



Berkshire Hathaway  
Specialty Insurance

**Berkshire Hathaway Specialty Insurance Company**  
(a Stock Insurance Company)  
1314 Douglas Street, Suite 1400  
Omaha, NE 68102-1944

**DECLARATIONS**  
**Stop Loss Policy (Florida)**

PLEASE READ ~~YOUR~~THIS POLICY CAREFULLY

This is a REIMBURSEMENT POLICY ONLY between Us and You.

You, or Your ~~Plan~~plan administrator, are responsible for the administration of ~~Your~~the Plan, including making all benefit determinations under ~~Your~~the Plan. We have no duty, authority or obligation to administer, settle, adjust or provide advice regarding any claims filed under ~~Your~~the Plan.

Policyholder: 1[ABC Company]  
Policyholder Address: 2[123 Main Street Every City, Any State 99999]  
Policy Number: 3[12345]  
Policy Effective Date: 4[January 1, 2016]  
~~Policy Renewal Effective Date: 5[January 1, 2017]~~  
~~Policy Revision Effective Date: 6[July 1, 2016]~~

In consideration of the Policyholder’s payment of the premium charged, Berkshire Hathaway Specialty Insurance Company agrees to pay the benefits provided by this Policy in accordance with all of the terms and conditions of this Policy. This Policy is issued in reliance on the Application submitted by the Policyholder, a copy of which is attached and, together with any Riders, Endorsements, Addenda and Amendments hereto, constitute this Policy.

The Policyholder will hereafter be referred to as “You,” “Your,” and “Yours.”

Berkshire Hathaway Specialty Insurance Company will hereafter be referred to as “We,” “Our,” and “Us,” and can be reached at [(XXX) XXX-XXXX].

With respect to any date in this Policy, all days begin at 12:00:00 a.m. and end at 11:59:59 p.m. local standard time at Your address listed above.



Ralph Tortorella, Secretary

Peter Eastwood, President



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## SCHEDULE OF BENEFITS

**Policyholder:** ~~1~~ **1**{ABC Company}

**Policy Number:** ~~2~~ **2**{12345}

**Premium Due Date:** ~~3~~ **3**{INSERT}

### SPECIFIC BENEFIT

Original Specific Benefit Effective Date ~~4~~ **4**{January 1, 2016}

#### Benefit Specifications

~~5~~ **5**{Renewal} Policy Year ~~6~~ **6**{January 1, 2016} through ~~7~~ **7**{December 31, 2016}

Reimbursement Percentage ~~8~~ **8**{100%} of Eligible Expenses

~~9~~ **9**{Related Provider

Reimbursement Percentage ~~10~~ **10**{80%} of Eligible Expenses}

Covered Benefit(s) ~~11~~ **11** Medical ~~12~~ **12**{, excluding Prescription Drugs covered  
under a Prescription Drug Plan}

~~13~~ **13**{Prescription Drug Plan (PDP)}

Specific Benefit Deductible ~~14~~ **14**{\$100,000}

~~15~~ **15**{Aggregating Specific Deductible ~~16~~ **16**{\$30,000}}

Specific Benefit Lifetime Maximum

Eligible Expenses ~~17~~ **17**{\$10,000,000}

Specific Benefit Annual Maximum ~~18~~ **18**{\$1,000,000}

Eligible Expenses

Specific Benefit Claims Basis ~~19~~ **19**{Incurred in [XX] months and Paid in [XX] months  
Eligible Expenses include only those expenses that are Incurred and  
Paid during the Policy Year.}

~~20~~ **20**{Incurred in [XX] months and Paid in [XX] months ([X] Month Run-  
In)}

Eligible Expenses include only those expenses that are Incurred:

(a) during the Policy Year; or

(b) within the [XX] months immediately preceding the Policy Year (the  
"Run-In Period");

provided they are Paid during the Policy Year.}

~~21~~ **21**{Incurred in [XX] months and Paid in [XX] months ([X] Month Run-  
Out)}



Eligible Expenses include only those expenses that are Incurred during the Policy Year provided they are Paid:

(a) during the Policy Year; or

(b) within the [XX] months immediately following the Policy Year (the "Run-Out Period").

**16**[Paid (Renewal Policy Year Only)]

Eligible Expenses include only those expenses that are Incurred after [January 1, 2016] provided they are Paid during the Policy Year.

[Incurred Eligible Expenses include only those expenses that are Incurred during the Policy Year.]

**17**[Gapless (Renewal Policy Year Only)]

Eligible Expenses for this Policy Year will also include those Expenses that are Incurred on or after the Original Specific Benefit Effective Date provided they are Paid after the Run-Out Period of the immediately preceding Policy Year.

Covered Unit(s) **18**[Single Employee,] [Employee + 1 dependent,] [Employee + 2 dependents,] [Employee + family] [COBRA continue]

Retirees **19** [Covered][Not Covered]

Specific Benefit Premium Rate **20**[\$8.00] per [INSERT] per month  
[\$15.00] per [INSERT] per month

**1**[**AGGREGATE BENEFIT (OPTIONAL)**]

Original Aggregate Benefit Effective Date **2**[January 1, 2016]

**Benefit Specification**

**3**[Renewal] Policy Year [January 1, 2017] through [December 31, 2017]

Reimbursement Percentage **4**[100%] of Eligible Expenses

**5**[Related Provider

Reimbursement Percentage [80%] of Eligible Expenses]

Covered Benefit(s) **6**[Medical], excluding Prescription Drugs covered under a Prescription Drug Plan]

[Prescription Drug Plan (PDP)]

[Dental Plan]

[Vision Plan]



\_\_\_\_\_ [Short Term Disability Plan (STDP)]

Aggregate Benefit Maximum **7**[\$1,000,000]

Portion of Aggregate Benefit Maximum  
Available Per Covered Person For

Eligible Expenses **8**[\$100,000]

Aggregate Deductible Factor (ADF) The ADF per Benefit Month for each Covered Unit by Covered Benefit is as follows:

<b>9</b> Covered Benefit	Covered Unit	ADF
[Medical]	[INSERT]	[\$300.00]
[PDP]	[INSERT]	[\$150.00]
[Dental]	[INSERT]	[\$50.00]
[Vision]	[INSERT]	[\$30.00]
[STDP]	[INSERT]	[\$30.00]

Minimum Aggregate Deductible **10**The Minimum Aggregate Deductible for the Policy Year is equal to the greater of:

\_\_\_\_\_ [\$1,458,000]; or

(a) the amount obtained by multiplying:

(0) [70-90%] of the Monthly Aggregate Deductible for the first month of the Policy Year; by

(0) [1-36].

Aggregate Benefit Attachment Point The Aggregate Benefit Attachment Point is the greater of:

(-) the sum obtained by adding up all of the Monthly Aggregate Deductibles for the Policy Year; or

(-) the Minimum Aggregate Deductible for the Policy Year.

Aggregate Benefit Claims Basis **11**[Incurred in [XX] months and Paid in [XX] months  
Eligible Expenses include only those expenses that are Incurred and Paid during the Policy Year.]

\_\_\_\_\_ **12**[Incurred in [XX] months and Paid in [XX] months ([X] Month Run In)]

Eligible Expenses include only those expenses that are Incurred:



( ) — during the Policy Year; or

( ) — within the [XX] months immediately preceding the Policy Year (the “Run-In Period”);

provided they are Paid during the Policy Year.]

**13**[Incurred in [XX] months and Paid in [XX] months ([X] Month Run-Out)]

Eligible Expenses include only those expenses that are Incurred during the Policy Year provided they are Paid:

(a) — during the Policy Year; or

(b) — within the [XX] months immediately following the Policy Year (the “Run-Out Period”).]

[Paid (Renewal Policy Year Only)]

Eligible Expenses include only those expenses that are Incurred after [January 1, 2016] provided they are Paid during the Policy Year.]

Covered Unit(s) — **14**[Single Employee,] [Employee + 1 dependent,] [Employee + 2 dependents,] [Employee + family] [COBRA continue]

Retirees — **15**[Covered][Not Covered]

Aggregate Benefit Premium Rate — **16**[\$8.00] per [INSERT] per month]



## I. GENERAL DEFINITIONS

**Accumulated Aggregate Attachment Point:** The greater of:

~~(1) the sum of~~ (1) the sum of ~~obtained by adding~~ obtained by adding the Monthly Aggregate Deductibles for each month from the start of the Policy Year to the date of the calculation; ~~or~~

and (2) the Minimum Aggregate Deductible, divided by the total number of months in the Policy Year, then multiplied by the number of months from the start of the Policy Year to the date of the calculation.

**Accumulated Aggregate Losses:** The total amount of Eligible Expenses for all Covered Persons that have been paid by You from the beginning of the Policy Year to the date of the calculation (subject to the Aggregate Benefit Maximum Eligible Expenses ~~per~~Per Covered Person), multiplied by the Related Provider Reimbursement Percentage, ~~(if applicable).~~

**Adjusted Specific Deductible Amount:** The amount shown as the Adjusted Specific Deductible Amount (if applicable) on the Application, which is the amount of Eligible Expenses that You are responsible to pay for the named Covered Person(s) before benefits are reimbursable under this Policy. The Adjusted Specific Deductible Amount applies separately to each Covered Person shown in the Adjusted Specific Deductible section of the Application.

**Aggregate Benefit Attachment Point:** The amount of Eligible Expenses You must pay during the Claims Basis for such Aggregate Benefit ~~Claims Basis~~ before We will consider an Aggregate Benefit claim. ~~The~~ It is the greater of: ~~(1) the sum of the Monthly Aggregate Benefit Attachment Point is shown on Deductibles for the above Schedule of Benefits of this Policy under Year; and (2) the Benefits Specifications for Minimum Aggregate Benefit Deductible for the Policy Year.~~

**Aggregate Benefit Maximum:** The amount shown as the Aggregate Benefit Maximum on the Application, which is the maximum amount We will pay for the Aggregate Benefit as provided by this Policy.

**Aggregate Benefit Maximum Eligible Expenses ~~per~~Per Covered Person:** The amount shown as the Aggregate Benefit Maximum Eligible Expenses Per Covered Person on the Application, which is the maximum amount of Eligible Expenses for any one Covered Person that will be used to calculate the Aggregate Benefit. ~~The Aggregate Benefit Maximum Eligible Expenses per Covered Person is shown on the above Schedule of Benefits of this Policy under the Benefits Specifications for Aggregate Benefit. The Aggregate Benefit Maximum Eligible Expenses per Covered Person applies only to Eligible Expenses Incurred and Paid for the following Covered Benefits: 1 [Medical, excluding prescription drugs covered under a Prescription Drug Plan; Prescription Drug Plan.] as provided by this Policy.~~

~~The Aggregate Benefit Maximum Eligible Expenses per Covered Person shall apply to a Covered Person who is not a Dependent (such as the Employee) and his or her Dependents as a collective unit, and the collective unit shall be treated as a single Covered Person. The Aggregate Benefit Maximum Eligible Expenses per Covered Person for such collective unit shall include any expenses incurred by the members of the collective unit.~~

**Aggregate Deductible Factor ("ADF"):** The deductible factor per Benefit Month for each Covered Unit by Covered Benefit. ~~The Aggregate Deductible Factor for each Covered Benefit is as shown on the above Schedule of Benefits of this Policy under the Benefits Specifications for Aggregate Benefit, as shown on the Application.~~





**Aggregating Specific Deductible** ~~(only applicable if an Aggregating Specific Deductible is shown on the above Schedule of Benefits of this Policy under the Benefits Specifications for Specific Benefit, in which case that is the amount of the Aggregating Specific Deductible);~~ A deductible, in addition to the Specific Benefit Deductible, applied to the calculation of the Specific Benefit, which must be completely satisfied before Eligible Expenses are reimbursable under this Policy. The Aggregating Specific Deductible is ~~satisfied by applying~~applied against any Eligible Expenses that exceed the Specific Benefit Deductible for any Specific Benefit claim.

**Benefit Month:** Any calendar month during ~~which this~~the Policy ~~is in effect~~Year.

**Claims Basis:** The period of time ~~(as shown in the above Schedule(s) of Benefits of this Policy under the Benefits Specifications for Specific Benefit and Aggregate Benefit, as applicable)~~on the Application during which Eligible Expenses must be ~~Incurred~~incurred by a ~~Covered Person~~You and ~~Paid~~paid by You to be eligible for reimbursement under this Policy for any Specific Benefit or Aggregate Benefit, as applicable.

**Covered Benefits:** The benefit provisions of ~~Your~~the Plan that are insured for stop-loss coverage under this Policy ~~(as shown above in~~on the ~~Schedule(s) of Benefits)~~Application.

**Covered Person:** A person enrolled in ~~Your~~the Plan and entitled to receive benefits under ~~Your~~the Plan while this Policy is in effect. Retirees, as defined by ~~Your~~the Plan, may be Covered Persons if they are shown as included in the ~~above Schedule(s) of Benefits of this Policy~~Application under the ~~Benefits Specifications for Specific Benefit or Aggregate Benefit, as applicable (otherwise, they are Not Covered)~~. ~~Covered Person also includes a person enrolled in Your Plan and entitled to receive benefits under Your Plan during the Run-In Period (if a Run-In Period is provided by this Policy) who dies before the Policy Effective Date.~~not Covered Persons.

**Covered Unit:** A category of participants under ~~Your~~the Plan. ~~The Covered Unit(s) for this Policy are as shown on the above Schedule(s) of Benefits of this Policy under the Benefits Specifications for Specific Benefit or Aggregate Benefit, as applicable.~~the Plan (as shown on the Application).

**Dependent:** A person enrolled in ~~Your~~the Plan and entitled to receive benefits under ~~Your~~the Plan as a dependent of a Covered Person. ~~If, including a domestic partner that is covered under the Plan. Further, if~~ the law of the state where the Plan is issued requires that domestic partners be covered under ~~Your~~the Plan, then such individuals who are domestic partners under that state's law shall be considered Dependents under ~~the~~this Policy.

**Disclosed Risk:** Any medical condition that is identified as a known risk on the Disclosure Statement.

**Disclosure Statement:** The written statement from You, that is provided and acceptable to Us, which provides certain underwriting information, including information regarding~~on~~ Covered Units and Disclosed Risks.

**Eligible Expenses:**

~~1. Subject to the additional requirements in Paragraph 2. of this definition below with respect to Off-Label Drug Use, Eligible Expenses are those amounts~~ Paid ~~Amounts paid~~ by You for Medically Necessary and Appropriate expenses incurred by a Covered Person that:

a. are the Usual and Customary Charge; and

a-b. have been paid in accordance with the terms of ~~Your~~the Plan; and



~~b.c.~~ were ~~incurred~~ incurred and ~~Paid~~ paid during the applicable ~~claims basis (in the above Schedule(s) of Benefits); and~~ Claims Basis; and

~~e.d.~~ are paid under a Covered Benefit shown on the ~~above Schedule of Benefits~~ Application; and

~~d.e.~~ are not otherwise ~~limited or~~ excluded ~~by~~ under this Policy.

~~2.—In addition to satisfying the criteria in Paragraph 1. above for~~ Eligible Expenses, ~~will include such~~ expenses related to Off-Label Drug Use ~~will only be considered Eligible Expenses when~~ if all of the following ~~additional conditions are~~ criteria have been satisfied: ~~(in addition to satisfying all of the criteria in a. through e. above):~~

~~e.f.~~ the drug is not excluded under ~~Your~~ the Plan; and

~~f.g.~~ the drug has been approved by the ~~United States Food and Drug Administration (“FDA”); and~~

~~You can demonstrate to Our satisfaction that the Off-Label Drug Use is both~~

~~g.h.~~ the drug is appropriate and generally accepted in the medical community for ~~use with respect to~~ the condition ~~being~~ treated; and

~~h.i.~~ if the drug is used for the treatment of cancer, a nationally recognized compendia recognizes it as an appropriate treatment for such ~~condition, as determined by Us~~ cancer; and

a. the drug is not provided as part of a Phase I, ~~and/or Phase II, III or IV~~ of a clinical trial as defined by the National Institute of Health, National Cancer Institute, or the FDA.

~~3.—Eligible Expenses will also include the following fees Incurred and Paid by You provided they have been approved by Us in writing (which, if such fees are charged by your TPA or any subsidiary of your TPA, must be approved by Us in advance):~~

~~(—) reasonable hourly fees for case management services provided by a registered nurse case manager retained by You or Your TPA; and~~

~~(—) reasonable fees for: (1) hospital bill audits; (2) access to non-directed provider networks; and (3) negotiating out of network bills;~~

~~but only if You can demonstrate to Us that the work that generated the fees resulted in a cost savings to the Plan, in which case We will reimburse You up to 1 [[25%] of the amount saved.] 2 [up to a maximum of [\$5,000] for each hospital confinement per Covered Person].~~

~~4.—If You pay a state health care surcharge in connection with the payment of Eligible Expenses, such health care surcharge shall likewise be considered an Eligible Expense. However~~ Expense, ~~however~~ penalties or fines associated with the health care surcharge or the underlying expenses will not be considered Eligible Expenses.

~~Any otherwise Eligible Expenses that were incurred or paid by You after the early Termination Date of this Policy (if applicable) shall not be considered Eligible Expenses.~~

**Employee:** Employee shall have the same meaning as the use of that term in ~~Your~~ the Plan, but shall not include an independent contractor for whom no W-2 is issued.



**Experimental or Investigational Treatment:** ~~For~~If there is no definition in the Plan, then, for the purpose of determining Eligible Expenses under this Policy, a Treatment (other than covered Off-Label Drug Use) is an Experimental or Investigational Treatment if ~~the Treatment:~~

- a. ~~the Treatment~~ is governed by the ~~United States Food and Drug Administration (“FDA”)~~, and the FDA has not approved the Treatment for the particular condition at the time the Treatment is provided; or
- b. the Treatment is provided as part of ~~an ongoing~~ Phase I, ~~and/or Phase II, III or IV~~ clinical trial, as defined by the National Institute of Health, National Cancer Institute, or the FDA; or
- ~~(c)~~
  - c. there is documentation in published U.S. peer-reviewed medical literature indicating that further research, studies, or clinical trials are necessary to determine the safety, toxicity or efficacy of the Treatment.

However Experimental or Investigational Treatment shall not include any Treatment that would have been provided to the Covered Person if the Covered Person had not participated in the clinical trial.

**Incurred:** The date on which Treatment is provided.

**Independent Review Organization:** An organization for external review, as required under the external review process of the Patient Protection and Affordable Care Act.

**Medical Management Vendor:** A third party hired to reduce or control the cost of services or supplies provided to Covered Persons under ~~Your~~the Plan.

**Medically Necessary and Appropriate:** ~~For~~If there is no definition in the Plan, then, for the purpose of determining Eligible Expenses under this Policy, a Treatment is Medically Necessary and Appropriate if ~~We determine that it meets~~ all of the following criteria are satisfied:

- a. ~~it~~ is recommended and provided by a licensed physician, dentist or other medical practitioner who is practicing within the scope of his or her license; and
- b. ~~it~~ is generally accepted as the standard of medical practice and care for the diagnosis and treatment of the particular condition; and
- c. ~~it~~ is approved by the FDA, ~~(if applicable).~~

**Minimum Aggregate Deductible:** The minimum amount of Eligible Expenses ~~you~~that You must pay before You become eligible for an Aggregate Benefit under this Policy. The Minimum Aggregate Deductible is shown on the ~~above Schedule of Benefits of this Policy under the Benefits Specifications for Aggregate Benefit Application.~~

**Monthly Aggregate Deductible:** The sum of the deductibles for all Covered Benefits for all Covered Units for each Benefit Month. The deductible for each Covered Benefit is calculated by multiplying the number of Covered Units on the first day of the Benefit Month by the applicable Aggregate Deductible Factor (“ADF”) for each Covered Benefit as shown on the ~~above Schedule of Benefits of this Policy under the Benefits Specifications for Aggregate Benefit Application.~~

**Off-Label Drug Use:** The use of a drug for a purpose other than that for which it was approved by the FDA.



**Original ~~Aggregate Benefit~~ Effective Date:** ~~This is the~~The date (as shown in the above Schedule(s) of Benefits under the Benefits Specifications for ~~for this on the Application (whether listed for a Specific Benefit or~~ Aggregate Benefit) -when ~~Aggregate Benefits~~such coverage first became effective between You and Us ~~for that consecutive period.~~

**Original ~~Specific Benefit~~ Effective Date:** ~~This is the date (as shown in the above Schedule(s) of Benefits under the Benefits Specifications for Specific Benefit) when Specific Benefit coverage first became effective between You and Us for that consecutive period.~~

**Paid:** The date Your check or draft for payment of Eligible Expenses ~~incurred~~that are incurred by a Covered Person is issued and delivered to the payee, provided that the account upon which the payment is drawn contains sufficient funds to permit the check or draft to be honored. Checks or drafts that are returned unpaid for any reason will not be considered paid.

**Plan:** Your self-defined benefit plan established to provide benefits to Covered Persons as described in Your plan document. For the purpose of determining benefits payable under this Policy, the Plan shall not include any amendments made to the plan document after the Original ~~Aggregate Benefit Effective Date or the Original Specific Benefit Effective Date, whichever is earlier~~Effective Date, unless We notify You in writing that the amendment is acceptable to Us.

**Policy:** This Stop Loss Policy (including any riders, endorsements, addenda and amendments hereto) together with both the Application and the Disclosure Statement applicable to this Stop Loss Policy.

**Policy Year:** The period beginning on the effective date for this Policy as listed in the Declarations of this Policy and ending on the expiration date as shown on the Application, or the actual period of time during which this Policy is in force if this Policy terminates prior to the expiration date.

**Policyholder**~~Policyholders~~: The legal entity to whom this Policy is issued (also referred to herein as “You,” “Your,” and “Yours”).

**Prescription Drugs:** For the purpose of determining Eligible Expenses under this Policy, Prescription Drugs means all prescription drugs covered under ~~Your~~the Plan, other than prescription drugs administered to a Covered Person while he or she is confined in a hospital or other medical facility.

**Prescription Drug Plan:** A benefit ~~provisions~~provision of ~~Your~~the Plan, or a separate ~~employee benefit plan~~Employee Benefit Plan maintained by You, under which expenses for Prescription Drugs are paid independently of other medical expenses. ~~Expenses incurred under a Prescription Drug Plan will be included as Eligible Expenses only if the Prescription Drug Plan is included as a Covered Benefit in the above Schedule of Benefits of this Policy under the Benefits Specifications for Specific Benefit or Aggregate Benefit, as applicable. However a Prescription Drug Plan does not include prescription drug expenses paid subject to any deductibles or coinsurance applicable to other medical benefits under Your Plan.~~

**Provider Network:** As offered under ~~Your~~the Plan, a Preferred Provider Organization (~~“PPO”~~), Exclusive Provider Organization (~~“EPO”~~), Point of Service Plan (~~“POS”~~), self-funded Health Maintenance Organization (~~“HMO”~~), or any managed care network.

**Reimbursement Percentage:** The percent of Eligible Expenses that will be considered for reimbursement under this Policy, as shown on the Application for the Specific Benefit and/or the Aggregate Benefit (if applicable).

**Related Provider:** Any facility, service provider, pharmacy, or other vendor, ~~which~~that is owned, operated, controlled by, or affiliated with, the Policyholder (or the Covered Person’s employer, if different). Related Provider



includes any subsidiary, affiliate or parent company of the Policyholder- (or the Covered Person's employer, if different).

**Related Provider Reimbursement Percentage:** The percent of Eligible Expenses for any Treatment rendered by or purchased from a Related Provider that will be considered for reimbursement under this Policy.

~~**Schedule of Benefits:** This Policy's Stop Loss Schedule of Benefits above, which includes specific terms regarding the Specific Benefit coverage and/or Aggregate Benefit coverage provided under this Policy, as applicable.~~

~~**Specific Benefit - Specific Benefit Annual Maximum Eligible Expenses Per Covered Person:** The amount shown as the Specific Benefit Annual Maximum Eligible Expenses Per Covered Person on the Application, which is the maximum amount of Eligible Expenses that We will apply towards the Specific Benefit for a Covered Person(s) during a Policy Year. ~~The Specific Benefit Annual Maximum Eligible Expenses amount is shown in the above Schedule of Benefits of this Policy under the Benefits Specifications for Specific Benefit.~~~~

~~**Specific Benefit Deductible:** A deductible representing the The amount of Eligible Expenses relating to any Covered Person(s) that You ~~much~~ must pay separately for each Policy Year before You become eligible for a Specific Benefit ~~under this Policy, as shown on the Application~~, subject further to any applicable Aggregating Specific Deductible. ~~The and/or Adjusted Specific Benefit Deductible is shown on the above Schedule of Benefits of this Policy under the Benefits Specifications for Specific Benefit Amount.~~~~

~~**Specific Benefit Lifetime Maximum Eligible Expenses:** ~~The~~ Per Covered Person: The amount shown as the Specific Benefit Lifetime Maximum Eligible Expenses Per Covered Person on the Application, which is the maximum amount of Eligible Expenses that We will ~~ever~~ apply towards the Specific Benefit for a Covered Person during his or her lifetime. All Eligible Expenses that are incurred by a Covered Person during the first Policy Year and/or any subsequent Renewal ~~renewal~~ Policy Year(s) will apply toward the Specific Benefit Lifetime Maximum Eligible Expenses. ~~The Specific Benefit Lifetime Maximum Eligible Expenses amount is shown in the above Schedule of Benefits of this Policy under the Benefits Specifications for Specific Benefit Per Covered Person.~~~~

**Third Party Administrator ("TPA"):** A third party with whom You have entered into an agreement for them to provide administrative services to ~~Your~~ the Plan. Your TPA is not Our agent.

**Treatment:** Any treatment, procedure, service, device, supply or drug provided to a Covered Person.

**Usual and Customary Charge:** The usual and customary charge for the locality where the expenses are incurred.

## II. BENEFITS

### Specific Benefit

#### A. Additional Definitions

#### B. Additional Provisions

### Specific Benefit

The Specific Benefit for any Covered Person for any Policy Year equals:

( ) ~~the~~ sum of:



~~(0) amount obtained by multiplying the Specific Benefit Reimbursement Percentage shown on the Application against the quantity: (1) the total amount of Eligible Expenses for the Covered Person in that Policy Year multiplied by the Related Provider Reimbursement Percentage, (if applicable);~~  
minus

~~(0) (2) the Specific Benefit Deductible; (or the Adjusted Specific Deductible Amount, if applicable) and~~  
minus

~~(3) the Aggregating Specific Deductible, (if any, applicable) or any remaining portion thereof;~~

multiplied by:

~~(b) the lesser of the Reimbursement Percentage shown on the above Schedule of Benefits of this Policy under the Benefits Specifications for Specific Benefit, or 100%.~~

As used herein, the amount of Eligible Expense ~~with respect to for~~ any Covered Person(s) is subject to:

~~(1) the Specific Benefit Lifetime Maximum Eligible Expenses;~~

~~2. Per Covered Person; and (2) the Specific Benefit Annual Maximum Eligible Expenses; Per Covered Person.~~

~~as applicable.~~

Payment of a Specific Benefit is available for Specific Advance Funding upon the fulfillment of all of the following:

1. claims submitted for Specific Advance Funding have been fully processed by the TPA in accordance with the terms of the Plan and must be ready for payment under the Plan within the applicable Claims Basis Adjustment period during which the claim was incurred; and
2. You have completely satisfied the Specific Benefit Deductible or the Adjusted Specific Deductible Amount (if applicable) for the Covered Person and the Aggregating Specific Deductible (if applicable); and
3. each such advance funding request is for an amount equal to or greater than \$1,000; and
4. the claim, and supporting documentation satisfactory to Us, has been received by Us no later than fourteen days after the end of the applicable Claims Basis period. Requests received after that date are not eligible for Specific Advance Funding. Standard claim audit procedures will be implemented prior to any reimbursements being issued by Us. These procedures may include, but are not limited to, withholding a portion of the reimbursement for a claim pending finalization of an audit or final re-pricing of charges.

If the foregoing requirements are satisfied, We will promptly advance the Policyholder the amount that is eligible for reimbursement under the Specific Benefit.

If Any Run-Out Period will not apply if this Policy terminates prior to the end of the Policy Year, any portion of Our advance is not used to pay the claims under the Plan for any reason, such portion must be returned to Us within five working days after it is received by the Policyholder.

### **Aggregate Benefit (if applicable)**

#### **A. Additional Definitions**



**B. Additional Provisions**

**Aggregate Benefit**

The Aggregate Benefit equals:

~~( ) the sum of:~~

~~(0) the total amount~~ the amount obtained by multiplying the Aggregate Benefit Reimbursement Percentage shown on the Application against the quantity: the sum of Eligible Expenses for all Covered Persons (subject to the Aggregate Benefit Maximum Eligible Expenses ~~per~~ Per Covered Person) multiplied by the Related Provider Reimbursement Percentage  ~~(if applicable);~~ minus

~~the Aggregate Benefit Attachment Point;~~

~~multiplied by:~~

~~( ) the lesser of the Reimbursement Percentage shown on the above Schedule of Benefits of this Policy under the Benefits Specifications for Aggregate Benefit, or 100%.~~

The Aggregate Benefit will be calculated after the expiration of the ~~Aggregate Benefit~~ applicable Claims Basis period, as shown on the ~~above Schedule of Benefits of this Policy under the Benefits Specifications for Aggregate Benefit~~ Application.



However the amount payable under this Policy for the Aggregate Benefit ~~Claims Basis Adjustment~~

Any Run-Out Period will not apply if this Policy terminates prior to the end of the Policy Year.

#### ~~Aggregate Benefit Maximum~~

The Aggregate Benefit We will pay will not exceed the Aggregate Benefit Maximum shown on the above Schedule of Benefits of this Policy under the Benefits Specifications for Aggregate Benefit, as shown on the Application.

#### ~~Monthly Aggregate Accommodation~~

If, at the end of any Benefit Month during the Policy Year, Accumulated Aggregate Losses exceed the Accumulated Aggregate Attachment Point, upon written request from You We will provide You with an advance in an amount equal to the Accumulated Aggregate Losses minus:

- ~~( ) the Accumulated Aggregate Attachment Point; and~~
- ~~( ) any amount previously advanced to you under this provision.~~

However the minimum amount that You may request, and we will be obligated to advance, is ~~2~~[\$1,000].

~~If~~ We make an advance to You under this provision, and at the end of any subsequent Benefit Month the Accumulated Aggregate Attachment Point (for purposes of this sentence hereafter referred to as "A") is greater than the Accumulated Aggregate Losses minus any amount previously advanced to You (for purposes of this sentence hereafter referred to as "B"), You must pay Us the amount by which A exceeds B, up to the total amount previously advanced to You, within thirty one (31) days following the end of the Benefit Month in which the foregoing excess amount (i.e. A minus B) is due.

~~If~~ the Policy terminates before the end of the Policy Year, or if any amount is not paid to Us when such amount is due:

- ~~0.~~ the total of all outstanding amount owed to Us will become immediately due and payable; and
- ~~0.~~ We will not provide any additional advances under this provision; and
- ~~0.~~ We shall be entitled to reduce any benefit owed to You under this Policy by the amount You owe Us; and
- ~~0.~~ the amount You owe Us will be subject to interest at the then prevailing Prime Rate plus 2% (calculated from the date such payment was due); and
- ~~0.~~ We shall have the right to terminate this Policy.

#### ~~Clinical Trials Provision~~

The Clinical Trials Provision is added for the purpose of determining whether expenses incurred by a Covered Person resulting from his or her participation in a Phase 1, II, III or IV clinical trial ("Clinical Trial Expenses") are Eligible Expenses under this Policy.





However this Clinical Trials Provision does not apply to any expenses submitted for reimbursement under the Policy that are not Clinical Trial Expenses, and such other expenses shall be subject to all other Policy provisions as if this Clinical Trials Provision did not exist as to those other expenses.

Pursuant to this Clinical Trials Provision, Eligible Expenses will include Clinical Trial Expenses only if all of the following additional conditions are satisfied:

~~( )—You provide Us with copies of:~~

~~(0) the clinical trial treatment protocol from the facility that conducted the clinical trial; and~~

~~(0) the Covered Person's signed consent and authorization to participate in the clinical trial; and~~

~~( )—You provide Us with documentation that demonstrates to Our satisfaction that:~~

~~(0) the Treatment was provided as part of an ongoing Phase I, II, III or IV clinical trial sponsored by the National Cancer Institute, National Institute of Health, or the FDA; and~~

~~(0) the Treatment provided by the clinical trial is covered by Your Plan; and~~

~~(0) funding is not available for the routine costs of the clinical trial from the National Cancer Institute, the National Institute of Health, the FDA, or any other entity (as used in this sentence "routine costs" shall have the meaning attributed to that term by the Centers of Medicare and Medicaid Services in its Coverage Issues Manual for clinical trials; and~~

~~(0) the clinical trial has been approved by an institutional review board consisting of a committee of physicians, statisticians, researchers, community advocates and others which ensures that a clinical trial is ethical, and that the rights of trial participants are protected.]~~

### **III. LIMITATIONS AND EXCLUSIONS**

We will ~~NOT~~not reimburse You for the following, which are excluded from the benefits provided by this Policy:

~~0. expenses that are payable excluded (or reimbursable otherwise not covered) under any workers' compensation laws, benefits or coverage, or under any similar laws, occupational benefits or coverage, whether or not such coverage is in force;~~

~~0. expenses for any Experimental or Investigational Treatment;~~

~~0. expenses relating to non-human organ or tissue transplants, gene therapies, xenographs or cloning;~~

~~0. expenses 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 the Treatment unless the subject Treatment, travel and expenses were reported to and approved by Us in writing prior to such travel;~~

~~i.a. expenses for benefits in excess of Your Plan's limits, or expense that are excluded under Your Plan;~~

~~0. expenses in excess of the Usual and Customary Charge;~~



~~j.b.~~ any amount paid by You in excess of a negotiated provider discount, or any penalty or late charge incurred or discount lost, unless previously approved by Us in writing;

~~k.c.~~ expenses associated with the administration of ~~You~~the Plan, including claim payment fees, cost containment administrative fees, ~~Pharmacy Benefit Manager~~Medical Management Vendor administration fees, PPO access fees, premium functions, and medical review and consultant fees, except for such expenses that are otherwise specifically ~~insured~~approved by ~~this Policy~~Us;

~~l.d.~~ expenses paid by ~~you~~You relating to any litigation concerning ~~You~~the Plan, including attorneys' fees, extra-contractual damages, compensatory damages and punitive damages;

~~0.~~—any portion of an expense that You are not obligated to pay under Your Plan, or which is reimbursable to You under:

~~( ) — another group health program; or~~

~~( ) — a government or privately supported medical research program; or~~

~~( ) — Medicare; or~~

~~( ) — any coordination of benefits or non-duplication of benefits provision of Your Plan; or~~

~~( ) — any other source;~~

~~y.e.~~ expenses incurred by a person ~~(and expenses incurred by a Dependent of such person)~~ who is employed by You at any unit, subsidiary, or division of Yours that has not been underwritten by Us;

~~z.f.~~ expenses incurred for any illness or injury directly or indirectly caused by, resulting from, or aggravated by, war, whether declared or undeclared, civil war, or any warlike action;

~~0.~~—expenses paid by You for any ~~Treatment authorized or approved under any provision of Your Plan that:~~

~~( ) — allows the plan administrator to approve alternative care or alternative treatment, unless such alternative care or Treatment was reported to and approved by Us in writing prior thereto; or~~

~~( ) — allows the plan administrator to alter, modify, or waive Plan provisions or limitations; or~~

~~( ) — grants You or You plan administrator discretion to approve coverage for Treatment not otherwise covered under Your Plan.~~

~~0.~~—expenses for any ~~Transplant~~transplant if You have a separate insurance policy that covers ~~Transplants~~transplants and/or ~~transplant related expenses~~ for any Covered Persons, ~~regardless of whether or not the particular Covered Person is covered by that policy;~~

~~kk.g.~~ \_\_\_\_\_ to the extent of the coverage for those expenses covered under a Prescription Drug Plan, unless Prescription Drug Plan coverage is a Covered Benefit under Specific Benefits and/or Aggregate Benefits, as applicable, on the above Schedule of Benefits of this Policy ~~under that separate insurance period;~~

~~0.~~—any expense incurred by any Employee, or by the Employee's Dependents, ~~where~~if the Employee is a member of:



~~(1) one of the following entities or groups and such entity or group is not covered by the Plan as of the beginning of the Policy Year: (1) a division, unit, group, subsidiary, affiliate, or class of employees/employees of the Policyholder; or~~

~~pp.h. (2) an association, trust, cooperative or similar organization connected with the Policyholder; that is not covered by the Plan as of the Policy Renewal Effective Date;~~

~~0. any expenses Incurred by a Covered Person or Dependent if, on the Policy Effective Date or Policy Renewal Effective Date, that Covered Person is not Actively At Work, or that Dependent is totally disabled, is in an institution receiving medical care or Treatment, or is confined at home or elsewhere. This limitation will continue for all expenses Incurred by the Covered Person until he or she is Actively at Work, and similarly this limitation will continue for all expenses incurred by the Dependent until he or she 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 purpose of this provision, a Covered Person is considered to be Actively At Work if he or she:~~

~~(1) is working at Your usual place of business, or at such place or places that Your normal course of business may require, performing all of the duties of his or her occupation on a full-time basis; or~~

~~(2) remains eligible under Your Plan based on his or her accumulated hours worked as your Employee/union member.~~

~~If a Covered Person is not Actively At Work on the Policy Effective Date or Policy Renewal Effective Date solely because that day is not a regularly scheduled workday, the Covered Person will be deemed Actively At Work on that day.~~

~~For the purpose of this provision, a Dependent is considered totally disabled if he or she, solely because of injury or sickness, cannot engage in substantially all of the activities of a person of like age and sex in good health.~~

~~i. any loss or expenses caused by or resulting from occupational accidents or illnesses, or that are covered or eligible for coverage as provided by any workers' compensation law, statute, regulation, or similar law (whether as a participant or subscriber, or as a non-participant or non-subscriber in those states that permit one to opt out of the regular program established by such laws), including any payments made for workers' compensation as exceptions or with no liability concerning such coverage;~~

~~j. the portion of an expense that You are not obligated to pay under the Plan, or which is reimbursable to You under another group health program, a medical research program (public or private), Medicare, any coordination of benefits or non-duplication of benefits provision of the Plan, or from any other source;~~

~~k. expenses for any treatment or services which are considered an Experimental or Investigational Treatment.~~

#### **IV. CLAIM PROVISIONS**

##### **A. Proof of Claim**



Proof of claim must be submitted to Us as provided herein. ~~Expenses and/or claims~~ Claims submitted to Us that are not submitted in accordance with these ~~Proof~~ proof of ~~Claim provisions and this Policy~~ claim requirements are not reimbursable by Us, and shall not be considered Eligible Expenses under this Policy.

## 1. Specific Benefit

Written proof of claim, in a form and content satisfactory to Us, must be provided to Us as soon as reasonably possible after the Specific Benefit Deductible for a Covered Person has been completely satisfied, ~~but in no event shall such~~. Any proof of claim ~~be~~ provided to us later than ~~twelve (12) six~~ months after the end of the Claims Basis period applicable to such Specific Benefit ~~Claims Basis during which the claim arose~~ will not be reimbursable under this Policy.

Proof of claim regarding a Specific Benefit shall include all of the following:

a. a fully completed claim form; and

~~( ) a copy~~ complete details of the Covered Person's ~~original enrollment record~~ eligibility, including their hire date, benefit plan effective date and ~~records, if applicable, their work status, Coordination of any change in the Covered Person's coverage under Your Plan;~~ Benefits and

~~d.b. copies of all bills~~ COBRA (including a copy of the COBRA election form and invoices ~~for~~ \$25,000] COBRA payment verification for ~~expenses submitted for reimbursement under this Policy;~~ all months); and

~~e.c. proof of payment of any expenses submitted to Us for reimbursement under this Policy and/or a claims paid~~ detailed claims report, which includes ~~should include~~ all of the following: Dates ~~dates~~ of Service, Provider Name, Provider ~~service, provider name, provider~~ TIN, Amount Billed, Discount Amount, Eligible Amount, Amount Paid, Date Paid, Reimbursement Amount Requested, Previously Paid ~~Amount~~ amount billed, discount amount, eligible amount, amount paid, date paid, reimbursement amount requested, previously paid amount, ICD codes and ~~CBT Codes~~ CPT codes; and

~~f.d. any additional information~~ We may require to review and process the claim or otherwise satisfy any obligations under this Policy.

## 2. Aggregate Benefit (if applicable)

Written proof of claim, in a form and content satisfactory to Us, must be provided to Us as soon as reasonably possible after the end of the ~~Aggregate Benefit~~ Claims Basis period for the ~~Policy Year, but in no event shall such~~ Aggregate Benefit. Any proof of claim ~~be~~ provided to us later than ~~twelve (12) six~~ months after the end of the Claims Basis period applicable to such Aggregate Benefit ~~Claims Basis~~ will not be reimbursable under this Policy.

Proof of claim regarding an Aggregate Benefit claim shall include all of the following:

a. a complete aggregate calculation report; and

b. a detailed claims history report for all Eligible Expenses ~~incurred~~ that are incurred and ~~Paid~~ paid during the ~~Aggregate Benefit~~ applicable Claims Basis period; and

c. a report listing all Covered Units eligible for benefits under ~~Your~~ the Plan at any time during the ~~Aggregate Benefit~~ applicable Claims Basis period; and



~~( ) a copy of Your Plan in effect during the Policy Year, including any amendments thereto; and~~

- d. if Prescription Drug Plan coverage is included as a Covered Benefit on the ~~above Schedule of Benefits of this Policy under the Benefits Specifications for Aggregate Benefit Application~~, a copy of all prescription drug invoices and an itemization thereof, including the amounts of any rebates received by You; and
- e. any additional information We may require to review and process the claim or otherwise satisfy any obligations under this Policy.

## **B. Appeal of a Claim Determination**

You may appeal the initial claim determination made by Us under this Policy by submitting a written appeal to Us within ninety ~~(90)~~ days from the date of Our initial claim determination. Your appeal should state the basis of Your disagreement with Our initial ~~claims~~claim determination, and should include all documentation and information supporting Your appeal that has not been previously provided to Us. Once you receive a determination from Us regarding Your appeal, You will have exhausted Your administrative remedies under this Policy. The foregoing is without prejudice to D. Dispute Resolution Process in VI. GENERAL PROVISIONS.

## **~~C. Deferred Payments by You~~**

~~You must obtain prior written approval from Us in order for any Eligible Expenses Incurred in the Policy Year that are Paid after the end of the applicable Claims Basis of this Policy to be considered eligible for reimbursement under this Policy.~~

## **~~D. Payment of Claims~~**

~~All benefits due under this Policy will be paid to You. During the Policy Year, reimbursement will be disbursed when the amount payable exceeds 1[\$500.00]. Any reimbursable amount remaining unpaid at the end of a Policy Year will be paid within one hundred and eighty (180) days after the end of the Policy Year.~~



#### **EC. Independent Review Organization Coverage:**

In the event Eligible Expenses are ~~Paid~~paid by You for a Covered Person based on an Independent Review Organization's reversal of previously denied claims, and such expenses are ~~Paid~~paid after the last paid date provided in the applicable ~~Claim~~Claims Basis of this Policy, such ~~Paid~~paid Eligible Expenses shall be deemed to have been ~~Paid~~paid during the Policy Year in which the Eligible Expenses were incurred provided that such expenses are:

- a. not eligible for reimbursement under any other coverage or Policy; and
- b. otherwise eligible for ~~reimburse~~reimbursement under the terms of this Policy.

You (~~either directly or You~~ through your TPA) agree to provide notice to Us that an appeal has been sent to an Independent Review Organization on a claim that could or is expected to exceed the applicable deductible under this Policy within thirty (~~30~~) days of submitting that claim to the Independent Review Organization. We will not reimburse any claim under this Policy for such Eligible Expenses that are ~~Paid~~paid by You for a Covered Person based on an Independent Review Organization's reversal of previously denied claims if we do not receive such notice within thirty (~~30~~) days of submitting that claim to the Independent Review Organization.

When filing a reimbursement claim, You agree to provide Us with all documentation related to the Independent Review Organization's reversal of the previously denied Eligible Expenses. We will not reimburse any ~~stop-loss~~ claim where the Independent Review Organization's reversal documentation, along with any other information necessary to process the claim, is not received within ninety (~~90~~) days from the last date a claim is eligible for payment under the applicable ~~Claim~~Claims Basis period, or within ninety (~~90~~) days of the date the claim was ~~Paid~~paid if ~~Paid~~paid after the applicable ~~Claim~~Claims Basis period has lapsed.

Fees, or any similar expenses, paid to the Independent Review Organization for their services are not reimbursable under ~~the~~this Policy. This ~~Coverage~~coverage does not modify any other terms, conditions, deductibles or aggregating specific deductibles (if applicable) of this Policy. If coverage is available under a subsequent policy issued by Us, coverage shall be provided under this Policy and not the subsequent ~~policy~~Policy issued by Us.

#### **D. Claims Eligible Under Two Consecutive Policy Years**

A claim eligible for reimbursement under two consecutive Policy Years will be paid under the earlier Policy Year.



## V. RIGHTS AND RESPONSIBILITIES

### A. Your Rights and Responsibilities

#### 1. Authorization to Release Information

You are responsible for authorizing Your TPA, ~~Plan Administrator~~, case manager, Provider Network or other third party service provider to release to Us information We request to underwrite, review potential claims, make claim determinations, calculate potential reimbursements, or perform other obligations under this Policy. ~~If We do not~~Our failure to receive requested information, ~~it~~ in a timely manner may result in the delay, reduction or denial of a claim.

#### 2. Disclosure Requirements

This Policy has been underwritten based upon the information You provided to Us concerning all persons eligible for benefits under ~~Your~~the Plan on the Original ~~Specific Benefit Effective Date and/or the Original Aggregate Benefit~~ Effective Date (or on the effective date of any class of Covered Persons added thereafter), as applicable. This includes, but is not limited to, any Disclosed Risks.

Your signature on the Application ~~for this Policy~~ represents to Us that:

- (a) You or Your authorized representative have consulted with ~~your~~Your pharmacy benefit manager, Your precertification, utilization ~~review~~ and Medical Management Vendors ~~and,~~ Your former and/or current TPA, and any other such vendor to determine who must be ~~identified~~ as a Disclosed Risk on the Disclosure Statement; and
- (b) You have identified any person who should be included as a Disclosed Risk by either listing them on the Disclosure Statement, or by indicating any such person on the reports listed on the Disclosure Statement.

The Disclosure Statement completed by You or Your representative is part of this Policy. For a renewal policy, claim information provided in lieu of the Disclosure Statement will constitute a Disclosure Statement for purposes of that renewal. Failure to fully disclose all requested information will result in policy rescission or Us re-underwriting and/or declining coverage.

If you fail to properly identify an individual as a Disclosed Risk who should have been identified as a Disclosed Risk in accordance with the Disclosure Statement then We will have the right to revise the premium rates, deductibles, deductible factors, and terms and conditions of this Policy in accordance with Our underwriting practices in effect at the time ~~the~~this Policy was underwritten, retroactive to the Original Effective Date (as such term applies for the Specific Benefit ~~Effective Date~~ and/or ~~the Original Aggregate Benefit~~ ~~Effective Date~~, as applicable-).

#### 3. Reporting Requirements

~~You are required to provide periodic reports to Us as described below. If You, or Your TPA, do not provide Us the reports, or do not provide them on a timely basis, We reserve the right, once We receive them (or the information that should have been in those reports) to take whatever action We could have taken if the reports (and information) had been provided when required. Such action may include, but is not limited to, the right to revise premium rates, deductibles, and deductible factors, and to do so retroactive to the Original Specific Benefit Effective Date and/or the Original Aggregate Benefit Effective Date, as~~



~~applicable. However We will provide You with 45 days advance written notice prior to any change in premium.~~

You, or Your TPA, shall provide periodic reports to Us, in a timely manner, as described below:

**a. Specific Benefit Reporting**

You, or Your TPA, ~~are required to~~shall provide Us with notice of any potential Specific Benefit claim within ~~1~~thirty-one (31) days of the date:

1. a Covered Person's Eligible ~~Expense~~Expenses exceed 50% of the Specific Benefit Deductible; or
2. You, Your TPA, or Your medical management, utilization review ~~or~~ precertification vendors, or any other party acting on Your behalf, are notified that a Covered Person has been diagnosed with, or treated for, a Disclosed Risk.

**b. Aggregate Benefit Reporting (if applicable)**

You, or Your TPA, ~~are required to~~shall provide Us with a monthly report that lists:

1. the total amount of Eligible Expenses ~~incurred~~that are incurred by any Covered Person and ~~Paid~~paid by You, or ~~Paid~~paid on Your behalf, during the Benefit Month; and
2. the number of ~~each~~Covered Units, by type of Covered ~~Units~~Unit, on the first day of the Benefit Month.

You ~~must~~shall provide ~~the Aggregate Benefits~~such report to Us within ~~2~~thirty-one (31) days after the end of each Benefit Month.

**c. Renewal Reporting**

If You intend to renew this Policy, then ~~three (3)~~four months prior to the end of the Policy Year ~~either~~ You, or Your TPA, ~~are required to~~shall provide Us with a report that includes the following information:

1. monthly ~~Paid~~paid claims and enrollment data, organized by Covered Benefit; and
- ~~(0) large claim information (with amount, diagnosis and prognosis), including such information with respect to any Covered Person who has been diagnosed with a Disclosed Risk; and~~
2. large claim information for all Covered Persons that are expected to reach or exceed 50% of the Specific Benefit Deductible, which shall include, but is not be limited to, claims exceeding 50% of the Specific Benefit Deductible, trigger diagnosis, currently disabled, confined to a medical facility, case management, pre-certification, utilization review, pending or denied; and
- ~~(0) a census of all Covered Persons; and~~
- ~~6.3.~~ a summary of the number of Covered Persons by workplace zip code (if this Policy covers Employees at multiple locations); and
- ~~(0) a summary report of pre-certification, utilization review and case management services; and~~





~~7.4.~~ a summary report of Your Provider Network(s) or per diem arrangements, setting forth the average hospital discount or per diem charge per day; and

~~8.5.~~ a copy of all changes adopted by and/or proposed for ~~Your~~the Plan.

#### 4. Advance Notice/Approval of Changes

You ~~must~~shall notify Us in writing at least ~~31~~thirty-one (31) days before the effective date of any change ~~in or to Your:~~

~~( )~~ the Plan;

~~( )~~ TPA;

~~( )~~ Provider Networks; Network(s), or

Medical Management ~~Vendors; Vendor(s):~~

Our prior written agreement is required before the coverage under this Policy will apply based on any such changes. Otherwise, benefits under this Policy will be paid based upon the terms of the Plan as it existed prior to any such changes. We reserve the right to terminate this Policy as of the effective date of any change ~~in or to Your~~the Plan, Your TPA, Your Provider Network, or Your Medical Management Vendor.

However We will provide You with 45 days advance written notice prior to any Policy termination.

#### 5. Notice of Legal Action

You agree to give Us prompt notice of any lawsuit filed against You or Your Plan administrator that is brought by or on behalf of any Employee, Covered Person, Covered Unit, or any other such party regarding any actual or alleged Covered Benefits, Eligible Expenses, or other such amounts that do or may reasonably relate to the benefits provided by this Policy, ~~and to promptly provide. Such notice shall include providing~~ Us with copies of any and all non-privileged correspondence and pleadings relating to any such lawsuit.

#### 6. Hold Harmless

You agree to defend, indemnify and hold Us harmless from and against any and all claims, demands and causes of action of every kind, relating to any litigation that We, ~~without Our fault,~~ become involved in that relates with respect to this Policy or the Plan to the extent that such claims, demands and causes of action are not caused by Our own acts or omissions. You shall pay any and all attorneys' fees, costs, expenses, and damages (including compensatory, exemplary or punitive damages) ~~incurred~~Incurred by Us, or payable by Us, in connection with any such litigation. However this shall not apply to any claims, demands or causes of action against Us that specifically allege We negligently or intentionally caused harm or damage by Our own acts or omissions.

This Hold Harmless clause shall not apply to litigation solely between You and Us relating to this Policy.

#### 7. Refund of Overpayment

If We, You, or Your TPA determine that We have overpaid You under this Policy, You ~~will~~shall promptly refund such overpayment to Us within sixty ~~(60)~~ days of such a determination. If You disagree with Our



determination that We have overpaid You then You and We will work together in good faith to address and reconcile such disagreement in keeping with the **Dispute Resolution Process** provided in this Policy, and the time period for payment will be tolled while You and We are working through such disagreement. If We are required to take legal action to collect such overpayment, and prevail in such action, You agree to indemnify Us for any costs of collection, including attorneys' fees and court costs.

#### **8. Responsibility for Your TPA/Others**

You are solely responsible for the actions of Your ~~Plan Administrator~~plan administrator, Your TPA, and any other Employee, agent or independent contractor of Yours. Your TPA acts on Your behalf, not on Our ~~Behalf~~behalf. Your TPA is not Our agent. We are not responsible for any compensation owed to, or claimed by, Your TPA or other agents for services provided to, or on behalf of, ~~Your~~the Plan. This Policy does not make Us a party to any agreement between You and Your TPA, nor does it make Your TPA a party to this Policy.

#### **9. Right of Recovery**

You must pursue all valid claims, including claims for restitution, constructive trust, equitable lien, breach of contract, injunction, and any other state or federal law claims You or ~~Your~~the Plan may have against any third party responsible, in whole or in part, for any Eligible Expenses ~~Paid~~paid by You. You must immediately advise Us of any amount You recover from them. We reserve the right to pursue any and all such claims not pursued by You, and You agree to assign such claims to Us upon Our request.

### **B. Our Rights and Responsibilities**

#### **1. Audit**

We have the right, upon not less than seven days' notice, to inspect and audit any and all of Your records and procedures, and those of Your TPA and any other agent or independent contractor of Yours, that relate to any claim made by You under this Policy. Any such inspection and audit will be conducted in keeping with standard rules and procedures, and We will reimburse any extraordinary expenses incurred by You, Your TPA or such other agent or independent contractor of Yours provided We have been given notice of, and approved, such expenses in advance. We have the right to require documentation from You that demonstrates You paid an Eligible Expense, and that the payment was made in accordance with the terms of ~~Your~~the Plan. We reserve the right to employ a third party, at Our expense, to assist Us with any such audit.

#### **2. Determination of Eligible Expenses**

For the purpose of determining Eligible Expenses under this Policy, We have the right, ~~in our sole discretion,~~ to determine whether an expense was ~~Paid~~paid by You in accordance with the terms of ~~Your~~the Plan.

#### **3. Cost Containment**

We have the right to retain the services of a Medical Management Vendor, or other service providers, at Our expense to:

- a. ~~(a)~~ assist Us with cost containment with respect to claims under ~~Your~~the Plan; and/or



- b. ~~(b)~~ provide services to You, Yourthe Plan, or ~~Your~~ Plan participants to reduce cost, risk or expenses under Yourthe Plan.

We may ~~also cause request~~ a Medical Management Vendor or other service provider with whom we may have negotiated a set or discounted rate to contact You if, in Our determination, the Medical Management Vendor or other service provider provides a service that may allow You or Yourthe Plan to reduce your risk, costs and expenses.

#### 4. Confidentiality

We will protect the privacy and confidentiality of all personally identifiable and/or medical information provided to Us in the course of underwriting or administering this Policy in compliance with Our policies and applicable state and federal laws.

#### 5. ~~Offset/Recoupment~~

We ~~have the right to may~~ ~~offset/recoup from any benefit payable reimbursements due~~ to You under this Policy ~~any premium, refund or repayment against any claim overpayments by Us (except while You owe and We are working to resolve any disagreement regarding such overpayment) and premiums due and unpaid by You~~ to Us ~~that has not been paid. Our right of offset/recoupment does not impair Our right to terminate this Policy for non-payment of premium under the Termination provisions of this Policy.~~

#### 6. Right to Recalculate

We have the right to recalculate any applicable ~~Specific Benefit Premium Rate Rates~~, Specific Benefit Deductible, Aggregating Specific Deductible, Aggregate ~~Benefit Premium Rate, Aggregate~~ Deductible ~~Factor Factors~~, or Minimum Aggregate Deductible, all as shown on the Application, with respect to this Policy Year whenever any one or more of the following events occur:

- a. Yourthe Plan changes; or
- b. ~~You you~~ change Your TPA ~~to~~ Your Provider Network(s), and/or Medical Management Vendor(s) ~~);~~; or
- c. this Policy is amended; or
- d. the number of Covered Units on the first day of a Benefit Month increases or decreases by more than ~~{15%}~~% from the number of Covered Units on the first day of the Policy Year; or

~~(-) the number of Covered Units on the first day of a Benefit Month increases or decreases by more than {10%} from the first day of the prior Benefit Month; or~~

- e. a unit, division, subsidiary, or affiliated company of Yours is added to, or deleted from, this Policy; or
- f. the amount of Eligible Expenses paid in any one of the ~~1~~~~{three {3}}~~ months immediately preceding the beginning of the Policy ~~Effective Date Year~~ exceeds ~~2~~~~{125%}~~% of the monthly average of Eligible Expenses ~~incurred that are incurred~~ during the nine ~~{9}~~ months immediately preceding ~~-such~~ ~~3~~~~{three {3}}~~ month period; or



g. there are changes in Your, or Your TPA's claim paying system or ~~payment~~ practices that causes a variation of ~~4~~<sup>fifteen (15)</sup> days or more in the most recent ~~5~~<sup>twelve (12)</sup> month average of claim processing time; ~~or~~

h. If any Employees are absent from work in the event of strike, lockout or work stoppage, the number of Covered Units used to calculate the Monthly Aggregate Attachment Factor for each Policy Month during that event will remain at the level used for the month preceding that event.

Any right to recalculate exercised under this section may be made retroactive to the beginning of the Policy Effective Date at Our election. ~~Any recalculation, which~~ will be made in accordance with Our underwriting practices in effect at the time ~~the~~this Policy was underwritten. The right to recalculate shall survive the termination of this Policy.

However We will provide You with 45 days advance written notice prior to any change in premium.

## 7. Right of Reimbursement

Any portion of an Eligible Expense that You recover from a third party: is not eligible for reimbursement under this Policy, cannot be used to satisfy any deductible or attachment point under this Policy, and must be repaid to Us if We previously reimbursed You for it.

~~( ) is not eligible for reimbursement under this Policy; and~~

~~( ) cannot be used to satisfy any deductible or attachment point under this Policy; and~~

~~( ) must be repaid to Us if We previously reimbursed You for it.~~

Any repayment You owe Us may be ~~reduced~~offset, with Our consent, by any reasonable and necessary expenses You incurred in obtaining the recovery from the third party. Any repayment amount You owe to Us shall survive the termination of this Policy.

## VI.- GENERAL PROVISIONS

### A. Assignment

Your rights and interest in this Policy cannot be assigned.

### B. Bankruptcy or Insolvency

The bankruptcy, insolvency, dissolution, receivership or liquidation of You, ~~Your~~the Plan or Your TPA ~~will~~shall not impose upon Us any obligations other than those set forth in this Policy.

### C. Clerical Error

~~In the event of a clerical error in this Policy, the Policy will be revised to correct the error.~~

~~However Your failure to:~~

~~1. report the existence of a Covered Person; or~~



~~1. file proof of claim or respond to our request for information or documentation in a timely manner; or~~

~~1. comply with any of the terms and conditions of this Policy, including the reporting requirements of this Policy;~~

~~shall not constitute a clerical error.~~

No clerical error, whether made by You, the TPA, or Us, that relates to record keeping, reporting, payment of benefits or premiums, will invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. However, upon discovery of such error or delay an equitable adjustment of premiums or benefits will be made. In the event that claims data and/or enrollment information furnished to Us is missing or incorrect, We have the right to recalculate the Aggregate Deductible Factor(s) and Specific Monthly Premium Rate as shown on the Application using the corrected information.

#### D. Dispute Resolution Process

You and We (herein separately "Party" or collectively "Parties", as appropriate) shall attempt in good faith to resolve any dispute arising out of or relating to this Policy promptly by negotiation between the Parties' executives with authority to settle such dispute. ~~Either Party may submit a dispute to non-binding mediation.~~ The Parties will use their best efforts to agree on the terms of any such mediation process, but if they do not agree within thirty ~~(30)~~ days of either Party requesting mediation, ~~then~~ the dispute ~~will~~shall be submitted to JAMS for mediation. Each Party will bear their own costs, regardless of the mediation process used. If the dispute is not settled at mediation, no Party may commence an action against ~~any~~the other Party until at least thirty (30) days after the final mediation session.

#### E. Entire Contract

~~This Policy, along with any Riders, Endorsements or Amendments, and the Application completed by You, This Policy (as defined herein)~~ constitutes the entire contract of insurance between You and Us.

#### F. Legal Action

You may not bring a legal action against Us to recover on this Policy earlier than sixty (60) days after You have furnished Us with proof of claim in accordance with the ~~Proof~~proof of ~~Claim~~claim provisions of this Policy. Further, You may not bring any legal action against Us to recover on this Policy after five (5) years from the earliest date that proof of claim is required under the terms and conditions of this Policy.

#### G. Misrepresentation

If:

~~0. You make any misstatement, omission or misrepresentation, whether intentional or unintentional, in the Application, information or documentation. You, Your TPA or any other party acting on Your behalf, provide~~ make any material misrepresentations, misstatements or omissions, whether intentionally or unintentionally, in any of the information or documentation that is provided to Us, ~~which We rely upon~~ during ~~the~~Our underwriting of this Policy; (including on the Application or

~~0. Disclosure Statement) or~~ after this Policy ~~is has been~~ issued, (including if We learn of expenses or claims that were incurred or paid, but not reported to Us during the underwriting of this Policy;



), then We will have the right, ~~at Our election,~~ to either rescind this Policy or ~~to~~ revise the premium rates, deductibles, and /or terms and conditions of this Policy in accordance with Our underwriting practices in effect at the time ~~the~~this Policy was underwritten, ~~and any such (which~~ revisions may be made retroactive to the beginning of the Policy ~~Effective Date-Year).~~

#### H. No ERISA Liability

Under no circumstances will We accept responsibility as a “plan administrator” or be deemed a “plan fiduciary” with respect to ~~your~~the Plan under the Employee Retirement Income Security Act of 1974 (ERISA) or any amendment or revision thereto, including amendments relating to the Consolidated Omnibus Budget Reconciliation Act of 1985, or any laws that are similar to ERISA.

#### I. Policy Amendment

No change ~~into~~ this Policy, or waiver of any of its provisions, will be valid unless such change or waiver is ~~in~~ writing and agreed to by You and Us in writing and made a part of this Policy. No agent, broker, TPA, ~~managing general underwriter,~~ or any other third party has authority to change this Policy, or to alter, waive, or render inapplicable any of its provisions on Our behalf.

#### J. 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 the Application we receive from You with respect to such renewal policy and/or a Policy Amendment, if required, the endorsement(s) issued by Us with the Renewal Declarations for such policy.~~ Your payment of the renewal premium after receipt of the ~~revised Schedule of Benefits~~Renewal Declarations and ~~/or Policy Amendment any endorsement(s), if required,~~ shall constitute Your acceptance of such renewal policy ~~by You.~~ \_\_\_\_\_



## K. Premium Provisions

### a. ~~1.~~ Premium Payments

Premium is due on or before the ~~Premium Due Date.~~

### ~~2.~~ Grace Period

~~premium due date.~~ A grace period of ~~{forty-five-(45)}~~ days will be allowed for the payment of each premium due after the first premium has been paid. This Policy will continue in effect during the grace period. If ~~a~~ premium is not paid by the end of the grace period, this Policy will terminate, without notice to You, as of the last date for which premium was paid.

### b. ~~3.~~ Premium Data

You must provide a report to Us with each premium payment, in a form satisfactory to Us, ~~that~~which lists:

~~(1)~~ (1) the number of Covered Units, by each type of Covered Unit, for each Covered Benefit, under ~~Your~~the Plan on the first day of the Benefit Month; and

~~(2)~~ (2) the amount of premium paid.

We will use such premium data reports solely to process premium. They do not replace any report required, or which may be required, under any other provisions of this Policy.

## L. Reinstatement

If this Policy is terminated for non-payment of premium, We may, at Our ~~sole option and~~ discretion, agree to reinstate it as of the date it terminated upon payment ~~to Us~~ of all outstanding premiums. We may require You to provide certain information to Us before We will consider reinstating ~~the~~this Policy.

## M. Singular and Plural Form of a Word

If the singular or plural form of a word is used in this ~~policy~~Policy, where appropriate such word shall also include the other form as required in the context of the sentence using such word, including the words contained in ~~1-GENERAL DEFINITIONS~~ (for example: "Dependent" and "Dependents"), however this clause shall not alter or expand any of the benefits or rights provided by this Policy, including any Specific Benefit.

## N. Severability

In the event that a court of competent jurisdiction invalidates any provision of this Policy, all remaining provisions of this Policy shall continue in effect.

## O. Termination

1. If You fail to pay the premium, this Policy will terminate in accordance with the Premium Provision of this Policy.
2. If ~~Your~~the Plan is terminated, this Policy will terminate on the date the Plan terminated.



3. If You fail to maintain a minimum of {50} participants in ~~Your~~the Plan at any time during the Policy Year, We may elect to terminate this Policy at the end of the first month during which there are less than {50} participants;
4. This Policy will terminate at the end of the Policy Year unless You and We agree in writing to renew it;
5. If You, or Your TPA, fail to satisfy any of Your obligations under this Policy, We may terminate this Policy by giving You sixty ~~(60)~~ days advance written notice of such termination;
6. You may terminate this Policy at any time by providing Us with thirty-one ~~(31)~~ days advance written notice at the address listed for us in the Declarations of this Policy;
7. The parties to this Policy may agree in writing to terminate this Policy at any time.
8. If this Policy terminates for any reason prior to the end of the Policy Year, We will not be liable for any Plan benefits that are paid after such termination date.

#### **P. Time Limitations**

If any time limitation in this Policy is less than the time period required by applicable state law, then such time limitation is hereby extended to the minimum period of time required by such applicable state law.

#### **QQ. Florida Law**

Any provisions in this Policy that are in conflict with the requirements of any applicable Florida laws or regulations are automatically changed to satisfy the minimum requirements of such laws and regulations.

#### **R. Coverage Information Requests and Complaint Issues-**

If You need information regarding coverage, have a coverage inquiry or need assistance resolving a complaint arising out of or relating to this Policy, We can be reached at the phone number listed for us on Page 1 of this Policy.

#### **~~R. Various Optional Additional General Provisions (if any)~~**

##### **~~3. Renewal Rate Increase Cap~~**

~~If You renew Your Policy with Us, the Specific Benefit Premium Rate and the Aggregating Specific Deductible, if applicable, on Your renewal stop loss policy will not be increased more than 4[50]% over the Specific Benefit Premium Rate and the Aggregating Specific Deductible, if applicable, provided that:~~

- ~~1. Your Plan contains no changes that materially affect or alter the risk presented by Your current Policy; and~~
- ~~2. Your renewal stop loss policy contains no material changes from Your present Policy, including changes to:
  - ~~(a) the length of the Policy Year;~~
  - ~~(b) Covered Benefits;~~
  - ~~(c) coverage for Retirees;~~~~





- ~~(d) the Specific Benefit Deductible;~~
- ~~(e) the Claims Basis;~~
- ~~(f) Your TPA;~~
- ~~(g) Your Provider Networks;~~
- ~~(h) the commission payable;~~
- ~~(i) the Specific Benefit Lifetime Maximum or Annual Maximum Eligible Expensed, if applicable;~~
- ~~(j) the Specific Benefit Reimbursement Percentage, if applicable;~~

- ~~3. There are no material changes in the demographic distribution of Covered Persons under Your current Policy versus such persons to be covered by the renewal stop loss policy;~~
- ~~4. A new unit, division, subsidiary, affiliated company or class of Covered Persons is not added to this Policy;~~
- ~~5. There is no change in any assessment levied against Us by the state in which this Policy was issued.~~

~~We, in our sole discretion, shall determine whether any of the changes referenced in sections 1 through 3 above are material. If We determine that any such change is material, we shall adjust the Renewal Rate Increase Cap accordingly.~~

#### **~~5[No New Special Conditions Rider at Renewal~~**

~~If You renew Your Policy with Us, Your renewal stop loss policy will not contain a new or revised Special Conditions Rider provided that:~~

- ~~1. Your Plan contains no changes that materially affect or alter the risk presented by Your current Policy; and~~
- ~~2. Your renewal stop loss policy contains no material changes from Your present Policy; and~~
- ~~3. A new unit, division, subsidiary, affiliated company or class of covered persons is not added to this Policy.~~

~~However We reserve the right to carry over to such renewal any Special Conditions Rider that is part of this Policy.~~

~~We, in our sole discretion, shall determine whether any of the changes referenced in 1. through 3. above are material. If We determine that any such change is material, this provision shall be of no effect.~~

#### **~~6[Special Conditions Rider at Renewal~~**

~~If You renew Your Policy with Us, Your renewal stop loss policy may contain a new or revised Special Conditions Rider.~~

