Independence Life and Annuity Company

STOP-LOSS POLICY

Policyholder:	1[**ABC Company**]
Policy Number:	2[**12345**]
Policy Effective Date:	3[**January 1, 2019**]
Policy Renewal Effective Date:	4[**January 1, 2020**]
5[**Policy Revision Effective Date**	[**July 1, 2019**]]

This Policy is delivered in **6[**state**]** and is subject to the laws of that jurisdiction. Independence Life and Annuity Company agrees to pay the benefits provided by this Policy in accordance with the provisions contained herein. This Policy is issued in consideration of the Application submitted by the Policyholder, a copy of which is attached, and continued payment of premium by the Policyholder. The Application, and any Riders, Endorsements, Addenda and Amendments to this Policy are made part of this Policy.

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

Independence Life and Annuity Company will hereafter be referred to as "We," "Our," and "Us."

When determining any date under this Policy, all days begin at 12:00:00 a.m. and end at 11:59:59 p.m. standard time for Your headquarters.

Signed at Our Home Office, One Sun Life Executive Park, Wellesley Hills, Massachusetts, by:

7[

President

Assistant Vice President and
Senior Counsel and Secretary]

PLEASE READ YOUR POLICY
CAREFULLY
Non-Participating

This is a reimbursement policy. You, or Your Plan administrator, are responsible for making benefit determinations under Your Plan. We have no duty or authority to administer, settle, adjust or provide advice regarding claims filed under Your Plan.

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Schedule of Benefits
1[Individual Benefit

Original Individual Benefit Effective Date	2[January 1, 2019]

Benefit Specifications

3[Renewal] Policy Year	[January 1, 2019 through [December 31, 2019]
Reimbursement Percentage	4[100%]
5[Related Provider Reimbursement Percentage	[80%]]
Covered Benefits	Medical 6[, excluding Prescription Drugs covered under a Prescription Drug Plan] [Prescription Drug Plan (PDP)]
Individual Benefit Deductible	7[$100,000]
18 [Tiered Percentage]	[50%]
19 [Tiered Upper Bound]	[$150,000]
8[Transplant Deductible	[$150,000]]
9[Aggregating Individual Deductible	[$30,000]]
10[Individual Benefit Lifetime Maximum Eligible Expenses	[$10,000,000]]
16[Individual Benefit Annual Maximum 17Eligible Expenses	$1,000,000]]
Individual Benefit Claims Basis	11[[12/12] (Incurred and Paid) Eligible Expenses include only those expenses Incurred and Paid within the Policy Year.] [[15/12] ([3] Month Run-In) Eligible Expenses include only those expenses Incurred during the Policy Year, or within [3] months prior to the Policy Year (the "Run-In Period"), and Paid during the Policy Year.] [[12/15] ([3] Month Run-Out) Eligible Expenses include only those expenses Incurred during the Policy Year and: (a) Paid during the Policy Year; or (b) Paid within [3] months after the Policy Year (the "Run-Out Period").] [Paid (Renewal Policy Year Only) Eligible Expenses include only those expenses Incurred after [January 1, 2019 and Paid during the Policy Year.] [[Incurred Eligible Expenses include only those expenses Incurred during the Policy Year.]

Schedule of Benefits
1[Individual Benefit

[Bridge
Eligible Expenses include only those expenses Incurred prior to the Policy Year and Paid during the Policy Year.]

[Gapless (Renewal Policy Year Only)
Eligible Expenses for this Policy Year will also include those expenses Incurred on or after the Original Individual Benefit Effective Date and Paid after the Run-Out Period of the immediately preceding Policy Year.]

Covered Unit(s)	12[Single employee,] [Employee + 1 Dependent,] [Employee +2 Dependents,] [Employee + family] [COBRA continued]
Retirees	13[Not Covered]
Individual Benefit Premium Rate	14[$8.00] per [Covered Unit] per month 14[$15.00] per [Covered Unit] per month
Premium Due Date	15The Policy Effective Date and the [first] day of each succeeding month.]
[Experience Rating Refund	On each Policy Anniversary a retrospective experience rating refund process is applied to the Individual Benefit. We allot to this Policy such amount, if any, as We determine to be available as a refund as a result of that process. We reserve the right to change the basis of this process.]
20[Terminal Run-Out Period	[3] months]
Advance Reimbursement	[Eligible, Ineligible]]

Schedule of Benefits
1[Aggregate Benefit

Original Aggregate Benefit Effective Date 2[January 1, 2019]

Benefit Specifications

[Renewal] Policy Year	3[January 1, 2019] through [December 31, 2019]
Reimbursement Percentage	4[100%]
[Related Provider Reimbursement Percentage	5[80%]]
Covered Benefits	Medical 6[, excluding Prescription Drugs covered under a Prescription Drug Plan] [excluding all Prescription Drugs] [Prescription Drug Plan (PDP)] [Vision Plan] [Dental Plan] [Short Term Disability Plan (STD)]
Aggregate Benefit Maximum	7[$1,000,000]
Aggregate Benefit Maximum Eligible Expenses Per Covered Person	8[$100,000]
Aggregate Deductible Factor ("ADF")	The ADF per Benefit Month for each Covered Unit by Covered Benefit is as follows:

9Covered Benefit	Covered Unit	ADF
[Medical]	[Covered Unit]	[$300.00]]
[PDP]	[Covered Unit]	[$150.00]]
[Dental]	[Covered Unit]	[$50.00]]
[STD]	[Covered Unit]	[$30.00]]
[Vision]	[Covered Unit]	[$30.00]]

Minimum Aggregate Deductible

10The Minimum Aggregate Deductible for the current Policy Year is the greater of:

a) [$1,458,000], or
b) [90%] of the Monthly Aggregate Deductible for the first month of the Policy Year, then multiplied by [12].

Aggregate Benefit Attachment Point

The Aggregate Benefit Attachment Point is the greater of:

a) The sum of the Monthly Aggregate Deductibles for the Policy Year, or
b) The Minimum Aggregate Deductible.

11[Terminal Liability Aggregate Benefit Attachment Point	The Terminal Liability Aggregate Benefit Attachment Point is equal to the sum of the Aggregate Deductible Factors for all Covered Benefits, multiplied by the greater of: a) The sum of the number of Covered Units for each of the last 17[3] Benefit Months of the Policy Year, or b) The average number of Covered Units for all Benefit Months in the Policy Year, multiplied by 17[3].]
Aggregate Benefit Claims Basis	12[[12/12] (Incurred and Paid) Eligible Expenses include only those expenses Incurred and Paid within the Policy Year.] [[15/12] ([3] Month Run-In) Eligible Expenses include only those expenses Incurred during the Policy Year, or within [3] months prior to the Policy Year (the "Run-In Period"), and Paid during the Policy Year.] [[12/15] ([3] Month Run-Out) Eligible Expenses include only those expenses Incurred during the Policy Year and: (a) Paid during the Policy Year; or (b) Paid within [3] months after the Policy Year (the "Run-Out Period").] [Paid Eligible Expenses include only those expenses Paid during the Policy Year.]
Covered Unit(s)	13[Single employee,] [Employee + 1 dependent,] [Employee + 2 dependents,] [Employee +family] [COBRA continued]
Retirees	14[Not Covered]
Aggregate Benefit Premium Rate	15[$] per [Covered Unit] [per] [month]
Premium Due Date	16The Policy Effective Date and the first day of each succeeding [month].
[Experience Rating Refund	On each Policy Anniversary a retrospective experience rating refund process is applied to the Aggregate Benefit. We allot to this Policy such amount, if any, as We determine to be available as a refund as a result of that process. We reserve the right to change the basis of this process.]
18Aggregate Terminal Run-Out Period	[3] Months
Monthly Aggregate Accommodation	[Eligible, Ineligible]]

Section I
Definitions

1
2[**Alternative Care:** For the purpose of determining Eligible Expenses under this Policy, Alternative Care means a plan of Treatment identified through case management services provided to Your Plan. We may consider expenses arising from Alternative Care for reimbursement if the Treatment is cost-effective and Medically Appropriate and Necessary for the care of a Covered Person. Alternative Care must satisfy the requirements set forth in Section II, Expenses Eligible for Reimbursement.]

Benefit Month: Any calendar month during which this Policy is in force.

Catastrophic Diagnosis: Any medical condition that is a special risk on Our Special Risk Questionnaire.

Claims Basis: The period of time, shown on the Schedule(s) of Benefits, during which Eligible Expenses must be Incurred by a Covered Person and Paid by You to be eligible for reimbursement under this Policy.

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

3[**Covered Person:** A person enrolled in Your Plan and entitled to receive benefits under Your Plan while this Policy is in force. Retirees, as defined by Your Plan, may be Covered Persons if they are included on the Schedule(s) of Benefits. Covered Person also includes a person enrolled in Your Plan and entitled to receive benefits under Your Plan during the Run-In Period who dies before the Policy Effective Date.]

Covered Unit: A category of participants under Your Plan. The Covered Unit(s) for this Policy are shown on the Schedule(s) of Benefits.

4[**Dependent:** Defined the same as in Your Plan.]

5[**Drug or Alcohol Dependence**: Dependence on, or abuse of, a chemical substance or alcohol as classified by the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association ("DSM") or a comparable manual if the American Psychiatric Association stops publishing the DSM.]

6[**Experimental or Investigational Treatment:** For the purpose of determining Eligible Expenses under this Policy, a Treatment (other than covered Off-Label Drug Use) will be considered by Us to be experimental or investigational if:

1. The Treatment is governed by the United States Food and Drug Administration ("FDA") and the FDA has not approved the Treatment for the particular condition at the time the Treatment is provided; or
2. The Treatment is provided as part of an ongoing 19[Phase I, II, III or IV] clinical trial as defined by the National Institute of Health, National Cancer Institute or the FDA; or
3. There is documentation in published U.S. peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine the safety, toxicity or efficacy of the Treatment.

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

Home Office: 18 [One Sun Life Executive Park, Wellesley Hills, Massachusetts.]

Incurred: The date on which Treatment is provided.

7[**Independent Review Panel:** A panel retained through a third party vendor of medical review services that is comprised of three physicians who are board-certified in the medical specialty or subspecialty that most typically administers the Treatment under review.]

Section I
Definitions

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

8[**Medically Necessary and Appropriate**: For the purpose of determining Eligible Expenses under this Policy, a medically necessary and appropriate Treatment is one that We determine meets all of the following criteria:

1. 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
2. It is generally accepted as the standard of medical practice and care for the diagnosis and treatment of the particular condition; and
3. It is approved by the FDA, if applicable.]

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

10[**Original Aggregate Benefit Effective Date:** When We provide You with Aggregate Benefit coverage under this Policy for consecutive Policy Years, the Original Aggregate Benefit Effective Date is the date Aggregate Benefit coverage first became effective in the consecutive year period.]

11[**Original Individual Benefit Effective Date**: When We provide You with Individual Benefit coverage under this Policy for consecutive Policy Years, the Original Individual Benefit Effective Date is the date Individual Benefit coverage first became effective in the consecutive year period.]

Paid: The date Your check or draft for payment of expenses 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.

Plan: Your self-funded benefit plan established to provide benefits to Covered Persons as described in Your plan document. For the purpose of determining benefits payable under this Policy, the Plan shall not include any amendments made to the plan document after the Original Aggregate Benefit Effective Date or the Original Individual Benefit Effective Date, whichever is earlier, unless We notify You in writing from [Our Home Office] that We accept the amendment.

Policyholder: You, the legal entity to whom this Policy is issued.

Prescription Drugs: For the purpose of determining Eligible Expenses under this Policy, Prescription Drugs includes all prescription drugs covered under Your 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 Your Plan, or a separate employee benefit plan maintained by You, under which prescription drug expenses are paid independently of other medical expenses. Expenses incurred under a Prescription Drug Plan will be included as Eligible Expenses only if the Prescription Drug Plan is included as a Covered Benefit on the Schedule of Benefits. A Prescription Drug Plan does not mean prescription drug expenses paid subject to any deductibles and coinsurance applicable to other medical benefits under Your Plan.

Provider Network: 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 offered under Your Plan.

Reimbursement Percentage: The percent of Eligible Expenses that will be considered for reimbursement under this Policy.

12[**Related Provider:** Any facility, service provider, pharmacy or other vendor, which is owned, operated or 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.]

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

Schedule of Benefits: This Policy's schedule of Individual Benefit coverage or Aggregate Benefit coverage provided under this Policy.

Special Risk Questionnaire: A report used to provide Us with certain information We require to underwrite this Policy.

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

14[**Transplant:** The transplant of organs from human to human, including bone marrow, stem cell and cord blood transplants. Transplants include only those transplants that: (a) are approved for Medicare coverage on the date the Transplant is performed; and (b) are not otherwise excluded by this Policy.

A Transplant must be performed at a Transplant Facility in order to be considered for reimbursement under this Policy.]

15[**Transplant Deductible:** A deductible, in addition to the Individual Benefit Deductible, that must be satisfied before any Eligible Expenses Incurred in connection with a covered Transplant will be considered for reimbursement under this Policy.]

Transplant Facility: A hospital or facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations to perform a Transplant and:

For organ transplants: is an approved member of the United Network for Organ Sharing for such Transplant or is approved by Medicare as a transplant facility for such Transplant;

For unrelated allogeneic bone marrow or stem cell transplants: is a participant in the National Marrow Donor Program;

For autologous stem cell transplants: is approved to perform such Transplant by: (a) the state where the Transplant is to be performed; or (b) Medicare; or (c) the Foundation for the Accreditation of Hematopoietic Cell Therapy. Outpatient transplant facilities must be similarly approved.

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

17[**Usual and Customary Charge**: The usual charge made by the provider of care for a service, not to exceed the usual charge made by the majority of like providers for the same or like service in the same geographical area in which the service or treatment is performed. Additionally, a charge must be reasonable for the services or treatments being provided and the service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.]

Section II
Benefit Provisions
1[Individual Benefit

Definitions

2[**Aggregating Individual Deductible:** A deductible, in addition to the Individual Benefit Deductible, applied to the calculation of the Individual Benefit, that must be satisfied before Eligible Expenses are reimbursable under this Policy. The Aggregating Individual Deductible is satisfied by applying any Eligible Expenses that exceed the Individual Benefit Deductible for any Individual Benefit claim. The Aggregating Individual Deductible is shown on the Schedule of Benefits.]

7[**Individual Benefit Annual Maximum Eligible Expenses:** The Individual Benefit Annual Maximum Eligible Expenses is the maximum amount of Eligible Expenses We will apply towards the Individual Benefit for a Covered Person during a Policy Year. The Individual Benefit Annual Maximum Eligible Expenses amount is shown on the Schedule of Benefits.]

Individual Benefit Deductible: The amount of Eligible Expenses relating to a Covered Person that You must pay before You become eligible for an Individual Benefit.

3[The Individual Benefit Deductible shall apply to a Covered Person who is not a Dependent (the "Employee") and his or her Dependents as a collective unit and the collective unit shall be treated as a single Covered Person. The Individual Benefit Deductible for the collective unit may be satisfied by applying Eligible Expenses incurred by the members of the collective unit.]

8[**Individual Benefit Lifetime Maximum Eligible Expenses:** The Individual Benefit Lifetime Maximum Eligible Expenses is the maximum amount of Eligible Expenses We will ever apply towards the Individual Benefit for a Covered Person during his or her lifetime. All Eligible Expenses incurred by a Covered Person during the first Policy Year or any subsequent Renewal Policy Year will apply toward the Individual Benefit Lifetime Maximum Eligible Expenses. The Individual Benefit Lifetime Maximum Eligible Expenses amount is shown in the Schedule of Benefits.]

Terminal Run-Out Period: The number of months after the Policy Year during which the Individual Benefit Claims Basis will be extended. The Terminal Run-Out Period is shown on the Schedule of Benefits.

Tiered Percentage: The percentage of Eligible Expenses considered for reimbursement. The Tiered Percentage is shown on the Schedule of Benefits.

Tiered Upper Bound: The level of Eligible Expenses above the Individual Benefit Deductible at which the Tiered Percentage no longer applies. The Tiered Upper Bound is shown on the Schedule of Benefits.

Individual Benefit

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

1. The total amount of Eligible Expenses for the Covered Person 4[multiplied by the Related Provider Reimbursement Percentage, if applicable]; minus
2. The Individual Benefit Deductible[.] [; minus
3. The Aggregating Individual Deductible or any remaining portion thereof][.][; minus
4. The Transplant Deductible;]

multiplied by the Reimbursement Percentage shown on the "Schedule of Benefits – Individual Benefit," if that Reimbursement Percentage is less than 100%.

5. [the product of (A) times (B) where
    - (A) equals the Reimbursement Percentage less the Tiered Percentage, and
    - (B) equals the lessor of either:
        - 1 above minus Individual Benefit Deductible, or
        - Tiered Upper Bound minus Individual Benefit Deductible.]

8[The amount of Eligible Expenses with respect to any Covered Person is subject to the Individual Benefit Lifetime Maximum Eligible Expenses.]

7[The amount of Eligible Expenses with respect to any Covered Person is subject to the Individual Benefit Annual Maximum Eligible Expenses.]

5[**Individual Benefit Claims Basis Adjustment**
The Run-Out Period will not apply if this Policy terminates prior to the end of the Policy Year.]

9[**Advanced Reimbursement.** If eligible, reimbursement of an Eligible Expense may be made prior to the Eligible Expense being made Paid if in our sole determination We believe a payment is imminent and such payment will constitute an Individual Benefit under the terms of this Policy.]

6[**Terminal Liability**
If this Policy terminates at the end of a Policy Year, the Individual Benefit Claims Basis will be extended to include Eligible Expenses Incurred within the Policy Year [or the Run-In Period] and Paid within [3] months after the Policy Year (the "Terminal Run Out Period"); subject to the following conditions:

1. Eligible Expenses will be considered for reimbursement in accordance with the terms of Your Plan in effect on the day before the Policy termination date; and
2. You must use the TPA that administered Your Plan as of the Policy termination date to administer any claims during the Run-Out Period.]

Section II
Benefit Provisions
1[Aggregate Benefit

Definitions

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

1. The sum of the Monthly Aggregate Deductibles for each month from the start of the Policy Year to the date of the calculation; or

2. The Minimum Aggregate Deductible, divided by the total number of months in the Policy Year, multiplied by the number of months from the start of the Policy Year to the date of the calculation.]

2[**Accumulated Aggregate Losses:** The total amount of Eligible Expenses for all Covered Persons, subject to the Aggregate Benefit Maximum Eligible Expenses Per Covered Person, 9[multiplied by the Related provider Reimbursement Percentage, if applicable], which have been paid by You from the beginning of the Policy Year to the date of the calculation.]

Aggregate Benefit Attachment Point: The amount of Eligible Expenses You must pay during the Aggregate Benefit Claims Basis before We will consider an Aggregate Benefit claim. The Aggregate Benefit Attachment Point is shown on the Schedule of Benefits.

Aggregate Deductible Factor: The deductible factor per Benefit Month per Covered Unit by Covered Benefit. The Aggregate Deductible Factor for each Covered Benefit is shown on the Schedule of Benefits.

Aggregate Benefit Maximum Eligible Expenses per Covered Person: The maximum amount of Eligible Expenses for any one Covered Person that will be used to calculate the Aggregate Benefit. The Aggregate Benefit Maximum Eligible Expenses per Covered Person is shown on the Schedule of Benefits. 4[This maximum applies only to Eligible Expenses Incurred and Paid for the following Covered Benefits: Medical, excluding prescription drugs covered under a Prescription Drug Plan; Prescription Drug Plan.]]

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

Minimum Aggregate Deductible: The minimum amount of Eligible Expenses You must pay before You become eligible for an Aggregate Benefit. The Minimum Aggregate Deductible is shown on the Schedule of Benefits.

Monthly Aggregate Deductible: The sum of the deductibles for all Covered Benefits 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 Aggregate Deductible Factor for each Covered Benefit. The calculation of the Monthly Aggregate Deductible is subject to the 5% Adjustment Rule.

5% Adjustment Rule: If the Monthly Aggregate Deductible decreases from one month ("Month A") to the next ("Month B"), for any reason, the Monthly Aggregate Deductible for Month B shall not be less than 13[95%] of the Monthly Aggregate Deductible for Month A.

Section II
Benefit Provisions
1[Aggregate Benefit

6[Monthly Aggregate Accommodation
If, at the end of any Benefit Month during the Policy Year, Accumulated Aggregate Losses exceed the Accumulated Aggregate Attachment Point, upon written request from You, We will provide You with an advance in an amount equal to the Accumulated Aggregate Losses minus the Accumulated Aggregate Attachment Point minus any amount previously advanced to You under this provision. The minimum advance request is **10[**$1,000**]**.

If We make an advance to You under this provision and if at the end of any subsequent Benefit Month the Accumulated Aggregate Attachment Point ("A") is greater than the Accumulated Aggregate Losses minus any amount previously advanced to You ("B"), You must pay Us the amount by which A exceeds B, up to the total amount previously advanced to You. All payments must be made within **14[**thirty-one (31)**]** days of the end of the Benefit Month in which the payment is due.

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

1. The total outstanding amount owed to Us will become immediately due and payable;
2. We will not provide any additional advances under this provision;
3. We shall have the right to reduce any benefit payable to You under this Policy by the amount You owe Us;
4. The amount You owe Us will be subject to interest at the then prevailing Prime Rate plus **15[**2%**]** calculated from the due date; and
5. We shall have the right to terminate this Policy.

Any amount You may owe to Us under this provision will be deducted from any Aggregate Benefit payable to You. Any outstanding balance that remains after taking the deduction shall be subject to items **16[**1, 3 and 4**]** above.**]**

Section II
Benefit Provisions
1[Aggregate Benefit

Aggregate Benefit

The Aggregate Benefit equals:

1. The total amount of Eligible Expenses for all Covered Persons, subject to the Aggregate Benefit Maximum Eligible Expenses Per Covered Person, **9[**multiplied by the Related Provider Reimbursement Percentage, if applicable**]**; minus
2. The Aggregate Benefit Attachment Point; and

multiplied by the Reimbursement Percentage shown on the "Schedule of Benefits – Aggregate Benefit," if that Reimbursement Percentage is less than 100%.

The Aggregate Benefit will be calculated after the end of the Aggregate Benefit Claims Basis.

Aggregate Benefit Maximum

The Aggregate Benefit We will pay will not exceed the Aggregate Benefit Maximum shown on the Schedule of Benefits.

7[Aggregate Benefit Claims Basis Adjustment

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

8[Terminal Liability

If this Policy terminates at the end of a Policy Year, the Aggregate Benefit Claims Basis will be extended to include Eligible Expenses Incurred within the Policy Year **12[**or the Run-In Period**]** and Paid within **11[**3**]** months after the Policy Year (the "Aggregate Terminal Run-Out Period"); subject to the following conditions:

1. The Aggregate Benefit Attachment Point will be increased by an amount equal to the Terminal Liability Aggregate Benefit Attachment Point shown on the Schedule of Benefits; and
2. Eligible Expenses will be considered for reimbursement in accordance with the terms of Your Plan in effect on the day before the Policy termination date; and
3. You must use the TPA that administered Your Plan as of the Policy termination date to administer any claims during the Aggregate Terminal Run-Out Period.**]**

Section II
Benefit Provision

1[Medical Travel Benefits

Introduction

The Medical Travel Benefit Provision provides reimbursement for:

- Eligible Expenses incurred by a Covered Person for Treatment received outside of the United States;
- Medical Travel access fees, if such fees are covered under Your Plan;
- Travel, lodging and meal expenses incurred by a Covered Person (and the Covered Person's parents or legal guardian(s) if the Covered Person is a minor or one companion if the Covered Person is not a minor) in connection with the Medical Travel, if such expenses are covered under Your Plan; and
- Certain expenses and deductibles paid by the Covered Person for which Your Plan has reimbursed the Covered Person.

Definitions

Medical Travel: The travel by a Covered Person outside of the United States to obtain medical treatment from a doctor, hospital or healthcare provider.

Requirements

To receive reimbursement under the Medical Travel Benefit Provision all of the following criteria must be satisfied:

1. Your Plan must cover Treatment received by a Covered Person outside of the United States;
2. The Covered Person's Medical Travel must be provided by and arranged through a vendor approved by Us (the "Medical Travel Vendor").
3. You must demonstrate: (a) that Your Plan has paid for the Covered Person's Medical Travel and the Treatment provided in connection with it; and (b) that the Treatment has been provided to the Covered Person.
4. The expenses resulting from the Treatment provide in connection with the Medical Travel must be Eligible Expenses.

Eligible Expenses will also include the following fees paid by Your Plan in connection with a Covered Person's Medical Travel and the Treatment provided in connection with it:

1. Up to 2[$500-$10,000] for travel, lodging and meal expenses incurred by the Covered Person (and the Covered Person's parents or legal guardian(s) if the Covered Person is a minor or one companion if the Covered Person is not a minor) in connection with the Medical Travel if the Medical Travel was arranged by the Medical Travel Vendor;

2. Up to 3[$500-$5,000] for any deductible or co-payment Your Plan has reimbursed the Covered Person where the deductible or co-payment related to the Treatment for which the Medical Travel was undertaken.

3. Up to 4[$100-$5,000] for Medical Travel access fees.

Section II
Benefit Provision

For the purpose of this Medical Travel Benefit Provision only, the Limitation and Exclusion that provides that: "Expenses for any Treatment administered outside the United States if the Covered Person traveled to the location where the Treatment was received for the purpose of obtaining the Treatment" is hereby deleted. That Limitation and Exclusion shall continue to apply to any claim that does not fall under this Medical Travel Benefit Provision. All other Limitations and Exclusions set forth in the Policy shall remain in force and apply to this Medical Travel Benefit Provision.

5[This Medical Travel Benefit Provision shall not provide coverage for any Transplant received by a Covered Person outside of the United States.**]]**

Section II
Benefit Provisions

1[Clinical Trials Benefit Provision

The Clinical Trials Benefit Provision is added for the purpose of determining whether expenses incurred by a Covered Person resulting from his or her participation in a 2[Phase I, II, III or IV] clinical trial ("Clinical Trial Expenses") are Eligible Expenses.

For expenses submitted for reimbursement under the Policy other than Clinical Trial Expenses, all Policy provisions shall apply as if this provision did not exist.

Pursuant to this provision, Eligible Expenses will include Clinical Trial Expenses when:

(a) You provide Us with:

1. A copy of the clinical trial treatment protocol from the facility that conducted the clinical trial; and
2. A copy of the Covered Person's signed consent and authorization to participate in the clinical trial; and

(b) You provide documentation that demonstrates to Our satisfaction that:

1. The Treatment was provided as part of an ongoing 2[Phase I, II, III or IV] clinical trial sponsored by the National Cancer Institute, National Institute of Health or the FDA; and
2. The Treatment provided by the clinical trial is covered by Your Plan; and
3. Funding is not available for the routine costs of the clinical trial from the National Cancer Institute, the National Institute of Health, the FDA or any other entity. "Routine costs" shall have the meaning attributed to it by the Centers for Medicare and Medicaid Services in its Coverage Issues Manual for clinical trials; and
4. The clinical trial has been approved by an institutional review board. An "institutional review board" shall mean a committee of physicians, statisticians, researchers, community advocates and others that ensures that a clinical trial is ethical and that the rights of trial participants are protected.]

Section II
Benefit Provisions
Expenses Eligible for Reimbursement

Eligible Expenses
Eligible Expenses include any amount paid by You for Medically Necessary and Appropriate expenses incurred by a Covered Person which:

1. Have been paid in accordance with the terms of Your Plan; and
2. Have been paid in accordance with the TPA's standard claim payment protocols and procedures; and
3. Were Incurred and Paid during the applicable claims basis; and
4. Are paid under a Covered Benefit shown on the Schedule of Benefits; and
5. Are not otherwise excluded under this Policy.

1[Alternative Care
In addition to satisfying Eligible Expenses criteria 2[2, 3 and 4] above, expenses related to Alternative Care may be considered Eligible Expenses when all of the following additional criteria have been satisfied and submitted to Independent Life and Annuity Case Management for approval:

1. You demonstrate to Our satisfaction that providing the Alternative Care resulted in a cost savings to the Plan; and
2. The Alternative Care was recommended by case management services provided to Your Plan; and
3. The Alternative Care was Medically Necessary and Appropriate].

Off-Label Drug Use
In addition to satisfying the criteria for Eligible Expenses set forth above, expenses related to Off-Label Drug Use may be considered Eligible Expenses when all of the following additional criteria have been satisfied:

1. The drug is not excluded under Your Plan; and
2. The drug has been approved by the FDA; and
3. You can demonstrate to Our satisfaction that the Off-Label Drug Use is appropriate and generally accepted in the medical community for the condition being treated; and
4. If the drug is used for the treatment of cancer, a nationally recognized compendia as determined by Us, recognize it as an appropriate treatment and
5. The drug is not provided as part of a 3[Phase I, II, III or IV] clinical trial as defined by the National Institute of Health, National Cancer Institute or the FDA.

4[Reimbursement of Certain Fees
Eligible Expenses will also include the following fees Incurred and Paid by You, when approved by Us [at Our Home Office]:

1. Reasonable hourly fees for case management services provided by a registered nurse case manager retained by You or Your TPA; and
2. Fees for: (a) hospital bill audits; (b) access to non-directed provider networks; and (c) negotiating out of network bills.
3. Such fees shall be considered Eligible Expenses only if You can demonstrate to Us that the work that generated the fees resulted in a cost savings to the Plan. If the Plan can demonstrate such a cost savings, We will reimburse You up to 5[[25%] of the amount saved.] 6[, up to a maximum of [$5,000] per hospital confinement per Covered Person.]]

Fees charged by Your TPA or any subsidiary of Your TPA for any of these services will be considered Eligible Expenses only if prior approval has been obtained in writing from Us [.] [at Our Home Office.]

7[Reimbursement of Certain Fees
Eligible Expenses will also include the following fees Incurred and paid by You, when approved by Us [at Our Home Office]:

1. Reasonable hourly fees for case management services provided by a registered nurse case manager retained by You or Your TPA; and fees for: (a) hospital bill audits; (b) access to non-directed provider

networks; and (c) negotiating out of network bills. Such fees shall be considered Eligible Expenses only if You can demonstrate to Us that the work that generated the fees resulted in a cost savings to the Plan. If the Plan can demonstrate such a cost savings, We will reimburse You up to **8[[**25%**]** of the amount saved.]

2. The per claim fee charged by the **9**[program name] for Treatment provided to a Covered Person by a non-directly contracted provider up to a maximum of **10**[10%] of the actual charge billed for the Treatment provided to the Covered Person;

3. The per claim fee charged by the **9**[program name] for Treatment provided to a Covered Person by a directly contracted provider up to a maximum of **11**[10%] of the actual charge billed for the Treatment provided by the Covered Person.

Fees charged for any of these services will be considered Eligible Expenses only if prior approval has been obtained in writing from Us [.][at Our Home Office.]

State Health Care Surcharges
If You pay a state health care surcharge in connection with the payment of Eligible Expenses, the health care surcharge shall be considered an Eligible Expenses. Penalties or fines associated with the health care surcharge or the underlying expenses will not be considered Eligible Expenses.

Section II
Benefit Provisions
Limitations and Exclusions

We will NOT reimburse You for:

1. 1[Expenses for medical services rendered to a Covered Person by the Covered Person's family member or relative.]
2. [Expenses that are payable or reimbursable under any Workers' Compensation Law or similar legislation.]
3. [Expenses for any cosmetic Treatment as defined in Your Plan. This exclusion does not apply to expenses relating to breast reconstruction after mastectomy.]
4. [Expenses for any Experimental or Investigational Treatment.]
5. [Expenses for any transplant not included in the definition of Transplant.]
6. [Expenses relating to non-human organ or tissue transplants, gene therapies, xenographs or cloning.]
7. [Expenses for any Treatment administered outside the 2[United States] if the Covered Person traveled to the location where the Treatment was received for the purpose of obtaining the Treatment.]
8. [Expenses for benefits in excess of Your Plan's limits, or expenses that are excluded under Your Plan.]
9. [Expenses in excess of the Usual and Customary Charge.]
10. [Any amount paid by You in excess of a negotiated provider discount, or any penalty or late charge incurred, or any discount lost, unless previously approved in writing by Us [at Our Home Office.]]
11. [Expenses associated with the administration of Your Plan including, but not limited to, claim payment fees, cost containment administrative fees, Pharmacy Benefit Manager administration fees, PPO access fees, premium functions, medical review and consultant fees, unless otherwise covered under this Policy.]
12. [Expenses paid by You relating to any litigation concerning Your Plan, including, but not limited to, attorneys' fees, extra-contractual damages, compensatory damages and punitive damages.]
13. [Any portion of an expense which You are not obligated to pay under Your Plan, or which is reimbursable to You under:
    a) Another group health benefit program; or
    b) A pharmacy rebate or similar monetary incentive acquired through the pharmacy drug plan; or
    c) A government or privately supported medical research program; or
    d) Medicare; or
    e) Any coordination of benefits or non-duplication of benefits provision of Your Plan; or
    f) Worker's compensation; or
    g) Any other source.]
14. [Expenses incurred by a person who is employed by You at any unit, subsidiary or division of Yours that has not been underwritten by Us.]
15. [Expenses incurred for any illness or injury due to, or aggravated by, war or an act of war, whether declared or undeclared.]
16. [Expenses paid by You for any Treatment authorized or approved under any provision of Your Plan which:
    a) Allows the plan administrator to approve alternative care or alternative treatment; or
    b) Allows the plan administrator to alter, modify, or waive Plan provisions or limitations, or
    c) Grants You or Your plan administrator discretion to approve coverage for Treatment not otherwise covered under Your Plan;
    d) unless the Treatment satisfies the criteria for Alternative Care set forth in Section II.]

Section II
Benefit Provisions
Limitations and Exclusions

17. [Expenses for any Transplant if You have a separate insurance policy that covers Transplants for Covered Persons regardless of whether the Covered Person is covered by that policy.]
18. 3[Expenses covered under a Prescription Drug Plan, unless Prescription Drug Plan coverage is a Covered Benefit on the Schedule of Benefits.]
19. [Expenses incurred for any illness or injury due to or aggravated by:
    a) 4[The Covered Person's operation of any motorized vehicle while Intoxicated. "Intoxicated" means the person operating the motorized vehicle has a blood alcohol level that equals or exceeds the minimum blood alcohol level required to be considered operating a motorized vehicle under the influence of alcohol in the jurisdiction where the accident occurred. "Motorized vehicle" includes, but is not limited to, automobiles, motorcycles, boats and snowmobiles.]
    b) [The Covered Person's committing or attempting to commit an assault, felony or other criminal act; or]
    c) [The Covered Person's voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, unless used on the advice of a physician.]]
20. [Notwithstanding any other Policy provision, We will not reimburse any expense incurred by any employee, or by the employee's Dependents, where the employee is a member of: (a) a division, unit, group, subsidiary, affiliate, or class of employee of the Policyholder; or (b) an association, trust, cooperative or similar organization connected with the Policyholder, that is not covered by the Plan as of the Policy Renewal Effective Date.]]
21. [Regardless of any provision in Your Plan, if on the Policy Effective Date or Policy Renewal Effective Date, a Covered Person is not Actively At Work or a Dependent is totally disabled, is in an institution receiving medical care or Treatment, or is confined at home or elsewhere, any expenses Incurred by the Covered Person or Dependent will not be considered for Eligible Expenses under this policy. This limitation will continue for all expenses Incurred by the Covered Person until he or she is Actively at Work and for all expenses incurred by the Dependent until he or she is no longer totally disabled or is no longer in an institution receiving medical care or Treatment or confined at home or elsewhere.

    For the purpose of this provision:
    a) A Covered Person is considered to be Actively At Work if he or she is:
        i) Working at Your usual place of business or at such place or places that Your normal course of business may require;
        ii) Performing all of the duties of his or her occupation on a full-time basis; and
        iii) Not confined in any institution providing care or treatment of physical or mental infirmities.

    If a Covered Person is not Actively At Work on the Policy Effective Date or Policy Renewal Effective Date solely because that day is not a regularly scheduled workday, the Covered Person will be deemed Actively At Work on that day.
23. A Dependent is considered totally disabled if he or she, solely because of injury or sickness, cannot engage in substantially all of the normal activities of a person of like age and sex in good health. 5[An exception is made for any infant born before the Policy Effective Date who has not been discharged from the hospital since birth. Such infants will be considered for Eligible Expenses under this Policy.]
24. 6[Expenses in excess of the actual charge billed for Treatment provided to a Covered Person.]]

Section III
Claim Provisions

Proof of Claim
Proof of claim must be provided to Us [at Our Home Office]. Expenses for claims submitted to Us that are not submitted in accordance with the Proof of Claim provisions of this Policy are not reimbursable and shall not be considered Eligible Expenses under the Policy.

1[Individual 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 Individual Benefit Deductible for a Covered Person has been satisfied. Proof of claim must be provided to Us 2[no later than 12 months] after the end of the Individual Benefit Claims Basis during which the claim arose.

Proof of claim for an Individual Benefit claim shall include the following:

1. 3[[A fully completed claim form;]
2. [A copy of the Covered Person's original enrollment record and records of any change in the Covered Person's coverage under Your Plan;]
3. [Copies of all bills [over $25,000] and invoices for expenses submitted for reimbursement under this Policy;]
4. Proof of payment of any expenses submitted to Us for reimbursement under this Policy or a claims paid detailed report, which includes: Dates of Service, Provider Name, Provider TIN, Amount billed, Discount amount, Eligible Amount, Amount paid, Date paid, Reimbursement amount requested, Previously paid amount, ICD 9 codes and CBT Codes; and
5. Any additional information We may require to fulfill Our obligations under this Policy.]]

4[Aggregate 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 end of the Aggregate Benefit Claims Basis for the Policy Year. Proof of claim must be provided to Us 5[no later than twelve (12) months] after the end of the Aggregate Benefit Claims Basis.

Proof of claim for an Aggregate Benefit claim shall include the following:

1. A complete aggregate calculation report;
2. A detailed claims history report for all Eligible Expenses Incurred and Paid during the Aggregate Benefit Claims Basis;
3. A report listing all Covered Units eligible for benefits under Your Plan at any time during the Aggregate Benefit Claims Basis;
4. A copy of Your Plan in effect during the Policy Year and any amendments thereto;
5. If Prescription Drug Plan coverage is included as a Covered Benefit on the Schedule of Benefits, a copy of all prescription drug invoices and an itemization thereof, including the amounts of any rebates received by You; and
6. Any additional information We may require to fulfill Our obligations under this Policy.]

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 [at Our Home Office] within 6[ninety (90)] days from the date of Our 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.

Deferred Payments by You
You must obtain prior written approval from Us [at Our Home Office] during the Policy Year in order for any Eligible Expenses Incurred in the Policy Year, but that will be Paid after the end of the applicable claims basis to be considered eligible for reimbursement under this Policy.

Section III
Claim Provisions

Payment of Claims

All benefits due under this Policy will be paid to You. During the Policy Year, reimbursements will be disbursed when the amount payable exceeds **7[**$500.00**]**. Any reimbursable amount remaining unpaid at the end of a Policy Year will be paid after the end of the Policy Year.

Section IV
Your Rights and Responsibilities

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

Disclosure Requirements
This Policy has been underwritten based upon the information You provided to Us concerning all persons eligible for benefits under Your Plan on the Original Individual Benefit Effective Date and/or the Original Aggregate Benefit Effective Date (or on the effective date of any class of Covered Persons added thereafter). This includes, but is not limited to, those persons who are a special risk as defined in the Special Risk Questionnaire.

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

1. You or Your authorized representative have consulted with **3[**your precertification, utilization review and Medical Management Vendors and**]** Your TPA, or former TPA, to determine who must be disclosed as a special risk on the Special Risk Questionnaire, and
2. You have identified any person who is or may be a special risk by either listing them on the Special Risk Questionnaire or by indicating any such person on the reports listed on the Special Risk Questionnaire.

If You fail to disclose an Individual as a special risk, who should have been disclosed as a special risk in accordance with the Special Risk Questionnaire, We will have the right to revise the premium rates, deductibles, deductible factors and terms and conditions of this Policy, retroactive to the Original Individual Benefit Effective Date and/or the Original Aggregate Benefit Effective Date.

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

1[Individual Benefit Reporting

You, or Your TPA, are required to provide Us with notice of any potential Individual Benefit claim within **4[**thirty-one (31)**]** days of the date:

1. A Covered Person's Eligible Expenses exceed 50% of the Individual 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 Catastrophic Diagnosis.**]**

2[Aggregate Benefit Reporting

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

1. The total amount of Eligible Expenses Incurred by any Covered Person and Paid by You, or Paid on Your behalf, during the Benefit Month; and
2. The number of each type of Covered Unit on the first day of the Benefit Month.

You must provide the Aggregate Benefit report to Us within **5[**thirty-one (31)**]** days after the end of each Benefit Month.**]**

Section IV
Your Rights and Responsibilities

Plan Changes
You must notify Us in writing [at Our Home Office] at least 6[thirty-one (31)] days before the effective date of any change in, or to:

1. Your Plan;
2. Your TPA;
3. Your Provider Networks; or
4. Your Medical Management Vendors.

Our prior written agreement is required before the coverage under this Policy will apply to any such change. Otherwise, benefits under this Policy will be paid based upon the terms of Your Plan, as it existed prior to any such change. We reserve the right to terminate this Policy as of the effective date of any change in or to Your Plan, Your TPA, 3[Your Provider Network, or Your Medical Management Vendor.] We also reserve the right to retroactively approve or terminate this Policy to the effective date of any change in or to Your Plan, Your TPA[.][, Your Provider Network, or Your Medical Management Vendor.]

Notice of Legal Action
You agree to give Us prompt notice of: (a) any event that might result in a lawsuit relating to this Policy; or (b) any lawsuit involving this Policy; and to promptly provide Us with copies of any correspondence and pleadings relating to any such event or lawsuit.

7[Hold Harmless
You agree to defend, indemnify and hold Us harmless from and against any and all claims, demands and causes of action of every kind, relating to any litigation, that We, without Our fault, become involved with that relates to this Policy or Your Plan. 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.

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

Refund of Overpayment
If We, You, or Your TPA determine that We have overpaid You under this Policy, You will promptly refund such overpayment to Us within 8[60 days] of such a determination. If We are required to take legal action to collect such overpayment, You agree to indemnify Us for any costs of collection, including, but not limited to, attorneys' fees and court costs.

Responsibility for Your TPA
You are solely responsible for the actions of Your Plan Administrator, Your TPA and any other agent 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, Your 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.

Section IV
Your Rights and Responsibilities

Right of Recovery
You must pursue all valid claims including, but not necessarily limited to, claims for restitution, constructive trust, equitable lien, breach of contract, injunction, and any other state or federal law claims You or Your 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

Section V
Our Rights and Responsibilities

Audit
We have the right to inspect and audit any and all of Your records and procedures, and those of Your TPA and any other party, that relate to any claim made by You under this Policy. We have the right to require documentation from You that demonstrates You paid an Eligible Expense and that the payment was made in accordance with the terms of Your Plan. We reserve the right to employ a third party, at Our expense, to assist Us with any audit function.

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 Your Plan.

1[If We determine that:
1. You have paid expenses incurred by a Covered Person in accordance with the terms of Your Plan; and
2. the expenses were incurred and paid during the applicable Claims Basis; and
3. the expenses are paid under a Covered Benefit as shown on the Schedule of Benefits; and
4. the expenses were paid in accordance with standard claim payment protocols and procedures,

then the expenses paid by You shall be considered Eligible Expenses unless otherwise barred by the Limitations and Exclusions **2**[8, 10, 11, 12, 14, 15, 17, and 19**]** stated in this Policy.**]**

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 Your Plan; or (b) provide services to You, Your Plan, or Your Plan Participants to reduce cost, risk or expenses under Your Plan. We may also cause 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 Your Plan to reduce your risk, costs and expenses.**]**

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 accordance with Our policies and applicable state and federal laws.

Recoupment
We have the right to recoup from any benefit payable to You under this Policy any premium You owe to Us that has not been paid. Our right of recoupment does not impair Our right to terminate this Policy for non-payment of premium under the Termination Provisions of this Policy.

Right to Recalculate
We have the right to recalculate any **4[**Individual Benefit Premium Rate, Individual Benefit Deductible, Aggregating Individual Deductible,**]** Aggregate Benefit Premium Rate, Aggregate Deductible Factor or Minimum Aggregate Deductible with respect to this Policy Year whenever any one or more of the following events occur:

1. Your Plan changes;
2. You change Your TPA**3[**, Your Provider Network(s), or Medical Management Vendor(s);**]**
3. This Policy is amended;
4. The number of Covered Units on the first day of a Benefit Month increases or decreases by more than **5[**15%**]** from the number of Covered Units on the first day of the Policy Year;
5. The number of Covered Units on the first day of a Benefit Month increases or decreases by more than **6[**10%**]** from the first day of the prior Benefit Month;
6. A unit, division, subsidiary, or affiliated company of Yours is added to, or deleted from, this Policy;
7. The amount of Eligible Expenses paid in any one of the **7[**three (3)**]** months immediately preceding the Policy Effective Date (the "**7[**three**]** month period") exceeds **8[**125%**]** of the monthly average of Eligible Expenses Incurred during the nine **9[**(9)**]** months immediately preceding the **7[**three**]** month period; or
8. There are changes in You, or Your TPA's, claim paying system or payment practices that causes a variation of **10[**fifteen (15)**]** days or more in the most recent **11[**twelve (12)**]** month average of claim processing time.

12[9. There are other circumstances or conditions agreed to in writing by You and Us.]

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

Section V
Our Rights and Responsibilities

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

1. Is not eligible for reimbursement under this Policy; and
2. Cannot be used to satisfy any deductible or attachment point under this Policy; and
3. Must be repaid to Us if We previously reimbursed You for it.

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

Section VI
General Provisions

Assignment
Your interest in this Policy cannot be assigned.

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

Clerical Error
In the event of a clerical error in this Policy, the Policy will be revised to correct the error. Your failure to:

1. Report the existence of a Covered Person; or
2. File proof of claim in a timely manner; or
3. Comply with the reporting requirements of this Policy;

shall not constitute clerical error.

Entire Contract
This Policy, along with any Attachments, Riders, Endorsements, Addenda or Amendments, and the Application completed by You constitutes the entire contract of insurance between us.

Legal Action
You may not bring a legal action against Us to recover on this Policy earlier than **1**[sixty (60)] days after You have furnished Us with proof of claim in accordance with the Proof of Claim provisions of this Policy. You may not bring any legal action against Us to recover on this Policy after **2**[three (3)] years from the time proof of claim is required under this Policy.

Misrepresentation
If:

1. You make any misstatement, omission or misrepresentation, whether intentional or unintentional, in the information or documentation You, Your TPA or any other party acting on Your behalf, provide to Us, and which We rely upon during the underwriting of this Policy; or
2. After this Policy is issued, We learn of expenses or claims that were incurred or paid, but not reported to Us, during the underwriting of this Policy,

We have the right, at Our election, to rescind this Policy or to revise the premium rates, deductibles, and terms and conditions of this Policy and to make any revision retroactive to the Policy Effective Date.

No ERISA Liability
Under no circumstance will We accept responsibility as a “Plan Administrator” or be deemed a “plan fiduciary” with respect to Your Plan under the Employee Retirement Income Security Act of 1974, as amended.

Non-Participating Policy
This Policy is non-participating and does not share in Our surplus earnings.

Policy Amendment
No change in this Policy, or waiver of any of its provisions, will be valid unless such change or waiver is in writing and agreed to by Us [at Our Home Office] and made a part of this Policy. No agent, broker, TPA, or managing general underwriter has authority to change this Policy or waive any of its provisions.

Section VI
General Provisions

Policy Renewal
This Policy may be renewed unless it has been terminated or is subject to termination in accordance with the Termination Provisions of this Policy. Policy changes for any renewal policy will appear on a revised Schedule of Benefits and/or a Policy amendment. Your payment of the renewal premium after receipt of the revised Schedule of Benefits and/or Policy amendment constitutes acceptance of the renewal policy by You.

3[No New Special Conditions Rider at Renewal
We guarantee that if You renew Your Policy with Us, Your renewal stop loss policy will not contain a new or revised Special Conditions Rider, provided that:

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

We reserve the right to carry over to the renewal stop loss policy any Special Conditions Rider that is part of Your current Policy.

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

4[Special Conditions Rider at Renewal
If You renew Your Policy with Us, Your renewal stop loss policy may contain a new or revised Special Conditions Rider.]

5[Renewal Rate Increase Cap
If You renew Your Policy with Us**,** We guarantee that the Individual Benefit Premium Rate 6[and the Aggregating Individual Deductible] on Your renewal stop loss policy will not be increased more than 7[50]% over the Individual Benefit Premium Rate 6[and the Aggregating Individual Deductible] shown on the Schedule of Benefits, provided that:

1. Your Plan contains no changes that materially affect or alter the risk presented by Your current Policy;
2. Your renewal stop loss policy contains no material changes from Your present Policy; including, but not limited to, changes to: a) the length of the Policy Year; (b) Covered Benefits; (c) coverage for Retirees; (d) the Individual Benefit Deductible; (e) the Claims Basis; 8[(f) the Individual Benefit Lifetime Maximum or Annual Maximum Eligible Expensed;] 9[(g) the Individual Benefit Reimbursement Percentage;] (h) the commission payable; (i) Your TPA; or (j) Provider Networks;
3. There are no material changes in the demographic distribution of the group covered by Your current Policy versus the group covered by the renewal stop loss policy; and
4. A new unit, division, subsidiary, affiliated company or class of covered people is not added to this Policy.
5. There is no charge in any assessment levied against Us by the state in which this Policy was issued.

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

5[Renewal Trend Increase Cap
If You renew Your Policy with Us**,** We guarantee that the Individual Benefit Premium Rate 6[and the Aggregating Individual Deductible] on Your renewal stop loss policy will be increased by no more than 7[10]% over the Individual Benefit Premium Rate 6[and the Aggregating Individual Deductible] shown on the Schedule

of Benefits and that there will be no change to the Special Condition Rider, provided that:

1. Your Plan contains no changes that materially affect or alter the risk presented by Your current Policy; You increase the Individual Benefit Deductible by 7[10%].

2. Your renewal stop loss policy contains no material changes from Your present Policy; including, but not limited to, changes to:
   (a) the length of the Policy Year;
   (b) Covered Benefits;
   (c) coverage for Retirees;
   (d) the Claims Basis;
   8[(e) the Individual Benefit Lifetime Maximum or Annual Maximum Eligible Expensed;]
   9[(f) the Individual Benefit Reimbursement Percentage;]
   (g) the commission payable;
      (i) Your TPA; or
      (ii) Provider Networks;

3. There are no material changes in the demographic distribution of the group covered by Your current Policy versus the group covered by the renewal stop loss policy; and

4. A new unit, division, subsidiary, affiliated company or class of covered people is not added to this Policy.
5. There is no charge in any assessment levied against Us by the state in which this Policy was issued.

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

Section VI
General Provisions

[Experience Rating Refund

On each Policy Anniversary a retrospective experience rating refund process is applied to the **10**[Individual Benefit] **11**[and Aggregate Benefit]. We allot to this Policy such amount, if any, as We determine to be available as a refund as a result of that process. We reserve the right to change the basis of this process.]

Premium Provisions

Premium Payments

Premium is due on or before the Premium Due Date.

Grace Period

A grace period of **12[**forty-five (45)**]** days will be allowed for the payment of each premium due after the first premium has been paid. This Policy will continue in force during the grace period. If a premium is not paid by the end of the Grace Period, this Policy will terminate, without notice to You, as of the last date for which premium was paid.

Premium Data

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

1. The number of each type of Covered Unit, for each Covered Benefit, under Your Plan on the first day of the Benefit Month; and
2. The amount of premium paid.

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

Severability

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

Termination Provisions

1. If You fail to pay the premium, this Policy will terminate in accordance with the Premium Provision of this Policy;
2. If Your Plan is terminated, this Policy will terminate on the date the Plan terminated; or
3. If You fail to maintain a minimum of **13[**50**]** participants in Your 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 **13[**50**]** participants.
4. This Policy will terminate at the end of the Policy Year unless agreed by You and Us to renew.
5. If You, or Your TPA, fail to satisfy any of Your obligations under this Policy, We may terminate this Policy by giving You **14[**sixty (60) days**]** advance written notice.
6. We may terminate this Policy at the end of the Policy Year by providing you **15[**31**]** days advanced written notice.
7. You may terminate this Policy at any time by providing Us with **15[**31**]** days advance written notice **[**at Our Home Office**]**.

The parties to this Policy may agree in writing to terminate it at any time.

Reinstatement

If this Policy is terminated for non-payment of premium, We may, at Our sole 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 the Policy.

Time Limitations

If any time limitation in this Policy is less than that permitted by the law of the state in which the Application was taken, the limitation is hereby extended to the minimum period permitted by the law.