

SERFF Tracking Number: WESA-127060961 State: Arkansas
Filing Company: Arch Insurance Company State Tracking Number: 48260
Company Tracking Number: ARCH-11-018
TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.001 Accident & Sickness
Product Name: Arch ESL
Project Name/Number: Arch ESL/ARCH-11-018

Filing at a Glance

Company: Arch Insurance Company

Product Name: Arch ESL

TOI: H12 Health - Excess/Stop Loss

Sub-TOI: H12.001 Accident & Sickness

Filing Type: Form

SERFF Tr Num: WESA-127060961 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 48260

Co Tr Num: ARCH-11-018

State Status: Approved-Closed

Authors: Darcy Lebau, Carolyn
Smart

Reviewer(s): Rosalind Minor

Disposition Date: 05/04/2011

Date Submitted: 03/16/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Arch ESL

Project Number: ARCH-11-018

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 05/04/2011

State Status Changed: 05/04/2011

Created By: Darcy Lebau

Corresponding Filing Tracking Number: ARCH-11-018

Filing Description:

March 16, 2011 via SERFF

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Darcy Lebau

The Honorable Julie Benafield Bowman

Commissioner of Insurance

Arkansas Insurance Department

1200 West Third Street

Little Rock, AR 72201

Attn: Life & Health Division

SERFF Tracking Number: WESA-127060961 State: Arkansas
Filing Company: Arch Insurance Company State Tracking Number: 48260
Company Tracking Number: ARCH-11-018
TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.001 Accident & Sickness
Product Name: Arch ESL
Project Name/Number: Arch ESL/ARCH-11-018

Re: Arch Insurance Company

FEIN#: 43-0990710

NAIC#: 1279 11150

Arch Filing Designation # ARCH-11-018

Specific Transplant Step-Down Deductible Form #00 ESL0001 00 12 10

Endorsement

Aggregating Specific Endorsement Form #00 ESL0002 00 12 10

Domestic Facility Reimbursement Endorsement Form #00 ESL0004 00 12 10

Family Specific Deductible Endorsement Form #00 ESL0006 00 12 10

Separate Specific Deductible or Benefit Form #00 ESL0007 00 12 10

Period Endorsement

Specific Transplant Critical Care Endorsement Form #00 ESL0008 00 12 10

Specific Terminal Liability Option Endorsement Form #00 ESL0009 00 12 10

Application for Stop Loss Insurance Form #00 ESL0010 00 01 11

Administrative Services Only Specific Terminal Form #00 ESL0011 00 01 11

Liability Option Endorsement

Policy Changes Endorsement Form #00 ESL0012 00 01 11

Statement of Variability Form # Form Number

Honorable Commissioner Bowman:

I respectfully submit the amendment form filing referenced above on behalf of Arch Insurance Company ("Arch") for your review and approval prior to use in your state. Westmont Associates, Inc. has been requested to file these forms on behalf of Arch. Please see the enclosed authorization letter.

Your Department approved the original filing on September 30, 2002. Arch has initiated these filings to bring the previously approved forms current with market needs.

For any existing cases, the endorsements may be issued on the respective forms as indicated in this submission and for new cases, we may incorporate the language directly into the policy.

The Employer Stop Loss product will be marketed by licensed agents, brokers, and third party administrators to eligible groups.

In accordance with Arkansas' filing requirements, enclosed please find:

- Readability Certification
- Letter of Authorization
- Forms
- Statement of Variability
- Certificate of Compliance
- Rule 49 Appendix A

SERFF Tracking Number: WESA-127060961 State: Arkansas
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 Product Name: Arch ESL
 Project Name/Number: Arch ESL/ARCH-11-018

• Consumer Information Notice

I thank you in advance for the time spent on this filing and trust that you will find everything in order. Please do not hesitate to contact me directly at 856-216-0220, x 221 or at Darcy@Westmontlaw.com if you have any questions or require additional information.

Respectfully,
 Darcy Lebau
 Darcy Lebau

Company and Contact

Filing Contact Information

Darcy LeBau, darcy@westmontlaw.com
 25 Chestnut Street, Suite 105 856-216-0220 [Phone]
 Haddonfield, NJ 08033

Filing Company Information

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

| | | |
|-----------------------------|-------------------------|-------------------------------------|
| Arch Insurance Company | CoCode: 11150 | State of Domicile: Missouri |
| 300 Plaza Three | Group Code: 1279 | Company Type: Property and Casualty |
| Jersey City, NJ 07311-1107 | Group Name: | State ID Number: |
| (201) 743-4000 ext. [Phone] | FEIN Number: 43-0990710 | |

Filing Fees

| | |
|------------------|--|
| Fee Required? | Yes |
| Fee Amount: | \$50.00 |
| Retaliatory? | Yes |
| Fee Explanation: | Missouri, Arch Insurance Company's state of domicile, charges \$50.00 per form filing. |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|------------------------|----------|----------------|---------------|
| Arch Insurance Company | \$50.00 | 03/16/2011 | 45636847 |
| Arch Insurance Company | \$450.00 | 04/07/2011 | 46384137 |

SERFF Tracking Number: WESA-127060961

State: Arkansas

Filing Company: Arch Insurance Company

State Tracking Number: 48260

Company Tracking Number: ARCH-11-018

TOI: H12 Health - Excess/Stop Loss

Sub-TOI: H12.001 Accident & Sickness

Product Name: Arch ESL

Project Name/Number: Arch ESL/ARCH-11-018

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 05/04/2011 | 05/04/2011 |
| Disapproved | Rosalind Minor | 04/29/2011 | 04/29/2011 |

Objection Letters and Response Letters

Objection Letters

| Status | Created By | Created On | Date Submitted |
|---------------------------|----------------|------------|----------------|
| Pending Industry Response | Rosalind Minor | 03/17/2011 | 03/17/2011 |

Response Letters

| Responded By | Created On | Date Submitted |
|--------------|------------|----------------|
| Darcy Lebau | 05/03/2011 | 05/03/2011 |

Amendments

| Schedule | Schedule Item Name | Created By | Created On | Date Submitted |
|----------|----------------------------|-------------|------------|----------------|
| Form | Policy Changes Endorsement | Darcy Lebau | 04/07/2011 | 04/07/2011 |

Filing Notes

| Subject | Note Type | Created By | Created On | Date Submitted |
|-----------------------------|---------------|----------------|------------|----------------|
| Objection letter of 3/17/11 | Note To Filer | Rosalind Minor | 04/21/2011 | 04/21/2011 |

SERFF Tracking Number: WESA-127060961 *State:* Arkansas
Filing Company: Arch Insurance Company *State Tracking Number:* 48260
Company Tracking Number: ARCH-11-018
TOI: H12 Health - Excess/Stop Loss *Sub-TOI:* H12.001 Accident & Sickness
Product Name: Arch ESL
Project Name/Number: Arch ESL/ARCH-11-018

Disposition

Disposition Date: 05/04/2011

Implementation Date:

Status: Approved-Closed

Comment:

This submission has been re-opened in order to revise and replace Form 00 ESL0010 00 01 11 with 00 ESL0010 04 05 11.

The entire submission is approved effective on this date.

Rate data does NOT apply to filing.

SERFF Tracking Number: WESA-127060961 State: Arkansas
 Filing Company: Arch Insurance Company State Tracking Number: 48260
 Company Tracking Number: ARCH-11-018
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.001 Accident & Sickness
 Product Name: Arch ESL
 Project Name/Number: Arch ESL/ARCH-11-018

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---------------------|---|----------------------|---------------|
| Supporting Document | Application | Approved-Closed | Yes |
| Supporting Document | Flesch Certification | Approved-Closed | Yes |
| Supporting Document | Letter of Authorization | Approved-Closed | Yes |
| Supporting Document | Statement of Variability is attached. | Approved-Closed | Yes |
| Supporting Document | Cover Letter | Approved-Closed | Yes |
| Form | Specific Transplant Step-Down Deductible Endorsement | Approved-Closed | Yes |
| Form | Aggregating Specific Endorsement | Approved-Closed | Yes |
| Form | Domestic Facility Reimbursement Endorsement | Approved-Closed | Yes |
| Form | Family Specific Deductible | Approved-Closed | Yes |
| Form | Separate Specific Deductible or Benefit Period Endorsement | Approved-Closed | Yes |
| Form | Specific Transplant Critical Care Endorsement | Approved-Closed | Yes |
| Form | Specific Terminal Liability Option Endorsement | Approved-Closed | Yes |
| Form (revised) | Arkansas Application for Stop Loss Insurance | Approved-Closed | Yes |
| Form | Administrative Services Only Specific Terminal Liability Option Endorsement | Approved-Closed | Yes |
| Form (revised) | Policy Changes Endorsement | Approved-Closed | Yes |
| Form | Application for Stop Loss Insurance | Replaced | Yes |
| Form | Policy Changes Endorsement | Replaced | Yes |

SERFF Tracking Number: WESA-127060961 *State:* Arkansas
Filing Company: Arch Insurance Company *State Tracking Number:* 48260
Company Tracking Number: ARCH-11-018
TOI: H12 Health - Excess/Stop Loss *Sub-TOI:* H12.001 Accident & Sickness
Product Name: Arch ESL
Project Name/Number: Arch ESL/ARCH-11-018

Disposition

Disposition Date: 04/29/2011

Implementation Date:

Status: Disapproved

Comment:

This submission is being disapproved since I have not received a response to my Objection Letter of 3/17/11 nor my Note to Filer on 4/21/11.

Rate data does NOT apply to filing.

SERFF Tracking Number: WESA-127060961 State: Arkansas
 Filing Company: Arch Insurance Company State Tracking Number: 48260
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 Product Name: Arch ESL
 Project Name/Number: Arch ESL/ARCH-11-018

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---------------------|---|----------------------|---------------|
| Supporting Document | Application | Approved-Closed | Yes |
| Supporting Document | Flesch Certification | Approved-Closed | Yes |
| Supporting Document | Letter of Authorization | Approved-Closed | Yes |
| Supporting Document | Statement of Variability is attached. | Approved-Closed | Yes |
| Supporting Document | Cover Letter | Approved-Closed | Yes |
| Form | Specific Transplant Step-Down Deductible Endorsement | Approved-Closed | Yes |
| Form | Aggregating Specific Endorsement | Approved-Closed | Yes |
| Form | Domestic Facility Reimbursement Endorsement | Approved-Closed | Yes |
| Form | Family Specific Deductible | Approved-Closed | Yes |
| Form | Separate Specific Deductible or Benefit Period Endorsement | Approved-Closed | Yes |
| Form | Specific Transplant Critical Care Endorsement | Approved-Closed | Yes |
| Form | Specific Terminal Liability Option Endorsement | Approved-Closed | Yes |
| Form (revised) | Arkansas Application for Stop Loss Insurance | Approved-Closed | Yes |
| Form | Administrative Services Only Specific Terminal Liability Option Endorsement | Approved-Closed | Yes |
| Form (revised) | Policy Changes Endorsement | Approved-Closed | Yes |
| Form | Application for Stop Loss Insurance | Replaced | Yes |
| Form | Policy Changes Endorsement | Replaced | Yes |

SERFF Tracking Number: WESA-127060961 State: Arkansas
Filing Company: Arch Insurance Company State Tracking Number: 48260
Company Tracking Number: ARCH-11-018
TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.001 Accident & Sickness
Product Name: Arch ESL
Project Name/Number: Arch ESL/ARCH-11-018

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 03/17/2011

Submitted Date 03/17/2011

Respond By Date

Dear Darcy LeBau,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application for Stop Loss Insurance, 00 ESL0010 00 01 11 (Form)

Comment:

The application must contain a notice as outlined under our Bulletin 6-2008. The language for that bulletin is outlined below:

Bulletin 6-2008

Applications for stop loss insurance policies

TO: ALL LICENSED INSURANCE COMPANIES, HEALTH MAINTENANCE ORGANIZATIONS, HOSPITAL MEDICAL SERVICE CORPORATIONS, RATE SERVICE OR ADVISORY ORGANIZATIONS, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AND OTHER INTERESTED PARTIES

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: APPLICATIONS FOR STOP LOSS INSURANCE POLICIES

EFFECTIVE DATE: June 1, 2008

DATE: April 3, 2008

The Arkansas Insurance Department ("Department") is issuing this Bulletin on applications for stop loss insurance policies to set forth the Department's position regarding Ark. Code Ann. § 23-62-111. It is the Department's position that a disclosure to policyholders is needed to inform the employer/applicant that the purchase of stop loss coverage does not fully relieve the employer of all potential risks. This Bulletin shall apply to all applications used by all insurance companies selling stop loss policies to self-funded medical plans.

SERFF Tracking Number: WESA-127060961 State: Arkansas
Filing Company: Arch Insurance Company State Tracking Number: 48260
Company Tracking Number: ARCH-11-018
TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.001 Accident & Sickness
Product Name: Arch ESL
Project Name/Number: Arch ESL/ARCH-11-018

Accordingly, the Department will require the following notice to be added to all applications for stop loss insurance. This requirement will apply to stop loss policies written by accident and health carriers as well as casualty carriers that are writing this type of policy.

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

To comply with this requirement:

1. Carriers may add this notice to their stop loss applications and file the applications with the Department for approval. If the amended application is filed electronically with a certification that the only change is the addition of above Notice along with the \$20 filing fee, the Insurance Department will process the filing within two business days; or
2. If after the effective date of this Bulletin any carrier has not filed an amended application for approval, carriers should deliver a copy of the required disclosure notice with their stop loss applications including a signature section whereby the applicant acknowledges the receipt of the disclosure notice.
3. All stop loss applications used in this State after December 31, 2008 must include the required Notice.

Questions concerning this Bulletin should be directed to the Arkansas Insurance Department Legal Division at 501-371-2820 or by e-mail to legal.division@arkansas.gov .

Objection 2

- Specific Transplant Step-Down Deductible Endorsement, 00 ESL0001 00 12 10 (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 \$500.00. Please submit an additional \$450.00 for this submission.

SERFF Tracking Number: WESA-127060961 *State:* Arkansas
Filing Company: Arch Insurance Company *State Tracking Number:* 48260
Company Tracking Number: ARCH-11-018
TOI: H12 Health - Excess/Stop Loss *Sub-TOI:* H12.001 Accident & Sickness
Product Name: Arch ESL
Project Name/Number: Arch ESL/ARCH-11-018

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

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: WESA-127060961 State: Arkansas
Filing Company: Arch Insurance Company State Tracking Number: 48260
Company Tracking Number: ARCH-11-018
TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.001 Accident & Sickness
Product Name: Arch ESL
Project Name/Number: Arch ESL/ARCH-11-018

Response Letter

Response Letter Status Submitted to State
Response Letter Date 05/03/2011
Submitted Date 05/03/2011

Dear Rosalind Minor,

Comments:

Good morning, Rosalind.

Thank you for reopening this filing. Please accept this Response Letter as Arch Insurance Company's response to your objection letter dated March 17, 2011.

Response 1

Comments: Please see attached revised Application form.

Related Objection 1

Applies To:

- Application for Stop Loss Insurance, 00 ESL0010 00 01 11 (Form)

Comment:

The application must contain a notice as outlined under our Bulletin 6-2008. The language for that bulletin is outlined below:

Bulletin 6-2008

Applications for stop loss insurance policies

TO: ALL LICENSED INSURANCE COMPANIES, HEALTH MAINTENANCE ORGANIZATIONS, HOSPITAL MEDICAL SERVICE CORPORATIONS, RATE SERVICE OR ADVISORY ORGANIZATIONS, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AND OTHER INTERESTED PARTIES

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: APPLICATIONS FOR STOP LOSS INSURANCE POLICIES

EFFECTIVE DATE: June 1, 2008

SERFF Tracking Number: WESA-127060961 *State:* Arkansas
Filing Company: Arch Insurance Company *State Tracking Number:* 48260
Company Tracking Number: ARCH-11-018
TOI: H12 Health - Excess/Stop Loss *Sub-TOI:* H12.001 Accident & Sickness
Product Name: Arch ESL
Project Name/Number: Arch ESL/ARCH-11-018

DATE: April 3, 2008

The Arkansas Insurance Department ("Department") is issuing this Bulletin on applications for stop loss insurance policies to set forth the Department's position regarding Ark. Code Ann. § 23-62-111. It is the Department's position that a disclosure to policyholders is needed to inform the employer/applicant that the purchase of stop loss coverage does not fully relieve the employer of all potential risks. This Bulletin shall apply to all applications used by all insurance companies selling stop loss policies to self-funded medical plans.

Accordingly, the Department will require the following notice to be added to all applications for stop loss insurance. This requirement will apply to stop loss policies written by accident and health carriers as well as casualty carriers that are writing this type of policy.

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

To comply with this requirement:

1. Carriers may add this notice to their stop loss applications and file the applications with the Department for approval. If the amended application is filed electronically with a certification that the only change is the addition of above Notice along with the \$20 filing fee, the Insurance Department will process the filing within two business days; or
2. If after the effective date of this Bulletin any carrier has not filed an amended application for approval, carriers should deliver a copy of the required disclosure notice with their stop loss applications including a signature section whereby the applicant acknowledges the receipt of the disclosure notice.
3. All stop loss applications used in this State after December 31, 2008 must include the required Notice.

Questions concerning this Bulletin should be directed to the Arkansas Insurance Department Legal Division at 501-371-2820 or by e-mail to legal.division@arkansas.gov .

SERFF Tracking Number: WESA-127060961 State: Arkansas
 Filing Company: Arch Insurance Company State Tracking Number: 48260
 Company Tracking Number: ARCH-11-018
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.001 Accident & Sickness
 Product Name: Arch ESL
 Project Name/Number: Arch ESL/ARCH-11-018

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

| Form Name | Form Number | Edition Date | Form Type | Action | Action Specific Data | Readability Score | Attach Document |
|--|---------------|--------------|-----------------------------|---------|----------------------|-------------------|--|
| Arkansas Application for Stop Loss Insurance | 00 ESL0010 | 04 05 11 | Application/Enrollment Form | Initial | | 50.200 | AR APPLICA TION 00 ESL0010 00 01 11.pdf |

Previous Version

| | | | | | | | |
|-------------------------------------|---------------|----------|-----------------------------|---------|--|--------|--|
| Application for Stop Loss Insurance | 00 ESL0010 | 00 01 11 | Application/Enrollment Form | Initial | | 50.200 | APPLICA TION 00 ESL0010 00 01 11.pdf |
|-------------------------------------|---------------|----------|-----------------------------|---------|--|--------|--|

No Rate/Rule Schedule items changed.

Response 2

Comments: The additional filing fee has been submitted.

Related Objection 1

Applies To:

- Specific Transplant Step-Down Deductible Endorsement, 00 ESL0001 00 12 10 (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 \$500.00. Please submit an additional \$450.00 for this submission.

SERFF Tracking Number: WESA-127060961 *State:* Arkansas
Filing Company: Arch Insurance Company *State Tracking Number:* 48260
Company Tracking Number: ARCH-11-018
TOI: H12 Health - Excess/Stop Loss *Sub-TOI:* H12.001 Accident & Sickness
Product Name: Arch ESL
Project Name/Number: Arch ESL/ARCH-11-018

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.

Thank you for your time and attention to this filing.

Respectfully,

Darcy Lebau

Sincerely,

Carolyn Smart, Darcy Lebau

SERFF Tracking Number: WESA-127060961 *State:* Arkansas
Filing Company: Arch Insurance Company *State Tracking Number:* 48260
Company Tracking Number: ARCH-11-018
TOI: H12 Health - Excess/Stop Loss *Sub-TOI:* H12.001 Accident & Sickness
Product Name: Arch ESL
Project Name/Number: Arch ESL/ARCH-11-018

Note To Filer

Created By:

Rosalind Minor on 04/21/2011 09:17 AM

Last Edited By:

Rosalind Minor

Submitted On:

04/29/2011 01:26 PM

Subject:

Objection letter of 3/17/11

Comments:

On 3/17/11 I sent you an objection letter stating that the application that was attached under the Supporting Documentation tab, must have certain language that it outlined under our Bulletin 6-2008. As of this date, the application has not been revised.

If a revised application is not received by April 29, 2011, the filing will be disapproved.

We appreciate your cooperation in this matter.

SERFF Tracking Number: WESA-127060961 State: Arkansas
 Filing Company: Arch Insurance Company State Tracking Number: 48260
 Company Tracking Number: ARCH-11-018
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.001 Accident & Sickness
 Product Name: Arch ESL
 Project Name/Number: Arch ESL/ARCH-11-018

Amendment Letter

Submitted Date: 04/07/2011

Comments:

Good afternoon.

By this Amendment, the undersigned has uploaded a revised Policy Changes Endorsement.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

| Form Number | Form Type | Form Name | Action | Form Action Other | Previous Filing # | Replaced Form # | Readability Score | Attachments |
|-------------|---------------|---|---------|-------------------|-------------------|-----------------|-------------------|--|
| 00 ESL0012 | Policy/Contr | Policy | Initial | | | | 50.200 | ESL Policy Endorsement 00 ESL0012 00 01 11.docV2.pdf |
| 00 01 11 | act/Fraternal | Changes Certificate: Endorsemen Amendment, t Insert Page, Endorsemen t or Rider | | | | | | |

SERFF Tracking Number: WESA-127060961 State: Arkansas
 Filing Company: Arch Insurance Company State Tracking Number: 48260
 Company Tracking Number: ARCH-11-018
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.001 Accident & Sickness
 Product Name: Arch ESL
 Project Name/Number: Arch ESL/ARCH-11-018

Form Schedule

Lead Form Number: 00 ESL0012 00 01 11

| Schedule Item | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|-----------------------------------|---------------------------|-----------------------------------|--|---------|----------------------|-------------|---|
| Approved- Closed 05/04/2011 | 00 ESL0001 00 12 10 | Policy/Cont ract/Fratern al | Specific Transplant Step-Down Deductible Certificate: Endorsement Amendmen t, Insert Page, Endorseme nt or Rider | Initial | | 50.200 | Specific Transplant Step Down Deductible End 00ESL000100 1210.pdf |
| Approved- Closed 05/04/2011 | 00 ESL0002 00 12 10 | Policy/Cont ract/Fratern al | Aggregating Specific Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider | Initial | | 50.200 | Aggregating Specific End 00ESL000200 1210.pdf |
| Approved- Closed 05/04/2011 | 00 ESL0004 00 12 10 | Policy/Cont ract/Fratern al | Domestic Facility Reimbursement Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider | Initial | | 50.200 | Domestic Reimburseme nt End 00ESL000400 1210.pdf |
| Approved- Closed 05/04/2011 | 00 ESL0006 00 12 10 | Policy/Cont ract/Fratern al | Family Specific Deductible Certificate: | Initial | | 50.200 | Family Specific Deductible End |

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|--------------------------|------------------------------------|------------------------|-----------------------------|
| SERFF Tracking Number: | WESA-127060961 | State: | Arkansas |
| Filing Company: | Arch Insurance Company | State Tracking Number: | 48260 |
| Company Tracking Number: | ARCH-11-018 | | |
| TOI: | H12 Health - Excess/Stop Loss | Sub-TOI: | H12.001 Accident & Sickness |
| Product Name: | Arch ESL | | |
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| Closed | Enrollment for Stop Loss | | |
| 05/04/2011 | Form Insurance | | |
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|---------------------------------|--------------------------------------|-------------------------------|--|
| <i>SERFF Tracking Number:</i> | <i>WESA-127060961</i> | <i>State:</i> | <i>Arkansas</i> |
| <i>Filing Company:</i> | <i>Arch Insurance Company</i> | <i>State Tracking Number:</i> | <i>48260</i> |
| <i>Company Tracking Number:</i> | <i>ARCH-11-018</i> | | |
| <i>TOI:</i> | <i>H12 Health - Excess/Stop Loss</i> | <i>Sub-TOI:</i> | <i>H12.001 Accident & Sickness</i> |
| <i>Product Name:</i> | <i>Arch ESL</i> | | |
| <i>Project Name/Number:</i> | <i>Arch ESL/ARCH-11-018</i> | | |
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THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

SPECIFIC TRANSPLANT STEP-DOWN DEDUCTIBLE ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached as of the Effective Date shown below. This Endorsement applies only to Losses that occur on or after the Effective Date. This Endorsement ends at the same time as the Policy. This Endorsement is subject to all of the provisions, terms and limitations of the Policy, excepts as they are changed by it.

[Any changes in premium apply as of the first premium due date on or after the Effective date of this Endorsement.]

It is agreed that the above Policy is endorsed on the Policy Effective Date as follows:

SECTION 4 – SPECIFIC STOP LOSS INSURANCE is endorsed as follows:

For Losses for organ or tissue transplants that are performed at a preapproved centers of excellence network facility at the contracted rate, the Covered Person's Specific Deductible Amount will be reduced by [\$10,000] [15%] .

All other terms and conditions of the Policy remain unchanged.

Endorsement Number:

Policy Number:

Named Insured:

This endorsement is effective on the inception date of this policy unless otherwise stated herein.

Endorsement Effective Date:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

AGGREGATING SPECIFIC ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached as of the Effective Date shown below. This Endorsement applies only to Losses that occur on or after the Effective Date. This Endorsement ends at the same time as the Policy. This Endorsement is subject to all of the provisions, terms and limitations of the Policy, excepts as they are changed by it.

[Any changes in premium apply as of the first premium due date on or after the Effective date of this Endorsement.]

It is agreed that the above Policy is endorsed on the Policy Effective Date as follows:

SECTION 1 - SCHEDULE OF STOP LOSS INSURANCE is endorsed as follows:

B. SPECIFIC/INDIVIDUAL STOP LOSS INSURANCE

7. AGGREGATING SPECIFIC DEDUCTIBLE:

SECTION 2 - DEFINITIONS is endorsed to include the following:

AGGREGATING SPECIFIC DEDUCTIBLE is a deductible applied in addition to the Specific Deductible Amount. At the start of the Policy Year, Losses for each Covered Person in excess of the Specific Deductible Amount multiplied by the Benefit Percentage Payable In Excess Of the Specific Deductible will be added together until the cumulative total equals the Aggregating Specific Deductible amount shown in the Schedule of Stop Loss Insurance. A Specific Stop Loss reimbursement subject to the Maximum Specific Benefit is not paid until the Aggregate Specific Deductible has been satisfied.

All other terms and conditions of the Policy remain unchanged.

Endorsement Number:

Policy Number:

Named Insured:

This endorsement is effective on the inception date of this policy unless otherwise stated herein.

Endorsement Effective Date:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

DOMESTIC FACILITY REIMBURSEMENT ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached as of the Effective Date shown below. This Endorsement applies only to Losses that occur on or after the Effective Date. This Endorsement ends at the same time as the Policy. This Endorsement is subject to all of the provisions, terms and limitations of the Policy, excepts as they are changed by it.

[Any changes in premium apply as of the first premium due date on or after the Effective date of this Endorsement.]

It is agreed that the above Policy is endorsed on the Policy Effective Date as follows:

SECTION 1 - SCHEDULE OF STOP LOSS INSURANCE is endorsed as follows:

Number A. 4. is deleted and replaced with the following:

A. AGGREGATE STOP LOSS INSURANCE

4. BENEFIT PERCENTAGE PAYABLE IN EXCESS OF THE AGGREGATE ATTACHMENT POINT: .

[Losses for treatment rendered at the Your facilities (Domestic Losses): [80%]
Losses for treatment rendered at outside facilities (Foreign Losses): [100%]]

Number B. 4. is deleted and replaced with the following:

B. SPECIFIC/INDIVIDUAL STOP LOSS INSURANCE

4. BENEFIT PERCENTAGE PAYABLE IN EXCESS OF THE SPECIFIC DEDUCTIBLE

[Losses for treatment rendered at the Your facilities (Domestic Losses): [80%]
Losses for treatment rendered at outside facilities (Foreign Losses): [100%]]

All other terms and conditions of the Policy remain unchanged.

Endorsement Number:

Policy Number:

Named Insured:

This endorsement is effective on the inception date of this policy unless otherwise stated herein.

Endorsement Effective Date:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FAMILY SPECIFIC DEDUCTIBLE ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached as of the Effective Date shown below. This Endorsement applies only to Losses that occur on or after the Effective Date. This Endorsement ends at the same time as the Policy. This Endorsement is subject to all of the provisions, terms and limitations of the Policy, excepts as they are changed by it.

[Any changes in premium apply as of the first premium due date on or after the Effective date of this Endorsement.]

It is agreed that the above Policy is endorsed on the Policy Effective Date as follows:

SECTION 1 - SCHEDULE OF STOP LOSS INSURANCE is endorsed as follows:

B. SPECIFIC/INDIVIDUAL STOP LOSS INSURANCE

3. **DEDUCTIBLE PER COVERED FAMILY**

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

SECTION 2 - DEFINITIONS is endorsed to include the following

COVERED FAMILY shall have the same meaning as COVERED PERSON.

All other terms and conditions of the Policy remain unchanged.

Endorsement Number:

Policy Number:

Named Insured:

This endorsement is effective on the inception date of this policy unless otherwise stated herein.

Endorsement Effective Date:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

SEPARATE SPECIFIC DEDUCTIBLE OR BENEFIT PERIOD ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached as of the Effective Date shown below. This Endorsement applies only to Losses that occur on or after the Effective Date. This Endorsement ends at the same time as the Policy. This Endorsement is subject to all of the provisions, terms and limitations of the Policy, excepts as they are changed by it.

[Any changes in premium apply as of the first premium due date on or after the Effective date of this Endorsement.]

It is agreed that the above Policy is endorsed on the Policy Effective Date as follows:

SECTION 1 - SCHEDULE OF STOP LOSS INSURANCE is endorsed as follows:

A. AGGREGATE STOP LOSS INSURANCE

For COVERED PERSON [COVERED FAMILY] :

Number A. 2. is deleted and replaced with the following:

2. POLICY BASIS/BENEFIT PERIOD:

Eligible Expenses Incurred from through ; and
Eligible Expenses Paid from through

B. SPECIFIC/INDIVIDUAL STOP LOSS INSURANCE

For COVERED PERSON [COVERED FAMILY] :

Numbers B. 2, 3 and 5 are deleted and replaced with the following:

2. POLICY BASIS/BENEFIT PERIOD:

Eligible Expenses Incurred from through ; and
Eligible Expenses Paid from through

3. DEDUCTIBLE PER COVERED PERSON [COVERED FAMILY] :

5. MAXIMUM SPECIFIC BENEFIT PAYABLE MINUS THE SPECIFIC DEDUCTIBLE (PER LIFETIME PER COVERD PERSON [COVERED FAMILY]), WHILE THIS POLICY IS IN FORCE:

All other terms and conditions of the Policy remain unchanged.

Endorsement Number:

Policy Number:

Named Insured:

This endorsement is effective on the inception date of this policy unless otherwise stated herein.

Endorsement Effective Date:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

SPECIFIC TRANSPLANT CRITICAL CARE ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached as of the Effective Date shown below. This Endorsement applies only to Losses that occur on or after the Effective Date. This Endorsement ends at the same time as the Policy. This Endorsement is subject to all of the provisions, terms and limitations of the Policy, excepts as they are changed by it.

[Any changes in premium apply as of the first premium due date on or after the Effective date of this Endorsement.]

It is agreed that the above Policy is endorsed on the Policy Effective Date as follows:

SECTION 1 – SCHEDULE OF STOP LOSS INSURANCE is endorsed as follows:

B. SPECIFIC/INDIVIDUAL STOP LOSS INSURANCE:

7. TRANSPLANT POLICY BASIS/BENEFIT PERIOD:

Benefit Period: The period that begins 10 consecutive days before the Organ Tissue Transplant is performed and ends 12 consecutive months after the date of surgery. For a bone marrow tissue transplant, the date the marrow is reinfused is deemed the date of the transplant.

Policy Basis: Eligible services incurred 12 consecutive months from the date of transplant for transplants that take place during the Policy Year. Eligible services paid/reported/filed within [14] months from the end of the Policy Year.

If this Policy terminates prior to the Expiration Date and a Covered Person has established a Transplant Benefit Period for which benefits are not exhausted, benefits will be paid for the remaining part of the Transplant Benefit Period as if such coverage had not ended. Benefits will be based on the plan in force for that Covered Person on the date this Policy terminated.

8. TRANSPLANT DEDUCTIBLE PER TRANSPLANT PER COVERED PERSON:

9. BENEFIT PERCENTAGE PAYABLE IN EXCESS OF THE SPECIFIC TRANSPLANT DEDUCTIBLE: [_____ IN-NETWORK AND _____ OUT-OF-NETWORK]

10. MAXIMUM SPECIFIC TRANSPLANT BENEFIT PAYABLE MINUS THE SPECIFIC TRANSPLANT DEDUCTIBLE (PER [LIFETIME or POLICY YEAR] PER COVERED PERSON), WHILE THIS POLICY IS IN FORCE:

11. SPECIFIC MONTHLY TRANSPLANT PREMIUM RATE:

Single: Family: Composite:

SECTION 2 - DEFINITIONS is endorsed as follows:

AIR AMBULANCE means the conveyance of a Donor, organ, or patient by means of a private non-scheduled airline when the life of the patient or the viability of the organ to be transplanted may not be sustained by normal commercial means of transportation.

ALLOGENEIC BONE MARROW TRANSPLANT means a harvest of stem cells, whether from the bone marrow or the peripheral blood, from a third party Donor, for reinfusion into a Recipient. It includes the procedure known as alleric peripheral stem cell transplant.

AUTOLOGOUS BONE MARROW TRANSPLANT means a harvest of stem cells, whether from the bone marrow or peripheral blood, to remedy damage to or suppression of the Covered Person's bone marrow or blood forming system resulting from the receipt of chemotherapy or radiation therapy. It includes the procedure known as autologous peripheral stem cell transplant.

COMPANION means a spouse, parent or person chosen by the Organ or Tissue Transplant Recipient to accompany the Recipient to the Hospital. If the Recipient is a minor, two Companions may accompany the minor to such Hospital.

CONSECUTIVE DAYS OF CONFINEMENT means that a Covered Person's stay in the Transplant Hospital or Transplant Facility is not separated by three (3) days of discharge from the inpatient department of the Transplant Hospital or Transplant Facility performing the transplant. In the case of a Hospital Facility or Transplant Facility that performs the Transplants in an Inpatient/Outpatient scheduled program, consecutive days shall be counted as those consecutive days within the inpatient and scheduled outpatient departments of the Hospital Facility or Transplant Facility performing the Transplant procedure. Consecutive stays will be separated by a three (3) day discharge from the inpatient and outpatient departments of the Hospital Facility or Transplant Facility performing the procedure.

DONOR means a live or cadaveric person donating an organ for the sole purpose of reinfusing, transfusing, or transplanting.

IN-NETWORK HOSPITAL means any Hospital, Skilled Nursing Facility, or Provider with which We or Our designee have a specific agreement or contract to perform a covered service or treatment at an agreed upon rate under the Organ/Tissue Transplant Benefit Plan.

ORGAN TRANSPLANT means the surgical removal from one person to another of any of the organs described in the Organ/Tissue Transplant Benefit Plan.

OUT OF NETWORK HOSPITAL means any Hospital, Skilled Nursing Facility or Provider that does not have a special agreement or contract with Us or Our designee to provide a covered service or treatment under the Organ/Tissue Transplant Benefit Plan.

HARVEST AND PROCUREMENT. All medically necessary services related to the harvest and/or acquisition of solid organs, blood, bone marrow or peripheral stem cells, are covered services: *Provided, however,* that such harvesting or acquisition must be performed for the purpose of providing a Covered Transplant Procedure for a Member of a Plan which is covered by the Agreement. Such services include, but are not limited to: (1) surgical services for the harvest or acquisition of solid organs, bone marrow or peripheral stem cells; (2) hospitalization for up to two days for bone marrow puncture or for organ harvesting; (3) processing and storage of organs, bone marrow or peripheral stem cells for up to a thirty-day period; (4) purging or manipulation of bone marrow or blood; and (5) other services directly related to or part of harvest or acquisition. Notwithstanding the foregoing, in the case of a living donor, services required by complications arising from the donation shall not be considered covered services.

RECIPIENT means a Covered Person who is the subject of a Covered Transplant Procedure.

TISSUE TRANSPLANT means the surgical transfer of Bone Marrow from one person to another (Allogeneic Bone Marrow Transplant) or from self to self (Autologous Bone Marrow Transplant).

TRANSPLANT EVALUATION means an evaluation by a Transplant Hospital or Transplant Facility to determine whether or not an organ or tissue transplant would be a Medically Necessary

and appropriate treatment.

TRANSPLANT HOSPITAL or TRANSPLANT FACILITY means a Hospital that is equipped to perform an Organ or Tissue Transplant and is recognized in the medical community as specializing in the performance of Organ or Tissue Transplant.

TRANSPLANT PERIOD means the period of time described in the Organ/Tissue Transplant Benefit Plan. Two or more Transplant Periods will be treated as separate Transplant Periods if:

1. They are due to unrelated causes; or
2. They are due to related causes and the Transplant Periods are separated by 6 consecutive months, and the Covered Person is not confined at home or in a Transplant Hospital or Transplant Facility or Skilled Nursing Facility on the day immediately preceding the second Transplant Period.

TRANSPLANT RELATED SERVICES. All medically necessary services resulting from and/or directly related to a Covered Transplant Procedure are covered services. Such services include, but are not limited to: (1) services provided by the transplant facility; (2) hospital or skilled nursing facility services (including, but not limited to, room and board, pharmacy, chemotherapy, and radiation and other normal and customary services/supplies); (3) physician services; (4) nursing services, including private duty nursing; (5) outpatient treatment and follow-up; (6) speech, physical and/or occupational therapy; (7) anesthesia and anesthesia services; (8) radiology services; (9) laboratory services; (10) oxygen; (11) durable medical equipment; (12) blood, blood products, and blood transfusions; (13) dressings; and (14) pharmacy, including anti-rejection drugs. A service shall be considered "resulting from and/or directly related to" a Covered Transplant Procedure if: (1) the service in question is normally and customarily associated with, or otherwise necessitated by, the Covered Transplant Procedure and/or the post-transplant recovery process; or (2) the service in question is provided in response to, or is necessitated by, complications arising in whole or material part from the Covered Transplant Procedure.

TRANSPORTATION means if the Recipient's covered transplant procedure is performed at a participating Transplant Hospital that is in excess of 50 miles of the Recipient's home, We will pay the Eligible Expenses incurred by the Recipient and a Companion for transportation to and from the site of the participating Transplant Hospital where the Covered Transplant Procedure is performed. If the Recipient is a minor, transportation benefits will be provided for up to two persons who travel with such Recipient. Air flights are limited to 2 round trip flights per eligible companion. All trips and means of transportation must be approved by the transplant case manager. Benefits will be limited to the number of trips and Transportation, Lodging, and Meals Maximum indicated in the Schedule. Itemized receipts are required to support all such expenses.

LODGING AND MEALS means if the Recipient's Covered Transplant Procedure is performed at a participating Transplant Hospital, We will pay the Covered Charges incurred for lodging and meals incurred by the Recipient's companion(s) during the time the Recipient is confined to the participating Transplant Hospital and/or Extended Care Facility due to the Covered Transplant Procedure. Benefits for lodging and meals will be limited to the Lodging and Meals Daily maximum amount shown in the Schedule. Benefits will not exceed the Transportation, Lodging, and Meals maximum shown in the Schedule. Itemized receipts are required to support all such expenses.

SECTION 4 – SPECIFIC STOP LOSS INSURANCE is endorsed as follows:

The following under "Payment of Policy benefits is deleted:

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

And replaced with:

Payment will not include: A. any amounts paid or payable by Us to You for Aggregate Stop Loss Insurance according to the terms in [Section 3] of this Policy; or B. charges and/or expenses in connection with organ and tissue transplant procedures which are covered under the Specific Organ/Tissue Transplant Benefit are not Eligible Expenses under the Specific Stop Loss Insurance. Without limiting the foregoing, this Policy will not cover charges and/or expenses for co-payments or deductible amounts which are not covered under the Specific Organ/Tissue Transplant Benefit in connection with such organ and tissue transplant procedures.

Specific Organ/Tissue Transplant Benefit

This Benefit pays for Eligible Expenses incurred for the medical care and treatment of a Covered Person for services and supplies furnished in connection with the following Covered Organ or Tissue Transplant Procedure: [bone marrow, heart, heart and lung, lung, double lung, liver, liver and kidney, kidney, pancreas, pancreas after kidney, simultaneous pancreas and kidney, intestine] .

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

1. the amount by which Transplant related Losses Paid during the Benefit Period exceed the Specific Transplant Deductible Amount as shown in the Schedule multiplied by:
2. the Benefit Percentage Payable for Specific Stop Loss Insurance as shown in the Schedule, subject to:

IN-NETWORK

Covered Percent: [100%] of the Eligible Expenses, subject to the following:

NMDP Search and Registry Benefit: [\$15,000] related to a covered transplant limited to [\$2,000] per search.

Maximum Organ Procurement Benefit Non-living Donor: [100%] during any Transplant Period

Maximum Organ Procurement Benefit Living Donor: [100%] during any Transplant Period

Maximum Bone Marrow Harvesting Benefit: [100%] during any Transplant Period

Maximum Transportation, Lodging and Meals Benefit: [\$10,000] during any Transplant Period. Expenses for Air Ambulance Services are limited under the Air Ambulance Benefit Maximum and not this Benefit Maximum.

Maximum Daily Benefit for Lodging : [\$200] during Recipient Hospital Confinement

Maximum Daily Benefit for Meals will be paid as a [\$50] per diem without need for documentation while the Recipient is Confined in the participating Transplant Hospital

Maximum Air Ambulance Benefit: [\$10,000] during any Transplant Period

Maximum Private Duty Nursing Benefit: [\$10,000] during any Transplant Period

Maximum Transplant Evaluation Benefit: [100%]

Maximum Daily Outpatient Treatment Benefit: [150%]

Maximum Hospital or Skilled Nursing Facility Confinement Benefit: [100%]

Maximum Surgical Benefit for Organ or Tissue Transplant: [100%]

Maximum for Physician Benefit Charges Including Surgery Benefit for Organ or Tissue

Transplant: [100%]
 Maximum Outpatient Treatment Benefit: [100%]

We must certify that the Covered Person qualifies for the In-Network Schedule of Benefits based upon the Transplant Evaluation of an In-Network Transplant Facility or Hospital.

OUT-OF-NETWORK

Covered Percent: [60%] of Eligible Expenses, subject to the following:

Maximum Organ Procurement Benefit Non-living Donor: As per Schedule during any Transplant Period

Maximum Organ Procurement Benefit Living Donor: As per Schedule during any Transplant Period

Maximum Bone Marrow Harvesting Benefit: [\$10,000] during any Transplant Period

Maximum Transportation, Lodging and Meals Benefit: [\$10,000] during any Transplant Period. Expenses for Air Ambulance Services are limited under the Air Ambulance Benefit Maximum and not this Benefit Maximum

Maximum Daily Benefit for Lodging and Meals: [\$200] during any Transplant Period

Maximum Air Ambulance Benefit: [\$10,000] during any Transplant Period

Maximum Private Duty Nursing Benefit: [\$10,000] during any Transplant Period

Maximum Transplant Evaluation Benefit: [\$500]

Maximum Daily Outpatient Treatment Benefit : [\$150]

Maximum Hospital or Skilled Nursing Facility Confinement Benefit or Outpatient Treatment Benefit:

For Organ and Allogeneic Tissue Transplants and for Autologous Bone Marrow Tissue Transplants for the following conditions [Neuroblastoma, Hodgkin's disease, Non-Hodgkin's lymphoma, Acute lymphocytic leukemia, and Acute non-lymphocytic leukemia,] . We will not pay during any Transplant Period for more than:

1. [\$2,000] per day for each of the first consecutive 30 days of a Covered Person Confinement; and
2. [\$1,700] per day for each day of a Covered Person's Confinement on or after the 31st day.

For all other Autologous Tissue Transplants, We will not pay during any Transplant Period for more than:

1. [\$1,500] per day for each of the first consecutive 30 days of a Covered Person Confinement; and
2. [\$850] per day for each day of a Covered Person's Confinement on or after the 31st day.

Maximum Surgical Benefit: [\$10,000]

Maximum for Physician Benefit Charges Including Surgery Benefit for Organ or Tissue Transplant: [\$10,000]

Out-of-Network Organ and Tissue Procurement Schedule of Benefits

| <i>Transplant</i> | <i>Maximum Benefit</i> |
|--------------------------|-------------------------------|
| Lung | \$17,500 |
| Double Lung | not covered |

| | |
|-----------------|----------|
| Heart | \$17,500 |
| Liver | \$22,500 |
| Heart/Lung | \$17,500 |
| Pancreas | \$25,000 |
| Kidney/Pancreas | \$25,000 |
| Kidney | \$17,500 |

3. the Maximum Specific Transplant Benefit as shown in the Schedule.

If this Policy terminates prior to the Expiration Date and a Covered Person has established a Transplant Benefit Period for which benefits are not exhausted, benefits will be paid for the remaining part of the Transplant Benefit Period as if such coverage had not ended. Benefits will be based on the plan in force for that Covered Person on the date this Policy terminated.

All other terms and conditions of the Policy remain unchanged.

Endorsement Number:

Policy Number:

Named Insured:

This endorsement is effective on the inception date of this policy unless otherwise stated herein.

Endorsement Effective Date:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

SPECIFIC TERMINAL LIABILITY OPTION ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached as of the Effective Date shown below. This Endorsement applies only to Losses that occur on or after the Effective Date. This Endorsement ends at the same time as the Policy. This Endorsement is subject to all of the provisions, terms and limitations of the Policy, excepts as they are changed by it.

[Any changes in premium apply as of the first premium due date on or after the Effective date of this Endorsement.]

It is agreed that the above Policy is endorsed on the Policy Effective Date as follows:

The Policy Basis / Benefit Period for Specific Stop Loss Insurance is revised as follows:

The revised Specific Stop Loss Insurance Eligible Expenses Paid Period under Policy Basis / Benefit Period will be as stated in the SCHEDULE OF STOP LOSS INSURANCE plus the [ninety (90)] days immediately thereafter.

Specific Terminal Liability is effective:

1. Only if this Policy is terminated at the end of the Policy Year, and
2. Only if You do not replace this Policy with another stop loss or excess loss policy of any kind whatsoever.

You must select the Specific Terminal Liability Option at the beginning of the Policy Year stated above. Monthly, You must pay the Specific Terminal Liability Option premium as stated in the SCHEDULE.

If You terminate Your Stop Loss Insurance Coverage or this Policy for any reason before the last date of the Policy Year, this Amendment will be void.

All other terms and conditions of the Policy remain unchanged.

Endorsement Number:

Policy Number:

Named Insured:

This endorsement is effective on the inception date of this policy unless otherwise stated herein.

Endorsement Effective Date:



ARCH INSURANCE COMPANY
(A Missouri Corporation)

Home Office Address:
3100 Broadway, Suite 511
Kansas City, MO 64111

Administrative Address:
One Liberty Plaza, 53rd Floor
New York, NY 10006
Tel: (800) 817-3252

ARKANSAS APPLICATION FOR STOP LOSS INSURANCE

Application Instructions:

1. Whenever used in this Application, Arch Insurance Company shall mean (The Company).
2. Whenever used in this Application, the term "Applicant" shall mean the insured and all subsidiaries.
3. Include all requested underwriting information and attachments. Provide a complete response to all questions and attach additional pages if necessary.

1. Name of Applicant (Plan Sponsor):
(Full Legal Name)

Street Address:
City: State: Zip: Telephone:

Name and Telephone of Primary Contact: Telephone:

Federal Employer's Tax I.D.#: Number of Years in Business:
 Corporation Partnership Proprietorship Other

2. Insurance/Business Type and Description: SIC Code:

3. Name and Addresses of Subsidiaries to be covered:

| Name: | Type of Business: | Relationship | Address (City, State, Zip) | Number of Employees: |
|-------|-------------------|--------------|-------------------------------|-------------------------|
| | | | | |
| | | | | |
| | | | | |

4. Number of Employees at all Locations listed above:
 Actives COBRA Retirees Disables

[Single:
Employee + 1:
Employees and Spouse:
Employees and Child(ren):

Family (Employee/Spouse/Children):
Composite:
COBRA Continuees:
Retirees:

5. Name of Administrator:
Tax I.D. #:
Street Address:
City: State: Zip:

6. Proposed Effective Date of Policy:

Policy Year Requested:

From to both days at 12:01 a.m. at the principal address of the insured.

Hospital domestic (inpatient) charge reimbursement limitations apply. 80 %

A. AGGREGATE STOP LOSS INSURANCE

7. Requested Under the Policy: Yes No

BENEFITS TO BE INCLUDED:

- Medical
- Prescription Drug (Major Med)
- Prescription Drug Card
- Vision
- Weekly Income
- Other:

8. Policy Basis/Benefit Period for Aggregate Stop Loss Insurance (check one):

12/12 15/12 paid 12/15 other 24/12

Eligible Expenses Incurred From through ; and Eligible Expenses Paid from through .

Claim Reporting Deadline:

9. Aggregate Stop Loss Premium Rates Per Covered Unit:

| | | | |
|----|--------------------------|----|-----------------------------------|
| \$ | Single/Employee only | \$ | Employee + 1 |
| \$ | Employees and Spouse | \$ | Family (Employee/Spouse/Children) |
| \$ | Employees and Child(ren) | \$ | Composite |

Annual aggregate premium: \$

Monthly Aggregate Accommodation Endorsement:

Included Additional Premium \$ Not Included

10. Aggregate monthly factors:

| | | | |
|----|--------------------------|----|-----------------------------------|
| \$ | Single/Employee only | \$ | Employee + 1 |
| \$ | Employees and Spouse | \$ | Family (Employee/Spouse/Children) |
| \$ | Employees and Child(ren) | \$ | Composite |

11. Maximum Aggregate Benefit: \$1,000,000

Minimum Attachment Point: \$1,000,000

Run-in Limit (if applicable): \$0

Benefit percentage payable: 100%

| | |
|---|------|
| [Losses for treatment rendered at Your facilities (Domestic Losses): | 80% |
| Losses for treatment rendered at outside facilities (Foreign Losses): | 100% |

B: SPECIFIC STOP LOSS INSURANCE

12. Requested Under the Policy: Yes No

Benefit Description:

Medical Prescription Drugs Prescriptions (Maj Med) Other:

13. Policy Basis/Benefit Period for Specific Stop Loss Insurance (check one):

12/12 15/12 paid 12/15 other 24/12

Eligible Expenses Incurred From through ; and Eligible Expenses Paid from through .

Claim Reporting Deadline:

14. Specific Deductible per covered: Person Family \$25,000

Aggregating Specific Deductible: \$ Entire Group Named Individuals Only

Maximum Specific Benefit minus the deductible per Covered Person or Covered Family per Lifetime or Policy Year

Run-in Limit (if applicable): \$0

Benefit percentage payable: 100%

Losses for treatment rendered at Your facilities (Domestic Losses): 80%
Losses for treatment rendered at outside facilities (Foreign Losses): 100%

15. Separate Individual Specific Deductible and/or individuals named under an Aggregating-Specific Deductible:

\$15,000 initial
\$15,000 initial

16. Specific monthly premium rates:

| | | | |
|----|--------------------------|----|-----------------------------------|
| \$ | Single/Employee only | \$ | Employee + 1 |
| \$ | Employees and Spouse | \$ | Family (Employee/Spouse/Children) |
| \$ | Employees and Child(ren) | \$ | Composite |

Annual specific premium: \$

Specific Advance Funding Endorsement: Included Not Included

C: SPECIFIC TRANSPLANT CRITICAL CARE

17. Requested Under the Policy: Yes No

18. Transplant Deductible per Transplant per covered person: \$25,000

19. Benefit percentage payable in excess of the specific transplant deductible: in-network and out-of-n

20. Maximum Specific Transplant benefit payable minus the Specific Transplant Deductible (per [Lifetime or Policy Year] per Covered Person), while this policy is in force: \$

Benefit percentage payable: 100%

21. Specific monthly transplant premium rates:

\$ Single/Employee only \$ Family (Employee/Spouse/Children) \$ Composite

Annual specific transplant premium: \$

22. Additional options requested and included in premiums stated above:

- | | | | |
|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | Organ transplant carved out | <input type="checkbox"/> | Specific Transplant Step-Down Deductible |
| <input type="checkbox"/> | ASOSpecific Terminal Liability Option \$ | <input type="checkbox"/> | Specific Transplant Critical Care |
| <input type="checkbox"/> | Aggregate Terminal Liability Option \$ | <input type="checkbox"/> | Family Specific Deductible |
| <input type="checkbox"/> | Other | <input type="checkbox"/> | None |

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

It is understood and agreed that as a condition precedent to the approval of the Application that:

- A. THE APPLICANT AGREES AND ACKNOWLEDGES THAT, DEPENDING UPON THE COVERAGE SELECTED AND THE TERMS OF ANY EXPIRING COVERAGE OR COVERAGE THE APPLICANT MAY ELECT IN THE FUTURE, THE APPLICANT MAY EXPERIENCE LOSSES THAT ARE NOT COVERED UNDER THE POLICY, WHEN ISSUED, OR UNDER ANY SUCH PRIOR OR SUBSEQUENT COVERAGE.
- B. Any Stop Loss Insurance resulting from this Application shall be described in and shall be subject to the terms and provisions of the Policy, when issued. Such Policy shall become effective on the date specified in this Application; provided that, including, without limitation: (1) a true and correct Disclosure Statement has been received, (2) the underwriting requirements have been satisfied, (3) the required premiums have been paid, (4) a copy of the executed Plan is received and acceptable to the Company pursuant to paragraph C. below, and (5) the Policy has been issued.
- C. Within ninety (90) days from the date of this Application, the Applicant shall furnish to Arch Insurance Company (the Company), for its approval, a copy of the executed employee benefit plan (the Plan) describing the benefits provided by the Plan. The Plan shall be kept on file in the office of the Company. No Policy will be released nor claim reimbursed until such time as an acceptable Plan is received and accepted by the Company. If a copy of the Plan is not received by the Company within ninety (90) days from the date of this application, all premium will be refunded and coverage will be automatically null and void retroactive to the proposed effective date. If in the sole judgment of the Company there is a material variance between the provisions of the Plan received by the Company, and the Plan provision upon which the terms and rates of the aggregate and specific excess coverage were based, the Company may, at its option, notify the Applicant of such variances and decline to release the Policy until such time as an amended Plan is received and accepted and, in the event such amended Plan is not received and accepted by the Company within thirty (30) days of such notice, all premium will be refunded and coverage will automatically be null and void retroactive to the proposed effective date.
- D. The Applicant will provide or employ supervision and claim administration facilities acceptable to the Company to administer the Plan and to process and pay claims according to the Plan.
- E. The receipt by the Company of the deposit listed in item number [23] of this Application and the deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the

event that the Company does not approve this Application, its sole obligation shall be to refund the deposit to the Applicant.

F. The Applicant represents that the statements and declarations made in this Application, the Disclosure Statement, and in the Plan referred to in this Application are true and complete and the Policy, when issued, will be issued in reliance upon the truth and completeness of such statements and declarations. The Disclosure Statement, this Application and the Plan shall form a part of the Policy, and the Policy shall constitute all agreements existing between the Applicant and the Company, or any of their respective agents, relating to this Stop Loss Insurance for which this application is being made.

G. Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud.

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

NOTICE: Employers/plan sponsors of self funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

Date:
Applicant's Executive Officer (print):
Title:
Signature: _____

Date:
Insurance Agency:
Insurance Agency Taxpayer ID or SSN:

Licensed Agent's Name (print):
Title:
Agent License No.

Signature: _____.]

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

**ADMINISTRATIVE SERVICES ONLY
SPECIFIC TERMINAL LIABILITY OPTION ENDORSEMENT**

It is agreed that the Policy is amended on the Policy Effective Date as follows:

If You terminate the Administrative Services Only Agreement with [], The Policy Basis / Benefit Period for Specific Stop Loss Insurance is revised as follows:

The revised Specific Stop Loss Insurance Eligible Expenses Paid Period under Policy Basis / Benefit Period will be as stated in the SCHEDULE plus the [ninety (90)] days immediately thereafter following such termination on the following basis:

1. If this Policy is terminated at the end of the Policy Year,
2. You must select the Specific Terminal Liability Option at the beginning of the Policy Year stated above;
3. You must notify Us within [thirty (30)] days prior to the end of the Policy Year of Your intent to invoke the ASO SPECIFIC TERMINAL LIABILITY OPTION and You must remit additional premium equal to:
 - a. The average enrollment for the three (3) month period immediately preceding the termination date;
 - b. Multiplied by the Specific Terminal Liability premium as stated in the SCHEDULE; and
 - c. Multiplied (by [three 3]).

If You terminate Your Stop Loss Insurance Coverage or this Policy for any reason before the last date of the Policy Year, this Amendment will be void.

All other terms and conditions of the Policy remain unchanged.

Endorsement Number:

Policy Number:

Named Insured:

This endorsement is effective on the inception date of this policy unless otherwise stated herein.

Endorsement Effective Date:

LOSS OR LOSSES, HOWEVER, DOES NOT INCLUDE:

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

The **DEFINITION** of **MINIMUM AGGREGATE ATTACHMENT POINT** is deleted and replaced with:

MINIMUM ANNUAL AGGREGATE ATTACHMENT POINT means the amount stated in the Schedule.

The following **PROVISIONS** are added to **SECTION 9-GENERAL PROVISIONS**:

RECOVERY OF OVERPAYMENT

If benefits are overpaid, We have the right to recover the amount overpaid by the following methods:

1. A request for lump sum payment of the overpaid amount; or
2. A reduction of any amounts payable under the Policy.

OFFSET

We have the right to offset any Losses payable to You under this Policy against premiums due and unpaid by You *or against any overpayment of benefits*. This right will not prevent the termination of this Policy for the non-payment of premium under the Termination provision of this Policy.

SUBCONTRACTING

Our rights and obligations under this Policy may be performed wholly, or in part, through an authorized representative, subsidiary, affiliate or parent of the Insurance Company. Any subcontracting agreement made by Us will not increase or diminish the rights or obligations of the Policyholder or the Insurance Company.

All other terms and conditions of the Policy remain unchanged.

Endorsement Number:

Policy Number:

Named Insured:

This endorsement is effective on the inception date of this policy unless otherwise stated herein.

Endorsement Effective Date:

SERFF Tracking Number: WESA-127060961 State: Arkansas
 Filing Company: Arch Insurance Company State Tracking Number: 48260
 Company Tracking Number: ARCH-11-018
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.001 Accident & Sickness
 Product Name: Arch ESL
 Project Name/Number: Arch ESL/ARCH-11-018

Supporting Document Schedules

| | Item Status: | Status Date: |
|---|---------------------|-------------------------|
| Satisfied - Item: Application | Approved-Closed | 05/04/2011 |
| Comments: Application is attached. | | |
| Attachment: APPLICATION 00 ESL0010 00 01 11.pdf | | |

| | Item Status: | Status Date: |
|--|---------------------|-------------------------|
| Satisfied - Item: Flesch Certification | Approved-Closed | 05/04/2011 |
| Comments: Readability Certification, Rule 49 Appendix A, Consumer Information Notice and Certificate of Compliance are attached. | | |
| Attachments: ESL Readability Cert (2).pdf AR ESL - Rule 49 Appendix A - 00ESL0013040311.pdf AR ESL Consumer Information Notice (2).pdf Certificate of Compliance with Rule 19 (2).pdf | | |

| | Item Status: | Status Date: |
|---|---------------------|-------------------------|
| Satisfied - Item: Letter of Authorization | Approved-Closed | 05/04/2011 |
| Comments: Letter of Authorization is attached. | | |
| Attachment: Arch Employer Stop Loss Letter of Authorization.pdf | | |

| | Item Status: | Status Date: |
|--|---------------------|-------------------------|
| Satisfied - Item: Statement of Variability is attached. | Approved-Closed | 05/04/2011 |
| Comments: Statement of Variability is attached. | | |
| Attachment: | | |

SERFF Tracking Number: WESA-127060961 State: Arkansas
Filing Company: Arch Insurance Company State Tracking Number: 48260
Company Tracking Number: ARCH-11-018
TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.001 Accident & Sickness
Product Name: Arch ESL
Project Name/Number: Arch ESL/ARCH-11-018
SOV.v2 CLEAN.pdf

| | Item Status: | Status |
|---|---------------------|-------------------------|
| Satisfied - Item: Cover Letter | Approved-Closed | Date: 05/04/2011 |
| Comments: Cover Letter is attached. | | |
| Attachment: ESL Cover Letter.doc - AR.pdf | | |



ARCH INSURANCE COMPANY
(A Missouri Corporation)

Home Office Address:
3100 Broadway, Suite 511
Kansas City, MO 64111

Administrative Address:
One Liberty Plaza, 53rd Floor
New York, NY 10006
Tel: (800) 817-3252

APPLICATION FOR STOP LOSS INSURANCE

Application Instructions:

1. Whenever used in this Application, Arch Insurance Company shall mean (The Company).
2. Whenever used in this Application, the term "Applicant" shall mean the insured and all subsidiaries.
3. Include all requested underwriting information and attachments. Provide a complete response to all questions and attach additional pages if necessary.

1. Name of Applicant (Plan Sponsor):
(Full Legal Name)

Street Address:
City: State: Zip: Telephone:

Name and Telephone of Primary Contact: Telephone:

Federal Employer's Tax I.D.#: Number of Years in Business:
 Corporation Partnership Proprietorship Other

2. Insurance/Business Type and Description: SIC Code:

3. Name and Addresses of Subsidiaries to be covered:

| Name: | Type of Business: | Relationship | Address (City, State, Zip) | Number of Employees: |
|-------|-------------------|--------------|-------------------------------|-------------------------|
| | | | | |
| | | | | |
| | | | | |

4. Number of Employees at all Locations listed above:
 Actives COBRA Retirees Disables

[Single:
Employee + 1:
Employees and Spouse:
Employees and Child(ren):
Family (Employee/Spouse/Children):
Composite:
COBRA Continuees:
Retirees:

5. Name of Administrator:
Tax I.D. #:
Street Address:

B: SPECIFIC STOP LOSS INSURANCE

12. Requested Under the Policy: Yes No

Benefit Description:

Medical Prescription Drugs Prescriptions (Maj Med) Other:

13. Policy Basis/Benefit Period for Specific Stop Loss Insurance (check one):

12/12 15/12 paid 12/15 other

Eligible Expenses Incurred From through ; and Eligible Expenses Paid from through .

Claim Reporting Deadline:

14. Specific Deductible per covered: Person Family \$25,000

Aggregating Specific Deductible: \$ Entire Group Named Individuals Only

Maximum Specific Benefit minus the deductible per Covered Person or Covered Family per Lifetime or Policy Year

Run-in Limit (if applicable): \$0

Benefit percentage payable: 100%

Losses for treatment rendered at the Your facilities (Domestic Losses): 80%
Losses for treatment rendered at outside facilities (Foreign Losses): 100%

15. Separate Individual Specific Deductible and/or individuals named under an Aggregating-Specific Deductible:

\$15,000 initial
\$15,000 initial

16. Specific monthly premium rates:

| | | | |
|----|--------------------------|----|-----------------------------------|
| \$ | Single/Employee only | \$ | Employee + 1 |
| \$ | Employees and Spouse | \$ | Family (Employee/Spouse/Children) |
| \$ | Employees and Child(ren) | \$ | Composite |

Annual specific premium: \$

Specific Advance Funding Endorsement: Included Not Included

C: SPECIFIC TRANSPLANT CRITICAL CARE

17. Requested Under the Policy: Yes No

18. Transplant Deductible per Transplant per covered person: \$25,000

19. Benefit percentage payable in excess of the specific transplant deductible: in-network and out-of-n

20. Maximum Specific Transplant benefit payable minus the Specific Transplant Deductible (per [Lifetime or Policy Year] per Covered Person), while this policy is in force: \$

Benefit percentage payable: 100%

21. Specific monthly transplant premium rates:

\$ Single/Employee only \$ Family (Employee/Spouse/Children) \$ Composite

Annual specific transplant premium: \$

22. Additional options requested and included in premiums stated above:

- | | | | |
|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | Organ transplant carved out | <input type="checkbox"/> | Specific Transplant Step-Down Deductible |
| <input type="checkbox"/> | ASOSpecific Terminal Liability Option \$ | <input type="checkbox"/> | Specific Transplant Critical Care |
| <input type="checkbox"/> | Aggregate Terminal Liability Option \$ | <input type="checkbox"/> | Family Specific Deductible |
| <input type="checkbox"/> | Other..... | <input type="checkbox"/> | None |

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

It is understood and agreed that as a condition precedent to the approval of the Application that:

- A. THE APPLICANT AGREES AND ACKNOWLEDGES THAT, DEPENDING UPON THE COVERAGE SELECTED AND THE TERMS OF ANY EXPIRING COVERAGE OR COVERAGE THE APPLICANT MAY ELECT IN THE FUTURE, THE APPLICANT MAY EXPERIENCE LOSSES THAT ARE NOT COVERED UNDER THE POLICY, WHEN ISSUED, OR UNDER ANY SUCH PRIOR OR SUBSEQUENT COVERAGE.
- B. Any Stop Loss Insurance resulting from this Application shall be described in and shall be subject to the terms and provisions of the Policy, when issued. Such Policy shall become effective on the date specified in this Application; provided that, including, without limitation: (1) a true and correct Disclosure Statement has been received, (2) the underwriting requirements have been satisfied, (3) the required premiums have been paid, (4) a copy of the executed Plan is received and acceptable to the Company pursuant to paragraph C. below, and (5) the Policy has been issued.
- C. Within ninety (90) days from the date of this Application, the Applicant shall furnish to Arch Insurance Company (the Company), for its approval, a copy of the executed employee benefit plan (the Plan) describing the benefits provided by the Plan. The Plan shall be kept on file in the office of the Company. No Policy will be released nor claim reimbursed until such time as an acceptable Plan is received and accepted by the Company. If a copy of the Plan is not received by the Company within ninety (90) days from the date of this application, all premium will be refunded and coverage will be automatically null and void retroactive to the proposed effective date. If in the sole judgment of the Company there is a material variance between the provisions of the Plan received by the Company, and the Plan provision upon which the terms and rates of the aggregate and specific excess coverage were based, the Company may, at its option, notify the Applicant of such variances and decline to release the Policy until such time as an amended Plan is received and accepted and, in the event such amended Plan is not received and accepted by the Company within thirty (30) days of such notice, all premium will be refunded and coverage will automatically be null and void retroactive to the proposed effective date.
- D. The Applicant will provide or employ supervision and claim administration facilities acceptable to the Company to administer the Plan and to process and pay claims according to the Plan.
- E. The receipt by the Company of the deposit listed in item number [23] of this Application and the deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event that the Company does not approve this Application, its sole obligation shall be to refund the deposit to the Applicant.
- F. The Applicant represents that the statements and declarations made in this Application, the Disclosure Statement, and in the Plan referred to in this Application are true and complete and the Policy, when issued, will be issued in reliance upon the truth and completeness of such statements and declarations. The Disclosure Statement, this Application and the Plan shall form a part of the Policy, and the Policy shall constitute all agreements existing

between the Applicant and the Company, or any of their respective agents, relating to this Stop Loss Insurance for which this application is being made.

- G. Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud.

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

Date:

Applicant's Executive Officer (print):

Title:

Signature: _____

Date:

Insurance Agency:

Insurance Agency Taxpayer ID or SSN:

Licensed Agent's Name (print):

Title:

Agent License No.

Signature: _____.]

**ARKANSAS NOTICE TO POLICYHOLDERS
APPENDIX "A"**

**LIMITATIONS AND EXCLUSIONS UNDER THE
ARKANSAS LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
425 West Capitol Avenue, Suite 3700
Little Rock, AR 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net

cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1, 000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

CONSUMER INFORMATION NOTICE

You may contact Arch Insurance Company at:

One Liberty Plaza, 53rd Floor
New York, NY 10006
(800) 817-3252

You may contact the Arkansas Insurance Department at:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904
(501) 371-2600 or 1-800-282-9134

(If applicable)

You may contact your Agent at:

Arch Insurance Company

Home Office: 3100 Broadway, Suite 511, Kansas City, MO 64111
Administrative Office: 300 - Plaza Three, 3rd Fl., Jersey City, NJ 07311

CERTIFICATE OF COMPLIANCE

I certify that the attached submission meets the provisions of Rule 19 as well as all applicable requirements of the Arkansas Insurance Department.



Dated: March 2, 2011



www.archinsurance.com

Arch Insurance Group
300 – Plaza Three
Jersey City, NJ 07311-1107

T 201.743.4000
F 201.743.4005

February 1, 2011

Arch Insurance Company
Filing Designation #ARCH-11-018
FEIN#: 43-0990710
NAIC#: 1279 11150

Letter of Authorization
Filing of Forms, Rates and Rules

Dear Sir or Madame:

In accordance with the applicable statutes and regulations in your state, Darcy Lebau and Westmont Associates are hereby authorized to file form, rate and rate filings on behalf of Arch Insurance Company.

Very truly yours,

A handwritten signature in black ink that reads "Carol Kennedy". The signature is fluid and cursive.

Carol Kennedy
Vice President & Director of Compliance

Arch Insurance Company
STATEMENT OF VARIABILITY
For

Administrative Services Only Specific Terminal Liability Option Endorsement Form # 00 ESL0011 00 01 11
Aggregating Specific Endorsement Form # 00 ESL0002 00 12 10
Domestic Facility Reimbursement Endorsement Form # 00 ESL0004 00 12 10
Family Specific Deductible Endorsement Form # 00 ESL0006 00 12 10
Separate Specific Deductible or Benefit Period Endorsement Form # 00 ESL0007 00 12 10
Specific Terminal Liability Option Endorsement Form # 00 ESL0009 00 12 10
Specific Transplant Critical Care Endorsement Form # 00 ESL0008 00 12 10
Specific Transplant Step-Down Deductible Endorsement Form # 00 ESL0001 00 12 10
Application for Stop Loss Insurance Form # 00 ESL0010 00 01 11
Policy Changes Endorsement Form # 00 ESL0012 00 01 11

Language that is bracketed in the form is intended to be variable. Below is an explanation of those variables.

| Application/Rider Page | Provision/Title | Variable # | Variability Range | Description of Variable |
|--|---|-------------------|--------------------------------|--|
| Administrative Services Only Specific Terminal Liability Option Endorsement | | | | |
| 1 | 2 nd Sentence/2 nd Paragraph | 1 | Include/Exclude | # of days 90 to 180 |
| 1 | 3 rd Paragraph | 2 | Include/Exclude | # of days 30, 45, or 60 |
| 1 | Item 3c | 3 | Include/Exclude | 3 or 6 |
| Aggregating Specific Endorsement | | | | |
| 1 | 2 nd Sentence/2 nd Paragraph | 1 | Include/Exclude | Allows Policyholder to determine whether to include/exclude provision. |
| Domestic Facility Reimbursement Endorsement | | | | |
| 1 | 2 nd Paragraph | 1 | Include/Exclude | Allows Policyholder to determine whether to include/exclude provision. |
| 1 | A. Aggregate Stop Loss Insurance 4. Benefit Percentage Payable in Excess of the Aggregate Attachment Point Losses for treatment rendered at Your facilities | 2 | Include/Exclude 0% to 100% | Allows Policyholder to determine whether to include and the benefit percentage from 0% to 100%. |
| 1 | A. Aggregate Stop Loss Insurance 4. Benefit Percentage Payable in Excess of the Aggregate Attachment Point Losses for treatment at outside facilities | 3 | Include/Exclude 50% to 100% | Allows Policyholder to determine whether to include and the benefit percentage from 50% to 100%. |
| 1 | B. Specific/Individual Stop Loss Insurance 4. Benefit Percentage Payable in Excess of the Specific Deductible Losses for treatment rendered at Your facilities | 4 | Include/Exclude 0% to 100% | Allows Policyholder to determine whether to include and the benefit percentage from 0% to 100%. |
| 1 | B. Specific/Individual Stop Loss Insurance 4. Benefit Percentage Payable in Excess of the Specific Deductible Losses for treatment rendered at outside facilities | 5 | Include/Exclude 50% to 100% | Allows Policyholder to determine whether to include and the benefit percentage from 50% to 100%. |
| Family Specific Deductible Endorsement | | | | |

| | | | | |
|--|---|---|---------------------------|--|
| 1 | 2 nd Sentence/2 nd Paragraph | 1 | Include/Exclude | Allows Policyholder to determine whether to include/exclude provision. |
| Separate Specific Deductible or Benefit Period Endorsement | | | | |
| 1 | 2 nd Sentence/2 nd Paragraph | 1 | Include/Exclude | Allows Policyholder to determine whether to include/exclude provision. |
| 1 | Section 1, A. | 2 | Include/Exclude | Allows Policyholder to determine whether to include family coverage. |
| 1 | Section 1, B | 3 | Include/Exclude | Allows Policyholder to determine whether to include family coverage. |
| 1 | Section 1, B, 3 | 4 | Include/Exclude | Allows Policyholder to determine whether to include family coverage. |
| 1 | Section 1, B, 5 | 5 | Include/Exclude | Allows Policyholder to determine whether to include family coverage. |
| Specific Terminal Liability Option Endorsement | | | | |
| 1 | 2 nd Sentence/2 nd Paragraph | 1 | Include/Exclude | Allows Policyholder to determine whether to include/exclude provision. |
| 1 | 5 th Paragraph | 2 | Select # of days | 90 or 180 |
| Specific Transplant Critical Care Endorsement | | | | |
| 1 | 2 nd Sentence/2 nd Paragraph | 1 | Include/Exclude | Allows Policyholder to determine whether to include/exclude provision. |
| 1 | Section 1, B, 7, Policy Basis | 2 | # of months: 12, 14 or 16 | Allows Policyholder to determine number of months from end of Policy Year within which eligible services must be paid/reported/filed. |
| 1 | Section 1, B, 9, Deductible | 3 | Percentage | Allows Policyholder to determine amount in-network and out-of-network. 50 to 100% |
| 1 | Section 1, B, 10 | 4 | Include/Exclude | Allows Policyholder to select Lifetime or Policy Year for Deductible. |
| 4 | Section 4 | 1 | Include/Exclude | Allows Policyholder to change the Section number relating to Aggregate Stop Loss Insurance in the event of future changes to the Policy. |
| 4 | Specific Organ/Tissue Transplant Benefit, 1 st Paragraph | 2 | Include/Exclude | Allows Policyholder to select the Covered Organ or Tissue Transplant Procedures. \$ amounts and percentages are variable. |
| Specific Transplant Step-Down Deductible Endorsement | | | | |
| 1 | 2 nd Sentence/2 nd Paragraph | 1 | Include/Exclude | Allows Policyholder to determine whether to include/exclude provision. |
| 1 | Section 4, \$ amount/% Specific Deductible Amount is reduced | 2 | Include/Exclude | Allows Policyholder to select dollar amount or percentage and from |
| Application for Stop Loss Insurance | | | | |

| | | | | |
|-----------------------------------|---|---|-----------------|--|
| 2 | 11. Maximum Aggregate Benefit, Benefit percentage payable | 1 | Include/Exclude | Allows Policyholder to determine whether to include/exclude provision. |
| 4 | #20 | 1 | Include/Exclude | Allows Policyholder to select Lifetime or Policy Year for Deductible. |
| 4 | E | 2 | Include/Exclude | Allows Policyholder to change the item number of the Application relating to deposit received by Company in the event of future changes to the Policy. |
| Policy Changes Endorsement | | | | |
| 1 | 2 nd Sentence/2 nd Paragraph | 1 | Include/Exclude | Allows Policyholder to determine whether to include/exclude provision. |
| 1 | Number of employees under coverage | | | Policyholder selects how they want coverage rates: single family, tier or composite. |
| 1 | 7. AGGREGATE MONTHLY FACTOR(s) | | | Calculation |
| 1 | 8. AGGREGATE RATE | | | Policyholder selects how they want coverage rates: single family or composite. |
| 1 | MINIMUM ANNUAL AGGREGATE ATTACHMENT POINT | | | Calculation |
| 1 | 1. BENEFITS COVERED | | Include/Exclude | Allows Policyholder to select benefits covered. |
| 1 | 3. SPECIFIC DEDUCTIBLE | | | |
| 1 | MAXIMUM SPECIFIC BENEFIT PAYABLE | | Include/Exclude | Allows Policyholder to select Per Lifetime or Per Policy Year for .Deductible. |
| 1 | MAXIMUM SPECIFIC BENEFIT PAYABLE | | | Up to unlimited based on what is selected by Policyholder. |
| 2 | SPECIFIC RUN IN LOSS LIMIT | | | Calculation |
| 2 | B, 7, SPECIFIC MONTHLY PREMIUM RATE | | | Policyholder selects how they want coverage rates: single family, tier or composite. |
| 2 | OPTIONAL RIDERS/ENDORSEMENTS | | Include/Exclude | Allows Policyholder to determine # of provision as well as the optional riders/endorsements. |
| 2 | WAIVER OF ACTIVELY AT WORK ELECTED | | Include/Exclude | Allows Policyholder to determine # of provision. |



March 16, 2011

via SERFF

The Honorable Julie Benafield Bowman
Commissioner of Insurance
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
Attn: Life & Health Division

Re: Arch Insurance Company
FEIN#: 43-0990710
NAIC#: 1279 11150
Arch Filing Designation # ARCH-11-018

| | |
|--|----------------------------------|
| Specific Transplant Step-Down Deductible Endorsement | Form #00 ESL0001 00 12 10 |
| Aggregating Specific Endorsement | Form #00 ESL0002 00 12 10 |
| Domestic Facility Reimbursement Endorsement | Form #00 ESL0004 00 12 10 |
| Family Specific Deductible Endorsement | Form #00 ESL0006 00 12 10 |
| Separate Specific Deductible or Benefit Period Endorsement | Form #00 ESL0007 00 12 10 |
| Specific Transplant Critical Care Endorsement 10 | Form #00 ESL0008 00 12 |
| Specific Terminal Liability Option Endorsement | Form #00 ESL0009 00 12 10 |
| Application for Stop Loss Insurance | Form #00 ESL0010 00 01 11 |
| Administrative Services Only Specific Terminal Liability Option Endorsement | Form #00 ESL0011 00 01 11 |
| Policy Changes Endorsement | Form #00 ESL0012 00 01 11 |
| Statement of Variability | Form # Form Number |

Honorable Commissioner Bowman:

I respectfully submit the amendment form filing referenced above on behalf of Arch Insurance Company ("Arch") for your review and approval prior to use in your state. Westmont Associates, Inc. has been requested to file these forms on behalf of Arch. Please see the enclosed authorization letter.

Your Department approved the original filing on September 30, 2002. Arch has initiated these filings to bring the previously approved forms current with market needs.

For any existing cases, the endorsements may be issued on the respective forms as indicated in this submission and for new cases, we may incorporate the language directly into the policy.

The Employer Stop Loss product will be marketed by licensed agents, brokers, and third party administrators to eligible groups.

In accordance with Arkansas' filing requirements, enclosed please find:

- Readability Certification
- Letter of Authorization
- Forms
- Statement of Variability
- Certificate of Compliance
- Rule 49 Appendix A
- Consumer Information Notice

I thank you in advance for the time spent on this filing and trust that you will find everything in order. Please do not hesitate to contact me directly at 856-216-0220, x 221 or at Darcy@Westmontlaw.com if you have any questions or require additional information.

Respectfully,

Darcy Lebau

Darcy Lebau

SERFF Tracking Number: WESA-127060961 State: Arkansas
 Filing Company: Arch Insurance Company State Tracking Number: 48260
 Company Tracking Number: ARCH-11-018
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.001 Accident & Sickness
 Product Name: Arch ESL
 Project Name/Number: Arch ESL/ARCH-11-018

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

| Creation Date: | Schedule | Schedule Item Name | Replacement Creation Date | Attached Document(s) |
|----------------|----------|-------------------------------------|------------------------------|---|
| 03/02/2011 | Form | Application for Stop Loss Insurance | 05/03/2011 | APPLICATION 00 ESL0010 00 01 11.pdf (Superseded) |
| 03/02/2011 | Form | Policy Changes Endorsement | 04/07/2011 | ESL Policy Endorsement 00 ESL0012 00 01 11.pdf (Superseded) |



ARCH INSURANCE COMPANY
(A Missouri Corporation)

Home Office Address:
3100 Broadway, Suite 511
Kansas City, MO 64111

Administrative Address:
One Liberty Plaza, 53rd Floor
New York, NY 10006
Tel: (800) 817-3252

APPLICATION FOR STOP LOSS INSURANCE

Application Instructions:

1. Whenever used in this Application, Arch Insurance Company shall mean (The Company).
2. Whenever used in this Application, the term "Applicant" shall mean the insured and all subsidiaries.
3. Include all requested underwriting information and attachments. Provide a complete response to all questions and attach additional pages if necessary.

1. Name of Applicant (Plan Sponsor):
(Full Legal Name)

Street Address:

City: State: Zip: Telephone:

Name and Telephone of Primary Contact: Telephone:

Federal Employer's Tax I.D.#: Number of Years in Business:

Corporation Partnership Proprietorship Other

2. Insurance/Business Type and Description: SIC Code:

3. Name and Addresses of Subsidiaries to be covered:

| Name: | Type of Business: | Relationship | Address (City, State, Zip) | Number of Employees: |
|-------|-------------------|--------------|-------------------------------|-------------------------|
| | | | | |
| | | | | |
| | | | | |

4. Number of Employees at all Locations listed above:

Actives COBRA Retirees Disables

[Single:

Employee + 1:

Employees and Spouse:

Employees and Child(ren):

Family (Employee/Spouse/Children):

Composite:

COBRA Continuees:

Retirees:

5. Name of Administrator:

Tax I.D. #:

Street Address:

B: SPECIFIC STOP LOSS INSURANCE

12. Requested Under the Policy: Yes No

Benefit Description:

Medical Prescription Drugs Prescriptions (Maj Med) Other:

13. Policy Basis/Benefit Period for Specific Stop Loss Insurance (check one):

12/12 15/12 paid 12/15 other 24/12

Eligible Expenses Incurred From through ; and Eligible Expenses Paid from through .

Claim Reporting Deadline:

14. Specific Deductible per covered: Person Family \$25,000

Aggregating Specific Deductible: \$ Entire Group Named Individuals Only

Maximum Specific Benefit minus the deductible per Covered Person or Covered Family per Lifetime or Policy Year

Run-in Limit (if applicable): \$0

Benefit percentage payable: 100%

Losses for treatment rendered at the Your facilities (Domestic Losses): 80%
Losses for treatment rendered at outside facilities (Foreign Losses): 100%

15. Separate Individual Specific Deductible and/or individuals named under an Aggregating-Specific Deductible:

\$15,000 initial
\$15,000 initial

16. Specific monthly premium rates:

| | | | |
|----|--------------------------|----|-----------------------------------|
| \$ | Single/Employee only | \$ | Employee + 1 |
| \$ | Employees and Spouse | \$ | Family (Employee/Spouse/Children) |
| \$ | Employees and Child(ren) | \$ | Composite |

Annual specific premium: \$

Specific Advance Funding Endorsement: Included Not Included

C: SPECIFIC TRANSPLANT CRITICAL CARE

17. Requested Under the Policy: Yes No

18. Transplant Deductible per Transplant per covered person: \$25,000

19. Benefit percentage payable in excess of the specific transplant deductible: in-network and out-of-n

20. Maximum Specific Transplant benefit payable minus the Specific Transplant Deductible (per [Lifetime or Policy Year] per Covered Person), while this policy is in force: \$

Benefit percentage payable: 100%

21. Specific monthly transplant premium rates:

\$ Single/Employee only \$ Family (Employee/Spouse/Children) \$ Composite

Annual specific transplant premium: \$

22. Additional options requested and included in premiums stated above:

- | | | | |
|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | Organ transplant carved out | <input type="checkbox"/> | Specific Transplant Step-Down Deductible |
| <input type="checkbox"/> | ASOSpecific Terminal Liability Option \$ | <input type="checkbox"/> | Specific Transplant Critical Care |
| <input type="checkbox"/> | Aggregate Terminal Liability Option \$ | <input type="checkbox"/> | Family Specific Deductible |
| <input type="checkbox"/> | Other..... | <input type="checkbox"/> | None |

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

It is understood and agreed that as a condition precedent to the approval of the Application that:

- A. THE APPLICANT AGREES AND ACKNOWLEDGES THAT, DEPENDING UPON THE COVERAGE SELECTED AND THE TERMS OF ANY EXPIRING COVERAGE OR COVERAGE THE APPLICANT MAY ELECT IN THE FUTURE, THE APPLICANT MAY EXPERIENCE LOSSES THAT ARE NOT COVERED UNDER THE POLICY, WHEN ISSUED, OR UNDER ANY SUCH PRIOR OR SUBSEQUENT COVERAGE.
- B. Any Stop Loss Insurance resulting from this Application shall be described in and shall be subject to the terms and provisions of the Policy, when issued. Such Policy shall become effective on the date specified in this Application; provided that, including, without limitation: (1) a true and correct Disclosure Statement has been received, (2) the underwriting requirements have been satisfied, (3) the required premiums have been paid, (4) a copy of the executed Plan is received and acceptable to the Company pursuant to paragraph C. below, and (5) the Policy has been issued.
- C. Within ninety (90) days from the date of this Application, the Applicant shall furnish to Arch Insurance Company (the Company), for its approval, a copy of the executed employee benefit plan (the Plan) describing the benefits provided by the Plan. The Plan shall be kept on file in the office of the Company. No Policy will be released nor claim reimbursed until such time as an acceptable Plan is received and accepted by the Company. If a copy of the Plan is not received by the Company within ninety (90) days from the date of this application, all premium will be refunded and coverage will be automatically null and void retroactive to the proposed effective date. If in the sole judgment of the Company there is a material variance between the provisions of the Plan received by the Company, and the Plan provision upon which the terms and rates of the aggregate and specific excess coverage were based, the Company may, at its option, notify the Applicant of such variances and decline to release the Policy until such time as an amended Plan is received and accepted and, in the event such amended Plan is not received and accepted by the Company within thirty (30) days of such notice, all premium will be refunded and coverage will automatically be null and void retroactive to the proposed effective date.
- D. The Applicant will provide or employ supervision and claim administration facilities acceptable to the Company to administer the Plan and to process and pay claims according to the Plan.
- E. The receipt by the Company of the deposit listed in item number [23] of this Application and the deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event that the Company does not approve this Application, its sole obligation shall be to refund the deposit to the Applicant.
- F. The Applicant represents that the statements and declarations made in this Application, the Disclosure Statement, and in the Plan referred to in this Application are true and complete and the Policy, when issued, will be issued in reliance upon the truth and completeness of such statements and declarations. The Disclosure Statement, this Application and the Plan shall form a part of the Policy, and the Policy shall constitute all agreements existing

between the Applicant and the Company, or any of their respective agents, relating to this Stop Loss Insurance for which this application is being made.

- G. Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud.

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

Date:

Applicant's Executive Officer (print):

Title:

Signature: _____

Date:

Insurance Agency:

Insurance Agency Taxpayer ID or SSN:

Licensed Agent's Name (print):

Title:

Agent License No.

Signature: _____.]

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

POLICY CHANGES ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached as of the Effective Date shown above. This Endorsement applies only to Losses that occur on or after the Effective Date. This Endorsement ends at the same time as the Policy. This Endorsement is subject to all of the provisions, terms and limitations of the Policy, excepts as they are changed by it.

[Any changes in premium apply as of the first premium due date on or after the Effective date of this Endorsement.]

SECTION 1 – SCHEDULE OF STOP LOSS INSURANCE is endorsed as follows:

The following is added:

Number of all employees under coverage:

| | | | |
|--|--------------------------------|--|-----------------------------------|
| <input checked="" type="checkbox"/> Active | <input type="checkbox"/> COBRA | <input type="checkbox"/> Retirees | <input type="checkbox"/> Disabled |
| [Single: [100] | | Family (Employee/Spouse/Children): [0] | |
| Employee + 1: [0] | | Composite: [0] | |
| Employees and Spouse: [0] | | COBRA Continuees: [0] | |
| Employees and Child(ren): [0] | | Retirees: [0] | |

Prescriptions (Major Med) is added to Number A. 1.

Number A. 3. is deleted and replaced with the following:

Number A. 7 & A. 8 are added as follows:

7. AGGREGATE MONTHLY FACTOR (S):

| | |
|---------------------------------|--|
| [\$xx] Single/Employee only | [\$xx] Employee + 1 |
| [\$xx] Employees and Spouse | [\$xx] Family (Employee/Spouse/Children) |
| [\$xx] Employees and Child(ren) | [\$xx] Composite] |

8. AGGREGATE RATE (PER EMPLOYEE):

| | |
|---------------------------------|--|
| [\$xx] Single/Employee only | [\$xx] Employee + 1 |
| [\$xx] Employees and Spouse | [\$xx] Family (Employee/Spouse/Children) |
| [\$xx] Employees and Child(ren) | [\$xx] Composite] |

MINIMUM ANNUAL AGGREGATE ATTACHMENT POINT: \$[_____]

Number B. 1 is deleted and replaced with the following:

1. **BENEFITS COVERED:** Medical
 Prescriptions (Major Med)
 Prescription Drug Card
 Other(s)

Number B. 3 is deleted and replaced with the following:

3. **SPECIFIC DEDUCTIBLE PER COVERED PERSON:** [\$25,000]

Number B. 5 is deleted and replaced with the following:

MAXIMUM SPECIFIC BENEFIT PAYABLE MINUS THE SPECIFIC DEDUCTIBLE (PER [LIFETIME or PER POLICY YEAR] PER COVERED PERSON), WHILE THIS POLICY IS IN FORCE: [XX]

Number B. 6 is deleted and replaced with the following:

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

The **DEFINITION** of **MINIMUM AGGREGATE ATTACHMENT POINT** is deleted and replaced with:

MINIMUM ANNUAL AGGREGATE ATTACHMENT POINT means the amount stated in the Schedule.

The following **PROVISIONS** are added to **SECTION 9-GENERAL PROVISIONS**:

RECOVERY OF OVERPAYMENT

If benefits are overpaid, We have the right to recover the amount overpaid by the following methods:

1. A request for lump sum payment of the overpaid amount; or
2. A reduction of any amounts payable under the Policy.

OFFSET

We have the right to offset any Losses payable to You under this Policy against premiums due and unpaid by You *or against any overpayment of benefits*. This right will not prevent the termination of this Policy for the non-payment of premium under the Termination provision of this Policy.

SUBCONTRACTING

Our rights and obligations under this Policy may be performed wholly, or in part, through an authorized representative, subsidiary, affiliate or parent of the Insurance Company. Any subcontracting agreement made by Us will not increase or diminish the rights or obligations of the Policyholder or the Insurance Company.

All other terms and conditions of the Policy remain unchanged.

Endorsement Number:

Policy Number:

Named Insured:

This endorsement is effective on the inception date of this policy unless otherwise stated herein.

Endorsement Effective Date: