Stop-Loss Underwriting Guidelines
Specific and Aggregate Requirements
For AHRA

Traditional Stop-Loss

The Tillinghast model will be used for traditional and aggregate stop loss.

Minimum number of lives for new and renewal business will be 20 employee lives (e.g. 20 enrolled). If less than 20 employee lives, the group is ineligible for coverage. Exceptions may be made at Partner Re's approval on a case-by-case basis

Minimum participation allowed is 51% of all eligible employees; 40% with spousal waiver if individual applications are reviewed and approved by Montgomery Management for all enrollees. Any new enrollees to the plan after initial review and acceptance must be reviewed and accepted by Montgomery Management in order to be covered. Non-Medicare Primary retirees must not comprise more than 20% of employee census. If these conditions are not met the group is ineligible for coverage.

New groups will complete a group health questionnaire (copy attached) and each employee requesting coverage will complete a personal health questionnaire (copy attached). Upon completion of these questionnaire, the application is electronically forwarded to Montgomery Management for underwriting. Montgomery Management will underwrite the group within 2 business days of receiving all enrollment packages and forward the results to AHRA who will issue final rates to the perspective employer participant within 24 hours of receiving results from Montgomery Management. Upon acceptance of the final rates the employer is eligible to become a member

Individual health questionnaires will be submitted for all groups applying with less than 100 employees and in cases requested by the President or CUO of Montgomery Management. Individual health questionnaires can be avoided if the employer has access to loss runs from the previous carrier for applicant groups with more than 50 employees as approved by the President or CUO of Montgomery Management. For these groups AHRA will obtain their claim experience for the last 18 months, including any large claims with the prognosis and the census to avoid submitting individual health questionnaires. Montgomery Management will use group underwriting techniques to evaluate the risk and set rates.

Virgin groups may be considered if individual applications are submitted by 100% of the enrolled population and the group application is approved by the President and CUO of Montgomery Management. This is subject to eligibility requirements.

Fully insured groups >150 lives would require a minimum of 18 months of claim and premium experience and disclose all recent large claims within the last 18 months as well as the expected prognosis. Fully insured groups <150 lives can be offered a quote based on the Tillinghast specific and aggregate manual with a maximum discretion of 25%. Full disclosure is required. If these conditions are not met, the group is ineligible for coverage.

Initial stop-loss quote may be provided based on 18 months of consecutive experience for cases that are currently self-funded. If the group is a 1st year self-funder account with less than 150 employee lives, quote can be released based on 8 months of claims experience. If it exceeds 150 employee lives, prior year fully insured claims data is required as well as the information in the first sentence of this document. If these conditions are not met, the group is ineligible for coverage.

Minimum specific deductible is $15,000 per group.

Minimum annual gross premium is $50,000 per group.

Rate guarantees are for one year and no multi-year rate or aggregate attachment guarantees are allowed.

Groups can only have three carriers or less during the last five years. If the group has four or more carriers during the past five years, the group is ineligible for coverage.

No sealed bid quotations.

New business contracts greater than 24/12 (run-in) and 12/18 (run-out) are not allowed.

Limit Domestic Billed charges on Provider quotes to 60%-70%. Underwriter can quote up to 80% Domestic reimbursement on new business opportunities where current reimbursement structure is 80% and the total number of employees is 400 or less. Underwriter should review quote request to ensure whether reimbursement structure is based on 100% of billed charges, or subject to a PPO schedule. If these conditions are not met the group is ineligible for coverage.

The following trend factors are used.

Coverage	**Percentage**
Medical & Prescription	9%
Medical	9%
Prescription	12%
Dental	6%
Vision	4%

Specific

Run-in Limits equal to the specific retention should be applied to all new business quotes with contract terms of 15/12 or greater. The run-in cap can be waived on 15/12 contracts if the group has been with the current TPA for more than 24 months, the TPA is a preferred TPA of Underwriter, and Underwriter receives claim reports prior to binding containing pending claims, large denied claims in the prior three months, claims in the process of being re-priced by the PPO, and any potential large claims known by the applicant.

A minimum premium of 80% of the specific premium based on the issued census will be required.

Aggregate

Minimum aggregate attachment point is 125% of Expected Claim Costs. For groups with less than 100 employee lives than the attachment point is 130% expected claims.

Minimum aggregate attachment point is no less than 95% of Attachment Point. A manual quote for all groups of less than 300 life years must be completed.

Groups with more than 150 employee lives must have at least 18 months of mature experience to provide aggregate quote.

Minimum aggregate attachment point is $100,000.

Minimum aggregate premium is $7,500.

All previously self-funded groups must provide at least 18 months of mature experience to provide aggregate regardless of number of employees. If the group is a 1st year self-funded account with less than 150, employee lives, quote can be released based on 8 months of claims. If it exceeds 150 employee lives, prior year fully insured claims data is required. If these conditions are not met, the group is ineligible for coverage.

Paid claims through 12 months are required before finalizing aggregate factors. If paid claims for the 12-months is more than 10% above the average for the previous 10-months, the aggregate factors should be revised.

Run-In limitation should be set at 15% of maximum claims for all new business accounts with 18/12 or greater contracts.

Run-In Limits can be waived if the group has been with the current TPA for more than 24 months, the TPA is a preferred TPA of MMC, and MMC receives the claim reports prior to binding containing pending claims, large denied claims in the prior three months and claims in the process of being re-price by the PPO.

Aggregate maximum is $1 million.

Renewal Rating (Experience Rates)

The renewal premium rates will be experience rated based on the group's prior claim experience, and we believe band rating is appropriate and can be applied. The following describes how experience rated renewal rates will be calculated based on recent experience. In developing the rate increase, we will utilize the paid claims and collected premiums received during the most recent twelve-month period. In addition, we collect premium accruals for due and uncollected premiums as well as premiums paid in advance. Lastly, we gather the amount of reinsurance recoveries (claims paid more than the reinsurance stop loss) as well as any current large unpaid claims.

Based on the data provided, we start with collected premium income. We adjust the premium for any premium accruals. If twelve months of premium is not provided, we estimate the amount of premium that would be paid during the twelve-month period. Likewise, for claims we start with paid claims and subtract reinsurance recoveries. We then add the change in the unpaid claims (current claim reserve minus the claim reserve at the beginning of the period). We calculate the claim reserve using the claims paid and lag time between the incurred date and paid date.

We calculate the paid loss ratio and then adjust the paid claims to an incurred basis by multiplying the paid claims by an incurred claims completion factor. The incurred loss ratio is then adjusted for the current medical inflation rate. We adjust the trend factor for any plan benefits that have been added or subtracted as well as expense adjustments (reduction in administration costs, change in managed care carriers, etc.). The trend factor is applied from the midpoint of the experience period to the midpoint of the rating period. Adjusting the incurred claims for the trend results in an expected incurred loss ratio as well as estimated incurred claims for the next twelve months. Similar to premium income, we adjust the paid claims to twelve months if less experience is provided.

We estimate percent of premium expenses that include acquisition/commission, premium tax, administration, and reinsurance. Fixed expenses are converted to a percent of premium and added to the estimated percent of premium expenses. These expenses are added to the expected incurred claims resulting in a required premium. Dividing the required premium by the original premium provides the rate increase without margin. Finally, we include a margin of 5% or 10% of expected benefits and expenses, yielding our final recommended rate increase.

Please note that if the reinsurance recoveries are not subtracted from the paid claims, we exclude reinsurance premiums from the percent of premium expenses thereby assuming that reinsurance recoveries are an offset to reinsurance premiums. These rates are finally blended with the appropriate new business rates using the procedure outlined previously in the Credibility Factors Section.

We will utilize band rating, when large rate increases are necessary. Individual groups can be experienced rated or band rated by categorizing them into three (or more) classifications by their claims loss ratios (tier or band rating). This type of rating charges groups with poor experience higher increases, and those with good experience, lower increases. Groups with good experience are usually retained using this procedure. Therefore, when recommending large rate increases, we do not recommend a flat increase be given to all groups. If this were done, the good groups might leave and the insurer will be left with only the poor groups. The rate increase then would be insufficient to cover future claims and later rates would spiral upward.

Agreed and Acknowledged:

By: **Montgomery Management Inc.**

Authorized Signatory_____ Date_____

By: **Companion Life Insurance**

Authorized Signatory_____ Date_____

By: **Partner Re America Insurance Company**

Authorized Signatory_____ Date_____

By: **Artex Risk Solutions**

Authorized Signatory_____ Date_____

By: **Idilus Plan Management Services**

Authorized Signatory_____ Date_____

By: **Alex Zeid and Associates**

Authorized Signatory_____ Date_____

By: **Innovative Reinsurance Group**

Authorized Signatory_____ Date_____