

State: Arkansas **Filing Company:** RGA Reinsurance Company
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.003 Provider
Product Name: PEL-1000 6/2012 Provider Excess Loss - RGA Reinsur
Project Name/Number: PEL-1000 6/2012 Provider Excess Loss - RGA Reinsurance Company /PEL-1000 6/2012 Provider Excess Loss - RGA Reinsurance Company

Filing at a Glance

Company: RGA Reinsurance Company
Product Name: PEL-1000 6/2012 Provider Excess Loss - RGA Reinsur
State: Arkansas
TOI: H12 Health - Excess/Stop Loss
Sub-TOI: H12.003 Provider
Filing Type: Form
Date Submitted: 10/10/2012
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State Tr Num:
State Status: Approved-Closed
Co Tr Num: PEL-1000 6/2012

Implementation: On Approval
Date Requested:
Author(s): SPI McHughConsulting
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 10/12/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

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General Information

Project Name: PEL-1000 6/2012 Provider Excess Loss - RGA Reinsurance Company Status of Filing in Domicile: Not Filed

Project Number: PEL-1000 6/2012 Provider Excess Loss - RGA Reinsurance Company Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 10/12/2012

State Status Changed: 10/12/2012

Deemer Date:

Created By: SPI McHughConsulting

Submitted By: SPI McHughConsulting

Corresponding Filing Tracking Number:

Filing Description:

RGA Reinsurance Company

NAIC No. 93572

FEIN No. 43-1235868

PEL-1000-AR 6/2012 Provider Excess Loss Policy

PEL-1001-AR 6/2012 Application

PEL-1002-EXP END Experience Refund Endorsement

PEL-1003-AMD Amendment

McHugh Consulting Resources, Inc. has been requested to file the attached forms on behalf of the above-referenced company. We have provided an authorization letter for your files.

The above-referenced forms are submitted for your review and approval. The forms are new and do not replace any forms previously approved by your department.

The medical provider excess loss policy is intended to provide coverage for catastrophic losses. More specifically, it is a type of stop loss protection against catastrophic claims for medical provider organizations that assume financial risk through the use of capitated payment agreements. It has been designed to mitigate the unanticipated financial loss that may be incurred by a capitated medical provider in treating a catastrophic illness or injury. The coverage offers eligible medical provider groups, e.g., physician hospital organizations and preferred provider organizations, the opportunity to insure their capitation arrangements with stop loss insurance. It will be marketed via licensed agents and brokers.

Printing of all forms is subject to changes in page numbers, margins, positioning and format. Printing standards will never be less than required under your law. Electronic use of this form may result in changes or variations in margins, formatting and pagination. However, the text will not be less than ten-point type.

Variable data is bracketed and may vary from case to case. Amounts may vary or provisions may be modified to fit a specific Insured's request. Variable data will never exclude or limit provisions required by your state. We have attached the Statement of Variability which provides for the variables that may be included upon issuance of the policy. Also attached are the required certifications, transmittal forms and/or filing fees (if applicable). If you should have any questions or concerns regarding this submission, please do not hesitate to contact us. We thank you in advance for your time and consideration.

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Sincerely,

Tim Hager
 Compliance Analyst
 Mchugh Consulting Resources, Inc.
 215-230-7960
 mcr@mchughconsulting.com

Attachments

Company and Contact

Filing Contact Information

Ashley Schute, mcr@mchughconsulting.com
 2005 South Easton Road 215-230-7960 [Phone]
 Suite 207 215-230-7961 [FAX]
 Doylestown, PA 18901

Filing Company Information

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

RGA Reinsurance Company	CoCode: 93572	State of Domicile: Missouri
100 Washington Avenue South	Group Code:	Company Type:
Minneapolis, MN 93572	Group Name:	State ID Number:
(612) 217-6028 ext. [Phone]	FEIN Number: 43-1235868	

Filing Fees

Fee Required? Yes
 Fee Amount: \$200.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

Company	Amount	Date Processed	Transaction #
RGA Reinsurance Company	\$200.00	10/10/2012	63628747

State: Arkansas Filing Company: RGA Reinsurance Company
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/12/2012	10/12/2012

State: Arkansas
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Filing Company: RGA Reinsurance Company

Disposition

Disposition Date: 10/12/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Provider Excess Loss Insurance Policy	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Experience Refund Endoresment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes

State: Arkansas

Filing Company:

RGA Reinsurance Company

TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.003 Provider

Product Name: PEL-1000 6/2012 Provider Excess Loss - RGA Reinsur

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Form Schedule

Lead Form Number: PEL-1000-AR 6/2012

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 10/12/2012	PEL-1000-AR 6/2012	POL	Provider Excess Loss Insurance Policy	Initial:	0.000	PEL-1000-AR 6_2012 RGA PEL Policy- Clean.PDF
2	Approved-Closed 10/12/2012	PEL-1001-AR 6/2012	AEF	Application	Initial:	0.000	PEL-1001-AR 6_2012 RGA PEL Application- Clean.PDF
3	Approved-Closed 10/12/2012	PEL-1002-EXP END	POLA	Experience Refund Endoresment	Initial:	0.000	PEL-1002-EXP END RGA PEL Exp Refund End.PDF
4	Approved-Closed 10/12/2012	PEL-1003-AMD	POLA	Amendment	Initial:	0.000	PEL-1003-AMD RGA PEL Amendment.PDF

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

RGA REINSURANCE COMPANY
[1370 Timberlake Manor Parkway
Chesterfield, Missouri 63017-6039]
[1.888.736.5445]

PROVIDER EXCESS LOSS INSURANCE POLICY

RGA Reinsurance Company (“The Company”) agrees to pay the **Insured** for the **Losses** within the **Policy Limits**, which may accrue during the **Policy Period** for the **Eligible Services** herein, upon receipt of satisfactory **Proof of Loss**. Payment will be made in accordance with and subject to the terms and conditions of this Policy.

This Policy is issued to the **Insured** in consideration of the **Insured’s** application and the payment of the required **Premiums** as they become due. The first **Premium** is due on or before the Effective Date; subsequent **Premiums** are due as stated herein.

All defined terms appear in **bold**. Read the Definitions section carefully.

This Policy shall be governed by the laws of the State of Arkansas.

The Company issues this Policy as of the **Effective Date** shown in the **Schedule of Insurance**. The **Policy Period** is shown on the **Schedule of Insurance** and will begin and end at 12:01 A.M. at the principal office of the **Insured**.

IN WITNESS WHEREOF, this Policy has been signed on behalf of **RGA Reinsurance Company** by:

[insert Secretary signature]
Secretary

[insert President signature]
President

READ THIS POLICY CAREFULLY

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[

SCHEDULE OF INSURANCE

The following is a description of those coverages selected, the limits of insurance, and any **Specific Deductible(s)** and **Coinsurance** which may apply. The Policy consists of the coverages specifically indicated below, any coverage which is not listed below, or is not subsequently added by endorsement or amendment, is not covered under this Policy.

INSURED: [ABC Provider]
[12345 Main Street
Any City, ST 12345]

[Subsidiary or affiliated entities included in this Policy:
DEF Provider
678 Main Street
City, ST 67890]

POLICY NUMBER: [XXXX XXX]

EFFECTIVE DATE: [January 1, 2012]

POLICY PERIOD: [January 1, 2012 through December 31, 2012]

[MANAGED CARE ORGANIZATION(S) AND COVERED PLANS INCLUDED IN THIS POLICY:

Name of Organization and Covered Plan: [XXX, Inc.]
Address: [Any City, ST 44444]

Type of **Managed Care Organization:** [ABC Health Maintenance Organization]

Covered Membership Type: (Determined by agreement between the parties and provided to the Company prior to any effective date of coverage):

[Commercial [HMO, POS, PPO], Medicare, Medicaid,
Other_____]

CLAIMS BASIS:

Losses that are:

[Incurred from [January 1, 2012 through December 31, 2012];

- Paid and reported by [June 30, 2013]; and
- Submitted by [July 31, 2013]].

[Incurred on or after the Effective Date of the Policy Period and Paid within the Policy Period]

[Incurred within the Policy Period and Paid within the Policy Period plus _____ months following the Expiration Date of the Policy Period]

[Paid within the Policy Period]

SPECIFIC DEDUCTIBLE: [\$15,000 - \$1,250,000] per **Member** per **Policy Period** [for all **Eligible Services**]

[\$15,000 - \$1,250,000] per **Member** per **Policy Period** [for all eligible **Physician Services**]

[[\$15,000 - \$1,250,000] per **Member** per **Policy Period** [for all other **Eligible Services**]

[\$5,000 - \$1,250,000] per **Policy Period** for [XYZ **Member**][Per Episode Maximum: [3 months - 12 months]]

COINSURANCE: [50% - 100%] (**Insured** retains [50% - 100%])
[50% - 100%](**Insured** retains [50% - 100%])]

POLICY LIMIT: [\$1,000,000 - \$20,000,000] [Unlimited] per **Member** per **Policy Period**
[\$2,000,000 - \$20,000,000] [Unlimited] per **Member** per Lifetime]

ELIGIBLE SERVICES: [Ambulance Services]
[Dialysis Services]
[Drug Related Services]
[Durable Medical Equipment]
[Home Health Care Services]
[Inpatient Hospital Services]
[Inpatient Rehabilitation Services]
[Long Term Acute Care Hospital Services]
[Out of Area Emergency Services]
[Transplant Services]
[Skilled Nursing Facility Services]
[Outpatient Health Services]
[Physician Services]

[Episodes Of Care]

Episodes of Care for:

[Diabetes Treatment]
[Cancer Treatment]
[Heart Conditions]
[Traumatic Brain/Spinal Injury]
[Hospital Care]]
[Per Episode Maximum: [3 months – 24 months]]
[Services as described in the **Insured**'s attached [Provider]
[Risk] [Contract] Agreement]

PREMIUM: [\$XX.XX] per [Commercial [HMO], [POS], [PPO] **Member** per month]
[\$XX.XX] per [Medicaid] **Member** per month]
[\$XX.XX] per [Medicare] **Member** per month]
[\$XX.XX] per [Other _____] **Member** per month

PREMIUM PAYMENT BASIS: [Monthly]

[**MINIMUM PREMIUM:** [\$25,000 - \$2,000,000] [Does Not Apply]]

[Optional Endorsement(s):

[EXPERIENCE REFUND: ER Endorsement]

[Optional Attachments:]

]

SECTION I: DEFINITIONS

The following definitions apply to the terms used in this Policy. In the event of conflict in the meaning of the terms or the content of provisions between this Policy and the **Member Services Agreements**, provider contracts, **Capitated Provider Agreement**, **Covered Plan**, Division of Financial Responsibilities “DOFR” portion of **Capitated Provider Agreement** or the Division of Financial Responsibilities “DOFR” matrix, the definitions herein and the provisions of this Policy will govern.

[“**Ambulance Services**” means air and ground ambulance charges for emergency transportation, or for transfers between inpatient facilities.]

“**Capitated Provider Agreement**” means the written and executed agreement or contract, including any and all amendments and additions thereto, between the **Insured** and the **Managed Care Organization** through which the **Insured** agrees to provide **Eligible Services** to **Members** in exchange for a fixed monthly fee per **Member**. The section of the **Capitated Provider Agreement** that sets forth the division of financial responsibilities (“DOFR”) must be provided to the Company for review. In the event of a conflict between the terms of the **Capitated Provider Agreement** and the Policy, the Policy will govern.

“**Coinsurance**” means the percentage of eligible charges paid by the Company in excess of the **Specific Deductible**, as set forth in the **Schedule of Insurance**.

“**Covered Membership Type**” means the lives covered under a **Capitated Provider Agreement** as described in the Schedule of Insurance.

[“**Covered Plan(s)**” means the health benefits and medical services provided or made available to **Members** through the [Managed Care Organization(s)] [Insured] as set forth in the **Schedule of Insurance**. Such benefits and services must fall within the terms and provisions of the applicable **Member Services Agreement** to be considered as **Eligible Services**.]

[“**Custodial Care**” means those services, which can occur in different settings that follow an episode of acute **Illness** or **Injury**, where the patient is considered medically stable and no longer demonstrates measurable signs of improvement. This care is required to maintain the patient’s long term care needs, which may include, but are not limited to, ventilator management, oxygen administration, continuous positive airway pressure (CPAP), tracheostomy care, GI feedings, parenteral feedings (TPN), or medication administration.]

[“**Dialysis Services**” means all **Eligible Services** for hemodialysis and peritoneal dialysis treatment provided in a home or outpatient setting. These services may include equipment, supplies, injectable and oral drugs, laboratory tests and other items and services provided for dialysis treatment.]. [Inpatient dialysis treatment, **Physician** visits and nursing visits are not included in **Dialysis Services**.]

[“**Durable Medical Equipment**” means reusable medical equipment for use in the home that is not billed by a facility. These services may include blood glucose monitors, bone growth stimulators, canes, commode chairs, crutches home oxygen equipment, hospital beds, infusion pumps, nebulizers, patient lifts, prosthetic and orthotics, scooters, suction pumps, traction equipment, transcutaneous electronic nerve stimulators (TENS), ventilators or respiratory assist devices, walkers and wheelchairs.]

[“**Drug Related Services**” means all **Eligible Services** [for hemodialysis and related services;] for oral, self-administered or professionally administered chemotherapy agents and related services; self-administered or professionally administered injectables, IV therapy, and blood products [; and **Specialty Drugs**. [Retail Prescription Drugs are not included in **Drug Related Services**]

“Eligible Services” means any medically necessary services, treatments or supplies which are provided to a **Member** for which the **Insured** has agreed to provide services or reimburse other payors for services and is eligible for reimbursement pursuant to the terms of this Policy as selected by the **Insured** and stated under *Section III: Liability of Company*. Only services specifically stated in the **Capitated Provider Agreement** as the sole responsibility of the **Insured** to provide to the **Member**, as shown on the **Schedule of Insurance**, will be considered an Eligible Service. **Eligible Services** may include the following:

- a. **[Ambulance Services]**
- b. **[Dialysis Services]**
- c. **[Drug Related Services]** [and] **[Specialty Drugs]**
- d. **[Durable Medical Equipment]**
- e. **[Inpatient Hospital Services]**
- f. **[Inpatient Rehabilitation Services]**
- g. **[Long Term Acute Care Hospital Services (LTACH)]**
- h. **[Outpatient Health Services]**
- i. **[Physician Services]**
- j. **[Skilled Nursing Facility Services]**
- k. **[Subacute Care Services]**
- l. **[Transplant Services]**
- m. **[Outpatient Transplant Services]**

[Episodes Of Care]

Episodes of Care for:

[Diabetes Treatment]

[Cancer Treatment]

[Heart Conditions]

[Traumatic Brain/Spinal Injury]

[Hospital Care]

[Per Episode Maximum: [3 months – 24 months]]

[Services as described in the **Insured’s** attached [Provider] [Risk] [Contract] Agreement]

Retail Prescription Drugs are not included in **Drug Related Services.**]

“Episode of Care” means services as defined in **Insured’s** attached [**Capitated Provider Agreement**][Provider] [Risk] [Contract] [Agreement].] and shown on the **Schedule of Insurance** under **Eligible Services.**]

“False Claim” means any written statement which is a part of or supports a claim for payment or other benefit under this Policy which is knowingly presented or prepared with knowledge or belief that it will be presented to the Company and which the preparer or presenter knows to contain materially false information or omissions, as part of or in support of or concerning that claim.

“Home Health Care Services” means those services that are provided by a licensed home health agency, or home health care specialists. This may include skilled nursing services, physical therapy, occupational therapy, speech therapy and medical supplies.]. Examples of services not included in **Home Health Care Services** are **Custodial Care, Dialysis Services, Drug Related Services and Durable Medical Equipment.**]

“Illness” means a bodily, emotional or nervous disorder, or mental infirmity. **Illness** includes pregnancy (including resulting childbirth, non-elective therapeutic abortion when medically necessary, miscarriage, or complications).

“Incurred” means the date services are rendered or supplies are provided to the **Member**.

“Injury” means Bodily trauma which is caused directly (and independently of all other causes) by accidental or unexpected events.

“Inpatient Hospital Services” means those acute care, short-term diagnostic and therapeutic services, provided in a licensed acute care hospital, for which there is a room and board charge.

[Inpatient Hospital Services also include ambulance charges for transportation to licensed acute care hospitals for services as described in this section.]

Examples of services not included in **Inpatient Hospital Services** are **Physician Services, Custodial Care, Long Term Acute Care Hospital Services, Subacute Care Services, Skilled Nursing Facility Services** and care that is rendered primarily for the purposes of ventilator management.]

If a **Member** is confined in an inpatient hospital or facility on the date membership terminates, and the **Insured** is liable for services provided to that **Member** for additional days or until discharged, then those services provided during the duration of that confinement shall also be considered “**Eligible Services**” under this Policy, to the extent they qualify under *Section III: Liability of the Company*. Only services **Incurred** during the **Policy Period** are **Eligible Services**.

[“**Inpatient Rehabilitation Services**” means those services that are part of a separate and distinct inpatient program that provides skilled rehabilitation care to registered bed patients.]

“**Insolvent**” or “**Insolvency**” means:

1. The entry by a court of competent jurisdiction of:
 - a. A final order declaring the **Insured** insolvent, or
 - b. A final order appointing a receiver or receivers, or trustee or trustees, or liquidators of the **Insured** or of all or any substantial part of its property; or
2. The entry of an order pertaining to the **Insured** for relief under Title 11 of the United States Code or any similar order under any applicable law or statute of the United States or any state thereof.

“**Insured**” means the entity [institutional or professional provider of care] named in the **Schedule of Insurance** to whom this Policy is issued.

[“**Long Term Acute Care Hospital (LTACH) Services**” means comprehensive inpatient services in a licensed acute care hospital for patients who require specialized, complex services, and are stable enough to move to an LTACH. These services require daily **Physician** monitoring and intensive nursing care, generally with a length of stay of twenty-five (25) days or more. Examples include ventilator dependent patients and patients requiring wound care management, IV therapy, dialysis, and telemetry.]

“**Loss**” or “**Losses**” means charges for **Eligible Services Incurred** during the **Policy Period** by a **Member** in the course of treatment for an **Injury** or **Illness** as defined in the **Member Services Agreement**. A **Loss** shall be deemed **Incurred** on the date on which the **Member** receives the services..

For services where there are no specific fee payments, but reimbursement is provided for under an alternative payment arrangement of services rendered provided to the Company (as set forth in Request For Excess Loss Reimbursement Form) will, at the Company's discretion, be allowed in lieu of proof of payment. **Eligible Services** not rendered by the **Insured** must be paid by the **Insured** prior to being considered for reimbursement under this Policy. For services not rendered by the **Insured**, date of payment is evidenced by the date of the check issuance or electronic funds transfer payment of such service. In no event shall the insurance coverage be more than the actual amount for which the **Insured** is liable. **Loss** shall not include payments for which the **Insured** has no legal obligation to pay, interest, [withholds,][or] [capitation] payments paid by the **Insured**.

“**Managed Care Organization**” means the organization(s) listed in the Schedule of Insurance and to which the **Insured** has entered into a **Capitated Provider Agreement**.

“**Member**” means:

- a. a person who is (a) enrolled and eligible to receive **Eligible Services** under a **Covered Plan** in accordance with the terms and provisions of the **Member Services Agreement** ;
- b. is included in the **Covered Membership Type** as identified in the Schedule of Insurance; and
- c. for whom **Premium** is paid according to the terms of this Policy.

“**Member Services Agreement(s)**” means the contractual agreement(s) that describe covered services provided to a **Member** under a **Covered Plan(s)**[through a **Managed Care Organization(s)**

["**Network Hospital(s)**"] means the hospital(s) listed on [Attachment A] as may be amended from time to time by mutual agreement of the Company and the **Insured**.]

["**Out of Area Emergency Services**"] means **Eligible Services** for services provided to a **Member**, which due to an emergency, are provided outside the Plan's service area [as defined in **Member Services Agreement**]. [An emergency exists when there is a sudden onset of **Illness** or **Injury** occurring while the **Member** is outside the service area of the Plan:

- a. Requiring such immediate treatment that the life or health of the **Member** might be jeopardized if taken to a hospital, **Physician** or surgeon within the service area; or
- b. When the **Member** is incapable of making the decision on treatment.

For **Out of Area Emergency Services** to be eligible, the **Member** must reside in the Plan's service area for at least 7 months of each year, and the **Member** must return to the service area as soon as medically stable and authorized for transfer.]]

["**Outpatient Health Services**"] means those diagnostic and therapeutic services and products, generally and customarily provided in an ambulatory care [or home] setting. **Outpatient Health Services** shall also include the facility charges for ambulatory surgical procedures, x-rays and diagnostic procedures, radiation therapy, lab and pathology and medical supplies [and **Durable Medical Equipment**]. [**Outpatient Health Services** for home health care must be in accordance with a plan of care prescribed by a licensed **Physician**, for example, care provided by a registered nurse (R.N.) a licensed practical nurse (L.P.N.) or a licensed physical, speech or occupational therapist.]

Examples of services not included in **Outpatient Health Services** are **Inpatient Hospital Services, Physician Services, Custodial Care** [or ambulance charges].]

["**Outpatient Health Services**"] means those diagnostic and therapeutic services and supplies, generally and customarily provided in an ambulatory care or home setting. **Outpatient Health Services** shall also include the facility charges for ambulatory surgical procedures, x-rays and diagnostic procedures, radiation therapy, lab and pathology, medical supplies, and **Durable Medical Equipment**.

Outpatient Health Services for home health care must be in accordance with a plan of care prescribed by a licensed **Physician**, for example care provided by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed physical, speech or occupational therapist. Examples of services not included in **Outpatient Health Services** are **Inpatient Hospital Services, Physician Services, Custodial Care** [or ambulance charges].]

["**Outpatient Transplant Services**"] means bone marrow or stem cell transplant services, beginning on the first day of preparative or mobilization therapy and ending 30 calendar days after the stem cell infusion. **Outpatient Transplant Services** also includes the stem cell harvesting charges. **Outpatient Transplant Services** are covered under **Transplant Services**. Outpatient services which do not meet the above criteria will not be eligible under **Transplant Services** but may be eligible under **Outpatient Health Services**.]

"**Physician**" means a person duly licensed or certified to treat the type of **Injury** and **Illness** for which a claim is made and is practicing within the scope of his license.

["**Physician Services**"] means services or treatments rendered to a **Member** by a licensed **Physician** who has a contract or agreement with the **Insured** for the providing of services specified in the **Capitated Provider Agreement**. These services may include supplies (materials provided by the **Physician** over and above those customarily included with an office visit such as sterile trays or casting materials) and professional charges for lab and x-ray services.]

"**Policy Limit**" means the maximum amount of insurance reimbursable under this Policy for **Incurred Losses** for any one **Member** as set forth in the **Schedule of Insurance**.

"**Policy Period**" means the period of time beginning on the first date, and ending at midnight (Central Time) on the last date shown in the **Policy Period** on the **Schedule of Insurance**.

“**Premium**” means the amount to be remitted to the Company by the **Insured** for the insurance provided under this Policy as set forth in the **Schedule of Insurance**.

“**Proof of Loss**” means the formal documentation of those claims which the **Insured** submits to the Company for reimbursement under this Policy. This documentation must include at least the following minimum information:

1. A completed Request for Excess Loss Reimbursement Form providing all information requested in the form;
2. Copies of statements itemizing the occurrence, nature and extent of **Loss**; and
3. Any other detailed information that the Company may request.

[“**Reasonable and Customary**” means the amount allowed for **Eligible Services** shall be based upon the lesser of:]

- [1.] [The provider's standard charge for furnishing an **Eligible Service**;]
- [2.] [The negotiated rate with the **Physician**, facility or medical supply provider;]
- [3.] [The amount charged by providers for the same or similar services, treatments or supplies to persons who reside in the same or similar geographic practice area, and whose **Illness** or **Injury** is comparable in nature and severity to the **Eligible Services** performed.]

[However, if the **Eligible Service** is provided under a Medicare or Medicaid program or a private fee arrangement which is;

- a. defined by state or federal law;
- b. negotiated with the **Managed Care Organization**; or
- c. negotiated with other providers;

then the **Reasonable and Customary** charge shall be the appropriate fee defined under the applicable law or agreement.]

[“**Retail Prescription Drugs**” means pharmaceutical or biological medications filled and dispensed by a pharmacist that are covered under a traditional outpatient prescription drug benefit as defined in the **Member Service Agreement** which costs less than [\$750 - \$5,000 per thirty (30) day supply.]

“**Schedule of Insurance**” means the page or pages that detail the matters mentioned or referred to in the Policy and is attached to this Policy, which may be amended from time to time. The **Schedule of Insurance** is attached and a part of this Policy.

[“**Skilled Nursing Facility Services**” means restorative services received in a licensed skilled facility, either freestanding or part of a hospital, that accepts patients in need of rehabilitation and medical care that is of a lesser intensity than that received in an acute care hospital. The **Skilled Nursing Facility** shall provide twenty-four hour skilled nursing services under the supervision of a **Physician**.]

[“**Specialty Drugs**” means high cost (cost in excess of [\$750 - \$5,000 per thirty (30) day] supply) oral, injectable, infused, or inhaled medications that are either self-administered or professionally administered and are used in either a home or health care setting.]

“**Specific Deductible**” means the amount of **Losses** wholly retained by the **Insured** without reimbursement by the Company. This amount is shown in the **Schedule of Insurance**, and applies separately per **Member** per **Policy Period**.

[“**Subacute Care Services**” means comprehensive inpatient services for patients who do not require acute care services, but continue to require short-term, complex interventions. Examples include ventilator dependent patients, including newborns, and patients requiring medically complex treatment such as wound healing, IV therapy, pain management or AIDS treatment care.

Subacute Care Services can be provided in a variety of settings, including skilled nursing facilities, acute hospitals, and long term acute care facilities. For purposes of this Policy, **Subacute Care Services** are covered only as **Skilled Nursing Facility Services**.]

["Transplant Global Rate" means a pre-negotiated, inclusive case rate or flat fee (includes Diagnosis Related Group (DRG) or per diem arrangements) that generally includes the transplant procedure and inpatient or outpatient hospital charges and may include transplant evaluation charges, organ acquisition and/or **Physician** charges. The **Transplant Global Rate** may provide for a certain number of inpatient days that the flat fee covers and include a provision for additional inpatient days to be paid at a per diem rate. It may also include an inlier provision which designates that the negotiated payable amount will be the lesser of the case rate or a percent of billed charges.]

["Transplant Services" means those inpatient or **Outpatient Transplant Services** that are provided for solid organ or stem cell (bone marrow or peripheral stem cells) transplantation, including organ or stem cell acquisition, transplant procedure, hospital and ancillary services. **Transplant Services** do not include **Outpatient Health Services** or **Physician Services** unless they are included in a **Transplant Global Rate** and paid at the **Transplant Global Rate**. **Transplant Services** also include any affiliated access fees charged by a transplant network in association with the organ or stem cell transplantation. **Transplant Services** may also include charges for transportation and lodging associated with the **Member** receiving **Transplant Services** at a transplant network facility, provided that they are included in the **Member Services Agreement**.]

SECTION II: COVERED MEMBERSHIP TYPES

The **Covered Membership Types** are set forth in the attached **Schedule of Insurance** and are limited to those **Member Services Agreements** issued in the United States to cover United States residents. All **Members** under each **Member Services Agreement** must be covered under this Policy, unless otherwise agreed to by the Company and the **Insured** and shown on the **Schedule of Insurance**.

SECTION III: LIABILITY OF THE COMPANY

All **Loss** payments made by the **Insured** that are within the terms of this Policy as set forth in the **Schedule of Insurance** and which are within the terms and conditions of the **Member Services Agreement**, shall be binding upon the Company, who agrees to pay all amounts for which it may be liable.

Specific Deductible and Coinsurance. During the **Policy Period**, the Company shall not be liable for any **Losses** within the **Specific Deductible** amount. [The amount of the **Specific Deductible** may vary by type of **Eligible Service** as shown on the **Schedule of Insurance**.] The Company shall reimburse the **Insured** for the amount by which such **Loss** or **Losses** exceed the **Specific Deductible** during the **Policy Period**, multiplied by the **Coinsurance**, not to exceed the **Policy Limit** as set forth on the **Schedule of Insurance**.

[**Carry Over Provision:** If this Policy is renewed in accordance with *Section V: Term and Termination*, any **Loss Incurred** by the **Insured** on behalf of any one **Member** during the last thirty-one (31) days of the **Policy Period** for which no benefits were payable because the **Specific Deductible** was not satisfied shall be applied to the **Specific Deductible** for the next **Policy Period**.]

The Company agrees to reimburse the **Insured** for the **Losses** within the **Policy Limit**, which may accrue to the **Insured** during the **Policy Period** for the following **Eligible Services**:

1. **Inpatient Hospital Services.** **Inpatient Hospital Services** [including **Transplant Services**, network access fees and associated charges,] shall be limited for each **Member** to the lesser of:

Network Hospital Services

- (a) [[25-100] %] of billed charges; or
- (b) The amount paid by the **Insured**; or
- (c) [70% - 200%] of [Year] [Medicare Allowable Expense] [Medicaid Allowable Expense]. [; or
- (d) the per diem rate in [the following facilities or settings] [XYZ Hospital], subject to a maximum limit as shown below:

[Medical/Surgical-[\$500 - \$20,000]]

[Coronary Care-[\$500 - \$20,000]]

[Intensive Care Unit (ICU) - [\$500 - \$20,000]]

[Neonatal Intensive Care Unit (NIC) -[\$500 - \$20,000]]

[; or

Non-Network Hospital Services

- (a) [[25-100] %] of billed charges; or
- (b) The amount paid by the **Insured** [; or
- (c) [70% - 200%] of [Year] [Medicare Allowable Expense] [Medicaid Allowable Expense].]; or
- (d) The contracted rate as accepted by, and on file with the Company, [(Attachment A)], on the **Effective Date** of this Policy or as subsequently agreed to in writing by the Company and the **Insured**]; or
- (e) the per diem rate in [the following facilities or settings] [XYZ Hospital], subject to a maximum limit as shown below:

[Medical/Surgical-[\$500 - \$20,000]]

[Coronary Care-[\$500 - \$20,000]]

[Intensive Care Unit (ICU) - [\$500 - \$20,000]]

[Neonatal Intensive Care Unit (NIC) -[\$500 - \$20,000]]

[Daily Maximum[– Network and non-Network Hospitals]. Inpatient Hospital Services, with the exception of 2 (b) and (c) below [and services rendered by the **Insured** and valued using the per diems under (e) above], claims shall be limited to an average daily maximum for all hospital stays [during the **Policy Period**] [for each period of continuous **Inpatient Hospital Services**] stay for each **Member** as shown below:

- (a) [\$2,000 - \$20,000] for all [**Network Hospitals**] [Hospitals];
- [(b)] [[\$2,000 - \$20,000] for all non-**Network Hospitals**]; and
- [(c)] [\$2,000 - \$50,000] for each of the first [ten (10) days] [and [\$2,000 - \$50,000] for each of the next [ten (10) days] for **Transplant Services** paid at a percent of billed charges; and [\$2,000 - \$50,000] for each day thereafter for **Transplant Services** paid at a percent of billed charges basis.]

The cumulative average daily maximum allowed shall be calculated by multiplying the total number of room and board days during the **Policy Period** times the applicable average daily maximum amount. [The average daily maximum for **Network Hospitals** shall be calculated separately from the average daily maximum for non-**Network Hospitals** and from the average daily maximum for **Transplant Services**.]

[2.] [**Transplant Services.** Subject to the limitations in 1 above, **Transplant Services** will be considered eligible for reimbursement under **Inpatient Hospital Services**. **Eligible Services** include:

[(a)] For Transplants paid:
(1) At the **Transplant Global Rate** [which includes an inlier provision], the average daily maximum shown in 1., above shall be waived.

(2) At a percent of billed charges basis, the average daily maximum shown in 1. above shall apply. This includes those instances when a portion of the charges are paid at a case rate and a portion paid on a percent of billed charges basis; all such payments will be subject to this subsection (2).]

[(b)] **Network Access Fees.** Transplant network access fees shall be eligible for reimbursement.] [The network access fee is not subject to the average daily maximum provision in 2 (2).]

[(c)] **Associated Charges.** Transportation and lodging charges associated with the **Member** receiving transplant services shall be considered as **Eligible Services** [subject to a maximum limit in **Transplant Services** the amount of [\$10,000 - \$25,000]].

[3.] [**Long Term Acute Care Hospital Services.** **Long Term Acute Care Hospital Services** shall be limited for each Member to [an annual maximum of [\$15,000 – \$500,000] and]:

For [name of Provider(s)] [other] [**Network Providers**] [Non- **Network Providers**][all other providers], to the lesser of :

- [(a)] [25-100%] of billed charges; or]
- [(b)]The amount paid by the **Insured**; or]
- [(c)] A per day limit of [\$500 – \$20,000; or]
- [(d)] [70% - 200%] of [amount payable by Medicaid] [as of date] [area] [geographic practice area];
- [(e)] [70% - 200%] of [Medicare Allowable Expense] [as of date] [area] [geographic practice area]

[4.] [**Skilled Nursing Facility Services.** **Skilled Nursing Facility Services** shall be limited for each **Member** to [an annual maximum of [\$15,000 – \$200,000] and]:

For [name of Provider(s)] [other] [**Network** Providers] [Non- **Network** Providers][all other providers], to the lesser of :

- [(a) [25-100%] of billed charges; or]
- [(b)The amount paid by the **Insured**; or]
- [(c) A per day limit of [\$500 – \$20,000; or]
- [(d) [70% - 200%] of [amount payable by Medicaid] [as of date] [area] [geographic practice area];
- [(e) [70% - 200%] of [Medicare Allowable Expense] [as of date] [area] [geographic practice area]

- [5.] **Inpatient Rehabilitation Services. Inpatient Rehabilitation Services** shall be limited for each **Member** to [an annual maximum of [\$15,000 – \$500,000] and]:

For [name of Provider(s)] [other] [**Network** Providers] [Non- **Network** Providers][all other providers], to the lesser of :

- [(a) [25-100%] of billed charges; or]
- [(b)The amount paid by the **Insured**; or]
- [(c) A per day limit of [\$500 – \$20,000; or]
- [(d) [70% - 200%] of [amount payable by Medicaid] [as of date] [area] [geographic practice area];
- [(e) [70% - 200%] of [Medicare Allowable Expense] [as of date] [area] [geographic practice area]

- [6.] **Out of Area Emergency Services. Out of Area Emergency Services** shall be limited for each **Member** to [an annual maximum of [\$15,000 – \$500,000] and]:

For [name of Provider(s)] [other] [**Network** Providers] [Non- **Network** Providers][all other providers], to the lesser of :

- [(a) [25-100%] of billed charges; or]
- [(b)The amount paid by the **Insured**; or]
- [(c) A per day limit of [\$500 – \$20,000; or]
- [(d) [70% - 200%] of [amount payable by Medicaid] [as of date] [area] [geographic practice area];
- [(e) [70% - 200%] of [Medicare Allowable Expense] [as of date] [area] [geographic practice area]

- [7.] **Ambulance Services. Ambulance Services** shall be limited for each **Member** to [an annual maximum of [\$15,000 – \$100,000] and]:

For [name of Provider(s)] [other] [**Network** Providers] [Non- **Network** Providers][all other providers], to the lesser of :

- [(a) [25-100%] of billed charges; or]
- [(b)The amount paid by the **Insured**; or]
- [(c) A per day limit of [\$500 – \$20,000; or]
- [(d) [70% - 200%] of [amount payable by Medicaid] [as of date] [area] [geographic practice area];
- [(e) [70% - 200%] of [Medicare Allowable Expense] [as of date] [area] [geographic practice area]

- [8.] **Outpatient Health Services. Outpatient Health Services** shall be limited for each **Member** to [an annual maximum of [\$15,000 – \$150,000] and]:

For [name of Provider(s)] [other] [**Network** Providers] [Non- **Network** Providers][all other providers], to the lesser of :

- [(a) [25-100%] of billed charges; or]
- [(b)The amount paid by the **Insured**; or]
- [(c) A per day limit of [\$500 – \$20,000; or]
- [(d) [70% - 200%] of [amount payable by Medicaid] [as of date] [area] [geographic practice area];
- [(e) [70% - 200%] of [Medicare Allowable Expense] [as of date] [area] [geographic practice area]

[9.] **Dialysis Services.** **Dialysis Services** shall be limited for each **Member** to [an annual maximum of [\$15,000 – \$500,000] and]:

For [name of Provider(s)] [other] [**Network** Providers] [Non- **Network** Providers][all other providers], to the lesser of :

- [(a) [25-100%] of billed charges; or]
- [(b)The amount paid by the **Insured**; or]
- [(c) A per day limit of [\$500 – \$20,000; or]
- [(d) [70% - 200%] of [amount payable by Medicaid] [as of date] [area] [geographic practice area];
- [(e) [70% - 200%] of [Medicare Allowable Expense] [as of date] [area] [geographic practice area]

[10.] **Durable Medical Equipment.** **Durable Medical Equipment** shall be limited for each **Member** [to a maximum of [\$5,000 - \$500,000] to [an annual maximum of [\$15,000 – \$500,000] and]:

For [name of Provider(s)] [other] [**Network** Providers] [Non- **Network** Providers][all other providers], to the lesser of :

- [(a) [25-100%] of billed charges; or]
- [(b)The amount paid by the **Insured**; or]
- [(c) A per day limit of [\$500 – \$20,000; or]
- [(d) [70% - 200%] of [amount payable by Medicaid] [as of date] [area] [geographic practice area];
- [(e) [70% - 200%] of [Medicare Allowable Expense] [as of date] [area] [geographic practice area]

[11.] **Home Health Care Services.** **Home Health Care Services** shall be limited for each **Member** to [an annual maximum of [\$15,000 – \$500,000] and]:

For [name of Provider(s)] [other] [**Network** Providers] [Non- **Network** Providers][all other providers], to the lesser of :

- [(a) [25-100%] of billed charges; or]
- [(b)The amount paid by the **Insured**; or]
- [(c) A per day limit of [\$500 – \$20,000; or]
- [(d) [70% - 200%] of [amount payable by Medicaid] [as of date] [area] [geographic practice area];
- [(e) [70% - 200%] of [Medicare Allowable Expense] [as of date] [area] [geographic practice area]

[12.] **Physician Services.** [In-Network] [Out-of-Network] **Physician Services** shall be limited for each **Member** to the lesser of:

- (a) [50-100%] of billed charges; or
- (b) [The amount paid by the **Insured**] [; or]
- (c) [70% - 200%] of the [year] [Medicare] [Medicaid]allowable [as of date], with appropriate conversion factors, units and modifiers, for the [area][geographic practice area]
- (d) [25% - 100%] of billed charges [or the amount paid] for **Physician Services** with no [Medicare] [Medicaid] allowable amount.

[13.] **[Drug Related Services. Drug Related Services** shall be limited for each **Member** [to the lesser of:

- (a) [25-100%] of billed charges; or
- (b) The amount paid by the **Insured**]; or
- (c) [70% - 200%] of [Medicare Allowable Expense] [Medicaid Allowable Expense].

[Drug Related Services. Drug Related Services administered and or billed by a hospital or facility shall be limited for each **Member** [to the lesser of:

- (a) [25-100%] of billed charges; or
- (b) The amount paid by the **Insured**]; or
- (c) [70% - 200%] of [Medicare Allowable Expense] [Medicaid Allowable Expense].

[Drug Related Services. Drug Related Services administered and or billed by a **Physician** shall be limited for each **Member** [to the lesser of:

- (a) [25-100%] of billed charges; or
- (b) The amount paid by the **Insured**]; or
- (c) [25% - 200%] of Drugs Average Wholesale Price].]
- (d) [25% - 200%] of Drugs Wholesale Acquisition Cost].] [; or
- (e) [70% - 200%] of [Medicare Allowable Expense] [Medicaid Allowable Expense].

[Drug Related Services. Drug Related Services shall be limited as follows:

- (a) **Drug Related Services** rendered while a **Member** is receiving **Inpatient Hospital Services** are subject to the average daily maximum in 1. above.[If services are rendered in a **Long Term Acute Care Hospital, Skilled Nursing Facility** or **Inpatient Rehabilitation Facility**, such services are subject to the annual maximums that apply to those settings as shown above.]]
- [(b) **Drug Related Services** rendered in settings other than those listed in (a) above are limited to a maximum of [\$50,000 - \$1, 000, 000] of **Eligible Services** per **Member** per **Policy Period**. Such services are not subject to maximums otherwise applicable to services rendered in those settings.]
- [(c) **Drug Related Services** administered and or billed by a hospital or facility are limited to a maximum of [\$50,000 - \$1,000,000] of **Eligible Services** per **Member** per **Policy Period**. Such services are not subject to maximums otherwise applicable to services rendered in those settings.]

[“Specialty Drugs” means high cost (cost in excess of [\$750 - \$5,000 per thirty (30) day] supply) oral, injectible, infused, or inhaled medications that are either self-administered or professionally administered and are used in either a home or health care setting.]

[14.] **[Mental Health and Chemical Dependency. Mental Health and Chemical Dependency Services** shall be limited to:

- (a) [25-100%] [of billed charges]; or
- (b) [The amount paid by the **Insured**];
- (c) [[15-365 days] for inpatient mental health services;]
- (d) [[15-365 days] for inpatient chemical dependency services;]
- (e) [[15-365 days] for inpatient mental health and chemical dependency services combined;]
- (f) [[70% - 200%] of [Medicare Allowable Expense] [payable by Medicaid].]
- (g) [[\$250-\$10,000] per day].]

Policy Limit. The maximum amount payable under this Policy, during any **Policy Period** for each **Member** as set forth on the **Schedule of Insurance**. The lifetime maximum amount payable under this Policy, arising out of and inclusive of all **Policy Periods** for **Eligible Services** for each **Member** as set forth on the **Schedule of Insurance**.

Limitations and Exclusions

The Company shall not be liable to the **Insured** for any of the following:

1. Professional liability or liability for any act or omission, tortious or otherwise, in connection with any services rendered to any person or persons by the **Insured** or any affiliated group entity or person employed by or under contract with a provider agreement with the **Insured**.

Damages, actions or claims made against the Company and caused by the **Insured's** acts or omissions or failure to use diligence.

Expenses and **Losses**, which are due to any noncompliance or violation of any law by the **Insured**.

2. Liability that is incurred while this Policy, the **Covered Plan, Member Services Agreement** or **Capitated Provider Agreement** applicable to the **Member** is not in force [, even when these Agreements require continuation of services].
 3. Liability assumed by the **Covered Plan** in excess of the **Member Services Agreement**, or which is assumed by the **Covered Plan** under any contract other than the **Member Services Agreement**, unless otherwise stated as reimbursable in this Policy or an endorsement attached to this Policy.
 4. Liability assumed by the **Insured** in excess of the **Capitated Provider Agreement** applicable to a **Member** or which is assumed by the **Insured** under any contract or agreement other than the **Capitated Provider Agreement**.
 5. **Losses** excluded or not covered by the **Capitated Provider Agreement, Covered Plan** or **Member Services Agreement** applicable to a **Member**.
 6. Expenses or **Losses**, which the **Insured** has paid as settlement and released any persons or entity from its legal liability.
 7. Any liability, **Loss** or expense caused or contributed to by war (declared or undeclared), hostilities, invasion, civil war or participation by **Members** in riot or civil disturbance.
 8. Liability as a result of **Illness** or **Injury** not covered by the **Member Services Agreement** unless notice has been provided in accordance with this Policy and the Company has specifically agreed to provide coverage.
- [9.] **[Retail Prescription Drug charges.]**
- [10.] Liability that results from an **Illness** or **Injury** covered by or eligible to be covered by any Federal, state or local government social welfare program unless specifically reimbursable under the **Member Services Agreement**.
- [11.] Liability which is incurred for an **Illness** or **Injury** which arises out of or in the course of any employment for wage or profit or for which the **Member** is entitled to benefits under a Workers' Compensation, Occupational Disease, or similar law.
- [12.] **Losses** in excess of the **Policy Limit** or any other limit or maximum for **Eligible Services**.
- [13.] **Losses** or expenses **Incurred** by the **Insured** in connection with its **Member Services Agreement**, including but not limited to dividends, commissions or taxes.
- [14.] **[Losses that are: Incurred in excess of Reasonable and Customary charges, or which is in excess of any amount that would have been charged the Insured in the absence of the Capitated Provider Agreement.]**

- [15.] Administration costs or salaries paid to employees of the **Insured**.
- [16.] Expense to the extent that the **Insured** receives any payment or receives a reduction in charges by reason of a coordination of benefits provision in the **Insured's Member Services Agreement** or by any other source. The **Company** will only indemnify the **Insured** for that amount in excess of the amount received or applied as reductions in charges, whether collected or not.
- [17.] Any charges not payable because the Insured received a reduction in charges through negotiated agreements with providers, or is reimbursed, for any reason, by any person or entity.

SECTION IV: RESPONSIBILITIES OF THE INSURED

The **Insured** is solely responsible to provide all services to **Members** as set forth under the **Member Services Agreement(s)**, for compensation of all liability to its providers and to its **Members**, and for payment of all expenses to its **Members**. The Company has no responsibility for payment of salaries or expenses of the **Insured's** employees or representatives. The Company has no responsibility to provide any direct services or pay expenses to any **Member**. This Policy is solely between Company and the **Insured**.

The **Insured** is required to maintain a valid license to operate in the **State of Arkansas**, and all other licenses and approvals needed to conduct the business insured under this Policy.

Access to Records. Upon request, the **Insured** shall provide the Company or its designated representative, with detailed information in a timely manner on the coverage that forms the subject matter of this Policy, including, at the Company's expense, copies of the whole or part of any documents relating to the insurance and risk assumed under this Policy. Such information includes, but is not limited to, underwriting files, claim files, accounting files, internal and external correspondence, correspondence with intermediaries, audit reports, and actuarial studies as relating to the insurance risks. Such information, as well as access to **Insured** personnel familiar with such information, shall be made available during the **Insured's** normal office hours to the Company's representative(s) who shall be named in advance. The Company shall have this right of access as long as the Company has obligations under this Policy, and the **Insured** agrees to cooperate fully with the Company in providing this access.

The **Insured** shall cooperate with the Company and shall furnish the Company with such information as may be required by the Company with respect to **Losses** and settlements. Upon notification of **Losses**, the Company shall have the right to participate in the settlement or the defense of any claim or suit or proceeding involving the insurance under this Policy at its own expense.

Insured Change, Member Services Agreement or Covered Plan Change: The **Insured** shall give the Company written notice at least [thirty-one (31)] days in advance of any **Insured** change or change in the **Member Services Agreement** or **Covered Plan**, as defined herein.

Upon receipt of the written notice of an **Insured** change or change in the **Member Services Agreement** or **Covered Plan**, the Company shall have the right to terminate this Policy as set forth in *Section V: Term and Termination*.

If the Company elects to accept the changes and does not terminate this Policy pursuant to its rights stated herein, the Company shall have the right to change the **Premium** for or provisions of the Policy. Subject to *Section VIII: Material Change*, any such change is to be effective concurrent with the effective date of any **Insured** change, **Member Services Agreement** or

Covered Plan change or on some other date mutually agreed upon by the Company and the **Insured**.

SECTION V: TERM AND TERMINATION

Renewal and Subsequent Policy Periods. This Policy will terminate at the end of the **Policy Period** shown in the **Schedule of Insurance**; it is not automatically renewable.

[Sixty (60) days] prior to the end of the **Policy Period**, if the **Insured desires** to renew insurance hereunder, the Insured shall submit a completed renewal information form provided by the Company. The parties will negotiate the terms of a subsequent **Policy Period**. Such **Policy Period** must be agreed upon in writing by the Company and the **Insured**. The terms and conditions for such subsequent **Policy Period** will be evidenced by the issuance of a new Policy which shows the new **Premium** rates, details of coverage, and other new terms and conditions.

If the **Insured** submits **Premiums** after expiration of the **Policy Period**, such payment shall have no force and effect with respect to renewing this Policy.

Failure to Pay Premium. In the event that **Premiums** are not paid within [thirty-one (31) – ninety (90) days] of the due date, coverage hereunder will terminate as set forth in *Grace Period in Section VI*.

Insolvency. Should the **Insured** become **Insolvent**, this Policy shall automatically terminate as of the date of **Insolvency**.

Effect of Termination. Except as otherwise specifically provided in this Policy, termination shall have no effect on the rights and obligations of the parties arising prior to termination. Nothing herein shall be construed to extend Company's liability for payment under this Policy for any **Loss** arising, **Incurred** or paid by the **Insured** that was not properly paid, reported and submitted within the required time periods as provided in this Policy.

SECTION VI: PREMIUM PROVISIONS

Premium Due. In return for the payment of the **Premium**, and subject to all the terms of this Policy, the Company agrees to provide the insurance as stated in this Policy. During the **Policy Period**, the **Insured** shall remit to the Company the **Premium** as set forth in the **Schedule of Insurance**. **Premiums** are due on [the first day of each month] during the **Policy Period**, and must be received by the Company within [thirty-one (31) - ninety (90) days] thereafter, or this Policy will terminate, as set forth in Grace Period below.[Minimum **Premium** adjustments are due [sixty (60) days] after the end of the **Policy Period**.]

Grace Period. A grace period of [thirty-one (31) – ninety (90)] days from the **Premium** due date will be allowed for the receipt of each **Premium** due after the first. The first **Premium** must be received on or before the effective date of this Policy for insurance under this Policy to begin. If any **Premium** is not paid by the end of the Grace Period, the Company may cancel this Policy by providing the **Insured** ten (10) days written notice of cancellation. Such notice shall be issued as of the last day of the Grace Period and insurance under this Policy will terminate.

Premium Basis. **Premiums** shall be based on:

- 1) an estimate of the number of **Members**;
- 2) by **Covered Membership Type** covered by this Policy for the upcoming month; and
- 3) an adjustment for the previous months' actual number of **Members**.

Monthly adjustments will not be made more than [three (3) months] after the month for which the adjustment applies.

The Company shall have the right to adjust the **Premium** for any Material Changes as set forth in *Section VIII: Material Change*.

SECTION VII: CLAIMS PROVISIONS AND REPORTING REQUIREMENTS

Notice of Claim. In no event shall the Company be liable to the **Insured** for **Losses** unless the following conditions are met:

The **Insured** must submit written **Proof of Loss** to the Company. It must be received by the Company, the earlier of:

- a. the time period stipulated for submitting **Losses** in the Claims Basis section of the **Schedule of Insurance**; or
- b. [seven (7) months – twelve (12) months] after termination.

The **Insured** will have the earlier of twelve (12) months after the **Policy Period** in which the **Loss** was **Incurred** or twelve (12) months after termination to submit the following **Losses** to the Company:

- a. unsettled **Losses** due to coordination of benefits, as defined in the applicable **Member Services Agreement**;
- b. contested claims, and
- c. unsettled **Losses** subject to **Reimbursement** as set forth in *Section IX, General Provisions*.

Failure by Insured to submit written **Proof of Loss** within the time period specified on the Claims Basis section of the Schedule of Insurance will result in the Company's nonpayment of such a **Loss**. Company has no obligation to demonstrate prejudice with respect to this limitation.

Notification Of Losses:

1. **Monthly Excess Loss Reports.** The **Insured** shall submit to the Company a monthly Excess Loss Report within [(15)] days of the end of each month.
2. **Loss Reporting.** The **Losses** are paid and reported by the **Insured**, in writing, to the Company, the earlier of:
 - (a) the time period stipulated in the Claims Basis section of the **Schedule of Insurance**; or
 - (b) [six months - twelve months] after Termination.
3. **Failure to Timely Report.** A continual failure to submit Monthly Excess Loss Reports in a timely manner shall constitute a Material Change as set forth in Section VIII: Material Change and shall allow the Company all remedies set forth therein.
- [4. **Electronic Submission of Losses.** The **Insured** must report **Losses** electronically in a format acceptable to the Company which may include spreadsheets or data files with all information that is necessary for reimbursement of such **Losses** to the **Insured**.]

Loss Settlements. With respect to disputed **Losses**, all **Loss** settlements made by the **Covered Plan** that are within the terms of this Policy and the **Member Services Agreement** and do not constitute **Losses** for which there is no legal obligation to pay, shall be binding upon the Company.

Payment of Claims. No reimbursement will be made under this Policy for any **Losses** within the **Specific Deductible** amount. When the total amount of the **Losses** by the **Insured** has been determined, the Company will promptly, but in no event more than forty (40) calendar days later reimburse the **Insured** for that amount of the claim falling within the terms of this Policy.

False Claims. If the **Insured** knowingly submits false claim(s) or **Losses** or makes any material misrepresentation relating to claims or **Losses** to the Company, this Policy, at Company's discretion, will terminate from either the date of such false claim, or the date when the material misrepresentation is discovered, and the **Insured** shall reimburse the Company for any amounts paid under such false claim, **Loss** or as a result of the material misrepresentations.

Refund. If the Company makes a payment for a **Loss** and it is later determined that a lesser amount should have been paid, the Company shall be entitled to a prompt refund of the excess paid. In no event shall the insurance coverage be more than the actual amount for which the **Insured** is liable on any **Loss**.

SECTION VIII: MATERIAL CHANGE

A Material Change is a change that materially alters the nature, quality or quantity of the business or risk of the **Insured**. A Material Change includes, but is not limited to, the following:

1. A merger, consolidation or reorganization of the **Insured**, which results in substantial restructuring of the **Insured**'s corporate or financial structure, or an acquisition of substantially all of its assets;
2. A material change in the operations or financial condition of the **Insured**;
3. Changes in the **Member Services Agreements** including any changes or modifications in any covered benefits included in the **Member Services Agreement** which would materially alter the type or amount of benefits provided or the terms or conditions for eligibility or participation (e.g., the elimination of a significant exclusion);
4. Any changes or modifications to contracted rates with providers;
5. Material changes in the information provided by the **Insured** to the Company, directly or indirectly, upon which assessment of risk was based;
6. If the actual **Losses** for the prior **Policy Period** differ by more than [twenty-five percent (25%)] from **Losses** or potential **Losses** reported by the **Insured**, at the time of renewal, for the prior **Policy Period**;
7. A continuing failure to provide notices as required by *Section VII: Claims and Reporting Requirements*; or
8. Material changes in the **Covered Plan**, which may increase or extend the liability or exposure of the Company.

Notice of Material Change. The **Insured** must provide written notice to the Company of any Material Change. Such notice must be made in advance, whenever possible, or as soon as reasonably possible thereafter, but in no event more than [thirty (30) days] following a Material Change.

Effect of Material Change. Upon receipt of a Material Change notice, the Company may, [at its discretion]:

1. Accept the Material Change without revising the **Premium** and coverage terms;
2. Accept the Material Change and revise the **Premium** and/or coverage terms, but if the **Insured** rejects the revision within [thirty (30)] days after notice of the revised rates or terms, this Policy shall terminate, effective as of the date of the Material Change;
3. Not accept the Material Change but continue to provide coverage and adjudicate claims as if the Material Change had not occurred;
4. If the Material Change is as identified in 6. above, then Company may, at its option, and without waiver of any other right or remedy, adjust the **Premium** to reflect such percentage change in **Losses**, and such **Premium** adjustment will be retroactively effective as of the first day of the current **Policy Period**. Such adjusted **Premium** shall be immediately payable upon notice from Company; or
5. Terminate this Policy effective as of the date of the Material Change.

If this Policy is terminated in accordance with this provision, then the coverage and **Premium** shall be prorated according to the number of days in the reduced coverage period. In addition, if any **Losses** have been paid by the Company after the effective date of termination, i.e., after the date of the Material Change, such **Loss** payment shall be refunded to the Company.

Changes in this Policy as a result of a Material Change will be effective as of the date of the Material Change or on some other date mutually agreed upon by the **Company** and the **Insured**. Until the Company accepts any Material Change in the **Member Services Agreement** which would alter the type or amount of benefits provided or the terms or conditions for eligibility or participation, **Losses** will continue to be based upon the **Member Services Agreement**, unchanged.

Failure to Give Notice. If the **Insured** fails to give the Company timely notice of a Material Change, (or fails to give notice at all) the Company may, at its discretion:

1. Choose an option described in the *Effect of Material Change* section above; or
2. Rescind this Policy as of the coverage period first affected by the Material Change. In that event, the Company will refund all **Premium** paid and the **Insured** will return all **Loss** payments for the applicable period.

Legal and Equitable Rights. Nothing in this Section is intended or shall be interpreted to limit any rights the Company may have or be entitled to under law or the principles of equity, nor shall the Company's exercise of any rights under this Section constitute or be deemed a waiver of such other legal or equitable rights.

SECTION IX - GENERAL PROVISIONS

Arbitration.

Scope. Any dispute or other matter in that arises out of, or relating to, the formation, interpretation, performance, or breach of this Policy, whether such dispute arises before or after termination of this Policy, and whether in contract, tort, or otherwise, shall be settled by arbitration.

Notice. To initiate arbitration, either the **Insured** or the Company shall notify the other party in writing of its desire to arbitrate. The notice shall identify the claimant, the Policy at issue, and the nature of the claims and/or issues. Arbitration will take place at a mutually agreed time and place. Notice shall be sent certified mail, with return receipt, or another service that produces a receipt. The arbitration will be deemed to have been commenced on the date the notice of arbitration is received.

Selection of Arbitrators. Within 15 days after the commencement of arbitration, each party shall select a person to act as arbitrator and the two selected shall select a third arbitrator within 10 days of their appointment. The party-selected arbitrators will serve in a neutral capacity. If the arbitrators selected by the parties are unable or fail to agree upon the third arbitrator, the third arbitrator shall be selected by the American Arbitration Association.

Fees. Unless the arbitrators decide otherwise, each party will bear the expense of its own arbitration activities, including its appointed arbitrator and any outside attorney and witness fees. The parties will jointly and equally bear the expense of the third arbitrator and other costs of the arbitration.

Appeal. Either party to the arbitration may petition the court to confirm, correct or vacate the award.

Assignment. This Policy may not be assigned by either party without the prior written consent of the other.

Conformity with State Statutes: This Policy will be interpreted in accordance with the laws of the state where it is issued or delivered. If any provision of this Policy conflicts with such laws, it will be deemed amended so as to conform with the minimum requirements of such laws.

Confidentiality. All information disclosed to the Company by the **Insured**, or to the **Insured** by the Company, either in the course of conducting negotiations or as the result of complying with the terms and conditions of this Policy, shall be considered to be proprietary and confidential information (“Confidential Information”) by both the **Insured** and the Company and shall not be disclosed without written consent of the other, except to auditors, attorneys and retrocessionaires and as required by applicable law or judicial process. The parties agree to maintain strict confidentiality under applicable federal and state laws and regulations relating to personally identifiable health information of **Members** to which the parties gain access pursuant to this Policy. The parties understand that they may be obligated to enter into a separate agreement pursuant to the Health Insurance Portability and Accountability Act (42 U.S.C. § 201, et seq.) which shall identify the respective responsibilities of the parties with regards to certain types of Confidential Information. Confidential Information shall not include any information which at the time of disclosure or thereafter is generally available to and known by the public other than by way of a wrongful disclosure by the Company or the **Insured**. The confidentiality and nondisclosure obligations set forth herein supersede any prior agreement between the parties addressing such obligations regarding the subject matter of this Policy.

Compliance. The **Insured** and the Company each represent that to the best of its knowledge and belief it is, and shall use its best efforts to continue to be, in substantial compliance in all material respects with all laws, regulations, and judicial and administrative orders applicable to the insurance provided under this Policy. This includes the maintenance of an effective anti-money laundering policy to the extent the **Insured** is required to have such a policy in place. Neither the **Insured** nor the Company shall be required to take any action under this Policy that would result in it being in violation of any law, which for purposes of companies subject to U.S. regulation, including the Company, shall include requirements enforced by the U.S. Treasury Department Office of Foreign Asset Control.

The **Insured** and the Company acknowledge and agree that a claim under this Policy is not payable if payment would cause the Company to be in violation of any law. Should either party discover a payment has been made in violation of any law, it shall notify the other party and the parties shall cooperate in order to take all necessary corrective actions. The **Insured** will return the payment to the Company to the extent, and at such time, as permitted by law.

Entire Contract: This Policy, including the **Schedule of Insurance**, Riders and Endorsements, exhibits, and the **Insured's** application which are attached hereto, contains the entire contract between the **Insured** and the Company. In the absence of fraud, any statements made by the **Insured** are representations and not warranties. No statement will void this insurance or reduce benefits under the Policy unless the statement is contained in a written instrument signed by the **Insured**, and a copy of that written statement has been furnished to the **Insured**. All changes to this Policy must be in writing and signed by officers of the **Insured** and the Company.

Errors and Omissions: Any inadvertent delays, errors or omissions made in connection with this Policy shall not be held to relieve either the Company or the **Insured** from any liability which would attach to such party if such delays, omissions or errors had not been made, provided such errors or omissions are advised and rectified promptly upon discovery. The provisions of the preceding sentence, however, do not apply to any **Loss** or claim reporting obligations of the insured under this Policy.

Extra Contractual Obligations: In no event shall the Company participate in punitive or compensatory damages or statutory penalties which are awarded against the **Insured** in connection with the **Losses** insured under this Policy.

Extra Contractual Obligations include, but are not limited to:

- a. any amount paid by the **Insured** for legal expenses; or
- b. punitive or exemplary damages, or compensatory damages or;
- c. any other extra contractual damages awarded to any **Member** arising out of the conduct of the **Insured's** investigation, trial or settlement of any claim; or
- d. failure to pay or delay in payment of any benefits or rendering of any services under the **Member Services Agreement(s)**.

Extra Contractual Obligations also include any statutory penalty imposed upon the **Insured** due to any unfair trade practice, any unfair claim practice or any fraudulent or criminal act by any officer or director of the **Insured** acting individually or collectively or in collusion with any individual or corporation or any other organization or party involved in the presentation, defense or settlement of any claim covered or allegedly covered under this Policy.

Disclaimer: The Company acts only as a provider of excess loss insurance coverage to the **Insured**. The Company is not a fiduciary. The Company does not assume any duty to perform any of the functions or provide any of the reports required by the Employee Retirement Income Security Act of 1974, as amended. In no event shall the Company participate in punitive or compensatory damages or statutory penalties which are awarded against the **Insured** or **Covered Plan** in connection with the **Losses** insured under this Policy.

The Company has no right or obligation to pay any person or provider of professional or medical services. The Company's sole liability is to the **Insured**, subject to the terms and conditions of this Policy. Nothing in the Policy shall be construed to permit a **Member** to have a direct right of action against the Company. The Company will not be considered a party to the **Member Services Agreement** or to any supplement or amendment to it.

Insolvency: If the **Insured** should become **Insolvent**, this Policy shall automatically terminate as provided in *Section V: Term and Termination*, as of the date of the **Insolvency**. The Company shall have no obligation with respect to administration of underlying **Covered Plan** benefits or for making any direct payments to any party other than the **Insured** or its liquidator, receiver, rehabilitator, trustee, administrator or other statutory successor (collectively referred to as "Successor") for any **Losses Incurred** before the date of the **Insolvency**. The Company will make payments directly to the **Insured** or its Successor, with reasonable provisions for verification, without diminution because of the **Insolvency** of the **Insured**.

The **Insured** or its Successor will cooperate with the Company upon reasonable notice in providing full access to the **Insured** records and personnel, at the **Insured**'s expense, to enable the Company to reasonably determine its obligations.

The **Insured** or its Successor shall give written notice to the Company of pending claims against the **Insured** within a reasonable time after such claims are presented to the **Insured** or its Successor or when such claims are filed in an **Insolvency** proceeding. During the pendency of such claims, the Company may investigate such claims and interpose, at its own expense, in the proceeding where such claims are to be adjudicated, any defense or defenses which it may deem available to the **Insured** or its Successor. As soon as practicable after such time as the **Insured** may become **Insolvent**, the **Insured** or its Successor shall take any and all steps necessary to obtain any court approval which may be required to permit expenses incurred by the Company to be chargeable against the **Insolvent Insured** as part of the expenses of liquidation or rehabilitation. If no such court approval is required, such expenses shall automatically become chargeable as expenses of liquidation or rehabilitation entitled to such priority as may attach as a matter of applicable law. Nothing contained herein requires the Company to take such actions, and the Company's obligations remain limited to the terms of this Policy.

Notice of the **Insured**'s date of **Insolvency** or date of cessation of operations shall be communicated to the Company by the **Insured** or its Successor at the earliest possible time.

The **Insured** shall notify the Company immediately of the pendency of action, which may lead to **Insolvency** or any intentions the organization may have of ceasing operation.

The Company and the **Insured** or its Successor shall have the right to offset to the maximum extent permitted by applicable law.

Legal Action

No suit or action at law or in equity may be brought to recover benefits under this Policy prior to the expiration of sixty (60) days after written **Proof of Loss** has been furnished. No suit or action at law or in equity may be brought more than three (3) years from the date **Proof of Loss** was required.

Offset. The Company shall have the right to offset any balance or amounts due from the **Insured** under the terms of this Policy. However, in the event of **Insolvency** of any party hereto, offset shall only be allowed in accordance with applicable law.

Other Insurance. In the event there is any other insurance, whether or not collectible, applicable to **Eligible Services** falling within the **Deductible(s)**, the **Insured** will continue to be responsible for the full **Deductible(s)** before the insurance under this Policy applies. If any other valid and collectible insurance Policy applies to a claim that is also covered by this Policy, this Policy will apply excess of the other insurance Policy, unless such other coverage is specifically issued to be excess of the insurance afforded by this Policy.

Notices. All notices and communications hereunder, excluding **Loss** notices, shall be in writing and shall become effective when received. Any written notice shall be by either certified or registered mail, return receipt requested, or overnight delivery service (providing for delivery receipt) or delivered by hand.

Reimbursement. The Company shall be credited with reimbursement obtained or recovery made by the **Insured** from liable third parties (less the reasonable and necessary expenses the **Insured** paid in recovering from the liable third party. the actual cost, excluding salaries of officials and employees of the **Insured** and sums paid to attorneys as retainer, of obtaining such reimbursement or making such recovery), on account of claims and settlements involving the insurance hereunder. The recovered amount cannot be used to meet a deductible amount or an attachment point. Such credit will be applied to any amounts either paid by the Company or that would be payable by the Company under this Policy regardless of whether this Policy is still in force on the date of recovery., and such credit will be repaid by the **Insured** to the Company within thirty (30) days, to the extent that the Company has paid **Loss** amounts related to the reimbursement or recovery. If the **Insured** fails to provide any reimbursement to which the Company is entitled to under this provision, the Company has the right to offset such overpayment against any other benefit payable to the **Insured** to the extent of such overpayment.

Exceptions. The only exceptions to this section are previously reported **Losses** that are: (i) unsettled Losses due to coordination of benefits, as defined in the applicable Member Service Agreement, (ii) contested claims, and (iii) unsettled **Losses** subject to reimbursement.

Severability. If any provision of this Policy, or its application to any party or circumstance, shall be adjudged by a court or other authority to be invalid or unenforceable, the parties agree that such judgment shall in no way affect the validity and enforceability of other provisions of this Policy that reasonably can be given effect apart from that which is invalidated.

Third Party Beneficiaries. This is a contract between the **Insured** and the Company only, and nothing herein shall in any manner create any obligations or establish any rights against either the **Insured** or the Company in favor of any third parties or persons not party to this Policy.

Waiver. The failure of either party to insist on strict compliance with this Policy, or to exercise any right or remedy hereunder, shall not constitute a waiver of any rights contained herein nor stop either party from thereafter demanding full and complete compliance nor prevent the parties from exercising such a remedy in the future.

[**Agent/Representative of the Insured:** The **Insured** may retain a third party to act as an agent or representative for the **Insured** in performing any or all of the duties as designated by the **Insured**. [ABC Administrator] is hereby recognized as the designated third party under this Policy. All communications relating to administration and negotiation of the insurance provided under this Policy shall be transmitted from one party to the other through such third party at the following address [insert name and applicable address for communications]. The parties acknowledge that **Premium** payments and administration of claims and claim payments are being administered directly between the **Insured** and the Company.]

[TO BE USED WHEN **PREMIUM** IS NOT BEING HANDLED THROUGH THIRD PARTY]

[**Agent/Representative of the Insured:** The **Insured** may retain a third party to act as an agent or representative for the **Insured** in performing any or all of the duties as designated by the **Insured**. [ABC Administrator] is hereby recognized as the designated third party under this Policy. All communications relating to administration and negotiation of the insurance provided under this Policy shall be transmitted from one party to the other through such third party at the following address [insert name and applicable address for communications]. The parties acknowledge that **Premium** payments and administration of claims and claim payments are being administered directly between the **Insured** and the Company.]

[ATTACHMENT A]

Provider Contracted Rates

[As reviewed and accepted by the Insurer.]

I, the undersigned, have reviewed this attachment.

Insured

Date

RG REINSURANCE COMPANY
[1370 Timberlake Manor Parkway
Chesterfield, Missouri 63017-6039]
[1.888.736.5445]

APPLICATION FOR PROVIDER EXCESS LOSS INSURANCE

1. **INSURED:** [ABC Provider]
ADDRESS: 12345 Main Street,
City, ST 12345
- [Subsidiary or affiliated entities included in this Policy:
DEF Provider
678 Main Street
City, ST 67890]
2. **POLICY NUMBER:** [12345]
3. **[PROPOSED] EFFECTIVE DATE:** [01/01/2012] (subject to the Company's acceptance)
4. **POLICY PERIOD:** [January 1, 2012 through December 31, 2012]
5. **COVERED MEMBERSHIP TYPE(S):**
- [Commercial [HMO, POS, PPO], Medicare, Medicaid,
 Other _____]
6. **COVERAGE: Specific Excess Loss Insurance**
- A. **Specific Deductible:** [\$15,000 - \$1,250,000] per Member per Policy Period
[for all Eligible Services]
[[\$15,000 - \$1,250,000] per Member per Policy Period [for all eligible
Physician Services]
[[\$15,000 - \$1,250,000] per Member per Policy Period [for all other
Eligible Services]
- B. **Coinsurance:** [50% - 100%] (Insured retains [50% - 100%])
[50% - 100%] Other _____]
- C. **Policy Limit:** [\$1,000,000 - \$20,000,000] [Unlimited] per **Member per Policy Period**
[\$2,000,000 - \$20,000,000] [Unlimited] per **Member per Lifetime**

7. **CLAIMS BASIS:** [Losses that are:

[Incurred from [January 1, 2012 through December 31, 2012]]; Paid and reported by [June 30, 2013]; and Submitted by [July 31, 2013].

[Incurred on or after the Effective Date of the Policy Period and Paid within the Policy Period]

[Incurred within the Policy Period and Paid within the Policy Period plus _____ months following the Expiration Date of the Policy Period]

[Paid within the Policy Period]

8. **ELIGIBLE SERVICES:**

- [Ambulance Services]
- [Dialysis Services]
- [Drug Related Services]
- [Durable Medical Equipment]
- [Home Health Care Services]
- [Inpatient Hospital Services]
- [Inpatient Rehabilitation Services]
- [Long Term Acute Care Hospital Services]
- [Out of Area Emergency Services]
- [Transplant Services]
- [Skilled Nursing Facility Services]
- [Outpatient Health Services]
- [Physician Services]

[[Episodes of Care]

Episodes of Care for:

- [Diabetes Treatment]
- [Cancer Treatment]
- [Heart Conditions]
- [Traumatic Brain/Spinal Injury]
- [Hospital Care]
- [Per Episode Maximum: [3 months – 24 months]]
- [as described in the Insured's attached [Provider] [Risk] [Contract] Agreement]

[9.] **[ENDORSEMENTS:** Yes

EXPERIENCE REFUND:

ER Endorsement

[10.] **PREMIUM:**

[\$00.00] per [Commercial [HMO, POS, PPO] Member per month]

[\$00.00] per [Medicaid] Member per month]

[\$00.00 per [Medicare] Member per month]

[\$00.00 per [Other] _____] Member per month

Premium Payment Basis: [Monthly]

Premium Due Date: [The first day of each month]

[11.] **[MINIMUM PREMIUM:** [\$25,000 - \$2,000,000] [Does Not Apply]

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

This Policy is approved, and the terms contained within it are accepted by the Insured as issued by the Company.

This Application must be executed in duplicate. One copy will be attached to the Policy, and the other must be returned to RGA Reinsurance Company.

The Insured acknowledges that:

- (a) a true and accurate copy of the Member Services Agreement [and the Capitation Agreement(s) Division of Financial Responsibilities section] in force on the effective date of this Policy, and all other applicable information must be provided to the Company for the Policy to be fully executed and losses reimbursable; and
- (b) changes in such Agreement(s) must be reported as required by the Policy.[Changes to the capitation agreement(s) may require changes to the rating basis indicated in the Schedule of Insurance.]

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

[FRAUD NOTICE - Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.]

For: _____
(Legal Name of Insured)

By: _____ (Signature) _____ (Title)

At: _____ (City, State) Date: _____

Witness: _____ On: _____

Countersigned by: _____
(To be signed by Resident Agent where required by law)

EXPERIENCE REFUND ENDORSEMENT

This Endorsement is attached to and made part of Provider Excess Loss Policy Number [XXXXXX] issued to [Insured]. This Endorsement is subject to all the provisions, limitations and exclusions of the Policy except as they are specifically modified herein. The effective date of this Endorsement is [the Effective Date of the Policy to which it is attached].

The following provision is hereby made an additional part of the Policy between the Company and the Insured. [However, this provision will only apply if premium for this Policy Period is [\$250,000 – 1,000,000] or greater.]

1. Requirements. For this Policy Period, if: (a) all Premiums and/or payments which are due under the Policy are paid in full to the Company, (b) there have been no Material Changes to the Policy, and (c) there is no termination of the Policy prior to the date stated on the Schedule of Insurance, an Experience Refund shall be provided as follows:

The Experience Refund shall be calculated by the Company ninety (90) days following the Claims Submission Period as stated in the Claims Basis section of the Schedule of Insurance. The Company will send the Insured documentation of this calculation for the Insured to certify. After the Insured provides written certification of the Experience Refund calculated by Company, Company will issue the Experience Refund.

2. Premium Credit. The Company shall calculate a credit in the amount of [50% - 85]% of the Premium received by the Company for this Policy Period.

3. Losses. The Company shall calculate the final amount of Losses that have been or shall be reimbursed to the Insured for the Policy Period.

4. Net Balance. The net balance is the Premium Credit less the Losses.

5. Experience Refund. The Experience Refund shall be [10% - 50]% of the net balance, provided that the net balance is greater than zero (0).

6. Deficit Balance. If the application of the above calculation results in a deficit balance, such deficit balance shall be carried forward and applied against future calculations of the Experience Refund. A deficit balance will be carried forward for a maximum of three (3) Policy periods.

7. Subsequent Policy Period Requirements. Any payment due to the Insured under this provision shall be contingent upon entering into a Policy for a subsequent Policy Period with the subsequent Policy Period's premium of at least 50% of the premium of the expiring Policy Period.

All other terms, conditions, limitations and exclusions of the Policy remain unchanged.

[Signed on behalf of **RG A Reinsurance Company** by:

[insert Secretary signature]
Secretary

[insert President signature]
President

RG A REINSURANCE COMPANY
[1370 Timberlake Manor Parkway
Chesterfield, Missouri 63017-6039]
[1.888.736.5445]

This Amendment is attached to and made part of Excess Loss Policy Number [XXXXXX] issued to [Insured]. This Amendment is subject to all the provisions, limitations and exclusions of the Policy except are specifically provided herein. The effective date of this Amendment is shown below.

It is understood and agreed that the Policy is amended as follows:

- [1. The name of the Insured is changed to:

[XYZ Provider]
- [2. The address of the Insured is changed to:

456 Oak Street
Anytown, ST]

All other terms, conditions, limitations and exclusions of the Policy remain unchanged.

Signed on behalf of **RG A Reinsurance Company** by:

[insert Secretary signature]
Secretary

[insert President signature]
President

Insured's Authorized Representative

Print Name:

Title _____

Date _____

Amendment Number: [XXXX] _____

Effective Date: [[01.01.10] _____]

SERFF Tracking #:

MCHX-G128716656

State Tracking #:

Company Tracking #:

PEL-1000 6/2012

State: Arkansas

Filing Company:

RGA Reinsurance Company

TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.003 Provider

Product Name: PEL-1000 6/2012 Provider Excess Loss - RGA Reinsur

Project Name/Number: PEL-1000 6/2012 Provider Excess Loss - RGA Reinsurance Company /PEL-1000 6/2012 Provider Excess Loss - RGA Reinsurance Company

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	10/12/2012
Comments:	Please see form schedule.		

		Item Status:	Status Date:
Satisfied - Item:	Authorization Letter	Approved-Closed	10/12/2012
Comments:			
Attachment(s):			
04_30_12 Authorization Letter - RGA Reins.PDF			

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/12/2012
Comments:			
Attachment(s):			
AR Readability Certification.PDF			
AR Cert of Compliance 23-79-138 and R&R 49.PDF			
AR Cert of Compliance, Rule & Reg 19.PDF			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved-Closed	10/12/2012
Comments:			
Attachment(s):			
AR RGA PEL Statement of Variability-Clean.PDF			



April 30, 2012

NAIC Company Code: 93572

RE: Attached Filing Submission

Please accept this letter as authorization from RGA Reinsurance Company for McHugh Consulting Resources, Inc. to file any or all policy forms and/or rates as referenced in the corresponding SERFF filing on behalf of RGA Reinsurance Company.

Sincerely,

A handwritten signature in blue ink, appearing to read "Michelle Fallahi", is positioned above the typed name.

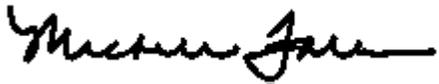
Michelle Fallahi
Senior Vice President
Healthcare Reinsurance

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: RGA Reinsurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of the Arkansas Insurance Code 23-80-201 through 23-80-208, cited as the Life and Accident and Health Insurance Policy Language Simplification Act.

Form Number	Score
PEL-1000-AR 6/2012	48.25
PEL-1001-AR 6/2012	48.25
PEL-1002-EXP END	48.25
PEL-1003-AMD	48.25

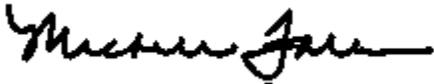
Signed: 
Name: Michelle Fallahi
Title: Senior Vice President
Date: September 28, 2012

CERTIFICATE OF COMPLIANCE

Insurer: RGA Reinsurance Company

Form Numbers: PEL-1000-AR 6/2012, PEL-1001-AR 6/2012,
PEL-1002-EXP END, PEL-1003-AMD

I hereby certify that the filing above meets all applicable Arkansas requirements including Regulation 49 (Life and Health Guaranty Fund Notice) and Ark. Code Ann. 23-79-138 and Bulletin 15-2009 (Consumer Information Notice).



Signature of Company Officer

Michelle Fallahi

Name

Senior Vice President

Title

September 28, 2012

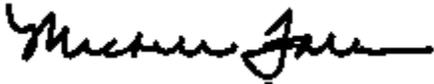
Date

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: RGA Reinsurance Company

Form Number(s): PEL-1000-AR 6/2012, PEL-1001-AR 6/2012, PEL-1002-EXP END, PEL-1003-AMD

I hereby certify that to the best of my knowledge and belief, the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Michelle Fallahi

Name

Senior Vice President

Title

September 28, 2012

Date

RGA Reinsurance Company
Statement of Variability
Policy Form PEL-1000-AR 6/2012 et al.

Arkansas

Purpose and Use of Forms

- No changes will be made to the forms which are in conflict with state law or are outside the parameters of the variability described herein and reflected in the forms.

In no case is the bracketing intended to indicate that contractual language can be changed beyond the parameters of that which has been filed and approved. The variable language will always comply with minimum statutory requirements. Variable material indicated by hard brackets ([]) that enclose an entire page, benefit, coverage, paragraph, phrase or words indicate that it may be included or excluded as provided. Variable and illustrative material will never be more restrictive than permitted by law.

- Brackets around numbers or alphas in a listing and punctuation in a listing will be included or deleted as needed in order to make the statement read correctly.
- Numeric variables within the schedule, endorsements or amendments will always comply with the minimum statutory requirements of the state in which the policy is issued.
- All names, dates, amounts and other numbers, such as percents, time periods, page numbers, are illustrative and will vary from case to case.
- No changes will be made to the forms which are in conflict with state law or are outside the parameters of the variability described herein and reflected in the forms.
- Except for numerical values and certain plan-specific information in the schedule, variable language will be included or omitted in its entirety. If a provision includes a choice of two or more bracketed language variations, then one of the listed language options will be included in its entirety with the other(s) omitted in their entirety.

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

PROVIDER EXCESS LOSS APPLICATION, FORM PEL-1001-AR 6/2012

- The Application contains sample language for filing purposes. All names and dates will vary from case to case. Numeric variables are shown as typical ranges. . In all cases of ranges, both the minimum and maximum limits will comply with any applicable state requirements.
- The Application specifies those types of coverages/services available and the options and amounts to be selected by the applicant/insured.

PROVIDER EXCESS LOSS POLICY, FORM PEL-1000-AR 6/2012

Schedule of Insurance

- The Schedule contains sample language for filing purposes; numeric variables are shown as typical ranges. The amounts listed vary based upon the amount requested from the capitated provider and agreed to by the carrier.

The Schedule will specify, for example, the types of benefits provided and reimbursement amounts for various services elected by the Insured, the Covered Membership Types which may include multiple types that are part of a managed care organization covering plans that e.g. Commercial, Medicaid, Medicare and other state programs.

- The range of coverage varies as the risk assumed by each capitated medical provider is different.
- In all cases of ranges, both the minimum and maximum limits will comply with any applicable state requirements.

Definitions

- Variable definitions may be included or omitted in their entirety as applicable to the selected coverages. For example, skilled nursing services may be omitted if these services are not covered under the policy.

Liability of the Company

- Numeric variables are shown as typical ranges; where no range is provided, periods of time will not be more than that shown. Variable language will be included or omitted in its entirety based on the options and amounts elected by the applicant/insured, e.g. if daily maximums apply, this wording will be included; otherwise it will be omitted. In all cases of ranges, both the minimum and maximum limits will comply with any applicable state requirements.

Limitations and Exclusions

- Variable wording in Item 3, may be included if mutually agreed to by the both parties; otherwise it will be omitted. Item 9 may be included or omitted based on the coverage selected.

Responsibilities of the Insured

- Bracketed periods of time will not be more than that shown.

Term and Termination

- Numeric variables/number of days are shown as typical ranges; where no range is provided, periods of time will not be more than that shown. In all cases of ranges, both the minimum and maximum limits will comply with any applicable state requirements.

Premium Provisions

- Numeric variables/number of days are shown as typical ranges; where no range is provided, periods of time will not be more than that shown. In all cases of ranges, both the minimum and maximum limits will comply with any applicable state requirements.

Claims and Reporting Requirements

- Numeric variables/number of days are shown as typical ranges; where no range is provided, periods of time will not be more than that shown. In all cases of ranges, both the minimum and maximum limits will comply with any applicable state requirements.

Material Change

- Numeric variables, percentages and number of days are shown as typical ranges; where no range is provided, periods of time and percentages will not be more than that shown. In all cases of ranges, both the minimum and maximum limits will comply with any applicable state requirements.

EXPERIENCE REFUND ENDORSEMENT, FORM PEL-1002-EXP END

- Numeric variables are shown as typical ranges. In all cases of ranges, both the minimum and maximum limits will comply with any applicable state requirements.

POLICY AMENDMENT, FORM PEL-1003-AMD

- This Amendment may be used for a variety of administrative and coverage modifications within the parameters of that which has been filed and approved. For example, the amendment may be used for address or name changes and/or a change of Schedule items.