
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Approved- SP 5 155	Policy/Cont Aggregate Liability	Initial	0.000	SP 5 155
Closed 0911	ract/Fratern Basis Endorsement			0911.pdf
10/03/2011	al			
	Certificate:			
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Approved- SP 5 156	Policy/Cont Aggregate Monthly	Initial	0.000	SP 5 156
Closed 0911	ract/Fratern Premium Rate			0911.pdf

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10/03/2011	al	Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider		
Approved- Closed 10/03/2011	SP 5 157 0911	Policy/Cont Aggregating Specific Initial ract/Fratern Retention Option al Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	0.000	SP 5 157 0911.pdf
Approved- Closed 10/03/2011	SP 5 158 0911	Policy/Cont Annual Payment of Initial ract/Fratern Premium al Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	0.000	SP 5 158 0911.pdf
Approved- Closed 10/03/2011	SP 5 159 0911	Policy/Cont Attachment Point Initial ract/Fratern Endorsement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	0.000	SP 5 159 0911.pdf
Approved- Closed 10/03/2011	SP 5 160 0911	Policy/Cont Covered Unit(s) Initial ract/Fratern Specific and al Aggregate Excess Certificate: Endorsement	0.000	SP 5 160 0911.pdf

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Approval Status	SP	Policy/Cont	Covered Unit(s)	Initial	Amount	File Name
Approved- Closed	SP 5 161 0911	Policy/Cont	Covered Unit(s) racted/Fratern Specific Excess	Initial	0.000	SP 5 161 0911.pdf
10/03/2011 al Endorsement Certificate						
Approved- Closed	SP 5 162 0911	Policy/Cont	Delete Plan racted/Fratern Endorsement	Initial	0.000	SP 5 162 0911.pdf
10/03/2011 al Certificate: Amendmen						
t, Insert Page, Endorseme						
nt or Rider						
Approved- Closed	SP 5 163 0911	Policy/Cont	Insured Endorsement	Initial	0.000	SP 5 163 0911.pdf
10/03/2011 al Certificate: Amendmen						
t, Insert Page, Endorseme						
nt or Rider						
Approved- Closed	SP 5 164 0911	Policy/Cont	Aggregate Loss Limit	Initial	0.000	SP 5 164 0911.pdf
10/03/2011 al Endorsement Certificate: Amendmen						
t, Insert Page, Endorseme						
nt or Rider						
Approved- Closed	SP 5 165 0911	Policy/Cont	Monthly Aggregate	Initial	0.000	SP 5 165 0911.pdf
10/03/2011 al Reimbursement						

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10/03/2011	al	Endorsement		
		Certificate:		
		Amendmen		
		t, Insert		
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		Endorseme		
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Approved- SP 5 167	Policy/Cont	Non-Medical Benefits	Initial	0.000
Closed 0911	ract/Fratern	Covered Specific and		
10/03/2011	al	Aggregate Excess		
		Certificate: Endorsement		
		Amendmen		
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		Endorseme		
		nt or Rider		
Approved- SP 5 168	Policy/Cont	Non-Medical Benefits	Initial	0.000
Closed 0911	ract/Fratern	Covered Specific		
10/03/2011	al	Excess Endorsement		
		Certificate:		
		Amendmen		
		t, Insert		
		Page,		
		Endorseme		
		nt or Rider		
Approved- SP 5 169	Policy/Cont	Participant	Initial	0.000
Closed 0911	ract/Fratern	Endorsement		
10/03/2011	al			
		Certificate:		
		Amendmen		
		t, Insert		
		Page,		
		Endorseme		
		nt or Rider		
Approved- SP 5 170	Policy/Cont	Plan Name	Initial	0.000
Closed 0911	ract/Fratern	Endorsement		
10/03/2011	al			
		Certificate:		

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 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
 Product Name: AR - ESL - Enhanced Stop Loss Program - Form Filing
 Project Name/Number: AR - ESL - Enhanced Stop Loss Program - Form Filing/WIC-ESL-AR-11-06144-1-F

	Amendmen t, Insert Page, Endorseme nt or Rider			
Approved- SP 5 172 Closed 0911 10/03/2011	Policy/Cont Policy Period ract/Fratern Endorsement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	SP 5 172 0911.pdf
Approved- SP 5 173 Closed 0911 10/03/2011	Policy/Cont Quarterly Payment of Initial ract/Fratern Premium al Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider		0.000	SP 5 173 0911.pdf
Approved- SP 5 174 Closed 0911 10/03/2011	Policy/Cont Specific Retention ract/Fratern Each Person al Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	SP 5 174 0911.pdf
Approved- SP 5 175 Closed 0911 10/03/2011	Policy/Cont Specific Excess ract/Fratern Premium al Endorsement Certificate: Amendmen t, Insert	Initial	0.000	SP 5 175 0911.pdf

SERFF Tracking Number: ERCB-127633272 State: Arkansas
 Filing Company: Westport Insurance Corporation State Tracking Number: 49864
 Company Tracking Number: WIC-ESL-AR-11-06144-1-F
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
 Product Name: AR - ESL - Enhanced Stop Loss Program - Form Filing
 Project Name/Number: AR - ESL - Enhanced Stop Loss Program - Form Filing/WIC-ESL-AR-11-06144-1-F

Approved- Closed 10/03/2011	SP 5 176 0911	Page, Endorseme nt or Rider Policy/Cont Specific Indemnity ract/Fratern Percentage al Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	SP 5 176 0911.pdf
Approved- Closed 10/03/2011	SP 5 177 0911	Policy/Cont Specific Liability ract/Fratern Basis Endorsement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	SP 5 177 0911.pdf
Approved- Closed 10/03/2011	SP 5 337 0911	Policy/Cont Major Diagnosis ract/Fratern Endorsement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	SP 5 337 0911.pdf
Approved- Closed 10/03/2011	SP 5 338 0911	Policy/Cont Specific Terminal ract/Fratern Liability Option al Endorsement Certificate: Amendmen t, Insert Page, Endorseme	Initial	0.000	SP 5 338 0911.pdf

SERFF Tracking Number: ERCB-127633272 State: Arkansas
 Filing Company: Westport Insurance Corporation State Tracking Number: 49864
 Company Tracking Number: WIC-ESL-AR-11-06144-1-F
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
 Product Name: AR - ESL - Enhanced Stop Loss Program - Form Filing
 Project Name/Number: AR - ESL - Enhanced Stop Loss Program - Form Filing/WIC-ESL-AR-11-06144-1-F

Approved- Closed 10/03/2011	SP 5 340 0911	Policy/Cont Aggregate Terminal ract/Fratern Liability Option al Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	SP 5 340 0911.pdf
Approved- Closed 10/03/2011	SP 5 341 0911	Policy/Cont International Trade ract/Fratern Controls Amendatory al Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	SP 5 341 0911.pdf
Approved- Closed 10/03/2011	SP 5 342 0911	Policy/Cont Medicare Benefits ract/Fratern Exclusion al Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	SP 5 342 0911.pdf
Approved- Closed 10/03/2011	SP 5 343 0911	Policy/Cont Other Carrier ract/Fratern Transplant Coverage al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	SP 5 343 0911.pdf
Approved- Closed 10/03/2011	SP 5 344	Policy/Cont Specific Policy	Initial	0.000	SP 5 344

SERFF Tracking Number: ERCB-127633272 State: Arkansas
Filing Company: Westport Insurance Corporation State Tracking Number: 49864
Company Tracking Number: WIC-ESL-AR-11-06144-1-F
TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
Product Name: AR - ESL - Enhanced Stop Loss Program - Form Filing
Project Name/Number: AR - ESL - Enhanced Stop Loss Program - Form Filing/WIC-ESL-AR-11-06144-1-F
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Westport Insurance Corporation

A Stock Company
5200 Metcalf Avenue, P.O. Box 2991, Overland Park, KS 66201-1391
(913) 676-5200 / (800) 255-6931

EXCESS MEDICAL INDEMNITY POLICY

Insured:

Policy Number:

Effective Date:

State of Delivery:

This **Policy** is a legal contract. In consideration of premium **Paid**, Westport Insurance Corporation agrees to reimburse **Losses** in accordance with the terms of this **Policy**. Various provisions in this **Policy** restrict coverage. Read the entire **Policy** carefully to determine your rights, duties and what is and is not covered.

Throughout this **Policy** and the **Schedule**, the words "you" and "your" refer to the Insured shown above. The words "we," "us" and "our" refer to Westport Insurance Corporation. Other words and phrases that appear in bold letters have defined meaning. Refer to the **Policy** and **Schedule** if you have questions on the meaning of these terms.

This **Policy** is issued in, and will be governed by, the laws of the State of Delivery shown above, unless otherwise preempted by federal law. Acceptance of this **Policy** means that the Insured agrees to the terms and conditions of this **Policy**.

This **Policy** is executed by printing the facsimile signatures of our President and Secretary on the attached signature page and by the actual signature of the authorized representative on the **Schedule**.

THE ATTACHED DISCLOSURES, COVERAGE FORM(S) AND OTHER FORMS AND ENDORSEMENTS, IF ANY, FORM THE ATTACHED POLICY.

IN WITNESS WHEREOF, Westport Insurance Corporation has caused this **Policy** to be executed and attested by our duly authorized representative(s).

WESTPORT INSURANCE CORPORATION

Facsimile signature to be inserted

Facsimile signature to be inserted

President

Secretary

TABLE OF CONTENTS

	Page
Schedule of Insurance	4
Section One: Definitions	6
Section Two: Premium	8
Section Three: Specific Excess	9
Section Four: Aggregate Excess	9
Section Five: Amendments	10
Section Six: Exclusions	10
Section Seven: Claims	13
Section Eight: Renewal and Cancellation	17
Section Nine: General Provisions	18

SCHEDULE OF INSURANCE

**THIS IS A CLAIMS PAID POLICY
PLEASE READ CAREFULLY**

The following insurance only applies to the **Policy Period** shown in this **Schedule**. A separate **Schedule** will be issued for each succeeding **Policy Period**.

1. **INSURED:**

2. **ADDRESS:**

3. **POLICY NUMBER:**

4. **POLICY PERIOD:**

5. **PLAN NAME:**

6. **SPECIFIC EXCESS:**

a. Liability Basis:

(1) Claims Incurred from: _____ through _____

(2) Claims Paid from: _____ through _____

b. Retention each Person:

c. Indemnity Percentage:

d. Policy Period Limit:

e. Covered Unit(s):

f. Non-medical Benefits covered:

g. Premium:

Rating Classification

Monthly Rate

7. **AGGREGATE EXCESS:**

This Policy *includes* *excludes* Aggregate Excess Coverage. (If neither or both boxes are marked, then the assumption is that Aggregate Excess Coverage is excluded under this **Policy**.)

a. Liability Basis:

(1) Claims Incurred from: _____ through _____

(2) Claims Paid from: _____ through _____

b. Loss Limit Per Person:

c. Attachment Point:

(1) Estimated Attachment Point:

(2) Factor:

(3) Minimum Attachment Point:

d. Indemnity Percentage:

e. Indemnity Limit:

f. Covered Unit(s):

g. Non-medical Benefits covered:

h. Monthly Premium Rate:

8. **ADMINISTRATOR:**

9. **ENROLLMENT:** Total Covered Employees:

10. **MINIMUM NUMBER OF COVERED LIVES:**

WESTPORT INSURANCE CORPORATION

Authorized Westport Representative

Date

SECTION ONE: DEFINITIONS

1. **ADMINISTRATOR** means the organization contracted by you to adjudicate all claims arising from the **Plan**. The act of adjudication shall include but not be limited to the investigation, payment, denial and settlement of claims for **Benefits** under the **Plan**. The **Administrator** is designated in Schedule Item 8.
2. **ALTERNATIVE CARE** means a **Treatment**, identified through a case management provider, which substitutes a covered expense under your **Plan** for another covered expense under your **Plan**. Guidelines regarding the eligible expenses of **Alternative Care Treatment** under this **Policy** are set forth within Section Seven: Claims, Item 5.
3. **BENEFITS** means any medical coverage(s) provided by the **Plan**, and any non-medical coverage(s), provided by the **Plan**, specifically listed in Schedule Items 6(f) or 7(g). Dental, vision, hearing, prescription drugs, prescription drug card, retail prescription drugs, and weekly income **Benefits** are examples of non-medical coverages. Non-medical coverages not listed in the **Schedule** are not covered by this **Policy**.
4. **CASE MANAGEMENT FEES** are fees **Paid** to an independent third party case management provider for the coordination and management of health care delivery to a **Person** covered under the **Plan** through appropriate referrals to qualified and approved medical providers.
5. **COVERED UNIT** means a particular class of **Employees** (and the eligible covered dependents of the **Employees** under the **Plan**) who are covered under the **Plan** and indemnified by this **Policy** and identified under Schedule Items 6(e) or 7(f). A **Covered Unit** may be identified by company name, division, location or group.
6. **EMPLOYEE** means any individual who is employed by you in a **Covered Unit** and is eligible for coverage under the terms of the **Plan**. This does not include retired **Employees** or the dependents of retired **Employees** unless specifically identified for coverage under this **Policy** as listed in Schedule Items 6(e) and/or 7 (f).
7. **ENDORSEMENT** means a written alteration or amendment to the terms of this **Policy** issued by us and which is made a part of this **Policy**.
8. **EXPERIMENTAL AND/OR INVESTIGATIONAL** means a **Treatment** which does not constitute accepted medical practice within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the United States of America medical community or the U.S. federal government oversight agencies at the time services were rendered.
9. **INCURRED** means the date on which services for covered **Benefits** for a covered **Person** are performed by a qualified medical provider.
10. **INDEPENDENT MEDICAL REVIEW** means the analysis of the **Treatment** by a clinical reviewer of a URAC (formerly known as the Utilization Review Accreditation Commission) accredited independent review organization, who is a board certified physician in the same medical specialty or subspecialty of the underlying **Loss**, and both external and independent to the **Plan** and the **Administrator**.
11. **LOSS** or **LOSSES** means the amount **Paid** for claims by you or the **Administrator** for **Benefits** under the **Plan**. **Loss** includes the amount **Paid** by you or the **Administrator** in settlement of claims or in satisfaction of judgments for **Benefits** under the **Plan**. **Loss** also includes **Case Management Fees Paid** by you or the **Administrator** when claims exceed the Retention amount shown in Schedule Item 6(b).
12. **MATERIAL** or **MATERIAL CHANGE** means a change or combination of changes in the risk assumed by us, as solely determined by us. **Material** or **Material Change** includes but is not limited to the following:
 - a. a change, modification, or revision to the **Plan** that we determine would increase our risk under this **Policy**;

- b. a change or increase in liability due to the acquisition of, merger with, or sale of the Insured to another company or employer;
 - c. a change in your management, **Administrator's** management, or PPO contracts; or
 - d. a change in the majority ownership of the Insured.
13. **MEDICALLY NECESSARY** means a **Treatment** that is prescribed by a physician or licensed medical practitioner, who is acting within the scope of his or her license, and meets all of the following elements:
- a. Is appropriate for the diagnosis and **Treatment** of an illness, injury, or pregnancy in accordance with generally accepted medical practice and professional standards;
 - b. Is the most appropriate treatment, supply, device, or level of service to provide safe and adequate care; and
 - c. Is not **Experimental and/or Investigational**, Cosmetic, Custodial in Nature, or Unproven.

Cosmetic means a **Treatment** or portion of a **Treatment** with the purpose of improving appearance rather than curative or restoration of general health. Noted exceptions to this definition are repairs of congenital cleft palates and breast reconstruction after mastectomy.

Custodial in Nature is care which is primarily for the purpose of assisting the individual in the activities of daily living or in meeting personal rather than medical needs, which is not specific therapy for an illness or injury and is not skilled care. Activities of daily living are defined as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered.

Unproven is the lack of scientific evidence or outcome studies to demonstrate the medical effectiveness of the proposed medical **Treatment**.

14. **PAID** means that a claim has been adjudicated by the **Administrator** and funds have actually been disbursed by the **Plan** or **Administrator** as unconditional and direct payment to the applicable **Person** or health care provider(s) during the **Claims Paid** period as defined in Schedule Item 6(a)(2) and/or Schedule Item 7(a)(2), if applicable.

Payment will be deemed made on the date that both:

- a. the **Plan** or **Administrator** directly tenders payment by mailing, transmitting or other delivery of a draft, check or wire transfer; and
 - b. the account upon which the payment is drawn contains and continues to contain sufficient funds to permit the draft, check or wire transfer to be honored by the financial institution upon which it is drawn.
15. **PERSON** means any **Employee** included in a **Covered Unit**, and the eligible covered dependents of the **Employee**, who are enrolled and covered for **Benefits** under the **Plan**.
16. **PLAN** means the self-insured employee benefit plan named in Schedule Item 5 and recorded within a **Plan Document**. You agree to furnish us a copy of the **Plan Document** within ninety (90) days after the beginning of the **Policy Period**. A copy of the **Plan Document** is attached and made a part of this **Policy** as Exhibit A.
17. **PLAN CHANGE** means any alteration or amendment to the **Plan**, but unless each change is sent to us and accepted in writing by us, this **Policy** will apply as if the change had not been made. You agree to furnish a copy of any **Plan Change** to us at least thirty (30) days before it becomes effective.

18. **PLAN DOCUMENT** means the complete written **Plan** and/or trust which govern the operation and administration of the **Plan**, including eligibility, coverage, claim procedures and payment of **Benefits**. The **Plan Document** is not the descriptive booklet given to covered **Persons**, or the summary plan description. The **Plan Document** includes all written instruments governing the **Plan** including any amendments(s) accepted by us pursuant to this **Policy**.
19. **POLICY** means this Excess Medical Indemnity Policy, and the **Schedule**, Exhibits, and **Endorsements** (if any). The **Policy** is a contract of insurance between you (the Insured shown in Schedule Item 1) and us (the Insurer named on the face page of this **Policy**). The terms and conditions of this **Policy** may not be altered or waived except by **Endorsement** issued by us.
20. **POLICY PERIOD** means the period of time shown in Schedule Item 4 and any succeeding **Schedules**.
21. **PROOF OF LOSS** means the documentation of claims **Incurred** under the **Plan** and submitted for reimbursement under this **Policy**. Documentation must be to our satisfaction. The standards of Proof of Loss for each type of claim are further set forth in Section Seven: Claims, Item 11.
22. **SCHEDULE** means the pages of this **Policy** which show your name, the name of the **Plan** and other terms of insurance included in the Schedule of Insurance. A separate **Schedule** will be issued for each succeeding **Policy Period**.
23. **TREATMENT** means any medical procedure, service, device, supply, drug, care or treatment provided to a **Person** by a physician or medical provider.
24. **USUAL, REASONABLE AND CUSTOMARY** means the standard charges assessed by a group, entity, or individual for physician or medical provider services, hospital supplies, hospital bed rates, drugs, ancillary services, or durable medical equipment, to the extent that such charges do not exceed the general level of charges made by other physicians or medical providers who render similar **Treatments** to similarly ill or injured persons in the same geographical area.

SECTION TWO: PREMIUM

1. **CALCULATION**. Each month's premium due and payable to us for coverage under this **Policy** must be calculated by you or the **Administrator** by applying the Rates shown in Schedule Items 6(g) and 7(h) to the number of **Employees** in each **Covered Unit** eligible for coverage under the **Plan** on the first day of each month during the **Policy Period**.
2. **DUE DATE**. Premium is due to us on the first day of each month during the **Policy Period**. Each premium payment must be accompanied by a report showing the number of **Employees**, as of the first day of the month, who are part of each Rating Classification shown in Schedule Items 6(g) and 7(h).
3. **GRACE PERIOD**. A Grace Period of thirty-one (31) days following the premium due date will be granted for the payment of each month's premium. Coverage under this **Policy** shall continue in full force and effect during the Grace Period.
4. **NON-PAYMENT**. Failure to pay in full any month's premium within the Grace Period will cancel the **Policy** as of the premium due date, which will be the cancellation date of this **Policy**. Partial premium payments made during the Grace Period will be insufficient to avoid cancellation of the **Policy** for non-payment if the full monthly premium is not paid prior to the expiration of the Grace Period.
5. **REINSTATEMENT**. If any premium that is due and owing to us is paid after the expiration of the Grace Period, we may at our sole discretion elect to reinstate the **Policy** on the terms and conditions that we elect at that time.

6. **ADJUSTMENTS.** If you pay any premium in excess of the amounts due to us, you can either: a) request a refund payment from us for the excess amount paid; or b) offset the excess amount paid from the next premium payment due to us. A request for refund or a claim of offset for a future premium payment must be given to us in writing, stating the basis and calculation of the excess amount paid. However, no request for a refund or offset of premium will be honored or recognized after ninety (90) days from the end of the month in which the premium payment amount was adjusted. No premium adjustments will be allowed after ninety (90) days following the conclusion of the **Policy Period**.
7. **MINIMUM MONTHLY PREMIUM PAYMENTS.** Monthly payments of premium due under this **Policy** will not be less than the minimum monthly premium payment. The minimum monthly premium payment is calculated by multiplying the Minimum Number of Covered Lives, as defined in Schedule Item 10, by the per **Person** premium rates for Specific Excess coverage, as defined in Schedule Item 6(g) and if applicable, for Aggregate Excess coverage, Schedule Item 7(h).

SECTION THREE: SPECIFIC EXCESS

1. **RETENTION EACH PERSON.** You must retain (not be reimbursed by us under the **Policy**) the amount of **Loss** shown in Schedule Item 6(b) which is **Incurred** during the dates shown in Schedule Item 6(a)(1) and **Paid** by you or the **Administrator** for **Benefits** under the **Plan** for each **Person** during the dates shown in Schedule Item 6(a)(2).
2. **INDEMNITY.** We will indemnify and reimburse you the percentage shown in Schedule Item 6(c) of the amount of **Loss Paid** by you or the **Administrator** during the **Policy Period** that exceeds the Retention. We will not reimburse you more frequently than one (1) time each month for each **Person** under this **Policy**.
3. **POLICY PERIOD LIMIT.** The amount shown in Schedule Item 6(d) is the limit of the **Loss** for which we will reimburse you with respect to each **Person** during the **Policy Period**. The Policy Period Limit includes the amount of Retention Each Person for each **Policy Period**.

SECTION FOUR: AGGREGATE EXCESS

1. **ATTACHMENT POINT.** You must retain (not be reimbursed by us under the **Policy**) the amount of **Loss** equal to the Attachment Point, as defined in Schedule Item 7(c), which is **Incurred** during the dates shown in Schedule Item 7(a)(1) and **Paid** by you or the **Administrator** during the dates shown in Schedule Item 7(a)(2).

The Attachment Point is calculated for each **Policy Period** as follows: the sum of the number of **Employees** within each **Covered Unit** who are covered by the **Plan** on the first day of each month during the **Policy Period** multiplied by the Attachment Point Factor shown in Schedule Item 7(c)(2). The calculated Attachment Point will not be less than the Minimum Attachment Point amount shown in Schedule Item 7(c)(3).

The Estimated Attachment Point, as stated in Schedule Item 7(c)(1), is a calculation based upon the total number of covered **Employees** at the beginning of the **Policy Period**, as stated in Schedule Item 9, multiplied by the total number of months within the **Policy Period**, times the Attachment Point Factor, as stated in Schedule Item 7(c)(2). The Estimated Attachment Point is only a reference point for the anticipated aggregate excess retention amount upon binding of this **Policy**. However, for purposes of determining the actual Aggregate Excess retention amount, the above stated Attachment Point calculation will be utilized.

2. **INDEMNITY.** We will reimburse you an amount equal to the Indemnity Percentage as shown in Schedule Item 7(d) multiplied by the difference between the total **Loss** minus the calculated Attachment Point. In calculating the total **Loss** for the applicable **Policy Period**, we will utilize a **Loss Limit Per Person** amount.
3. **LOSS LIMIT PER PERSON.** When calculating our Aggregate Excess indemnity obligation to you, **Loss(es)** pertaining to each **Person** during each **Policy Period** will be limited to the amount shown in Schedule Item 7(b).

4. **AGGREGATE EXCESS INDEMNITY LIMIT.** Our Aggregate Excess Indemnity for each **Policy Period** will not exceed the Indemnity Limit shown in Schedule Item 7(e).
5. **CANCELLATION.** If you cancel this **Policy** before the **Policy Period** expires, no amounts will be reimbursed by us for Aggregate Excess **Losses** under this **Policy**.

SECTION FIVE: AMENDMENTS

1. **WE HAVE THE RIGHT TO AMEND ANY SCHEDULE ITEMS ON THE DATE THAT:**
 - a. we accept a **Material Plan Change**;
 - b. a **Covered Unit** is added or deleted;
 - c. the **Policy Period** expires;
 - d. you request a change in **Policy** terms;
 - e. a state or federal law **materially** alters your obligation under the **Plan**;
 - f. the total number of **Employees** in all **Covered Units** increases or decreases by more than:
 - i. Fifteen Percent (15%) during any single month of the **Policy Period**; or
 - ii. Twenty-Five Percent (25%) for any three (3) consecutive months of the **Policy Period** combined;
 - g. the total number of **Employees** in all **Covered Units** as reported for the first day of the **Policy Period** is fifteen percent (15%) higher or lower than the total number of **Employees** represented by you at binding of coverage of this **Policy** and documented as the Total Covered Employees within Schedule Item 9;
 - h. the average monthly claims **Paid** by you or the **Administrator** during the last two (2) months of the previous **Policy Period** exceeds by more than ten percent (10%) the average monthly claims **Paid** during all other months of the previous **Policy Period**;
 - i. a **Material Change** in the makeup of the **Employees** of the Insured due to merger or acquisition, unless we have agreed in writing to such change;
 - j. you or the **Administrator** provided us with incomplete or inaccurate census and/or claim information, inaccurate **Employee** or dependent qualification or classification, or any other mistake or misrepresentation, with respect to any **Material** term of this **Policy**; or
 - k. you or the **Administrator** change PPO networks.

SECTION SIX: EXCLUSIONS

1. **THIS POLICY DOES NOT APPLY:**
 - a. to **Loss Paid** by you or the **Administrator** and reported to us more than one (1) year after the end of the **Policy Period** in which the **Loss** is **Paid**;
 - b. to expenses, payments or expenditures for any non-medical expenses incurred as a result of the administration of the **Plan**, including but not limited to the following:

- i. claims administration, investigation fees, attorneys fees, court cost, and fees for obtaining medical records billed by the **Administrator** (including fees generated from companies owned in whole or in part by the **Administrator**, companies with a corporate or other legal affiliation or joint ownership with the **Administrator**, or by a spouse, child or immediate family member of the **Administrator**, unless we grant prior written authorization. Failure to provide prior disclosure of such an ownership or relationship interest will exclude all indemnifiable **Loss** under this **Policy** attributed to such fees);
- ii. compensation paid to officers, employees, consultants, brokers, actuaries, accountants, independent contractors, or any other person or entity performing non-claim services for the **Plan**; and
- iii. any surcharges, assessments, or taxes imposed by any federal, state or local government entity, hospital or agency upon self-insurers;
- c. to any **Material Plan Change** which we have not accepted in writing;
- d. to **Benefits Paid** by you in one **Policy Period** but allocated to another **Policy Period**. No reimbursement will be made under both the Aggregate and Specific Excess provisions of this **Policy** if, by so doing, we would in any way make reimbursement more than once for any **Loss**;
- e. to administrative fees related to a prescription drug card program, unless otherwise agreed to by us in writing;
- f. to **Experimental and/or Investigational Treatments**;
- g. to any **Treatment** that is not **Medically Necessary**;
- h. to the cost resulting from a **Loss** that is in excess of the **Usual, Reasonable and Customary** charges;
- i. to non-skilled custodial or residential services. Services are deemed to be non-skilled custodial or residential services if the services i) do not require the skill of a licensed Registered Nurse, ii) are not curative and/or restorative in nature, and iii) are primarily intended to assist in the activities of daily living as defined by Medicare (e.g. bathing, dressing, feeding, toileting, transferring);
- j. to expenses for **Benefits** for accidental bodily injury or sickness arising out of or in the course of any occupation for wage or profit, and for which the **Person** would be entitled to benefits under any Workers' Compensation, U.S. Longshoremen and Harbor Workers' or other occupational disease legislation, regulation or policy, whether or not such policy is actually in force;
- k. to expenses incurred while a **Person** is engaged in an act that is illegal under federal or state law, or as a result of their illegal act. Illegal acts include but are not limited to participation in a riot or other act of civil disobedience; operation of a motorized vehicle (including but not limited to automobile, motorcycle, ATV, boat, personal watercraft and snowmobiles) while intoxicated, as defined by the applicable state law, due to drugs, alcohol, or narcotics; voluntary consumption or use of a controlled substance that has not been legally prescribed by a treating medical provider; or any other charged felony or misdemeanor;
- l. to expenses incurred resulting from a war, declared or undeclared, hostilities, invasions, insurrections, or civil war;
- m. to expenses incurred by a **Person** resulting from a hazardous hobby or activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm or injury. Examples of hazardous hobbies or activities shall include, but not be limited to: skydiving; racing of an automobile, ATV, boat, personal watercraft or motorcycle; hang gliding; and bungee jumping;

- n. to expenses incurred by a **Person** while detained or incarcerated in a federal, state, or local jail, penitentiary, correctional facility or correctional hospital;
- o. to expenses incurred by a **Person** for cosmetic purposes, unless:
 - i. performed to correct functional disorders or congenital anomalies; or
 - ii. performed for breast reconstruction of the affected tissue incident to a mastectomy (Women's Health and Cancer Rights Act of 1998); or
 - iii. due to accidental injury occurring while the individual is a covered **Person**;
- p. to Medicare benefits, presuming that, when applying this exclusion, each **Person** eligible for coverage under Medicare became covered for any parts of Medicare on the earliest possible date entitled, and thereafter continuously maintained the Medicare coverage in force. If it is determined that **Benefits** were provided to a **Person** who was eligible for coverage under Medicare but he or she either i) failed to apply for such Medicare coverage or ii) failed to maintain Medicare coverage in force, then said **Benefits** will also be excluded;
- q. for any portion of an expense which you are not obligated to pay under the terms of the **Plan**, or which is reimbursable to you under:
 - i. another group health benefit plan; or
 - ii. a government or privately supported medical research program; or
 - iii. any coordination of benefits or non-duplication of benefit provisions of your **Plan**; or
 - iv. any other source;
- r. to any billing errors, duplicate bills or duplicate bill items;
- s. any amount **Paid** by you or the **Administrator** in excess of a negotiated provider discount, or any penalty or late charge incurred, or discount lost, unless said excess amount, penalty, or late charge has been previously approved by us in writing;
- t. to expenses for **Treatment** authorized or approved under any provision of the **Plan** which:
 - i. allows the **Administrator** to approve an **Alternative Care Treatment** without prior approval from us; or
 - ii. allows the **Administrator** to alter, modify, or waive a **Plan** provision, standard, or limitation; or
 - iii. grants you or the **Administrator** discretion to approve coverage for a **Treatment** not otherwise covered under the **Plan**.

However, if the **Treatment** satisfies the requirements set forth within Section Seven: Claims, Item 5, then such expenses will not be deemed excluded.
- u. to expenses for **Treatment** rendered to a **Person** by a family member or relative of the **Person**;
- v. to payment of medical expenses in excess of **Plan** limits or terms;
- w. to payment of medical expense not covered under the terms of the **Plan**. **Administrator's** use of discretionary authority under the **Plan** does not obligate us to recognize and/or reimburse you under this **Policy** for benefits excluded, limited or not listed within the terms of the current **Plan**; and

- x. to any of the following legal obligations:
 - i. any liability arising out of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or out of any similar federal or state law or regulation;
 - ii. any payment for litigation cost and expenses, extra-contractual damages, compensatory damages, punitive or exemplary damages or liabilities, including but not limited to those resulting from negligence, intentional wrong doings, fraud, bad faith or strict liability on the part of the **Insured, Plan, Administrator** or any agent or representative of the **Insured, Plan, or Administrator**; or
 - iii. any other fines or penalties imposed upon the **Insured, Plan or Administrator** by law or regulation, not already addressed herein.

SECTION SEVEN: CLAIMS

1. **ELIGIBLE EXPENSES.** Eligible expenses for a claim against this **Policy** comprise of amounts **Paid** by you for **Medically Necessary Treatments Incurred** by a covered **Person** which:
 - a. Have been **Paid** in accordance with the terms and conditions of your **Plan**; and
 - b. Were **Incurred** and **Paid** during the Liability Basis shown in Schedule Item 6(a) or 7(a); and
 - c. Are **Paid** under a **Benefit** covered by this **Policy**; and
 - d. Are not otherwise excluded under this **Policy** (Section Six: Exclusions).
2. **YOUR ADMINISTRATOR.**
 - a. **Administrator** is your contractual agent and does not represent us in any way.
 - b. You are solely responsible for all fees charged by the **Administrator** for its services rendered to you.
 - c. **Administrator** may be authorized by you to satisfy the obligations and duties assigned to you under this **Policy**; however the **Administrator's** failure to act or its error in acting will not excuse you from your obligations and duties arising under this **Policy**.
 - d. **Administrator** will hire counsel to defend all litigation arising out of a denied claim. We reserve the right to participate and control in the defense of any claim which may result in a **Loss** to us.
 - e. You will provide the **Administrator** with sufficient funds to pay all claims for **Benefits** under the **Plan** as they become due.
 - f. **Administrator** will pursue and take advantage of all discounts and other cost reducing procedures prior to playing a claim for **Benefits** under the **Plan**. We will not be held accountable for any lost discounts. If **Administrator** is unable to obtain any discount, or only able to obtain a nominal discount (ten percent (10%) or less), or unable to implement managed care opportunities with respect to any **Loss** under the **Plan**, you will notify us immediately. We reserve the right to independently investigate, negotiate and/or pursue any discounts or cost mitigation services available on all **Losses** under the **Plan**. **Administrator** will recognize and honor any discounts or other managed care opportunities identified by us.
 - g. If you plan to terminate or replace your **Administrator** during the **Policy Period**, you must notify us immediately.
3. **CASE MANAGEMENT PROVIDERS AND EXPENSES.**
 - a. The case management provider must be either:

- i. Approved by us in writing, or
 - ii. Have current and on-going accreditation by one of the following national organizations: URAC (formerly known as the Utilization Review Accreditation Commission), Commission for Case Manager Certification or the Case Management Society of America.
- b. Case management services provided by an employee or affiliated company of the **Administrator** are not eligible for indemnification under this **Policy** unless we give prior written approval.
 - c. If you or the **Administrator** do not utilize a case management provider, we reserve the right to retain and utilize the services of a case management provider at our own cost and expense.
 - d. **Case Management Fees** do not include fees **Paid** on a capitated basis (e.g. per **Employee** per month) by you or the **Administrator**.
 - e. **Case Management Fees** are eligible for indemnification only under a **Specific Excess Claim**, not for an **Aggregate Excess Claim**.
4. **COST CONTAINMENT FEES.** Fees or charges **Incurred** and **Paid** by you or the **Administrator** for the direct purpose of cost containment for the **Plan** are eligible as a **Loss** under this **Policy** if prior written approval for such fees or charges have been obtained from us. Examples of cost containment fees or charges include but are not limited to the following: negotiation fees, medical cost repricing fees, provider bill audits, network access fees, etc. Cost Containment Fees are subject to the following additional terms:
- a. Our acceptance of a cost containment fee or charge will be subject to a demonstration that the work that generated the fees or charges resulted in a cost savings to the **Plan**.
 - b. Cost containment fees are eligible for indemnification only under a **Specific Excess Claim**, not for an **Aggregate Excess Claim**.
 - c. Eligible cost containment fees or charges are only reimbursed for claims in which the total **Loss** exceeds the Retention amount shown in Schedule Item 6(b).
5. **COVERAGE GUIDELINES FOR EXPERIMENTAL AND/OR INVESTIGATIONAL, MEDICALLY NECESSARY, AND USUAL, REASONABLE AND CUSTOMARY MEDICAL TREATMENTS AND EXPENSES.**
- a. The **Administrator** will be guided by the following standards in making its determination of whether a **Treatment** is **Experimental and/or Investigational**:
 - i. If the drug or device 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 of the drug or device is furnished; or
 - ii. If "Documented Medical Evidence" shows that the **Treatment** is the subject of on-going Phase I or Phase II clinical trials, or is the research, experimental, study or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of **Treatment** or diagnosis; or
 - iii. If "Documented Medical Evidence" shows that the prevailing opinion among experts regarding the **Treatment** is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of **Treatment** or diagnosis.

"Documented Medical Evidence" shall mean published reports and articles within authoritative medical and scientific literature, or other publication, written or electronic, by a nationally recognized medical specialty group, in regard to a protocol or **Treatment**.

Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the U.S. Food and Drug Administration for general use.

Treatment for a specific form of cancer that has not completed U.S. Food and Drug Administration Phase III clinical trials, but is considered to be the current standard of care, may be referred to us for review and determination of exemption from a classification of **Experimental and/or Investigational**.

- b. The circumstances under which a physician or licensed medical practitioner has prescribed, ordered, recommended or approved any **Treatment** are not conclusive as to whether such **Treatment** is **Medically Necessary** within the scope of this **Policy**.
- c. The **Administrator** will make all initial determinations of **Experimental and/or Investigational** and **Medically Necessary** under the **Plan** and provide **Proof of Loss** documentation supporting its determination based upon the standards defined above. We reserve the right to investigate and make any final determination of what is **Experimental and/or Investigational** or **Medically Necessary** and eligible for indemnification under this **Policy** prior to reimbursement.
- d. **Usual, Reasonable and Customary ("URC")** charges are determined by the **Administrator** utilizing national and regional industry data, Medicare data, or other similar sources of medical cost data. The **URC** charges shall be based upon the:
 - i. complexity of the **Treatment**;
 - ii. the skill of the medical provider or physician;
 - iii. the intensity of medical service utilized; and
 - iv. the geographical standards for service and pricing.

We reserve the right to perform bill audit prior to payment of the provider by the **Administrator** and prior to reimbursement, if any, under this **Policy**. We will reimburse the lesser of eligible **URC**, billed charges, or the negotiated rate.

6. **ALTERNATIVE CARE.** **Treatments** of **Alternative Care** may be deemed eligible expenses under this **Policy** when all of the following criteria have been satisfied and evidence thereof has been remitted to us for approval:
 - a. You demonstrate to our satisfaction that providing the **Alternative Care** resulted in a cost savings to the **Plan**;
 - b. The **Alternative Care** was recommended by case management provider servicing your **Plan**;
 - c. The **Alternative Care** was **Medically Necessary**;
 - d. The **Alternative Care** replaces a **Treatment** that would be covered under your **Plan**;
 - e. The **Alternative Care** expenses do not exceed the maximum allowed under your **Plan** for the **Treatment** replaced by the **Alternative Care**; and
 - f. The **Alternative Care** was provided with the consent of the **Person**, or his or her legal representative.

If the **Alternative Care** is provided in lieu of inpatient hospitalization, the **Person** must meet utilization review criteria satisfactory to us for inpatient hospitalization for the entire period the **Alternative Care** is provided. In no event will **Alternative Care** that exceeds ninety (90) days be considered an eligible expense unless approved in writing by us.

7. **FIFTY PERCENT RETENTION AND MAJOR DIAGNOSIS NOTICE REQUIREMENTS.** You or the **Administrator** will give us written notice (in a form satisfactory to us) within thirty (30) days after a **Loss** for any covered **Person** exceeds fifty percent (50%) of the Retention shown in Schedule Item 6(b), or when any covered **Person** has been diagnosed with a medical condition that has been identified in the Major Diagnosis **Endorsement** attached to this **Policy**.
8. **LITIGATION OR OTHER LEGAL EXPOSURES.** You or the **Administrator** will give us written notice, within ten (10) days, of any lawsuit, threatened lawsuit, or other formal proceeding against the **Plan** which may result in a **Loss** under this **Policy**.
9. **LATE REPORTING PENALTY.** If we do not receive a request for reimbursement within one hundred twenty (120) days after a **Loss**, exceeding the Specific Retention, is **Paid** by you or the **Administrator**, we will reduce our indemnity due under this **Policy** by twenty-five percent (25%). Proof of prejudice is not required in our utilization and enforcement of this late reporting penalty.
10. **AGGREGATE EXCESS REPORT.**
 - a. You or the **Administrator** will send us an Aggregate Excess Report (in a form satisfactory to us), within twenty (20) days after the end of each calendar month during the **Policy Period**, containing the following data:
 - i. The number of **Employees** in each **Covered Unit** who are covered by the **Plan** as of the first day of the reporting month; and
 - ii. The total amount of **Losses** for all covered **Persons** during the reporting month.
 - b. Reported **Losses** must be within the **Loss Limit Per Person** shown in Schedule Item 7(b).
 - c. This report will identify and segregate **Losses** by each **Covered Unit**.
11. **PROOF OF LOSS.**
 - a. **SPECIFIC EXCESS CLAIMS.** We will reimburse you for a **Loss** covered by the **Policy** after we receive satisfactory **Proof of Loss**, as solely defined by us, that you or the **Administrator** has **Paid** the **Loss**. Satisfactory **Proof of Loss** of a Specific Excess claim includes, but is not limited to:
 - i. our completed loss advice form;
 - ii. proof of eligibility under the **Plan**;
 - iii. claim payment report with the following data: provider of services, **Incurred** from and to dates, service/procedure codes, billed amounts, **Paid** amounts, **Paid** dates, and check numbers;
 - iv. itemized medical bills (as applicable);
 - v. invoices from managed care and other cost containment vendors;
 - vi. comprehensive case management reports with updates;
 - vii. attending physician statements and medical narratives;
 - viii. date the accident occurred or date the sickness was diagnosed; and
 - ix. date that medical care was first received.

- b. **AGGREGATE EXCESS CLAIM.** After the end of the **Policy Period**, we will reimburse you for **Losses** covered by this **Policy** after we receive satisfactory **Proof of Loss** that you or the **Administrator** has **Paid** the **Loss**. You or the **Administrator** must provide us with **Proof of Loss** within ninety (90) days after the end of the period shown in Schedule Item 7(a)(2) in order for us to consider reimbursing an Aggregate Excess claim. Satisfactory **Proof of Loss** of an Aggregate Excess claim includes, but is not limited to:
- i. our completed loss advice form;
 - ii. computer reports of total **Paid** claims (month-by-month) during the **Policy Period** showing claimant, **Incurred** date, service/procedure code, billed amount, **Paid** date, provider and amount **Paid**;
 - iii. computer reports showing total **Employee** census information (month-by-month) during the **Policy Period**; and
 - iv. documentation showing any voided payments, refunds, or other adjustments.
- c. **ADDITIONAL DOCUMENTATION.** If we ask for **Loss** documentation that is not described in subsections a. or b. above, you agree to provide or require your **Administrator** to provide such documentation to us. It is your responsibility and financial obligation to provide us with satisfactory **Proof of Loss**.
12. **CLAIMS APPEAL PROCESS.** You may appeal any claim determination made by us under this **Policy** by submitting a written appeal within ninety (90) days from the date of our initial claim determination. Your written appeal must clearly state the basis of your disagreement with our claim determination and include all relevant documentation in support of your appeal that has not been previously provided to us.

Any appeal of a claim determination made by us on the grounds that the **Treatment** provided was either (i) not **Medically Necessary**; (ii) Cosmetic, Custodial in Nature, or Unproven; or (iii) **Experimental and/or Investigational**, must include a report from an **Independent Medical Review**. The **Independent Medical Review** report will be obtained at your expense. The utilized independent review organization must be mutually acceptable to you and us.

SECTION EIGHT: RENEWAL AND CANCELLATION

1. **RENEWAL.** In order for us to offer you a renewal for succeeding **Policy Periods**, you must provide us the following information at least three (3) months prior to the end of the **Policy Period**:
- a. a list of every **Employee** and the eligible dependents of each **Employee**, identified by the applicable **Covered Unit**, showing each **Person's** age, gender, and rating classification;
 - b. the total number of **Employees** working within each U.S. Postal Service Zip Code area for each **Covered Unit**;
 - c. the applicable PPO network for each **Employee**;
 - d. a report summarizing claims, segregated by the applicable **Covered Unit**, which exceed, or may exceed, fifty percent (50%) of the Retention for each **Person** shown in Schedule Item 6(b), or any **Persons** who have been diagnosed with a condition listed in the Major Diagnosis **Endorsement** attached to this **Policy**. The report will also identify any pending, denied, or claims placed on hold by you or your **Administrator** for the prior twelve (12) months;
 - e. a report summarizing aggregate month-by-month paid claims for all covered **Persons** along with monthly census and any specific claims excess of the Loss Limit Per Person;
 - f. any **Plan Change(s)** that are being considered by you; and
 - g. any other information we may request.

2. **NONRENEWAL.** If we elect not to renew this **Policy**, we will give you written notice by registered mail at least thirty (30) days, or longer if required by law, prior to the end of the **Policy Period** stating our reason for the nonrenewal.
3. **CANCELLATION.**
 - a. You may cancel this **Policy** at any time by giving us thirty (30) days advance written notice stating the cancellation date.
 - b. We may cancel this **Policy** as of:
 - i. The date your contract between you and the **Administrator** is cancelled, unless we give written consent and approve the replacement **Administrator**, if any;
 - ii. The date your **Plan** is terminated;
 - iii. The date in which premium was due but has not been paid by you within the Grace Period (pursuant to Section Two: Premium, Items 3 and 4);
 - iv. The first day of the month in which the number of covered **Employees** falls below one hundred (100) lives; or
 - v. The sixty-first (61st) day following issuance of notice by us to you for your failure or the failure of your **Administrator** to satisfy your obligations under this **Policy**, and such obligation had not been subsequently remedied.
 - c. Notice of cancellation by either party to the other will be given by registered mail, or as may be required by applicable law, stating the cancellation date.
4. **TERMINATION OF COVERAGE.** In the event this **Policy** is cancelled by you or by us pursuant to Item 3 above, and prior to the expiration of the **Policy Period**, as defined in Schedule Item 4, the following **Policy** terms will be revised to reflect the notified **Policy** cancellation date:
 - a. Schedule Item 4 – **Policy Period** end date;
 - b. Schedule Item 6(a)(1) – Specific Excess, Liability Basis, Claims Incurred end date;
 - c. Schedule Item 6(a)(2) – Specific Excess, Liability Basis, Claims Paid end date;
 - d. Schedule Item 7(a)(1) – Aggregate Excess, Liability Basis, Claims Incurred end date, if applicable; and
 - e. Schedule Item 7(a)(2) – Aggregate Excess, Liability Basis, Claims Paid end date, if applicable.

SECTION NINE: GENERAL PROVISIONS

1. **BANKRUPTCY.** Your bankruptcy will not relieve us from the payment of any claim covered by this **Policy**. Nothing in the **Policy** will increase our liability under the **Policy** beyond that which it would otherwise be if you had not become insolvent or bankrupt.
2. **INSPECTION OF RECORDS.** We or our representatives have the right (at no cost to us) to inspect any books, records or other documentation applicable to the **Plan** which are kept by you and/or the **Administrator**. The inspection may be made by us or our representatives at any time during the normal business hours of the organization where the inspection takes place.

3. **LEGAL ACTION.** No action at law or in equity will be brought against us to recover on this **Policy** prior to the expiration of sixty (60) days after written **Proof of Loss** has been furnished in accordance with the requirements of this **Policy**. No such action will be brought more than two (2) years after the time written **Proof of Loss** is required to be furnished.
4. **SUBROGATION AND RIGHT OF RECOVERY.** You agree to prosecute any and all valid claims against any third party that may arise from any claim for which **Benefits** were **Paid** under the **Plan**. You or the **Administrator** will notify us of any subrogation claims and will account to us for any **Losses** recovered. If you or the **Administrator** fails to pursue any action against any third party and you have received, or are entitled to receive, reimbursements from us for **Benefits Paid** under the **Plan**, we will be subrogated to your rights and the rights of any **Person** under the **Plan**. We have the right of recovery to any amounts you or any **Person** receiving **Benefits** under the **Plan** recover from any third party who is found liable for these amounts. You will do everything necessary to protect these rights and to help us enforce them. The recovered **Loss** remaining after deducting the expenses of our recovery will first be used to reduce our **Loss**; then we will pay the balance, if any, to you.
5. **CLERICAL ERROR.** This **Policy** will not be invalidated or terminated by clerical error or mutual mistake. Clerical error or mutual mistake will not continue this **Policy** if it has been terminated, and it will not expand our obligations under this **Policy**. Upon discovery of such clerical error, the **Policy** will be restored and amended to reflect the terms and conditions that were agreed to at the time of its execution.
6. **OTHER INSURANCE.** If any other insurance exists protecting you against **Loss** covered by this **Policy**, this **Policy** will apply in excess of the other insurance.
7. **PARTIES.** We are the Insurer under this **Policy** and you are the Insured. **Employees** and their dependents are not parties to this **Policy**. We do not insure or pay **Benefits** to your **Employees** or their dependents under the **Plan**. We are limited under the **Policy** to reimbursing you for **Losses** under this **Policy** that are **Incurred** and **Paid** by you as self-insurer of the **Plan**.
8. **REPRESENTATIONS.** We issued and may renew this **Policy** relying upon the information furnished us as to the number of your **Employees** and the claims experience under the **Plan**. If the initial or renewal underwriting information is incorrect or incomplete, we have the right to amend the **Schedule** to reflect what we would have shown in the **Schedule** using the accurate and complete information. This amendment will be effective at the beginning of the **Policy Period** in which we learn of the incorrect or incomplete information.
9. **REFUND OF OVERPAYMENTS.** If we, you or the **Administrator** determine that we have overpaid under this **Policy** due to a claim credit which may be the result of a coordination of benefits change, a subrogation recovery, an audit or billing/payment error or other circumstance, then you will promptly refund such overpayment to us within sixty (60) days of discovery of the overpayment. We reserve the right to recover such overpayments from future claim payments due under this **Policy** if a refund payment is not received within sixty (60) days. If no future claim payments are due and the refund of an overpayment is not made by you, then we may take legal action to collect such overpayment. You agree to indemnify us for any cost of collection, including but not limited to, attorney's fees and court cost.
10. **SELF-INSURANCE.** You are now and will remain until the end of the **Policy Period** self-insured for the **Benefits** provided by the **Plan**. It is your responsibility to make all filings required by federal and state authorities regulating self-insured plans.
11. **TRANSFER.** Your rights or duties under this **Policy** may not be transferred or assigned to anyone else without our written consent.
12. **CHANGES.** Notice to or knowledge possessed by any agent, broker, or other person shall not effect a change or waiver of any part of this **Policy**, nor prevent us from asserting any rights under this **Policy**. No part of this **Policy** can be changed or waived, except by written **Endorsement** issued by us.

13. **HEADINGS.** The descriptions in the headings and sub-headings of this **Policy** are solely for convenience, and form no part of the terms and conditions of coverage.
14. **ENTIRE AGREEMENT.** The parties agree that this **Policy**, including the **Schedule**, the Disclosure Statement, the Binder, the **Plan**, Exhibits, and any **Endorsements**, constitutes the entire agreement between you and us relating to this **Policy**.

We executed this **Policy** by printing the facsimile signatures of our President and Secretary on the attached signature page and by the actual signature of the authorized Westport Insurance Corporation representative on the **Schedule**.

Westport Insurance Corporation

SPECIFIC NO LASER RATE CAP (NLRC) ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

In consideration for the assessment of the No Laser Rate Cap (NLRC) premium factor as stated within the Binder for Excess Medical Indemnity Coverage (Binder) of the **Policy**, we agree that at the time of renewal of your **Policy** with us for the next **Policy Period**, your **Policy** will not contain any **additional Persons** with Specific Excess Retentions, as listed in Schedule Item 6(b). We reserve the right to carry over to the renewal **Policy** any or all **Persons** that already have a Specific Excess Retention as listed within the Binder of the **Policy**.

In addition, the Specific Excess Premium rates of the renewal **Policy**, as listed in Schedule Item 6(g), will not be increased more than forty-five percent (45%) over the Specific Excess Premium rates of the current **Policy**.

If your **Policy** reflects the application of an Aggregating Specific Retention Option via an **Endorsement**, the amount of the Aggregating Specific Retention on your renewal **Policy** will also increase by the same percentage as that of the Specific Excess Premium rates.

We reserve the right to change, modify or cancel this **Endorsement**, at our sole discretion, should you amend or change your **Plan** in any way that materially affects our risk or liability with regards to the **Policy** or this **Endorsement**, or if your renewal **Policy**:

1. Contains a **Policy Period** that is longer in duration than the **Policy Period** listed in the Schedule Item 4 of the current **Policy**; or
2. Contains coverage for Retirees, as listed in Schedule Item 6(e) Covered Unit(s), if coverage for Retirees was not previously purchased with the current **Policy**; or
3. Contains a different list of Specific Benefits Covered than what is listed in the Binder of the current **Policy**; or
4. Contains a Specific Excess Retention amount that is not equal to the Specific Excess Retention amount listed in Schedule Item 6(b) of the current **Policy**; or
5. Contains a Specific Excess Liability Basis that is not identical to the Specific Excess Liability Basis listed in Schedule Item 6(a) of the current **Policy**; or
6. Contains a Specific Excess Annual Policy Period Limit that is higher than the Specific Excess Annual Policy Period Limit listed in Schedule Item 6(d) of the current **Policy**; or
7. Contains a Specific Excess Indemnity Percentage that is higher than the Specific Excess Indemnity Percentage listed in Schedule Item 6(c) of the current **Policy**.

If your **Policy** reflects the application of the Aggregating Specific Retention Option, we reserve the right to change, modify or cancel this **Endorsement** if you:

1. Cancel the Aggregating Specific Retention Option on any renewal **Policy**, or
2. Request the Aggregating Specific Retention to be decreased on any renewal **Policy**; or
3. Request the Aggregating Specific Retention to be increased by a percentage less than the increase of the Specific Excess Premium rates as allowed by this **Endorsement**.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

WESTPORT INSURANCE CORPORATION

Facsimile signature to be inserted

Facsimile signature to be inserted

President

Secretary

Westport Insurance Corporation

ADD PLAN ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, the following **Plan** is added to Schedule Item 5. as follows:

5. **PLAN NAME:**

A copy of the new **Plan** is attached to this **Policy** as Exhibit ____.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

WESTPORT INSURANCE CORPORATION

Facsimile signature to be inserted

Facsimile signature to be inserted

President

Secretary

Westport Insurance Corporation

ADDRESS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

- I. As of the effective date of this **Endorsement**, Schedule Item 2. Address is deleted and replaced with the following:
 2. **ADDRESS:**

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

WESTPORT INSURANCE CORPORATION

Facsimile signature to be inserted

Facsimile signature to be inserted

President

Secretary

Westport Insurance Corporation

ADMINISTRATOR ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 8. Administrator is deleted and replaced with the following:

8. **ADMINISTRATOR:**

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

WESTPORT INSURANCE CORPORATION

Facsimile signature to be inserted

Facsimile signature to be inserted

President

Secretary

Westport Insurance Corporation

AGGREGATE INDEMNITY LIMIT ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(e) is deleted and replaced with the following:

7. **AGGREGATE EXCESS:**

e. Indemnity Limit:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

WESTPORT INSURANCE CORPORATION

Facsimile signature to be inserted

Facsimile signature to be inserted

President

Secretary

Westport Insurance Corporation

AGGREGATE INDEMNITY PERCENTAGE ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(d) is deleted and replaced with the following:

7. **AGGREGATE EXCESS:**

d. Indemnity Percentage:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

WESTPORT INSURANCE CORPORATION

Facsimile signature to be inserted

Facsimile signature to be inserted

President

Secretary

Westport Insurance Corporation

AGGREGATE LIABILITY BASIS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(a) is deleted and replaced with the following:

7. **AGGREGATE EXCESS:**

a. Liability Basis:

(1) Claims Incurred from _____ through _____

(2) Claims Paid from _____ through _____

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

WESTPORT INSURANCE CORPORATION

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President

Secretary

Westport Insurance Corporation

AGGREGATE MONTHLY PREMIUM RATE ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(h) is deleted and replaced with the following:

7. **AGGREGATE EXCESS:**

h. Monthly Premium Rate:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

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AGGREGATING SPECIFIC RETENTION OPTION ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. Schedule Item 6. Specific Excess is amended by adding the following:

6. **SPECIFIC EXCESS:**

- h. Aggregating Specific Retention. In addition to retaining the Specific Retention each Person amount for each **Loss Incurred** under this **Policy**, as defined in Schedule Item 6(b), you also agree to retain the following Aggregating Specific Retention amount for all **Persons** with a **Loss** under this **Policy**:

Only those amounts of the **Losses** exceeding the Specific Retention each Person will be aggregated to satisfy the Aggregating Specific Retention amount. We will not indemnify you on a specific **Loss** prior to your reaching the above defined Aggregating Specific Retention amount.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

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ANNUAL PAYMENT OF PREMIUM ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

It is agreed that the **Policy** is hereby amended as follows:

I. Section Two: Premium is hereby deleted in its entirety and replaced by the following:

SECTION TWO: PREMIUM

1. **DEPOSIT PREMIUM.** A deposit premium of \$_____ is due on the first day of the **Policy Period**.
2. **CENSUS REPORT.** Within twenty (20) days after the end of the **Policy Period**, you must send us a census report showing the number of **Employees** within each rating classification shown in Schedule Item 6(g) who were covered by the **Plan** on the first day of each month in the **Policy Period**.
3. **FINAL PREMIUM.** The final premium due for the **Policy Period** shall be determined by applying the Rates shown in Schedule Items 6(g) and 7(h) to the number of **Employees** in each **Covered Unit** eligible for coverage under the **Plan**.
4. **ADJUSTMENT PREMIUM.** At the end of the **Policy Period**:
 - a. if the final premium is more than the deposit premium, you will send us your payment of the difference along with the Census Report; or
 - b. if the final premium is less than the deposit premium, we will return the difference to you promptly after we receive the Census Report.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

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ATTACHMENT POINT ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(c) is deleted and replaced with the following:

7. **AGGREGATE EXCESS:**

c. Attachment Point:

- (1) Estimated Attachment Point:
- (2) Factor:
- (3) Minimum Attachment Point:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

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COVERED UNIT(S) SPECIFIC AND AGGREGATE EXCESS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

- I. As of the effective date of this **Endorsement**, Schedule Items 6(e) and 7(f) are deleted and replaced with the following:
- 6. **SPECIFIC EXCESS:**
 - e. Covered Unit(s):
 - 7. **AGGREGATE EXCESS:**
 - f. Covered Unit(s):

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

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Secretary

Westport Insurance Corporation

COVERED UNIT(S) SPECIFIC EXCESS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(e) is deleted and replaced with the following:

6. **SPECIFIC EXCESS:**

e. Covered Unit(s):

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

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Westport Insurance Corporation

DELETE PLAN ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, the following **Plan** is deleted from Schedule Item 5:

5. **PLAN NAME:**

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

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Westport Insurance Corporation

INSURED ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

- I. As of the effective date of this **Endorsement**, Schedule Item 1. Insured is deleted and replaced with the following:
 1. **INSURED:**

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

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Westport Insurance Corporation

AGREGATE LOSS LIMIT PER PERSON ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 7(b) is deleted and replaced with the following:

7. **AGGREGATE EXCESS:**

b. Loss Limit Per Person:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

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Westport Insurance Corporation

MONTHLY AGGREGATE REIMBURSEMENT ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

- I. Section One: Definitions is amended by adding Item 25. Monthly Attachment Point as follows:
 25. **MONTHLY ATTACHMENT POINT** shall mean the number of **Employees** within each **Covered Unit** who are covered by the **Plan** on the first day of each month of the **Policy Period** multiplied by the Factor as stated in Schedule Item 7(c)(2). The **Monthly Attachment Point** is cumulative for each month of the **Policy Period**, meaning that the **Monthly Attachment Point** for each prior month is added together to determine the current **Monthly Attachment Point**.
- II. Section Four: Aggregate Excess is hereby amended by adding Item 6. Monthly Aggregate Reimbursement as follows:
 6. **MONTHLY AGGREGATE REIMBURSEMENT.** Subject to all other provisions of the **Policy**, we will reimburse you for **Loss** during the **Policy Period** in excess of the **Monthly Attachment Point** subject to the following conditions:
 - a. For the first three months of the **Policy Period**, no monthly aggregate reimbursements will be made to you.
 - b. After the end of the fourth month of the **Policy Period**, and at the end of each subsequent month of the **Policy Period**, we will reimburse you the amount of **Loss** which exceeds the cumulative **Monthly Attachment Point**, but only if the **Loss** exceeds the **Monthly Attachment Point** by at least \$5,000 (USD).
 - c. The **Loss** will be paid to the **Administrator** within fifteen (15) business days after the requirements of Section Seven: Claims, Item 10, Aggregate Excess Report, Item 11(b) Proof of Loss, Aggregate Excess Claims, and Item 11(c), Proof of Loss, Additional Documentation, have been satisfied by you.
 - d. After the end of the **Policy Period**, if your total **Loss** does not exceed the **Minimum Attachment Point**, as defined in Schedule Item 7(c)(3), you will reimburse us the total amount of **Loss** paid to you via the monthly aggregate reimbursements within fifteen (15) business days after you or the **Administrator** receives our demand for reimbursement. Failure to reimburse us within fifteen (15) business days will result in a two percent (2%) per month penalty until such amounts are paid in full.

- e. After the end of the **Policy Period**, if the total amount of **Loss** paid to you during the **Policy Period** is greater than the total **Loss** due to you under Section Four: Aggregate Excess, Item 2. Aggregate Excess Indemnity for the **Policy Period**, you will reimburse us the difference within fifteen (15) business days after you or the **Administrator** receives our demand for reimbursement. Failure to reimburse us within fifteen (15) business days will result in a two percent (2%) per month penalty until such amounts are paid in full.
- f. If the **Policy** terminates prior to the end of the **Policy Period**, then you or the **Administrator** must reimburse us the total amount of **Loss** paid to you within fifteen (15) business days after the termination date. Failure to reimburse us will result in a two percent (2%) per month penalty until such amounts are paid in full.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

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President

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Westport Insurance Corporation

NON-MEDICAL BENEFITS COVERED SPECIFIC AND AGGREGATE EXCESS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

- I. As of the effective date of this **Endorsement**, Schedule Items 6(f) and 7(g) are deleted and replaced with the following:
 - 6. **SPECIFIC EXCESS:**
 - f. Non-medical Benefits covered:
 - 7. **AGGREGATE EXCESS:**
 - g. Non-medical Benefits covered:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

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Westport Insurance Corporation

NON-MEDICAL BENEFITS COVERED SPECIFIC EXCESS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(f) is deleted and replaced with the following:

6. **SPECIFIC EXCESS:**

f. Non-medical Benefits covered:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

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PARTICIPANT ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

- I. Section One: Definitions, Item 6. Employee is deleted in its entirety and replaced by the following:
 6. **Participant** means any individual who is employed by or otherwise participates in a **Covered Unit** and is eligible for coverage under the terms of the **Plan**. This does not include retired **Participants** or the dependents of retired **Participants** unless otherwise agreed to by us.
- II. Throughout this **Policy**, the term "**Employee**" is hereby deleted and replaced with the term "**Participant**."

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

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President

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Westport Insurance Corporation

PLAN NAME ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 5. Plan Name is deleted and replaced with the following:

5. **PLAN NAME:**

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

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POLICY PERIOD ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

- I. As of the effective date of this **Endorsement**, Schedule Item 4. Policy Period is deleted and replaced with the following:
4. **POLICY PERIOD:**

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

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QUARTERLY PAYMENT OF PREMIUM ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

I. Schedule Item 6. Specific Excess, subsection g. Premium is deleted and replaced with the following:

6. **SPECIFIC EXCESS:**

g. Premium:

Rating Classification

Quarterly Rate

II. Schedule Item 7. Aggregate Excess, subsection h. Monthly Premium Rate is deleted and replaced with the following:

7. **AGGREGATE EXCESS:**

h. Quarterly Premium Rate:

II. Section Two: Premium is deleted in its entirety and replaced with the following:

SECTION TWO: PREMIUM

1. **CALCULATION.** The premium for each three months under the **Policy Period** ("Policy Quarter") that is due and payable to us for coverage under this **Policy** must be calculated by you or the **Administrator** by applying the Rates shown in Schedule Items 6(g) and 7(h) to the number of **Employees** in each **Covered Unit** eligible for coverage under the **Plan** on the first day of each Policy Quarter.
2. **DUE DATE AND QUARTERLY REPORT.** Premium is due on the first day of each Policy Quarter during the **Policy Period**. Each premium payment must be accompanied by a report showing the total number of **Employees** as of the first day of each Policy Quarter covered under the **Policy**. If your **Policy** has more than one Rating Classification, as stated in Schedule Items 6(g), then your report should also reflect a breakout of **Employee** numbers per Rating Classification.
3. **GRACE PERIOD.** A Grace Period of thirty-one (31) days following the premium due date will be granted for the payment of each quarterly premium. Coverage under this **Policy** shall continue in full force and effect during the Grace Period.
4. **NON-PAYMENT.** Failure to pay in full the Policy Quarter premium within the Grace Period will cancel the **Policy** as of the premium due date, which will be the cancellation date of this **Policy**. Partial premium payments made during the Grace Period will be insufficient to avoid cancellation of the **Policy** for non-payment if the full Policy Quarter premium is not paid prior to the expiration of the Grace Period.

5. **REINSTATEMENT.** If any Policy Quarter premium that is due and owing to us is paid after the expiration of the Grace Period, we may at our sole discretion elect to reinstate the **Policy** on the terms and conditions that we select at that time.

6. **ADJUSTMENTS.** If you pay any Policy Quarter premium in excess of the amounts due, you can either: a) request a refund payment from us for the excess amount paid; or b) offset the excess amount paid from the next quarterly premium payment due. A request for refund or a claim offset for a future quarterly premium payment must be given to us in writing, stating the basis and calculation of the excess amount paid. However, no request for a refund or offset of premium will be honored or recognized after ninety (90) days from the end of the month in which the Policy Quarter premium payment amount was adjusted. No Policy Quarter premium adjustments will be allowed after ninety (90) days following the conclusion of the **Policy Period**.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

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SPECIFIC RETENTION EACH PERSON ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(b) is deleted and replaced with the following:

6. **SPECIFIC EXCESS:**

b. Retention each Person:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

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SPECIFIC EXCESS PREMIUM ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(g) is deleted and replaced with the following:

6. **SPECIFIC EXCESS:**

g. Premium:

Rating Classification

Monthly Rate

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

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SPECIFIC INDEMNITY PERCENTAGE ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(c) is deleted and replaced with the following:

6. **SPECIFIC EXCESS:**

c. Indemnity Percentage:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

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SPECIFIC LIABILITY BASIS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

SCHEDULE OF INSURANCE

I. As of the effective date of this **Endorsement**, Schedule Item 6(a) is deleted and replaced with the following:

6. **SPECIFIC EXCESS:**

a. Liability Basis:

(1) Claims Incurred from _____ through _____

(2) Claims Paid from _____ through _____

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

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Westport Insurance Corporation

MAJOR DIAGNOSIS ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY - PLEASE READ IT CAREFULLY

IT IS AGREED that this Policy is hereby amended as follows:

Pursuant to Section Seven: Claims, Item 7, you or the **Administrator** will give us written notice if any covered **Person** has been diagnosed with any of the following ICD-9 Codes or Diagnoses identified in Item I below or otherwise identified in Item II below:

I. Diagnoses	<u>ICD-9 Codes</u>
Accidental Injury classified with an "E" code.	Any "E" code
AIDS	042
Alpha 1 (Antitrypsin Deficiency)	277.6
Amyloidosis	277.3
Anterior Horn Cell Disease	335.2
Blood Disorder (Hemophilia, aplastic anemia sickle cell, primary thrombocytopenia, etc.)	286-287.9
Burn - Severe	941-949
Cancer, Leukemia, Lymphoma, etc.	140-239.9
Cardiomyopathy	425
Cerebral Vascular Disease/Stroke	430-438
Chronic Inflammatory Demylinating Polyneuropathy (CIDP)	356
Congenital Anomalies/Premature Infants	740-779.9
Cystic Fibrosis	277
Gaucher's Disease	272.7
Heart/Lung Disease	416-429
Hepatitis	070
High Risk Pregnancy	640-648, 651, V23.4
Liver Disease	570-573
Multiple Sclerosis	340
Nervous System Disorder	320-389
Pancreatitis	577
Renal Disease	584-587
Respiratory Problem	416 480-482, 496, 513-516, 519
Traumatic Injury - Major (spinal cord, head, trauma, etc.)	800-809, 828-829, 850-54, 860-871, 873-875, 885-887, 895-897, 900-904, 925-929, 952-953

II. ALSO IDENTIFY ANY OF THE FOLLOWING:

- Potential transplants, except cornea (Including transplant rejection or complications).
- Any **Person** with three (3) or more admissions in a six (6) month period.
- Any **Person** with one (1) hospitalization of seven (7) days or more.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

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SPECIFIC TERMINAL LIABILITY OPTION (TLO) ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY - PLEASE READ IT CAREFULLY

IT IS AGREED that the **Policy** is hereby amended as follows:

In the event this **Policy** is cancelled by either party or the **Policy Period** expires and you do not renew coverage with us, but instead become fully insured, the following TLO coverage terms will apply:

For each **Person**, any **Loss Paid** by you within the first ninety (90) days after the end of the **Policy Period** as a result of medical expenses **Incurred** during the **Policy Period** will be subject to the **Policy** coverage as if **Paid** by you during the **Policy Period**.

Schedule Item 6(a) will be amended to reflect the following liability basis for your Specific Excess coverage.

SCHEDULE OF INSURANCE

6. SPECIFIC EXCESS

a. Liability Basis:

(1) Claims Incurred from _____ through _____

(2) Claims Paid from _____ through _____

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

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President

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Westport Insurance Corporation

AGGREGATE TERMINAL LIABILITY OPTION (TLO) ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY - PLEASE READ IT CAREFULLY

IT IS AGREED that the **Policy** is hereby amended as follows:

In the event this **Policy** is cancelled by either party or the **Policy Period** expires and you do not renew coverage with us, but instead become fully insured, the following TLO coverage terms will apply:

For each **Person**, any **Loss Paid** by you within the first ninety (90) days after the end of the **Policy Period** as a result of medical expenses **Incurred** during the **Policy Period** will be subject to the **Policy** coverage as if **Paid** by you during the **Policy Period**.

Schedule Item 7(a) will be amended to reflect the following liability basis for your Aggregate Excess coverage. Schedule Item 7(c) will be amended to reflect your revised Attachment Point criteria.

SCHEDULE OF INSURANCE

7. AGGREGATE EXCESS:

a. Liability Basis:

(1) Claims Incurred from _____ through _____

(2) Claims Paid from _____ through _____

c. Attachment Point:

(1) Estimated Attachment Point

(2) Factor:

(3) Minimum Attachment Point:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

WESTPORT INSURANCE CORPORATION

Facsimile signature to be inserted

Facsimile signature to be inserted

President

Secretary

Westport Insurance Corporation

INTERNATIONAL TRADE CONTROLS AMENDATORY ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that the **Policy** is hereby amended as follows:

- I. Section Six: Exclusions shall be amended to add Item 2 as follows:
 2. **INTERNATIONAL TRADE CONTROLS EXCLUSION.** We will not be deemed to provide coverage, nor shall we be liable to pay any claim or pay any **Benefit** hereunder to the extent that the provision of such coverage, payment of such claim, or provision of such **Benefit** would expose us to any sanction, prohibition or restriction under any United Nations resolutions or the trade or economic sanctions, laws or regulations of any jurisdiction applicable to us.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

WESTPORT INSURANCE CORPORATION

Facsimile signature to be inserted

Facsimile signature to be inserted

President

Secretary

Westport Insurance Corporation

MEDICARE BENEFITS EXCLUSION ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IT IS AGREED that this **Policy** is hereby amended as follows:

- I. As of the effective date of this **Endorsement**, Section Six: Exclusions, Item 1(p) is deleted and replaced with the following:
 - 1. **THIS POLICY DOES NOT APPLY:**
 - p. to Medicare **Benefits** and any **Benefits** which would have been covered by Medicare if not for the fact that the **Person** either i) failed to enroll for Medicare coverage on the earliest possible date entitled, or ii) failed to maintain Medicare coverage previously in force.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

WESTPORT INSURANCE CORPORATION

Facsimile signature to be inserted

Facsimile signature to be inserted

President

Secretary

Westport Insurance Corporation

OTHER CARRIER TRANSPLANT COVERAGE

THIS ENDORSEMENT CHANGES THE POLICY - PLEASE READ IT CAREFULLY

IT IS AGREED that the **Policy** is hereby amended as follows:

I. As of the effective date of this Endorsement, Section Six: Exclusions, Item 1(y) is added as follows:

1. THIS POLICY DOES NOT APPLY:

y. to transplant and transplant related charges **Incurred** during the **Policy Period** if you have purchased a transplant medical indemnity policy through another carrier whose policy covers a period of time coinciding, in total or partially, with the **Policy Period** of this **Policy**. However, our **Policy** will cover such transplant and transplant related charges if a) the **Person** is excluded due to the other carrier's transplant policy pre-existing conditions terms, or b) the transplant and transplant related expense(s) are **Incurred** outside of the other carrier's transplant benefit period as defined by that policy, but with within our **Policy Period**. You will provide us with a copy of the other carrier's transplant medical indemnity policy, including all endorsements, for qualification and adjudication of eligible claims under the **Policy**.

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

WESTPORT INSURANCE CORPORATION

Facsimile signature to be inserted

Facsimile signature to be inserted

President

Secretary

Westport Insurance Corporation

SPECIFIC POLICY PERIOD LIMIT ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY - PLEASE READ IT CAREFULLY

IT IS AGREED that the **Policy** is hereby amended as follows:

- I. As of the effective date of this **Endorsement**, Schedule Item 6(d) Policy Period Limit is deleted and replaced with the following:

SCHEDULE OF INSURANCE

6. **SPECIFIC EXCESS:**

- d. Policy Period Limit:

All other terms and conditions of this **Policy** shall remain unchanged.

This **Endorsement** forms a part of the **Policy** to which attached, effective on the inception date of the **Policy** unless otherwise stated herein.

(The information below is required only when this **Endorsement** is issued subsequent to the preparation of the **Policy**.)

Endorsement Effective

Policy No.

Named Insured

WESTPORT INSURANCE CORPORATION

Facsimile signature to be inserted

Facsimile signature to be inserted

President

Secretary

SERFF Tracking Number: ERCB-127633272 State: Arkansas
 Filing Company: Westport Insurance Corporation State Tracking Number: 49864
 Company Tracking Number: WIC-ESL-AR-11-06144-1-F
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
 Product Name: AR - ESL - Enhanced Stop Loss Program - Form Filing
 Project Name/Number: AR - ESL - Enhanced Stop Loss Program - Form Filing/WIC-ESL-AR-11-06144-1-F

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	10/03/2011
Bypass Reason:	Application, SP 4 291AR 0608, was filed and approved under AR File Number 39461		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/03/2011
Comments:			
Attachment:	Flesch Reading Ease Certification.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Forms Memo	Approved-Closed	10/03/2011
Comments:			
Attachment:	AR Explanation of General Endorsements.pdf		

FLESCH SCORE CERTIFICATION

I, David Newkirk, Vice President of Westport Insurance Corporation do certify that the forms contained in this filing meet the minimum reading ease score on the Flesch Reading Ease as so stated in 23-80-206. The Flesch score for the policy form was 49. The averaged Flesch Reading Ease score on the endorsements was 53.

A handwritten signature in black ink, appearing to read "David Newkirk". The signature is written in a cursive style with a large initial "D".

David Newkirk, Vice President
Westport Insurance Corporation
5200 Metcalf
Overland Park, KS 66201

Westport Insurance Corporation
Excess Medical Indemnity Policy
Excess Stop Loss Enhanced Program
Explanation of General Endorsements

SP 5 149 – Specific No Laser Rate Cap Endorsement - This is an optional endorsement that will be attached to the Policy if the self-insured employer wants to set a higher specific retention level for a unique situation, choosing to absorb more of the costs himself for a particular risk.

SP 5 150 - Add Plan Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to add another self-insured employee benefit Plan onto coverage in mid-Policy Period. For example, at mid Policy Period, the employer offers a Long Term Care benefit Plan to certain high level employees.

SP 5 151- Address Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer's address to be changed in mid-Policy Period.

SP 5 152 - Administrator Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to name a new Administrator in mid-Policy Period.

SP 5 153 - Aggregate Indemnity Limit Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Aggregate Indemnity Limit as provided in Section Four Aggregate Excess paragraph 4 in mid-Policy Period.

SP 5 154 - Aggregate Indemnity Percentage Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Aggregate Indemnity Percentage as provided in Section Four Aggregate Excess Paragraph 2 in mid-Policy Period.

SP 5 155 - Aggregate Liability Basis Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Aggregate Liability Basis in mid-Policy Period.

SP 5 156 - Aggregate Monthly Premium Rate Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Aggregate Monthly Premium Rate in mid-Policy Period.

SP 5 157 - Aggregating Specific Retention Option Endorsement - In addition to the Specific Retention each Person indicated in Schedule Item 6(b), the Employer must also satisfy an aggregate retention for all Persons covered under the Policy. This acts as a second retention. This amount varies based on the size of the group and the specific retention amount.

SP 5 158 - Annual Payment of Premium Endorsement - Under section two of the Policy, premium is Paid on a monthly basis. This Endorsement permits the Employer to remit premium on an annual basis for payment of a deposit Premium on the first day of the Policy Period.

SP 5 159 - Attachment Point Endorsement - A new Schedule is issued with respect to each new Policy Period. This endorsement permits the employer to change the Attachment Point in mid-Policy Period, subject to applicable state regulations.

SP 5 160 - Covered Unit(s) Specific and Aggregate Excess Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to add additional or delete existing Covered Units for Aggregate and Specific Excess in mid-Policy Period. A Covered unit is a particular class of Employees (and the eligible covered dependents of the Employees under the Plan) who are covered under the Plan and indemnified by the Policy. A Covered Unit may be identified by company name, division, location or group.

SP 5 161 - Covered Units Specific Excess Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to add additional or delete existing Covered Units for Specific Excess in mid-Policy Period. A Covered unit is a particular class of Employees (and the eligible covered dependents of the Employees under the Plan) who are covered under the Plan and indemnified by the Policy. A Covered Unit may be identified by company name, division, location or group.

SP 5 162 - Delete Plan Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to delete a self-insured employee benefit Plan from coverage in mid-Policy Period.

SP 5 163 - Insured Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the named Insured in mid-Policy period. Such a change may be necessary, due to a business entity change, such as a merger or acquisition or a business name change.

SP 5 164 - Aggregate Loss Limit Per Person Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Loss Limit Per Person in mid-Policy Period.

SP 5 165 - Monthly Aggregate Reimbursement Endorsement - Paragraph 11 (b) of Section Seven, Claims provides that Westport will reimburse the Employer after the end of the Policy Period for any Aggregate Excess losses. This Endorsement permits Westport to reimburse the Employer for any Aggregate Excess Losses that exceed the Monthly Attachment Point at the end of each month of the Policy Period. At the end of the Policy Period any Losses Paid under this Endorsement are reconciled with any Aggregate Excess Losses which would have been Paid under Section Seven (b) of the Policy.

SP 5 167 - Non-Medical Benefits Covered Specific and Aggregate Excess Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Non-Medical Benefits Covered under the Aggregate and Specific Excess in mid-Policy Period.

SP 5 168 - Non-Medical Benefits Covered Specific Excess Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Non-Medical Benefits Covered under the Specific Excess in mid-Policy Period.

SP 5 169 - Participant Endorsement - Most policies will be issued to self-insured Employers. However, certain Policies may be issued to Associations or other groups in which the Employer/Employee relationship is not as well defined. This Endorsement substitutes the term "Participant" for "Employee" in order to eliminate any inconsistencies.

SP 5 170 - Plan Name Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Plan Name in mid-Policy Period. Such a change may be necessary, due to a business entity change, such as a merger or acquisition or a business name change.

SP 5 172 - Policy Period Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Policy Period in mid-Policy Period.

SP 5 173 - Quarterly Payment of Premium Endorsement - Under Section two of the Policy, Premium is Paid on a monthly basis. This Endorsement permits the Employer to remit premium on a quarterly (every 3 months) basis.

SP 5 174 - Specific Retention Each Person Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the retention each Person in mid-Policy Period subject to applicable state regulations.

SP 5 175 - Specific Excess Premium Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer and Westport to change the Specific Premium in mid-Policy Period due to changes in retention levels, Employees and/or Covered Units eligible for coverage under the Plan.

SP 5 176 - Specific Indemnity Percentage Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Specific Indemnity Percentage as stated under Section three (2) Indemnity in mid-Policy Period.

SP 5 177 - Specific Liability Basis Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Specific Liability Basis in mid-Policy Period.

SP 5 338 - Specific Terminal Liability Option Endorsement - Provides 3 months of paid claim run-out protection on the specific coverage in the event the employer terminates their policy. The claims must be incurred prior to the end of the policy period.

SP 5 339 - Aggregate Liability Basis Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Liability Basis to include Claims incurred within certain dates as indicated on the endorsement and claim paid within dates as indicated on the endorsement.

SP 5 340 - Aggregate Terminal Liability Option Endorsement - Provides 3 months of paid claim run-out protection on the aggregate in the event that the employer terminates their stop loss policy. The claims must be incurred prior to the end of the policy period.

SP 5 341- International Trade Controls Amendatory Endorsement - This endorsement will be optional and will act to clarify our intent not violate U.S. sanctions law in providing excess stop loss coverage. In compliance with the Office of Foreign Assets Control (OFAC) of the US Department of the Treasury advisory 11-16-07, the most reliable approach for insuring risks without violating U.S. sanctions law is to insert in insurance policies an explicit exclusion for risks that would violate U.S. sanctions law. This endorsement inserts the exclusion as stated by the OFAC.

SP 5 342 - Medicare Benefits Exclusion Endorsement - This endorsement clarifies the Medicare benefits exclusion contained within the policy. As this form is adding clarification to an existing exclusion, there is no rate impact.

SP 5 343 - Other Carrier Transplant Coverage - Provides instruction as to coverage for organ transplants when there is an existing transplant medical indemnity policy through another carrier that covers a period of time coinciding with the Policy Period of the Westport policy.

SP 5 344 - Specific Policy Period Limit Endorsement - A new Schedule is issued with respect to each new Policy Period. This Endorsement permits the Employer to change the Specific Policy Period Limit as stated under Section Three in the policy.