AMERICAN ALTERNATIVE INSURANCE CORPORATION
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Statutory Office: 2711 Centerville Road, Suite 400; Wilmington, DE 19805
(a stock insurance company)

EXCESS LOSS INSURANCE POLICY

POLICYHOLDER: ABC COMPANY

POLICY NUMBER: 33A2ESXXXXXX

POLICY EFFECTIVE DATE: JANUARY 1, XXXX

American Alternative Insurance Corporation ("Company") agrees to reimburse the Policyholder as outlined under the provisions of this Excess Loss Insurance Policy ("Policy").

This Policy is legally binding between the Policyholder and American Alternative Insurance Corporation. The Company issues the Policy in consideration of the Policyholder's:

1. Application for Excess Loss Insurance, and
2. payment of premiums as provided hereinafter.

All periods of coverage will begin and end 12:01 a.m. local time at the principal office of the Policyholder.

This Policy is issued in and is governed by the laws of the state of Policyholder State .

IN WITNESS WHEREOF American Alternative Insurance Corporation has caused this Policy to be executed by its President and Secretary at the Company's Home Office.

President

Secretary

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

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SCHEDULE OF EXCESS LOSS INSURANCE ("SCHEDULE")

APPLICATION FOR EXCESS LOSS INSURANCE ("APPLICATION")

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

DEFINITIONS

ALTERNATIVE CARE means a plan of treatment, identified through case management services provided to the Plan, which substitutes an Eligible Expense under the Plan for another Eligible Expense under the Plan.

APPROVED CLINICAL TRIAL means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.

An Approved Clinical Trial must meet the following conditions:

1. The clinical trial is conducted by one of the following:
   a. A federally funded trial sponsored by the United States National Institutes of Health, Centers for Disease Control, Agency for Healthcare Research and Quality and Centers or Center for Medicare and Medicaid Services; or
   b. A cooperative group or center of the National Institutes of Health; or
   c. A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants; or
   d. A study conducted under an investigational new drug application reviewed by the United States Food and Drug Administration (FDA); or
   e. A drug trial that is exempt from the requirement of an FDA investigational new drug application; or
   f. A study by The United States Department of Defense, Department of Veterans Affairs, or Department of Energy if the study has been reviewed and approved through a peer review system comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; and

2. The patient is a Covered Person who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition, and determination has been made that the Covered Person's participation in the clinical trial is appropriate to treat the disease or condition; and

3. The Covered Person has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.

ASSESSMENTS means any charge assessed, including but not limited to service fees, healthcare surcharges, taxes, or premium rate loads, by a state or federal authority on the Company or Policyholder.

BENEFIT PERIOD means the period of time specified on the Schedule in which an Eligible Expense must be Incurred by the Covered Person and Paid by the Plan to be eligible for reimbursement under this Policy.

CLAIM ADMINISTRATOR means the entity that has entered into a written agreement with the Policyholder to pay claims and/or provide administrative services on behalf of the Policyholder. For purposes of this Policy, the Claim Administrator is solely the agent of the Policyholder and not the agent of the Company.

COVERED PERSON means**:**

1. An employee;
2. A dependent;
3. A participating COBRA Beneficiary; and
4. Retiree(s), if so indicated on the Application for Excess Loss Insurance.

COVERED UNIT means a category of participants under the Plan. The Covered Unit(s) for this Policy are shown on the Schedule.

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

EFFECTIVE DATE means the first day of the Policy Period as shown on the Schedule.

EMPLOYEE BENEFIT PLAN ("**PLAN**") means the self-funded health care plan established by the Policyholder to provide certain benefits to Covered Persons. The benefits are described in a written Plan Document.

EXPERIMENTAL OR INVESTIGATIONAL means, for the purpose of determining Eligible Expenses under this Policy, a treatment, device, supply, service, procedure or drug (other than covered Off-Label Drug Usage), which, in the discretion of the Company:

1. Is not yet fully approved or recognized (for other than experimental, investigational, research or clinical trial purposes) by the National Cancer Institute (NCI), Food & Drug Administration (FDA), or other pertinent governmental agency or professional organization, or are approved for a specific medical condition but applied to another condition.
2. Is not proven through controlled clinical trials with results published in peer-reviewed English-language medical journals, to be of greater safety and efficacy than conventional treatment, in both the short and long term.
3. Is not generally accepted medical practice in the state where the claimant resides or as generally accepted throughout the United States as determined in the Company's discretion, by reference to any one or more of the following: peer-reviewed English-language medical literature, consultation with physicians, authoritative medical compendia, the American Medical Association, or other pertinent professional organization or governmental agency.
4. Is described as investigational, experimental, a study, or for research or the like in any consent, release or authorization which the claimant, or someone acting on his or her behalf, may be required to sign.

INCURRED means, with respect to medical services or supplies, the date on which the services are rendered or supplies are purchased by the Covered Person; and, with respect to disability income benefits if selected on the Schedule, the date each periodic benefit payment becomes payable to the Covered Person (not the date the disability commences).

INDEPENDENT REVIEW ORGANIZATION ("IRO") means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

LOSS, LOSSES means amounts Paid by the Plan for Eligible Expenses.

MEDICALLY NECESSARY and APPROPRIATE means any procedure, treatment, service, supply, equipment, drug or medicine provided for the diagnosis and treatment of a specific illness or injury that is:

1. Ordered or recommended by a licensed physician, dentist, or other medical practitioner who is practicing within the scope of his or her license and specialty or primary area of practice and
2. Required for the treatment or management of a medical condition or symptom; and
3. The most appropriate supply or level of service to provide safe and adequate care under the Plan; and
4. Provided in accordance with approved and generally accepted medical or surgical practice and is not considered Experimental or Investigational, cosmetic, custodial in nature, or unproven; and
5. Not for the convenience of a Covered Person or a Covered Person’s physician or other provider.

NETWORK PROVIDERS means physicians, hospitals and other healthcare practitioners or facilities that have contracted with the Policyholder’s Claim Administrator to provide specific medical care at negotiated prices.

OFF-LABEL DRUG USAGE means the use of a drug for a purpose other than for which it was approved by the Federal Drug Administration (FDA).

PAID means the date, during the Benefit Period, for Eligible Expenses that have been adjudicated and approved according to the terms of the Plan, when:

1. a check or draft is both issued and mailed; or
2. a wire or other legal electronic fund transfer has been directly deposited to the payee.

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

Sufficient funds must be on deposit on the date the check, draft or electronic transfer is issued to permit the check, draft, or electronic fund transfer to be honored. A draft or check voided or returned to the Claim Administrator for any reason, or any credit transaction not honored by the payee for any reason, will not be considered Paid.

PLAN DOCUMENT means the written document approved by the Policyholder which describes the Employee Benefit Plan.

POLICYHOLDER means the entity named on the Schedule and to whom this Policy is issued.

POLICY PERIOD means the period of time specified on the Schedule, beginning with the Effective Date, and ending at the earlier of the date coverage terminates in accordance with the TERMINATION PROVISIONS of this Policy or the date specified on the Schedule.

PROOF OF LOSS means receipt of a completed claim form and Paid claim documentation, satisfactory to the Company, and other supporting documentation required by the Company.

PROVIDER means any hospital, healthcare facility, or healthcare practitioner that is licensed or otherwise authorized to provide health care services.

PROVIDER NETWORK means a Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Point of Service Plan (POS), Health Maintenance Organization (HMO) or any managed care network offered under the Plan.

ROUTINE PATIENT CARE COSTS means healthcare items or services that are furnished to a Covered Person enrolled in an Approved Clinical Trial in accordance with widely accepted and established standards of care for a particular diagnosis which are consistent with the coverage provided under the Plan for a Covered Person who is not enrolled in an Approved Clinical Trial.

Routine Patient Care costs must be determined to be Eligible Expenses under the Policyholder's Plan.

Routine Patient Care costs do not include any of the following:

1. The cost of the investigational item, drug, device or service, including but not limited to any item, drug, device or service which is paid for by the manufacturer, the distributor or the provider of the drug or device.
2. Non-health care services that a Covered Person may be required to receive as a result of being enrolled in the Approved Clinical Trial.
3. All costs associated with managing the research related to the Approved Clinical Trial, including data management costs, lab and imaging testing performed purely for research purposes and associated physician visits for the purpose of the Approved Clinical Trial.
4. Costs that would not be covered under the Plan for non-investigational/experimental treatments.
5. The cost of services which are not provided as part of the Approved Clinical Trial's stated protocol or other similar guidelines.
6. Costs for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

USUAL, CUSTOMARY, AND REASONABLE CHARGE ("UCR") means the amount determined by the Company as the amount generally charged by others in the same geographic area who render or furnish the same or similar services, treatments or supplies. If the Policyholder, Plan or Claim Administrator has a contracted fee arrangement with certain Providers, UCR shall mean the lesser of the applicable fees as defined in that fee arrangement contract or the amount generally charged by others in the same geographic area who render or furnish the same or similar services, treatments or supplies.

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

SPECIFIC EXCESS LOSS INSURANCE

DEFINITIONS

SPECIFIC BENEFIT PERIOD REIMBURSEMENT MAXIMUM means the limit of the Company's liability, as shown on the Schedule.

SPECIFIC DEDUCTIBLE PER COVERED PERSON ("Specific Deductible") means the amount of Eligible Expenses which must be Paid by the Plan for any Covered Person before benefits are reimbursable under the Policy, as shown on the Schedule.

REIMBURSEMENT

No specific reimbursement will be made until a Plan Document is received and accepted by the Company. Any reimbursement under the Specific Excess of Loss Insurance will be subject to the terms and conditions of this Policy including the Schedule and any Endorsements.

If Eligible Expenses for a Covered Person exceed that Covered Person's Specific Deductible, the amount by which Eligible Expenses exceed that Specific Deductible shall be called the "Specific Excess Amount." The Company shall multiply the Specific Excess Amount by the Specific Reimbursement Percentage shown on the Schedule. The result of this calculation shall be called the specific reimbursement.

If Specific Excess Loss Insurance terminates before the end of the Policy Period, the Specific Deductible will not be reduced; however, the Benefit Period, as shown on the Schedule, will be modified.

Eligible Expenses will not include any amounts reimbursed by the Company under any other provision of this Policy. Any expense Incurred at a time when the person to whom the expense relates is not a Covered Person will not be eligible for Specific Excess Loss Insurance.

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

EXPEDITED REIMBURSEMENT

Without waiving any rights under the Excess Loss Insurance Policy, the Company agrees to provide expedited specific reimbursement, provided that all of the following conditions are met:

1. the claim must be fully processed by the Claim Administrator and ready for payment under the Plan within the Benefit Period during which the claim was Incurred,
2. the Policyholder must have Paid Eligible Expenses that exceed the Specific Deductible shown on Schedule, plus an amount not less than $1,000,
3. the claim, and supporting documentation satisfactory to the Company, must be received by the Company no later than 10 calendar days after the end of the Benefit Period during which the claim was Incurred and processed,
4. the request for expedited reimbursement must be for more than $1,000, and
5. premium must be paid through the month in which the claim was submitted to the Company.

If the foregoing requirements are satisfied, the Company will promptly send to the Policyholder the amount that is eligible for reimbursement under Specific Excess Loss Insurance. Upon receipt of the expedited reimbursement, the Policyholder must pay the Plan's payment within five (5) business days. The Company's reimbursement may not be deposited until the Plan's payment has been Paid. If the Policyholder does not pay the Plan's payment within the five (5) business day period, the reimbursement must be refunded to the Company.

If any portion of the Company's reimbursement is not used to pay the applicable benefits under the Employee Benefit Plan, due to discounting or any other reason, such portion must be returned to the Company within 5 business days after it is received by the Policyholder by refund, credit, or otherwise.

SPECIFIC TERMINAL LIABILITY

If the Policyholder does not renew this Policy, the Policyholder may modify the Benefit Period of this Policy by providing written notice to the Company within 15 days after the end of the Policy Period.

If the Terminal Liability option is exercised, the Benefit Period for Specific Excess Loss Insurance will be revised so that the time period during which Eligible Expenses must be Paid by the Plan shall be extended by an additional 90 days. The Company will issue a revised Schedule.

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

AGGREGATE EXCESS LOSS INSURANCE

DEFINITIONS

ACCUMULATED ACCOMMODATION POINT means the sum of the Monthly Aggregate Deductibles for each month commencing with the first month of the Policy Period and ending with the last month of the same Policy Period, for which the Accumulated Accommodation Point is to be calculated. The Accumulated Accommodation Point at the end of any month shall not be less than the Minimum Annual Aggregate Deductible, as shown on the Schedule, multiplied by the proportion of the Policy Period elapsed at the end of the month of calculation.

AGGREGATE ACCOMMODATION BALANCE means the sum of all Aggregate Accommodation reimbursements made to the Policyholder, during the Policy Period, minus any repayment by the Policyholder of such Aggregate Accommodation payments during the Policy Period.

AGGREGATE BENEFIT PERIOD REIMBURSEMENT MAXIMUM means the limit of the Company's liability, as shown on the Schedule.

AGGREGATE MAXIMUM ELIGIBLE EXPENSE PER COVERED PERSON means the maximum amount eligible for consideration as an expense under Aggregate Excess Loss Insurance as shown on the Schedule.

ANNUAL AGGREGATE DEDUCTIBLE for any one Policy Period means the greater of the:

1. sum of the Monthly Aggregate Deductibles; or
2. Minimum Annual Aggregate Deductible as shown on the Schedule.

MONTHLY AGGREGATE DEDUCTIBLE means, with respect to a particular month, the total number of Covered Units for that given Policy month multiplied by the corresponding Monthly Aggregate Factors as specified on the Schedule.

MONTHLY AGGREGATE FACTORS means the deductible factor per Policy month per Covered Unit as shown on the Schedule.

REIMBURSEMENT

No aggregate reimbursement will be made until a Plan Document is received and accepted by the Company. Any reimbursement under the Aggregate Excess of Loss Insurance will be subject to the terms and conditions of this Policy including the Schedule and any Endorsements.

At the end of the aggregate Benefit Period, an audit of the data provided for the aggregate calculation will occur. The aggregate reimbursement is equal to:

1. the total amount of Eligible Expenses for all Covered Persons subject to the Aggregate Maximum Eligible Expense per Covered Person; minus
2. the Annual Aggregate Deductible for the Policy Period; multiplied by
3. the Aggregate Reimbursement Percentage, as shown on the Schedule.

In no event will the reimbursement exceed the Aggregate Benefit Period Reimbursement Maximum. If Aggregate Excess Loss Insurance terminates before the end of the Policy Period, no reimbursement will be made under this Aggregate Excess Loss Insurance.

Eligible Expenses will not include any amounts reimbursed by the Company under any other provision of this Policy. Any expense Incurred at a time when the person to whom the expense relates is not a Covered Person will not be eligible for Aggregate Excess Loss Insurance and will not be considered for the purpose of satisfying the Annual Aggregate Deductible.

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

AGGREGATE ACCOMMODATION

If Eligible Expenses under the Aggregate Excess Loss Insurance exceed the Accumulated Accommodation Point by more than $5,000 at the end of any month during the Policy Period, the Company will make an Aggregate Accommodation reimbursement to the Policyholder, if requested.

The Aggregate Accommodation reimbursement, if any, will be calculated on a monthly basis, as follows:

1. the total amount of Eligible Expenses for all Covered Persons subject to the Aggregate Maximum Eligible Expense per Covered Person; minus
2. the Accumulated Accommodation Point for the Policy Period; multiplied by
3. the Aggregate Reimbursement Percentage; minus
4. any Aggregate Accommodation Balance.

Conditions for Aggregate Accommodation reimbursement:

1. An Aggregate Accommodation will be available to the Policyholder, provided that:
   a. all premium payments due for Specific and Aggregate Excess Loss Insurance have been received up to and including the month in which the Aggregate Accommodation reimbursement is calculated;
   b. the Policyholder has Paid all claims for Eligible Expenses under the Plan; and
   c. all claims have been reported as required by the Policy.
2. No Aggregate Accommodation reimbursement is payable for the final month of the Policy Period.
3. Any Aggregate Accommodation Balance at the end of the Policy Period shall be deducted from any amount otherwise payable under the Aggregate Excess Loss Insurance.
4. If Eligible Expenses have not been properly Paid, the Company has the right to terminate this provision.
5. An Aggregate Accommodation reimbursement is not an advance on any Eligible Expenses yet to be Paid by the Policyholder.
6. Prior to releasing any Aggregate Accommodation reimbursement, the Company reserves the right to audit the data provided for the calculation.

Repayment by the Policyholder
If at any time the Policyholder's Eligible Expenses under the Aggregate Excess Loss Insurance are less than the Accumulated Accommodation Point *plus* any Aggregate Accommodation Balance, the Policyholder must make repayment within 10 days to the Company, equal to the lesser of:

1. the amount by which the sum of the Accumulated Accommodation Point *plus* the Aggregate Accommodation Balance exceeds the Policyholder's Eligible Expenses under the Aggregate Excess Loss Insurance; or
2. the full amount of the Aggregate Accommodation Balance.

At the end of the aggregate Benefit Period, an audit of the data provided for the aggregate calculation will occur. A final calculation of the aggregate reimbursement will occur and is equal to:

1. the total amount of Eligible Expenses for all Covered Persons subject to the Aggregate Maximum Eligible Expense per Covered Person; minus
2. the Annual Aggregate Deductible for the Policy Period; multiplied by
3. the Aggregate Reimbursement Percentage, as shown on the Schedule.

If the aggregate reimbursement is greater than the Aggregate Accommodation Balance, the Company shall calculate and pay the additional aggregate reimbursement due the Policyholder from the Company. If the aggregate reimbursement is less than the Aggregate Accommodation Balance, the Policyholder must make repayment to the Company, equal to the amount of any Aggregate Accommodation Balance less the aggregate reimbursement. A final repayment of any balance due must be made within 30 days of the end of the Policy Period. If the Policy terminates before the end of the Policy Period, the Policyholder will immediately repay all Aggregate Accommodation reimbursements on the date the Policyholder's coverage terminates.

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The Company will have preference over all other creditors for the return of any Aggregate Accommodation reimbursement. Further, the Policyholder will be liable for all costs and expenses (including reasonable attorney fees) incurred by the Company in the collection of any Aggregate Accommodation reimbursement outstanding. If the Policyholder fails to make repayment when due, the Company, at its option, may:

1. deduct the outstanding payment due from any reimbursement due the Policyholder under Specific or Aggregate Excess Loss Insurance; or
2. terminate the Excess Loss Insurance Policy.

If the Policyholder fails to make repayment within 10 days, this provision will terminate automatically for the remainder of the Policy Period.

AGGREGATE TERMINAL LIABILITY

If the Policyholder does not renew this Policy, the Policyholder may modify the Benefit Period of this Policy by providing written notice to the Company, within 15 days after the end of the Policy Period, that it shall exercise this option.

If the Terminal Liability option is exercised, the following terms will apply to the Policy Period that ends on the date the Policyholder terminates Excess Loss Insurance Coverage with the Company:

1. the revised Annual Aggregate Deductible for the Policy Period shall be calculated to equal the greater of:
   a. 125% of the calculated Annual Aggregate Deductible for that Policy Period, or
   b. the sum of the Monthly Aggregate Deductibles for the 3 months prior to the last day of the Policy Period, plus the calculated Annual Aggregate Deductible for that Policy Period.
2. The Benefit Period for Aggregate Excess Loss Insurance will be revised so that the time period during which Eligible Expenses must be Paid by the Plan shall be extended by an additional 90 days. The Company will issue a revised Schedule.

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

EXPENSES ELIGIBLE FOR REIMBURSEMENT

ELIGIBLE EXPENSE means Usual, Customary and Reasonable charges covered and payable under the terms of the Plan, and which are not excluded or otherwise limited by the terms of this Policy, and are:

1. Incurred while the Plan is in effect;
2. Paid according to the terms of the Plan; and
3. Incurred and Paid as defined by this Policy's Benefit Period.

ALTERNATIVE CARE

Alternative Care may be considered as an Eligible Expense if the Company, in its sole discretion, decides that the Alternative Care meets any combination of the following:

Alternative Care:

1. resulted in a cost savings to the Plan;
2. was recommended by case management services provided to the Plan;
3. was Medically Necessary and Appropriate and not performed for the convenience of the Covered Person or a Covered Person's physician or other provider;
4. was provided with the consent of the Covered Person, or his/her representative, and with the approval of the Covered Person's licensed healthcare provider, and was approved by the Plan or Claim Administrator;
5. replaces treatment that would be covered under the Plan;
6. expenses do not exceed the maximum allowed under the Plan for the treatment replaced by the Alternative Care.

Further, Alternative Care in excess of 180 days must be accepted by the Company to be considered an Eligible Expense under this Policy.

CLAIM SURCHARGES

If the Plan pays a surcharge in connection with the payment of a claim, the surcharge shall be considered an Eligible Expense provided:

1. The provider charges are Eligible Expenses according to the terms of the Plan; and
2. Documentation is provided showing that the surcharge/assessment has been appropriately applied to each claim; and
3. Proof of payment is provided and reflected in the claim submission.

The Company will not reimburse surcharges made on a per Covered Person or per Covered Family basis, or penalties or fines assessed by the state against the Policyholder.

APPROVED CLINICAL TRIAL EXPENSES

Routine Patient Care Costs furnished in connection with participation of a Covered Person in an Approved Clinical Trial are considered Eligible Expenses.

Nothing in this Policy shall create a presumption that the Company recommended, directed, endorsed or required any Covered Person's participation in an Approved Clinical Trial. The Company may require a copy of the Approved Clinical Trial's study protocol before determining if any benefits are payable.

INDEPENDENT REVIEW ORGANIZATION EXTENDED BENEFIT

The Benefit Period, as shown on the Schedule, shall be extended for a period not to exceed 24 months to pay any claim that was denied during the Benefit Period but is later Paid by the Plan after the end of such Benefit Period due to a reversal by an IRO under an independent medical review required by and performed in accordance with applicable federal or state law, provided that the Policyholder gave written notice to the Company within 30 days of the denied claim being submitted for independent medical review.

Such Eligible Expenses giving rise to the previously denied claim must:

1. have been incurred by the Covered Person within the Incurred dates of the Benefit Period,

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

2. be paid by the Policyholder's Claim Administrator on the Policyholder's behalf within the Paid dates of the Benefit Period as extended herein;
3. be otherwise payable under the terms of the Policy, and
4. not be eligible for payment under any other coverage, including another excess loss policy.

The Company may require a copy of the independent medical review before determining if reimbursement is payable under this Policy. This provision does not alter the Effective Date, Policy Period, or waive this Policy's eligibility requirements.

LATE ENTRANT
Expenses for a Late Entrant will not be considered Eligible Expenses unless the employee or dependent is accepted as a Covered Person, in writing, by the Company. A Late Entrant is a person who did not enroll for insurance under the Plan when initially eligible and who subsequently enrolls for such insurance.

OFF-LABEL DRUG USE EXPENSES
Expenses related to Off-Label Drug Use may be considered Eligible Expenses if all of the following criteria have been satisfied:

1. The drug is covered under the Plan;
2. The drug has been approved by the FDA;
3. Usage of the drug is appropriate and generally accepted standard for the condition being treated; and
4. If used for the treatment of cancer, the American Hospital Formulary Service Drug Information, The Compendia-Based Drug Bulletin, National Comprehensive Cancer Network, Centers for Medicare and Medicaid Services, recognize it as an appropriate treatment for that form of cancer.

REIMBURSEMENT OF FEES:
If approved in advance by the Company, Eligible Expenses shall include the following fees Incurred and Paid by the Policyholder:

1. Hospital bill audits;
2. Access to non-directed Provider Networks;
3. Negotiation of out of network bills;
4. Case management services provided by a nurse case manager retained by the Policyholder or Claim Administrator; and
5. Cost Containment Vendors. Cost Containment Vendor means a third party contracted to reduce or control the cost of services or supplies provided to Covered Persons under the Plan.

Such fees shall be considered Eligible Expense only if the service that generated the fees resulted in a cost savings to the Plan and the Company. The Company will consider such fees Eligible Expenses, up to 25% of such cost savings per claim expense. If services are billed on an hourly rate, the Company will consider such fees and Eligible Expenses up to $130/hour. Any fees charged by the Claim Administrator and its affiliates for these services will be considered Eligible Expenses only if prior approval has been obtained, in writing, from the Company.

CLAIM PROVISIONS

BENEFITS DETERMINATION UNDER POLICY
Although determination of benefits under the Plan Document is the responsibility of the Policyholder, or a party designated by the Policyholder, the Company reserves the right, for purposes of determining benefits under this Policy, to make an independent determination as to whether a particular claim is payable or was properly paid by the Plan, without deference to the Plan's decision.

NOTICE OF LOSS
The Policyholder shall give written notice of claims to the Company within 30 days of the date:

1. A Covered Person's Eligible Expenses exceed 50% of the Specific Deductible; or
2. The Policyholder, Claim Administrator, medical management, utilization review, prescription drug, precertification vendors, or any other party acting on behalf of the Policyholder, becomes aware that Eligible Expenses for a Covered Person will be Incurred that may reasonably exceed 50% of the Specific Deductible.

PAYMENT OF CLAIMS
All reimbursements under this Policy will be paid directly to the Policyholder, after the Company:

1. Accepts submitted Proof of Loss as satisfactory;
2. Receives proof of payment of Eligible Expenses under the Plan;
3. Completes an audit of the claim, if required by the Company; and
4. Reimbursements exceed $1,000.

Any reimbursement remaining unpaid at the end of a Policy Period will be paid at such time.

PAYMENT BY PLAN
The Policyholder agrees to provide funds for payment of all Eligible Expenses under the Plan. The Policyholder will pay all eligible claims under the Plan within 90 days from the date adequate Proof of Loss is provided to the Policyholder. If the Policyholder fails to provide funds for timely payment within the 90-day time limit, that claim will not count toward the satisfaction of the Aggregate and/or Specific Deductible(s) or be reimbursed under the Policy. The Policyholder will provide funds necessary to pay claims within the foregoing timeframes and failure to do so will cause this Policy to terminate as shown in the TERMINATION PROVISIONS of this Policy.

PROOF OF LOSS
The Policyholder, or the Claim Administrator on the Policyholder's behalf, shall provide written Proof of Loss to the Company of any payment by the Plan which exceeds the Specific Deductible within 90 days of making the payment. The Policyholder, or the Claim Administrator on the Policyholder's behalf, must request payment and provide complete and accurate Proof of Loss, in form and content acceptable to the Company, within 6 months after the end of the Benefit Period. The Company may deny any claim(s) received after the end of such period or any claim that remains incomplete for more than 6 months after the end of the Benefit Period.

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

MATERIAL CHANGE AND MISSTATED DATA PROVISIONS

MATERIAL CHANGE The Policyholder must give written notice to the Company at least 30 days prior to the effective date of any Material Change which in the Company's reasonable judgment may have a material financial, economic or other effect on the Company's liability under this Policy. A Material Change includes, but is not limited to, any of the following:

1. A change to, or of:
   a. the terms of this Policy;
   b. the Plan Document;
   c. the Claim Administrator;
   d. the Provider Network;
2. Adding or divesting of subsidiaries or affiliated companies or divisions;
3. The month in which the number of Covered Employees varies more than 15% from the number of Covered Employees on the Policy's Effective Date;
4. There is more than a 15% variance between the Covered Units on the sold excess loss proposal issued by the Company and the Covered Units on the Policy's Effective Date.

The Company shall review the Material Change and reserves the right to:

1. Accept the change with no modification to the rates, factors and terms of the Excess Loss Insurance Policy; or
2. Accept the change and modify any term or condition of this Policy and issue an amended Excess Loss Insurance Policy as of the effective date of the change; or
3. Decline the change and apply the terms of the Plan that existed prior to any such change; or
4. Terminate the Policy as of the effective date of the change.

MISSTATED DATA The Company shall be entitled to rely upon information provided by the Policyholder or any agent of the Policyholder to underwrite and administer this Policy. Misstated Data includes, but is not limited to the following:

1. The Policyholder or any agent of the Policyholder, including the Claim Administrator, makes any material misstatement, omission or misrepresentation, whether intentional or unintentional or knowingly or unknowingly, in the information or data provided to the Company; or
2. The Company becomes aware of any expense or claim that was Incurred or Paid before the Effective Date, but was not reported to the Company during the underwriting of this Policy.

The Company shall review the data and reserves the right to:

1. Accept the data with no modification to the rates, factors and terms of the Excess Loss Insurance Policy; or
2. Amend any term or condition of this Policy in accordance with the Company's underwriting practices in effect on the Policy Effective Date and reissue a new Excess Loss Insurance Policy as of the Policy's Effective Date; or
3. Exclude any Loss pertaining to the Misstated Data; or
4. Rescind the Policy.

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

PREMIUM PROVISIONS

PAYMENT OF PREMIUMS The initial premium is due on the Effective date of this Policy; all subsequent monthly premiums are due on the first (1st) day of each succeeding month in the Policy Period. No coverage under this Policy will be in effect until the first month's premium is paid to the Company. The entire amount of the applicable premium shall be paid when due. For coverage to remain in effect, all premium payments, as shown on the Schedule, must be paid on or before their respective due dates, subject to the Grace Period. Premiums are not considered paid until the premium payment is received by the Company with sufficient funds on deposit to honor payment.

Premiums or other payments made by the Policyholder to its Claim Administrator, agent, or broker shall not be deemed or considered payments to the Company until actually received by the Company with sufficient funds on deposit to honor payment.

GRACE PERIOD A Grace Period of 31 calendar days will be allowed for the payment of each premium due after the first premium has been Paid. This Policy will continue in force during the Grace Period. If premium is not paid by the end of the Grace Period, this Policy will terminate as of the last date for which premium was paid. The Company may deduct the amount of any premium due for a Grace Period from any benefit the Company may owe the Policyholder under this Policy.

The Policyholder will not have a Grace Period if the Company delivered or mailed to such Policyholder a notice of its intent not to renew this Policy.

If a premium otherwise due is not paid in full and received by the Company during the Grace Period, this Policy will terminate without further notice.

PREMIUM AMOUNT The premiums will be calculated using rates determined by the Company, as shown on the Schedule.

The Policyholder will be liable for any taxes assessed at any time against the Company, except premium taxes payable by the Company.

All requests for adjustments, credits, or refunds because of overpayment of premiums must be reported, in writing, with accompanying detail no later than 60 days after termination of the applicable Policy Period in order to be considered for repayment.

The Company will not refund any portion of the premiums paid if this Policy terminates during the Policy Period.

OFFSET The Company shall be entitled to offset the following against reimbursements due the Policyholder under this Policy:

1. Any premiums due and unpaid;
2. Any overpayments made by the Company to the Policyholder;
3. Any other reimbursements made in error or made due to receipt of incorrect information; and
4. Any other amounts due the Company.

The right of offset shall not prevent the Company's right to terminate the Policy for non-payment of premium pursuant to the TERMINATION PROVISIONS.

PREMIUM CALCULATION Premium calculations are based upon those Covered Units that are effective for any part of any month regardless of whether the Covered Unit is covered under the Plan for the entire month. Any month a Covered Unit is effective, regardless of the number of days, the Covered Unit is included in the premiums due.

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

TERMINATION AND REINSTATEMENT PROVISIONS

TERMINATION PROVISIONS

This Policy and coverage provided hereunder will terminate upon the earliest of:

1. The premium due date of any premium which remains unpaid at the end of the Grace Period;
2. The premium due date next following receipt by the Company of advance written notice from the Policyholder that this Policy is to be terminated;
3. The date of termination of the Plan;
4. The date the Policyholder suspends active business operations or dissolves;
5. The end of the Policy Period;
6. The date the Policyholder does not pay claims or make available funds to pay claims as required by the Policy; or
7. The date the Policyholder makes a Material Change deemed unacceptable to the Company.

This Policy may also be terminated, at the Company's option, on the earliest of:

1. The last day of the 3rd consecutive month during which there are fewer than 51 Covered Units enrolled in the Plan as shown on the Schedule, unless the Company agrees, in writing, to continue coverage;
2. The date the Policyholder fails to comply with the terms of this Policy; or
3. The date the Policyholder's agreement with the Claim Administrator as shown on the Application is terminated or breached.

The Company will not refund any portion of the premiums paid if this Policy is terminated during the Policy Period. In the event of termination, the Company's liability will be modified as described in the Benefit Period shown on the Schedule.

REINSTATEMENT PROVISION

If this Policy terminates for any of the reasons shown above, the Company may, at its option, approve the Policyholder's request to reinstate this Policy. The Policyholder shall submit to the Company any forms and data the Company may require. If this Policy is reinstated, the Policyholder shall pay to the Company the premiums due from the date this Policy terminated to the date of reinstatement.

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

SUBSEQUENT POLICY PERIOD PROVISIONS

At the end of a Policy Period, a subsequent Policy Period may be agreed upon in writing by the Company and the Policyholder. The terms and conditions for a subsequent Policy Period will be documented by the submission of a new Application for Excess Loss Insurance by the Policyholder and evidenced by the issuance of a new Policy by the Company which shows the new premium rates, Benefit Period and other new terms.

This Policy is not automatically renewable. The Company may refuse to renew the coverage under this Policy by giving the Policyholder at least 30 days advance written notice before the end of the Policy Period. If such notice is mailed, the Company will use the last address on file for the Policyholder.

GAPLESS RENEWAL

If the Policyholder renews this Policy for a subsequent Policy Period, any expense that is Incurred during the Policy Period of this Policy but Paid after the Specific Benefit Period of this Policy will be included as an Eligible Expense for the Specific Benefit Period of the renewed Policy.

However, such Eligible Expense must be Paid within 60 days after the expiration of the Benefit Period of this Policy. Such Eligible Expenses are subject to all other terms and conditions of the Policy including, but not limited to, satisfaction of the Specific Deductible for the renewed Policy. If the renewed Policy terminates before the end of its Policy Period, the expense will not be included in the Benefit Period of the renewed Policy and the resulting overpayment in any specific reimbursement will be due the Company on the date the Policyholder's coverage terminates.

This provision does not apply to expenses for individuals identified in the Special Conditions Endorsement of this Policy.

RATE CAP AND NO NEW ALTERNATIVE SPECIFIC DEDUCTIBLE "RENEWAL GUARD"

If the Policyholder renews this Policy for a subsequent Policy Period:

1. No additional Covered Person will be subject to an Alternative Specific Deductible in the subsequent Policy Period. A Covered Person subject to an Alternative Specific Deductible in the current Policy Period shall continue to be subject to that same Specific Deductible in the subsequent Policy Period, unless the Company decides to reduce or eliminate a Specific Deductible.

2. The Rate Cap, as shown on the Schedule, is the maximum increase to the specific premium rate(s) for the subsequent Policy Period over the current Policy Period provided that:
   a. The Plan contains no change that materially alters the risk from the current Policy.
   b. The subsequent Policy contains no Material Change in any terms or conditions from the Current Policy.
   c. There is no Material Change between the demographic distribution of the group covered under the current Policy and the group covered under the subsequent Policy.
   d. There has been no adding or divesting of subsidiaries or affiliated companies or divisions to this Policy.
   e. There is no change in any assessment or tax levied against the Company by the state in which this Policy is delivered.

   The Company shall determine, at its discretion, if a change described in clauses a. through e. constitutes a Material Change and will adjust the Rate Cap accordingly.

The provisions, set forth above, shall only apply to the subsequent Policy Period immediately following this Policy. This option may be extended for another Policy Period at the Company's discretion.

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

GENERAL PROVISIONS

ASSIGNMENT The Policyholder may not assign, pledge or transfer, in whole or in part, this Policy or any interest therein or any reimbursement under this Policy without the Company's prior written consent.

AUDITS The Company will have the right to:

1. Inspect and audit all records and procedures of the Policyholder and the Policyholder's Claim Administrator, developed and maintained for the Plan, that are applicable to the administration of this Policy; and
2. Require, upon request, proof satisfactory to the Company that payment has been made to the Covered Person or the provider of such services or benefits which are the basis for any Loss by the Policyholder hereunder.

The Company's audit rights shall survive the termination of the Policy.

CHANGES TO THE POLICY Only the President, a Vice President, or the Secretary of the Company has the authority to alter this Policy, or to waive any of the Company's rights and then only in writing. No such alteration of this Policy shall be valid unless endorsed and attached to this Policy. No agent, broker, or Claim Administrator has the authority to alter this Policy or to waive any of its provisions.

CLAIM ADMINISTRATOR The Policyholder must retain a Claim Administrator at all times. The Claim Administrator is the Policyholder's agent in performing any and all of the duties as designated by the Policyholder. The Company shall have no liability for any act or omission by the Claim Administrator. Without waiving any of its rights under this Policy, and without making the designated Claim Administrator a party to this Policy, the Company agrees to recognize the Claim Administrator as an agent of the Policyholder. If claims are Paid by a Claim Administrator, the Company may require the Policyholder to provide the Company with any information possessed by the Claim Administrator that will assist the Company in underwriting or administering this Policy.

Any statements and answers provided by the Claim Administrator are binding on the Policyholder. For the purpose of any notice required from the Company under the provisions of this Policy, notice to the Policyholder's Claim Administrator shall be considered notice to the Policyholder. The Policyholder will immediately notify the Company in writing if the agreement between the Policyholder and the Claim Administrator terminates or is breached.

CLERICAL ERROR Clerical errors, whether by the Policyholder or by the Company, in transmitting or communicating any information or data pertaining to this Policy, will neither invalidate nor limit coverage otherwise validly in-force nor continue coverage otherwise validly terminated.

Clerical error shall not include failure of the Policyholder or any agent of the Policyholder, including the Claim Administrator, to:

1. Comply with the requirements relating to notice of claims or payment of claims; or
2. Disclose underwriting information requested by the Company, whether or not intentional, and regardless of the actual knowledge of the person providing the information.

Clerical errors, as provided in this Policy, are strictly limited to errors made in transmitting or communicating data to effectuate or administer this Policy. Clerical error does not extend to errors committed by the Policyholder, or an agent of the Policyholder, in administering the Plan (e.g., failure to offer COBRA coverage in a timely manner).

CONFIDENTIALITY The Company will protect the privacy and confidentiality of all personally identifiable and/or medical information provided to the Company in the course of underwriting and administering this Policy in accordance with the Company's policies and applicable state and federal laws.

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

CONFORMITY WITH LAW If any provision of this Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

ENTIRE POLICY The entire Policy between the Company and the Policyholder will consist of:

1. This Excess Loss Insurance Policy;
2. Application for Excess Loss Insurance;
3. Schedule of Excess Loss Insurance;
4. Any Endorsement(s) and/or Amendments to the Policy.

INDEMNIFICATION The Policyholder agrees to indemnify, defend and hold the Company harmless from any liability, including but not limited to, interest, penalties, attorneys fees, extra-contractual, exemplary or punitive damages, or expenses arising from or related to the following:

1. Any negligence, error, omission, defalcation, bad faith, or intentional acts by the Policyholder, Plan, Claim Administrator or any other agent or representative of the Policyholder, Plan or Claim Administrator; or
2. Any dispute involving Covered Person(s), former Covered Person(s) or any person(s) claiming entitlement to benefits under the Plan.

INSOLVENCY Nothing in this Policy shall either relieve an insolvent or bankrupt Policyholder from the obligation to pay premiums when due or delay or abate cancellation of this Policy for failure to do so.

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 the Company any liability other than the liability defined in this Policy. In particular, the insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Covered Persons under the Plan. Claims under the Plan must be continued to be funded and Paid within contractual timeframes in order to be eligible for reimbursement under this Policy.

LEGAL ACTION The Policyholder cannot file suit until 60 days after the date on which Proof of Loss is given to the Company. The Policyholder cannot file suit more than 3 years after the date on which the Policyholder must give the Company proof of claim.

OTHER COVERAGE This Policy is in excess of all other insurance, of any kind, that would reimburse the Policyholder for the same expenses reimbursable hereunder.

PARTIES TO THE POLICY The parties to this Policy are the Policyholder and the Company. The Company's sole liability under this Policy is to the Policyholder. This Policy does not create any rights, liability or legal relation between the Company and a Covered Person under the Plan, or with any other third-party. The Company shall not be considered a party to the Plan of the Policyholder, or to any supplement or amendment. This Policy will also not be deemed to make the Company a party to any agreement between the Policyholder and any third party, including the Claim Administrator.

POLICYHOLDER REQUIREMENTS The Policyholder will provide to the Company reports and documents that may be reasonably requested in order for the Company to underwrite and administer the terms and conditions of this Policy. The Policyholder will be responsible for the investigation, auditing, calculating and the payment of all claims under the Plan.

RECORDS The Policyholder will maintain records of all Covered Persons under the Plan during the Policy Period and for a period of 7 years after the end of the Policy Period. The Policyholder will make all such records available to the Company as needed to evaluate its liability under this Policy. The Policyholder will maintain a separate record of all amounts Paid in excess of benefits eligible under the Plan.

SEVERABILITY CLAUSE Any clause deemed void, voidable, invalid, or otherwise unenforceable, whether or not such a provision is contrary to public policy, will not render any of the remaining provisions of this Policy invalid.

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

TERMINATION OF THE POLICYHOLDER'S PLAN The Policyholder shall immediately notify the Company if the Plan is terminated.

THIRD PARTY RECOVERY The Plan shall pursue all claims against any person or entity (i.e., third party) that may be legally responsible for a claim or loss under this Policy. Further, the Policyholder shall pay to the Company any amounts recovered which were previously reimbursed by the Company under this Policy, regardless of whether this Policy is in-force on the date of recovery.

Additionally, the Policyholder shall notify the Company immediately upon discovering that such a claim may exist. Should the Policyholder fail to pursue any valid claims against a third party and the Company becomes liable under this Policy, the Company shall have the right to exercise and enforce all of the Policyholder's and/or Plan's rights against such third party.

If the payment received from a third party is less than the total amount paid by the Plan, the Company is entitled to recover first, in full, any amount paid by the Company under this Policy as well as any expenses of collection incurred by the Company. All remaining amounts shall be paid to the Policyholder.

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.

EXCLUSIONS AND LIMITATIONS

The Company will not reimburse the Policyholder for any of the following:

1. Any payment that does not strictly comply with the terms and conditions of the Plan Document or with the terms and conditions of this Policy and the Schedule.
2. Any payment which is Incurred for an Injury or Illness for which the claimant has or had a right to compensation under any Workers' Compensation insurance or similar insurance, or under any Workers' Compensation law, occupational disease law, or similar law, whether or not coverage under such law is actually in force.
3. Any portion of an expense which the Policyholder is not obligated to pay under the Plan, or which is reimbursable to the Policyholder pursuant to or as a result of:
   a. Prescription drug rebates refunded to the Policyholder by a Pharmacy Benefit Management (PBM) vendor; or
   b. Any other source.
4. Any Expenses Incurred for Experimental or Investigational treatment, or for any hospital confinement or treatment that results from Experimental or Investigational treatment.
5. Any payment that results from war (declared or undeclared), hostilities, invasion or civil war or any payment that is the result of an injury or illness caused by a nuclear or radioactive accident.
6. Any payment under the Plan which would not have been paid if benefits had been coordinated with Medicare, whether or not Medicare is elected by the Covered Person.
7. Any payment for expenses associated with the administration of the Plan including, but not limited to, claim payment fees, PPO access fees, PBM administration fees, medical review and consultant fees, unless otherwise covered under this Policy.
8. Expenses for injury or complications from an injury sustained by the Covered Person while committing a felony under the laws of the state in which such act occurred, whether or not such Covered Person was actually charged or convicted of any criminal conduct.
9. Expenses Incurred by any Consolidated Omnibus Budget Reconciliation Act (COBRA) continuant whose COBRA continuation coverage was not offered in a timely manner or was not elected in a timely manner, as required under COBRA and/or any regulations thereunder, or for which premiums were not paid in a timely manner.
10. Expenses resulting from the failure of the Policyholder's Claim Administrator to make timely payment to providers within the timeframe required to obtain discounted fees for services or supplies. The Company will only reimburse for amount of the discounted fees had timely payment be made by the Claim Administrator.
11. Any payment for expenses Incurred outside the United States except in emergency. Emergencies are defined as instances of a serious injury; the onset of a serious or life-threatening condition which requires immediate medical intervention to prevent death. Emergencies do not include elective care or care of minor illness or injury.

The actual policy may vary, due to policyholder situs, state regulations, and benefit provisions.