PENNSYLVANIA MANUFACTURERS' ASSOCIATION INSURANCE COMPANY

380 Sentry Parkway, Blue Bell, PA 19422
610-397-5462

STOP LOSS INSURANCE POLICY

Policyholder: [Legal business name]

Policy Number: [1234567]

Original Policy Effective Date [date]

All insurance begins and ends at 12:00 a.m. local time at the Policyholder's address as shown in the Schedule of Insurance.

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

In consideration of the Application made by the Policyholder (referred to as the Policyholder, You, or Your) and the payment of premiums due in accordance with the terms of this Policy, Pennsylvania Manufacturers' Association Insurance Company (referred to as the Company, We, Us, or Our) agrees to pay benefits as described herein in accordance with the terms, provisions, and Limitations and Exclusions as set forth in this Policy. This Policy provides benefits to the Policyholder when Eligible Claims Expenses by the Policyholder through the covered underlying Plan(s), exceed the levels defined in this Policy and the Schedule of Insurance. The benefits of this Policy and the terms and conditions that apply to this Policy are set forth herein.

The Policyholder and Claim Administrator are responsible for making employee benefit Plan determinations. Pennsylvania Manufacturers' Association Insurance Company has no duty or authority to administer, settle, adjust or provide advice regarding claims filed under the Policyholder's Plan.

This Policy has been issued in consideration of: (1) Your Application, (2) Your Disclosure Statement, (3) Your Summary Plan Description and (4) Your payment of premiums when due. This Policy, the Endorsements, and Your executed Application form the entire Agreement between Us. In issuing this Policy, We have relied upon the information including, but not limited to, the information above, supplied to Us during the underwriting process by: (1) You, (2) Your Claims Administrator, and (3) Your agent or broker. We have also relied on this information being both complete and accurate in issuing this Policy.

This Policy may be renewed for subsequent Policy Terms in accordance with the renewal terms outlined in this Policy. Such renewal may be subject to revisions in the terms and conditions of coverage under this Policy.

THIS POLICY IS A LEGAL CONTRACT. PLEASE REVIEW YOUR POLICY CAREFULLY.

Signed for Pennsylvania Manufacturers' Association Insurance Company by

Derek Hopper, CEO

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SECTION 1 – INSURANCE COVERAGE

[A. Aggregate Coverage

Subject to all the terms, conditions and limitations of this Policy and any attached endorsements, We will reimburse You for Eligible Claims Expenses that exceed the Annual Aggregate Attachment Point. All claims are subject to Our Claim Audit provision under Section 8, Claims.

When Benefits will be Paid.
Upon acceptance of Proof of Loss, as described in Section 8, Claims, and subject to all terms, provisions, Limitations and Exclusions of this Policy, We will reimburse You for Eligible Claims Expenses under Aggregate Coverage after the end of the Benefit Period, provided the Annual Aggregate Attachment Point for claims Paid, as described below, is satisfied. Eligible Claims Expenses must be:

1. Incurred while the Plan is in force.
2. Paid on behalf of a Covered Person according to the terms of the Plan; and
3. Incurred and Paid during the Benefit Period shown in the Schedule of Insurance.

Amount of Benefits Payable.
The Aggregate Coverage benefit payable shall be equal to the product of:

1. The Aggregate Payable Percentage, multiplied by
2. The amount of Eligible Claims Expenses paid by You, less, the Annual Aggregate Attachment Point for the Benefit Period.

The following are not considered Eligible Claims Expenses under Aggregate Coverage and are not eligible for reimbursement:
1. Benefits payable or paid under any Specific Coverage issued to You by Us or any policy issued by another insurer providing the same or similar coverage; or
2. Eligible Claims Expenses in excess of any Specific Attachment Point.
3. Eligible Claims Expenses in excess of the Aggregate Claim Limit Per Covered Person.

The Aggregate Payable Percentage and Benefit Period is shown in the Schedule of Insurance. In no event will We reimburse You more than the Maximum Aggregate Reimbursement as shown in the Schedule of Insurance.

To Whom Benefits will be Paid.
Aggregate Coverage benefits will be paid directly to You or Your designated representative. We will not make payment to any Covered Person, Provider or anyone other than You or Your designated representative.]

[B. Specific Coverage

Subject to all the terms, conditions and limitations of this Policy and any attached endorsements, We will pay You a Specific Coverage benefit as it becomes due for claims for Eligible Claims Expenses in excess of the Specific Attachment Point. All claims are subject to Our Claim Audit provision under Section 8, Claims.

When Benefits Will be Paid.
Upon acceptance of acceptable Proof of Loss as described in Section 8, Claims, and subject to all terms, provisions, Limitations and Exclusions of this Policy, We will reimburse You for Eligible Claims

Expenses that are:

1. Incurred while the Plan is in force.
2. Paid on behalf of a Covered Person according to the terms of the Plan; and
3. Incurred and Paid during the Benefit Period shown in the Schedule of Insurance.

Amount of Benefits Payable.
Subject to the Maximum Specific Benefit Limit(s) shown in the Schedule of Insurance, the Specific Coverage benefit payable shall be equal to the product of:

1. The Specific Payable Percentage, multiplied by
2. The Eligible Claims Expenses Paid to or on behalf of a Covered Person under the Plan during the Benefit Period that exceeds the Specific Attachment Point.

To Whom Benefits Will be Paid.
Specific Coverage benefits will be paid directly to You or Your designated representative. We will not make payment to any Covered Person, Provider or anyone other than You or Your designated representative.

SECTION 2 – DEFINITIONS

The definitions of terms apply wherever the terms are used anywhere in this Policy.

Actively at Work means an individual [, associate or member] is employed by the Policyholder, and is capable of performing his regular duties for the full number of hours and at the full rate of compensation as set by the Policyholder's employment practices, either at one of the individual's usual places of business or at some other location to which the Policyholder business requires the individual to travel. Any person who is absent from work due to a regularly scheduled vacation, holiday, or Policyholder approved paid leave of absence will be considered to be Actively at Work.

Aggregate Claim Limit Per Covered Person means the maximum amount of Eligible Claims Expenses for any one person that will be counted towards satisfaction of the Annual Aggregate Attachment Point under the Aggregate Stop Loss. This amount is shown in the Schedule of Insurance.

Aggregate Coverage means the benefit provided by Us to You under this Policy for reimbursement of Eligible Claims Expenses that exceed the Annual Aggregate Attachment Point.

Aggregating Specific Deductible means a deductible applied in addition to the Specific Attachment Point. Eligible Claims Expenses for each Covered Person in excess of the Specific Attachment Point multiplied by the Benefit Percentage Payable will be added together until the cumulative total equals the Aggregating Specific Deductible amount shown in the Schedule of Insurance. [If the Aggregating Specific Deductible amount shown in the Schedule of Insurance is a Per employee per month composite rate, the Aggregating Specific Deductible will equal the cumulative amount of the monthly employee reported lives multiplied by the Per Employee per month composite rate.] A Specific Stop Loss reimbursement will not be paid until the Aggregate Specific Deductible has been satisfied.

Annual Aggregate Attachment Point means the amount of Eligible Claims Expenses covered under this Policy that are wholly retained by You, before an Aggregate Coverage benefit will be paid to You.

It is the greater of:

1. the sum of Monthly Aggregate Attachment Points for each month of the Policy Term, determined by multiplying the total number of Covered Units by the Monthly Aggregate Factor amounts; or
2. the Minimum Annual Aggregate Attachment Point shown in the Application and Schedule of Insurance.

Benefit Period means the period as shown in the Schedule of Insurance that identifies the time period during which Eligible Claims Expenses are eligible for reimbursement under this Policy. This period does not alter the Policy's effective date or Policy Term but includes any Run-In or Run-Out Periods shown in the Schedule of Insurance.

Claim Administrator means the firm or person, shown in the Schedule of Insurance, that has entered into a written agreement with You to administer and pay claims for Your Plan. The Claim Administrator acts on Your behalf and as Your agent and not as Our agent.

Cost Containment Program means any third party contracted by You, your Claims Administrator or Us, to reduce or control the cost of services or supplies provided to Covered Persons under the Plan.

Covered Person means a person who meets the terms and conditions of eligibility for coverage set forth in Your Plan, and who is enrolled, covered, and for whom required premium contributions to the Plan have been made.

Covered Service means any service, supply or treatment for which the Covered Person has Incurred an Eligible Claims Expense during the Benefit Period and for which benefits are paid through the Plan.

Covered Unit means a category of participants under Your Plan as shown in the Schedule of Insurance. Covered Unit will be used for the purposes of determining the Annual Aggregate Attachment Point and premiums payable by You.

Disclosure Statement means the disclosure statement submitted by You to Us in connection with the issuance of this Policy which identifies and provides the claim information and other documentation, or data requested by Us.

Eligible Claims Expense(s) means an expense Incurred for a Covered Service under the terms of the Plan, which You or Your Claim Administrator have Paid for a Covered Person.

This term does not include an expense:

1. Not specifically included under the terms of the Plan.
2. Excluded under the terms of the Plan.
3. Excluded under the terms of this Policy, or shown in Special Risk Limitations; or
4. Paid but subsequently recovered by You from any third party.

Experimental or Investigational means a medical service, treatment, or supply that:

1. Has not been approved by the United States Food and Drug Administration (FDA) for the service, treatment, device, drug or supply for a particular condition or diagnosis at the time the treatment, procedure, device or drug is provided.
2. Is provided as part of an ongoing Phase I, II or III clinical trial, or is under study to determine its maximum tolerated dose, its safety, its efficacy, or its toxicity as compared

with the standard means of treatment for a condition or diagnosis.

3. Is the subject of documentation in published U.S. peer reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine the safety, toxicity or efficacy of the treatment; or
4. Is being provided subject to the Covered Person's execution of an informed consent that references determinations of safety, toxicity or efficacy in comparison to conventional alternatives.

To determine if a medical service, treatment, or supply is Experimental or Investigational, the Company will rely on recognized medical sources such as, but not limited to, the American Medical Association, FDA, Department of Health and Human Services, National Institutes of Health, Council of Medical Specialty Societies, American Hospital Formulary Services Drug Information, American Academy of Pediatrics, and other accepted medical authorities and sources.

Family means an employee and the eligible dependents of such person who are covered, or who become eligible for coverage in Your Plan.

Incurred means the date on which services, supplies, or treatment for an Eligible Claims Expense were provided to a Covered Person under Your Plan.

Individual Specific Attachment Point means a separate Specific Attachment Point for the Covered Person(s) or Classes identified under Special Risk Limitations in the Schedule of Insurance, which You must retain before any Specific Coverage benefits become payable under this Policy with respect to those Covered Persons or Classes.

Key Policy Factors means, as applicable, the Specific Premium Rate per Policy Month per Covered Unit, the Aggregate Premium Rate per Policy Month per Covered Unit, the Monthly Aggregate Factors per Covered Unit, and the Specific Attachment Point(s), as shown in the Schedule of Insurance.

Material Change means any amendment or change in Your business that may result in an adverse effect, financial or economic, on Our liability or risk under this Policy. A Material Change includes a change to any of the following:

1. The information in Your Disclosure Statement upon which Our assessment of liability or risk was based;
2. The Plan description, eligibility requirements, limitations or exclusions, and any amendments or addendums thereto.
3. The Claim Administrator.
4. The Prescription Benefit Manager.
5. The Provider Network.
6. The Reference Based Pricing Vendor.
7. An increase or decrease in the number of Covered Persons that exceeds 15 % of the Covered Units shown in the Schedule of Insurance.
8. Your insolvency, filing for bankruptcy, or inability to pay general obligations or obligations under the Plan. or
9. A merger, acquisition, change of ownership, or similar transaction involving You or any of the subsidiaries or associated entities named in the Schedule of Insurance.

Medically Necessary means a medical treatment, service, device, drug or supply that:

1. Is appropriate and essential for the diagnosis or treatment of the Covered Person's condition; or
2. Is needed to restore function and prevent deterioration of the Covered Person's health.
3. Does not exceed the scope, duration or intensity of that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.
4. Is in accordance with generally recognized current professional medical practice, as a standard of care for the control or cure of the illness or injury being treated by physicians practicing in the same or related specialty field.
5. Is not Experimental or Investigational or related to a medical treatment, service, device, drug or supply that is Experimental or Investigational.

A treatment, service, device, drug or supply will not be considered Medically Necessary if it is provided primarily as a convenience to the Covered Person or Provider.

The fact that a physician may prescribe, order, recommend or approve a treatment, service, supply or medicine does not, of itself, make it Medically Necessary.

Minimum Annual Aggregate Attachment Point means the amount shown in the Schedule of Insurance which is the minimum amount of Eligible Claims Expenses for the Policy Term that You must retain before We reimburse You for any benefits You Paid under the Plan.

Monthly Aggregate Attachment Point means the Monthly Aggregate Factor multiplied by the number of Covered Units reported by You or Your Claim Administrator at the start of the Policy month.

Monthly Aggregate Factor means the factor shown in the Schedule of Insurance that is multiplied by the number of Covered Units for each Policy month and used in calculating the Annual Aggregate Attachment Point.

[Monthly Expected Claims means the amount of expected claims per month per Covered Unit. The initial Monthly Expected Claims are as shown in the Schedule of Insurance. We will recalculate the Monthly Expected Claims on the effective date of any Material Change.]

Paid means the date Eligible Claims Expenses have been processed and approved for payment by the Policyholder or the Policyholder's Claim Administrator in accordance with the Policyholder's or Claim Administrator's standard business practices, and funds have been disbursed by the Policyholder or the Claim Administrator for payment of the claim expenses to a Covered Person or Provider. Disbursement is considered to have occurred when the draft or check is mailed, or the wire or other legal electronic transfer of funds has been issued by You to the Covered Person or Provider.

In addition, the account upon which payment is drawn must contain sufficient funds on the date the check, draft, wire, or other legal electronic transfer is issued to permit the check, draft, wire, or other legal electronic transfer to be honored by the institution upon which it is drawn in order for Eligible Claims Expenses to be considered Paid. If for any reason a draft or check is voided or returned, or a wire or legal electronic transfer is not honored, the Eligible Claim Expense will not be considered Paid.

Prescription Benefit Manager means a third party separate from the Claim Administrator contracted by You to administer the prescription drug benefit program under Your Plan. The Prescription Benefit Manager is shown in the Schedule of Insurance.

Plan means a self-funded, detailed, written employee welfare benefit plan under which the Policyholder provides benefits for Covered Persons and their eligible dependents, and which has been provided to Us prior to issuing this Policy for the purpose of determining Our liability.

Policy means this Stop Loss Insurance Policy issued by the Company to the Policyholder.

Policyholder, You and Your means the Policyholder shown on the face page of this Policy.

Policy Term means the time period shown on the Schedule of Insurance unless coverage terminates earlier in accordance with the Termination provision of this Policy.

Prescription Drug Plan means either a benefit provision of the Plan or a separate benefit plan maintained by You, under which prescription drug expenses are paid independently of other medical expenses.

Provider means any hospital, physician or other person or facility that is licensed and operating within the scope of that license to provide health care services.

Provider Network means a list of the doctors, other health care Providers, and hospitals that a Plan has contracted with to provide medical care to its members.

Reasonable and Customary means the reasonable charge for the same or comparable service or supply in the geographic area in which the service or supply is furnished. Reasonable and Customary Charges include but are not limited to:
1. The amount of resources expended to deliver the treatment.
2. The complexity of the treatment rendered.
3. Charging protocols and billing practices generally accepted by the medical community.
4. Any applicable Cost Containment Program.

Reference Based Pricing Vendor means a third party separate from the Claim Administrator contracted by You to administer Your Plan benefit payments using a reference based pricing mechanism.

Run-In Period means the period immediately preceding the Policy Term during which period an Eligible Claims Expense Incurred may be covered under the Policy according to the Schedule of Insurance.

Run-Out Period means the period immediately following the end of the Policy Term. During this period Eligible Claims Expenses Incurred during the Policy Term but Paid after the end of the Policy Term may be covered under the Policy according to the Schedule of Insurance.

Specific Annual Maximum Reimbursement means the maximum amount of Eligible Claims Expenses We will apply towards the Specific Coverage for a Covered Person during the Benefit Period. The Specific Annual Maximum Limit is shown in the Schedule of Insurance.

Specific Payable Percentage means the percentage of Eligible Claims Expense We will consider eligible for reimbursement after the application of the Specific Attachment Point subject to any Specific Risk Limitation.

Specific Coverage means benefits provided by Us to You under this Policy for reimbursement of Eligible Claims Expenses that exceed the Specific Attachment Point(s).

Specific Attachment Point means the amount of Eligible Claims Expense which must be Incurred by a Covered Person and Paid under the Plan which is wholly retained by You, and which must be met before benefits are reimbursable under the Specific Coverage of this Policy, as shown on the Schedule of Insurance.

Specific Lifetime Maximum Limit means the maximum amount of Eligible Claims Expense We will apply towards the Specific Coverage benefit for a Covered Person during the Covered Person's lifetime. The Specific Lifetime Maximum Limit is shown in the Schedule of Insurance.

SECTION 3 – EXCLUSIONS AND LIMITATIONS

If You or Your Claim Administrator fails to disclose to Us any illness or medical condition(s) of a Covered Person known to You or Your Claim Administrator at the time Application is made for this Policy, or who later becomes eligible for benefits under Your Plan:

1. We will not reimburse You for any benefits paid related to the illness or condition that was required to be disclosed; and
2. Such benefits paid under the Plan may not be used to satisfy the Specific Attachment Point for such Covered Person ; and
3. Such benefits paid under the Plan may not be used to satisfy the Aggregate Attachment Point.

The following are not Eligible Claims Expenses regardless of whether such expenses are paid under the Plan, and are not eligible for reimbursement under this Policy:

1. Any portion of an expense which You are not obligated to pay under the Plan, or which is reimbursable to You pursuant to or because:
   a. Other insurance is or may be liable.
   b. Another group health benefit program is or may be liable.
   c. The Covered Person is covered under Medicare, the Railroad Retirement Act of 1974, or any similar federal, state, or local program or statute, or treatments that are provided and covered under the programs listed above.
   d. Services or supplies for the treatment of an occupational injury or sickness which are eligible for or paid under any Workers' Compensation, occupational disease law or similar law.
   e. Any coordination of benefits or non-duplication of benefits provision of the Plan; or
2. Expenses covered by Plan changes made prior to Our approval of these changes.
3. An amount which is Paid by the Policyholder in excess of the amount a Provider of hospital, surgical or medical services bills a participant for a Covered Service, unless required by a negotiated fee agreement.
4. Preferred Provider Organization (PPO) access fees.
5. Benefits paid under the Plan which are in excess of Reasonable and Customary Charges.
6. Benefits paid under the Plan that result from any treatment, service or supply that is not Medically Necessary.
7. Expenses associated with the administration of the Plan including, but not limited to, claim payment fees, premium functions, medical review and consultant fees, any tax liability,

interest, or penalty imposed by any regulatory or taxing authority.

8. Expenses paid by You or the Claim Administrator relating to any litigation concerning the Plan, including, but not limited to, attorneys' fees, legal or investigative expenses, expert fees, extra-contractual damages, compensatory damages, and punitive damages.
9. Expenses Incurred by any Covered Person, or expenses Paid by the Plan for a Covered Person who is covered under or eligible to be covered under COBRA:
    a. whose continuation of coverage was not offered in accordance with COBRA regulations or any amendments thereto.
    b. whose coverage under COBRA is continued beyond the timeframes specified by federal law for any reason including clerical error of the Policyholder.
    c. who do not receive a valid COBRA extension offer within the required number of days following the date of notice of a COBRA qualifying event.
    d. who fail to make a valid, signed COBRA election within the required number of days following the receipt of COBRA election rights from the Policyholder; or
    e. who fail to remit COBRA premium within the minimum periods specified by federal law.
10. Expenses incurred and paid prior to the date a Covered Person Employed by You meets the definition of Actively at Work.
11. Benefits paid for expenses for medical services, supplies, or treatment received outside of the United States except in an emergency, and only if otherwise covered by Your Plan.
12. Expenses Incurred for any illness or injury resulting from war or an act of war, whether declared or undeclared.
13. Expenses for injury or complications from an injury sustained by a Covered Person during the commission of a felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation.
14. Expenses for Experimental or Investigational medical services, supplies or treatment or hospital confinement that results from Experimental or Investigational treatment.
15. Liabilities, expenses, or losses that would not have been incurred but for the noncompliance or violation of any federal or state statute, rule or regulation by You or the Claim Administrator.
16. Expenses that, if reimbursed by Us, would violate any applicable federal law or state statute.
17. Claim payments not administered or paid according to the Plan, or for which there is no documented Proof of Loss.
18. Expenses that are the result of Provider error(s).
19. Expenses that are the result of facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to Centers for Medicare and Medicaid Services (CMS) guidelines.
20. [Expenses or charges associated with an organ, tissue, bone marrow, or stem cell transplant.]

We will not reimburse You for any expenses paid by You when a Covered Person is covered by other insurance or health benefit plan which, when combined with the benefits payable by such other insurance or plan, would cause the total paid by that plan and Your Plan to exceed 100% of the Covered Person expenses.

We will not reimburse You for the portion of any expense due to Your or Your Claim Administrator's failure to provide payment to Providers in their required time frame that results in non-receipt of any discounted fees for services or supplies. We will reimburse only for the amount of the discounted amount had timely payment been made by You or Your Claim Administrator.

SECTION 4 – PREMIUMS

Payment of Premiums. No coverage under this Policy shall be in effect until the first premium for the Policy is paid. The premium rate(s) for coverage provided under this Policy is shown in the Schedule of Insurance. The premium due each month is calculated based upon the types of Covered Units shown in the Schedule of Insurance and number of Covered Units reported in the Policy month.

The first premium is due and payable on or before the first day of the Policy Term and subsequent premium payments are due on the first day of each [month]. Subject to the Grace Period, each premium must be paid on or before its due date in order for coverage under this Policy to remain in effect.

Premium Change. The initial premium rate(s) are stated in the Schedule of Insurance. We may change the premium rate(s) if:

1. You make a Material Change that affects this Policy; or
2. Coverage changes due to the addition or deletion of endorsements to the Policy; or
3. The coverage provided under this Policy is changed from what was initially issued based on the Application for coverage.

Grace Period. We will allow a 31 day Grace Period for the payment of each premium due after the payment of the first premium. During this Grace Period, this coverage shall remain in force unless the Policyholder gives us written notice of termination. If any premium is not paid within this 31 day period, coverage under this Policy will immediately terminate without further notice. Such termination will be effective as of the premium due date immediately following the end of the last period for which the minimum monthly premium has been paid.

Reinstatement. In the event that this Policy is terminated due to nonpayment of premium, at Your request We may agree to reinstate this Policy. We may undertake a reassessment of Our liability or risk under this Policy prior to reinstatement. You must make full payment of all past due premiums. Past reinstatements create no right or presumption of future reinstatement.

SECTION 5 –TERMINATION

Policy Termination:

Termination by Policyholder. You may terminate this Policy by giving Us written notice specifying the termination date. The termination date cannot be earlier than the date We receive your notice.

Automatic Termination. This Policy will automatically terminate without notice on:

1. The last day for which premium was paid if You fail to pay the required premium by the end of the Grace Period; or
2. The last day of the Policy Term.

Termination by the Company. This Policy will terminate on the earliest of the following circumstances:

1. The date We notify You that We are terminating the Policy due to a Material Change.
2. The date You have refused to accept any necessary adjustment to the premium or other terms and conditions of the Policy due to a Material Change, in accordance with that provision.
3. The date the Plan terminates.
4. The last day of the month after We notify You that We have become aware there are less than 51 covered employees enrolled under the Plan.
5. You or the Claim Administrator fail to satisfy any of Your or the Claim Administrator's obligations under this Policy. We will give You [60] days advance notice of termination.
6. The date You file for bankruptcy, or become subject to liquidation, receivership or conservatorship.
7. The date the contractual agreement between You and the Claim Administrator terminates unless We have agreed in writing to a new Claim Administrator.
8. The date mutually agreed to by the Policyholder and the Company.

Termination shall be without prejudice of any claim for reimbursement of Eligible Claims Expenses Incurred and Paid while coverage was in effect. In the event of termination, We will return the unearned portion of any premium paid.

If this Policy is terminated prior to the last day of the Policy Term, the Policy Term will be shortened to reflect the revised termination date of the Policy. The Benefit Period, as shown in the Schedule of Insurance, will also be reduced as necessary to match the shortened Policy Term.

Renewal. Unless this Policy is terminated prior to the end of the Policy Term, You may request, and We may agree to renew this Policy upon Your request.

Renewal is subject to Your completion of a Renewal Endorsement and Our receipt of any requested claim information prior to the beginning of the subsequent Policy Term, as well as Your written acceptance of the terms and conditions that apply to the renewal prior to the beginning of the subsequent Policy Term. We reserve the right to revise the terms and conditions, including Key Policy Factors, that apply to the renewal Policy.

SECTION 6 – MATERIAL CHANGES

Material Change. You must give Us written notice within 31 days of any Material Change that may have a material financial or economic adverse effect on Our liability under this Policy. Failure to provide such notice may result in termination of this Policy or denial of benefits. Notice must be provided to Our address shown in this Policy.

Upon receipt of a Material Change We reserve the right to:

1. Accept the Material Change and recalculate Key Policy Factors as shown in the Schedule of Insurance and/or other terms and conditions of this Policy.
2. Not accept the Material Change and terminate this Policy.
3. Not accept the Material Change and pay benefits under this Policy as if the Material Change had not occurred.
4. Accept the Material Change without revising the Premium Rates and/or other terms and conditions of this Policy.

If We accept the Material Change, We will consider the Material Change approved on the date of Our acceptance of the Material Change. You must provide written acceptance of any necessary adjustment to the premium or provisions of this Policy.

Plan Amendments. You must give Us written notice of any amendment to the Plan at least 31 days prior to the effective date of the amendment. If the amendment changes the benefits under the Plan, the Key Policy Factors will be recalculated. Any revision(s) to Your Key Policy Factors due to an amendment of the Plan will become effective on the effective date of the amendment. If We receive a written notice of an amendment to the Plan after the effective date of such amendment, We will advise if benefits are payable based on Your Key Policy Factors calculated (1) without the amendment, or (2) with the amendment.

SECTION 7 – POLICYHOLDER REPORTING

Reporting Requirements. You are required to provide periodic reports on Eligible Claims Expenses and enrollment information for Covered Persons in the Plan to Us as described below.

High Dollar Reporting Threshold. For Specific Coverage benefit reporting, You or the Claim Administrator must give notice to Us when the total amount of Eligible Claims Expenses for a Covered Person equals or exceeds the High Dollar Reporting Threshold of 50 percent of the Specific Attachment Point per Covered Person or has the potential to exceed that amount. Notice must be provided within 30 days.

You or the Claim Administrator are required to provide Us with notice of any claim that exceeds the High Dollar Reporting Threshold within 30 days of the earlier of the date:

1. A Covered Person's Eligible Claims Expenses exceed High Dollar Reporting Threshold; or
2. You or the Claim Administrator or Your medical management, utilization review, Prescription Benefit Manager, precertification vendors, or any other party acting on Your behalf, are notified that a Covered Person has been diagnosed with, or treated for, a condition which may result in an Eligible Claims Expense under this Policy that would equal or exceed the High Dollar Reporting Threshold.

On a monthly basis, You or the Claim Administrator and the Prescription Benefit Manager are required to provide Us with a detailed claims report in an electronic format prescribed by Us that shows, for each Covered Person who meets or exceeds the High Dollar Reporting Threshold:

1. Proof of payment of any expenses submitted to Us for reimbursement; and
2. Information used to determine how the claim was Paid by You or the Claim Administrator or the Prescription Benefit Manager.

You shall provide any additional information We may require to fulfill Our obligations under this Policy.

In addition, on a monthly basis, You or the Claim Administrator and the Prescription Benefit Manager are required to provide Us with the following:

1. A report including detailed demographic information for all Covered Persons in the Plan as listed for the Classes identified in the Schedule of Insurance.
2. Aggregate stop loss summary reports, including the total amount of Eligible Claims Expenses for all Covered Person Incurred within the Benefit Period, and Paid by You or on Your behalf during that month.

SECTION 8 – CLAIMS

Claim Audit. The Policyholder or the Policyholder's Claim Administrator shall keep appropriate records regarding administration of the Plan. We may periodically examine any of Your and/or the Claim Administrator's records relating to the benefits under this Policy and any claims filed under the Plan. You shall allow Us reasonable access to review and copy all records affecting Our Liability under this

Policy. We have the right to audit all claims with respect to Eligible Claims Expenses, in the event of a claim for benefits. You and the Claim Administrator shall maintain books and records related to this Policy for a period of no less than the later of 6 years or the term required by the State of jurisdiction, after the Policy expires or is terminated according to the provisions of this Policy. This clause shall survive the termination of this Policy.

Notice of Claim. Except for claims exceeding the High Dollar Reporting Threshold, which are subject to the notice requirements in Section 7, Policyholder Reporting, You will submit to Us written notice of claims within 30 days of the Eligible Claims Expense or as soon as reasonably possible. Failure to furnish written notice will not invalidate or reduce any claim, if it was not reasonably possible to provide such written notice within the time period required. We will furnish the Policyholder with claim forms for filing Proof of Loss within 15 days after receiving Notice of claim.

Proof of Loss. You or the Claim Administrator must request payment and provide complete and accurate Proof of Loss, in form and content acceptable to Us, to support a claim no later than within 90 days of the loss. You shall provide any additional information We may require to fulfill Our obligations under this Policy. If You do not provide Proof of Loss within 90 days, benefits will still paid for that loss if: (1) it was not reasonably possible to give proof within those 90 days; and (2) proof is provided as soon as reasonably possible but no later than 1-year after the end of those 90 days.

Cost Containment Program
We have the right to participate, at Our option and expense, in any savings or Cost Containment Program that You have in place or supplement Your Cost Containment Program with one of Our choice. If no such program exists, We have the right to retain the services of a third party to implement a Cost Containment Program.

Offset. Any payment or overpayment of a claim made to the Policyholder in error or due to the receipt of incorrect information must be promptly refunded to the Company upon notice to the Policyholder of the error or overpayment. We may offset any refund owed to the Company for such payment or overpayment or any premium owed to the Company against any reimbursement due the Policyholder.

Payment of Claims. All benefits payable under this Policy will be made within 30 days after receipt of due written Proof of Loss to You or Your designated representative and to no one else. In no event will We be liable for any claims which are not Incurred and Paid by the Policyholder within the Benefit Period indicated in the Schedule of Insurance.

Reimbursement of Certain Fees. Fees with respect to the following will be considered Eligible Claims Expenses subjected to terms of the Benefit Period stated on the Scheduled of Insurance:
1. Hospital bill audits.
2. Access to transplant Provider Networks.
3. Negotiation of out-of-network bills.
4. Claims repricing.

You must demonstrate to Our reasonable satisfaction that the services that generated the fees resulted in a cost savings to the Plan and Us. We will consider the actual fees paid by You to be an Eligible Claims Expense, subject to a maximum amount on such fees equal to 30% of cost savings to the Plan.

You or Your Claim Administrator will take all steps necessary to secure potential prompt payment discounts available by providing payment to Providers for services or supplies in their required time frame. However, if You lose a prompt payment discount for failure to pay within the required time frame due to Your negotiation of a discounted rate, We will base Our payment of Eligible Claims Expenses on the negotiated rate.

Responsibility for Claims under Your Plan. While the determination of benefits under the Plan is Your sole responsibility, We will interpret the terms and conditions of the Plan as it applies to this Policy. We have the authority to approve or deny benefit payments under this Policy.

SECTION 9 – CLAIM ADMINISTRATOR RESPONSIBILITIES

Claim Administrator Responsibilities. The Claim Administrator acts on Your behalf and as Your agent. We shall have no liability for any act or omission by the Claim Administrator. We agree to recognize the Claim Administrator as an agent of the Policyholder. By doing so we do not waive any rights under this Policy.

The Claim Administrator shall:

1. Investigate, audit, calculate, and pay claims in accordance with the Plan, and maintain an accurate record of all claims processed, including expenses not covered under the Plan.
2. Keep and make available to the Company any information possessed by the Claim Administrator to assist the Company in underwriting or administering this Policy, make payments under this Policy, or project future expected claims under the Plan; and
3. Submit a monthly report in an electronic format acceptable to Us, that meets the Reporting Requirements under Section 7, Policyholder Reporting, showing a detailing listing of Paid claims and enrollment numbers detailed by coverage type.

You are solely responsible for the actions of the Claim Administrator and any other agent acting on Your behalf. The Claim Administrator is not Our agent and does not act on Our behalf. We are not responsible for any compensation owed to, or claims by, the Claim Administrator or other agents for services provided to, or on behalf of, You or the Plan. This Policy does not make Us a party to any agreement between You and the Claim Administrator, nor does it make the Claim Administrator a party to this Policy.

Claim Administrator Changes. You must give Us written notice of any replacement of a Claim Administrator listed in this Policy at least 31 days prior to the effective date of the replacement. If We do not receive such notice from You prior to the effective date of the replacement, We will have the right to terminate this Policy in accordance with the Termination by the Company provision in Section 5, Effective Date and Termination.

SECTION 10 – GENERAL PROVISIONS

Arbitration. If mutually agreeable, any controversy or dispute involving Us that arises out of or relates to this Policy, shall be decided by arbitration in the city of the Policyholder's principal place of business, under the rules of the American Arbitration Association. The Policyholder and the Company will each appoint one member of the arbitration panel. The third member will be selected by the first two members or by the American Arbitration Association if the two parties cannot agree on the third

arbitrator. A majority vote of the panel will decide the dispute and there will be no right of appeal, unless otherwise permitted by the rules of the American Arbitration Association. Any decision of the arbitration panel shall be binding and fully enforceable as if rendered in a court of competent jurisdiction. The cost of arbitration shall be paid by Us, to include any deposits or administrative fee required to commence a dispute in arbitration, as well as any other fee including an arbitrator's fee. Where there is an inconsistency between the terms of this Policy and American Arbitration Association rules, this Policy will govern. This provision shall survive the termination of this Policy.

Assignment. This Policy and amounts payable shall not be sold, assigned, or transferred by You without Our prior written consent.

Clerical Error. Clerical error, whether by You or by Us, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated. However, upon discovery of such error, an equitable adjustment of premium or benefits will be made. In the event that claims data and/or enrollment information furnished to Us was missing or incorrect, We may recalculate the Key Policy Factors as shown in the Schedule of Insurance using the corrected information.

Conformity with State Statutes. Any provision of this Policy which, on the effective date of this Policy, conflicts with any law of the state where this Policy is issued, shall be deemed to be automatically amended to conform to the minimum requirements of such law.

Entire Contract. The entire contract between You and Us consists of:

1. The Policy including the Schedule of Insurance.
2. Your Application (a copy of which is attached to this Policy).
3. Any endorsements included with and made part of this Policy.
4. The Disclosure Statement (a copy of which is attached to this Policy).

In the absence of fraud, all statements made by You shall be deemed representations and not warranties. No such statement shall be used in defense of a claim under this Policy unless it is contained in the written Application and is signed by You and is attached to this Policy.

Indemnification. You agree to indemnify, defend and hold Us harmless from any liability, damages of any kind, interest, penalties, or expenses (including without limitation, attorney fees) arising from, relating to or concerning in any way whatsoever, any dispute or legal action by or involving a Covered Person, Provider or any State or Federal Authority.

Independent Review Organization Extended Benefit. If previously denied Eligible Claims Expenses for a Covered Person are Paid due to a reversal by an independent review organization, and such expenses are then Paid after the Benefit Period, the Benefit Period to pay such expenses will be extended for a period not to exceed 12 months, and such expenses will be excluded from any other benefit period in a subsequent policy. We will consider the date the claim was originally denied as the "Paid" date under this Policy, provided:

1. Such expenses are not eligible for payment under any other policy or group health benefit program; and
2. Such expenses are otherwise payable under the terms of this Policy.

If You terminate this Policy for any reason prior to the last day of the Policy Term shown on the face page of this Policy, this provision will not apply.

Legal Action. Legal action may not be taken to recover on this Policy until 60 days after the date Proof of Loss has been furnished in accordance with the terms of this Policy. Legal action must be taken within 3 years after the time Proof of Loss is required to be furnished.

Misrepresentation/Misstated Data. We have relied upon underwriting information provided by You or the Claim Administrator. If:

1. You make any material misstatement, omission or misrepresentation, whether intentional or unintentional, in the information or documentation that You , the Claim Administrator or any other party acting on Your behalf provide to Us, and which We rely upon during the underwriting of this Policy; or
2. After this Policy is issued, We learn of any expense or claim that was Incurred or Paid, but not reported to Us during the underwriting of this Policy,

We may deny a claim, rescind or cancel this Policy or revise the Key Policy Factors and terms, conditions and limitations of this Policy in accordance with Our underwriting practices in effect at the time the Policy was underwritten. Any such revisions may be made retroactive to the effective date of this Policy. This Policy will be incontestable after 2 years from the Policy Effective Date, except for fraudulent misstatements. No statements made by the Policyholder shall be used to void this Policy or deny a claim for loss after it has been in force for 2 years from the Policy Effective Date unless the statement is contained in a written statement signed by the Policyholder.

Non-Participating. This Policy does not pay a dividend and You shall not be entitled to share in Our surplus earnings.

Parties to the Contract. The Policyholder and the Company are the only parties to this Policy. The Company's sole liability under this Policy is to the Policyholder. We will neither have the right or obligation under this Policy to directly pay any Covered Person or Provider of Covered Services for any benefit that You have agreed to provide through the terms of the Plan. This Policy does not create any right or legal relationship between the Company and any Covered Person or Provider under the Plan. This Policy will not make Us a party to the Plan, or any contract or agreement between the Policyholder and a third party. The Company's obligations under this Policy are limited to the terms, conditions and limitations herein. We are not a plan administrator or a fiduciary with respect to the Plan as those terms are used in the Employee Retirement Income Security Act of 1974, as amended.

Policy Amendments/Changes. No change in this Policy is valid unless it is in writing, approved and signed by one of Our executive officers, and endorsed on or attached to this Policy. Agents or brokers do not have the right to change this Policy, waive any of its provisions, or bind Us in any way.

Reimbursement. Your rights under the Plan to recover sums from third parties Paid during the Benefit Period on behalf of a Covered Person are assigned by You to Us to the extent We reimbursed such sums under this Policy. You agree to promptly recover such sums on Our behalf, at Your cost, by initiating legal action or other effective means. Within 10 days of initiating any action or other means for recovery, You shall notify Us, and We shall have the right to intervene in any suit or other proceeding to protect Our reimbursement rights. We shall be entitled to receive full reimbursement of benefits We paid under this Policy.

Any portion of an Eligible Claims Expense which You recover from a third party:

1. Is not eligible for reimbursement under this Policy; and
2. Cannot be used to satisfy any Attachment Point under this Policy; and
3. Must be repaid to Us if We previously paid You for it.

Any repayment amount You owe Us may be reduced, 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.

If less than the full value of the legal action is recovered for any cause, then the claim shall be diminished in the same proportion as the injured party's interest is diminished. We shall be entitled to recover first up to Our full share of reimbursed claims before the Policyholder shares in any amount recovered whether by way of subrogation or otherwise.

State Assessment Loads. State and Federal laws may assess stop loss insurance carriers based on the number of that state's residents who are covered under stop loss policies. We may increase or adjust the premium rate(s) to cover expected [, retrospective,] or incurred state assessment costs.

State Health Care Surcharges. If You pay a state health care surcharge in connection with the payment of Eligible Claims Expenses, the health care surcharge shall be [included or excluded] as an Eligible Claims Expense [provided that the charges were submitted and duly noted as such and provided that state health care surcharges, to the extent previously paid, were included in the claim experience reports You submitted to Us at the time of underwriting of this Policy]. Penalties or fines of any kind, including but not limited to, penalties or fines associated with the failure to pay or late payment of any health care surcharge or the underlying expenses will not be considered Eligible Claims Expenses.

U.S. Economic and Trade Sanctions. Should any coverage provided by this Policy be in violation of any U.S. economic or trade sanctions such as, but not limited to, those sanctions administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"), such coverage shall be null and void. Similarly, any coverage relating to any claim that would be in violation of U.S. economic or trade sanctions as described.

Your Bankruptcy or Insolvency. Eligible Claims Expenses will not be affected by Your bankruptcy or insolvency. In the event of Your bankruptcy or insolvency, subject to the terms, conditions, and limitations of this Policy, We may pay to Your receiver, trustee, liquidator, or legal successor amounts otherwise payable under this Policy. We will make such payments only if You have paid all required premiums and have Paid all Eligible Claims Expenses under the Plan and have complied with all Your obligations under this Policy. The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or the Policyholder's Claim Administrator will not impose upon Us any liability other than the liability defined in this Policy.