UNIMERICA INSURANCE COMPANY

A Stock Company
Administrative Offices: 11000 Optum Circle, Eden Prairie, MN 55344
Phone: 1-800-454-0233

APPLICATION FOR EXCESS LOSS INSURANCE

The undersigned Applicant requests the Excess Loss Insurance Benefits shown herein and provided by Unimerica Insurance Company, and agrees to be bound by the terms and provisions of the Excess Loss Insurance Policy.

Full Legal Name of Applicant: Vigo County Government
Address: 121 Oak Street, Terre Haute, IN 47807
Key Contact: Connie Flood **Telephone:** 812-462-3249 **Tax ID:** 35-6000207

Applicant is a: ☐ **Corporation** ☐ **Labor Union** ☐ **Partnership** ☐ **Association** ☐ **Proprietorship** ☒ **Other:** _____
Nature of Business of the Group to be Insured: Gov't Entity **Requested Effective Date:** July 1, 2019

Total number of eligible persons: **Employees:** 561 **Retirees:** Ø but eligible
Are retirees covered: ☒ **Yes** ☐ **No.**

Affiliates or Subsidiaries: **Addresses of Affiliates or Subsidiaries:**

Full Name of Administrator: UMR Prescription Benefit Manager : Maxor - Pamela Fournier
Address: 11 Scott Street, Suite 100, Wausau, WI 54403 Pfournier@maxor.com
Key Contact: Jason Lester **Telephone:** 812-242-1414 806-242-7703
Agent or Broker: Sycamore Insurance Associates, LLC - Jason Lester 320 South Polk, Suite 200
Tax ID: 27-3200291 Amarillo, TX 79101
Address: 999 Ohio St. Terre Haute, IN 47807

SPECIFIC EXCESS LOSS INSURANCE ☒ Yes ☐ No

Benefit Period: Covered Expenses Incurred from July 1, 2018 through June 30, 2020 and Paid from July 1, 2019 through June 30, 2020.

Specific Deductible: per Covered Person: $100,000

Specific Percentage Reimbursable: 100%

Maximum Specific Benefit per Covered Person: ☒ Unlimited ☐ Other

Covered Expenses under Specific Excess Loss: ☒ Medical ☒ Stand Alone Prescription Drug Program

Common Accident Provision: ☒ Yes ☐ No

Description:	Specific Premium Rates per month
Employee	$ 77.34
Family	$ 185.12

Specific Accommodation Reimbursement Endorsement	☒ Yes ☐ No	
Specific Step-Down Deductible Endorsement	☐ Yes ☒ No	
Specific Terminal Liability Endorsement	☐ Yes ☒ No	
Aggregating Specific Deductible Endorsement	☒ Yes ☐ No	$50,000
Independent Review Organization Extended Liability Endorsement	☒ Yes ☐ No	

AGGREGATE EXCESS LOSS INSURANCE: ☒ **YES** ☐ **NO**

Benefit Period: Covered Expenses Incurred from July 1, 2018 through June 30, 2020, and Paid from July 1, 2019 through June 30, 2020.

Covered Expenses under Aggregate Excess Loss Coverage: ☒ Medical ☐ Dental ☐ Vision
☒ Stand Alone Prescription Drug Program
☐ Other (Please Specify)

Aggregate Percentage Reimbursable: 100%
Maximum Aggregate Benefit: ☐ $500,000 ☒ $1,000,000 ☐ Other
Minimum Annual Aggregate Deductible: $6,909,612 or 100% of the first Monthly Aggregate Deductible amount times 12, whichever is greater.
Maximum Covered Expenses per Covered Person accumulating toward the Maximum Aggregate Benefit: $100,000

Aggregate Excess Loss Premium: $3.74 per Employee per month

Aggregate Terminal Liability Endorsement: ☐ **Yes** ☒ **No**
Aggregate Accommodation Endorsement: ☐ **Yes** ☒ **No**
Independent Review Organization Extended Liability Endorsement ☒ **Yes** ☐ **No**

Covered Persons	Medical	Prescription Drugs
Employee	$ 764.08	Included
Family	$1,680.31	Included

It is understood and agreed by the undersigned that:

1. The statements, declarations and representations made in this Application, any request for proposal, the underwriting information provided by or on behalf of the undersigned and the Plan Document are the undersigned's representations; that any Policy is issued in reliance upon the truth of such statements, declarations, and representations; and that such statements, declarations, and representations will form a part of the Excess Loss Insurance Policy. Any inaccuracy in such information or failure to disclose any such information, including all claims or possible claims, paid or pending, or which the Employer should otherwise know about, if discovered later, can result in rejection of this Application, or can change the terms, conditions or premiums, or can void coverage.
2. As a condition precedent to the approval of this Application, the undersigned shall furnish to the Company a copy of the executed Plan Document within 90 days after the date of this application describing the benefits provided by the Plan, which shall be kept on file in the office of the Company. If the Company does not receive the Plan Document within 90 days, the Company may refund all premium and the Application shall have been null and void when signed. No Excess Loss Insurance will be effective nor reimbursement made unless a Plan Document is received and accepted by the Company.
3. The Company will evaluate the undersigned's risk, as requested by this application, the underwriting data received and represented by the Plan and may require adjustments of rates, factors, and/or special limitations.
4. Any coverage resulting from this Application shall be subject to the terms and provisions of the Policy herein applied for. Coverage shall become effective on the date specified in this Application if all requirements of the Company, including the Plan Document and the underwriting requirements have been met and the required premiums paid.
5. The receipt by the Company of the first month's premium and deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event the Company does not approve this application, its sole obligation shall be to refund such sum to the undersigned.
6. The undersigned will provide or employ an Administrator to administer the Plan and to process and pay claims according to the Plan Document. The undersigned acknowledges that the Administrator is the undersigned's agent and not the agent of the Company and that statements and answers given by the Administrator are binding on the undersigned.
7. Other:
    - This Excess Loss Insurance Policy includes Experience Refund.
    - Benefits eligible under the Policy Holder's Transplant insurance policy are excluded under this Excess Loss Insurance Policy.
    - The above Specific rates include a feature which will guarantee your Subsequent Policy Period beginning July 1, 2020 will not contain any new Specific Deductible greater than the group's standard Specific Deductible for any covered person. Additionally, the Specific Monthly Premium Rates and Aggregating Specific Deductible will not increase more than 50% over the rate and Aggregating Specific Deductible in force (the "Rate Cap"). The Rate Cap will not apply if the Company determines there is a material change to the Policyholder's Plan, the terms or conditions of the Excess Loss Insurance Policy, or the nature or composition of the group to whom the coverage is offered. *The Company reserves the right to remove the Rate Cap option once the maximum Rate Cap has been applied for two consecutive Policy Periods.

The undersigned has read the entire Application for Excess Loss Insurance and understands that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.

Full Legal Name of Applicant: Vigo County Government

Signature of Authorized Person: [signature]

Print Name: Brad Anderson Title: County Commissioner

Date: 04/23/2019

Signature of Agent or Broker: [signature]

Print Name of Agent or Broker: Jason B. Lester

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For applicants in Arkansas, Louisiana, New Mexico and Rhode Island:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in Colorado:
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For applicants in District of Columbia:
WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

For applicants in Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For applicants in Kentucky, New Mexico, Ohio, and Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For applicants in Maine, Tennessee and Virginia:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

For applicants in New Jersey:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For applicants in all other states:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

OPTUM

THIS MUST BE SIGNED BY A REPRESENTATIVE AT THE POLICYHOLDER

ACH (Electronic) Claim Reimbursement Process:

The policyholder will need to complete the attached Reimbursement Agreement form. This form needs to be filled out by a representative at the policyholder who is authorized on the claim account. When the form is completed it should be emailed or mailed to:

Optum Stop Loss
Attn: Lynn Newcomb
Mail Stop: MN101-E010
11000 Optum Circle
Eden Prairie, MN 55344

Lynn.newcomb@optum.com

Please allow up to 5 working days for receipt of the Reimbursement Agreement to allow us to complete the ACH process set up.

Once ACH is set up and operational, live checks will no longer be generated for stop loss reimbursements. Copies of the explanation of benefits (EOBs) will be e-mailed to the Administrator for reconciliation purposes. The ACH deposit will be in the client's account within 2 banking days after the claim is adjudicated.

OPTUM

Agreement Regarding Electronic Transfer of Claim Funds (ACH)

THIS MUST BE SIGNED BY A REPRESENTATIVE AT THE POLICYHOLDER

I agree to accept payment of any claim benefits which may be due under the terms of my excess risk policy via electronic transfer of funds into the below bank account.

I understand that by authorization of electronic funds transfer, claim checks will not be issued as payment of claim benefits.

I reserve the right to revoke this acceptance at any time. Such revocation must be in writing and must be received by Optum Stop Loss in order to be valid.

Unless revoked in accordance with the terms of the immediately preceding paragraph, this agreement will remain valid for the duration of my excess risk coverage. If my banking information changes, it is my responsibility to notify Optum Stop Loss of the change.

If payment is issued under the Specific Accommodation Option, the Plan must pay all claims related to all such payment(s) within five (5) days of receipt of such payment. It shall be the responsibility of the employer to coordinate with its benefit administrator to ensure that this provision is complied with.

Electronic funds transfer is authorized to the following account:

Bank Name _____

ABA No. _____ Bank Account No _____

_____
Employer Name

Co Comm
_____
Signature and Title of Authorized Representative at the Policyholder

4/23/19
_____
Date

OptumHealth Financial Services Lockbox Address:

Mail to: **OptumHealth Financial Services**
Lockbox #78910
Milwaukee, WI 53278-0910

Overnight to: U.S. Bank Milwaukee, N.A.
777 East Wisconsin Avenue
Milwaukee, WI 53202
Ref: Lockbox Dept. Clybourn Level, LockBox #78910

Wiring Instructions:

Banking Information

ACH Transfers
U.S. Bank of Minnesota, N.A.
101 East Fifth Street
St. Paul, MN 55101

ABA: #091000022
Account: #873536445
Account Name: OptumHealth Financial Services Premium Lockbox

Notify OptumHealth Financial Services of the date and amount of the ACH/wire.
Please fax or email a copy of the premium statement or payment back-up to:

Email: Premdocs@optum.com
Phone: 952-205-6363

Optum
11000 Optum Circle
Eden Prairie, MN 55344

www.myoptumhealthcomplexmedical.com

March 10, 2019

Policyholder:	Vigo County Government
Policy Date:	7/1/2019 to 6/30/2020
Policy Number:	1000805
Premium Due Date:	7/1/2019

The Policyholder has selected the following critical care benefits plan: Optum's Managed Transplant Program

Renewal Premium Rates:	Single: $5.38
	Family: $12.89

Please notify Optum if you have any changes in your Third Party Administrator, Case Management or Agent of Record. This will allow Optum to continue to administer the Managed Transplant Program without disruption.

By signing this document I agree to renew the Managed Transplant Program policy.

_____

(Signature)

County Commissioner

(Title)

04/23/2019

(Date)

dental health OPTIONS by Health Resources, Inc.

POLICY

4/12/2019

Please check one plan renewal election box:			[X]		[ ]
	Current Policy		**Renewal Policy**		**Alternative Policy**
Policy Length (in months)			12		
Policy Effective Dates			Jul 01, 2019 - Jun 30, 2020		
DHO Plan	DHO 3	DHO 4	DHO 3	DHO 4	
Plan Annual Maximum	$1,000	$1,500	$1,000	$1,500	
Ortho Coverage	Child Only	Adult/Child	Child Only	Adult/Child	
Ortho Liftime Maximum	$1,000	$1,500	$1,000	$1,500	
Deductible	$0 / $0	$0 / $0	$0 / $0	$0 / $0	
Rates: **Employee Only:** **Employee + Spouse:** **Employee + Child(ren):** **Employee + Family:**	$21.10 $43.20 $47.20 $72.20	$29.00 $60.75 $66.55 $101.25	$21.10 $43.20 $47.20 $72.20	$29.00 $60.75 $66.55 $101.25	Contact HRI or your agent for other Dental Health Options
Additional Fees / Services	• If HRI administers your COBRA, $0.24 per subscriber per month fee will be added and billed on your monthly invoice.				
Message Board	• This plan does not include unlimited pediatric benefits.				

EMPLOYER GROUP INFORMATION

	Current Information	**Requested Group Changes**
Group Number	All Groups	
Group Name	Vigo County Government	
Address	131 Oak Street	
City, State, Zip	Terre Haute, IN 47808	
Phone	(812) 462-3249	
Fax	(812) 231-5617	
Plan Type	Voluntary	☐ Voluntary ☐ Employer Contribution
Network Option	In and Out-of-Network	☐ In-Network Only ☐ In and Out of Network
Dependent Coverage	Age: 26	
Full Time Student Verification	Age: 26	
COBRA Administration	HRI Does Not Administer COBRA	

Policy Approval Signature	Print Name and Title	Date
[signature]	County Commissioner	04/23/2019

Unless an alternative policy is elected and/or employer group information has been updated, a signed renewal is not required and the current policy will renew automatically on the effective date and renewal rates indicated above.

dental health OPTIONS by Health Resources, Inc.

InsuringSmiles.com
PO Box 659
Evansville, IN 47704
Tel: (800) 727-1444 • Fax: (812) 401-4558

A Plan Sponsor Certification (PSC) must be completed at the time of signing the Master Group Policy (MGP) and updated during Policy/Agreement Renewal or with a change in employer contacts to perform plan administration functions.

Legal Business Name listed below is the Plan Sponsor of the Health Resources, Inc. (HRI) dental plan. The Plan Sponsor performs plan administration functions for the Plan and needs access to the Plan participants' Protected Health Information to carry out those plan administration functions.

Group Number	All Groups
Group Name (Legal Business Name)	Vigo County Government
Phone / Fax	Phone: (812) 462-3249 / Fax: (812) 231-5617
Street Address City, State Zip	131 Oak Street Terre Haute, IN 47808

The following employees or persons under control of the Plan Sponsor are authorized to receive Protected Health Information to perform Plan Administrative functions, ***this includes website access***. HRI will only provide the minimum necessary Protected Health Information to the individuals who are identified on this list:

Contact	First & Last Name	Email	Phone / ext. & Fax (if different from above)	Address (if different from above)
Benefits Administrator	No Changes			
Invoice Recipient				
IT				
Benefits Adviser / Agent				
Third Party Administrator				
Ben Admin System Contact				
Additional Contact				
Additional Contact				

The Plan Sponsor is aware that the plan document has been amended to comply with the requirements of 45 CFR § 164.504(f)(2) (HIPAA Administration Simplification). The amendment provides the required assurance that the Plan Sponsor will appropriately safeguard and limit the use and disclosure of the plan participants' Protected Health Information that the Plan Sponsor may receive from Health Resources, Inc.

X _____ 4/23/19

Signature Required: Plan Sponsor is an authorized signatory of the MGP. **Date**