

**State:** Arkansas **Filing Company:** The Union Labor Life Insurance Company  
**TOI/Sub-TOI:** H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness  
**Product Name:** GROUP STOP LOSS INSURANCE POLICY  
**Project Name/Number:** SL-2012/

## Filing at a Glance

Company: The Union Labor Life Insurance Company  
Product Name: GROUP STOP LOSS INSURANCE POLICY  
State: Arkansas  
TOI: H12 Health - Excess/Stop Loss  
Sub-TOI: H12.001 Accident & Sickness  
Filing Type: Form/Rate  
Date Submitted: 09/13/2012  
SERFF Tr Num: ULCC-128684855  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: STOP LOSS SL-2012  
  
Implementation: On Approval  
Date Requested:  
Author(s): Carla Wallace  
Reviewer(s): Rosalind Minor (primary)  
Disposition Date: 09/18/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

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## General Information

Project Name: SL-2012 Status of Filing in Domicile:  
 Project Number: Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments:  
 Explanation for Combination/Other: Market Type:  
 Submission Type: New Submission Overall Rate Impact:  
 Filing Status Changed: 09/18/2012  
 State Status Changed: 09/18/2012 Deemer Date:  
 Created By: Carla Wallace Submitted By: Carla Wallace  
 Corresponding Filing Tracking Number:

Filing Description:  
 Re: NEW GROUP STOP LOSS INSURANCE POLICY FORMS FILING  
 Group Stop Loss Insurance Policy, form SL-2012  
 Schedule of Stop Loss, form SLS-2012

The Union Labor Life Insurance Company  
 NAIC 781-69744 FEIN 13-1423090

Dear Sir or Madam:

Please find enclosed the above-referenced group Stop Loss insurance policy forms for your review and approval. These forms are new and do not replace any forms currently on file with the Department.

Group Stop Loss Insurance Policy, form SL-2012

This policy is designed to provide Specific and Aggregate Stop Loss coverage.

The policy reimburses the group policyholder, as opposed to the individual group member, for medical claims paid to individual group members under self-insured plans.

Schedule of Stop Loss, form SL-2012

This schedule is the vehicle by which group policyholders request benefits under this group Stop Loss coverage.

The completed schedule will be attached to and made a part of the policy.

This group Stop Loss product will be marketed using salaried sales personnel to Taft-Hartley and Welfare Funds (labor unions) as well as large employer groups (51+ employers). The salesperson may sell directly to the group policyholder or through brokers and consultants.

An Actuarial Memorandum and the rating methodology applicable to this product is provided for your review and approval.

Finally, we have included a Readability Certification that indicates the Flesch/Kincaid Readability test scores and a Variable Memorandum that explains the variability shown in brackets for the policy and schedule forms

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To the best of our knowledge and belief, these forms comply with all applicable state insurance laws and regulations.

All forms are in final print format.

If you have any questions, please let me know.

## Company and Contact

### Filing Contact Information

Carla Wallace, Compliance Analyst cwallace@ullico.com  
 8403 Colesville Rd 202-962-2901 [Phone]  
 Silver Spring, MD 20910

### Filing Company Information

The Union Labor Life Insurance Company	CoCode: 69744	State of Domicile: Maryland
8403 Colesville Road	Group Code: 781	Company Type: Life and Health
Silver Spring, MD 20910	Group Name:	State ID Number:
(202) 682-0900 ext. [Phone]	FEIN Number: 13-1423090	

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$250.00  
 Retaliatory? Yes  
 Fee Explanation: 1 policy form @ \$125.00 = \$125.00  
                           1 Schedule form @ \$125.00 = \$125.00  
 Per Company: No

Company	Amount	Date Processed	Transaction #
The Union Labor Life Insurance Company	\$250.00	09/13/2012	62663193

SERFF Tracking #:

ULCC-128684855

State Tracking #:

Company Tracking #:

STOP LOSS SL-2012

State:

Arkansas

Filing Company:

The Union Labor Life Insurance Company

TOI/Sub-TOI:

H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness

Product Name:

GROUP STOP LOSS INSURANCE POLICY

Project Name/Number:

SL-2012/

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/18/2012	09/18/2012

**State:** Arkansas  
**TOI/Sub-TOI:** H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness  
**Product Name:** GROUP STOP LOSS INSURANCE POLICY  
**Project Name/Number:** SL-2012/

**Filing Company:** The Union Labor Life Insurance Company

## Disposition

Disposition Date: 09/18/2012

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
The Union Labor Life Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Form	GROUP STOP LOSS INSURANCE POLICY	Approved-Closed	Yes
Form	SCHEDULE OF STOP LOSS	Approved-Closed	Yes
Rate	Stop Loss Specific 2012 Rating Manual	Approved-Closed	No
Rate	Stop Loss Aggregate 2012 Rating Manual	Approved-Closed	No
Rate	Stop Loss Rating Options - 2012	Approved-Closed	No

State: Arkansas

Filing Company:

The Union Labor Life Insurance Company

TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident &amp; Sickness

Product Name: GROUP STOP LOSS INSURANCE POLICY

Project Name/Number: SL-2012/

## Form Schedule

### Lead Form Number:

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 09/18/2012	SL-2012	POL	GROUP STOP LOSS INSURANCE POLICY	Initial:	50.400	GROUP STOP LOSS INSURANCE POLICY.pdf
2	Approved-Closed 09/18/2012	SLS-2012	SCH	SCHEDULE OF STOP LOSS	Initial:	52.300	SCHEDULE OF STOP LOSS.pdf

### Form Type Legend:

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



**THE UNION LABOR LIFE INSURANCE COMPANY**  
[Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910  
Executive Office: 1625 Eye Street, Washington, DC 20006]

## **GROUP STOP LOSS INSURANCE POLICY**

POLICY NUMBER: [SLIXXXX]  
PLAN SPONSOR: [XYZ WWELFARE FUND]  
EFFECTIVE DATE OF POLICY: [January 1, 2013] at 12:01 a.m. local time at the  
address of the Policyholder

This Policy is issued in consideration of the Plan Sponsor's Schedule of Stop Loss and payment of the first premium.

We will pay the Plan Sponsor when the Plan Sponsor has an eligible claim, subject to the limits of liability, exclusions, conditions and all other terms of this Policy.

This Policy is delivered in [the District of Columbia] and is governed by its laws. The Plan Sponsor's Schedule of Stop Loss, other attached forms and Amendments, Endorsements, or Riders, if any, form part of this Policy.

This Policy has been signed on Our behalf by Our Secretary and President.

**SECRETARY**

**PRESIDENT**

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## SECTION I.

### DEFINITIONS

Other terms may be defined where they are used in this Policy.

Actively at Work means the Covered Person is performing, or available to perform, on a full time basis all regular duties of his or her normal occupation on the Effective Date of this Policy or on his or her last regularly scheduled work day prior to the Effective Date, or on the date a Covered Person becomes eligible, if after the Effective Date of this Policy.

Actively at Life means that the Covered Person or Covered Dependent is able to perform the same lifestyle functions of a person of similar age and sex who is in good health. A Covered Person's Covered Dependent is not Actively at Life if hospital confined.

Administrator means a firm or person having a written agreement with the Plan Sponsor to process its benefits and provide administrative services. The selected Administrator must be acceptable to Us.

Adverse Benefit Determination means a determination by the Plan, its Administrator, or its utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

Aggregated Specific Deductible means a deductible, in addition to the Specific Deductible, applied to the calculation of the Specific Stop Loss Reimbursement that must be satisfied before Eligible Expenses are reimbursable under this Policy. The Aggregated Specific Deductible is satisfied by applying any Eligible Expenses that exceed the Specific Deductible up to the Specific Limit of Liability per Plan Participant per Plan Period for any Specific Stop Loss Reimbursement. The Aggregated Specific Deductible is shown on the Schedule of Stop Loss.]

Annual Aggregate Deductible / Aggregate Deductible means the portion of Eligible Expenses that is wholly retained by the Plan Sponsor and which is not payable to the Plan Sponsor under the terms of this Policy. It is the greater of:

1. the total of the number of Covered Units in each Policy month multiplied by the Monthly Aggregate Deductible Factor from the Schedule of Stop Loss for each Policy month; or
2. the Minimum Annual Aggregate Deductible shown in the Schedule of Stop Loss.

If coverage under this Policy terminates during the Plan Period, the Annual Aggregate Deductible will be based on the full Number of Plan Months shown in the Schedule of Stop Loss. For purposes of this calculation only, the number of Covered Units in the last full month in which the Policy is in force will be considered the number of Covered Units during the balance of the Plan Period remaining after the termination of the Policy.])

Aggregate Run-In Limit means the maximum amount of Eligible Expenses shown in the Schedule of Stop Loss, Incurred prior to the Effective Date, that will be included in determining an Aggregate Stop Loss Reimbursement. Eligible Expenses Incurred prior to the Effective Date and in excess of the Aggregate Run-In Limit will not be included in determining an Aggregate Stop Loss Reimbursement.])

Aggregate Stop Loss Reimbursement means the amount calculated under the Aggregate Stop Loss Insurance provision as payable by Us to the Plan Sponsor.])

## SECTION I.

### DEFINITIONS (Continued)

Benefit Period means the period established for Specific and/or Aggregate Stop Loss Insurance during which an expense must be Incurred by a Plan Participant and be Paid by the Plan Sponsor for it to be considered an Eligible Expense under this Policy.

Benefit Plan means the program of self-funded accident and sickness benefits provided to Plan Participants by the Plan Sponsor which:

1. is written in the Plan Document that is in effect on the effective date of this Policy, or as amended and so accepted by Us;
2. complies with all required Federal laws and regulations; and
3. meets the minimum requirements of the State in which this Policy is issued.

Clinical Trial means items and services in connection with a scientific study of a new therapy or intervention for the treatment, palliation, or prevention of cancer or other life threatening illness that meets all of the following requirements:

1. The treatment or intervention is provided pursuant to an approved clinical trial for cancer or other life threatening illness that has been funded authorized or approved by one of the following:
  - a. The National Institutes of Health (NIH) including the National Cancer Institute (NCI);
  - b. The United States Food and Drug Administration (FDA) in the form of an investigational new drug (IND) exemption;
  - c. The United States Department of Veteran Affairs (VA);
  - d. Centers for Disease Control and Prevention (CDC);
  - e. Agency for Healthcare Research and Quality (AHRQ); or
  - f. Centers for Medicare and Medicaid Services (CMS).
2. The proposed therapy or intervention has been reviewed and approved by the applicable qualified Institutional Review Board.
3. The available clinical or pre-clinical data indicate that the treatment or intervention provided pursuant to the approved clinical trial will be at least as effective as standard therapy, if such therapy exists, and is anticipated to constitute an improvement in effectiveness for treatment, prevention, or palliation of cancer or other life threatening illness.
4. The facility and personnel providing the treatment are capable of doing so by virtue of their experience and training.
5. The trial consists of a scientific plan of treatment that included specific goals, a rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of the quantitative measures for determining treatment response, and methods for documenting and treating adverse reactions. All such trials must have undergone a review for scientific content and validity, as evidenced by approval from one of the federal entities identified above. ]

## SECTION I.

### DEFINITIONS (Continued)

6. The trial must:
- a. Evaluate a service which is otherwise an Eligible Expense; and
  - b. Have a therapeutic intent (i.e., not designed exclusively to test toxicity or disease pathophysiology); and
  - c. Enroll diagnosed Plan Participants. ]

Covered Dependent means the Covered Person's dependent if such dependent is eligible and covered for benefits under the Benefit Plan.

Covered Person / Person means an employee or member of the Plan Sponsor or any other individual who is eligible for benefits other than as a dependent under the Benefit Plan.

Covered Units means single Persons, single Persons with dependents (families), or a composite of both.

Eligible Expenses means only the charges which:

1. are covered and payable under the Benefit Plan, as shown on the Schedule of Stop Loss;
2. have been Paid by the Plan Sponsor in accordance with the terms of the Benefit Plan for the Benefit Period shown on the Schedule of Stop Loss; and
3. are not excluded or limited under this Policy.

[The following items and services in connection with a Clinical Trial will also be deemed Eligible Expenses by Us:

1. Otherwise covered physician fees, laboratory expenses, and expenses associated with a hospitalization;
2. The costs of evaluation and treatment of the patient associated with the underlying condition;
3. The costs of care consistent with the usual standards of care whenever a patient receives medical care associated with an approved clinical trial; and
4. The costs of any other care that would be covered by the Benefit Plan if such items and services were provided other than in connection with an approved Clinical Trial.

The term does not include the following items and services in connection with a Clinical Trial:

1. The costs of the investigational drugs, devices or services that are the subject of the Clinical Trial;
2. The costs of any non-health services that might be required for a Plan Participant to receive the clinical trial treatment or intervention (e.g., transportation, hotel, meals and other travel expenses);
3. The costs of managing the Clinical Trial research; or
4. The costs of any items or services that would not be covered under the Benefit Plan for non-investigational treatments. ]

## SECTION I.

### DEFINITIONS (Continued)

[Notwithstanding any other provision of this Policy, Eligible Expense will not include deductibles, coinsurance amounts, or any other expense or claims which are not payable under the terms of the Benefit Plan. Eligible Expenses will not include:

1. charges which are paid or which can be reimbursed from any other source;
2. any cost of a claim payment or expense of litigation; nor
3. any expenses or claims in excess of the Specific Limit of Liability per Plan Participant per Plan Period.]

Experimental or Investigative means services, treatments, procedures, technology, supplies or drugs which:

1. have not been approved by the Federal Food and Drug Administration; or
2. are not generally recognized and accepted as effective, safe and appropriate for the Plan Participant's condition, sickness or injury by the medical profession in the U.S., including but not limited to services, treatments, procedures, technology, supplies or drugs:
  - a. which are in the research or investigative stage, or are administered or conducted for research or similar purposes; or
  - b. have been administered or conducted in conjunction with a release or other document signed by the Plan Participant indicating that the treatment is Experimental or Investigative or other term of similar meaning.

In determining any of the above, the Company will rely on recognized medical sources such as, but not limited to, the American Medical Association, including the Council of Technology Assistance Program and the Council on Medical Special Services; the National Institutes of Health; the Centers for Medicare and Medicaid Services; the Food and Drug Administration and other generally accepted medical authorities and sources.

The fact that a treatment is determined to be Medically Necessary does not, of itself, mean that the charge is not Experimental or Investigative.

Incurred means the date on which:

1. a covered service was rendered to or supply was received by a Plan Participant; or
2. a periodic disability income benefit payment becomes payable to the Plan Participant (not the date disability commences) under the Benefit Plan.

Independent Review Organization means an independent review organization (IRO) that is accredited by a nationally-recognized accrediting organization to conduct the external review pursuant to the procedures established by the Plan as required by the applicable law.

Medically Necessary means that the services, supplies, treatment and confinement must be generally recognized in the physician's profession as effective and essential for treatment of the injury or illness for which they are ordered; and that they must be rendered at the appropriate level of care in the most appropriate setting based on diagnosis. To be considered Medically Necessary, the care must be based on generally recognized and accepted standards of medical practice in the United States and it must be the type of care that could not have been omitted without an adverse effect on the patient's condition or the quality of medical care.

## SECTION I.

### DEFINITIONS (Continued)

Services, treatment, supplies or confinement will not be considered Medically Necessary if they are an Experimental or Investigative or primarily limited to research in their application to the injury or illness; are primarily for scholastic, educational, vocational or developmental training; or are primarily for the comfort, convenience or administrative ease of the provider or the patient or his or her family or caretaker.

[The Company will make a final determination as to whether a service or supply is Medically Necessary within the meaning of this Policy.] [We reserve the right to review medical care and make a determination as to whether the services, treatment, supplies, confinement, or portion of a confinement, are Medically Necessary.] We may rely on Our medical review department or an independent reviewer for this determination. The fact that a physician or any other health care provider may order or recommend services, treatment, supplies or confinement does not, of itself, make them Medically Necessary.

Minimum Annual Aggregate Deductible means, for the Policy Year, the amount shown in the Schedule of Stop Loss, regardless of how long coverage under this Policy is in force.]

Monthly Aggregate Deductible means for any month the total of the number of Covered Units in a Policy month multiplied by the Monthly Aggregate Deductible Factor from the Schedule of Stop Loss for a Policy month.]

Paid / Pay / Payment means charges that, as of the dates shown on the Schedule of Stop Loss for the Benefit Period:

1. are covered and payable under the Benefit Plan; and
2. have been adjudicated and approved;

Payment will be deemed made on the date that both (1) payment has actually been disbursed by mailing (or otherwise delivering) a draft, check or electronic fund transfer, and (2) the account upon which the payment is drawn contains, and continues to contain, sufficient funds to permit the check or draft to be honored.

Our reimbursements will not be made until all of these conditions are satisfied. Checks or drafts that are returned to the payor unpaid for any reason will not be considered Paid.

Plan Document means the written form of the Benefit Plan, which must be filed with and approved by Us. The Plan Document is the basis on which claims are paid under this Policy. Without such document on file, claims will not be paid. The Plan Document includes any amendments that are approved in accordance with the provisions of this Policy.

Plan Participant means a Covered Person or a Covered Dependent who is eligible for benefits under the Benefit Plan. Plan Participants are limited to those individuals for whom premiums are received by Us from the Plan Sponsor.

Plan Period means the date specified in the Schedule of Stop Loss. This is the period on which premiums are based. The Plan Period will conclude with the earlier of the Renewal Date or the date coverage terminates according to the **TERMINATION** and **CANCELLATION** provisions of this Policy.

Policy means this Group Stop Loss Insurance Policy issued by Us.

## SECTION I.

### DEFINITIONS (Continued)

**Reasonable and Customary** means charges for medical expenses that are determined and calculated by Us utilizing an industry-wide data system with reference to the charges for the same service by such providers in the same or similar geographic area in which the care is provided. Medical expenses include but are not limited to, physician and facility services, hospital supplies, hospital bed rates, drugs, ancillary services and durable medical equipment. To determine the Reasonable and Customary charge, We use an industry-wide data system that collects data on providers' charges by zip code and procedure code. The industry-wide data system arrays these charges and calculates percentiles. A charge will be deemed Reasonable and Customary if the charge does not exceed the 90<sup>th</sup> percentile for the prevailing fee for such charges for the same service in the same or similar geographic area. The prevailing fee is developed from a statistically valid sample which:

1. equitably recognizes geographic variations;
2. is produced every six months; and
3. is collected on the basis of procedure codes developed and maintained by recognized authorities.

In cases where Reasonable and Customary charges cannot be determined by reference to the industry-wide data system described the above, a charge which does not exceed 200% of the Medicare reimbursement rate in effect at the time services were provided for the same service in the same or similar geographic area, as determined by a generally accepted industry source for such reimbursement rates, will be deemed a Reasonable and Customary charge.

**The fact that a treatment is determined to be Medically Necessary does not, of itself, mean that the charge is Reasonable and Customary.]**

OR

**Reasonable and Customary** means the usual charge made by an individual, group or entity who renders or furnishes services, treatment or supplies which are covered under this Policy. In no event does it mean a charge in excess of the general level of charges made by others who render or furnish similar services, treatments or supplies to individuals:

1. who reside in the same geographical area; and
2. whose illness or Injury is comparable in nature or severity.

**The fact that a treatment is determined to be Medically Necessary does not, of itself, mean that the charge is Reasonable and Customary.]**

**Specific Stop Loss Reimbursement** means the amount calculated under the Specific Stop Loss Insurance provision as payable by Us to the Plan Sponsor.]

**Specific Deductible** means the amount which is wholly retained by the Plan Sponsor as shown in the Schedule of Stop Loss. The Specific Deductible applies separately to each Plan Participant for each Plan Period.]

We / Our / Us / The Company means The Union Labor Life Insurance Company.

## SECTION II.

### BENEFIT

We will reimburse the Plan Sponsor for Eligible Expenses that exceed the Specific Deductible shown in the Schedule of Stop Loss and the Aggregate Deductible as calculated by the terms of this Policy.

#### **[ SPECIFIC STOP LOSS INSURANCE**

We will pay, subject to the terms, conditions, and limitations of this Policy, the Specific Stop Loss Reimbursement, if any, to the Plan Sponsor.

Claims under Specific Stop Loss Insurance will be paid by Us after our acceptance of proof of Payment and satisfactory proof of Eligible Expense under the Benefit Plan. A Specific Deductible applies to each Plan Participant. The Specific Deductible is identified in the Schedule of Stop Loss. Each Specific Deductible can be met only by Eligible Expenses as to the particular Plan Participant, which are Incurred and Paid by the Plan Sponsor during the Benefit Period specified in the Schedule of Stop Loss. Any Payment the Plan Sponsor makes will be applied to the Plan Period in which Payment is actually made. There will be no coverage for payments made which have been or will be reimbursed by another source.

The Specific Stop Loss Reimbursement applies to a Plan Period or any fraction of that Plan Period. It is:

1. Payments made for Eligible Expenses during the Benefit Period with regard to a Plan Participant; less
2. the Specific Deductible for the Plan Participant; with
3. the result multiplied by the Specific Reimbursement Factor from the Schedule of Stop Loss.

**[**Additionally, the Aggregated Specific Deductible must be met before We will reimburse the Plan Sponsor under this Specific Stop Loss Insurance provision. The Aggregated Specific Deductible is shown in the Schedule of Stop Loss. **]** In no event will the amount of the Specific Stop Loss Reimbursement to the Plan Sponsor for a Plan Participant exceed the Specific Limit of Liability per Plan Participant per Plan Period shown in the Schedule of Stop Loss.

#### Claim Documentation

The following documentation is required to file a Specific Stop Loss claim:

1. a completed Specific Stop Loss claim form;
2. a copy of the Covered Person's enrollment form, including the Covered Person's hire date and the original effective date of coverage;
3. complete details regarding eligibility, and if applicable, information regarding work status, subrogation, coordination of benefits, and COBRA;
4. copies of explanations of benefits and checks attached to the corresponding itemized bills;
5. miscellaneous information as applicable, including, but not limited to:
  - a. complete accident details, including how, when, and where an accident may have occurred;
  - b. police reports for motor vehicle accidents or for services for which a law enforcement agency is involved;
  - c. a subrogation and right to recovery reimbursement agreement if charges were Incurred as a result of a third party liability;
  - d. coordination of benefits documentation;
  - e. PPO discount / repricing sheets; **]**

## SECTION II.

### BENEFIT (Continued)

- f. large case management reports; and
- g. any other documentation We may request.

#### ADVANCE FUNDING

Upon Our receipt of the Plan Sponsor's written request at least 30 days prior to the end of the Specific Benefit Period, the Company may provide advance funding to the Plan Sponsor for Eligible Expenses Incurred, though not Paid, for a Benefit Period shown in the Schedule of Stop Loss. The advance funding with regard to a Plan Participant will be provided only if all of the following conditions are met:

1. the Company receives satisfactory proof that the requested funding is for Eligible Expenses Incurred by the Plan Sponsor, including all information requested by Us to determine Our liability for the claim.
2. the Plan Sponsor must have made Payments for Eligible Expenses sufficient to exceed the Plan Participant's Specific Deductible by at least \$1,000; and
3. the Eligible Expenses submitted for advance funding must have been fully processed according to the terms of the Benefit Plan and ready for Payment;

Within five (5) business days of its receipt of advance funding from the Company, the Plan Sponsor must Pay the Eligible Expense. If for any reason the Plan Sponsor does not use the advance funding or any portion of it to Pay the Eligible Expense within five (5) business days of receipt of the advance funding, the Plan Sponsor will return the unused portion of the advanced funding to the Company within five (5) business days.

The amount payable by Us under the Policy to the Plan Sponsor as the Specific Stop Loss Reimbursement will be reduced by any amounts provided as advance funding under this Policy for the same Benefit Period. At the end of the Benefit Period, any advance funding amounts that exceed the Specific Stop Loss Reimbursement must be repaid within thirty (30) days of written notice from Us.

## SECTION II.

### BENEFIT (Continued)

#### AGGREGATE STOP LOSS INSURANCE

We will pay, subject to the terms, conditions, and limitations of this Policy, the Aggregate Stop Loss Reimbursement, if any, to the Plan Sponsor. Payment will be made at the end of the Plan Period or after the termination of coverage if coverage terminates during the Plan Period.

We will pay the Aggregate Stop Loss Reimbursement after Our acceptance of proof of Payment and satisfactory proof of Eligible Expenses under the Benefit Plan. There will be no coverage for Eligible Expenses which have been or will be reimbursed by another source or any amounts paid or payable as a Specific Stop Loss Reimbursement under this Policy.

The Aggregate Stop Loss Reimbursement for the Plan Period or any fraction of that Plan Period is determined as follows:

1. Payments made for Eligible Expenses during the Benefit Period, less
2. Eligible Expenses that were Incurred prior to the Effective Date in excess of the amount shown in the Schedule of Stop Loss as the Aggregate Run-In Limit, if any; less
3. any Eligible Expenses in excess of the Maximum Per Plan Participant Annual Aggregate Limit shown on the Schedule of Stop Loss; less
4. the Annual Aggregate Deductible; with
5. the result multiplied by the Aggregate Reimbursement Factor shown on the Schedule of Stop Loss.

The amount of the Aggregate Stop Loss Reimbursement will be the lesser of 5 above or the Aggregate Limit of Liability shown in the Schedule of Stop Loss.

The amount owed to the Plan Sponsor as the Aggregate Stop Loss Reimbursement will be reduced by any amounts paid under this Policy for the same Plan Period as Aggregate Accommodations that were not repaid as overpayments and were not offset against the Specific Stop Loss Reimbursement. At the end of the Plan Period, any Aggregate Accommodations or any portion thereof that exceed the Aggregate Stop Loss Reimbursement must be repaid within thirty (30) days of written notice from Us.

#### Claim Documentation

The following documentation is required to file an Aggregate Stop Loss claim:

1. a completed year end aggregate Stop Loss claims form;
2. Paid claims analysis report indicating each Plan Participant's name, Incurred date, charged amount, Paid amount and Paid data;
3. eligibility listing which identifies birth date, effective date, termination date and coverage type;
4. proof of funding, including monthly bank statements or other documentation of claims account funding;
5. report of voids, refunds and extra-contractual claims;

## SECTION II.

### BENEFIT (Continued)

6. aggregate claims report;
7. report showing which claimants have exceeded the Specific Deductible or loss limit;
8. listing of payments made outside the Aggregate Stop Loss Insurance (i.e., dental, weekly income, vision, PPO fees and drug card administrative fees);
9. monthly check register;
10. outstanding overpayment and subrogation log;
11. if prescription drug charges are included, itemized monthly invoices and verification of Payment, if not included on the monthly check registers;
12. COBRA documentation for COBRA participants; and
13. other documentation We may request.

We may also request this information for the period covering one month following the expiration date of the Policy to review for retroactive adjustments.

### AGGREGATE ACCOMMODATION

Upon the Plan Sponsor's proper filing of an Aggregate Accommodation request, We may make an Aggregate Accommodation to the Plan Sponsor if the requested Aggregate Accommodation exceeds \$1,000.

The Aggregate Accommodation for a plan month is:

1. Payments made for Eligible Expenses during the Benefit Period; less
2. Eligible Expenses that were Incurred prior to the Effective Date in excess of the amount shown in the Schedule of Stop Loss as the Aggregate Run-In Limit, if any; less
3. any Eligible Expenses in excess of the Maximum Per Plan Participant Annual Aggregate Limit shown on the Schedule of Stop Loss; less
4. the total of all Monthly Aggregate Deductibles for the current Plan Period; with
5. the result multiplied by the Aggregate Reimbursement Factor shown on the Schedule of Stop Loss; less
6. any other Aggregate Accommodations made in the current Benefit Period.

However, if an Aggregate Accommodation has been made during the Benefit Period, the Company reserves the right to recalculate the amounts payable at the end of any subsequent month during the Plan Period. If, at such later month, the recalculation reveals that prior Aggregate Accommodations exceed the amount that would currently be payable had the previous Aggregate Accommodations not been made, the Company may, at our option, require repayment of the amount overpaid or may reduce reimbursements due to the Plan Sponsor for the Aggregate Stop Loss Insurance Benefit or the Specific Stop Loss Insurance Benefit by the amount overpaid. Repayments for amounts overpaid must be made to the Company within 30 days of our request.

In any case, the sum of the Aggregate Accommodations made in the current Benefit Period will not exceed the Aggregate Limit of Liability per Plan Period.

Aggregate Accommodations will not be paid during the last month of the Benefit Period for Aggregate Stop Loss Reimbursement.

## SECTION III.

### DUTIES OF PLAN SPONSOR

The Plan Sponsor will either perform the duties of the Administrator, if approved by the Company, or will have under contract an Administrator acceptable to the Company to act as the Plan Sponsor's agent. The duties of the Plan Sponsor or its approved Administrator are listed below.

- **Plan Document.** The Plan Sponsor will provide the Company with its Plan Document for its approval by the Company.
- **Records and Data.** The Plan Sponsor will maintain such records and data as may be required by the Company for this Policy during this Plan Period and for a period of seven (7) years after the termination of this Policy. Such records and data will be made available to Us upon Our request. These records and data may include, but are not limited to, the required claim documentation. The Company may periodically examine any records or data relating to coverage under this Policy and any claims filed under the Benefit Plan.
- **Audit.** The Company has the right to inspect and audit at Our expense all data, claim records and procedures, included but not limited to an onsite audit, relating to this Policy and the claims filed under the Benefit Plan during the Plan Period and for two years after the expiration date of the Policy. These will include records held by the Plan Sponsor and the Administrator.

As a result of any examination of these records, the Company will be entitled to readjust benefits, premiums, deductible factors, or reimburse for Eligible Expenses, as may be necessary to reflect the true intent of this Policy. We specifically reserve the right to change premium rates and/or factors as provided under the **PREMIUM RATES & DEDUCTIBLE FACTORS** provision in the **GENERAL PROVISIONS** section of this Policy.

- **Payment of Claims.** The Plan Sponsor will evaluate and either Pay or deny claims under the Benefit Plan. The Plan Sponsor is to have available sufficient funds to Pay claims. All claims for Eligible Expenses must be Paid within thirty (30) days from the date adequate proof of claim is provided to the Administrator.

Provider discounts of any kind lost due to untimely payment of claims by the Policyholder or the Policyholder's authorized representative are not payable under this Policy.

The Plan Sponsor agrees to utilize and comply with all Plan utilization review, cost containment and/or managed care provisions and requirements.

- **Amendments to the Benefit Plan.** The Benefit Plan will not be changed or amended while this Policy is in force without the Company's prior written consent. Written notification of proposed amendments to the Benefit Plan must be received at our Executive Office prior to the effective date of the change and the Company must consent to the change. For the purposes of payment of benefits under this Policy, changes to the Plan Document will become effective not earlier than the first day of the month following the Company's approval of the proposed amendment. In the absence of the Company's prior written consent of the amendment, benefits will be payable under this Policy as though the Plan Document had not been amended.

### SECTION III.

#### DUTIES OF PLAN SPONSOR (Continued)

- **Amendments to the Administrative Agreement or Administrator.** Any Administrator retained by the Plan Sponsor must, at all times, be acceptable to the Company and the Company reserves the right to reject an Administrator proposed by the Plan Sponsor. The Plan Sponsor will provide the Company with a copy of its written agreement with the Administrator, and all amendments thereto. The Plan Sponsor agrees that a copy of any further amendment to or change in said agreement will be provided to the Company at least sixty (60) days prior to the time it becomes effective. The Plan Sponsor further agrees to provide the Company sixty (60) days prior written notice of its designation of a successor Administrator. The Company reserves the right to reject the designation of a successor Administrator. The Plan Sponsor will provide the Company with a copy of its written agreement with any successor Administrator. The Company will not reimburse the Plan Sponsor for claims paid by someone not approved by the Company or not licensed as a claims administrator, if applicable.
- **Disclosure Requirements.** This Policy has been underwritten based upon the information the Plan Sponsor provided to the Company concerning all Plan Participants eligible for benefits under the Benefit Plan on the effective date of this Policy or on the effective date of any class of Plan Participants added thereafter.

The Plan Sponsor's signature on the application for this Policy represents to the Company that the Plan Sponsor or the Plan Sponsor's authorized representative has consulted with the Plan Sponsor's pre-certification, utilization review and medical management vendors and the Plan Sponsor's Administrator, or former Administrator, to determine who must be disclosed on the Stop Loss Disclosure Statement.

The Company will not reimburse any Eligible Expenses for any Plan Participant or known medical conditions that were not fully disclosed on the most recent Stop Loss Disclosure Statement signed by the Plan Sponsor and accepted by the Company for the Plan Period.

- **Reporting Requirements.** The Plan Sponsor will submit by the 15<sup>th</sup> day of each month all proofs, reports, and supporting documents as the Company may require for the preceding Policy Month, including but not limited to:
  1. summary of all claims Paid;
  2. number of Plan Participants;
  3. premium paid; and
  4. deductible amounts.

The Company will rely upon the claims experience submitted each month to establish the Monthly Aggregate Deductible Factor. If the Company determines that the information provided is inaccurate or incomplete, the Company has the right to change the deductible factors retroactively.

## SECTION III.

### DUTIES OF PLAN SPONSOR (Continued)

- **Notice of Claim.** The Plan Sponsor will give the Company written notice on our customary proof of loss form within sixty (60) days of the date when a Plan Participant:
  1. is diagnosed with a trigger diagnosis as specified by Us to the Plan Sponsor;
  2. incurs Eligible Expenses for any diagnosis which equal or exceed, or would reasonably suggest to a prudent claims administrator the possibility that Eligible Expenses which are covered by this Policy will equal or exceed, fifty percent (50%) of the Specific Deductible shown in the Schedule of Stop Loss or \$100,000, whichever is less fifty percent (50%) of the Specific Deductible shown in the Schedule of Stop Loss or \$100,000, whichever is less.

The Plan Sponsor will give the Company written notice on our customary proof of loss form within thirty (30) days of the date Eligible Expenses are Incurred which will be submitted for reimbursement under this Policy and which equal or exceed **75%** of **the** Annual Aggregate Deductible.

The Plan Sponsor will submit on a timely basis all claims, proofs, reports, and supporting documents.

In addition to the notice of claim requirements above, the Plan Sponsor must immediately notify the Company in writing as soon as it is aware of any loss for Eligible Expenses Incurred by a Plan Participant which may result in a claim under this Policy for any of the conditions, treatments, or circumstances listed below:

1. continuous confinement of more than 30 days in a hospital, skilled nursing facility, rehabilitation or other medical facility; or
2. claims for which a third party may be liable.

The Plan Sponsor's failure to give prompt notice may result in an adjustment of Our reimbursement to the Plan Sponsor, if any, to reflect any savings We could have obtained had a prompt 50% notification been given.

- **Rights of Reimbursement and Subrogation**

If the Plan Sponsor is entitled to recover from any third party charges paid under the Benefit Plan, such amounts cannot be used to satisfy either the Specific Deductible or Aggregate Deductible, and such amounts are not an Eligible Expense. The Plan Sponsor must pursue all valid claims including, but not limited to, claims for restitution, constructive trust, equitable lien, breach of contract, injunction, and any other state or federal law claims the Plan Sponsor may have against any third party responsible, in whole or in part, for any charges reimbursed by Us. The Plan Sponsor must keep Us informed of its recovery efforts and must immediately advise Us of any amounts recovered from third parties.

If We have reimbursed the Plan Sponsor for all or part of a charge and the Plan Sponsor recovers any part of the charge from any party, the Plan Sponsor must repay Us to the extent of Our reimbursement regardless of whether the Policy is still in force at the time of recovery. The Plan Sponsor must reimburse Us first and in full before the Plan Sponsor receives any benefit of the recovery. We retain the right to employ our own independent counsel to assist us in recovery activities and, further, the Plan Sponsor assigns to us its rights to recovery to the extent of Our reimbursement to the Plan Sponsor. In the event the Plan Sponsor reimburses Us in a matter where Our designated counsel is not involved, the Plan Sponsor's repayment may be reduced by the reasonable and necessary expenses the Plan Sponsor incurred in recovering from the third party.

### **SECTION III.**

#### **DUTIES OF PLAN SPONSOR (Continued)**

If the Plan Sponsor fails to prosecute any valid claims for recovery and We have reimbursed the Plan Sponsor under this Policy, then We will assume and be subrogated to all of the Plan Sponsor's rights to pursue any valid claims against third parties. The Plan Sponsor will be responsible for any reasonable legal expenses incurred in the course of pursuing the recovery. The Plan Sponsor is required to provide the Company with such information as We request in order to protect Our right to reimbursement. The Plan Sponsor agrees to cooperate fully and do all things reasonably required by the Company to pursue any action to recover against the third party. Any amounts recovered will be used first to reimburse the expenses of recovery and then to reimburse Us for any payments made under the Policy. Any amounts remaining thereafter will be paid to the Plan Sponsor.

## **SECTION IV.**

### **INDEMNIFICATIONS**

#### **LIABILITY AND INDEMNIFICATION**

The Company has no obligation whatsoever under this Policy to make any payment directly to any Plan Participant or provider of services for any benefits provided under the Benefit Plan. The Company's sole liability, if any, is to the Plan Sponsor, and subject to all the terms, conditions and limitations of this Policy.

Our sole liability under this Policy is to the Plan Sponsor for Payments made for Plan Participants for Eligible Expenses under the Benefit Plan, subject to the terms and conditions of this Policy. The Policy does not create any right or obligation to pay any Plan Participant, Administrator, or provider of professional or medical services. Nothing in this Policy will be construed to permit a Plan Participant to have a direct right of action against the Company. The Plan Sponsor agrees to hold the Company harmless from any damages, expenses incurred, or judgments awarded arising out of any dispute involving a Plan Participant covered by this Policy, with respect to the Plan Participant's claim of any rights under the Benefit Plan. The Plan Sponsor will indemnify the Company for all expenses, including attorney's fees, that the Company incurs in defending claims or lawsuits brought against the Company by a Plan Participant. This Policy will not be deemed to make the Company a party to any agreement between the Plan Sponsor and the Administrator. We will not be considered a party to the Benefit Plan of the Plan Sponsor or to any supplement or amendment to it. The Plan Sponsor agrees to hold the Company harmless from damages of any kind which are not caused by the Company's own acts or omissions.

#### **TAXES AND ASSESSMENTS**

If, by any law, administrative ruling or judicial decision, premium taxes or state assessments should be assessed against the Company or the Plan Sponsor with respect to claims Paid under the Benefit Plan or the number of members participating in the Benefit Plan, the Plan Sponsor will save and hold the Company harmless from any such premium tax or state assessment liability. The Plan Sponsor will reimburse the Company for the amount of such premium tax or state assessment liability, interest, penalty or any cost due and payable upon receipt by the Company of such notification. The Plan Sponsor agrees that reimbursement may take the form of a retroactive premium adjustment.

## SECTION V.

### EXCLUSIONS

The Company will not make any payment under this Policy for any loss which is caused by or which results from:

1. [expenses Incurred while the Benefit Plan is not in force [ with regards to a Covered Person or Covered Dependent for whom a claim is paid ]];
2. [payments under the Benefit Plan which are recoverable under the Benefit Plan's coordination of benefits, subrogation or right of recovery provisions, or to the extent that a payment may be made by another insurer, employee benefit plan or any other party, including, but not limited to, a government or privately supported medical research program, to either the Benefit Plan, Plan Sponsor or Plan Participant. This provision is applicable irrespective of how such payment is characterized and whether or not payment has actually been made for any or all of the Plan Participant's losses;]
3. [expenses Paid under the Benefit Plan that are in excess of Reasonable and Customary charges; or any amount Paid which is in excess of the Benefit Plan benefits; ]
4. [expenses Incurred as a result of accidental bodily injury or sickness that is employment-related or for which the Plan Participant is entitled to receive benefits under any workers' compensation, occupational disease law, or similar law whether or not such coverage is actually in force;]
5. [expenses for the administration of claims Payments or expenses incurred for a claim which has been submitted in connection with the administration of the Benefit Plan's utilization review, cost containment and/or managed care provisions and requirements ];
6. [expenses arising out of, contributed to or in consequence of war, hostilities (whether war be declared or not), invasion or civil war;]
7. [expenses for any services, treatments, procedures, technology, supplies or drugs that are Experimental or Investigative;]
8. [expenses due to services or supplies rendered to a transplant donor of any organ or bodily element; expenses for the acquisition cost of any organ or bodily element ];
9. [expenses relating to non-human organ/tissue transplants, gene therapies, xenographs or cloning ];
10. [expenses for any legal process or litigation;]
11. [with respect to [ Specific ] [ and ] [ Aggregate ] Stop Loss Insurance, expenses resulting from dental, vision, prescription drug, hearing care, or expenses for weekly income, unless specifically stated in the Schedule of Stop Loss;]
12. [expenses Incurred or paid for services, treatment or supplies, including any hospital confinement, or any portion of a hospital confinement, or confinement in any facility or institution, which are not deemed Medically Necessary and not deemed Eligible Expenses under this Policy;]

## SECTION V.

### EXCLUSIONS (Continued)

13. [with respect to each retired Covered Person who is eligible for benefits under Medicare, Payment otherwise payable under this Policy will be reduced by the amount of any similar Medicare benefits so that the total reimbursements on behalf of a Covered Person will not exceed 100% of the Covered Person's actual expenses. This provision will be administered in accordance with Federal laws and regulations;]
14. [expenses Incurred outside the United States, its territories or possessions;]
15. [expenses Incurred for individuals who are not citizens of the United States or lawful permanent residents of the United States, unless the individual is lawfully employed in the United States and maintains lawful immigration status at the time the expenses are Incurred, and is otherwise an eligible Plan Participant;]
16. [liability otherwise assumed by the Plan Sponsor though excludable under the Benefit Plan; and]
17. [expenses resulting from the Plan Participant's commission or attempted commission of a felony.]

## **SECTION VI.**

### **MEDICAL CONVERSION**

A Plan Participant whose coverage under the Benefit Plan ends solely due to termination of employment or loss of eligibility due to change in classification, may apply for an individual medical conversion policy. A Plan Participant whose coverage under the Benefit Plan ends due to loss of dependency status or loss of dependent eligibility due to change in classification may also apply for an individual medical conversion policy.

Eligibility for conversion is determined as follows:

1. the Plan Participant must have been covered for group medical coverage under the Benefit Plan for at least three (3) consecutive months;
2. the Plan Participant must be under the age of sixty-five (65) and not be eligible for or receiving benefits under the federal Medicare Program or similar coverage under any group, individual, or pre-payment plan;
3. the Plan Participant's Legal Residence must be in the United States. For purposes of medical conversion only, the term "Legal Residence" means a place of permanent residence. This is a fixed place of residence which the Plan Participant intends to be his home and to which he intends to return despite any temporary residences elsewhere; and
4. the Plan Participant's coverage under the Benefit Plan must terminate prior to the termination of this Policy.

An individual medical conversion policy will be issued subject to the following:

1. within thirty-one (31) days after coverage under the Benefit Plan terminates, the Plan Participant's completed application and payment of the first premium are received. All rules and details concerning the individual conversion policy are governed by the designated conversion carrier;
2. proof of good health will not be required;
3. the effective date of the conversion policy will be the day coverage terminates under the Benefit Plan, if all requirements have been met and the Plan Participant is accepted for conversion; and
4. the Plan Participant may elect to cover his dependents who were covered under the Benefit Plan and whose coverages are also terminating.

The Plan Sponsor will be required to give each Plan Participant at least fifteen (15) days written notice prior to the date on which his right to convert would expire.

## **[SECTION VII.]**

### **GENERAL PROVISIONS**

#### **ACTIVELY AT WORK & ACTIVELY AT LIFE**

If a Covered Person is not Actively at Work or a Plan Participant is Totally Disabled on the Effective Date of this Policy, then no benefits will be provided under this Policy for any Eligible Expense incurred with respect to the individual.

No Eligible Expenses Incurred with respect to such Plan Participant will be used to satisfy any deductible in this Policy, unless they were Incurred the day following the later of:

1. the date the Covered Person returns to work on a full-time basis; or
2. the date the Plan Participant is no longer Totally Disabled.

For purposes of this provision only, "Totally Disabled" means the Covered Person is unable to perform all of the material and substantial duties of his job on a full-time basis due to disability. For Covered Dependents, it means that on the Effective Date of the Policy, the Plan Participant is unable to meet the Actively At Life requirement.

Regardless of any provisions in this Policy to the contrary, this limitation applies to all Plan Participants, whether covered under the Benefit Plan on or after the Effective Date of this Plan Period.

The Actively at Work requirement may be waived if shown in the Schedule of Stop Loss.

In the event that application is made to include retired persons and/or persons who have elected COBRA (whether the COBRA election is effective on the Policy Effective Date or not), such persons are subject to the Actively at Life requirement unless waived in the Schedule of Stop Loss.

#### **NOTICE**

For the purpose of any notice required from Us under the terms of this Policy, notice to the Plan Sponsor will be deemed notice to the Administrator and notice to the Administrator will be deemed notice to the Plan Sponsor.

#### **NOTICE OF APPEAL**

Any objection, notice of legal action, request for review or appeal, or complaint received by the Plan Sponsor or Administrator on a claim processed under the Benefit Plan, and on which it reasonably appears that reimbursement may be payable under this Policy, will be brought to Our immediate attention.

#### **CHANGES**

No agent or any other person except an authorized officer of the Company has the authority to effect a waiver or change any part of this Policy or to stop the Company from asserting any right under the terms of this Policy. The terms of this Policy cannot be waived or changed, except by amendment, endorsement, or rider issued to, and which forms a part of, this Policy.

## **[SECTION VII.]**

### **GENERAL PROVISIONS (Continued)**

#### **REIMBURSEMENT OF CLAIMS**

Prior to making any reimbursement, the Company has the right to review each claim submitted to Us to determine if the Plan Sponsor is entitled to any reimbursement under this Policy. This review may include, but is not limited to, an on-site audit or requests for additional documentation. Submission by the Plan Sponsor or Administrator of a claim for reimbursement under the Policy constitutes a representation and warranty that the Plan Sponsor or Administrator has Paid the providers the Eligible Expenses for which reimbursement is sought.

#### **LATE CLAIMS**

Complete Claim Documentation and proof of loss must be submitted within [ninety (90) days] after the Plan Sponsor has Paid Eligible Expenses on behalf of any Plan Participant. We are not obligated to reimburse a claim submitted after such period. However, We will reimburse such claim in the event the Plan Sponsor shows that timely submission was not reasonably possible, and the Plan Sponsor made the submission as soon as possible. In no event will We reimburse claims submitted more than [one year] after proof of such loss was otherwise due.

#### **ADJUSTMENT OF CLAIMS**

It is the responsibility of the Plan Sponsor to notify the Company regarding any claim adjustments made by the Benefit Plan for claims submitted to Us for reimbursement under this Policy. Any claim reimbursements made by Us for Eligible Expenses that were overpaid by the Benefit Plan for any reason or subsequently recovered by the Benefit Plan, must be promptly refunded to the Company.

#### **ADVERSE BENEFIT DETERMINATION APPEALS**

For a claim in which there has been an Adverse Benefit Determination (ABD) by the Plan prior to the end of the Specific Benefit Period as defined in the Schedule of Stop Loss, that results in a request for an external review by an Independent Review Organization (IRO) as required of the Plan by the applicable law and that later results in a decision by the IRO to reverse or modify the ABD by the Plan, the Paid date of these claims will be the date the ABD was issued. The Company must be notified by the Plan Sponsor of any ABD that, if reversed or modified, is expected to result in a claim that exceeds the Specific Deductible within [30] days of the date of the request for external review and prior to [12] months after the end of the Specific Benefit Period. The notification must include the details of the ABD, including but not limited to: Covered Person, amount of claim, Incurred expenses, date of Incurred expenses, date of ABD and diagnosis codes. All other terms and conditions of the Policy remain the same.

Expenses paid by the Plan for the ABD review will not be considered Eligible Expenses. Claims that are the subject of external review by an IRO are not eligible for Advance Funding.

#### **COST CONTAINMENT PROGRAM**

We have the right to participate, at Our option and expense, in any savings or cost containment program maintained by the Plan Sponsor. If no such program is maintained, We have the right to retain the services of a third party to implement a cost containment program with respect to claims submitted to Us for reimbursement.

**[SECTION VII.]**

**GENERAL PROVISIONS  
(Continued)**

**MEDICAL MANAGEMENT**

The Plan Sponsor agrees to furnish upon request clinical information about Plan Participants who may incur or have incurred claims submitted for reimbursement under this Policy. The Company will make available to the Plan Sponsor and the Administrator, without obligation, preferred medical management services to benefit the Plan and its Plan Participants. The Plan Sponsor agrees to allow the Company to identify and offer services that may benefit the Plan Sponsor's Plan Participants.

**PREMIUMS AND GRACE PERIOD**

Each premium for the insurance provided under this Policy is payable on or before its due date at the [Administrative Office of the Company]. Payment of premium will not maintain the insurance under this Policy in force beyond the period for which such premium is paid, except as otherwise stated in this provision.

A grace period of [ thirty-one (31) days ] will be allowed for the payment of each premium due after the first payment. If any premium after the first payment is not paid when due, all benefits provided under this Policy will terminate upon the earliest of the following dates:

1. the due date of such premium if, on or before the due date for premium, the Plan Sponsor provides written notice to Us and We receive such notice that the Plan Sponsor is terminating this Policy;
2. at the end of the grace period if, after the due date for premium and during the grace period, the Plan Sponsor provides written notice to Us and We receive such notice that the Plan Sponsor is terminating this Policy;
3. at the end of the grace period if the Plan Sponsor does not provide Us written notice that the Plan Sponsor is terminating this Policy.

The Plan Sponsor will continue be liable for the pro-rata portion of any unpaid premium due for any period during which the insurance under this Policy is continued in-force after the due date of such unpaid premium.

If coverage terminates during the Benefit Period, there will be a refund of premium paid but unearned, if any, based on Our rules then in effect for refunding premium paid but unearned.

[We reserve the right to offset any benefits payable to the Plan Sponsor under this Policy against premiums due and unpaid by the Plan Sponsor. This right will not prevent termination of this Policy for non-payment of premium in accordance with the **TERMINATION BY INSURER** provision [ The Company also reserves the right to require an interest payment to be made on premium payments made after the due date. The interest rate charged will be \_\_\_\_\_% ]. ]

**PREMIUM RATES & DEDUCTIBLE FACTORS**

We have the right to establish new premium rates, Aggregated Specific Deductible, and Monthly Aggregate Deductible Factors at any time during the Plan Period, if:

1. the number of Plan Participants changes by more than [ ten percent (10%) ] from the number used in the most recent premium rate calculation;
2. an increase or decrease in the premium due under this Policy exceeds fifteen percent (15%) over any prior month or thirty percent (30%) over any period of three consecutive months;
3. the Benefit Plan is amended;

**[SECTION VII.]**

**GENERAL PROVISIONS  
(Continued)**

4. this Policy is amended;
5. there is a change in law or regulation that affects this Policy;
6. the Plan Sponsor adds or deletes any subsidiary or affiliated companies or divisions; and/or
7. there is a change in the Administrator, preferred provider network, or any other cost containment program.

**DIVIDENDS**

This Policy will share in the distribution of divisible surplus, if any. The amount of any dividend will be determined by Us at the end of each Benefit Period, if the Policy has continued in-force and all premiums have been paid throughout the Benefit Period.

[The dividend will be based on the group life and health dividend formula for pooled policies, as approved by the Company's Board of Directors. ]

[The dividend will be based on the group life and health dividend formula for a retrospectively rated policy as approved by the Company's Board of Directors. If the Policy does not remain in-force for the entire Plan Period, shown in the Schedule, no dividend will be paid. ]

Dividends will be paid to the Plan Sponsor, or, at the Plan Sponsor's request, be applied toward the payment of premiums. Payment of the dividend will completely discharge Us from any liability with respect to the dividend so paid.

**TERMINATION OF BENEFIT PLAN**

The Plan Sponsor will immediately notify Us if the Benefit Plan is terminated. In the event of termination, the Specific Deductible and the Minimum Annual Aggregate Deductible for the full Benefit Period will continue to apply as stated in the Schedule of Stop Loss.

**TERMINATION BY MUTUAL AGREEMENT**

The Policy may be terminated on a date and time set by mutual agreement between the Plan Sponsor and Us.

**TERMINATION BY PLAN SPONSOR**

The Plan Sponsor may terminate this Policy by mailing written notice to Us stating when such cancellation is to be effective. Notice must be received by Us not less than thirty-one (31) days prior to the effective date of cancellation. The Specific Deductible will be the amount shown in the Schedule of Stop Loss. The Annual Aggregate Deductible will be determined as provided in the definition of Annual Aggregate Deductible.

**TERMINATION BY INSURER**

We may terminate this Policy for any of the following reasons:

## [SECTION VII.]

### GENERAL PROVISIONS (Continued)

1. the number of Covered Persons under this Policy becomes [ forty-nine 49 or less ] [ for three (3) consecutive months ];
2. the Plan Sponsor fails to perform its duties under this Policy;
3. the Administrator fails to meet our administrative requirements;
4. the termination of the Benefit Plan;
- [5. any other group policy issued by Us in conjunction with this Policy is terminated; ]
6. the Plan Sponsor suspends active business operations;
7. the Plan Sponsor becomes insolvent or bankrupt or subject to liquidation, receivership, or conservatorship;
8. the Plan Sponsor dissolves;
9. the agreement between the Plan Sponsor and the Administrator terminates, unless We have received the Plan Sponsor's notification of the designation of a successor Administrator and a copy of the agreement between the Plan Sponsor, and both are acceptable to Us; or
10. the Plan Sponsor fails to pay premium when due, subject to the grace period described in **PREMIUMS AND GRACE PERIOD**.

If this Policy, or coverage for an employer, affiliate, location, subsidiary or employee unit, if any, is terminated before the end of the Benefit Period shown on the Schedule of Stop Loss, only those claims that have been Paid prior to the date of termination will be considered Eligible Expenses under this Policy. The Benefit Period will not extend beyond the date of termination.

### **RENEWAL**

This Policy may be renewed at Our option for subsequent 12-month periods by written acceptance from the Plan Sponsor of Our renewal terms. Payment of premium with the renewal terms We offered will also constitute acceptance by the Plan Sponsor.

We will give the Plan Sponsor at least [ 30 days ] advance written notice of a renewal action.

#### *Renewal Rate*

[A renewal rate guarantee will apply to the Specific Stop Loss Insurance if the Plan Sponsor renews coverage as of the Renewal Date shown on the Schedule of Stop Loss. A renewal rate increase [ of [ 8% ] will be [ ] cap not to exceed [ 40% ] of the current Plan Period premium may be ] applied to the Monthly Specific Premium Rates, subject to the *Exceptions to Renewal Rate* provision below. ]

[The current Specific Stop Loss premium rates will be continued for the renewal period if the Plan Sponsor renews coverage as of the Renewal Date shown on the Schedule of Stop Loss, subject to the *Exceptions to Renewal Rate* provision below. ]

## **[SECTION VII.]**

### **GENERAL PROVISIONS (Continued)**

[In recognition of a Retrospectively Rated Policy a renewal rate guarantee will apply to the Specific Stop Loss Insurance if the Plan Sponsor renews coverage as of the [ next two ] Renewal Date[ s ]. A renewal rate increase of [15% ] will be applied to the Monthly Specific Premium Rates, subject to the *Exceptions to Renewal Rate* provision below. ]

#### *Exceptions to Renewal Rate:*

We will adjust the renewal rates accordingly before applying any renewal rate increase [ or rate caps ], if the:

1. number of Covered Units changes by more than [ 15% ] during the current Plan Period; and/or
2. Plan Sponsor changes the terms of the Benefit Plan.

#### *[Renewal Lasers:*

In the event of a renewal of the Policy pursuant to the provisions of this **RENEWAL** provision, no [ new ] Plan Participant lasers will be included at renewal. Unless otherwise agreed to by the Plan Sponsor and Us, any Plan Participant lasers in effect for the current Plan Period will continue under the renewal Policy.

Laser means the coverage applied to a Plan Participant for whom:

1. the Specific Deductible is higher than the Specific Deductible per Plan Participant shown on the Schedule of Stop Loss;
2. the Benefit Period is different than shown on the Schedule of Stop Loss; or
3. coverage under the Policy is excluded due to prior termination of eligibility or because the Plan Participant is deceased. ]

### **CLERICAL ERROR**

Clerical error, whether by the Plan Sponsor or by Us in keeping any records pertaining to the insurance provided under this Policy will not invalidate coverage otherwise validly in-force or continue coverage otherwise validly terminated.

### **ASSIGNMENT**

The Plan Sponsor cannot assign this Policy.

### **LEGAL ACTION**

No action at law or in equity will be brought to recover on this Policy prior to the expiration of [ 60 days ] after delivery by Us of an explanation of reimbursement regarding a claim submitted to Us. No such action will be brought after the expiration of [ three years ] after the delivery by Us of an explanation of reimbursement.

**[SECTION VII.]**

**GENERAL PROVISIONS  
(Continued)**

**CONFORMITY WITH STATE STATUTES**

Any provision of this Policy that is in conflict with the laws of the state in which this Policy is delivered, or issued for delivery, is amended to conform to the minimum requirements of those laws.

**CONFORMITY WITH FEDERAL LAW AND REGULATIONS**

This Policy is automatically amended to comply with any Federal law or regulation with which this Policy is not in compliance. This Policy is deemed to be automatically amended on the date any Federal law or regulation is enacted which is applicable to this Policy; the effective date of any such amendment will be that governed by Federal law or regulation.

**INDEPENDENT MEDICAL EXAMINATIONS**

The Company has the right and opportunity through its medical representative to examine any living Plan Participant while a claim is pending and as often as it may reasonably require.

**NO ERISA LIABILITY**

We will not accept responsibility as an Administrator or be deemed a plan fiduciary as these terms are defined and used in the Employment Retirement Income Security Act (ERISA) of 1974 as amended.

**WAIVER**

If either party fails or neglects to enforce any or all of the provisions of this Policy or to insist upon strict compliance, it will not be construed as a waiver of any rights or privileges. A waiver of a past act or circumstance does not waive any subsequent act or circumstance or prevent future enforcement of the provisions of this Policy.

The parties agree that the inclusion of this provision or acceptance of late payments is not considered a waiver of Our right to receive timely funds under this Policy. At no time is the Plan Sponsor to withhold payment or pay an amount less than that billed as calculated as due under the terms and conditions of this Policy.

**SEVERABILITY**

If any part of this Policy is invalid or unenforceable under applicable law, the remaining parts of this Policy will remain in full force and effect.

**COMPANY LIABILITY**

We rely upon the information provided by the Plan Sponsor in determining the risk assumed under this Policy. If We discover, after the issuance of this Policy, that there is information that would have affected the liability, or acceptance, of this Policy, We reserve the right to terminate this Policy, adjust any specific Plan Participant's deductible, or revise the applicable rates, factors or other terms and conditions.

**[SECTION VII.]**

**GENERAL PROVISIONS  
(Continued)**

**CONCEALMENT / FRAUD**

This entire Policy will be void if the Plan Sponsor, or its agent, Administrator or other authorized representative of the Plan Sponsor has intentionally or negligently concealed, misrepresented or failed to disclose any material fact or circumstance, which concerns the insurance under this Policy including any claim; or in any case of fraud by any such entity.



**THE UNION LABOR LIFE INSURANCE COMPANY**  
**Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910**  
**Executive Office: 1625 Eye Street, Washington, DC 20006**

**SCHEDULE OF STOP LOSS**

This Policy provides only those coverages shown below. If lines are left blank, no coverage is provided for that category.

Plan Sponsor: Trustees of the ABC Company

Address: 123 ABC Street, Washington, DC 20001

Policy Number: XXXX

Group Purchasing Pool: \_\_\_\_\_

Group Stop Loss Insurance Policy Dividend Basis:

- Pooled  
 Retrospectively Rated for Plan Periods beginning MM/DD/YY and ending MM/DD/YY.

Specific Stop Loss Insurance:  Yes  No  
 Effective Date: MM/DD/YYYY

Plan Period: From MM/DD/YYYY to MM/DD/YYYY (Renewal Date)

Number of Plan Months: X

Eligible Expenses include:  Medical  Prescription Drug Card  Prescription Drugs Under Medical  
 Other: \_\_\_\_\_

Options:  Advance Funding  
 Medical Conversion  
 Other: \_\_\_\_\_

Specific Renewal Options:

- No New Laser Option with Renewal Rate Increase not to Exceed XXX%  
 2-Year Rate Lock-In Option  
 Renewal Rate Increase Option XXX%

Monthly Specific Premium Rates:

<input type="checkbox"/> 1-Tier Option	<input type="checkbox"/> 2-Tier Option	<input type="checkbox"/> 3-Tier Option	<input type="checkbox"/> 4-Tier Option
<u>Employee* \$[X.XX]</u>	<u>Employee* \$[X.XX]</u>	<u>Employee* \$[X.XX]</u>	<u>Employee* \$[X.XX]</u>
<u>(Composite) [X.XX]</u>	Select One:	<u>Employee*+ 1 \$[X.XX]</u>	<u>Employee*+Spouse \$[X.XX]</u>
	<u>Family \$[X.XX]</u>	<u>Family \$[X.XX]</u>	<u>Employee*+Children \$[X.XX]</u>
	<u>Dependent(s) \$[X.XX]</u>		<u>Family \$[X.XX]</u>

\* The term "Employee" includes "Member"  
 SLS-2012

**SCHEDULE OF STOP LOSS  
(Continued)**

Specific Reimbursement Factor:    X   %  
 other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Specific Limit of Liability per Plan Participant per Plan Period:   \$ X.XX    
 Specific Limit of Liability per Plan Participant per Lifetime is:   UNLIMITED  

Plan Participants consist of covered employees/members and their Dependents, who meet the eligibility rules of the Plan Sponsor, which include:

- Active employees/members
- Dependents
- Retirees not eligible for Medicare
- Retirees eligible for Medicare
- Eligible Plan Participants of classes selected that elect COBRA
- Retiree Dependent not eligible for Medicare
- Retiree Dependent eligible for Medicare
- Other (Specify): \_\_\_\_\_

Specific Deductible per Plan Participant:   \$ X.XX  

Except for the following:

Laser: The specific coverage for the following plan participant(s) will be adjudicated using the following deductibles and contract basis:

Plan Participant	Lasered Deductible Amount	Contract Basis	Comment
_____	_____	_____	_____
_____	_____	_____	_____

Excluded: The following plan participant(s) will be excluded from specific coverage:

Plan Participant	Comment
_____	_____
_____	_____

Aggregated Specific Deductible per Plan Period:   \$ X.XX  

Plan Type:   12   /   12  

Specific Benefit Period: Eligible Expenses Incurred by Plan Participants from   MM/DD/YYYY   through   MM/DD/YYYY  , and Paid by the Plan Sponsor from   MM/DD/YYYY   through   MM/DD/YYYY  .

- Waivers:
- Actively at Work requirements Waived for Covered Persons.
  - Actively at Life Waived for all other Covered Participants.

**SCHEDULE OF STOP LOSS  
(Continued)**

Aggregate Stop Loss Insurance:  Yes  No

Effective Date: MM/DD/YYYY

Plan Period: From MM/DD/YYYY to Renewal Date: MM/DD/YYYY

Number of Plan Months: X

Eligible Expenses include:  Medical  Prescription Drug Card  Vision  Dental  
 Prescription Drugs Under Medical  Weekly Disability Income  
 Other: \_\_\_\_\_

Options:  Aggregate Accommodation  
 Medical Conversion  
 Other: \_\_\_\_\_

Monthly Aggregate Premium Rates:

<input type="checkbox"/> 1-Tier Option	<input type="checkbox"/> 2-Tier Option	<input type="checkbox"/> 3-Tier Option	<input type="checkbox"/> 4-Tier Option
Employee* \$ <u>X.XX</u>	Employee* \$ <u>X.XX</u>	Employee* \$ <u>X.XX</u>	Employee* \$ <u>X.X</u>
(Composite)	Select One:	Employee*+ 1	Employee*+Spouse
	Family	Family	Employee*+Children
	Dependent(s)		Family
	\$ <u>X.XX</u>	\$ <u>X.XX</u>	\$ <u>X.X</u>

Minimum Annual Aggregate Premium: \$ \_\_\_\_\_

Monthly Aggregate Deductible Factors:

<input type="checkbox"/> 1-Tier Option	<input type="checkbox"/> 2-Tier Option	<input type="checkbox"/> 3-Tier Option	<input type="checkbox"/> 4-Tier Option
Employee* \$ <u>X.XX</u>	Employee* \$ <u>X.XX</u>	Employee* \$ <u>X.XX</u>	Employee* \$ <u>X.X</u>
(Composite)	Select One:	Employee*+ 1	Employee*+Spouse
	Family	Family	Employee*+Children
	Dependent(s)		Family
	\$ <u>X.XX</u>	\$ <u>X.XX</u>	\$ <u>X.X</u>

Minimum Annual Aggregate Deductible: The greater of \$ X.XX or X% of the first Monthly Aggregate Deductible multiplied by the Number of Plan Months.

Maximum per Plan Participant Annual Aggregate Limit which may be applied to the Annual Aggregate Deductible: \$ X.XX

Aggregate Reimbursement Factor:  X%  
 other: \_\_\_\_\_

Aggregate Run-In Limit: \$ X.XX

Aggregate Limit of Liability per Plan Period: \$ X.XX

\* The term "Employee" includes "Member"  
 SLS-2012

**SCHEDULE OF STOP LOSS  
(Continued)**

Plan Participants consist of covered employees/members and their Dependents, who meet the eligibility rules of the Plan Sponsor, which include:

- Active employees/members
- Dependents
- Retirees not eligible for Medicare
- Retirees eligible for Medicare
- Eligible Plan Participants of classes selected that elect COBRA
- Retiree Dependent not eligible for Medicare
- Retiree Dependent eligible for Medicare
- Other (Specify): \_\_\_\_\_

Plan Type:      12   /   12  

Aggregate Benefit Period: Eligible Expenses Incurred by Plan Participants from MM/DD/YYYY through MM/DD/YYYY, and Paid by the Plan Sponsor from MM/DD/YYYY through MM/DD/YYYY.

Waivers:

- Actively at Work requirements Waived for Covered Persons.
- Actively at Life Waived for all other Covered Participants.

The amount reflected above as the “Maximum per Plan Participant which may be applied to the Annual Aggregate Deductible” also applies to any Plan Participant for whom Actively at Work/ Life is Waived.

**Special Risk Provisions**

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**SCHEDULE OF STOP LOSS  
(Continued)**

This Policy is hereby approved and all of its terms and provisions are accepted.

Dated at   Silver Spring, Maryland   this   1<sup>st</sup>   day of   July  ,   2012  .

EXECUTED FOR   PLAN SPONSOR  

By: \_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name and Title

Date: \_\_\_\_\_

]

SERFF Tracking #:

ULCC-128684855

State Tracking #:

Company Tracking #:

STOP LOSS SL-2012

State:

Arkansas

Filing Company:

The Union Labor Life Insurance Company

TOI/Sub-TOI:

H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness

Product Name:

GROUP STOP LOSS INSURANCE POLICY

Project Name/Number:

SL-2012/

### Rate Information

Rate data applies to filing.

Filing Method:

Approval

Rate Change Type:

Neutral

Overall Percentage of Last Rate Revision:

0.000%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

### Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
The Union Labor Life Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking #:

ULCC-128684855

State Tracking #:

Company Tracking #:

STOP LOSS SL-2012

State:

Arkansas

Filing Company:

The Union Labor Life Insurance Company

TOI/Sub-TOI:

H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness

Product Name:

GROUP STOP LOSS INSURANCE POLICY

Project Name/Number:

SL-2012/

## Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/18/2012
Bypass Reason:	The Schedule of Benefits acts as the application.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/18/2012
Comments:	Document Attached.		
Attachment(s):			
READABILITY CERTIFICATION.pdf			

# READABILITY CERTIFICATION

I certify that the following forms submitted with this filing achieved the following scores using the Flesch Test Reading Score standards.

<u>Form</u>	<u>Description</u>	<u>Flesch Score</u>
SL-2008	Group Stop Loss Insurance Policy	50.4
SLS-2008	Schedule of Stop Loss	45.2

THE UNION LABOR LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to be 'S. J. ...', written over a horizontal line.

By: \_\_\_\_\_

Title: Vice President of Operations

Date: September 13, 2012