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

PLEASE READ THIS POLICY CAREFULLY

This is a REIMBURSEMENT POLICY ONLY between Us and You.
You, or Your plan administrator, are responsible for the administration of the Plan, including making all benefit determinations under the Plan. We have no duty, authority or obligation to administer, settle, adjust or provide advice regarding any claims filed under 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]**

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."

With respect to any date in this Policy, all days begin at 12:01:00 a.m. and end at 12:01 a.m. local standard time at Your address listed above.

Ralph Tortorella, Secretary

Peter Eastwood, President

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I. DEFINITIONS

Accumulated Aggregate Attachment Point: The greater of: (1) the sum obtained by adding the Monthly Aggregate Deductibles for each month from the start of the Policy Year to the date of the calculation; 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 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 before We will consider an Aggregate Benefit claim. It is the greater of: (1) the sum of the Monthly Aggregate Deductibles for the Policy Year; and (2) the Minimum Aggregate 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 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 as provided by this Policy.

Aggregate Deductible Factor ("ADF"): The deductible factor per Benefit Month for each Covered Unit by Covered Benefit, as shown on the Application.

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 applied against any Eligible Expenses that exceed the Specific Benefit Deductible for any Specific Benefit claim.

Benefit Month: Any calendar month during the Policy Year.

Claims Basis: The period of time as shown on the Application during which Eligible Expenses must be incurred by You and 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 the Plan that are insured for stop loss coverage under this Policy, as shown on the Application.

Covered Person: A person enrolled in the Plan and entitled to receive benefits under the Plan while this Policy is in effect. Retirees, as defined by the Plan, may be Covered Persons if they are shown as included in the Application under the Specific Benefit or Aggregate Benefit, as applicable (otherwise, they are not Covered Persons).

Covered Unit: A category of participants under the Plan (as shown on the Application).

Dependent: A person enrolled in the Plan and entitled to receive benefits under the Plan as a dependent of a Covered Person, including, but not limited to, 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 the Plan, then such individuals who are domestic partners under that state's law shall be considered Dependents under 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, but not limited to, information on Covered Units and Disclosed Risks.

Eligible Expenses: Amounts paid by You for Medically Necessary and Appropriate expenses incurred by a Covered Person that:

a. are the Usual and Customary Charge; and

b. have been paid in accordance with the terms of the Plan; and

c. were incurred and paid during the applicable Claims Basis; and

d. are paid under a Covered Benefit shown on the Application; and

e. are not otherwise excluded under this Policy.

Eligible Expenses will include such expenses related to Off-Label Drug Use if all of the following criteria have been satisfied (in addition to satisfying all of the criteria in a. through e. above):

f. the drug is not excluded under the Plan; and

g. the drug has been approved by the United States Food and Drug Administration ("FDA"); and

h. the drug is appropriate and generally accepted in the medical community for the condition treated; and

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

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

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 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 the Plan, but shall not include an independent contractor for whom no W-2 is issued.

Experimental or Investigational Treatment: 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:

a. the Treatment is governed by the 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 a Phase I and/or Phase II clinical trial as defined by the National Institute of Health, National Cancer Institute, or the FDA; or

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 the Plan.

Medically Necessary and Appropriate: 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 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 that You must pay before You become eligible for an Aggregate Benefit under this Policy. The Minimum Aggregate Deductible is shown on the 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 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 Effective Date: The date as shown for this on the Application (whether listed for a Specific Benefit or Aggregate Benefit) when such coverage first became effective between You and Us.

Paid: The date Your check or draft for payment of Eligible Expenses 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 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: 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 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 provision of the Plan, or a separate Employee Benefit Plan maintained by You, under which expenses for Prescription Drugs are paid independently of other medical expenses.

Provider Network: As offered under 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, 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.

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.

Specific Benefit Deductible: The amount of Eligible Expenses relating to any Covered Person(s) that You must pay separately for each Policy Year before You become eligible for a Specific Benefit, as shown on the Application, subject further to any applicable Aggregating Specific Deductible and/or Adjusted Specific Deductible Amount.

Specific Benefit Lifetime Maximum Eligible Expenses 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 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 or any subsequent renewal Policy Year(s) will apply toward the Specific Benefit Lifetime Maximum Eligible Expenses 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 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

The Specific Benefit for any Covered Person for any Policy Year equals the 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 (2) the Specific Benefit Deductible (or the Adjusted Specific Deductible Amount, if applicable) and minus (3) the Aggregating Specific Deductible (if applicable) or any remaining portion thereof.

As used herein, the amount of Eligible Expense for any Covered Person(s) is subject to: (1) the Specific Benefit Lifetime Maximum Eligible Expenses Per Covered Person; and (2) the Specific Benefit Annual Maximum Eligible Expenses Per Covered Person.

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 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 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)

The Aggregate Benefit equals 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 Covered Person) multiplied by the Related Provider Reimbursement Percentage (if applicable), minus the Aggregate Benefit Attachment Point.

The Aggregate Benefit will be calculated after the expiration of the applicable Claims Basis period, as shown on the Application.

However the amount payable under this Policy for the Aggregate Benefit will not exceed the Aggregate Benefit Maximum as shown on the Application.

III. LIMITATIONS AND EXCLUSIONS

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

a. expenses that are excluded (or otherwise not covered) under the Plan;

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;

c. expenses associated with the administration of the Plan, including, but not limited to, claim payment fees, cost containment administrative fees, Medical Management Vendor administration fees, PPO access fees, premium functions, and medical review and consultant fees, except for such expenses that are otherwise specifically approved by Us;

d. expenses paid by You relating to any litigation concerning the Plan, including, but not limited to, attorneys' fees, extra-contractual damages, compensatory damages and punitive damages;

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;

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;

g. expenses for any transplant if You have a separate insurance policy that covers transplants and/or transplant related expenses for any Covered Persons to the extent of the coverage for those expenses under that separate insurance policy;

h. any expense incurred by any Employee, or by the Employee's Dependents, if the Employee is a member of 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 of the Policyholder; or (2) an association, trust, cooperative or similar organization connected with the Policyholder;

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, but not limited to, 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. Claims submitted to Us that are not submitted in accordance with these proof of 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. Any proof of claim provided to us later than six months after the end of the Claims Basis period applicable to such Specific Benefit 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

b. complete details of the Covered Person's eligibility, including, but not limited to, their hire date, benefit plan effective date and, if applicable, their work status, Coordination of Benefits and COBRA (including a copy of the COBRA election form and COBRA payment verification for all months); and

c. proof of payment of any expenses submitted to Us for reimbursement under this Policy and/or a detailed claims report, which should include all of the following: dates of service, provider name, provider TIN, amount billed, discount amount, eligible amount, amount paid, date paid, reimbursement amount requested, previously paid amount, ICD codes and CPT codes; and

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 Claims Basis period for the Aggregate Benefit. Any proof of claim provided to us later than six months after the end of the Claims Basis period applicable to such Aggregate Benefit 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 that are incurred and paid during the applicable Claims Basis period; and

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

d. if Prescription Drug Plan coverage is included as a Covered Benefit on the 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 days from the date of Our initial claim determination. Your appeal should state the basis of Your disagreement with Our initial 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. Independent Review Organization Coverage:

In the event Eligible Expenses are paid by You for a Covered Person based on an Independent Review Organization's reversal of previously denied claims, and such expenses are paid after the last paid date provided in the applicable Claims Basis of this Policy, such paid Eligible Expenses shall be deemed to have been 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 reimbursement under the terms of this Policy.

You (either directly or 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 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 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 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 claim where the Independent Review Organization's reversal documentation, along with any other information necessary to process the claim, is not received within ninety days from the last date a claim is eligible for payment under the applicable Claims Basis period, or within ninety days of the date the claim was paid if paid after the applicable Claims Basis period has lapsed.

Fees, or any similar expenses, paid to the Independent Review Organization for their services are not reimbursable under this Policy. This 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 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, 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. Our failure to receive requested information 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 the Plan on the Original 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 represents to Us that:

(a) You or Your authorized representative have consulted with Your pharmacy benefit manager, Your precertification, utilization and Medical Management Vendors, 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 this Policy was underwritten, retroactive to the Original Effective Date (as such term applies for the Specific Benefit and/or Aggregate Benefit, as applicable).

3. Reporting Requirements

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, shall provide Us with notice of any potential Specific Benefit claim within thirty-one days of the date:

1. a Covered Person's Eligible 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, shall provide Us with a monthly report that lists:

1. the total amount of Eligible Expenses that are incurred by any Covered Person and paid by You, or paid on Your behalf, during the Benefit Month; and

2. the number of Covered Units, by type of Covered Unit, on the first day of the Benefit Month.

You shall provide such report to Us within thirty-one days after the end of each Benefit Month.

c. Renewal Reporting

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

1. monthly paid claims and enrollment data, organized by Covered Benefit; 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

3. a census of all Covered Persons; and a summary of the number of Covered Persons by workplace zip code (if this Policy covers Employees at multiple locations); and

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

5. a copy of all changes adopted by and/or proposed for the Plan.

4. Advance Notice/Approval of Changes

You shall notify Us in writing at least thirty-one days before the effective date of any change to the Plan, TPA, Provider Network(s), or Medical Management 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 to the Plan, Your TPA, Your Provider Network, or Your Medical Management Vendor.

5. Notice of Legal Action

You agree to give Us prompt notice of: (1) any event that might result in a lawsuit relating to this Policy; and (2) any lawsuit involving this Policy. Such notice shall include providing Us with copies of any non-privileged correspondence and pleadings relating to any such event or 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 become involved in 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 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 shall promptly refund such overpayment to Us within sixty 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, but not limited to, attorneys' fees and court costs.

8. Responsibility for Your TPA/Others

You are solely responsible for the actions of Your plan administrator, Your TPA, and any other Employee, agent or independent contractor of Yours. Your TPA acts on Your behalf, not on Our 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, 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, but not limited to, claims for restitution, constructive trust, equitable lien, breach of contract, injunction, and any other state or federal law claims You or the Plan may have against any third party responsible, in whole or in part, for any Eligible Expenses 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 reasonable 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 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 to determine whether an expense was paid by You in accordance with the terms of 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. assist Us with cost containment with respect to claims under the Plan; and/or

b. provide services to You, the Plan, or Plan participants to reduce cost, risk or expenses under the Plan.

We may 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 the 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

We may offset reimbursements due to You under this Policy against any claim overpayments by Us (except while You and We are working to resolve any disagreement regarding such overpayment) and premiums due and unpaid by You to Us.

6. Right to Recalculate

We have the right to recalculate any applicable Premium Rates, Specific Benefit Deductible, Aggregating Specific Deductible, Aggregate Deductible 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. the Plan changes; or

b. you change Your TPA, 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

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 three months immediately preceding the beginning of the Policy Year exceeds 125% of the monthly average of Eligible Expenses that are incurred during the nine months immediately preceding such three month period; or

g. there are changes in Your or Your TPA's claim paying system or practices that causes a variation of fifteen days or more in the most recent twelve month average 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 Year at Our election, which will be made in accordance with Our underwriting practices in effect at the time this Policy was underwritten. The right to recalculate shall survive the termination of this Policy.

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.

Any repayment You owe Us may be 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, the Plan or Your TPA shall not impose upon Us any obligations other than those set forth in this Policy.

C. 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. If any dispute cannot be resolved through such negotiations then You and We agree to submit the 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 days of either Party

requesting mediation then the dispute 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 the other Party until at least thirty (30) days after the final mediation session.

E. Entire Contract

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 of claim provisions of this Policy. Further, You may not bring any legal action against Us to recover on this Policy after three (3) years from the earliest date that proof of claim is required under the terms and conditions of this Policy**.** However if, under applicable law, such three year limitation period is invalid, then any such legal action shall be brought within the shortest limit of time permitted by law.

G. Misrepresentation

If:

1. You make any intentional misstatement, omission or misrepresentation in the Application, information or documentation You, Your TPA or any other party acting on Your behalf, provide to Us, which We rely upon during the underwriting of this Policy; or

2. after this Policy is issued, 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 rescind this Policy or to revise the premium rates, deductibles, and terms and conditions of this Policy in accordance with Our underwriting practices in effect at the time the Policy was underwritten, and any such revisions may be made retroactive to the Policy Effective Date.

H. No ERISA Liability

Under no circumstances will We accept responsibility as a "plan administrator" or be deemed a "plan fiduciary" with respect to the Plan under the Employee Retirement Income Security Act of 1974 (ERISA) or any amendment or revision thereto, including, but not limited to, amendments relating to the Consolidated Omnibus Budget Reconciliation Act of 1985, or any laws that are similar to ERISA.

I. Policy Amendment

No change to this Policy, or waiver of any of its provisions, will be valid unless such change or waiver is agreed to by You and Us in writing and made a part of this Policy. No agent, broker, TPA, 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 the Application we receive from You with respect to such renewal policy and, 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 Renewal Declarations and any endorsement(s), if required, shall constitute Your acceptance of such renewal policy.

K. Premium Provisions

a. Premium Payments

Premium is due on or before the premium due date. A grace period of forty-five 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 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. Premium Data

You must provide a report to Us with each premium payment, in a form satisfactory to Us, which lists: (1) the number of Covered Units, by each type of Covered Unit, for each Covered Benefit under the Plan on the first day of the Benefit Month; and (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 discretion, agree to reinstate it as of the date it terminated upon payment of all outstanding premiums. We may require You to provide certain information to Us before We will consider reinstating this Policy.

M. Singular and Plural Form of a Word

If the singular or plural form of a word is used in this 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 **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, but not limited to, 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 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 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 days advance written notice of such termination.

6. You may terminate this Policy at any time by providing Us with thirty-one 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.