

State: Arkansas **Filing Company:** Berkley Life and Health Insurance Company
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Employer Stop Loss
Project Name/Number: Employer Stop Loss/AH52021

Filing at a Glance

Company: Berkley Life and Health Insurance Company
Product Name: Employer Stop Loss
State: Arkansas
TOI: H12 Health - Excess/Stop Loss
Sub-TOI: H12.001 Accident & Sickness
Filing Type: Form
Date Submitted: 09/11/2012
SERFF Tr Num: BLAH-128608382
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: AH52021

Implementation: On Approval
Date Requested:
Author(s): Susan Bradbury, Lee Davidson, Darlene Leary
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 01/24/2013
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Berkley Life and Health Insurance Company
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Employer Stop Loss
Project Name/Number: Employer Stop Loss/AH52021

General Information

Project Name: Employer Stop Loss Status of Filing in Domicile: Pending
Project Number: AH52021 Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: Filing concurrently.
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small and Large
Group Market Type: Employer Overall Rate Impact:
Filing Status Changed: 01/24/2013 Deemer Date:
State Status Changed: 01/24/2013 Submitted By: Susan Bradbury
Created By: Susan Bradbury
Corresponding Filing Tracking Number:

Filing Description:

Berkley Life and Health Insurance Company wishes to submit the enclosed Employer Stop Loss/Excess Risk insurance forms for your review and approval as identified on the attached policy form listing. The forms are new and are not intended to replace any existing forms previously filed and approved by your Department.

Upon approval by the Department, any marketing will be either direct to the employer and his or her consultant or through licensed producers (brokers). All marketing methods will always be employed in accordance with state laws and regulation.

This program is intended to provide stop loss or excess risk coverage to employers with self-funded employee medical benefit plans. The program is intended to protect the employer from catastrophic losses when its plan's claims exceed a defined threshold. Benefits are provided for specific stop loss, aggregate stop loss, or both. Please note that this program does not provide medical benefits to the Policyholder's employees or dependents. Premiums are paid by, and benefits are payable to, the Policyholder.

The department has our assurance that no policy will be issued that has an annual attachment point for claims incurred per individual or an annual aggregate attachment point, as established by the state, under applicable state law, if any.

Berkley Life and Health Insurance Company is domiciled in Iowa and this filing has recently been submitted in Iowa and is currently pending review

Unless otherwise informed, we reserve the right on a case by case basis to alter the layout of the enclosed forms, including color, type face and font. We certify that the type size will always remain as the state required size or larger and all statutory/regulatory requirements will not be changed. Variable material indicated by hard brackets ([]) that enclose an entire page or paragraphs, phrases or words indicate that text may be included, excluded or modified. No change in the variable areas will be made which will be in conflict with any law, rules or regulations of your state.

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 prompt review of this filing.

Company and Contact

Filing Contact Information

Bradbury Susan, Compliance sbradbury@berkleyah.com

State: Arkansas **Filing Company:** Berkley Life and Health Insurance Company
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Employer Stop Loss
Project Name/Number: Employer Stop Loss/AH52021

599 West Crossville Raod 678-387-1804 [Phone]
 Suite 100-B
 Roswell, GA 30075

Filing Company Information

Berkley Life and Health Insurance Company	CoCode: 64890	State of Domicile: Iowa
11201 Douglas Avenue	Group Code: 98	Company Type: Accident and Health
Urbandale, IA 50322	Group Name: Berkley Companies	State ID Number:
(866) 723-4452 ext. [Phone]	FEIN Number: 91-6034263	

Filing Fees

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

Company	Amount	Date Processed	Transaction #
Berkley Life and Health Insurance Company	\$50.00	09/11/2012	62565942
Berkley Life and Health Insurance Company	\$650.00	09/12/2012	62622673

SERFF Tracking #:

BLAH-128608382

State Tracking #:

Company Tracking #:

AH52021

State: Arkansas
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Employer Stop Loss
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Filing Company: Berkley Life and Health Insurance Company

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/24/2013	01/24/2013
Approved-Closed	Rosalind Minor	09/14/2012	09/14/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	09/11/2012	09/11/2012

Response Letters

Responded By	Created On	Date Submitted
Susan Bradbury	09/12/2012	09/12/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Employer Stop Loss Application	Susan Bradbury	01/23/2013	01/23/2013

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Thank you	Note To Reviewer	Susan Bradbury	01/24/2013	01/24/2013
Request to re-open filing	Note To Filer	Rosalind Minor	01/23/2013	01/23/2013

State: Arkansas
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Employer Stop Loss
Project Name/Number: Employer Stop Loss/AH52021

Filing Company: Berkley Life and Health Insurance Company

Disposition

Disposition Date: 01/24/2013

Implementation Date:

Status: Approved-Closed

Comment:

This submission was re-opened in order to replace Form AH52022-AR. The replaced form is approved effective on this date.

The remainder of the submission will retain the original approval date of 9/14/12.

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):
Berkley Life and Health Insurance Company	%	%				%	%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Form	Employer Stop Loss Policy	Approved-Closed	Yes
Form (revised)	Employer Stop Loss Application	Approved-Closed	Yes
Form	Employer Stop Loss Application	Approved-Closed	Yes
Form	Terminal Liability Option Aggregate Coverage Endorsement	Approved-Closed	Yes
Form	Terminal Liability Option Specific Coverage Endorsement	Approved-Closed	Yes
Form	Monthly Aggregate Accommodation Endorsement	Approved-Closed	Yes
Form	Administrative Change Endorsement	Approved-Closed	Yes
Form	Specific Simultaneous Funding Endorsement	Approved-Closed	Yes

SERFF Tracking #:

BLAH-128608382

State Tracking #:**Company Tracking #:**

AH52021

State:

Arkansas

Filing Company:

Berkley Life and Health Insurance Company

TOI/Sub-TOI:

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

Product Name:

Employer Stop Loss

Project Name/Number:

Employer Stop Loss/AH52021

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	No New Special Limitations and Rate Cap Endorsement	Approved-Closed	Yes
Form	Aggregating Specific Endorsement	Approved-Closed	Yes
Form	Exclusions Coverage Endorsement	Approved-Closed	Yes
Form	Experimental or Investigative Services Endorsement	Approved-Closed	Yes
Form	Organ Transplant Endorsement	Approved-Closed	Yes
Form	Actively At Work Endorsement	Approved-Closed	Yes
Form	External Appeal Endorsement	Approved-Closed	Yes
Rate	Employer Stop Loss Actuarial Memo	Approved-Closed	No
Rate	Employer Stop Loss Actuarial Memo	Approved-Closed	No
Rate	Employer Stop Loss Aggregate Rates	Approved-Closed	No
Rate	Employer Stop Loss Specific Rates	Approved-Closed	No

State: Arkansas
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Employer Stop Loss
Project Name/Number: Employer Stop Loss/AH52021

Filing Company: Berkley Life and Health Insurance Company

Disposition

Disposition Date: 09/14/2012

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):
Berkley Life and Health Insurance Company	%	%				%	%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Form	Employer Stop Loss Policy	Approved-Closed	Yes
Form (revised)	Employer Stop Loss Application	Approved-Closed	Yes
Form	Employer Stop Loss Application	Approved-Closed	Yes
Form	Terminal Liability Option Aggregate Coverage Endorsement	Approved-Closed	Yes
Form	Terminal Liability Option Specific Coverage Endorsement	Approved-Closed	Yes
Form	Monthly Aggregate Accommodation Endorsement	Approved-Closed	Yes
Form	Administrative Change Endorsement	Approved-Closed	Yes
Form	Specific Simultaneous Funding Endorsement	Approved-Closed	Yes
Form	No New Special Limitations and Rate Cap Endorsement	Approved-Closed	Yes
Form	Aggregating Specific Endorsement	Approved-Closed	Yes
Form	Exclusions Coverage Endorsement	Approved-Closed	Yes

SERFF Tracking #:

BLAH-128608382

State Tracking #:**Company Tracking #:**

AH52021

State:

Arkansas

Filing Company:

Berkley Life and Health Insurance Company

TOI/Sub-TOI:

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

Product Name:

Employer Stop Loss

Project Name/Number:

Employer Stop Loss/AH52021

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Experimental or Investigative Services Endorsement	Approved-Closed	Yes
Form	Organ Transplant Endorsement	Approved-Closed	Yes
Form	Actively At Work Endorsement	Approved-Closed	Yes
Form	External Appeal Endorsement	Approved-Closed	Yes
Rate	Employer Stop Loss Actuarial Memo	Approved-Closed	No
Rate	Employer Stop Loss Actuarial Memo	Approved-Closed	No
Rate	Employer Stop Loss Aggregate Rates	Approved-Closed	No
Rate	Employer Stop Loss Specific Rates	Approved-Closed	No

State: Arkansas **Filing Company:** Berkley Life and Health Insurance Company
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Employer Stop Loss
Project Name/Number: Employer Stop Loss/AH52021

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 09/11/2012
Submitted Date 09/11/2012
Respond By Date

Dear Bradbury Susan,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Employer Stop Loss Policy, AH52021 (Form)
- Employer Stop Loss Application, AH52022-AR (Form)
- Terminal Liability Option Aggregate Coverage Endorsement, AH52023 (Form)
- Terminal Liability Option Specific Coverage Endorsement, AH52024 (Form)
- Monthly Aggregate Accommodation Endorsement, AH52025 (Form)
- Administrative Change Endorsement, AH52026 (Form)
- Specific Simultaneous Funding Endorsement, AH52027 (Form)
- No New Special Limitations and Rate Cap Endorsement, AH52028 (Form)
- Aggregating Specific Endorsement, AH52029 (Form)
- Exclusions Coverage Endorsement , AH52030 (Form)
- Experimental or Investigative Services Endorsement, AH52031 (Form)
- Organ Transplant Endorsement, AH52032 (Form)
- Actively At Work Endorsement, AH52033 (Form)
- External Appeal Endorsement , AH52035 (Form)

Comments:

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

The fee for this submission is \$50.00 per form for a total of \$700.00. Please submit an additional \$650.00 for this submission.

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

Conclusion:

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

Please feel free to contact me if you have questions.

Sincerely,
Rosalind Minor

State: Arkansas **Filing Company:** Berkley Life and Health Insurance Company
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Employer Stop Loss
Project Name/Number: Employer Stop Loss/AH52021

Response Letter

Response Letter Status Submitted to State
Response Letter Date 09/12/2012
Submitted Date 09/12/2012

Dear Rosalind Minor,

Introduction:

Hello Rosalind....

Response 1

Comments:

I have updated the filing fee tab to include an additional \$650.00.

Related Objection 1

Applies To:

- Employer Stop Loss Policy, AH52021 (Form)
- Employer Stop Loss Application, AH52022-AR (Form)
- Terminal Liability Option Aggregate Coverage Endorsement, AH52023 (Form)
- Terminal Liability Option Specific Coverage Endorsement, AH52024 (Form)
- Monthly Aggregate Accommodation Endorsement, AH52025 (Form)
- Administrative Change Endorsement, AH52026 (Form)
- Specific Simultaneous Funding Endorsement, AH52027 (Form)
- No New Special Limitations and Rate Cap Endorsement, AH52028 (Form)
- Aggregating Specific Endorsement, AH52029 (Form)
- Exclusions Coverage Endorsement, AH52030 (Form)
- Experimental or Investigative Services Endorsement, AH52031 (Form)
- Organ Transplant Endorsement, AH52032 (Form)
- Actively At Work Endorsement, AH52033 (Form)
- External Appeal Endorsement, AH52035 (Form)

Comments:

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

The fee for this submission is \$50.00 per form for a total of \$700.00. Please submit an additional \$650.00 for this submission.

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

Changed Items:

- No Supporting Documents changed.
- No Form Schedule items changed.
- No Rate/Rule Schedule items changed.

Conclusion:

Thank you for your continued review.

Sincerely,
Susan Bradbury

State: Arkansas
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Employer Stop Loss
Project Name/Number: Employer Stop Loss/AH52021

Filing Company: Berkley Life and Health Insurance Company

Amendment Letter

Submitted Date: 01/23/2013

Comments:

Thank you so much for allowing me to resubmit the application. Nothing has changed except the correction of the following errors.

- 1) The last block under #12, page 2, did say Maximum Annual Aggregate Attachment Point, when now it correctly states Minimum Annual.....
- 2) The last block under #13, page 2, did say Lifetime Maximum Specific Benefit, when now it correctly states Annual Maximum.....
- 3) The block #14, page 3 was missing the last three endorsements which filed and approved in the initial filing. Exclusions, Organ Transplant and Appeals have been added to the endorsement list.
- 4) The block, page 3 stating "It is understood and agreed etc. was missing the lines outlining the section and that has been corrected.

Thank you so much for allowing me to correct these errors without doing a complete new filing.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Employer Stop Loss Application	AH52022-AR	AEF	Initial		0.000	AH52022AR.pdf	Date Submitted: 01/23/2013 By:
<i>Previous Version</i>								
1	<i>Employer Stop Loss Application</i>	<i>AH52022-AR</i>	<i>AEF</i>	<i>Initial</i>		<i>0.000</i>	<i>AH52022AR.pdf</i>	<i>Date Submitted: 09/11/2012 By: Susan Bradbury</i>

No Rate Schedule Items Changed.

SERFF Tracking #:

BLAH-128608382

State Tracking #:

Company Tracking #:

AH52021

State:

Arkansas

Filing Company:

Berkley Life and Health Insurance Company

TOI/Sub-TOI:

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

Product Name:

Employer Stop Loss

Project Name/Number:

Employer Stop Loss/AH52021

No Supporting Documents Changed.

State: Arkansas **Filing Company:** Berkley Life and Health Insurance Company
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Employer Stop Loss
Project Name/Number: Employer Stop Loss/AH52021

Note To Reviewer

Created By:

Susan Bradbury on 01/24/2013 09:15 AM

Last Edited By:

Susan Bradbury

Submitted On:

01/24/2013 09:15 AM

Subject:

Thank you

Comments:

That is correct, these errors were noticed prior to any issue. We are just putting this into our systems to begin marketing.
Thank you.

State: Arkansas **Filing Company:** Berkley Life and Health Insurance Company
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Employer Stop Loss
Project Name/Number: Employer Stop Loss/AH52021

Note To Filer

Created By:

Rosalind Minor on 01/23/2013 12:20 PM

Last Edited By:

Rosalind Minor

Submitted On:

01/23/2013 12:20 PM

Subject:

Request to re-open filing

Comments:

As requested in our telephone conversation on this date, this filing is being re-opened in order to make minor corrections. As discussed, the form has not been issued as of this date.

State: Arkansas
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Employer Stop Loss
Project Name/Number: Employer Stop Loss/AH52021

Filing Company: Berkley Life and Health Insurance Company

Form Schedule

Lead Form Number: AH52021								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 09/14/2012	Employer Stop Loss Policy	AH52021	POL	Initial		50.100	AH52021.pdf
2	Approved-Closed 01/24/2013	Employer Stop Loss Application	AH52022-AR	AEF	Initial		0.000	AH52022AR.pdf
3	Approved-Closed 09/14/2012	Terminal Liability Option Aggregate Coverage Endorsement	AH52023	POLA	Initial		0.000	AH52023.pdf
4	Approved-Closed 09/14/2012	Terminal Liability Option Specific Coverage Endorsement	AH52024	POLA	Initial		0.000	AH52024.pdf
5	Approved-Closed 09/14/2012	Monthly Aggregate Accommodation Endorsement	AH52025	POLA	Initial		0.000	AH52025.pdf
6	Approved-Closed 09/14/2012	Administrative Change Endorsement	AH52026	POLA	Initial		0.000	AH52026.pdf
7	Approved-Closed 09/14/2012	Specific Simultaneous Funding Endorsement	AH52027	POLA	Initial		0.000	AH52027.pdf
8	Approved-Closed 09/14/2012	No New Special Limitations and Rate Cap Endorsement	AH52028	POLA	Initial		0.000	AH52028.pdf
9	Approved-Closed 09/14/2012	Aggregating Specific Endorsement	AH52029	POLA	Initial		0.000	AH52029.pdf
10	Approved-Closed 09/14/2012	Exclusions Coverage Endorsement	AH52030	POLA	Initial		0.000	AH52030.pdf

State: Arkansas
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Employer Stop Loss
Project Name/Number: Employer Stop Loss/AH52021

Filing Company: Berkley Life and Health Insurance Company

Lead Form Number: AH52021

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
11	Approved-Closed 09/14/2012	Experimental or Investigative Services Endorsement	AH52031	POLA	Initial		0.000	AH52031.pdf
12	Approved-Closed 09/14/2012	Organ Transplant Endorsement	AH52032	POLA	Initial		0.000	AH52032.pdf
13	Approved-Closed 09/14/2012	Actively At Work Endorsement	AH52033	POLA	Initial		0.000	AH52033.pdf
14	Approved-Closed 09/14/2012	External Appeal Endorsement	AH52035	POLA	Initial		0.000	AH52035.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

Berkley Life and Health Insurance Company



Urbandale, Iowa

[Underwriting Office:
2445 Kuser Road, Suite 201
Hamilton Square, NJ 08690]

Stop Loss Insurance Policy

Policyholder: [ABC Company]

Policy Number: [12345]

Original Policy Effective Date: [May 1, 2013]

Berkley Life and Health Insurance Company (“the Company”) agrees to reimburse the Policyholder as outlined under the provisions of this Stop Loss Insurance Policy (“this Policy”), subject to all the terms and conditions of this Policy.

This Policy is legally binding between the Policyholder and the Company. This Policy is issued in consideration of the application and the payment of premiums as provided hereinafter.

The first premium is due on the first day of the Policy Period. Subsequent monthly premiums are due on the first day of each month thereafter. The premium is not considered paid until the premium payment is received by the Company.

All periods of coverage will begin and end 12:01 a.m. Standard Time at the principal office of the Policyholder.

This Policy is governed by the laws of the state in which it was issued except to the extent to which such state law is pre-empted by ERISA.

Signed for the Company:

[]

President

[]

Secretary

**PLEASE READ THIS POLICY CAREFULLY
ISSUED TO THE POLICYHOLDER IDENTIFIED ON THE SCHEDULE OF INSURANCE**

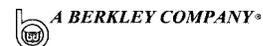
[This Policy is Participating/Non-Participating]

Berkley Life and Health Insurance Company is a member company of the W.R. Berkley Corporation .

Table of Contents

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Berkley Life and Health Insurance Company



Urbandale, Iowa

[Underwriting Office:
2445 Kuser Road, Suite 201
Hamilton Square, NJ 08690]

[Renewal] Schedule of Insurance

Policyholder: [ABC Company]
State of Issue: [xx]
Policy Number: [12345]
Original Effective Date: [May 1, 2012]
Renewal Effective Date: [May 1, 2013]
Policy Period [May 1, 2013 through April 30, 2014]

PERSONS TO BE COVERED UNDER THE STOP LOSS POLICY: [Covered Person(s)] who meet the eligibility requirements as set forth under the Policyholder's employee benefit Plan, including:

- [Retired Employees]
- COBRA Continuees

[AGGREGATE STOP LOSS Yes No

Benefit Period:

Losses Incurred from May 1, 2013 through April 30, 2014
 and Paid from May 1, 2013 through April 30, 2014

Losses Incurred prior to the original Policy Effective Date will be limited to \$ _____

Plan Coverages applying to Aggregate Stop Loss:

<u>Included</u>	<u>Not Included</u>	<u>Coverage Type</u>	<u>Included</u>	<u>Not Included</u>	<u>Coverage Type</u>
<input type="checkbox"/>	<input type="checkbox"/>	Medical	<input type="checkbox"/>	<input type="checkbox"/>	Vision care
<input type="checkbox"/>	<input type="checkbox"/>	Prescription drugs	<input type="checkbox"/>	<input type="checkbox"/>	Disability income
<input type="checkbox"/>	<input type="checkbox"/>	Dental care	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Aggregate Percentage Reimbursable (Excess of Attachment Point) [100%]

Monthly Aggregate Factors:

	<u>Employee</u>	<u>Employee & Spouse</u>	<u>Employee & Child(ren)</u>	<u>Employee & Family</u>
Medical	\$ _____	\$ _____	\$ _____	\$ _____
Dental care	\$ _____	\$ _____	\$ _____	\$ _____
Vision care	\$ _____	\$ _____	\$ _____	\$ _____
Disability income	\$ _____	\$ _____	\$ _____	\$ _____
Other	\$ _____	\$ _____	\$ _____	\$ _____

All included coverages are combined for determination of Aggregate Stop Loss liability under the terms of this Policy.

Maximum Aggregate Benefit per Benefit Period
 (Excess of Annual Aggregate Attachment Point) \$ _____

Maximum Plan Losses per [Covered Person] per Benefit Period \$ _____

Minimum Annual Aggregate Attachment Point \$ _____]

[SPECIFIC STOP LOSS Yes No

Benefit Period:

Losses Incurred from May 1, 2013 through April 30, 2014
and Paid from May 1, 2013 through April 30, 2014

Losses Incurred prior to the original Policy Effective Date will be limited to \$_____ per [Covered Person]

Plan Coverages applying to Specific Stop Loss:

<u>Included</u>	<u>Not Included</u>	<u>Coverage Type</u>	<u>Included</u>	<u>Not Included</u>	<u>Coverage Type</u>
<input type="checkbox"/>	<input type="checkbox"/>	Medical	<input type="checkbox"/>	<input type="checkbox"/>	Vision care
<input type="checkbox"/>	<input type="checkbox"/>	Prescription drugs	<input type="checkbox"/>	<input type="checkbox"/>	Disability income
<input type="checkbox"/>	<input type="checkbox"/>	Dental care	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Specific Deductible (Per [Covered Person]) \$_____

Special Limitations:
[the Specific Deductible for John Doe is \$_____]

Aggregating Specific Deductible (if Aggregating Specific Endorsement is selected) \$_____

Specific Percentage Reimbursable (Excess of Deductible) _____ [100%]

Annual Maximum Specific Benefit (per [Covered Person] in excess of the Specific Deductible) \$_____

PREMIUMS

[Aggregate Premium per (month/annum): Employee Only \$ _____
 Employee & Spouse \$ _____
 Employee & Child(ren) \$ _____
 Employee & Family \$ _____]

[Specific Premium per month: Employee Only \$ _____
 Employee & Spouse \$ _____
 Employee & Child(ren) \$ _____
 Employee & Family \$ _____]

ENDORSEMENTS ATTACHED:

- Terminal Liability Option Aggregate Coverage \$ _____]
- Terminal Liability Option Specific Coverage \$ _____]
- Monthly Aggregate Accommodation \$ _____]
- Specific Simultaneous Funding \$ _____]
- Aggregating Specific \$ _____]
- No New Special Limitations [and Rate Cap] \$ _____]
- Experimental or Investigative Services \$ _____]
- Exclusions \$ _____]
- Organ Transplant \$ _____]
- Actively at Work \$ _____]
- Appeals \$ _____]

DESIGNATED TPA:

TPA Name			
Address	City	State	Zip

[In accepting this renewal, the Policyholder represents that such information accurately reflects the true facts and that the undersigned has authority to bind the Policyholder to the proposed renewal Policy. Accordingly, this renewal Schedule of Insurance, including any required Disclosure Statement, will be a part of the Policy if accepted by the Company.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signed at _____ this ___ day of _____, [2013]

Signed for the Policyholder	
X	
Name	Title]

Definitions

[ANNUAL AGGREGATE ATTACHMENT POINT for any one Policy Period means the greater of:

- the sum of the Monthly Aggregate Attachment Points; or
- the Minimum Annual Aggregate Attachment Point.]

BENEFIT PERIOD means the period of time in which a claim must be Incurred by the [Covered Person] and Paid by the Plan to be eligible for reimbursement under this Policy. This period does not alter the Effective Date, Policy Period, or waive the Policy's eligibility requirements.

[CLINICAL TRIALS means an ongoing Phase I, II, or III clinical trial as defined by the National Institutes of Health, National Cancer Institute, or the Food and Drug Administration (FDA).]

[COVERED PERSON] means any one individual enrolled and entitled to benefits under the specific terms and provisions of the Plan. Only eligible classes and individual(s) whose initial and continued eligibility is fully described in the copy of the Plan on file with the Company and shown in the Policy schedule shall be considered a [Covered Person].

COVERED UNIT means the following person or persons who are covered under the Plan:

- A [Covered Person]
- A [Covered Person] with Dependents
- Such other defined unit as agreed upon between the Company and the Policyholder.

COVERED SERVICES means the benefit provisions contained within your Plan that are not specifically excluded under this Policy.

[DESIGNATED THIRD PARTY ADMINISTRATOR (DESIGNATED TPA) means a firm or person which has been retained by the Policyholder to pay claims and/or provide administrative services on behalf of the Policyholder Plan. Administrator in this definition does not have the same meaning as the term "Plan Administrator" used in the Employee Retirement Income Security Act of 1974 (ERISA), unless the Policyholder has specifically appointed their Administrator to perform as such.]

DISCLOSURE STATEMENT means the disclosure statement(s) provided by the Policyholder to the Company in connection with the issuance or renewal of this Policy.

EFFECTIVE DATE means the date set forth on the cover page of the Policy.

[EXPERIMENTAL OR INVESTIGATIVE SERVICES means medical treatments, procedures, technology, supplies or drugs which:

1. Have not been approved by the FDA for the particular condition at the time the service, medical treatment, procedure, technology, supply, or drug is provided; or
2. Are the subject of ongoing Phase I, II, or III Clinical Trial as defined by the National Institutes of Health, National Cancer Institute, or FDA, except for certain cancer drugs as outlined below; or
3. Have documentation published in U.S. peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine the safety, toxicity, or efficacy of the service, medical treatment, procedure, technology, supply, or drug; or
4. The patient has been asked to sign or has signed a release or other document indicating that the treatment is Experimental or Investigational 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; Medicare; the FDA; National Comprehensive Cancer Network, and other accepted medical authorities and sources.

In the context of drugs used in the treatment of cancer, the use of a drug will not be considered Experimental and/or Investigational where (1) the drug is not excluded under your Plan; and (2) the drug has been approved by the FDA; and (3) the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network Drugs & Biologics Compendium™, Thomson Micromedex DRUGDEX, Thomson Micromedex DrugPoints, or Clinical Pharmacology; or (4) the drug is provided in association with a Phase III or IV Clinical Trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute.

Routine costs will not be considered Experimental and/or Investigational for [Covered Persons] accepted into an approved Clinical Trial (as defined by Section 2709(d) of the Public Health Services Act). Routine costs are limited to: (1) covered health services for which benefits are typically provided in the absence of a Clinical Trial; (2) covered health services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects or item of service, or the prevention of complications; and (3) covered health services needed for reasonable and necessary care arising for the provision of an investigational item or service.

Routine costs for a Clinical Trial does not include: (1) the investigational item, device, or service itself; (2) items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the [Covered Person]; and (3) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. As such, these items are considered Experimental or Investigational and are excluded.]

INCURRED means the date on which the services are rendered or supplies are received by the [Covered Person].

[**ANNUAL MAXIMUM SPECIFIC BENEFIT** means the amount set forth on the Schedule of Insurance.]

LOSS means expenses incurred by a [Covered Person]:

1. For which benefits are eligible and paid by the Policyholder under the Plan, and
2. Which are not in excess of the Usual and Customary Charge(s) for those services, and
3. Which are Medically Necessary and Appropriate for the treatment of an illness or injury or for any preventative care covered by the Plan, and
4. Which are reimbursable under this Policy subject to its terms, deductible(s), limitations and exclusions.

[**MAXIMUM AGGREGATE BENEFIT PER BENEFIT PERIOD** means the maximum amount as specified in the Schedule of Insurance under the Aggregate Stop Loss benefit reimbursable by the Company to the Policyholder for the entire Policy Period as set forth in the Schedule of Insurance.]

[**MAXIMUM PLAN LOSSES [PER COVERED PERSON] PER BENEFIT PERIOD** means the maximum amount of losses which can be reimbursed under this Policy as set forth in the Schedule of Insurance.]

[**MEDICALLY NECESSARY AND APPROPRIATE** means for the purposes of determining benefits under this Policy, a Medically Necessary and Appropriate treatment is one that we determine meets all of the following criteria:

- It is recommended and provided by a licensed physician, dentist, or other medical practitioner who is practicing within the scope of their license; and
- It is generally accepted as the standard of medical practice and care for the diagnosis and treatment of the particular condition; and
- It is approved by the FDA, if applicable.

Such treatment, to be considered Medically Necessary and Appropriate, must be clinically appropriate in terms of type, frequency, extent, site, and duration for the diagnosis or treatment of the sickness or injury. The Medically Necessary and Appropriate setting and level of services is that setting and level of service which, considering the [Covered Person's] medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary and Appropriate must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the [Covered Person's] sickness or injury without adversely affecting the [Covered Person's] medical condition.

Merely because a physician recommends, approves or orders a treatment and/or service does not in and of itself make it Medically Necessary and Appropriate.

The Company retains the right to determine whether care or treatment is Medically Necessary and Appropriate. Medically Necessary and Appropriate determinations are made regardless of Provider Network agreement terms and conditions.]

MINIMUM ANNUAL AGGREGATE ATTACHMENT POINT means the lowest amount of the Policyholder's responsibility for the Policy Period, as set forth in the Schedule of Insurance, for Losses under the Plan.]

[MONTHLY AGGREGATE ATTACHMENT POINT means the total number of Covered Units for that given Policy month multiplied by the corresponding Monthly Aggregate Factors, as specified in the Schedule of Insurance. [However, in the event of a reduction in the number of Covered Units under the Plan, the Monthly Aggregate Attachment Point will not be reduced more than [five] percent from the preceding Monthly Aggregate Attachment Point.]

[TRANSPLANT means the transplant of solid organ(s), bone marrow, stem cell, umbilical cord blood, and islet cell from human to human performed to replace an organ or tissue (excluding cornea). Coverage for Transplants is only provided if the Transplant is performed at a facility that is:

- Accredited by the Joint Commission on Accreditation of Healthcare Organizations to perform a Transplant; and
- (For organ Transplants) Is an approved member of the United Network for Organ Sharing for such transplant or is approved by Medicare as a transplant facility for the transplant being performed; and
- (For bone marrow, stem cell or umbilical cord blood Transplants) Is a participant in the National Marrow Donor Program and is approved to perform such transplant by the state where the Transplant is to be performed or by Medicare or by the Foundation for the Accreditation of Hemopoietic Cell Therapy; and
- Outpatient Transplant facilities must be similarly approved; and
- Not otherwise excluded under this Policy or the Plan.]

PAY, PAID, PAYMENT means checks or drafts issued and deposited in the U.S. Mail or otherwise delivered to the payee, with sufficient funds on deposit on the date the check or draft is issued.

[PLAN means the self-funded employee benefit plan adopted and issued by the Policyholder as required under ERISA. A copy of the Plan and any amendments in effect on the Policy Effective Date is on file with the Company and utilized for purposes of determining the Company's liability under this Policy. The Plan does not waive or modify any of the provisions of this Policy.]

POLICY PERIOD means the specified period in the Schedule of Insurance, beginning no earlier than the Effective Date of the Policy and continuing until coverage terminates in accordance with the Policy Termination provision.

POLICYHOLDER means the legal entity, named on the face page, to which the Company has issued this Policy.

SPECIAL LIMITATIONS means a higher Specific Stop Loss Deductible for a specific [Covered Person], or any reduction, exclusion from coverage, or other limitation of the reimbursement that would otherwise be made under the Policy with respect to a specific [Covered Person(s)] as shown in the Schedule of the Policy within the Special Limitations Provision.

[SPECIFIC DEDUCTIBLE means the amount of the Policyholder's deductible for each [Covered Person] under the Plan during the Benefit Period as specified in the Schedule of Insurance. For each [Covered Person], the Specific Deductible will apply separately to each Benefit Period.

[USUAL AND CUSTOMARY CHARGE(S)] means the usual charge made by the provider of care for a service, not to exceed the usual charge made by the majority of like providers for the same or like service in the same geographical area in which the service or treatment is performed. Additionally, a charge must be reasonable for the services or treatments being provided and the service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.]

[Aggregate Stop Loss

If the Policyholder's Losses for the Benefit Period, stated in the Schedule of Insurance, exceed the Annual Aggregate Attachment Point for the Policy Period, the Company will reimburse the Policyholder, subject to the terms and conditions of this Policy, including the limits set forth in the Schedule of Insurance, an amount equal to:

- the Aggregate Percentage Reimbursable times the amount by which Losses exceed the Annual Aggregate Attachment Point; and
- not to exceed the Maximum Plan Losses per [Covered Person] per Benefit Period; and
- not to exceed the Maximum Aggregate Benefit per Benefit Period.

If this Policy terminates before the end of the Policy Period as stated in the Schedule of Insurance:

- the Annual Aggregate Attachment Point will be deemed not satisfied; and
- the Company will not be liable for any reimbursement under this Aggregate Stop Loss benefit.

After the end of the Benefit Period, the Company will reimburse the Policyholder for the Aggregate Stop Loss within a reasonable period of time, once satisfactory evidence of Payment of such Loss is received and approved by the Company.

While the determination of benefits under the Plan is the sole responsibility of the Policyholder, the Company reserves the right to interpret the terms and conditions of the Plan as they apply to this Policy. If Company finds that any Payment was not made in accordance with the terms of the Plan, or is not an eligible benefit under the Plan, the Company may exclude such Payment from Losses. The Company has the sole authority to approve or deny reimbursements under this Policy.]

[Specific Stop Loss

If the Policyholder's Losses for the Benefit Period, as shown in the Schedule of Insurance, exceed the Specific Deductible, the Company will reimburse the Policyholder, subject to the terms and conditions of this Policy, including the limits in the Schedule of Insurance, an amount equal to:

- the Specific Percentage Reimbursable of Specific Stop Loss times the amount by which Losses exceed the Specific Deductible amount; but
- not to exceed the Annual Maximum Specific Benefit.

Losses for any [Covered Person] during the Policy Period will be determined according to the Benefit Period, as shown in the Schedule of Insurance.

The Specific Deductible amount as shown in the Schedule of Insurance applies separately to each [Covered Person] during a Benefit Period.

While the determination of benefits under the Plan is the sole responsibility of the Policyholder, the Company reserves the right to interpret the terms and conditions of the Plan as they apply to the Stop Loss Insurance Policy. If the Company finds that any Payment was not made in accordance with the terms of the Plan, or is not an eligible benefit under the Plan, the Company may exclude such Payment from Losses. The Company has the sole authority to approve or deny reimbursements under this Policy.]

[Reimbursement of Certain Fees Under Specific Stop Loss: The following fees will be included as eligible Losses for Specific Stop Loss when Incurred and Paid by the Policyholder, and approved by the Company:

1. Reasonable hourly fees, not to exceed [\$100.00] per hour unless prior approval is received by Company, for case management services provided by a registered nurse case manager retained by the Policyholder or by the Designated TPA. Company retains the right to deny reimbursement of case management fees, if case management reports do not demonstrate quality case management services; and
2. Fees from a third party for: (a) hospital bill audits; (b) access to non-directed provider networks; and (c) negotiating out of network bills or negotiating additional discounts on in network bills. If the Policyholder can demonstrate a cost savings and submits a signed provider agreement, the Company will reimburse the Policyholder up to [25%] of the amount saved, but not to exceed [75%] of the amount paid to the provider up to a maximum of [\$3,000]. To determine the amount saved, the Company will compare the amount the Plan would have paid without the application of the savings against the amount that was paid because of the work performed.

The Company has the sole authority to approve or deny any payment of fees under this Policy.]

Fees charged by the Designated TPA or any subsidiary, affiliate, related entity, or entity with shared common ownership for any of these services will be considered Losses only if prior approval has been obtained in writing from the Company.]

[Exclusions

The Company will not reimburse any Loss or expense caused by or resulting from any of the following:

- [1. Legal expenses, court costs, or interest upon judgments.]
- [2. Punitive or other damages assessed against the Policyholder, Designated TPA or other Party associated with the Plan.]
- [3. Amounts Paid for administration of the Policyholder's Plan including, but not limited to, claim payment fees, cost containment administrative fees, PPO access fees, medical review and consultant fees, premium functions, unless otherwise covered under a provision within this Policy.]
- [4. Amounts Paid for:
 - any individual who is not eligible for benefits under the Plan;
 - any services or supplies, rendered to a [Covered Person], when such service or supply is not a covered service under the Plan.]
- [5. Amounts Paid for [Covered Persons] which are in excess of Usual and Customary charges as determined by the Company.]
- [6. Amounts Paid for expenses that are covered by any other medical plan or insurance, including amounts recoverable under any coordination of benefits provision.]
- [7. Claims arising out of, caused by, contributed to, or in consequence of declared or undeclared war or act of war.]
- [8. Amounts Paid for coverages provided by the employer, but not shown as covered in the Schedule of Insurance.]
- [9. Claims arising out of or in the course of any occupation or employment for wage or profit or claims for which the [Covered Person] is entitled to benefits under any Workers Compensation or Occupational Disease Act or Law.]
- [10. Any managed care discount, negotiated discount, audit savings, or other discount or savings forfeited or waived by the Policyholder for any reason, including, but not limited to, untimely payment.]
- [11. Experimental or Investigative services, treatments, procedures technology, supplies, or drugs.]
- [12. Amounts paid for care or service that is not Medically Necessary and Appropriate .]
- [13. Amounts paid for [Covered Persons] who reside outside of the United States.]
- [14. Amounts paid for any treatment administered outside the United States [if the [Covered Person] traveled to the location where the treatment was received for the purpose of obtaining treatment.]]

[15. Regardless of any provision within the Plan, if on the Policy Effective Date or Policy Renewal Effective Date, a [Covered Person] is not actively at work or a dependent is totally disabled, in an institution receiving medical care or treatment, or confined at home or elsewhere, any expense incurred by the [Covered Person] will not be considered a covered expense under this Policy. This exclusion will continue for all expenses incurred by the [Covered Person] until he or she is actively at work or for a Dependent who is no longer totally disabled or is no longer in an institution receiving medical care or treatment or confined at home or elsewhere.

For the purposes of this exclusion, a [Covered Person] is considered to be actively at work if he or she is working at your usual place of business or at such places that your normal course of business may require; and performing all of the duties of his or her occupation on a full-time basis, and is not confined in any institution providing care or treatment of physical or mental infirmities.

If a [Covered Person] is not actively at work on the Policy Effective Date or Policy Renewal Effective Date solely because it was not a regularly scheduled work day, the [Covered Person] will be deemed to be actively at work on that day, provided the [Covered Person] is actively at work on the next regularly scheduled work day.

A Dependent is considered totally disabled if they, solely because of injury or sickness, cannot engage in substantially all of the normal activities of a person of like age and sex in good health.

Actively at work will not apply to those individuals previously disclosed and accepted by the Company.]

[16. Amounts Paid for [Covered Persons]: whose coverage extension under the Consolidated Omnibus Budget Reconciliation Act (COBRA) is continued beyond the timeframes specified by federal law for any reason, including clerical error of the Policyholder; who do not receive a valid COBRA extension offer within the 44 days immediately following a COBRA qualifying event; who fail to make a valid, signed COBRA election within the 60 days immediately following the receipt of COBRA election rights from the Policyholder; or who fail to remit COBRA premium within the period specified by federal law. The Company will require written documentation that these requirements have been satisfied.]

[17. Amounts paid for [Covered Persons] who are eligible for coverage under Medicare, any benefit reimbursable to the Policyholder under this Policy shall be reduced by the amount of any similar Medicare benefit paid or reimbursable so that the total reimbursements, with respect to a [Covered Person] or his or her dependents, shall not exceed 100% of such person's actual expenses].

[18. For expenses associated with a Transplant.]]

Premiums and Factors

PAYMENT OF PREMIUMS: No coverage under this Policy will be in effect until the first premium is paid. For coverage to remain in effect, each subsequent Payment as shown in the Schedule of Insurance for the applicable Policy Period, must be paid on or before its due date. The Policyholder is responsible for the Payment of its premiums. Premiums are not considered paid until the premium Payment is received by the Company.

GRACE PERIOD: A Grace Period of [31] days from the due date will be allowed for the Payment of each premium after the first premium Payment. During the Grace Period, the coverage will remain in effect, provided the premium is paid before the end of the Grace Period. If a premium otherwise due is not paid during the Grace Period, this Policy will be terminated without further notice, as of the date for which premiums were last paid.

PREMIUM AMOUNT: The Policyholder's premiums will be calculated using rates determined by the Company, as set forth in the Schedule of Insurance. The amount of total premium due is the sum obtained by multiplying each rate shown in the Schedule of Insurance by the Covered Units to which the rate applies. Any correction to the [Specific] [or Aggregate] premium of the Covered Units for the preceding Policy Period must be reported to the Company within sixty days after the last Policy month of the preceding Policy Period.

PREMIUM RATE [AND MONTHLY AGGREGATE FACTOR] CHANGE: The Company may change the Policyholder's premium rate [or Monthly Aggregate] Factor on any of the following:

- [the date when the terms of this Policy are changed; or
- the date the Policyholder adds or deletes subsidiary or affiliated companies or divisions; or
- the date of any accepted revision to the Plan; or
- the date the geographic area in which the Policyholder has Employees or the nature of business in which the Policyholder is engaged in changes; or
- the date there is a change in enrollment exceeding [10%] of the first month's enrollment of the current Policy Period or the [9th] month of the prior Policy Period; or
- the date the Policyholder changes its Designated TPA; or
- the date the Policyholder changes the provider network it utilizes.]

[The Company reserves the right to recalculate the premium rate [and the Monthly Aggregate Factor] for the Policy Period, if there is more than a [ten/twenty-five percent] (10%/25%) variance between:

- the average monthly Paid claims under the Plan for the last two months of the prior Policy Period; and
- the average monthly Paid claims under the Plan for the first ten months of the prior Policy Period.]

Policy Termination

This Stop Loss Insurance Policy will continue in effect until the end of the Policy Period, unless coverage is terminated, as set forth below.

This Policy and all related benefits will terminate upon the earliest of the following dates:

- on the due date of any premium which is not paid, subject to the Grace Period; or
- the premium due date next following receipt by the Company of written notice from the Policyholder that this Policy is to be terminated; or
- the date of termination of the Plan; or
- the date the Policyholder suspends active business operations or is placed in bankruptcy or receivership; or
- the date the Policyholder dissolves.

This Policy may also be terminated at the Company's option immediately upon delivery of a written notification to the Policyholder, effective on:

- the date the number of [Covered Persons] under the Plan becomes less than [seventy-five][or][70% of those eligible];
- the date the Policyholder fails to perform any of its duties and obligations as set forth in this Policy;
- the date the Plan fails to pay claims promptly or to make funds available for the payment of claims as required by the Plan; or
- the date the Designated TPA or Network is changed by the Plan if notice is not provided to the Company and prior acceptance of the change obtained as required by the terms of this Policy.

If this Policy is terminated before the end of the Policy Period stated in the Schedule of Insurance, the Company has no obligation to reimburse the Policyholder for any Losses that are Paid after the date this Policy is terminated. The Company will not refund any portion of the premium paid by the Policyholder whose Plan terminated during the Policy Period.

PLAN TERMINATION: The Policyholder will immediately notify the Company in writing, if the Policyholder's Plan is terminated.

Claims Provisions

CLAIMS ELIGIBLE UNDER TWO POLICIES: If a claim for reimbursement can be filed under two different Policy years, it must be filed under the earliest Policy year and is ineligible under the subsequent Policy or subsequent renewal.

LIABILITY: The Company will have neither the right nor the obligation under this Policy to directly pay any [Covered Person], provider of professional or medical services, or other third party. The Company's sole liability is to the Policyholder, subject to the terms and conditions of this Policy. Nothing in this Policy shall be construed to permit a [Covered Person] to have a direct right of action against the Company. The Company will not be considered a party to the Plan or to any supplement or amendment to it. The Policyholder may not assign reimbursement under this Policy, and the Company will not recognize any such assignment.

NOTICE OF CLAIMS: The Policyholder must give written notice to the Company of a [Covered Person] receiving Eligible Services where the eligible paid claims are expected to exceed or have exceeded [50%- 75%] of the Specific Deductible within [30] days (or as soon thereafter as reasonably possible) of the date incurred or the date the Policyholder becomes aware of the potential/actual claim. Written notice must include: [Covered Person's] first and last name, date of birth, identification number, claims paid and pending amount, primary diagnosis, date of onset, prognosis and anticipated liability for the Policy Period.

The Policyholder must report to the Company any [Covered Person] who is a potential/actual transplantation recipient (excluding corneal and cochlear transplants). Notification for potential/actual transplantation recipients must include the details provided above and the type of transplantation, donor type, date of evaluation, date of listing, facility name, and transplantation network contract provider name. The Policyholder must provide a minimum of quarterly updates to an initial notification or more frequently, if a salient change from the initial reported notice of claim has occurred or upon request of the Company.

The Policyholder must also give written notice of claims to the Company within [30] days of the date the Policyholder and their agents or other representatives become aware of the existence of facts which would reasonably suggest the possibility that Losses will be Incurred which are covered by this Policy, and which are subject to the Aggregate Stop Loss benefit and equal or exceed the Annual Aggregate Attachment Point or are expected to exceed that amount. In addition, the Policyholder must notify the Company immediately when it receives a claim for any potentially catastrophic loss as identified in Exhibit A.

PAYMENT OF CLAIMS: Amounts payable under this Policy will be paid to the Policyholder within a reasonable timeframe upon receipt, review and acceptance by the Company of Proof of Loss when the amount exceeds [\$500.00]. Any reimburseable amount remaining unpaid at the end of the Policy Period will be paid after the end of the Policy Period.

PROOF OF LOSS: The Policyholder's written Proof of Loss must be submitted to the Company within [90] days of a claim Paid by the Policyholder. Later proof will be accepted only if it is shown to have been furnished as soon as reasonably possible and in no event later than one year after the date of Loss.

[RISK MANAGEMENT: The Company has the right to retain the services of medical management vendors, at our expense, to assist us with cost containment when we anticipate that a [Covered Person's] eligible expenses will exceed 50% of the Specific Deductible or when a [Covered Person's] eligible expenses have exceeded the Specific Deductible during the Policy Year. We also may have a medical management vendor or other service provider contact you if, in our determination, that vendor provides a service that may allow your Plan to reduce costs and expenses.]

[REPORTS AND AUDITS: The Policyholder will submit by the [15th] day of each month all Proof of Loss reports and supporting documents including, but not limited to, a monthly summary of all Losses Paid by the Policyholder and total number of Covered Units covered under the Plan during the prior month. The Policyholder will be responsible for the investigation, auditing, calculating, and the Payment of all claims under the Plan.

The Company will have the right:

- to inspect, copy, and audit all records and procedures of the Policyholder and Designated TPA developed and maintained for the Plan that are applicable to the administration of the Stop Loss Insurance Policy; and
- to require, upon request, documents, such as medical and eligibility records, case management notes, and other similar documents which are satisfactory to the Company that any Payment made to the [Covered Person] or the provider of such services or benefits were Paid in accordance with your Plan and for which are the basis for any purported Loss by the Policyholder.

The Policyholder and its Designated TPA must cooperate with the Company in the event the Company exercises its right to audit as set forth herein. The Company reserves the right to employ a third party to assist us with any audit function.]

RECOUPMENT: We have the right to recoup from any claims payment any premium funds owed to the Company that have not been paid. Our right of recoupment does not impair our right to terminate this Policy for non-payment of premium under the termination provisions of this Policy.

OFFSET: Any payment or overpayment of a claim made to the Policyholder due to error or mistake must be promptly refunded to the Company upon notice to the Policyholder of such error or mistake. The Company may offset any funds owed to the Company against any funds due the Policyholder.

RIGHT OF REIMBURSEMENT: Amounts Paid which are reimbursed by, or payable by other insurance companies, reinsurers, or third parties will not be included in [Aggregate Stop Loss] [or] [Specific Stop Loss] benefits, nor can they be used to satisfy any Deductible under this Policy. Additionally:

- If the Company reimburses the Policyholder for amounts that are later recovered from another party, the amount recovered must be refunded by the Policyholder to the Company to the extent of any paid claims under this Policy. Any repayment amount you owe us survives the termination of this Policy and recoveries made after this Policy terminates must be repaid to us.
- Should there be an over-reimbursement made to the Policyholder due to clerical or other error, the over-reimbursement must be refunded.
- If benefits for a [Covered Person] are payable under an extension of benefits provision of a previous insurance carrier, the Company will not accept responsibility for the expenses payable under the prior coverage for such individuals.

[SUBROGATION/RIGHT OF RECOVERY: The Policyholder 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 may have against any third party responsible, in whole or in part, for any Claims paid by the Plan. You must immediately advise us of any amount you recover from them. If the Policyholder fails to pursue any action against a third party and the Company has made benefit payments under this Policy, the Company will be subrogated to all of the Policyholder's rights to make recoveries. The Policyholder is required to cooperate fully and do all things necessary and required for the Company to pursue any action to recover against the third party; the scope of the Policyholder's cooperation shall include, without limitation, the execution of a Subrogation receipt or assignment in favor of the Company and the granting of authorization to the Company to commence litigation or other legal proceedings in the name of the Policyholder to seek recoveries from third parties. The Company agrees to pay its pro rata portion of the Policyholder's attorneys' fees or other costs associated with a claim or lawsuit to the extent that the Company recovers any portion of the benefits paid under this Policy pursuant to its Subrogation right.]

General Provisions

[ARBITRATION: All disputes between the Policyholder and the Company shall be settled by arbitration in accordance with the Commercial Rules of the American Arbitration Association, except with regard to rules governing the selection of arbitrators. It is further stipulated that the arbitrator(s) shall, when adjudicating any dispute under this Policy, consider the terms and conditions of this Policy, applicable substantive law, and may, in the arbitrators' discretion, consider applicable custom and practice in the Accident and Health industry [and the Employer Stop Loss sector.] All matters shall be decided by a panel of three (3) arbitrators, all of whom must be either current or former officers or directors of Life, Health and Accident insurers or current or former insurance brokers or administrators with substantial experience in the [Employer Stop Loss sector.] Each party shall select its own party arbitrator and the parties' chosen arbitrators shall jointly select the third; in the event that the two party-arbitrators cannot agree on the third arbitrator, each party shall appoint three candidates, two of whom shall be stricken by the other party, and the third arbitrator shall thereafter be chosen from the remaining two candidates by the drawing of lots. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction.

This provision shall survive the termination or expiration of this Policy. The arbitrators shall have no power or authority to award punitive or exemplary damages. Any arbitration shall be confidential, and except as required by law, neither party may disclose the existence, content or results of any arbitration hereunder without the prior written consent of the other parties, except that disclosure is permitted to a party's auditors and legal advisors. The parties hereto may alter any of the terms of this provision only by express written agreement, although such alteration may be before or after any rights or obligations arise under this provision. This provision will survive the termination or expiration of this Policy.]

ASSIGNMENT: Your interest in this Policy cannot be assigned.

CLERICAL ERROR: Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery. Your failure to report the existence of a [Covered Person] or comply with the reporting requirements of this Policy shall not constitute clerical error.

[DESIGNATED THIRD PARTY ADMINSTRATOR: Without waiving any rights under this Policy, and without making the Designated TPA a party to this Policy, we agree to recognize the Designated TPA as the administrator of the Policyholder's Plan(s), subject to the following:

- The Designated TPA is responsible on behalf of the Policyholder for auditing, calculating, and processing all claim expenses for the underlying Plan within a reasonable amount of time, preparing reports as required by us, and maintain and making available to us, at all times such information as we may reasonable require for proof of payment of claims.
- The Designated TPA must perform such other duties as may be reasonable required by us, including but not limited to, maintaining an accurate record of the [Covered Persons] under the Plan.
- We are not responsible for nor will this Policy reimburse any compensation or fees due to the Designated TPA for functions performed by them for the Policyholder in relation to this Policy.
- Notice to the Designated TPA by us under the provisions of this Policy will be considered notice to the Policyholder and notice to the Policyholder will be deemed notice to the Designated TPA.]

ENTIRE CONTRACT/CHANGES: The entire contract between the Company and the Policyholder will consist of this Policy, the attached application and Disclosure Statement, any attached amendments or endorsements, and the Policyholder's Plan which is on file with the Company.

This Policy can be altered only with the consent of the Company and then only in writing. No such alteration of this Policy shall be valid unless endorsed on or attached to this Policy. No agent, broker, or Designated TPA has the authority to alter this Policy or to waive any of its provisions, including premiums shown in the Schedule of Insurance.

INSOLVENCY: The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder, The Plan or the Policyholder's Designated TPA will not impose upon the Company any liability other than the liability defined in this Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including [Covered Persons] under the Plan.

LEGAL ACTION: No legal action may be brought against the Company until there has been full compliance with all the terms of this Policy. All Policy terms will be interpreted under the laws of the state shown on page 1 of this Policy. No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been furnished. No legal action may be brought after two (2) years from the time written Proof of Loss is required to be furnished.

MISREPRESENTATION, CONCEALMENT, FRAUD: This entire Policy will be void and subject to rescission if the Company determines that the Policyholder or its agent has concealed or misrepresented any material fact or circumstance concerning this Policy, including without limitation material facts contained within the Policy application, the Disclosure Statement, any other material facts provided by the Policyholder to the Company prior to the Policy Effective Date, or regarding any claim or any case of fraud by the Policyholder [or its Designated TPA] or other agent relating to this Policy.

MISSTATED DATA: The Company has relied upon the underwriting information provided by the Policyholder, its Designated TPA, or other agent in the issuance of this Policy. Should subsequent information become known which, if known prior to issuance of this Policy, would have affected the rates, deductibles, terms, or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms, or conditions as of the Effective Date of issuance, by providing written notice to the Policyholder or the Policyholder's agent. Nothing contained within this provision shall be deemed to in any way, affect the Company's right to rescind the Policy in the event of a material misrepresentation by the Policyholder or the Policyholder's agent.

[NON-PARTICIPATING POLICY: This Policy is non-participating and does not share in the company's surplus earnings.]

[NO ERISA LIABILITY: Under no circumstance will the Company accept responsibility as a "Plan Administrator" or be deemed a "plan fiduciary" with respect to your Plan under the Employee Retirement Security Act of 1974, as amended.]

[NOTICE: For the purpose of any notice required from the Company under the provisions of this Policy, notice to the Designated TPA shall be considered notice to the Policyholder and notice to the Policyholder shall be considered notice to the Designated TPA. Notice from the Policyholder to the Designated TPA and notice from the Designated TPA to the Policyholder shall not be considered notice to the Company.]

NOTICE OF APPEAL OR LITIGATION: The Policyholder must promptly provide the Company with written notice of any objection, appeal, or Insurance Department complaint received on a claim processed under the Plan on which it reasonably appears a reimbursement under this Policy may be payable. A copy of any document filed by or against the Policyholder in any court in connection with litigation under the Plan must be promptly furnished to the Company.

OTHER COVERAGE: The reimbursement provided by this Policy is in excess of other coverages such as group insurance, excess insurance, reinsurance, plan benefits including insurance or benefits established by any federal, state or local law.

[PARTICIPATING POLICY: This Policy is a participating Policy. Your Policy is eligible to share in the divisible surplus. We will determine its share and credit it as a dividend at the end of each contract year. Dividends may be applied to reduce your premium or paid to you in cash. Unless you advise us otherwise in writing, we will pay dividends, if any, in cash.]

PARTIES TO THE POLICY: The parties to this Policy are exclusively the Policyholder and the Company. The Company's sole liability under this Policy is to the Policyholder. This Policy does not create any right or legal relation between the Company and a [Covered Person] under the Plan. This Policy will not be deemed to make the Company a party to any agreement between the Policyholder and any third party.

PLAN: The Policyholder will provide to the Company a complete copy of the Plan document governing the Plan. No Plan change will affect this Policy without the Company's written consent. Written notice of the Plan change must be given to the Company at least 31 days prior to the effective date of the change. The Company will have the right to modify premium rates and/or other terms and conditions of coverage if the Company determines that its liability under this Policy has been affected by such Plan change. If advance written notice is not received and accepted and required herein, the Company's reimbursement may be made as if the Plan had not been amended, at the Company's discretion. The Company's reimbursement will be made according to the amended Plan, once the notice is received and accepted.

POLICY RENEWAL: This Policy may be renewed unless it has been terminated or is subject to termination in accordance with the termination provisions of this Policy. Policy changes for any renewal Policy will appear on a revised Schedule of Benefits and/or a Policy amendment. Your payment of the renewal premium after receipt of the revised Schedule of Benefits and/or Policy amendment constitutes acceptance of the renewal Policy by you. At the end of the Policy Period, but only by mutual agreement of the Policyholder and the Company, this Policy may be renewed for another Policy Period. The renewal may be subject to new premium rates, new underwriting terms, a new Benefit Period and new Policy terms.

RECORDS: The Policyholder will maintain records of all [Covered Persons] under the Plan during the Policy Period and for a period of seven years after the termination of this Policy. The Policyholder shall make such records available to the Company as needed to evaluate its liability under this Policy.

REINSTATEMENT: If any premium that is due and owing to the Company is paid after the expiration of the Grace Period, the Company may at its option elect to reinstate the Policy on the terms and conditions that the Company elects at that time.

SEVERABILITY: In the event that a court of competent jurisdiction invalidates any provision of this Policy, all remaining provision of this Policy shall continue in full force and effect.

[STATE HEALTH CARE SURCHARGES: If the Policyholder pays a state health care surcharge imposed by Louisiana, Massachusetts, or New York in connection with the payment of Losses, such health care surcharges are included as Losses. We will only reimburse health care surcharges imposed by New York up to 8.85% of the amount upon which the surcharge was levied.]

TAXES: In the event any state or federal taxing authority which has jurisdiction over either of the parties finds that additional taxes or other assessments, other than premium taxes paid by the Company with respect to this Policy, must be paid in respect of this Policy, the Plan, or related matters, the Policyholder shall be responsible for such additional taxes and the Company shall be held harmless from any such tax liability. Any payments made by the Company under this provision will be reimbursed by the Policyholder upon invoice. If payment is not received the Company reserves the right to offset any payments owed to the Policyholder until the tax is fully paid.

TIME LIMIT ON CERTAIN DEFENSES: In the absence of fraud, all statements made by the Policyholder shall be deemed representations and not warranties. No statement made by the Policyholder for the purpose of effecting insurance shall be used to contest this Policy or reduce benefits unless contained in a signed, written application, a copy of which has been provided to the Policyholder. No such statement will be used to contest this Policy after this Policy has been in force for two years.

WAIVER: Failure of the Company to strictly enforce its rights under this Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

Exhibit A

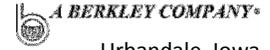
Claims which are considered to be potentially catastrophic are identified below:

1. [Organ, tissue, or bone marrow transplants
2. A length of stay request of more than 14 days
3. A second request for extension of length of stay
4. A second admission in 6 months or less
5. Multiple system failure
6. Multiple trauma
7. Large dollar claim identified during the interim or final billing that exceeds \$15,000
8. Request for intensive level of home health care supplies or services
9. Request for transfer to a rehabilitation facility
10. Ventilator patient greater than 4 days
11. Pain medication required every 8 hours or more frequently
12. Hyperalimentation (total parenteral nutrition)
13. Interim hospital billing
14. Home IV antibiotic therapy
15. Malignant neoplasms (any site)
16. End stage renal disease
17. Biopsy of brain
18. Craniotomy
19. Lobectomy (lung)
20. Pneumonectomy
21. Laryngectomy
22. Thoracostomy
23. Esophagectomy
24. Gastrostomy
25. Hepatectomy
26. Pancreatectomy
27. Nephrectomy
28. Amputation
29. Major burns in excess of 20% - 30% of the body
30. HIV Positive or AIDS (Acquired Immune Deficiency Syndrome) Related Illnesses, such as:
 - Encephalopathy
 - Confusion in patients younger than 50 years old
 - Kaposi's sarcoma
 - Cytomegalovirus
 - Pneumocystis carinii pneumonia
 - Lymphoreticular malignancy

- Toxoplasmosis
 - Cryptosporidium
 - Isospora infection
 - Bronchial or Pulmonary Candidiasis
 - Progressive Multifocal Leukoencephalopathy
 - Herpes simplex or herpes zoster
31. Blood deficiency disorder
- Severe immune deficiency disorder
 - Aplastic anemia
32. Cardiovascular disease
- Endocarditis
 - Cardiomyopathy
 - Late effects of cardiovascular disease
33. Cerebral Vascular Disease with Neurological Deficits
- Anoxic brain damage
 - Multiple fractures, skull/face
 - Cerebral lacerations/ contusion
 - Intercranial or subarachnoid hemorrhage
 - Coma
 - Acute vascular disease (stroke, cardiovascular accident)
 - Viral encephalitis
34. High Risk Neonatal
- Congenital anomalies including but not limited to spina bifida, cleft lip or palate, anomalies of the heart, GI tract, limbs, or circulatory, respiratory, or nervous system
 - Intestinal malabsorption
 - Slow fetal growth, fetal malnutrition (failure to thrive)
 - Short gestation, low birth weight
 - Birth trauma
 - Intrauterine hypoxia and birth asphyxia
 - Respiratory distress syndrome
 - Other respiratory conditions
 - Fetal neonatal hemorrhage
 - Fetal hemolytic disease
 - Apnea/bradycardia
 - Hemorrhage (grade 2-4)
 - Broncho-pulmonary dysplasia
 - Hyaline membrane disease
35. High Risk Obstetrical
- Previous preterm delivery
 - Preterm labor – current pregnancy
 - Anomalous uterus, DES daughter, uterine surgery
 - Second trimester abortion (spontaneous or therapeutic)
 - Incompetent cervix, cone biopsy, large fibroids
 - Multiple gestation
 - Pyelonephritis, recurrent urinary tract infections
 - Cervical dilation or effacement prior to 36 weeks
 - Uterine irritability prior to 36 weeks
 - Placenta previa; polyhydramnios
 - Bleeding

- Toxemia
 - Premature rupture of membranes
 - Abruptio placenta
 - Request for home uterine monitoring, or home monitoring of pregnancy-induced hypertension
36. Infectious diseases
- Tuberculosis
 - Septicemia
 - Meningitis
 - Subacute bacterial endocarditis
 - Crohn's disease
 - Septic Arthritis
 - Osteomyelitis
37. Diabetes mellitus, complicated by one or all of the following:
- Circulatory disorders
 - Neurologic impairment
 - Amputation
 - Chronic renal failure
 - Blindness
 - Cardiac complications
38. Spinal injury/trauma and closed head injury
- Paralytic syndromes
 - Quadriplegia, paraplegia, or hemiplegia
 - Spinal cord injury
 - Closed head injury
39. Neuromuscular
- Amyotrophic Lateral Sclerosis
 - Myopathy
 - Guillain-Barre Syndrome
 - Cerebral Palsy
 - Multiple Sclerosis]

Berkley Life and Health Insurance Company



Urbandale, Iowa

[Underwriting Office:
2445 Kuser Road, Suite 201
Hamilton Square, NJ 08690]

Stop Loss Insurance Application

Application is hereby made to the Berkley Life and Health Insurance Company ("Company") for [Aggregate] [and] [Specific] Stop Loss Insurance. This Application must be accepted and approved by the Company prior to any insurance being in effect.

POLICYHOLDER INFORMATION			
1. Full legal name of Policyholder			
2. Key contact at Policyholder			
3. Address	City	State	Zip
4. Subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) that are to be included. List legal names and addresses of such companies:			
5. Nature of Policyholder's business			
<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other (please describe)			
6. Insurance applied for replaces prior coverage as follows:			
<u>Name of company</u>	<u>Type of coverage</u>	<u>Termination date</u>	
7. Full name of the Employee Benefit Plan			
8. Name and address of Policyholder's Third Party Administrator			
9. Proposed initial Policy period			
10. Persons to be covered under the Stop Loss Policy			
Employees and dependents who meet the eligibility requirements, as set forth under the Policyholder's Employee Benefit Plan, with the exceptions noted below:			
<u>Yes*</u>	<u>No</u>	<u>Yes*</u>	<u>No</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retired employees		Employees who are not Actively at Work	
COBRA continuees			
* All "Yes" answers must have a Disclosure Statement attached to this Application.			
11. Total eligible employees		Estimated initial enrollment	

PREMIUMS

14. [Aggregate Premium per [month/annum]:	Employee only	\$ _____
	Employee & Spouse	\$ _____
	Employee & Child(ren)	\$ _____
	Employee & Family	\$ _____
[Specific Premium per month:	Employee only	\$ _____
	Employee & Spouse	\$ _____
	Employee & Child(ren)	\$ _____
	Employee & Family	\$ _____
[Endorsements/Amendments Attached:		
<input type="checkbox"/>	Terminal Liability Option Aggregate Coverage Endorsement	\$ _____
<input type="checkbox"/>	Terminal Liability Option Specific Coverage Endorsement	\$ _____
<input type="checkbox"/>	Monthly Aggregate Accommodation Endorsement	\$ _____
<input type="checkbox"/>	Specific Simultaneous Funding Endorsement	\$ _____
<input type="checkbox"/>	Aggregating Specific Endorsement	\$ _____
<input type="checkbox"/>	No New Special Limitations [and Rate Cap] Endorsement	\$ _____
<input type="checkbox"/>	Experimental Investigational Services Endorsement	\$ _____
<input type="checkbox"/>	Exclusions	\$ _____
<input type="checkbox"/>	Organ Transplant	\$ _____
<input type="checkbox"/>	Actively at Work	\$ _____
<input type="checkbox"/>	Appeals	\$ _____

IT IS UNDERSTOOD AND AGREED AS CONDITIONS PRECEDENT TO THE APPROVAL OF THIS APPLICATION THAT:

- The Policyholder is financially sound, with sufficient capital and cash flow to accept the risks inherent in a “self-funded” health care plan;
 - The Third Party Administrator retained by the Policyholder will be considered the Policyholder’s Agent and not the Company’s Agent;
 - All documentation requested by the Company must be submitted prior to any approval of this Application and must be received by the Company within [thirty (30) days] of the Effective Date;
 - The Company will evaluate the Policyholder’s risk and may require adjustments of rates, factors, and/or special limitations to accommodate for abnormal risks;
 - Premiums are not considered paid until the premium check is received by the Company and at the rates set forth in the Schedule of Stop Loss; and
 - If the Policyholder has more than one business location, a representative of the Policyholder at each location has reviewed and completed a Disclosure Statement.
- NOTICE:** Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

In making this Application, the Policyholder represents that such information accurately reflects the true facts and that the undersigned has authority to bind the Policyholder to the proposed Policy. Accordingly, this Application, including any attached Disclosure Statement, will be a part of the Policy, if accepted by the Company.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signed at _____ this _____ day of _____ [2012]

Signed for the Policyholder
X

Name _____ Title _____

Licensed Agent Signature _____ Licensed Agent Name _____
X

Social Security Number or Tax ID _____

Address _____ City _____ State _____ Zip _____

**Terminal Liability Option
Aggregate Coverage Endorsement**

This Endorsement revises and becomes a part of the Policy to which it is attached. This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

This Endorsement attaches to and is made part of Policy Number [XXXXXXX] issued to [XXXXXXXXXXXX].

The Annual Aggregate Attachment Point and the Benefit Period for the Aggregate Stop Loss benefit will be revised as outlined below:

The revised Aggregate Stop Loss Benefit Period will be as stated in the Schedule of Insurance plus Losses Paid in the [thirty (30) - ninety (90) days] immediately thereafter.

The revised Annual Aggregate Attachment Point will equal the greater of:

1. the Annual Aggregate Attachment Point for the Policy Period as stated in the Schedule multiplied times [1.25 – 2.00]; or
2. the Minimum Annual Aggregate multiplied times [1.25 – 2.00].

Extended Aggregate Coverage is effective:

1. only if this Policy is terminated at the end of the Policy Period as stated in the Schedule of Insurance; and
2. only if the Policy is not replaced with another stop loss or excess loss policy of any kind whatsoever.

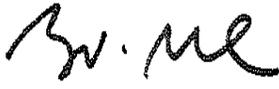
The Policyholder must select this Endorsement at the beginning of the Policy Period stated above and must pay the Endorsement premium as stated in the Schedule of Insurance. If the Aggregate Stop Loss benefit or the Policy are terminated for any reason before the last date of the Policy Period, this Endorsement will be void.

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

EFFECTIVE DATE OF ENDORSEMENT: [XXXXXXX]

Signed for the Company:

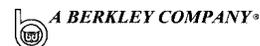
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President

Secretary

Berkley Life and Health Insurance Company



Urbandale, Iowa
[Underwriting Office:
2445 Kuser Road, Suite 201
Hamilton Square, NJ 08690]

Terminal Liability Option Specific Coverage Endorsement

This Endorsement revises and becomes a part of the Policy to which it is attached. This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

This Endorsement attaches to and is made part of Policy Number [XXXXXXX] issued to [XXXXXXXXXXXX].

The Benefit Period for the Specific Stop Loss benefit will be revised as outlined below.

The Specific Stop Loss Benefit Period will be revised so that the time period during which covered expenses must be paid by the Plan is extended an additional [thirty (30) to ninety (90)] days immediately after the date the Policy is terminated.

Extended Specific Coverage is effective:

1. only if this Policy is terminated at the end of the Policy Period; and
- [2. only if the Policy is not replaced with another stop loss or excess loss policy of any kind whatsoever; and]
3. you utilize the same TPA that administered your plan as of the Policy termination date to administer any run out claims; and
4. only if the additional premium set forth in the Schedule of Insurance has been paid.

The Policyholder must select this Endorsement at the beginning of the Policy Period.

If the Specific Stop Loss benefit or the Policy are terminated for any reason before the last date of the Policy Period, this Endorsement will be void.

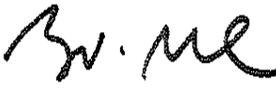
All other terms, conditions, limitations and exclusions of the Policy remain unchanged.

EFFECTIVE DATE OF ENDORSEMENT: [XXXXXXX]

Signed for the Company:

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President

[]

Secretary

Monthly Aggregate Accommodation Endorsement

This Endorsement revises and becomes a part of the Policy to which it is attached. This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

This Endorsement attaches to and is made part of Policy Number [XXXXXXX] issued to [XXXXXXXXXXXX].

Monthly Aggregate Benefit

If, in any month during the Policy Period, the total losses Paid by the Policyholder, for which reimbursement is provided under the terms of the Policy, exceed the sum of:

1. the greater of (a) the accumulated Monthly Aggregate Attachment Point or (b) the pro rata portion of the Minimum Annual Aggregate Attachment Point; and
2. any previous advances; and
3. [\$1,000]

the Policyholder may request an advance of the excess Aggregate benefit. The Policyholder must submit, within [20] days following the end of the month for which the advance is requested, Notice of Claim and Proof of Loss. The Company will then advance to the Policyholder the amount by which the sum of year to date losses paid exceeds the sum of 1 and 2 above.

Reconciliation

At the end of the Policy Period, the Policyholder must submit Proof of Loss showing the sum of all Losses Paid during the Policy Period. If the sum of what the Policyholder Paid is greater than the actual Annual Aggregate Attachment Point, then the Company will pay the amount of that excess less any amounts advanced.

If the Company advanced the Policyholder more than the amount of the Maximum Aggregate Benefit per Benefit Period, the Company may, at its option:

1. require repayment of the overpayment within [30] days after providing written notice of the amount due, subject to a late payment charge of [10%] per annum; or
2. reduce subsequent reimbursements under the Aggregate or Specific Stop Loss benefit by the amount of the overpayment.

Treatment Accommodation

The accommodation provided under this Endorsement shall be an obligation of the Policyholder for which no interest shall be charged and shall be repaid as provided herein. The accommodation is neither a loan nor an advance on any payments to be made pursuant to the Policy. Any accommodation shall at all times be considered funds of the Company for which the use by the Policyholder of such funds is provided in this Endorsement. The Company shall have preference over all other claimants for the return of an accommodation made under this Endorsement.

The Policyholder shall be liable for all costs and expenses, including reasonable attorney's fees, incurred in the collection of any amount of accommodation outstanding. If the policy terminates before the end of the Policy Period, then any amount owed to us becomes immediately due and payable.

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

EFFECTIVE DATE OF ENDORSEMENT: XXXXXXXX

Signed for the Company:

[]

President

[]

Secretary

Berkley Life and Health Insurance Company

 **A BERKLEY COMPANY***
Urbandale, Iowa
[Underwriting Office:
2445 Kuser Road, Suite 201
Hamilton Square, NJ 08690]

Administrative Change Endorsement

Amendment No: [XX]

This Amendment revises and becomes a part of the Policy to which it is attached. This Amendment is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Amendment conflict, the terms of this Amendment shall govern. Please read this Amendment carefully.

This Amendment attaches to and is made part of Policy Number [XXXXXXXX] issued to [XXXXXXXXXXXXX].

[This Endorsement may be used to make changes to administrative information, for example name changes, address changes, Policy number changes, Plan name changes, or change of TPA.]

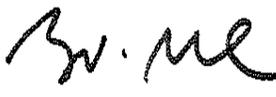
All other terms, conditions, limitations and exclusions of the Policy remain unchanged.

EFFECTIVE DATE OF AMENDMENT: [XXXXXXXX]

Signed for the Company:

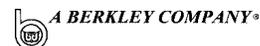
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President

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Secretary

Berkley Life and Health Insurance Company



Urbandale, Iowa
[Underwriting Office:
2445 Kuser Road, Suite 201
Hamilton Square, NJ 08690]

Specific Simultaneous Funding Endorsement

This Endorsement revises and becomes a part of the Policy to which it is attached. This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

This Endorsement attaches to and is made part of Policy Number [XXXXXXX] issued to [XXXXXXXXXXXXX].

Specific Simultaneous Funding Benefit

After the Specific Deductible with regard to a Covered Person has been satisfied, the Company will, upon request, simultaneously fund Specific Stop Loss benefits for Plan claims that have been Incurred but not yet Paid by the Policyholder, subject to the following:

- Simultaneous funding is only available for Plan claims greater than [\$1,000 – maximum annual reimbursement] over the Specific Deductible.
- Claims submitted for simultaneous funding must have been fully processed by the Policyholder or the Third Party Administrator according to the terms of the Plan and must be ready for Payment.
- Normal claim audit procedures will be implemented prior to any Specific Stop Loss benefits being paid by the Company.
- The Policyholder's Payment must be released to the providers of care within 10 working days of receiving the funding check by the Company. Payment within this time period will be considered a Paid claim within the Benefit Period. If such Payment is not made within the required time period, the funding check must be returned to the Company.
- Any portion of the funding check not used to Pay a Plan benefit, due to additional discounts or any other reason, must be returned to the Company within 10 days.
- [The request for simultaneous funding must be received by the Company prior to 30 days before the end of the Policy Period. Requests received after that date are not eligible for simultaneous funding.]

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

EFFECTIVE DATE OF ENDORSEMENT: [XXXXXXX]

Signed for the Company:

[]

[]

President

Secretary

No New Special Limitations [and Rate Cap] Endorsement

This Endorsement revises and becomes a part of the Policy to which it is attached. This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

This Endorsement attaches to and is made part of Policy Number [XXXXXXX] issued to [XXXXXXXXXXXX].

The Schedule of Insurance in the Stop Loss Policy is amended as follows:

[**The Specific Deductible section** is amended to include the following:

No New Special Limitations at Renewal Program

It is hereby agreed and understood that the Specific Stop Loss Coverage will provide the following at the next renewal:

- There will be no new Special Limitations or increase on existing Special Limitations applied to the Specific Stop Loss coverage, provided that your Plan contains no benefit or eligibility changes.
- Existing Special Limitations remain as shown in the current Schedule of Insurance.]

[**The Premium section** is amended to include the following:

Rate Cap at Renewal Program

Upon renewal, Specific premium rates are subject to a guaranteed maximum rate increase of [0-50%], provided:

- There are no changes to the Specific Benefit Period as shown in the Schedule of Insurance;
- There are no changes to the Specific Deductible as shown in the Schedule of Insurance;
- There are no changes to the commission level;
- There has not been more than a [10 - 30%] increase or decrease in the number of Covered Persons as shown in the Schedule of Insurance;
- There has not been a change to Persons to Be Covered Under the Policy; and
- There is no significant change in the Benefits provided under your Plan or any significant change in the Plan terms]

We reserve the right to change, modify or cancel this Endorsement, should you amend or change your Plan in any way that materially affects our risk or liability with regards to the Policy or this Endorsement, or if your renewal Policy contains any of the material changes described above.

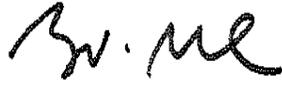
All other terms, conditions, limitations and exclusions of the Policy remain unchanged.

EFFECTIVE DATE OF ENDORSEMENT: [XXXXXXXX]

Signed for the Company:

[]

President

[]

Secretary

Aggregating Specific Endorsement

This Endorsement revises and becomes a part of the Policy to which it is attached. This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

This Endorsement attaches to and is made part of Policy Number [XXXXXX] issued to [XXXXXXXXXX].

1. The following Definitions are added to the Policy:

AGGREGATING SPECIFIC DEDUCTIBLE means the amount shown in the Schedule of Insurance, which will apply separately to each Benefit Period.

SPECIFIC EXCESS AMOUNT means the amount by which Losses for a Covered Person for the applicable Benefit Period exceed the Specific Deductible, multiplied by the Specific Percentage Reimbursable shown in the Schedule of Insurance. The Specific Excess Amount may not exceed the Annual Maximum Specific Benefit.

TOTAL SPECIFIC EXCESS AMOUNT means the total of the Specific Excess Amounts for all Covered Persons for whom Losses for the applicable Benefit Period exceed the Specific Deductible.

2. The Specific Stop Loss benefit is deleted and replaced with the following:

Specific Stop Loss

If the Policyholder's Losses for the Benefit Period, as shown in the Schedule of Insurance, exceed the Specific Deductible for a Covered Person, the Company will calculate the Specific Excess Amount for that Covered Person. The Company will monitor the Specific Excess Amounts for all Covered Persons for the applicable Benefit Period. No Specific Stop Loss benefit will be payable until the Total Specific Excess Amount exceeds the Aggregating Specific Deductible. Once exceeded, the Company will reimburse the Policyholder, subject to the terms and conditions of this Policy including the limits in the Schedule of Insurance:

- equal to the Specific Percentage Reimbursable of Specific Stop Loss times the amount by which Losses exceed the Aggregating Specific Deductible amount; but
- not to exceed the Annual Maximum Specific Benefit.

Losses for any [Covered Person] during the Policy Period will be determined according to the Benefit Period as shown in the Schedule of Insurance.

The Specific Deductible amount as shown in the Schedule of Insurance applies separately to each [Covered Person] during a Benefit Period.

While the determination of benefits under the Plan is the sole responsibility of the Policyholder, the Company reserves the right to interpret the terms and conditions of the Plan as they apply to the Stop Loss Insurance Policy. If the Company finds that any Payment was not made in accordance with the terms of the Plan, or is not an eligible benefit under the Plan, the Company may exclude such Payment from Losses. The Company has the sole authority to approve or deny reimbursements under this Policy.]

[Reimbursement of Certain Fees Under Specific Stop Loss: The following fees will be included as eligible Losses for Specific Stop Loss when Incurred and Paid by the Policyholder, and approved by the Company:

1. Reasonable hourly fees, not to exceed [\$100.00] per hour, unless prior approval is received by the Company, for case management service provided by a registered nurse case manager retained by the Policyholder or the Designated TPA. The Company retains the right to deny reimbursement of case management fees if case management reports do not demonstrate quality case management services; and
2. Fees from a third party for: (a) hospital bill audits; (b) access to non-directed provider networks; and (c) negotiating out of network bills or negotiating additional discounts on in-network bills. If the Policyholder can demonstrate a cost savings and submits a signed provider agreement, the Company will reimburse the Policyholder up to [25%] of the amount saved not to exceed [75%] of the amount paid to the provider up to a maximum of [\$3,000]. To determine the amount saved, the Company will compare the amount the Plan would have paid without the application of the savings against the amount that was paid because of the work performed.

The Company has the sole authority to approve or deny any payment of fees under this Policy.]

Fees charged by the Designated TPA , or any subsidiary, affiliate, related entity, or entity with shared common ownership, for any of these services will be considered Losses only if prior approval has been obtained in writing from the Company.]

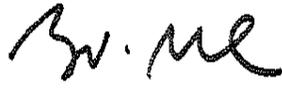
All other terms, conditions, limitations and exclusions of the Policy remain unchanged.

EFFECTIVE DATE OF ENDORSEMENT: [XXXXXXXX]

Signed for the Company:

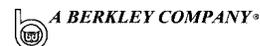
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President

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Secretary

Berkley Life and Health Insurance Company



Urbandale, Iowa
[Underwriting Office:
2445 Kuser Road, Suite 201
Hamilton Square, NJ 08690]

Exclusions Coverage Endorsement

This Endorsement revises and becomes a part of the Policy to which it is attached. This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

This Endorsement attaches to and is made part of Policy Number [XXXXXXX] issued to [XXXXXXXXXXXX].

The Policy exclusions contained in the Exclusion section of the Policy are deleted with the exception of exclusion numbers 1, 2, 3, 4, 6, 7, 8, 9, 10, 13, 16, and 17 and replaced with the exclusions, limitations and associated definitions contained within the Plan; or

The following Policy exclusions contained in the Exclusion section of the Policy are deleted: 5, 11, 12, 14, 15, and 18 and replaced with the exclusions, limitations and associated definitions contained within the Plan.

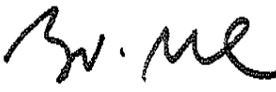
All other terms, conditions, limitations and exclusions of the Policy remain unchanged.

EFFECTIVE DATE OF ENDORSEMENT: [XXXXXXX]

Signed for the Company:

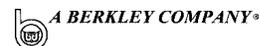
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President

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Secretary

Berkley Life and Health Insurance Company



Urbandale, Iowa
[Underwriting Office:
2445 Kuser Road, Suite 201
Hamilton Square, NJ 08690]

Experimental or Investigative Services Endorsement

This Endorsement revises and becomes a part of the Policy to which it is attached. This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

This Endorsement attaches to and is made part of Policy Number [XXXXXXX] issued to [XXXXXXXXXXXX].

EXPERIMENTAL OR INVESTIGATIVE SERVICES Endorsement

The definition of **EXPERIMENTAL OR INVESTIGATIVE SERVICES** in the Policy is hereby deleted and replaced with the experimental definition contained within the Plan on file with Berkley Life and Health Insurance Company.

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

EFFECTIVE DATE OF ENDORSEMENT: [XXXXXXX]

Signed for the Company:

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President

[]

Secretary

Organ Transplant Endorsement

This Endorsement revises and becomes a part of the Policy to which it is attached. This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

This Endorsement attaches to and is made part of Policy Number [XXXXXXX] issued to [XXXXXXXXXXXX].

The Company's Transplant Facility means a hospital or facility which is part of the Company's contracted network and is accredited by the Joint Commission on Accreditation of Healthcare Organizations to perform a Transplant and:

For Organ Transplants: is an approved member of the United Network for Organ sharing for such transplant or is approved by Medicare as a transplant facility for the transplant being performed.

For unrelated allogeneic bone marrow or stem cell transplants: is a participant in the National Marrow Donor Program;

For autologous stem cell transplants: is approved to perform such transplant by the state where the transplant is to be performed by Medicare or by the Foundation for the Accreditation of Hematopoietic Cell Therapy. Outpatient transplant facilities must be similarly approved.

ORGAN TRANSPLANT BENEFIT

This Policy contains an Organ Transplant benefit, under which your Specific Deductible shown in the Schedule of Insurance for a [Covered Person] can be reduced if the following criteria are met:

1. Your Plan requires precertification for Transplant-related hospitalizations and outpatient Transplant procedures; and treats the Company Transplant Network partners as in-network providers;
2. You require your Designated TPA and Provider Network(s) to permit [Covered Persons] to access the Company's Transplant Facilities;
3. You must advise the [Covered Person(s)] that they may access the Company's Transplant Facilities if they require a Transplant;
4. You agree to waive any exclusion under your Plan that would conflict with the Company's contracted arrangement, including such expenses to procure an organ when that fee is included in the Company's negotiated arrangement; and
5. You advise your Designated TPA and medical management vendor(s) that [Covered Person(s)] may access the Company's Transplant Facilities and instruct your Designated TPA and medical management vendor(s) to contact [Berkley's Clinical Risk Management Unit] at [1-800-xxx-xxxx] when they receive notice that a [Covered Person] may require a Transplant.

If all of the above criteria are satisfied by you and your Plan, and a [Covered Person] has a Transplant performed at the Company's Transplant Facility, we will reduce your Specific Deductible by [25/50/75/100%] for the [Covered Person] in the Policy Period in which the Transplant occurs. We will also pay any associated fee charged by the Company's Transplant Facility.

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

EFFECTIVE DATE OF ENDORSEMENT: [XXXXXXXX]

Signed for the Company:

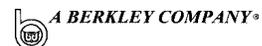
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President

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Secretary

Berkley Life and Health Insurance Company



Urbandale, Iowa
[Underwriting Office:
2445 Kuser Road, Suite 201
Hamilton Square, NJ 08690]

Actively At Work Endorsement

This Endorsement revises and becomes a part of the Policy to which it is attached. This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

This Endorsement attaches to and is made part of Policy Number [XXXXXX] issued to [XXXXXXXXXXXX].

Actively at Work

The Actively at Work exclusion in the Policy is hereby deleted and replaced with the eligibility requirements of the Plan on file with Berkley Life and Health Insurance Company. Anyone not meeting the eligibility provisions of the Plan on file with Berkley Life and Health Insurance Company are excluded from coverage under the Stop Loss Policy to which this amendment is attached.

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

EFFECTIVE DATE OF ENDORSEMENT: [XXXXXXXX]

Signed for the Company:

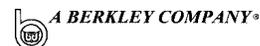
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President

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Secretary

Berkley Life and Health Insurance Company



Urbandale, Iowa
[Underwriting Office:
2445 Kuser Road, Suite 201
Hamilton Square, NJ 08690]

External Appeal Endorsement

This Endorsement revises and becomes a part of the Policy to which it is attached. This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

This Endorsement attaches to and is made part of Policy Number [XXXXXXX] issued to [XXXXXXXXXXXX].

In the event Covered Services are Paid for a [Covered Person] due to a reversal by an Independent Review Organization of a previous denial of such Covered Services, and such Covered Services are Paid after the last Paid date provided in the Benefit Period (the "Last Paid Date"), the Benefit Period to pay such Covered expenses will be extended for a period not to exceed [twelve (12)] months from the Last Paid Date provided:

- a. Such Losses are not eligible under any other coverage; and
- b. Such Losses are otherwise payable under the terms of the Policy; and
- c. The Company was informed in writing with the details of the Loss within [60] days of the filing of an appeal for the claim denial.
- d. The Policy renews and is in effect when the claim is Paid.

When Losses are Paid pursuant to the terms and conditions of this Endorsement, such Losses will relate back to the Benefit Period in which they were Incurred and will be excluded from any other Benefit Period.

For purposes of this Endorsement, Independent Review Organization means the organization for external review as required under the external review process of the Patient Protection and Affordable Care Act and as covered under the Plan.

If the Policyholder terminates this Policy for any reason prior to the end of the Policy Period this Endorsement will be void.

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

EFFECTIVE DATE OF ENDORSEMENT: [XXXXXXX]

Signed for the Company:

[]

[]

President

Secretary

SERFF Tracking #:

BLAH-128608382

State Tracking #:

Company Tracking #:

AH52021

State: Arkansas
TOI/Sub-TOI: H12 Health - Excess/Stop Loss/H12.001 Accident & Sickness
Product Name: Employer Stop Loss
Project Name/Number: Employer Stop Loss/AH52021

Filing Company: Berkley Life and Health Insurance Company

Rate Information

Rate data applies to filing.

Filing Method: Initial Submission

Rate Change Type: Neutral

Overall Percentage of Last Rate Revision: %

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):
Berkley Life and Health Insurance Company	%	%				%	%

SERFF Tracking #:

BLAH-128608382

State Tracking #:**Company Tracking #:**

AH52021

State:

Arkansas

Filing Company:

Berkley Life and Health Insurance Company

TOI/Sub-TOI:

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

Product Name:

Employer Stop Loss

Project Name/Number:

Employer Stop Loss/AH52021

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	09/14/2012
Comments:	The application is attached for approval under the form schedule. The form number is AH52022-AR		

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/14/2012
Comments:	Attached.		
Attachment(s):			
AR - Readability ESL.pdf			

CERTIFICATE OF COMPLIANCE
FOR ARKANSAS

This is to certify the attached form has achieved the Flesch Reading Ease Score given below and complies with the requirements of Arkansas Stat. Ann, 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language simplification Act.

Form Name: Stop Loss Insurance Policy

Form Number: AH52021

Flesch Reading Ease Score: 50.1

A handwritten signature in cursive script, reading "Lee D. Davidson", is written over a horizontal line.

Lee D. Davidson, Vice President

August 13, 2012

Date

SERFF Tracking #:

BLAH-128608382

State Tracking #:

Company Tracking #:

AH52021

State:

Arkansas

Filing Company:

Berkley Life and Health Insurance Company

TOI/Sub-TOI:

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

Product Name:

Employer Stop Loss

Project Name/Number:

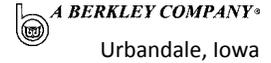
Employer Stop Loss/AH52021

Superseded Schedule Items

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

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/11/2012	Approved-Closed 09/14/2012	Form	Employer Stop Loss Application	01/23/2013	AH52022AR.pdf (Superseded)

Berkley Life and Health Insurance Company



Urbandale, Iowa

[Underwriting Office:
2445 Kuser Road, Suite 201
Hamilton Square, NJ 08690]

Stop Loss Insurance Application

Application is hereby made to the Berkley Life and Health Insurance Company ("Company") for [Aggregate] [and] [Specific] Stop Loss Insurance. This Application must be accepted and approved by the Company prior to any insurance being in effect.

POLICYHOLDER INFORMATION			
1. Full legal name of Policyholder			
2. Key contact at Policyholder			
3. Address	City	State	Zip
4. Subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) that are to be included. List legal names and addresses of such companies:			
5. Nature of Policyholder's business			
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Proprietorship	<input type="checkbox"/> Other (please describe)
6. Insurance applied for replaces prior coverage as follows:			
<u>Name of company</u>	<u>Type of coverage</u>	<u>Termination date</u>	
7. Full name of the Employee Benefit Plan			
8. Name and address of Policyholder's Third Party Administrator			
9. Proposed initial Policy period			
10. Persons to be covered under the Stop Loss Policy			
Employees and dependents who meet the eligibility requirements, as set forth under the Policyholder's Employee Benefit Plan, with the exceptions noted below:			
<u>Yes*</u>	<u>No</u>	<u>Yes*</u>	<u>No</u>
<input type="checkbox"/>	<input type="checkbox"/> Retired employees	<input type="checkbox"/>	<input type="checkbox"/> Employees who are not Actively at Work
<input type="checkbox"/>	<input type="checkbox"/> COBRA continuees		
* All "Yes" answers must have a Disclosure Statement attached to this Application.			
11. Total eligible employees		Estimated initial enrollment	

PREMIUMS		
14. [Aggregate Premium per [month/annum]:	Employee only	\$ _____
	Employee & Spouse	\$ _____
	Employee & Child(ren)	\$ _____
	Employee & Family	\$ _____]
[Specific Premium per month:	Employee only	\$ _____
	Employee & Spouse	\$ _____
	Employee & Child(ren)	\$ _____
	Employee & Family	\$ _____]
[Endorsements/Amendments Attached:		
<input type="checkbox"/> Terminal Liability Option Aggregate Coverage Endorsement		\$ _____]
<input type="checkbox"/> Terminal Liability Option Specific Coverage Endorsement		\$ _____]
<input type="checkbox"/> Monthly Aggregate Accommodation Endorsement		\$ _____]
<input type="checkbox"/> Specific Simultaneous Funding Endorsement		\$ _____]
<input type="checkbox"/> Aggregating Specific Endorsement		\$ _____]
<input type="checkbox"/> No New Special Limitations [and Rate Cap] Endorsement		\$ _____]
<input type="checkbox"/> Experimental Investigational Services Endorsement		\$ _____]
<input type="checkbox"/> Actively at Work Endorsement		\$ _____]]

IT IS UNDERSTOOD AND AGREED AS CONDITIONS PRECEDENT TO THE APPROVAL OF THIS APPLICATION THAT:

- The Policyholder is financially sound, with sufficient capital and cash flow to accept the risks inherent in a “self-funded” health care plan;
- The Third Party Administrator retained by the Policyholder will be considered the Policyholder’s Agent and not the Company’s Agent;
- All documentation requested by the Company must be submitted prior to any approval of this Application and must be received by the Company within [thirty (30) days] of the Effective Date;
- The Company will evaluate the Policyholder’s risk and may require adjustments of rates, factors, and/or special limitations to accommodate for abnormal risks;
- Premiums are not considered paid until the premium check is received by the Company and at the rates set forth in the Schedule of Stop Loss; and
- If the Policyholder has more than one business location, a representative of the Policyholder at each location has reviewed and completed a Disclosure Statement.

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

In making this Application, the Policyholder represents that such information accurately reflects the true facts and that the undersigned has authority to bind the Policyholder to the proposed Policy. Accordingly, this Application, including any attached Disclosure Statement, will be a part of the Policy, if accepted by the Company.			
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement is guilty of insurance fraud.			
Signed at _____ this _____ day of _____ [2012]			
Signed for the Policyholder			
X			
Name		Title	
Licensed Agent Signature		Licensed Agent Name	
X			
Social Security Number or Tax ID			
Address		City	State Zip