Amalgamated Life
Life • Accident • Disability

AMALGAMATED LIFE INSURANCE COMPANY

333 Westchester Avenue
White Plains, New York 10604

Amalgamated Life Insurance Company (the "Company"), agrees to pay Excess Loss Insurance benefits under the provisions of this Policy to the Policyholder ("PH") listed in the Schedule of Excess Loss Insurance.

READ YOUR POLICY CAREFULLY

This Policy is legally binding between the PH and the Company. The consideration for this Policy includes but is not limited to the signed Application, signed Disclosure Form and the payment of Premiums.

AGREEMENT

The Company will pay the Aggregate and/or Specific Benefits named in this Policy to the PH. Benefit Payment is subject to the terms, limitations and exceptions of this Policy and those contained in the PH's Participant Benefit Plan ("PBP").

The PH agrees to pay premiums when due. The PH also agrees to comply with the Policy provisions.

This Policy takes effect on the Effective Date shown in the Schedule. The Policy terminates on the end of the Policy Period ("PP") shown in the Schedule unless it is renewed. All periods in the Policy start and end at 12:01 A.M. standard time at the PH's office.

This Policy Form is governed by the laws of the state in which it is issued.

Signed for Amalgamated Life Insurance Company at its Home Office on its date of issue.

David J. Walsh
President

Ellen R. Dunkin
Secretary

Policy Providing Excess Loss Insurance

Nonparticipating

IF YOU HAVE QUESTIONS ABOUT THIS POLICY, CALL (914) 367-5361

AMALGAMATED LIFE INSURANCE COMPANY
SCHEDULE OF EXCESS LOSS INSURANCE

TABLE OF CONTENTS

Item		Page
Schedule		[3]
I.	Definitions	[6]
II.	Benefits	[8]
III.	Limitations and Exclusions	[9]
IV.	Premium Provisions	[9]
V.	Claim Provisions	[10]
VI.	Records and Reporting Required	[11]
VII.	Policy Renewal or Termination	[12]
VIII.	Miscellaneous Provisions	[12]

AMALGAMATED LIFE INSURANCE COMPANY
SCHEDULE OF EXCESS LOSS INSURANCE

1. Policy Number: [SL12345]

2. Policyholder: [XYZ Corp.]

3. Legal Address: [Main Street, Anytown, USA]

4. Subsidiary or affiliated entities (i.e., under common control through Policy, or otherwise) to be included (list legal name and address): [none]

5. Name and address of the Administrator or designated Third Party Administrator: [none]

6. Effective Date: [1/1/16]

7. State of Issue: [Connecticut]

8. GENERAL SCHEDULE OPTIONS: Attached and shown in Schedule A

SCHEDULE A

GENERAL SCHEDULE OPTIONS:

(a) Policy Period from [1/1/16] to [12/31/16].

(b)

Persons who are Active	[X] are [ ] are not covered
Persons who are on COBRA	[ ] are [X] are not covered
Persons who are Disabled	[ ] are [X] are not covered
Persons who are Hospital Confined on the Effective Date	[ ] are [X] are not covered
Persons who are Retired (under 65 and not on Medicare)	[X] are [ ] are not covered
Persons who are Retired (over 65 or covered by Medicare)	[ ] are [X] are not covered
Persons who are not Actively at Work on the Effective Date	[ ] are [X] are not covered
Persons who are temporarily disabled	[X] are [ ] are not covered
Persons who are on approved leave	[X] are [ ] are not covered
Persons who are receiving a severance package	[ ] are [X] are not covered
Other (specify) _____	[ ] are [ ] are not covered

(c) Aggregate Benefit [X] Yes [ ] No

Aggregate Policy Basis: Participant Benefit Plan Expenses must be
Incurred from [1/1/16] through [12/31/16].
Paid from [1/1/16] through [12/31/16].
Claims Incurred prior to the Policy Effective Date are limited to $ [1,000,000].

Aggregate eligible expenses include:

[X] Medical	[ ] Prescription Drugs
[ ] Dental Care	[ ] Short-term Disability Income
[ ] Vision Care	[ ] Other (specify)

Aggregate Monthly Factor per single Participant: $ [500]
Family: $ [500]
Composite: $ [500]

Aggregate Payable Percentage (excess of Deductible): 100%
Maximum Eligible Claim Expense Per Covered Person: $[250,000]
Minimum Aggregate Deductible (Minimum Aggregate Attachment): $[100,000]
Maximum Aggregate Benefit (excess of Deductible): $[500,000]

(d) Monthly Aggregate Accommodation [X] Yes [ ] No

(e) Terminal Liability [X] Yes [ ] No

(f) Specific Benefit [X] Yes [ ] No

Specific Policy Basis: Participant Benefit Plan Eligible Claims Payment Expenses must be
Incurred from [1/1/16] through [12/31/16].
Paid from [1/1/16] through [12/31/16].
Claims Incurred prior to the Policy Effective Date are limited to $ [500,000].

Specific Eligible Expense: [Medical and Prescription Drug]
Specific Deductible (per person): $ [50,000]
Specific Payable Percentage (excess of Deductible): [100] %
Aggregating-Specific (or Corridor) Deductible: $ [500,000]

PREMIUMS:

(a) Aggregate Premium
- Premium Per Month Per Unit: $[4,000]
- Minimum Annual Aggregate Premium: $[48,000]

Monthly Aggregate Accommodation
- Premium Per Month Per Unit: $[2,000]
- Annual Premium in Advance: $[2,000]

Terminal Liability
- Premium Per Month Per Unit: $[2,000]
- Annual Premium in Advance: $[24,000]

(b) Specific Premium
- Premium Per Month Per Single Participant: $ [400]
- Family: $ [4,000]
- Composite: $ [4,000]
- Minimum Monthly Specific Premium: $ [2,000]

SPECIAL RISK LIMITATIONS:

Level of Charge information is as follows:
Participant Benefit Plan uses what the PBP uses to pay Eligible Claims Expenses.

Policy will be based upon the current Participant benefits as defined in the Participant Benefit Plan by reference or by attachment:

OPTIONAL BENEFITS: Check all that apply.

(a) Advance Funding [ ]
(b) Specific Extension Benefit for _____ Months [ ]
(c) Aggregate Accommodation [ ]
(d) Aggregate Extension Benefit for _____ Months [ ]
(e) Expenses in Excess of UCR [ ]
(f) Other _____ [ ]
(g) Other _____ [ ]

I. DEFINITIONS

Administrator is the designated Administrator named in the Schedule that has been approved by the Company. This party has been chosen to administer the payment of claims and/or other duties as assigned by the PH.

Administrator or Agent, when referring to the PH means the PH's representative. This can include but is not limited to the PH's Designated Agent, Broker, Consultant or Administrator. Each entity must have a written agreement with the PH. The agreement covers services for the PBP. Each entity must also be acceptable to the Company. The Company reserves the right to reject an Administrator chosen by the PH. The term "Administrator" as used in this Policy does not refer to the Plan Administrator used in the Employee Retirement Income Security Act (ERISA) of 1974, as amended, unless the PH has specifically appointed the Administrator as such.

Advance Funding is an optional benefit. It will be in effect if elected in the Schedule. It covers Eligible Claim Payments. These claims should be fully processed according to the terms of the PBP and ready for Payment. The Company will pay the PH. The PH will use the Advance Funding within 10 business days to pay these claims. Such claim payments made within the 10 days (net of any amounts returned) will for purposes of this Policy be considered made on the Company's date of payment. If payment does not occur, the PH will return the funds to the Company within 5 more business days. If the funds are returned after 5 more business days, interest at Prime plus 4% is charged.

Aggregate Accommodation is an optional benefit. It is in effect if elected in the Schedule. It means conditional reimbursement of the Aggregate Excess Insurance Benefit before the end of the PP if aggregate claims for the PP exceed the Aggregate Deductible at the end of any month. A final accounting will be performed at the end of the PP. If the accounting shows that no benefits were due under this Policy or that the Aggregate Accommodation benefits paid exceed the annual benefit, the PH will remit the excess to the Company on the earlier of 30 days after termination, the end of the PP or the excess may be subtracted from any Specific excess loss claim payments due.

Aggregate Benefit means the amount that the Company agrees to pay the PH. This happens after the end of the PP for eligible claims Paid by the PH. This is set forth in the Schedule and pursuant to the terms, conditions and limitations of the Policy.

Aggregate Policy Basis identifies the dates during which PBP expenses must be Incurred and must be Paid to be considered eligible for reimbursement as Aggregate Benefits.

Aggregate Deductible Per Month means the Aggregate Monthly Factor shown in the Schedule. It is multiplied by the Number of Covered Units.

Aggregate Deductible means the sum of each Aggregate Deductible Per Month for each month during the PP or fraction thereof. It is subject to the Minimum Aggregate Deductible.

Aggregate Extension is an optional benefit. It is in effect if elected in the Schedule. It is provided only if the PBP becomes fully insured at or before the end of the PP. The plan must notify the Company in writing before the effective date of the insurance policy. The Policy will cover Eligible Claim Payments after the PP for the number of months chosen. The formula for calculating the Aggregate Deductible will be increased by one additional month. It will use the most current enrollment at time of notification. The time period in which Eligible Claim Payments may be Incurred is not changed by this provision. Other than the terms noted, the terms and conditions of this Policy are unaffected if this benefit is chosen.

Aggregating Specific Deductible is also referred to as the Corridor.

Continuation Beneficiary is a Covered Unit. It elects to extend its group health coverage under a PBP entitled under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Corridor means the amount shown in the schedule that the PH pays for all claims above the Specific Deductible. It is paid before the Company pays for any specific eligible expenses. An aggregating specific does not apply to the Aggregate Deductible.

Covered Person refers to each person who is a Covered Unit. In the case of a dependent it refers to a member of a Covered Unit.

Covered Unit means a Covered Person or such other defined unit as the Company and the PH agree to. This applies only if such Covered Person is covered under the PBP. This definition is for purposes of calculation of the premiums and the Aggregate Deductible Per Month.

Disabled Person is a Covered Person is a person defined by the PH EBP, if so defined, otherwise it is a person whose illness or accident prevents them from working at their regular employment. It also means a dependent or Continuation Beneficiary not Actively at Life on the Effective Date of this Policy or the date such person becomes eligible for coverage under the PBP.

Eligible Claims Payments means expenses of the PBP qualifying for coverage. These qualify only under the terms and conditions of this Policy as elected in the Schedule. If shown in the Schedule, an Aggregate Specific (Corridor) Deductible are not considered Eligible Claims Payments.

Eligible Dependents means

1. the lawful spouse of an insured;
2. the child of the Participant if the child is under 26 years of age;

Employee Benefit Plan may be referred to as a Participant Benefit Plan.

Incurred means the date a covered medical service was rendered, the date a covered medical purchase was made or the date a medical supply was received for a Covered Person under the PBP. For disability benefits it means the date payments become due, not the date disability commences and not the date when they are paid.

Maximum Aggregate Benefit means the amount in the Schedule as the maximum total Aggregate Benefit payable. It is payable only under the terms, conditions and limitations of this Policy during the PP.

Maximum Eligible Claim Expense Per Person means the maximum dollar amount of claims Paid on any one Covered Person that can apply toward an Aggregate Deductible. This also means claims that can apply toward the calculation of the Aggregate Benefit for a PP less any benefit limitations.

Minimum Aggregate Attachment is also known as the Minimum Aggregate Deductible.

Minimum Aggregate Deductible means the aggregate monthly factor shown in the schedule multiplied by the number of Covered Units provided in the PH's proposal request multiplied by the number of months in the PP multiplied by the minimum percentage shown in the Company's proposal.

Number of Covered Units means the total number of Covered Units existing in any Policy Month.

Paid means a claim where funds are actually disbursed by the PH or its Agent. Payment of a claim is the unconditional and direct payment of a claim to or on behalf of a Covered Person to their health care provider(s) and not rebated, refunded or returned by the provider(s). Payment will be deemed made on the date that the following two things occur. (1) the payer directly tenders payment by mailing or delivering a draft or check. (2) the account upon which the payment is drawn has and continues to have enough funds to pay the check or draft. The Company may consider any check or draft as not paid should the account from which payment is drawn not have enough funds to pay all outstanding checks and drafts. This is at the Company's sole discretion. This applies only to the total amount of the difference between the funds in the account and the sum of outstanding checks and drafts.

Participant Benefit Plan ("PBP") means the master plan document of the PH. The PBP provides medical expense benefits to the PH's Covered Persons in effect on the Effective Date of this Policy. A copy of the PBP is attached to and made a part of this Policy. Participant Benefit Plan may include an Employee Benefit Plan.

Payable Percentage means the percentage payable as shown in the Schedule. The calculation of Specific Benefits may be subject to a different Payable Percentage than the calculation of Aggregate Benefits.

Policy means the entire agreement between the PH and the Company. This includes the Policy Application, the Disclosure Form, the Policy Form, and the Policy Addenda (if any), and a copy of the PH's PBP.

Policy Month means a period measured from the Effective Date of this Policy while this Policy is in force. Each new Policy Month will begin on a day that corresponds to the Effective Date. If there is no such day in any applicable month then the last day of the month will be used.

Policy Period ("PP") is stated in the Schedule.

Policyholder ("PH") is named in the Schedule.

Proof of Loss is the form authorized by the Company to be used to submit claims. This includes the supporting documents reasonably needed for the Company's independent evaluation of the eligibility and extent of the claim. A separate Proof of Loss is required if the expense was not previously identified.

Schedule means the Schedule of Excess Loss Insurance or supporting Exhibit.

Specific Policy Basis identifies the dates during which PBP expenses must be Incurred and must be Paid to be considered eligible for reimbursement as Specific Benefits.

Specific Deductible means the per Covered Person deductible as shown in the Schedule.

Specific Extension is an optional benefit in effect if elected in the Schedule. It is provided only if the PBP becomes fully insured at or prior to the end of the PP. The PH must notify the Company in writing before the effective date of the insurance policy. The Policy will cover Eligible Claim Payments after the PP for the number of months elected. The time period in which Eligible Claim Payments may be Incurred is not altered by this provision. Unless specified, the terms and conditions of this Policy are not affected if this benefit is chosen.

Stepped Down Deductible means a lower deductible than the Specific Deductible that can be used for adjudicating a claim.

II. BENEFITS

The Company will pay the following benefits to the PH if in the Schedule within a reasonable time upon receipt of a fully executed Proof of Loss. The payment is subject to the terms, conditions and limitations of the Policy.

1. **Aggregate Benefit**

The Aggregate Benefit for the PP or fraction thereof is the total of the Eligible Claim Payments on an Incurred and/or Paid basis (this applies as shown in the Aggregate Policy Basis in the Schedule).

a. less the Aggregate Deductible or Minimum Aggregate Deductible, whichever greater; and
b. less the amount of the claims Paid by the PH in excess of the Maximum Eligible Claim Expense per Covered Person as shown in the Schedule; and
c. less amounts recovered from other sources.
d. all multiplied by the Aggregate Payable Percentage.

Aggregate Benefits are not payable until after the end of the Aggregate Policy Basis in the Schedule. If this Policy should terminate before the end of the PP, the Company will not be liable for Aggregate Benefits for eligible expenses Incurred or Paid by the PH after the termination date. In no event will the Aggregate Benefit exceed the Maximum Aggregate Benefit shown in the Schedule.

2. **Specific Benefit**

The Specific Benefit for each Covered Person is the total of the Eligible Claim Payments on an Incurred and/or Paid basis. It is as shown in the Specific Policy Basis of the Schedule.

a. less the Specific Deductible shown in the Schedule; and
b. less amounts recovered from other sources.
c. all multiplied by the Specific Payable Percentage.

The PH will not be entitled to any Specific Benefit until the PH has actually paid the full amount of the Specific Deductible. The PH will only be entitled to a Specific Benefit up to the amount actually Paid by the PH above the Specific Deductible. If this Policy terminates prior to the end of the PP, the Company will not be liable for Specific Benefits for eligible expenses Incurred or Paid by the PH after that date.

III. LIMITATIONS AND EXCLUSIONS

This Policy will not pay the PH for any loss or expense caused by or a result of:
[1. Expenses Incurred while the PBP is not in force for the Covered Person.]
[2. Expenses as a result of short-term disability income, dental, vision or any prescription card service unless shown in the Schedule.]
[3. Liability assumed by the PH under any Policy or service agreement other than the PBP.]
[4. Expenses as a result of extra-contractual damages or legal fees. This includes but is not limited to compensatory damages, exemplary damages, punitive damages, fines or statutory penalties.]
[5. Liability otherwise assumed by the PH though excludable under the PBP.]
[6. Expenses for benefits for accidental bodily injury, disease or sickness arising out of or in the course of any occupation for wage or profit. This includes eligible benefits under any Worker's Compensation, U.S. Longshoremen and Harbor Workers' or other occupational disease legislation or policy. This is so whether the other coverage is actually in force.]
[7]. Cost of the administration of claim payments, expense of litigation or consultation fees with individual claimants.

IV. PREMIUM PROVISIONS

1. **Payment of Premiums.** Each Premium for this Policy is payable on or before its due date as set forth in the Schedule to the Company or to its authorized representative. Payment of a premium will not maintain this Policy in force beyond the period for which such premium is paid. Exceptions will be as otherwise stated in the Grace Period.

   If the Effective Date of this Policy is other than the first day of a calendar month, premiums payable under this Policy are due and payable on the first of each calendar month. The first payment will include the period from the effective date to the first of the following month and the first full month's premium.

2. **Grace Period.** A Grace Period of thirty (31) days will be allowed for the payment of each premium after the first premium. Should a premium that is due not be paid during the Grace Period, this Policy will terminate without further notice. Termination will be retroactive to the date for which premiums were last paid. The liability of the Company will be limited to claims Paid by the PH prior to the termination date. If there is less than a full month premium payment, coverage will be prorated using the number of days in the month. There will be no refund of any PP premium payments. Nevertheless, the PH will be liable for premiums due and unpaid as of the termination date.

3. **Premium Rates.** The Company has the right to set new premium rates and deductible factors for each PP. The Company also reserves the right to set new premium rates and deductible factors at any time, provided the PH receives 45 days written advance notice if:
   a. The Number of Covered Units changes by more than ten percent (10%) from the number used in the most recent premium rate calculation.
   b. The benefits under the PBP are increased.
   c. The eligibility requirements under the PBP are eased.
   d. There is a change in law or regulation that affects this Policy.
   e. The PH adds or deletes any subsidiary or affiliated companies or divisions.

4. **Premium Taxes.** The PH will be responsible for any State premium taxes incurred with respect to funds paid to or by the PH under the PBP. Taxes incurred with respect to premiums paid for the Policy will be the responsibility of the Company.

5. **Offset.** The Company will be entitled to offset claim reimbursements to the PH against premiums due and unpaid by the PH.

V. CLAIM PROVISIONS

1. **Payment of Claims.** All benefits, as they become payable under this Policy, will be paid to the PH. All eligible expenses, as they become payable under the PBP, will be Paid by the PH. The Company will pay claims within a reasonable time after receiving fully executed Proofs of Loss and the documentation reasonably necessary to evaluate the eligibility and extent of the claim. The determination of benefits under the PBP is the sole responsibility of the PH. The Company will have the sole authority to reimburse or deny claims under this Policy.

2. **Representation.** The PH represents that all moneys needed to pay for services and supplies have been paid to the respective providers of medical services or supplies to which the claim for reimbursement relates when submitting an Aggregate Proof of Loss.

3. **Notice of Claim.** The PH will give written notice of a claim for injury or for sickness to the Company within thirty (30) days after the date of the accident causing such injury or the commencement of the disability from such sickness. Failure to give such notice within such time shall not invalidate nor reduce any claim if it was not reasonably possible to give such notice within the time required, provided written notice of claim is given as soon as reasonably possible, and in no event later than one year after the date written notice was otherwise required. IF COMPLETE INFORMATION TO PAY THE CLAIM IS NOT SUBMITTED, UPON NOTIFICATION TO THE PH, NO CLAIM WILL BE PAID TWELVE MONTHS AFTER THE LATER OF THE "PAID THROUGH" DATE OR "INCURRED THROUGH" DATE AS SHOWN IN THE POLICY SCHEDULE.

   The Company, upon receipt of a notice of claim, will furnish to the PH the Proof of Loss form within fifteen days. If the Company does not furnish such forms within fifteen (15) days after the giving of the required notice, the PH will be deemed to have complied with the requirements of this Policy as to Proof of Loss upon submitting, within the time fixed in the Policy for filing proofs of loss, affirmative written proof covering the occurrence, the character and the extent of the loss for which claim is made.

   The Company is not responsible for discounts lost due to late claim payments by the Administrator. The Company's reimbursement will assume the discount was achieved. In addition, claims should be consistently Paid by the PH within an average 30 day time limit. If this does not happen the Company may give written notice of such to the PH. Claims not paid within 30 days of receipt by the PH will not count toward the deductibles 45 days after such notice. They will also not be reimbursed under this Policy.

   The PH will give written notice to the Company on the Company's customary notice (Proof of Loss form) of potential claims within 30 days of the date the PH becomes aware of the existence of facts which would reasonably suggest the possibility that benefits will be Incurred which are covered by this Policy, if claims have one of the following characteristics for a Covered Person:

   a. the claim equals or exceeds 50% of the Specific Deductible or $25,000 whichever is less.
   b. the claim is pre-certified care and is expected to exceed 50% of the Specific Deductible.
   c. a large claim pended for eligibility.
   d. a large claim pended for subrogation.
   e. the Covered Person is Hospital Confined for 30 days.
   f. a claim with diagnoses specified in the Disclosure Form.

   The PH will give written notice to the Company of potential Aggregate claims within 30 days if at the end of any month eligible expenses are Incurred that, if annualized, equal, exceed or are expected to exceed the Aggregate Deductible.

The PH has an additional obligation of providing monthly summary claims data for the entire PBP by line of business.

The Company may waive the above requirements. This can happen on submission of a monthly detailed electronic claims listing. The electronic file would include a HIPPA compliant claim listing showing details for each claim. The details will show the patient identifier, patient date of birth, gender and plan code (if more than one benefit plan). The details will also show the date of service, date claim received, date of payment, check number, diagnosis code, procedure code, place of service code or inpatient identifier, prescription drug identifier, in-network indicator, claim charge, ineligible expense, amount disallowed, the deductible, copay amount, coinsurance amount and the amount paid.

4. **Claims Case Management.** The activities that control the cost of a claim and include but are not limited to preadmission certification, concurrent review, case management, discharge planning, fee negotiation, in-network channeling, cooperation with and review of care by the Company's claim management services. It is not a requirement that the PH have a formal arrangement with a case management service that is active and effective in controlling claim.

   If you work with the Company to achieve plan savings by using the Company's recommended case management firm or provider network, fee negotiation firm, audit firm or other contracted service, the company will provide a premium credit equal to the lesser of [10%] of the savings below the estimated PH cost or [$5,000] or an agreed to Stepped Down Deductible.

[5. **Subrogation.** The Company may recover expenses from a third party provided the amount recovered is explicitly for health and medical expenses. The PH will pursue any and all valid claims that the PH may have against third parties arising out of any occurrence resulting in a loss payment by the PH and account for any amounts recovered. Should the PH fail to pursue any valid claims against third parties and the Company thereupon becomes liable to make payments to the PH under the terms and conditions of this Policy, the Company shall make such payment and upon such payment the Company will assume all the PH's rights to pursue any valid claims against third parties. The PH will be responsible for any reasonable legal expenses incurred in the course of the pursuit. The PH agrees to cooperate fully and do all things necessary and required by the Company to pursue any action to recover against the third party. Any amounts recovered will be used first to reimburse the expenses of recovery and then to reimburse the Company for any benefit payments made on behalf of a Covered Person. All amounts remaining thereafter will be Paid to the PH.]

6. **Claim Recoveries.** The Company will be entitled to recover first up to its full share of reimbursed claims before the PH shares in any amount so recovered whether by way of subrogation or otherwise.

[7. **Arbitration.** Any controversy or claim arising out of or relating to this Policy, or the breach thereof, may be settled by judicial resolution of the dispute or by any other means for resolving controversies or claims. However, if Arbitration is chosen it shall be in accordance with the rules of the American Arbitration Association. This has the express stipulation that the arbitrator(s) will strictly abide by the terms of this Policy and will strictly apply rules of law applicable thereto. All matters will be decided by a panel of three (3) arbitrators. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction but any decision is not binding, and does not prevent the seeking of judicial or other resolution of the dispute.]

VI. RECORDS AND REPORTING REQUIRED

1. **Responsibilities of the PH.** The PH will maintain adequate records. These records must be acceptable to the Company to administer this Policy. The Company may periodically examine and audit any records relating to the coverage under this Policy. This may be done for claims filed, claims procedure benefits covered or premium payments.

   The PH or the Administrator will submit all proofs, reports and supporting documents required for the preceding month by the 15th day of each month. This includes but is not limited to a summary of all claims Paid, Number of Covered Units and premium paid. The Company has the right to change the deductible or aggregate factors retroactively if it determines that the information provided is inaccurate or incomplete. If

the benefits covered were not reported completely and accurately, the Company may require an additional [3%] premium payment to cover any additional risk.

2. **Administrator Duties.** The PH may administer items under this section. The PH may also use an Administrator. Without waiving any of its rights under this Policy, and without making the Administrator a party to this Policy, the Company agrees to recognize the Administrator in respect to the normal administration of the PH's Plan if the Administrator:
    a. is responsible on behalf of the PH.
    b. investigates, audits, calculates, processes and pays all claims eligible under the PBP.
    c. prepares periodic reports as required by the Company.
    d. maintains and makes available to the Company at all times information the Company reasonably requires for claim proof of payment.
    e. allows the Company to periodically examine and audit records relating to eligible coverage and for claims filed under this Policy.
    f. performs such other duties as may be reasonably required by the Company.

    The Company will not be responsible for any compensation due the Administrator for functions performed in relation to this Policy. This Policy does not make the Company a party to any agreement between the PH and the Administrator.

VII. POLICY RENEWAL OR TERMINATION

1. **Renewal.** Renewal of this Policy is automatic. Renewal may be subject to new premium rates. It may also be subject to new underwriting terms and new Policy terms.

2. **Termination.** The Policy and all benefits hereunder will terminate upon the earliest of the following dates:
    a. The termination date specified in writing by the PH provided that the Company is notified not less than 31 days in advance of the termination date.
    b. The end of any period for which premiums were paid and subsequent premiums are not paid.
    c. The end of the PP.
    d. The termination date of the PBP.
    e. The date of cancellation of the administrative agreement between the PH and the Administrator unless the Company has agreed in writing to the PH's designation of a successor Administrator. This must happen before such cancellation.
    f. This Policy will automatically terminate if the PH does not pay claims or make available funds to pay claims as required by the Policy.

VIII. MISCELLANEOUS PROVISIONS

1. **Entire Policy.** This Policy Form as issued to the PH, together with the PH's Application, the Disclosure form and a copy of the PH's PBP with all amendments, constitute the Entire Policy. The Company has relied upon the underwriting information provided by the PH or the PH's Agent, in the issuance of this Policy. The Company has the right to change the rates, deductibles, terms or conditions for coverage if subsequent information becomes known which, if known prior to issue would have changed such items. If there is a conflict between the provisions of the PBP and this Policy, this Policy will prevail.

2. **Amendments to the PBP.** The PBP will not be changed while this Policy is in force without the prior written consent of the Company. Notice of any amendment to the PBP must be given to the Company or its authorized representative at least thirty (30) days prior to the Effective Date of the amendment. The Company will have the sole option to accept the amendment to the PBP. If accepted, the Company reserves the right to revise the rates, deductibles, terms or conditions of the Policy as of the Effective Date of the amendment. If such amendment is not agreed to in writing, the Company will be liable to pay benefits as if the PBP was not changed.

3. **Amendments to this Policy.** The Company reserves the right to revise rates, deductibles, terms or conditions of the Policy on any date when
    a. the PH adds or deletes a subsidiary or affiliate.

b. the PH's geographical area changes.
c. the nature of business in which the PH is engaged changes.
d. there is an increase or decrease in the number of Covered Units which exceeds 10% in any one month or 20% over any period of three consecutive months.

4. **Changes.** Only the President, a Vice President or Assistant Vice president 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 will be valid unless endorsed on or attached to this Policy. No Agent, Broker, or Administrator has the authority to alter this Policy or to waive any of its provisions.

5. **Notice to PH.** Notice to the PH's Administrator will be considered notice to the PH. This is for the purpose of any notice required from the Company under the provisions of this Policy.

6. **Notice to Company of Objection, Legal Action or Complaint.** Any objection, notice of legal action, or complaint received on a claim processed by the PH or the Administrator, and on which it reasonably appears a benefit will be payable to the PH under this Policy, will be brought to the immediate attention of the claims department of the Company.

7. **Concealment and or Fraud.** Subject to the conditions stated in the Incontestability of Insurance provision, this entire Policy will be void if the PH or its Agent has concealed or misrepresented any material fact or circumstance related to the Policy or the subject thereof. This includes any claim or any case of fraud by the PH or its Agent relating thereto. This applies whether it happens before or after a claim or loss. No misrepresentation shall be deemed material unless knowledge by the Company of the facts misrepresented would have led to a refusal by the Company to make such Policy.

8. **Clerical Error.** Clerical error in keeping any records pertaining to the coverage, will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. This applies to errors made by the PH or the Company. No such error will expand the Company's obligations under this Policy. Upon discovery of a clerical error, an adjustment premium will be due pursuant to the terms and conditions of this Policy.

9. **Liability and Indemnification.** The Company is acting only as a provider of insurance to the PH. The Company is not and will not be considered a fiduciary and assumes no obligations required by the Employee Retirement Income Act (ERISA) of 1974, as amended.

   The Company's sole liability under this Policy is to the PH. This is for payments made for Covered Persons for Eligible Expenses under the PBP subject to the terms and conditions of this Policy. The Policy does not create any right or obligation to pay any Covered Person, Administrator or provider of professional or medical services. Nothing in this Policy will be construed to permit a Covered Person to have a direct right of action against the Company. The PH agrees to hold the Company harmless from any damages, expenses Incurred or judgments awarded arising out of any dispute involving a Covered Person, with respect to the Covered Person's claim of any rights under the PH's PBP. The PH will indemnify the Company for all expenses, including attorney fees incurred in defending claims or lawsuits brought against the Company by a Covered Person. This Policy will not deem the Company a party to any agreement between the PH and the Administrator. The Company will not be considered a party to the PBP of the PH or to any supplement or amendment to it. The PH agrees to hold the Company harmless from damages of any kind that are not caused by the Company's own acts or omissions.

10. **Insolvency.** The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors or dissolution of the PH or the PH's Administrator will not impose upon the Company any liability other than the liability defined in this Policy. In particular, the insolvency of the PH will not make the Company liable to the creditors of the PH, including Covered Persons.

11. **Incontestability of Insurance.** This Policy is issued based on the truth of statements made the PH. All statements made by the PH, in the absence of fraud, will be deemed representations and not warranties. Such statements will not be used to contest validity of insurance unless the statement is in a written instrument signed by the PH. Other than non-payment of premium, this Policy will not be contested after it has been in force for two years from the Policy Effective Date.

12. **Assignments.** The PH will not assign any of its rights under this Policy without the prior written consent of the Company. Any assignment without prior written consent will be void.

13. **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 the Policy invalid.

14. **Non Waiver**. The failure of either the PH or the Company to exercise any right or privilege contained in this Policy will not be deemed a waiver of any such right or privilege or a waiver of any rights or remedies available in the future.

15. **Legal Action.** No action at law or in equity will be brought to recover on this Policy prior to the expiration of sixty (60) days after written notice of loss has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of three (3) years after the time written Proof of Loss is required to be furnished.

16. **Conformity With Statutes.** This Policy is subject to the laws of the state in which it is issued. Any provision of this Policy that is in conflict with the statutes of the applicable jurisdiction on the Effective Date is hereby amended to conform to the minimum requirements of the law.

17. **Reinstatement.** If default is made in the payment of any agreed premium for this Policy, the subsequent acceptance of such defaulted premium by the Company or by any agent authorized by the Company to accept such premium, will reinstate the Policy. However, the reinstated Policy will cover only loss resulting from accidental injury thereafter sustained or loss due to sickness beginning more than ten (10) days after the date of such acceptance.

18. **Extension of time limitations**. If any limitation of this Policy with respect to giving notice of claim, furnishing Proof of Loss, or bringing any action on this Policy is less than that permitted by law of the state, district or territory in which the insured resides at the time this Policy is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

19. **Accuracy of Records.** The Company will have sole discretion to adjudicate claims based on the documents received on behalf of the PH. The Company may require an adjustment to the premium for any differential that would have been charged had accurate documents been submitted to the Company.