

SERFF Tracking Number: FRCS-125632225 State: Arkansas  
Filing Company: American Fidelity Assurance Company State Tracking Number: 38847  
Company Tracking Number: 4880  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Stop Loss Policy Filing  
Project Name/Number: AFA/66/66

## Filing at a Glance

Company: American Fidelity Assurance Company

Product Name: Stop Loss Policy Filing SERFF Tr Num: FRCS-125632225 State: ArkansasLH  
TOI: H21 Health - Other SERFF Status: Closed State Tr Num: 38847  
Sub-TOI: H21.000 Health - Other Co Tr Num: 4880 State Status: Approved-Closed  
Filing Type: Form Co Status: None Reviewer(s): Rosalind Minor  
Author: Kevin Wiggs Disposition Date: 05/06/2008  
Date Submitted: 05/02/2008 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: AFA/66  
Project Number: 66  
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending  
Date Approved in Domicile:  
Domicile Status Comments: This filing has been submitted to the domicile state on or about this same date.

Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:  
Filing Status Changed: 05/06/2008  
State Status Changed: 05/06/2008  
Corresponding Filing Tracking Number:

Market Type: Group  
Group Market Size: Large  
Group Market Type: Employer

Deemer Date:

Filing Description:

This filing is a stop loss / excess risk filing. This stop loss contract provides excess risk coverage to employers with self-funded health plans subject to the Employee Retirement Income Security Act of 1974 (ERISA). The Company provides the following assurances:

- That this product will be marketed to large groups only.
- That all benefits will be paid only to the policyholder (employer), and not to the employer's employees.

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<i>Project Name/Number:</i>	<i>AFA/66/66</i>		

- That the policy will be issued only to insure the employer, and not the employer's employees.
- That they will comply with any applicable state-required minimum specific deductible and minimum aggregate attachment point.

Variable Material: Other than the material marked as variable in the Application/Schedule of Benefits, there are no variables. Therefore, we have not included a description of variable material. It should be noted that no change in the variable areas will be made which will be in conflict with the law, rules and regulations of your state. In addition, no change in variability will be made which in any way expands the scope of the wording being changed.

Our fee of \$600 has been sent by EFT on this same date.

## Company and Contact

### Filing Contact Information

(This filing was made by a third party - FC01)

Kevin Wiggs, Compliance Specialist	kevin.wiggs@firstconsulting.com
1020 Central	(800) 927-2730 [Phone]
Kansas City, MO 64105	(816) 391-2755[FAX]

### Filing Company Information

American Fidelity Assurance Company	CoCode: 60410	State of Domicile: Oklahoma
PO Box 25523	Group Code: 330	Company Type:
Oklahoma City, OK 73125	Group Name: American Fidelity Group	State ID Number:
(800) 365-9180 ext. [Phone]	FEIN Number: 73-0714500	

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$600.00
Retaliatory?	Yes
Fee Explanation:	OK fee of \$50 for 1 policy and \$25 per other form for 22 forms = \$600
Per Company:	No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Fidelity Assurance Company	\$600.00	05/02/2008	20069885

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/06/2008	05/06/2008

*SERFF Tracking Number:*      *FRCS-125632225*                      *State:*                      *Arkansas*  
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*Company Tracking Number:*      *4880*  
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*Product Name:*              *Stop Loss Policy Filing*  
*Project Name/Number:*      *AFA/66/66*

## **Disposition**

Disposition Date: 05/06/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	List of Forms being submitted	Approved-Closed	Yes
Form	Excess Loss Insurance Policy	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Acceptance of Plan Document Changes	Approved-Closed	Yes
Form	Endorsement		
Form	Changes to Policyholder Information	Approved-Closed	Yes
Form	Endorsement		
Form	Qualified Clinical Trials Endorsement	Approved-Closed	Yes
Form	Exclusions/Limitations for Named	Approved-Closed	Yes
Form	Persons Endorsement		
Form	Domestic Claims Endorsement	Approved-Closed	Yes
Form	Specific Terminal Liability Endorsement	Approved-Closed	Yes
Form	Aggregate Specific Attachment Point	Approved-Closed	Yes
Form	Endorsement		
Form	Right to Medically Underwrite	Approved-Closed	Yes
Form	Endorsement		
Form	Aggregate Terminal Liability Endorsement	Approved-Closed	Yes
Form	Aggregate Accommodation Option	Approved-Closed	Yes
Form	Endorsement		
Form	Specific Advance Option Endorsement	Approved-Closed	Yes
Form	Addition of Subsidiary or Other Affiliated	Approved-Closed	Yes
Form	Group Endorsement		
Form	Policy Termination Endorsement	Approved-Closed	Yes
Form	Prescription Drugs Covered Under Plan	Approved-Closed	Yes
Form	Endorsement		
Form	Coverage of Disabled Persons	Approved-Closed	Yes
Form	Endorsement		
Form	Change in Premium Endorsement	Approved-Closed	Yes
Form	Change in Specific Excess Loss	Approved-Closed	Yes
Form	Coverage Endorsement		

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*Product Name:*              *Stop Loss Policy Filing*  
*Project Name/Number:*      *AFA/66/66*

<b>Form</b>	Change in Basis of Coverage Endorsement	Approved-Closed	Yes
<b>Form</b>	Change in Monthly Aggregate Factor Endorsement	Approved-Closed	Yes
<b>Form</b>	Change in Aggregate Excess Loss Coverage Endorsement	Approved-Closed	Yes
<b>Form</b>	Blank Endorsement	Approved-Closed	Yes

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## Form Schedule

**Lead Form Number:** AFA-SLP-2008(AR)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AFA-SLP-2008(AR)	Policy/Cont	Excess Loss ract/Fratern Insurance Policy al Certificate	Initial		56	AFA-SLP-2008_AR_john doe_dist.pdf
Approved-Closed	A-1253(AR)	Application/	Application Enrollment Form	Initial		50	A-1253_AR_john doe_dist.pdf
Approved-Closed	AMD-8300	Policy/Cont	Acceptance of Plan ract/Fratern Document Changes al Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50	AMD-8300_dist.pdf
Approved-Closed	AMD-8301	Policy/Cont	Changes to ract/Fratern Policyholder al Information Certificate: Endorsement Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50	AMD-8301_dist.pdf
Approved-Closed	AMD-8302	Policy/Cont	Qualified Clinical ract/Fratern Trials Endorsement al Certificate: Amendmen t, Insert Page,	Initial		50	AMD-8302_dist.pdf

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<i>Product Name:</i>	<i>Stop Loss Policy Filing</i>			
<i>Project Name/Number:</i>	<i>AFA/66/66</i>			
	<b>Endorseme nt or Rider</b>			
Approved- Closed	AMD-8303 Policy/Cont Exclusions/Limitation Initial ract/Fratern s for Named Persons al            Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50	AMD-8303 _dist.pdf
Approved- Closed	AMD-8304 Policy/Cont Domestic Claims ract/Fratern Endorsement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50	AMD-8304 _dist.pdf
Approved- Closed	AMD-8305 Policy/Cont Specific Terminal ract/Fratern Liability Endorsement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50	AMD-8305 _dist.pdf
Approved- Closed	AMD-8306 Policy/Cont Aggregate Specific ract/Fratern Attachment Point al            Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50	AMD-8306 _dist.pdf

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<i>Product Name:</i>	<i>Stop Loss Policy Filing</i>			
<i>Project Name/Number:</i>	<i>AFA/66/66</i>			
Approved- Closed	AMD-8307 Policy/Cont Right to Medically ract/Fratern Underwrite al Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50	AMD-8307 _dist.pdf
Approved- Closed	AMD-8308 Policy/Cont Aggregate Terminal ract/Fratern Liability Endorsement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50	AMD-8308 _dist.pdf
Approved- Closed	AMD-8309 Policy/Cont Aggregate ract/Fratern Accommodation al Option Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50	AMD-8309 _dist.pdf
Approved- Closed	AMD-8310 Policy/Cont Specific Advance ract/Fratern Option Endorsement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50	AMD-8310 _dist.pdf
Approved- Closed	AMD-8311 Policy/Cont Addition of ract/Fratern Subsidiary or Other	Initial	50	AMD-8311 _dist.pdf

<i>SERFF Tracking Number:</i>	<i>FRCS-125632225</i>	<i>State:</i>	<i>Arkansas</i>	
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<i>Product Name:</i>	<i>Stop Loss Policy Filing</i>			
<i>Project Name/Number:</i>	<i>AFA/66/66</i>			
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Approved- Closed	AMD-8312	Policy/Cont Policy Termination ract/Fratern Endorsement	Initial  50	AMD-8312 _dist.pdf
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Approved- Closed	AMD-8313	Policy/Cont Prescription Drugs ract/Fratern Covered Under Plan	Initial  50	AMD-8313 _dist.pdf
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Approved- Closed	AMD-8314	Policy/Cont Coverage of ract/Fratern Disabled Persons	Initial  50	AMD-8314 _dist.pdf
		al            Endorsement		
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Approved- Closed	AMD-8315	Policy/Cont Change in Premium ract/Fratern Endorsement	Initial  50	AMD-8315 _dist.pdf
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 Product Name: Stop Loss Policy Filing  
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Approved- AMD-8317 Policy/Cont Change in Basis of Initial 50 AMD-8317  
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Approved- AMD-8318 Policy/Cont Change in Monthly Initial 50 AMD-8318  
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Approved- AMD-8319 Policy/Cont Change in Aggregate Initial 50 AMD-8319  
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SERFF Tracking Number: FRCS-125632225 State: Arkansas  
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TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Stop Loss Policy Filing  
Project Name/Number: AFA/66/66

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Approved- AMD-8320 Policy/Cont Blank Endorsement Initial 50 AMD-8320  
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**American Fidelity  
Assurance Company**

**A member of the American Fidelity Group**

2000 North Classen Boulevard, Oklahoma City, Oklahoma 73106

**EXCESS LOSS INSURANCE POLICY  
Non-Participating**

**PLEASE READ CAREFULLY**

**Policyholder Name:** [ABC Employer]  
**Principal Address:** [123 Main Street  
Anycity, Anystate 99999]  
**Policy Number:** [SL 012345]  
**Effective Date:** [01-01-2009]  
**Expiration Date:** [02-31-2009]  
**YOUR Designated Third-Party Administrator:** [XYZ Administrators]

This Policy is issued in consideration of YOUR Application/Schedule and the payment of premiums. The attached Application/Schedule and a copy of YOUR ERISA Employee Welfare Benefit Plan Document form a part of this Policy. All periods of coverage will begin and end at 12:01 a.m. Standard Time at YOUR Principal Address.

This Policy is governed by the laws of the state of YOUR Principal Address.

This Policy is issued by US at OUR Underwriting Offices as of the Effective Date.



Secretary



President

**NOTICE:** This is a reimbursement Policy. YOU, or YOUR Plan Administrator, are responsible for making benefit determinations under YOUR Employee Welfare Benefit Plan. WE have no duty or authority to administer, settle, adjust, or provide advice regarding claims filed under YOUR Employee Benefit Plan.

**WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

**TABLE OF CONTENTS**

Section 1 ..... Definitions  
Section 2 ..... Specific Excess Loss Coverage  
Section 3 ..... Aggregate Excess Loss Coverage  
Section 4 ..... Reimbursement of Additional Coverages  
Section 5 ..... Limitations  
Section 6 ..... Exclusions  
Section 7 ..... Premiums and Factors  
Section 8 ..... Termination  
Section 9 ..... Reinstatement  
Section 10 ..... Claim Provisions  
Section 11 ..... General Provisions  
Exhibit 1  
Application/Schedule  
Endorsement(s), if any

## SECTION 1 — DEFINITIONS

The following terms, wherever used in this Policy, or an Application/Schedule, Endorsement, or Disclosure Statement attached hereto, shall have the meaning set forth in this Section.

**Aggregate Reimbursement Percentage** means the percentage at which Eligible Expenses, in excess of YOUR Annual Aggregate Attachment Point, will be reimbursed by US.

**Annual Aggregate Attachment Point** means, for the Policy Period or any portion of the Policy Period, the Plan Benefits covered by this Policy and wholly retained by YOU. It is not considered for reimbursement under this Policy, and is the greater of:

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

The maximum per Covered Person that may be applied annually to the Annual Aggregate Attachment Point, (i.e. Individual Claim Limit) is shown in the Application/Schedule.

**Application/Schedule** means the Excess Loss Insurance Application/Schedule signed by YOU and attached to this Policy. The Application/Schedule is subject to acceptance by US and, if accepted, will become a part of this Policy.

**Benefit Period** means the period of time shown in the Application/Schedule during which Eligible Expenses incurred by a Covered Person, which are Paid by YOU during the Policy Period, are eligible for reimbursement under this Policy. This period does not alter the Policy Effective Date or Policy Period but does include any Run-In Period and/or Run-Out Period as shown on the Policy Application/Schedule. It does not waive this Policy's eligibility requirements.

**COBRA Continuee** means a Covered Unit that elects to extend its group health coverage under the Plan as entitled under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and subsequent regulations.

**Company** (WE, US, OUR) means American Fidelity Assurance Company.

**Covered Family** means an employee and his or her dependents covered under the Plan.

**Covered Person** means an individual covered under the Plan.

**Covered Unit** means an employee, an employee with dependents, or such other defined unit as agreed upon between YOU and US, as shown in the Application/Schedule.

**Disabled Persons** are those persons who are or become unable to perform the same lifestyle functions as a person of similar age and sex who is in good health.

**Disclosure Statement** means the Disclosure Statement submitted by YOU to US in connection with the issuance of this Policy.

**Eligible Expenses** means the eligible charges payable under YOUR Plan and for which the Covered Person is liable to pay. It does not include expenses specifically excluded or limited by this Policy, YOUR Application/Schedule for this Policy, or any Endorsements.

**Endorsement** means a written amendment or addendum that alters the terms of this Policy.

**Experimental or Investigational** means medical services, supplies or treatments, including drugs, devices and biological products, provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II or III). The covered service will also be considered Experimental/ Investigational in any setting if the Covered Person is required to sign a consent form that indicates the proposed treatment, procedure, medical service, supply, drug, device or biological product is part of a scientific study or

medical research to determine its effectiveness or safety. Medical treatment, which is not considered standard treatment under the particular medical circumstances by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental/Investigational. Off-label usage of any drug will be considered Experimental/Investigational. A drug, device or biological product is considered Experimental/Investigational if it does not have FDA approval or it has FDA approval only under an interim step in the FDA process, i.e., an investigational device exemption or an investigational new drug exemption or is used off-label.

**HIPAA** refers to Public Law 104-191, otherwise known as the Health Insurance Portability and Accountability Act of 1996 and subsequent regulations.

**Incurred** means:

1. with respect to medical services or supplies, the date on which the services are rendered or supplies are received by the Covered Person; and
2. with respect to disability income benefits, the date each periodic benefit payment becomes payable to the Covered Person (not the date the disability commences), if this coverage was elected on the Application/Schedule; and
3. with respect to negotiated medical services or supplies, the date on which the service or supply was initially rendered or used.

**Individual Claim Limit** means the maximum amount of Payments for Eligible Expenses that will be allowed for any one Covered Person under Aggregate Excess Loss Coverage. The Individual Claim Limit is shown in the Application/Schedule. The maximum allowable amount of Eligible Expenses for a Covered Person who has been assigned a separate Specific Attachment Point will be the specified amount as shown under the Individual Claim Limit on the Application, regardless of that Covered Person's separate Individual Specific Attachment Point.

**Large Claim** (or **LC**) means Paid, denied or pending claims reaching, or with the potential to reach, 50% of the Specific Attachment Point or a Potentially Catastrophic Loss (PCL).

**Medically Necessary** means a service or supply that is necessary to diagnose and treat a condition. Such service or supply must be commonly recognized by the medical profession as standard of care for the control or cure of the illness or injury being treated by physicians practicing in the same or related specialty field. This does not include any services or supplies that:

1. are provided only as a convenience to the Covered Person or provider; or
2. exceed in scope, duration, or intensity, the level of care that is needed to provide safe, adequate, and appropriate diagnosis and treatment; or
3. are excluded under the Plan Document, or Exclusions section of this Policy; or
4. are not listed as Plan Benefits under the Plan Document.

**Minimum Annual Aggregate Attachment Point** means the lowest amount of total Payments YOU must make under YOUR Plan before YOU are eligible for reimbursement under Aggregate Excess Loss coverage. The Minimum Annual Aggregate Attachment Point is shown in the Application/Schedule.

**Monthly Aggregate Factor** means the factor(s) that is/are multiplied by the number of Covered Units for each Policy Month to determine the Annual Aggregate Attachment Point. The Monthly Aggregate Factor(s) is/are shown in the Application/Schedule.

**Monthly Aggregate Deductible** means the amount determined for each Policy Month by multiplying the number of Covered Units for that month by the applicable Monthly Aggregate Factor(s) shown on the Application.

**Paid** (or **Payment**) means that a claim has been adjudicated by the TPA and the funds are actually disbursed by the Plan prior to the end of the Benefit Period. Payment of a claim is the unconditional and direct payment of a claim to a Covered Person or their health care provider(s). Payment will be deemed made on the date that both:

1. the payer directly tenders payment by mailing (or by other form of delivery) a draft or check; and
2. the account upon which the payment is drawn contains, and continues to contain, sufficient funds of the Policyholder to permit the check or draft to be honored by the institution upon which it is drawn. If the account upon which the payment is drawn is funded by a separate account or line of credit or "sweep" account, then the funding account must contain sufficient funds to permit the check or draft to be honored by the institution upon which it is drawn.

**Plan** (or **Employee Welfare Benefit Plan**) means the self-insured health care plan YOU have agreed to make available to YOUR employees and their eligible dependents and that is the subject of this Policy, whether or not it is subject to the Employee Retirement Income Security Act of 1974, as is or as may be amended.

**Plan Benefits** means the health benefits covered by the Plan during the Policy Period that are:

1. Incurred on or after the Effective Date of this Policy; and
2. Incurred while this Policy is in force; and
3. Incurred and Paid during the Policy Period.

Plan Benefits will also include those health benefits covered by the Plan that are:

1. Incurred during the Policy Period and Paid during any Run-Out Period; and
2. Incurred during the Run-In Period and Paid during any Policy Period or Run-Out Period.

Plan Benefits do not include:

1. deductibles of the Plan; or
2. co-insurance or co-payment amounts of the Plan; or
3. expenses that are not covered by the Plan or this Policy; or
4. amounts recoverable from any other source; or
5. amounts Paid under a previous policy or arrangement of excess loss coverage, whether issued by US or another entity; or
6. Health Savings Accounts, Health Reimbursement Accounts, Flexible Spending Accounts or any similar plan enacted by legislation.

While the determination of benefits under the Plan is the sole responsibility of the Policyholder, WE reserve the exclusive right to interpret the terms and conditions of the Plan as it applies to this Policy. WE have the sole authority to approve or deny reimbursements under this Policy without deference to the benefit determination made by the Plan.

**Plan Document** means the written instrument that describes the Plan and names the fiduciaries or trustees who jointly and separately have authority to control and manage the operations and administration of the Plan. The Plan Document must be in effect on the Effective Date of this Policy. Any changes to the Plan Document must be accepted by US. (See the "Changes to YOUR Plan" provision.)

**Policy** means this Excess Loss Policy issued by US to YOU.

**Policy Month** means, for the first Policy Month, the period beginning on the Effective Date of this Policy and ending on the corresponding date of the following month. Subsequent Policy Months begin on the corresponding date of each calendar month and continue until the corresponding date of the next month to the Policy Expiration Date.

**Policy Period** means the time period beginning on the Effective Date and ending on the Expiration Date.

**Policyholder** (Plan Sponsor, YOU or YOUR) means the Plan Sponsor, named on the face page, to whom this Policy is issued.

**Potentially Catastrophic Loss** (PCL) means a Paid, denied or pending claim that has the potential to be catastrophic. PCLs include, but are not limited to the conditions listed in Exhibit I.

**Premium Due Date** is the first day of each calendar month. If the Effective Date of this Policy is other than the first day of a calendar month, the first month's premium will be pro-rated.

**Proof of Loss** means receipt of a complete claim form, satisfactory to the Company, and other supporting documentation required by the Company.

**Run-In Limit** means the maximum benefit amount paid by YOU under YOUR Plan for Eligible Expenses incurred by a Covered Person during the Run-In Period that will be applied toward payment under this Policy.

**Run-In Period** means the period of time shown in the Application/Schedule immediately prior to the first day of this Policy's Policy Period during which Eligible Expenses incurred by a Covered Person, which are Paid by YOU during the Policy Period, will be considered when determining benefit payments under this Policy.

**Run-Out Period** means the period of time shown in the Application/Schedule immediately following this Policy's Expiration Date during which Eligible Expenses incurred by a Covered Person, which are Paid by YOU during the Policy Period, will be considered when determining benefit payments under this Policy.

**Specific Attachment Point** means the amount that is retained and Paid by YOU during the Policy Period. It is not considered for reimbursement under this Policy. The Specific Attachment Point applies separately to each Covered Person. The Specific Attachment Point is shown in the Application/Schedule.

**Specific Lifetime Maximum Reimbursement** means the maximum amount WE will reimburse YOU with respect to any claims for a person covered under the Plan that have been filed or submitted under this and prior or later Policies issued by US. The Lifetime Maximum excludes the Specific Attachment Point amount. The Lifetime Maximum will not exceed the lesser of:

1. the amount shown in the Application/Schedule; or
2. the lifetime amount set forth in the Plan minus the sum of the Specific Attachment Point applicable to the claimant under each of the policies issued by US.

**Specific Reimbursement Percentage** means the percentage at which Eligible Expenses, in excess of YOUR Specific Attachment Point, will be reimbursed by US.

**Third-Party Administrator (TPA)** means a firm having a written agreement with YOU to process Plan Benefits and provide administrative services.

The term Third-Party 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 YOU have specifically appointed the Third-Party Administrator as such.

**Usual and Customary Charges** means the common charge for the same or comparable service or supply in the geographic area in which the service or supply is furnished. Usual and Customary Charges are determined based upon:

1. the amount of resources expended to deliver the treatment; and
2. the complexity of the treatment rendered; and
3. charging protocols and billing practices generally accepted by the medical community; and
4. the amount paid after discounts under governmental and private plans.

## SECTION 2 — SPECIFIC EXCESS LOSS COVERAGE

WE will reimburse YOU for Plan Benefits Paid in excess of the Specific Attachment Point, not to exceed the Specific Lifetime Maximum amount shown in the Application/Schedule.

WE will reimburse YOU after YOU have provided an acceptable proof of loss and satisfactory proof of Paid Plan Benefits.

The Specific Excess Loss benefit applies to a Policy Period or fraction thereof (due to termination). As determined with regard to each Covered Person, it is the lesser of:

1. the Specific Lifetime Maximum; or
2. eligible Plan Benefit Payments made with regard to a Covered Person, less the Specific Attachment Point, the result of which is then multiplied by the Specific Reimbursement Percentage.

If, for any reason, YOUR Specific Excess Loss coverage terminates before the end of the Policy Period:

1. all coverage under this Policy will end as of 12:01 a.m. on the date of YOUR termination;
2. the Run-Out Period, if any, will not apply; and
3. the Specific Attachment Point shown in the Application/Schedule will continue to apply and will not be reduced or prorated.

### SECTION 3 — AGGREGATE EXCESS LOSS COVERAGE

The Aggregate Excess Loss benefit for the Policy Period, or fraction thereof (due to termination), is the Plan Benefit Payment made for Eligible Expenses during the Policy Period less:

1. the greater of the Minimum Annual Aggregate Attachment Point or the calculated Annual Aggregate Attachment Point; and less
2. the Specific Excess Loss benefits that have been or will be reimbursed by US under the Specific Excess Loss coverage; and less
3. any payments that exceed any limitations of coverage under this Policy or that are excluded under this Policy; multiplied by
4. the Aggregate Reimbursement Percentage.

In no event will the Aggregate Excess Loss benefit exceed the Maximum Aggregate Reimbursement specified under Aggregate Excess Loss Coverage in the Application/Schedule.

If for any reason, YOUR Aggregate Excess Loss coverage terminates before the end of the Policy Period:

1. all coverage under this Policy will end as of 12:01 a.m. on the date of YOUR termination;
2. the Run-Out Period, if any, will not apply; and
3. the Minimum Annual Aggregate Attachment Point shown in the Application/Schedule will continue to apply and will not be reduced or prorated.

### SECTION 4 — REIMBURSEMENT OF ADDITIONAL COVERAGES

Plan Benefits that YOU have Paid under YOUR Prescription Drug Card Plan will be considered for reimbursement under Specific Excess Loss Coverage only if shown as included on the Application/Schedule.

Plan Benefits that YOU have Paid under YOUR Prescription Drug Card Plan, Vision Plan, Dental Plan, and/or Weekly Income Plan will be considered for reimbursement under Aggregate Excess Loss Coverage only if shown as included on the Application/Schedule. The most WE will reimburse YOU for Plan Benefits YOU Pay under YOUR Weekly Income Plan, if included for reimbursement, is shown in the Application/Schedule.

### SECTION 5 — LIMITATIONS

Our liability under this policy will not be increased if the Plan provides more liberal limitations provisions.

In addition to the limitations provided under the Plan, this Policy will not cover any of the following:

#### **Non-Disclosed Losses**

If YOU fail to disclose any required health information on:

1. a Covered Person when YOU make application for this Policy; or
2. on an employee, or a dependent of an employee, of a company YOU acquire or become affiliated with, when such subsidiary or affiliate will be included in YOUR Plan,

then:

1. WE will not reimburse YOU for any Plan Benefits Paid for the illness or condition that was required to be disclosed;
2. such Paid Plan Benefits may not be used towards satisfaction of the Specific Attachment Point for such Covered Person; and
3. such Paid Plan Benefits may not be used towards satisfaction of YOUR Annual Aggregate Attachment Point.

#### **Retired Employees**

WE will reimburse Paid Plan Benefits for Retired Employees and their dependents, who are eligible under the Plan, only if such persons are indicated as included in the Application/Schedule.

#### **COBRA Continuees**

With respect to those persons qualifying as COBRA Continuees, and continuing coverage under YOUR Plan as such, prior to, on or after the Effective Date of this Policy, WE will reimburse Paid Plan Benefits for such individuals only if YOU made timely notification to such individuals of their rights to COBRA continuation coverage

and if such individuals made a timely election of such coverage as required by applicable law and if all required COBRA premiums were paid timely.

### **Medicare Benefits**

With respect to Covered Persons who are eligible and entitled to coverage under Medicare, any benefit reimbursable to YOU under this Policy shall be reduced by the amount of any similar Medicare benefit paid or reimbursable so that the total reimbursements hereunder with respect to a Covered Person or his or her dependents shall not exceed 100% of such person's actual expenses otherwise reimbursable under this Policy.

### **Medical Hardware, Devices, Implants**

Reimbursements for medical hardware and devices and implants will be limited to an amount equal to 150% of the actual invoice cost of the medical hardware and device and implant paid by the hospital or other provider. No amount will be reimbursed under this Policy until a copy of the invoice is received by US.

### **Prescription Specialty Drugs and Drug Protocols**

For prescription specialty drugs and drug protocols delivered in an outpatient setting or in the physician's office, the maximum reimbursement will be 150% of the manufacturer's invoice price. No amount will be reimbursed under this Policy until:

1. a copy of the invoice is received by US; and
2. a copy of the physician's prescription instructions are received by US.

### **Liability For Reimbursement**

WE shall not be liable under this Policy to directly reimburse any Covered Person or provider of professional or medical services for any benefits that YOU have agreed to provide under the terms of the Plan. OUR sole liability is to YOU, in accordance with the terms of this Policy. YOU may not assign any Excess Loss benefits to Covered Persons or providers of services.

## **SECTION 6 — EXCLUSIONS**

WE will not reimburse YOU for any loss or expense caused by or resulting from:

1. expenses incurred while the Plan is not in force with respect to the Covered Person, or for a person not covered under the Plan;
2. expenses covered by Plan changes made prior to OUR written approval of such changes;
3. expenses that result from any prescription card service, mail order prescription plan or any pre-paid prescription drug plan, dental, vision, or weekly income benefits, unless specifically included on the Application/Schedule and approved by US.
4. liability or obligations assumed by YOU under any contract or service agreement other than the Plan;
5. expenses for services or supplies that are in violation of any law;
6. expenses for services or supplies billed above the Usual and Customary Charges for the area where provided, or that are greater than the Plan Benefits;
7. expenses resulting from or caused by war, whether declared or undeclared; civil war; invasion; hostilities; riot; resistance to armed aggression; or acts of terrorism, or complications therefrom;
8. expenses for benefits for accidental bodily injury or sickness arising out of or in the course of any occupation for wage or profit, or complications therefrom; or for which the Covered Person would be entitled to benefits under any Workers' Compensation, Longshoremen's and Harbor Workers' Compensation Act, or other occupational disease legislation or policy, whether or not such policy is actually in force;
9. cost of the administration of claims, including cost of investigation, payments, or other service(s) provided by YOUR TPA, consulting fees and/or expenses of any litigation;
10. expenses or complications resulting from an injury sustained while the Covered Person was committing a felony under the laws of the state in which such act occurred, whether or not such Covered Person was actually charged or convicted of any criminal conduct;
11. deductible, coinsurance, co-payment amounts, expenses that are not covered by the Plan or this Policy, amounts recoverable from any other source, or amounts Paid under a previous policy or arrangement of Excess Loss coverage, whether issued by US or another entity, Health Savings Accounts, Health Reimbursement Accounts, or Flexible Spending Accounts or any similar plan enacted by legislation;

12. expenses or costs resulting from noncontractual damages, court costs and legal fees, including but not limited to compensatory, exemplary and punitive damages, fines or statutory penalties;
13. medical expenses or complications in connection with Experimental or Investigational services, supplies or treatments, including drugs, devices and biological products, as defined in this Policy;
14. payments recoverable through YOUR Plan's Coordination of Benefits; Medicare, Medicaid, or TriCare where the other plan is primary;
15. expenses incurred by an employee or dependent of an employee of any affiliated or subsidiary company not included in the Application/Schedule, unless added by Endorsement;
16. legal expenses and fees including legal expenses and fees incurred on behalf of any Covered Person in obtaining medical treatment or expenses incurred in connection with a judgment or settlement arising out of YOUR negligence in providing, arranging, or failing to provide or arrange a benefit to a Covered Person;
17. payments YOU make under YOUR Plan for services and supplies that are not included in YOUR Plan or that are outside the requirements of YOUR Plan Document or this Policy even when the discretionary authority to make such payments is specifically granted in writing to the Plan Sponsor and/or Third-Party Administrator by that same Plan Document;
18. expenses incurred after the Expiration Date; or
19. in the event this Policy is terminated before the Expiration Date, expenses incurred after the date of such termination;
20. expenses incurred by any COBRA Continuee whose COBRA continuation coverage was not offered in a timely manner or was not elected in a timely manner or for which premiums were not paid in a timely manner;
21. YOUR TPA's failure to provide timely payment to providers in their required time frame that results in non-receipt of any discounted fees for services or supplies. WE will reimburse only for the amount of the discounted amount had timely payment been made by YOUR TPA.

## SECTION 7 — PREMIUMS AND FACTORS

### Payment of Premiums

No coverage under this Policy will be in effect until the first premium is paid. For coverage to remain in effect, each subsequent premium must be paid on or before the Premium Due Date. YOU are responsible for the payment of premiums. Payment of the premium to YOUR TPA does not constitute payment of the premium to US. Premium is not considered paid until the premium check is received at OUR Underwriting Office and sufficient funds are transferred from YOUR account into OUR account.

Upon termination of this Policy, or coverage hereunder, if the earned premium exceeds the premium paid, YOU will pay the excess to US; if less, WE will return to YOU the unearned portion of premium paid, subject to the minimum premium, if any, shown in the Application/Schedule.

### Grace Period

A Grace Period of 31 days from the due date will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the coverage will remain in effect, provided the premium is paid before the end of the Grace Period. If YOU do not pay the premium during the Grace Period, this Policy will terminate without further notice, retroactive to the date for which premiums were last paid.

### Changes in Premium Rates or Factors

WE may change YOUR premium rates and/or Monthly Aggregate Excess Loss Factors on any of the following dates:

1. The date when the terms of this Policy are changed.
2. The date YOU add or delete subsidiary or affiliated companies or divisions with OUR approval.
3. The date YOU change YOUR Plan with OUR written approval.

WE reserve the right to recalculate the premium rates and/or the Monthly Aggregate Excess Loss Factors retroactively for the Policy Period:

1. if there is more than 10% variance between:
  - a. the number of Covered Units on any premium due date; and
  - b. the number of Covered Units on the Policy Effective Date;or

2. if there is more than 10% variance between:
  - a. the average monthly Paid claims under the Plan for the last two months of the 12-month period immediately prior to the Effective Date of this Policy; and
  - b. the average monthly Paid claims under the Plan for the first 10 months of the 12-month period immediately prior to the Effective Date of this Policy;
 or
3. with respect to a Plan whose excess loss coverage arrangement for the period immediately prior to the Effective Date of this Policy contained a run-out period, if the claims paid during such run-out period of the prior excess loss coverage arrangement are more than 15% of the claims paid during the period of time beginning on the effective date of such prior excess loss coverage arrangement and the Effective Date of this Policy, whether the prior excess loss coverage arrangement was one of OUR policies or another carrier's.

## SECTION 8 — TERMINATION

This Policy and all coverage hereunder will end upon the earliest of the following:

1. At the end of any period for which the premium is paid, if the subsequent premium is not paid as provided in the Grace Period provision.
2. On the date YOU tell US YOU want to cancel this Policy, provided YOU have given US at least 31 days advance written notice. If YOU cancel within 30 days after the Effective Date, YOU may ask for a full refund of the premium less the amount of any reimbursements WE made to YOU before the time this Policy was terminated. If YOU do so, this Policy will terminate on the Effective Date. If YOU cancel this Policy after more than 30 days, WE may keep the premium earned to the date of termination.
3. The Expiration Date of this Policy.
4. On the Effective Date if, within 90 days after the Effective Date:
  - a. YOU fail to provide US any information or materials requested by US; or
  - b. YOU fail to comply with any condition imposed by US when this Policy is issued.
 If so, WE will return the premium paid by YOU, less the amount of any reimbursements WE made to YOU before the time this Policy was terminated. If the amount reimbursed to YOU exceeds the premium paid to US, YOU will pay US the difference.
5. The date the Plan terminates.
6. The date the administrative agreement between YOU and YOUR TPA terminates, unless WE consent in writing to YOUR naming of a new TPA.
7. The last day of the third consecutive month during which YOU fail to maintain the Minimum Plan Enrollment as stated in the Application/Schedule, unless WE agree in writing to continue coverage;
8. The date YOU:
  - a. suspend active business operations; or
  - b. are placed in bankruptcy or receivership; or
  - c. dissolve.
9. Any date on which YOU do not pay claims or make funds available to pay claims as required by the Plan.
10. At any time YOU intentionally and systematically withhold filing or paying claims so as to artificially control the timing of the payment of claims.
11. At date on which the Plan is found to be in violation of Federal law.

### **Concealment or Fraud**

This entire Policy may be void:

1. if, before or after a claim or loss, YOU or YOUR TPA have concealed or misrepresented any material fact or circumstance concerning this Policy, including any claim; (This includes failure to provide the required disclosure of health history of Disabled Persons, Large Claims or Potentially Catastrophic Losses.) or
2. in any case of fraud by YOU or YOUR TPA relating to this coverage.

## SECTION 9 — REINSTATEMENT

WE may, at OUR option, approve YOUR request to reinstate this Policy. YOU shall submit to US any forms and data WE may require, including YOUR representation as to losses incurred or Paid as of the date of YOUR request for reinstatement. If this Policy is reinstated, YOU shall pay to US the premiums due from the date this Policy terminated.

## SECTION 10 — CLAIM PROVISIONS

### Administration of Claims Under YOUR Plan

WE have no duty to settle or adjust claims filed under YOUR Plan. YOU must retain and pay a TPA at all times. No one, including YOU, may pay benefits for YOUR Plan unless named as the TPA on YOUR Application/Schedule and approved by US. WE will not reimburse YOU for Plan Benefits resulting from benefits paid by someone not authorized to do so.

YOU must make available sufficient funds to pay benefits when due.

The TPA shall:

1. supervise the administration and adjustment of all claims and verify the accuracy and computation of all claims, in accordance with the Plan;
2. maintain accurate records of all claim payments;
3. maintain separate records of expenses not covered; and
4. provide US, on or before the 15th day of each Policy Month, the following data for the preceding Policy Month:
  - a. number of Covered Persons and/or Covered Units; and
  - b. a total of claims paid.

### Management of a Large Claim (LC) or a Potentially Catastrophic Loss (PCL)

Notice of LC - YOU or YOUR TPA must notify US of any LC (regardless of whether charges have been Paid, denied or are pending payment) within 10 days of the date the claim exceeds or it appears that the claim will reach or exceed the defined limits for a LC.

Notice of PCL - YOU or YOUR TPA must notify US of any PCL within 10 days of receiving any information indicating that the claim (regardless of whether charges have been Paid, denied or are pending payment) is potentially catastrophic. (See Exhibit I of this Policy.)

Failure to Notify - If for any reason a LC or PCL is not properly submitted to the TPA, YOU shall promptly notify the TPA of the claim. In the event YOU or YOUR TPA fails to follow the notification requirements set forth in this provision, YOUR losses related to such LC or PCL will not be considered for reimbursement under this Policy.

If YOU receive information that any claim may be or become a PCL, YOU will immediately notify YOUR TPA.

### Notice of Claim

Specific Excess Loss - YOU must give written notice of claim to US within 30 days of the date YOU become aware of claims, with respect to a Covered Person, that have reached 50% of the Specific Attachment Point; however, LCs and PCLs should be reported within the time frame specified in the previous paragraph.

Aggregate Excess Loss - YOU must give written notice of claim to US within 30 days of the date YOU become aware of claims that have reached the Annual Aggregate Attachment Point.

YOUR failure to furnish written notice within 30 days will not invalidate or reduce any claim that was otherwise eligible for reimbursement if it was not reasonably possible to provide written notice within such time. However, written notice must be furnished as soon as possible, but in no event later than one year after the date written notice is first required. Claims under YOUR Plan must be funded and Paid within the Benefit Period in order to be eligible for reimbursement under this Policy.

YOU or YOUR TPA shall submit on a timely basis all proofs of claims, reports and supporting documents WE may request.

**Proof of Loss**

Written proof of loss must be submitted within 60 days after the date the Eligible Expenses under YOUR Plan meet the Specific or Aggregate Attachment Point. Eligible Expenses under YOUR Plan must be funded and Paid within the Benefit Period shown on the Application/Schedule. Late proof will be accepted only if it is shown to have been furnished as soon as reasonably possible and within one year after the Benefit Period shown on the Application/Schedule. Claims not submitted within one year after the Benefit Period shown on the Application/Schedule will not be eligible for payment under this Policy.

**Payment of Claims**

Amounts payable under this Policy will be paid upon receipt and acceptance by US of all the required material. Required material shall include proof of loss and proof of payment for Eligible Expenses under the Plan and any reasonably requested supporting documentation. WE will have sole authority to reimburse or deny claims under this Policy.

**Benefit Determination**

Determination of benefits under YOUR Plan is YOUR sole responsibility. WE have no duty to settle or adjust claims filed under YOUR Plan with YOU or YOUR TPA. WE have the right to review each claim YOU submit to US for reimbursement to determine if YOU are entitled to reimbursement under OUR Policy. This review may include but is not limited to an on-site audit or requests for additional documentation. Only WE have the authority to reimburse losses covered by this Policy.

**Recoveries/Subrogation**

YOU are required to investigate and prosecute all valid claims that YOU may have against first and third parties arising out of any claim for which benefits were Paid by the Plan. This requirement and obligation is not waived or negated if:

1. the Covered Person is not made whole; or
2. the recovery is allocated to other damages; or
3. the person is no longer covered under the Plan.

If YOU fail to pursue any action against a first or third party and WE have made benefit payments under this Policy, WE will be subrogated to all of YOUR rights to make recoveries. YOU are required to cooperate fully and do all things necessary as required for US to pursue any action to recover against the first or third party.

Any amounts recovered by YOU, YOUR TPA, or the person in such action shall be used first to reimburse US for any benefit payments made on behalf of any Covered Person, and then to reimburse the expenses of YOU and YOUR Plan, and then to reimburse the expenses of recovery. Any amounts recovered by US shall be used to reimburse US for any amount that WE may have paid or become liable to reimburse to YOU or YOUR Plan under the terms of this policy, and then to reimburse the expenses of collection. All remaining amounts shall be paid to YOU or YOUR Plan.

If WE have reimbursed YOU or YOUR Plan for all or part of a particular loss, and YOU or YOUR Plan later recover for that loss from a first or third party, YOU must repay US to the extent of OUR reimbursements, regardless of whether this Policy is still in force on the date YOU recover.

In the event YOU or YOUR TPA do not consider a first or third party to be liable for certain claims Paid under YOUR Plan but WE do, WE shall be subrogated to all of YOUR rights to make recoveries for such claims.

**Notice of Appeal**

Any objection, notice of legal action, or complaint received on a claim processed under YOUR Plan on which it reasonably appears an Excess Loss benefit will be payable to YOU under this Policy shall be brought to the immediate attention of OUR Underwriting Office.

**SECTION 11 — GENERAL PROVISIONS****Taxes**

If premium taxes should be assessed against YOU with respect to claims Paid under YOUR Plan, YOU shall hold US harmless from any tax liability.

**Entire Contract**

This entire contract consists of:

1. this Policy, including any Endorsements;
2. YOUR Application/Schedule and any attachments thereto, a copy of which is attached to this Policy;
3. YOUR Disclosure Statement and any attachments thereto; and
4. a copy of YOUR Plan.

All statements made by YOU or any Covered Person are, in the absence of fraud, understood to be representations and not warranties. Such statements will not be used to contest coverage unless contained in the Application/Schedule, or any attachments to the Application/Schedule.

In case of a conflict between the Plan and this Policy, this Policy will prevail. WE have relied on the information YOU and YOUR TPA provided to issue this Policy. YOU represent such information is accurate. Should WE later learn such information was not correct, or in case of a substantial change in such information, WE may modify this Policy as of the Effective Date to reflect the correct information, or WE may terminate this Policy on written notice as of the next premium due date.

**Policy Nonparticipating**

This policy does not entitle YOU to share in OUR earnings.

**Records and Review**

YOU and/or YOUR TPA must:

1. keep appropriate records regarding administration of YOUR Plan; and (YOUR records include records held by YOUR TPA.)
2. allow US to review and copy, during normal business hours, all records affecting OUR liability under this Policy; and
3. maintain records of all Covered Persons under the Plan during the Policy Period and for a period of seven years after the termination of this Policy; and
4. maintain a separate record of any and all amounts YOU pay that exceed or are not covered by the benefits under YOUR Plan.

As a result of any audit, WE may readjust premiums, attachment points or reimbursements to YOU as may be necessary to reflect YOUR and OUR original intent in issuing this Policy.

**Clerical Error**

If YOU or WE make a clerical error keeping records or calculating premiums or claims pertaining to this Policy, it will not invalidate this Policy. A clerical error will not expand OUR obligations under this Policy. A clerical error is a mistake in performing a clerical function, and does not include intentional acts or failure to comply with Plan or Policy provisions. A clerical error is not:

1. the failure to disclose the required disclosure of health history of Disabled Persons, Large Claims, or Potentially Catastrophic Losses; or
2. the failure to process a claim within the Benefit Period of this Policy.

**Changes To This Policy**

Changes to this Policy may be made only by a Company officer or OUR Underwriting Office, with OUR approval. Any change must be by written Endorsement.

**Changes To YOUR Plan**

WE must be notified of any change to YOUR Plan. This notice must be in writing and provided to US at least 31 days prior to the effective date of the change. WE must accept the change in writing before coverage affected by this change will be provided by this Policy. WE reserve the right to amend the Application/Schedule to include any change to a statute that increases OUR liability under this Policy. If WE do not receive advance written notice of the change, or WE decline to accept the changes under this Policy, WE will be liable only for benefits provided by the Plan prior to the change. YOU must provide US with a copy of YOUR written Plan and all amendments prior to the time the change becomes effective.

**Subsidiaries, Affiliated Companies Under YOUR Plan**

YOU must notify US in the event YOU acquire a subsidiary or affiliated company that will be included under YOUR Plan. If YOU do acquire a subsidiary or affiliated company that will be included under YOUR Plan, YOU must disclose certain required health history on persons whose coverage YOU will be assuming under YOUR Plan.

Failure to do so will subject benefits under this Policy to certain limitations, as described in “Non-Disclosed Losses,” in Section 5.

Acquisition of a subsidiary or affiliated company that will be included under YOUR Plan may affect YOUR premium rates and/or Monthly Aggregate Excess Loss Factors, as described in “Changes in Premium Rates or Factors,” in Section 7.

YOU must notify US in the event YOU cede or dissolve a subsidiary or affiliated company that was included under YOUR Plan. Failure to do so may subject this Policy to termination (if Minimum Plan Enrollment is not maintained), or may affect YOUR premium rates and/or Monthly Aggregate Excess Loss Factors, as described in “Changes in Premium Rates or Factors,” in Section 7.

### **Duties and Responsibilities of YOUR Designated Third-Party Administrator (TPA)**

YOUR TPA must be approved by US.

WE agree to recognize YOUR TPA as YOUR agent for the administration of YOUR Plan. YOU agree that YOUR TPA will:

1. audit, calculate and pay all claims eligible under the Plan;
2. prepare reports required by US and keep and make available to US data WE may require; and
3. do what is necessary for YOU to comply with the terms of this Policy.

If YOU give YOUR TPA a Power of Attorney, or revoke a Power of Attorney, neither is binding on US until WE receive it.

YOU will pay YOUR TPA for all administrative functions performed in relation to this Policy.

YOUR TPA is YOUR agent and not OURS. YOU authorize YOUR TPA to:

1. submit Notice/Proof of Loss;
2. certify the payment of claims;
3. transmit reports and payment of premiums to US; and
4. receive payments from US.

Payments by US to YOUR TPA are payments to YOU.

### **Notice**

For the purpose of any notice required from US under the terms of this Policy, notice to YOUR TPA is notice to YOU and notice to YOU is notice to YOUR TPA.

### **Disclaimer**

WE act only as a provider of Excess Loss Insurance coverage to YOUR Plan. WE are not a fiduciary. WE do not assume any duty to perform any of the functions or provide any of the reports required by the Employee Retirement Income Security Act of 1974, as amended.

While the determination of benefits under the Plan is the sole responsibility of the Policyholder, WE reserve the right to interpret the terms and conditions of the Plan as it applies to this Policy. WE have the sole authority to approve or deny reimbursement under this Policy.

WE have no right or obligation to pay any Covered Person or provider of professional or medical services. OUR sole liability is to YOU, subject to the terms and conditions of this Policy. Nothing in this Policy shall be construed to permit a Covered Person to have a direct right of action against US. WE will not be considered a party to YOUR Plan or to any supplement or amendment to it.

### **Indemnification, Defense and Hold Harmless**

YOU agree to indemnify, defend and hold US harmless from:

1. any liability resulting from or related to any negligence, error, omission or defalcation by YOUR TPA;
2. any liability related to:
  - a. any dispute involving a Covered Person unless it is a result of OUR sole negligence or intentional wrongful acts; and
  - b. any State premium taxes or assessments WE are assessed with respect to funds paid by or to YOU under YOUR Plan. Taxes on amounts paid to US as premiums for this Policy are excluded.

WE will notify YOU if YOU have obligations. WE may participate in the defense at OUR expense. If YOU do not act promptly, WE may defend and compromise or settle the claim or other matter on YOUR behalf, for YOUR account, and at YOUR risk.

**Offset**

WE may offset payments due YOU under this Policy against claim overpayments and premiums due and unpaid.

**Assignment**

YOU may not assign any of YOUR rights under this Policy.

**Severability**

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

**Insolvency**

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan or arrangement with creditors, or dissolution of YOU or YOUR TPA:

1. will not impose upon US any liability or additional duties other than those defined and provided for in this Policy; (For example, WE will have no responsibility to pay claims for YOUR Plan to ensure reimbursement under this Policy.) and
2. will not make US liable to YOUR creditors, including Covered Persons.

Claims under YOUR Plan must continue to be funded and Paid within the Benefit Period in order to be eligible for reimbursement under this Policy.

**Parties to This Policy**

YOU and WE are the only parties to this Policy. OUR sole liability under this Policy is to YOU. This Policy does not create any right or legal relation between US and a Covered Person under YOUR Plan. This Policy will not make US a party to any agreement between YOU and YOUR TPA.

**Physical Examination and Medical Evidence**

WE may require any medical evidence or other information, including a physical examination or health statement, regarding any Covered Person:

1. who submits an enrollment card for coverage under the Plan more than 31 days after completing the waiting period specified in the Plan. Such examination shall be provided without expense to US; or
2. for whom YOU have Paid a claim under the Plan and submitted such claim for reimbursement under this Policy. Such examination or evidence shall be provided as often as is reasonably necessary.

**Legal Action**

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

**Time Limit on Certain Defenses**

In the absence of fraud, all statements made by YOU or YOUR TPA shall be deemed representations and not warranties. If these statements appear as part of the written Application or other written instrument signed by YOU or YOUR TPA, WE may use them to contest this Policy. If WE do, WE will furnish YOU or YOUR TPA with a copy of the document in question. After two years, only fraudulent misstatements may be used to contest the coverage under this Policy.

**Waiver**

OUR failure to strictly enforce OUR rights under this Policy shall not waive any such right, regardless of the frequency or similarity of the circumstances.

## EXHIBIT 1 — POTENTIALLY CATASTROPHIC LOSSES (PCLs)

Some diagnoses that qualify as PCLs are listed below. This is not a comprehensive list. These are only examples of some types of conditions. WE reserve the right to change this list of PCLs at any time.

### INFECTIOUS AND PARASITIC DISEASES

- Septicemia
- AIDS/HIV
- AIDS related illnesses
- Hepatitis

### CANCER OF ANY TYPE

### ENDOCRINE, NUTRITIONAL, METABOLIC, IMMUNE DISORDERS

- Diabetes
- Cystic fibrosis
- Obesity/Hyperalimantation

### DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS

- Sickle cell anemia
- Coagulation defects and/or Hemophilia
- Aplastic anemia

### DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS

- Cerebral degenerations
- Quadriplegia and Quadripareisis
- Reye's Syndrome
- Paraplegia
- Encephalopathy
- Neuropathy/Myasthenia Gravis

### DISEASES OF THE CIRCULATORY SYSTEM

- Acute myocardial infarction
- Acute and Subacute Ischemic heart disease
- Coronary atherosclerosis
- Acute pulmonary heart disease
- Aneurysms
- Endocarditis
- Valve disorders
- Cardiomyopathy
- Subarachnoid/Intracerebral hemorrhage
- Cardiac dysrhythmias
- Heart failure
- Conduction disorders
- Cerebral artery occlusion
- Acute cerebrovascular accident
- Atherosclerosis
- Myocarditis
- Cardiomyopathy

### DISEASES OF THE RESPIRATORY SYSTEM

- Chronic obstructive pulmonary disease (COPD)
- Pulmonary collapse and/or respiratory failure
- Pneumonia
- Postinflammatory pulmonary fibrosis

### DISEASES OF THE DIGESTIVE SYSTEM

- Regional enteritis (Crohn's disease)
- Intestinal obstruction
- Diverticulitis of colon
- Peritonitis
- Liver disease and cirrhosis
- Pancreas diseases
- Gastrointestinal hemorrhage

### **DISEASES OF THE GENITOURINARY SYSTEM**

- Acute renal failure
- Chronic renal failure
- Impaired renal function
- Calculus of kidney and/or ureter
- Dialysis treatment

### **COMPLICATIONS OF PREGNANCY AND CHILDBIRTH**

- Placenta previa
- Eclampsia, pre-eclampsia
- Premature labor
- Gestational diabetes
- Multiple gestation
- Cervical incompetence
- Supervision of high-risk pregnancy

### **DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE**

- Osteoarthritis
- Spondylosis
- Intervertebral disc disorders
- Osteomyelitis and periostitis
- Kyphoscoliosis and scoliosis

### **CONGENITAL ANOMALIES**

- Aortic atresia/stenosis
- Other unspecified congenital anomalies
- Biliary atresia

### **CONDITIONS ORIGINATING IN THE PERINATAL PERIOD**

- Prematurity
- Respiratory distress syndrome
- Other respiratory conditions of a newborn
- Apnea
- Lack of expected normal physiological development
- Hyaline membrane disease
- Encephalocele
- Cephalohematoma
- Spina bifida

### **INJURY AND POISONING**

- Skull fracture
- Vertebral column fracture
- Spinal cord injury
- Multiple fractures
- Trauma to the elderly or chronically ill
- Internal injury
- Traumatic amputation
- Burns
- Intracranial injury

### **OTHER SERIOUS CONDITIONS**

- Transplants of any kind
- Continuous hospitalization of 2 weeks or more
- Evaluation for transplants of any kind
- Mental disorders requiring hospital confinement
- Any serious condition that may require Large Case Management
- Any illness or injury that requires intensive and prolonged treatment (such as nutritional support systems, intravenous therapies, and ventilators)
- Home health care greater than 20 days
- Coma
- Brain lesion or tumors
- Sleep apnea

**APPLICATION / SCHEDULE  
FOR EXCESS LOSS POLICY**

**SECTION 1 — POLICYHOLDER INFORMATION**

1. Full legal name of Policyholder (herein referred to as YOU/YOUR), as it will appear in Policy issued by US:  
[ABC Company]

2. Address of principal office (street, city, state, zip):  
[123 Main Street, Anycity, Anystate 99999]

3. Contact person:  
Name: [Jane Doe] Telephone Number: ([999]) [999-9999]  
E-Mail Address: [janedoe@abccompany.net] Fax Number: ([999]) [999-9990]

4. Nature of business:  
[widget sales and service]

5. If Employee Welfare Benefit Plans of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal names and addresses of such companies and the nature of their business:  
[ABC Wholesale]

6. Full name of YOUR Employee Welfare Benefit Plan:  
[ABC Company Health Plan]

**NOTE:** A copy of YOUR ERISA Employee Welfare Benefit Plan Document, and those of any subsidiary or affiliated companies that are to be included, must be attached to, and shall form a part of, this Application/Schedule.

7. YOUR designated Third-Party Administrator (for the purposes of claims administration under YOUR Employee Welfare Benefit Plan):  
Name: [XYZ Administrators] E-Mail Address: [customers@xyzadmin.net]  
Address: [987 Main Street, Anycity, Anystate 99999]  
Telephone Number: ([999]) [999-1111] Fax Number: ([999]) [999-1119]

8. YOUR broker/agent of record:  
Name: [Jackson Doe] E-Mail Address: [jacksondoe@bigsales.net]  
Address: [654 Main Street, Anycity, Anystate 99999]  
Telephone Number: ([999]) [999-1234] Fax Number: ([999]) [999-4321]

**SECTION 2 — REQUESTED POLICY PERIOD**

The Coverage shown as included in Section 3 and/or Section 4 is requested for, and applies only during, the Policy Period from [January 1, 2009] (the Effective Date) through [December 31, 2009] (the Expiration Date) and is further subject to all of the provisions of the Policy.

**SECTION 3 — SPECIFIC EXCESS LOSS COVERAGE**

1. Coverage Election:  YES — Specific coverage is included in this Policy.  
 NO — Specific coverage is not included in this Policy. **Do not complete this Section.**

2. Coverages to be included. Check one box below for each coverage listed:  
Yes No  
  Medical  
  Prescription Drug Service: \_\_\_\_\_

**NOTE:** In no event will Dental, Vision, or Weekly Income be included under Specific Excess Loss Coverage.

3. Specific Attachment Point:  
 Per Covered Person: \$ **[15,000.00]**  
 Per Covered Family: \$ \_\_\_\_\_

4. Specific Reimbursement Percentage: 100%

5. Specific Lifetime Maximum Reimbursement per Covered Person: \$ **[1,000,000.00]**

6. Basis of Specific Excess Loss coverage benefit payment (Benefit Period):  
 Applicable only to **[ABC Company and all of its subsidiaries and affiliates]** :  
 Plan Benefits Incurred from **[July 1, 2008]** through **[December 13, 2009]**  
 and Paid from **[January 1, 2009]** through **[March 31, 2010]**  
 Applicable only to \_\_\_\_\_ :  
 Plan Benefits Incurred from \_\_\_\_\_ through \_\_\_\_\_  
 and Paid from \_\_\_\_\_ through \_\_\_\_\_  
 Applicable only to \_\_\_\_\_ :  
 Plan Benefits Incurred from \_\_\_\_\_ through \_\_\_\_\_  
 and Paid from \_\_\_\_\_ through \_\_\_\_\_  
 Plan Benefits Incurred prior to the Effective Date (during the Run-In Period) will be limited to:  
 \$ **[250,000.00]** per Covered Person or  
 \$ \_\_\_\_\_ for all Covered Persons combined

7. Premium Rates (per month):

<i>Covered Unit Description</i>	<i>Amount</i>	<i>Covered Unit Description</i>	<i>Amount</i>
<b>[Composite]</b>	: \$ <b>[30.00]</b>	_____	: \$ _____
_____	: \$ _____	_____	: \$ _____
_____	: \$ _____	_____	: \$ _____

8. Minimum Annual Specific Premium: \$ \_\_\_\_\_

**SECTION 4 — AGGREGATE EXCESS LOSS COVERAGE**

1. Coverage Election:  YES — Aggregate coverage is included in this Policy.  
 NO — Aggregate coverage is not included in this Policy. **Do not complete this Section.**

2. Coverages to be included. Check one box below for each coverage listed:

Yes	No	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Medical
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Dental
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Vision
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Prescription Drug Service: _____
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Weekly Income: Maximum _____, per covered employee per Policy Period.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Other: _____

3. Monthly Aggregate Factor:

<i>Covered Unit Description</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Prescription Drug Service</i>	<i>Weekly Income</i>	<i>Totals</i>
<b>[Composite]</b>	\$ <b>[15.00]</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

4. Number of Covered Units:  Quoted  Actual

Covered Unit Description	Medical	Dental	Vision	Prescription Drug Service	Weekly Income
[Employee]	[255]				
[Spouse/Partner]	[100]				
[Child]	[432]				

5. Minimum Annual Aggregate Attachment Point: \$ [141,660.00]  
 (12 times Monthly Aggregate Factor(s), times total Number of Covered Units)

6. Aggregate Reimbursement Percentage: 100%

7. Individual Claim Limit: [\$1,000,000.00]

8. Maximum Aggregate Reimbursement (per Policy Period): \$ [5,000,000.00]

9. Basis of Aggregate Excess Loss coverage benefit payment (Benefit Period):  
 Applicable only to [ABC Company and all of its subsidiaries and affiliates] :  
 Plan Benefits Incurred from [July 1, 2008] through [December 31, 2009]  
 and Paid from [January 1, 2009] through [March 31, 2010]  
 Applicable only to \_\_\_\_\_ :  
 Plan Benefits Incurred from \_\_\_\_\_ through \_\_\_\_\_  
 and Paid from \_\_\_\_\_ through \_\_\_\_\_  
 Applicable only to \_\_\_\_\_ :  
 Plan Benefits Incurred from \_\_\_\_\_ through \_\_\_\_\_  
 and Paid from \_\_\_\_\_ through \_\_\_\_\_  
 Plan Benefits Incurred prior to the Effective Date (during the Run-In Period) will be limited to:  
 \$ \_\_\_\_\_ per Covered Person or  
 \$ [5,000,000.00] for all Covered Persons combined

10. Premium Rates (per month):

Covered Unit Description	Amount	Covered Unit Description	Amount
[Composite]	: \$ [50.00]		: \$ _____
	: \$ _____		: \$ _____
	: \$ _____		: \$ _____

11. Minimum Annual Aggregate Premium: \$ \_\_\_\_\_

**SECTION 5 — ELIGIBILITY, PREMIUM DEPOSIT, AND ENROLLMENT INFORMATION**

1. Check one box for each of the following groups of persons to indicate if such groups are to be considered as Covered Persons under the Policy:

Yes*	No	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Retired Employees
<input checked="" type="checkbox"/>	<input type="checkbox"/>	COBRA Continueses
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Disabled Employees
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Transplants

\*All "Yes" answers must have disclosure information attached to this Application/Schedule.

2. Initial premium deposit accompanying this Application/Schedule: \$ [62,9690.00]

3. Minimum Plan Enrollment:  [600] Covered Units or  
 \_\_\_\_\_ % of initial enrollment

**SECTION 6 — NOTICES AND SIGNATURES**

1. YOU have read the foregoing and understand and agree with the terms and conditions of the coverage as set forth by US and as reflected in this Application/Schedule. YOU represent that YOU have formed YOUR Employee Welfare Benefit Plan in compliance with and in reliance on the applicable provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other applicable law or regulation. It is agreed that the statements in this Application/Schedule or in any materials submitted with this Application/Schedule or attached to it are YOUR representations and shall be deemed material to acceptance of the risk by US and that the Policy is issued by US in reliance on the truth and accuracy of such representations. Should subsequent information become known which, if known prior to issuance of the Policy, would affect the premium rates, factors, terms or conditions for coverage hereunder, WE will have the right to revise the premium rates, factors, terms or conditions as of the Effective Date, by providing written notice to YOU. Any fraudulent statement will render the Policy null and void and claims, if any, will be forfeited.

2. **THIS APPLICATION DOES NOT BIND COVERAGE.** Upon approval of the application, the Policy evidencing that the coverage is in force will be issued by US through OUR Underwriting Manager. Coverage will commence on the Effective Date set forth in the Policy.

3. **NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.**

4. **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

**5. ACCEPTED BY THE POLICYHOLDER:**

Policyholder (full legal name): [ABC Company]  
Signed at (city, state): [Anycity, Anystate] Date: [October 22, 2008]  
Signed for the Policyholder by (officer's signature): \_\_\_\_\_  
Printed Name: [John Doe] Title: [President]  
Signature of Policyholder's broker/agent of record: \_\_\_\_\_

**6. ACCEPTED BY THE COMPANY:**

Signed at (city, state): [Anycity, Anystate] Date: [October 22, 2008]  
Signed for the Company by (officer's signature): \_\_\_\_\_  
Printed Name: [John Smith] Title: [Director]

**ENDORSEMENT TO  
EXCESS LOSS POLICY**

**Acceptance of Plan Document Changes**

As of the Effective Date of this Endorsement, WE consent to the following change(s) to YOUR Plan Document:

A copy of the Plan Document change(s) is attached to this Endorsement.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**  
This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	

**ENDORSEMENT TO  
EXCESS LOSS POLICY**

**Change to Policyholder Information**

YOU and WE agree that the Policy is changed as follows:

- YOUR full legal name and/or address is changed as follows:

**Name and address as of the Policy Effective Date:**

Name: \_\_\_\_\_

*Address of principal office:*

Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

**Name and address as of the Effective Date of this Endorsement:**

Name: \_\_\_\_\_

*Address of principal office:*

Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

- YOUR designated Third-Party Administrator is changed to the following:

Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

- YOUR broker/agent of record is changed to the following:

Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED HEREIN.** This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY

A handwritten signature in black ink, appearing to be 'A. J. ...', is written over a vertical red line.

Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	

**ENDORSEMENT TO  
EXCESS LOSS POLICY****Qualified Clinical Trials**

YOU and WE agree that the Policy is changed as follows:

WE will include Plan Benefits Paid for Patient Care Services furnished in connection with Covered Persons' participation in Qualified Clinical Trials when WE calculate reimbursements to YOU under the Policy. The Plan Benefits Paid for Patient Care Services furnished in connection with Covered Persons' participation in Qualified Clinical Trials, for which WE will consider in OUR reimbursement calculations, will be limited to {\$50,000 to \$250,000, in \$50,000 increments] per Covered Person's lifetime, under this and prior or later Policies issued by US. In no event does this consideration:

1. increase any reimbursement levels or limits stated in the Policy, or expand any other provision of the Policy; or
2. allow YOU to change the terms of YOUR Plan with respect to benefits YOU pay to Covered Persons incurring expense as the result of participation in a clinical trial.

This Endorsement shall apply only to Qualified Clinical Trial expenses for treatment incurred by a Covered Person after the Effective Date of this Endorsement. This Endorsement shall not apply to Qualified Clinical Trial expenses for treatment incurred by a Covered Person if the Covered Person:

1. is enrolled in; or
2. has been evaluated for participation in; or
3. has signed a consent form for; or
4. has been recommended to participate in,

a Phase II or III or IV clinical trial prior to the effective date of this Endorsement.

All Policy provisions shall apply as if this Endorsement did not exist for Plan Benefits Paid and submitted for reimbursement under the Policy that are for expenses other than Qualified Clinical Trial Eligible Expenses.

Excess Loss Policy benefits paid under this Endorsement shall not create any legal presumption that either WE or OUR Underwriting Manager have recommended, directed, endorsed or required any Covered Person's Participation in the Qualified Clinical Trial.

The following changes are made to the Policy as a result of the above added provision:

- (1)** In Section 1, the definition of **Eligible Expenses** is changed to include the following:

Eligible Expenses will not include expenses of a Qualified Clinical Trial unless 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
3. documentation that the clinical trial meets the definition and requirements to be a Qualified Clinical Trial.

- (2) The following definitions are added to Section 1:

**Patient Care Services** means health care items or services that are furnished to a Covered Person while he or she is enrolled in a Qualified Clinical Trial that:

1. are consistent with the usual and customary standard of care for someone with the Covered Person's diagnosis; and
2. are consistent with the study protocol for the Qualified Clinical Trial; and
3. would be considered eligible charges payable under YOUR Plan, regardless if the Covered Person was participating in the Qualified Clinical Trial.

An FDA-approved drug, device, or biological product shall be a Patient Care Service only to the extent that the drug, device, or biological product is not paid for by the manufacturer, the distributor, or the provider of such drug, device, or biological product.

The term Patient Care Services does not include any of the following:

1. Non-health care services that a Covered Person may be required to receive as a result of being enrolled in the Qualified Clinical Trial.
2. Costs associated with managing the research associated with the Qualified Clinical Trial.
3. Costs that would not be covered for non-investigational treatments.
4. Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Qualified Clinical Trial.
5. The costs of services that are not provided as part of the Qualified Clinical Trial's stated protocol or other similarly intended guidelines.

**Qualified Clinical Trial** means a clinical trial that meets all the following conditions:

1. The clinical trial is intended to treat cancer in a patient who has been so diagnosed.
2. The clinical trial has been peer-reviewed and is approved by at least one of the following:
  - a. One of the United States National Institutes of Health.
  - b. A cooperative group or center of the National Institutes of Health.
  - c. A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants.
  - d. The United States Food and Drug Administration, pursuant to an investigational new drug exemption.
  - e. The United States Department of Defense or Veterans Affairs.
  - f. With respect to Phase II, III, and IV clinical trials only, a qualified institutional review board.
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training, and treat a sufficient volume of patients to maintain that expertise.
4. The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.
5. The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.
6. The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial.
7. The clinical trial does not unjustifiably duplicate existing studies.
8. The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.

- (3) In Section 6, the exclusion for “medical expenses or complications in connection with Experimental or Investigational surgery or treatment” is changed to “medical expenses or complications in connection with Experimental or Investigational services, supplies or treatments, including drugs, devices and biological products, except as provided in any Endorsement providing reimbursement of Plan Benefits Paid for Qualified Clinical Trials.”

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED HEREIN.** This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

**ENDORSEMENT TO  
EXCESS LOSS POLICY**
**Exclusions / Limitations for Named Persons**

YOU and WE agree that if the individual(s) listed on the following page(s) is/are a Covered Person(s) under the Plan, then the claims on such Covered Person(s) will be excluded or limited, as described in this Endorsement.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

Name of Covered Person	Treatment of Such Covered Person's Claims under Specific Excess Loss Coverage	Treatment of Such Covered Person's Claims under Aggregate Excess Loss Coverage
	<p><i>Check only one box:</i></p> <input type="checkbox"/> No Specific Excess Loss Coverage provided under Policy. <input type="checkbox"/> Not covered. <input type="checkbox"/> Different Specific Attachment Point: \$ _____ <input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____	<p><i>Check only one box:</i></p> <input type="checkbox"/> No Aggregate Excess Loss Coverage provided under Policy. <input type="checkbox"/> Not covered. <input type="checkbox"/> Maximum amount of Paid Plan Benefits counted towards satisfaction of Annual Aggregate Attachment Point: \$ _____ <input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____
	<p><i>Check only one box:</i></p> <input type="checkbox"/> No Specific Excess Loss Coverage provided under Policy. <input type="checkbox"/> Not covered. <input type="checkbox"/> Different Specific Attachment Point: \$ _____ <input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____	<p><i>Check only one box:</i></p> <input type="checkbox"/> No Aggregate Excess Loss Coverage provided under Policy. <input type="checkbox"/> Not covered. <input type="checkbox"/> Maximum amount of Paid Plan Benefits counted towards satisfaction of Annual Aggregate Attachment Point: \$ _____ <input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____
	<p><i>Check only one box:</i></p> <input type="checkbox"/> No Specific Excess Loss Coverage provided under Policy. <input type="checkbox"/> Not covered. <input type="checkbox"/> Different Specific Attachment Point: \$ _____ <input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____	<p><i>Check only one box:</i></p> <input type="checkbox"/> No Aggregate Excess Loss Coverage provided under Policy. <input type="checkbox"/> Not covered. <input type="checkbox"/> Maximum amount of Paid Plan Benefits counted towards satisfaction of Annual Aggregate Attachment Point: \$ _____ <input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____
	<p><i>Check only one box:</i></p> <input type="checkbox"/> No Specific Excess Loss Coverage provided under Policy. <input type="checkbox"/> Not covered. <input type="checkbox"/> Different Specific Attachment Point: \$ _____ <input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____	<p><i>Check only one box:</i></p> <input type="checkbox"/> No Aggregate Excess Loss Coverage provided under Policy. <input type="checkbox"/> Not covered. <input type="checkbox"/> Maximum amount of Paid Plan Benefits counted towards satisfaction of Annual Aggregate Attachment Point: \$ _____ <input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____
	<p><i>Check only one box:</i></p> <input type="checkbox"/> No Specific Excess Loss Coverage provided under Policy. <input type="checkbox"/> Not covered. <input type="checkbox"/> Different Specific Attachment Point: \$ _____ <input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____	<p><i>Check only one box:</i></p> <input type="checkbox"/> No Aggregate Excess Loss Coverage provided under Policy. <input type="checkbox"/> Not covered. <input type="checkbox"/> Maximum amount of Paid Plan Benefits counted towards satisfaction of Annual Aggregate Attachment Point: \$ _____ <input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____

**ENDORSEMENT TO  
EXCESS LOSS POLICY**
**Domestic Claims**

YOU and WE agree that the Policy is changed as follows:

- (1) To ensure that Domestic Claim charges are considered at the negotiated percentage of accumulation and reimbursement, WE require that documentation of YOUR hospitals, centers, and facilities that YOU own, operate, or with which YOU are otherwise affiliated, be provided to US. Disclosing all such hospitals, centers, and facilities will ensure proper application of the Policy provisions. Notification of the addition or deletion of any hospitals, or centers, or facilities that YOU own, operate, or with which YOU are otherwise affiliated, must be provided to US in writing within 30 days of such change.

**Name and Addresses of Hospitals, Centers, and Facilities to be covered:**

(Attach additional pages, if necessary.)

Name	Address (City, State, Zip)	Tax ID #

- (2) Charges for Domestic Claims will be considered as follows: (Check only one box.)

- Charges for treatments, services and/or supplies rendered to Covered Persons of YOUR Plan in a hospital, or center, or facility which YOU own, operate, or with which YOU are otherwise affiliated, will not be considered Eligible Expenses.
- Eligible Expenses relating to charges for treatments, services and/or supplies rendered to Covered Persons of YOUR Plan in a hospital, or center, or facility that YOU own, operate, or with which YOU are otherwise affiliated, will be limited to \_\_\_\_\_ % of such hospital's or facility's actual charges.
- Eligible Expenses relating to charges for treatments, services and/or supplies rendered to Covered Persons of YOUR Plan in a hospital, or center, or facility that YOU own, operate, or with which YOU are otherwise affiliated, will be limited to \_\_\_\_\_ % of such hospital's or facility's negotiated PPO charges.
- Eligible Expenses relating to charges for treatments, services and/or supplies rendered to Covered Persons of YOUR Plan in a hospital, or center, or facility that YOU own, operate, or with which YOU

are otherwise affiliated, will be limited to \_\_\_\_\_ % of such hospital's or facility's Usual and Customary Charges.

- Eligible Expenses relating to charges for treatments, services and/or supplies rendered to Covered Persons of YOUR Plan in a hospital, or center, or facility that YOU own, operate, or with which YOU are otherwise affiliated, will be limited to \_\_\_\_\_ % of such hospital's or facility's Usual and Customary Charges, less any applicable PPO discounts.
- [  *Any other limitation of Domestic Charges that is agreed to by American Fidelity Assurance Company, such limitation being scribed by American Fidelity.*]

(3) The following definition is added to Section 1:

**Domestic Claim** means a claim for treatments, services and/or supplies that are provided to a Covered Person by one or more of YOUR hospitals, or centers, or facilities that YOU own, operate, or with which YOU are otherwise affiliated, that are licensed to provide such treatments, services and/or supplies.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED HEREIN.** This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

**ENDORSEMENT TO  
EXCESS LOSS POLICY**

**Specific Terminal Liability**

YOU and WE agree that the Policy is changed as follows:

WE will extend the payment period for Specific Excess Loss coverage for three months beyond the Expiration Date if YOU:

1. terminate YOUR Plan on the Expiration Date of this Policy; and
2. furnish US acceptable proof that YOU have purchased conventional group insurance coverage that immediately replaces YOUR terminated Plan.

Only those Plan Benefits Incurred during the Policy Period and prior to the Expiration Date will be considered under YOUR Specific Excess Loss coverage.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	

**ENDORSEMENT TO  
EXCESS LOSS POLICY**
**Aggregating Specific Attachment Point**

YOU and WE agree that the Policy is changed as follows:

The Policy will include an Aggregating Specific Attachment Point, as follows: (Check only one box.)

\$ \_\_\_\_\_

The greater of:

\$ \_\_\_\_\_; or

\$ \_\_\_\_\_ per month per Single covered unit, plus \$ \_\_\_\_\_ per month per Family covered unit.

The greater of:

\$ \_\_\_\_\_; or

\$ \_\_\_\_\_ per month per Composite covered unit.

No amounts will be payable to YOU under the Policy until the Aggregating Specific Attachment Point has been satisfied.

**Aggregating Specific Attachment Point** means an aggregate amount, in excess of and in addition to the Specific Attachment Point for each Covered Person, that YOU must also incur during the Policy Period before WE will reimburse YOU for Plan Benefits Paid.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

**ENDORSEMENT TO  
EXCESS LOSS POLICY**

**Right to Medically Underwrite**

YOU and WE agree that the Policy is changed as follows: (Check all applicable boxes.)

- Medical underwriting will be performed on any person currently covered under the HMO plan who applies for coverage under the PPO plan.
  
- It is assumed that Medicare is primary payor for the following Covered Person(s), as of the effective date(s) shown below. If, for any reason, Medicare does not pay primary on such Covered Person(s) (thereby making the Plan primary), WE have the right to:
  1. set a Specific Attachment Point on such Covered Person(s) in the amount shown below; and/or
  2. re-rate from the Covered Person's effective date of coverage; and/or
  3. effect another underwriting correction retroactively.

Covered Person

Effective Date

Attachment Point

- The Policy is issued on the basis that the Plan pays secondary on the Covered Person(s) listed below. YOU and WE agree that if, at some future date, the Plan becomes primary on such individual(s), WE reserve the right to medically underwrite to evaluate further coverage considerations on such individual(s):

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

**ENDORSEMENT TO  
EXCESS LOSS POLICY****Aggregate Terminal Liability**

YOU and WE agree that the Policy is changed as follows:

This Endorsement is applicable only if the following conditions exist:

1. The Policy to which this Endorsement is attached does not provide for payment of Aggregate Excess Loss coverage for claims Paid beyond the Expiration Date of the Policy.
2. In the event the Policy to which this Endorsement is attached is YOUR first policy, contract or agreement providing aggregate excess loss coverage:
  - a. this Endorsement must be attached and made effective the same date as the Policy Effective Date; and
  - b. the Policy does not provide for payment of claims incurred prior to the Effective Date of the Policy.
3. In the event the Policy to which this Endorsement is attached is subsequent to another Excess Loss policy, contract or agreement, issued by US or anyone else, all such previous Excess Loss Policies must have had this same or similar Endorsement attached thereto.

This Endorsement applies only to Aggregate Excess Loss Coverage and does not change or alter any coverage under the Specific Excess Loss Coverage provided by the Policy.

If, at the Expiration Date of the Policy, YOU terminate YOUR Plan and replace it with a fully-insured conventional group health benefit plan, WE will extend the Aggregate Excess Loss coverage provided by the Policy during the Terminal Extension Period, provided:

1. such fully-insured conventional group health benefit plan immediately replaces YOUR Plan, thereby eliminating any gap in coverage for YOUR Plan's beneficiaries;
2. such fully-insured conventional group health benefit plan provides benefits substantially similar to the benefits provided by YOUR Plan;
3. YOU provide proof acceptable to US of such replacement; and
4. YOUR Policy Period does not continue past the Expiration Date of the Policy.

If YOUR net Paid claims for the Policy Period plus the Terminal Extension Period exceed the Terminal Liability Extension Aggregate Reimbursement, WE will pay such excess amount to YOU. Net Paid claims are based on claims incurred prior to the Plan's termination date, less any claims reimbursed under the Specific Excess Loss coverage.

Any Aggregate Excess Loss benefit due under this Endorsement will be delayed until a final determination can be made following the Terminal Extension Period.

WE will reduce benefits payable under this Endorsement by the amount of benefits paid for the same losses by any other policy, contract or agreement.

YOU will pay a monthly service fee of \$\_\_\_\_\_ per Covered Unit during the period this Endorsement is in effect. This fee is due and payable on or before the first day of each month.

**Terminal Extension Period** means the three consecutive calendar months immediately succeeding the Expiration Date of the Policy.

**Terminal Liability Extension Aggregate Reimbursement** is established by combining the Annual Aggregate Attachment Point for the Policy and the Terminal Extension Period, as follows:

1. Multiply the Terminal Liability Extension Factors by the average of Covered Units for the three-month period immediately preceding the Expiration Date of the Policy and by three months.
2. Add the result of 1. above to the Annual Aggregate Attachment Point or Minimum Annual Aggregate Attachment Point, whichever is greater, that is determined for the Policy Period.

**Terminal Liability Extension Factors** are as follows:

Covered Unit Description: \_\_\_\_\_ : \$ \_\_\_\_\_  
 \_\_\_\_\_ : \$ \_\_\_\_\_  
 \_\_\_\_\_ : \$ \_\_\_\_\_  
 \_\_\_\_\_ : \$ \_\_\_\_\_

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

**ENDORSEMENT TO  
EXCESS LOSS POLICY****Aggregate Accommodation Option**

YOU and WE agree that the Policy is changed as follows:

WE will provide YOU an Aggregate Accommodation if:

1. in any month, the total eligible claims paid by YOU to date exceed the sum of:
  - a. the greater of:
    - (1) the cumulative Annual Aggregate Attachment Point; or
    - (2) the cumulative pro rata share of the Minimum Annual Aggregate Attachment Point;and
  - b. any previous advances of the Aggregate Excess Loss benefit; and
  - c. ;and
2. YOU properly pay claims, as described in the Policy; and
3. YOU meet the claims reporting requirements, as described in the Policy; and
4. YOUR premiums for coverage under the Policy are up-to-date; and
5. within 20 days following the end of the month for which the Aggregate Accommodation is requested, YOU submit to US:
  - a. Notice of Claim and Proof of Loss; and
  - b. evidence of Paid claims.

This Aggregate Accommodation Option is not available to YOU:

1. during the first ; or
2. during the last Policy Month of the Policy Period; or
3. during the last Policy Month the Policy is in effect, if the Policy is terminated before the end of the Policy Period.

Each Aggregate Accommodation will:

1. equal the sum of the drafts or checks prepared for payment; and
2. not exceed of the Minimum Annual Aggregate Attachment Point, when combined with any previous Aggregate Accommodations.

If an Aggregate Accommodation is determined to be payable at the end of the Policy Period, it will be reduced by the total of Aggregate Accommodations made, if any, according to the terms of this Endorsement.

Any Aggregate Accommodation made under the provisions of this Endorsement are for the sole purpose of claim payments under YOUR Plan. The claims cited as the basis for YOUR request for Aggregate Accommodation must be paid no later than five working days following YOUR receipt of the Aggregate Accommodation.

**Repayment of Aggregate Accommodation**

*WHEN THERE ARE OUTSTANDING AGGREGATE ACCOMMODATIONS DURING THE POLICY PERIOD:* If, during any month, the accumulated Annual Aggregate Attachment Point is greater than the accumulated claims plus outstanding Aggregate Accommodations, then YOU must repay US the amount by which the accumulated Annual Aggregate Attachment Point exceeds the accumulated claims plus outstanding Aggregate Accommodations. Such repayment by YOU must be made within 30 days of YOUR reaching this repayment condition.

*WHEN YOUR COVERAGE TERMINATES BEFORE THE END OF THE POLICY PERIOD:* In the event YOU or WE terminate the Policy prior to the end of the Policy Period, YOU will pay any outstanding Aggregate Accommodations to US within 30 days of the date YOUR coverage terminates.

**WHEN THERE ARE OUTSTANDING AGGREGATE ACCOMMODATIONS AT THE END OF THE POLICY PERIOD:** If, at the end of the Policy Period, the Annual Aggregate Attachment Point is greater than the Paid Plan Benefits, reduced by the outstanding Aggregate Accommodations, then YOU will pay to US the lesser of:

1. the amount of the outstanding Aggregate Accommodations; or
2. the amount by which the Annual Aggregate Attachment Point exceeds the Paid Plan Benefits, reduced by the outstanding Aggregate Accommodations,

within 30 days of the end of the Policy Period. Any Aggregate Accommodations not repaid at the end of the Policy Period will be deducted from any Aggregate or Specific Excess Loss benefits payable under the terms of the Policy.

An Aggregate Accommodation provided under this Option is YOUR obligation to US. Such amount must be repaid in accordance with this Option.

An Aggregate Accommodation is not a loan or an advance on any payments to be made under the Policy. Any Aggregate Accommodation shall, at all times, be considered OUR funds, which are provided for YOUR use in accordance with this Option.

WE will have preference over all other claimants for the return of any Aggregate Accommodations made under the Policy. YOU will be liable for all costs and expenses (including reasonable attorney fees) incurred in the collection of any outstanding Aggregate Accommodations.

WE will not charge YOU interest on the amount of any Aggregate Accommodation; however, if YOU do not repay any outstanding Aggregate Accommodation within the time frames stated in this Endorsement, then WE:

1. will assess a late payment penalty equal to \_\_\_\_\_ of the outstanding Aggregate Accommodations; and
2. will deduct any outstanding Aggregate Accommodations from any reimbursements due YOU under the Specific or Aggregate Excess Loss benefits; and
3. shall have the right to terminate the benefits and services provided to YOU under this Option.

By YOUR authorized representative's signature below, YOU are verifying that YOU have read and understand the terms of this Endorsement, and YOUR obligations hereunder.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.** This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY

Secretary 

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

**ENDORSEMENT TO  
EXCESS LOSS POLICY****Specific Advance Option**

YOU and WE agree that the Policy is changed as follows:

This provision is only applicable if indicated as included on the Application/Schedule.

1. **AVAILABILITY OF SPECIFIC ADVANCE.** The Specific Advance is available when a Policyholder's Plan sustains losses that:
  - a. exceed the Specific Attachment Point, plus \_\_\_\_\_ ;
  - b. are determined in accord with the Policyholder's Plan Document; and
  - c. are processed for payment before the Policy Period ends.
2. **REQUEST FOR SPECIFIC ADVANCE.** To receive a Specific Advance, the Policyholder must send the Company a written request, along with proof that the Policyholder has paid up to the Specific Attachment Point plus \_\_\_\_\_ and any other required documentation. The Company must receive this proof prior to the end of the Policy Period.
3. **USE OF REIMBURSEMENT.** Within five calendar days after receiving the Company's reimbursement, the Policyholder must:
  - a. pay the benefits described in 1.; and
  - b. deposit the Company's reimbursement draft.In no event may the Company's reimbursement draft be deposited before the benefits described in 1. have been paid. If the benefits are not paid within the five-day period, the reimbursement draft must be returned to the Company. The Policyholder must supply proof of such benefit payments, at the Company's request.
4. **REFUND OF ANY UNUSED AMOUNT.** If, for any reason, part of the reimbursement is not used to pay the eligible losses described in 1., then the Policyholder must refund the unused amount to the Company. This refund must be made within five business days after receiving the Company's reimbursement draft.

If the Policyholder fails to comply with the above conditions, the Policyholder's right to receive the Specific Advance shall be revoked. The Company does not waive any rights under this Excess Loss Insurance Policy by adding this provision.

By YOUR authorized representative's signature below, YOU are verifying that YOU have read and understand the terms of this Endorsement, and YOUR obligations hereunder.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:



A member of the American Fidelity Group

2000 N. Classen Blvd., Oklahoma City, Oklahoma

ENDORSEMENT TO EXCESS LOSS POLICY

Addition of Subsidiary or Other Affiliated Group

YOU and WE agree to the addition of a subsidiary, or other affiliated group, to YOUR Policy, as follows:

Name of Subsidiary or Affiliated Group:

Effective Date: \_\_\_\_\_

SPECIFIC EXCESS LOSS INSURANCE

Specific Attachment Point: \$ \_\_\_\_\_ [ ] per Covered Person or [ ] per Covered Family

Specific Lifetime Maximum Reimbursement per Covered Person: \$ \_\_\_\_\_

[ ] Of this amount, reimbursement for treatment of drug or alcohol abuse will be limited to:

- [ ] \$ \_\_\_\_\_ or
[ ] \_\_\_\_\_ days or
[ ] \_\_\_\_\_ days, up to \$ \_\_\_\_\_

or

[ ] Treatment of drug or alcohol abuse considered as any other illness.

Basis of Specific Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from \_\_\_\_\_ through \_\_\_\_\_
and Paid from \_\_\_\_\_ through \_\_\_\_\_ .

Plan Benefits Incurred prior to the Effective Date (Run-In Period) will be limited to:

- [ ] \$ \_\_\_\_\_ per Covered Person or
[ ] \$ \_\_\_\_\_ for all Covered Persons combined

Premium Rates (per month):

Table with 4 columns: Covered Unit Description, Amount, Covered Unit Description, Amount. Includes multiple rows for premium rates.

**AGGREGATE EXCESS LOSS INSURANCE**

**Monthly Aggregate Factor:**

<i>Covered Unit Description</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Prescription Drug Service</i>	<i>Weekly Income</i>	<i>Totals</i>
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

**Number of Covered Units:**     Quoted     Actual

<i>Covered Unit Description</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Prescription Drug Service</i>	<i>Weekly Income</i>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Minimum Annual Aggregate Attachment Point:** \$ \_\_\_\_\_  
 (12 times Monthly Aggregate Factor(s), times total Number of Covered Units)

**Maximum Aggregate Reimbursement (per Policy Period):** \$ \_\_\_\_\_

**Basis of Aggregate Excess Loss coverage benefit payment (Benefit Period):**

Plan Benefits Incurred from \_\_\_\_\_ through \_\_\_\_\_  
 and Paid from \_\_\_\_\_ through \_\_\_\_\_ .

Plan Benefits Incurred prior to the Effective Date (Run-In Period) will be limited to:

- \$ \_\_\_\_\_ per Covered Person
- \$ \_\_\_\_\_ for all Covered Persons combined

**Premium Rates (per month):**

<i>Covered Unit Description</i>	<i>Amount</i>	<i>Covered Unit Description</i>	<i>Amount</i>
_____ :	\$ _____	_____ :	\$ _____
_____ :	\$ _____	_____ :	\$ _____
_____ :	\$ _____	_____ :	\$ _____
_____ :	\$ _____	_____ :	\$ _____
_____ :	\$ _____	_____ :	\$ _____
_____ :	\$ _____	_____ :	\$ _____
_____ :	\$ _____	_____ :	\$ _____

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

**ENDORSEMENT TO  
EXCESS LOSS POLICY**
**Policy Termination**

YOU and WE agree that the Policy is changed as follows:

YOUR Policy is terminated effective \_\_\_\_\_ as a result of:

- YOUR request to terminate the Policy. (The stated termination date may or may not differ from the date you requested, based on the requirement that YOUR request must be a written notice, submitted as least 31 days in advance of the requested termination date.)
- YOUR failure to pay premium due. (Coverage ends on the last day for which premium has been paid.)
- 

Due to termination of YOUR Policy prior to the Expiration Date, the Benefit Period for YOUR Policy has been changed as follows:

SPECIFIC EXCESS LOSS COVERAGE:

- Not included
- Included and changed to the following:  
Plan Benefits Incurred from \_\_\_\_\_ through the date of termination  
and Paid from \_\_\_\_\_ through the date of termination.

AGGREGATE EXCESS LOSS COVERAGE:

- Not included
- Included and changed to the following:  
Plan Benefits Incurred from \_\_\_\_\_ through the date of termination  
and Paid from \_\_\_\_\_ through the date of termination.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

**ENDORSEMENT TO  
EXCESS LOSS POLICY**

**Prescription Drugs Covered Under Plan**

YOU and WE agree that the Policy is changed as follows:

YOUR Plan covers prescription drugs under the Medical coverage instead of providing for a Prescription Drug Service. As such, Plan Benefits which YOU have paid for prescription drugs will be considered for reimbursement under Specific Excess Loss Coverage and, if applicable, under Aggregate Excess Loss Coverage, regardless if the Prescription Drug Service box(es) has/have been checked on the Application/Schedule.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.** This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

**ENDORSEMENT TO  
EXCESS LOSS POLICY**

**Coverage of Disabled Persons**

YOU and WE agree that the Policy is changed as follows:

Claims on Disabled Persons, for whom WE have received a Disclosure Statement, are covered under the Excess Loss Policy to which this Endorsement is attached. The response in the Application/Schedule for the Excess Loss Policy as to whether or not Disabled Employees are covered is hereby changed to 'Yes.'

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.** This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

**ENDORSEMENT TO  
EXCESS LOSS POLICY**
**Change in Premium**

YOU and WE agree to the following changes to the Application/Schedule for the Excess Loss Policy to which this Endorsement applies:

- The monthly premium rates for SPECIFIC EXCESS LOSS COVERAGE, as specified in Section 3, item 7., are changed to the following:

**7. Premium Rates (per month):**

<i>Covered Unit Description</i>	<i>Amount</i>
_____	: \$ _____
_____	: \$ _____
_____	: \$ _____
_____	: \$ _____
_____	: \$ _____
_____	: \$ _____

- The Minimum Annual Specific Premium for SPECIFIC EXCESS LOSS COVERAGE, as specified in Section 3, item 8., is changed to \$ \_\_\_\_\_.

- The monthly premium rates for AGGREGATE EXCESS LOSS COVERAGE, as specified in Section 4, item 10., are changed to the following:

**10. Premium Rates (per month):**

<i>Covered Unit Description</i>	<i>Amount</i>
_____	: \$ _____
_____	: \$ _____
_____	: \$ _____
_____	: \$ _____
_____	: \$ _____
_____	: \$ _____

- The Minimum Annual Aggregate Premium for AGGREGATE EXCESS LOSS COVERAGE, as specified in Section 4, item 11., is changed to \$ \_\_\_\_\_.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

**ENDORSEMENT TO  
EXCESS LOSS POLICY**
**Change in Specific Excess Loss Coverage**

YOU and WE agree to the following changes to the Application/Schedule for the Excess Loss Policy to which this Endorsement applies:

- The Specific Attachment Point for SPECIFIC EXCESS LOSS COVERAGE, as specified in Section 3, item 3., is changed as follows:
- Per Covered Person: \$ \_\_\_\_\_
- Per Covered Family: \$ \_\_\_\_\_
- The Specific Lifetime Maximum Reimbursement per Covered Person for SPECIFIC EXCESS LOSS COVERAGE, as specified in Section 3, item 5., is changed to \$ \_\_\_\_\_.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

**ENDORSEMENT TO  
EXCESS LOSS POLICY**

**Change in Basis of Coverage**

YOU and WE agree to the following changes to the Application/Schedule for the Excess Loss Policy to which this Endorsement applies:

The basis for SPECIFIC EXCESS LOSS COVERAGE, as specified in Section 3, item 6., is changed to the following:

**6. Basis of Specific Excess Loss coverage benefit payment (Benefit Period):**

Applicable only to \_\_\_\_\_ :  
Plan Benefits Incurred from \_\_\_\_\_ through \_\_\_\_\_  
and Paid from \_\_\_\_\_ through \_\_\_\_\_

Applicable only to \_\_\_\_\_ :  
Plan Benefits Incurred from \_\_\_\_\_ through \_\_\_\_\_  
and Paid from \_\_\_\_\_ through \_\_\_\_\_

Applicable only to \_\_\_\_\_ :  
Plan Benefits Incurred from \_\_\_\_\_ through \_\_\_\_\_  
and Paid from \_\_\_\_\_ through \_\_\_\_\_

Plan Benefits Incurred prior to the Effective Date (during the Run-In Period) will be limited to:

- \$ \_\_\_\_\_ per Covered Person *or*
- \$ \_\_\_\_\_ for all Covered Persons combined

The basis for AGGREGATE EXCESS LOSS COVERAGE, as specified in Section 4, item 9., is changed to the following:

**9. Basis of Aggregate Excess Loss coverage benefit payment (Benefit Period):**

Applicable only to \_\_\_\_\_ :  
Plan Benefits Incurred from \_\_\_\_\_ through \_\_\_\_\_  
and Paid from \_\_\_\_\_ through \_\_\_\_\_

Applicable only to \_\_\_\_\_ :  
Plan Benefits Incurred from \_\_\_\_\_ through \_\_\_\_\_  
and Paid from \_\_\_\_\_ through \_\_\_\_\_

Applicable only to \_\_\_\_\_ :  
Plan Benefits Incurred from \_\_\_\_\_ through \_\_\_\_\_  
and Paid from \_\_\_\_\_ through \_\_\_\_\_

Plan Benefits Incurred prior to the Effective Date (during the Run-In Period) will be limited to:

- \$ \_\_\_\_\_ per Covered Person *or*
- \$ \_\_\_\_\_ for all Covered Persons combined

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

**ENDORSEMENT TO  
EXCESS LOSS POLICY**

**Change in Monthly Aggregate Factor**

YOU and WE agree to the following change to the Application/Schedule for the Excess Loss Policy to which this Endorsement applies:

The Monthly Aggregate Factor for AGGREGATE EXCESS LOSS COVERAGE, as specified in Section 4, item 3., is changed to the following:

**3. Monthly Aggregate Factor:**

<i>Covered Unit Description</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Prescription Drug Service</i>	<i>Weekly Income</i>	<i>Totals</i>
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

**ENDORSEMENT TO  
EXCESS LOSS POLICY**
**Change in Aggregate Excess Loss Coverage**

YOU and WE agree to the following changes to the Application/Schedule for the Excess Loss Policy to which this Endorsement applies:

- The Minimum Annual Aggregate Attachment Point for AGGREGATE EXCESS LOSS COVERAGE, as specified in Section 4, item 5., is changed to \$ \_\_\_\_\_ (12 times Monthly Aggregate Factor[s], times total Number of Covered Units).
- The Individual Claim Limit for AGGREGATE EXCESS LOSS COVERAGE, as specified in Section 4, item 7., is changed to \$ \_\_\_\_\_.
- The Maximum Aggregate Reimbursement (per Policy Period) for AGGREGATE EXCESS LOSS COVERAGE, as specified in Section 4, item 8., is changed to \$ \_\_\_\_\_.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

**ENDORSEMENT TO  
EXCESS LOSS POLICY**

**[Blank Endorsement]**

YOU and WE agree that the Policy is changed as follows:

[A change to Policy language that will either amend the terms of the Policy more favorably to the Policyholder, or amend the Policy to match the terms of the Plan Document.]

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached

Signed for AMERICAN FIDELITY ASSURANCE COMPANY



Secretary

Endorsement Number:	Endorsement Effective Date:
Policy Number:	
Policyholder Name:	
Signature of Policyholder's Authorized Representative:	
Authorized Representative's Title:	Date Signed:

*SERFF Tracking Number:*      *FRCS-125632225*                      *State:*                      *Arkansas*  
*Filing Company:*              *American Fidelity Assurance Company*              *State Tracking Number:*      *38847*  
*Company Tracking Number:*      *4880*  
*TOI:*                      *H21 Health - Other*                      *Sub-TOI:*                      *H21.000 Health - Other*  
*Product Name:*              *Stop Loss Policy Filing*  
*Project Name/Number:*      *AFA/66/66*

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: FRCS-125632225

State: Arkansas

Filing Company: American Fidelity Assurance Company

State Tracking Number: 38847

Company Tracking Number: 4880

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: Stop Loss Policy Filing

Project Name/Number: AFA/66/66

## Supporting Document Schedules

<b>Satisfied -Name:</b> Certification/Notice	<b>Review Status:</b> Approved-Closed	05/06/2008
<b>Comments:</b>		
<b>Attachments:</b>		
Auth_dist.pdf		
AR CoC.pdf		
AR RDB.pdf		
<b>Bypassed -Name:</b> Application	<b>Review Status:</b> Approved-Closed	05/06/2008
<b>Bypass Reason:</b> Not applicable with this filing.		
<b>Comments:</b>		
<b>Bypassed -Name:</b> Health - Actuarial Justification	<b>Review Status:</b> Approved-Closed	05/06/2008
<b>Bypass Reason:</b> Not applicable with this filing.		
<b>Comments:</b>		
<b>Bypassed -Name:</b> Outline of Coverage	<b>Review Status:</b> Approved-Closed	05/06/2008
<b>Bypass Reason:</b> Not applicable with this filing.		
<b>Comments:</b>		
<b>Satisfied -Name:</b> List of Forms being submitted	<b>Review Status:</b> Approved-Closed	05/06/2008
<b>Comments:</b>		
<b>Attachment:</b>		
AR Form List.pdf		



RONALD J. BYRNE, F.S.A., M.A.A.A.  
VICE PRESIDENT  
STRATEGIC ALLIANCES

PHONE: (405) 523-5486  
FAX: (405) 523-5514

March 3, 2008

To: The Insurance Commissioner

Authorization

This letter, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

Sincerely,

A handwritten signature in black ink, appearing to read 'Ronald J. Byrne', is written over a light gray rectangular background. The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Ronald J. Byrne

RJB:ld

**STATE OF ARKANSAS  
CERTIFICATION OF COMPLIANCE**

**Company Name:** American Fidelity Assurance Company

**Form Titles:** Excess Loss Insurance Policy, Application, Acceptance of Plan Document Changes Endorsement, Changes to Policyholder Information Endorsement, Qualified Clinical Trials Endorsement, Exclusions/Limitations for Named Persons Endorsement, Domestic Claims Endorsement, Specific Terminal Liability Endorsement, Aggregate Specific Attachment Point Endorsement, Right to Medically Underwrite Endorsement, Aggregate Terminal Liability Endorsement, Aggregate Accommodation Option Endorsement, Specific Advance Option Endorsement, Addition of Subsidiary or Other Affiliated Group Endorsement, Policy Termination Endorsement, Prescription Drugs Covered Under Plan Endorsement, Coverage of Disabled Persons Endorsement, Change in Premium Endorsement, Change in Specific Excess Loss Coverage Endorsement, Change in Basis of Coverage Endorsement, Change in Monthly Aggregate Factor Endorsement, Change in Aggregate Excess Loss Coverage Endorsement, Blank Endorsement

**Form Numbers:** AFA-SLP-2008(AR), A-1253(AR), AMD-8300, AMD-8301, AMD-8302, AMD-8303, AMD-8304, AMD-8305, AMD-8306, AMD-8307, AMD-8308, AMD-8309, AMD-8310, AMD-8311, AMD-8312, AMD-8313, AMD-8314, AMD-8315, AMD-8316, AMD-8317, AMD-8318, AMD-8319, AMD-8320

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



Ronald J. Byrne, FSA, MAAA  
Vice President & Risk Manager Strategic Alliances

April 28, 2008

Date

**STATE OF ARKANSAS  
READABILITY CERTIFICATION**

**COMPANY NAME:** American Fidelity Assurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<b>Form Number</b>	<b>Score</b>
AFA-SLP-2008(AR)	55.7
A-1253(AR)	50 *
AMD-8300, et al	50 *

\* Form achieves a score of 50+ when combined with the base policy form.

  
\_\_\_\_\_  
Ronald J. Byrne, FSA, MAAA  
Vice President & Risk Manager Strategic Alliances  
  
April 28, 2008  
\_\_\_\_\_  
Date

**AMERICAN FIDELITY ASSURANCE COMPANY  
EXCESS LOSS POLICY FILING FORMS LISTING  
Arkansas**

AFA-SLP-2008(AR)	Excess Loss Insurance Policy
A-1253(AR)	Application
AMD-8300	Acceptance of Plan Document Changes Endorsement
AMD-8301	Changes to Policyholder Information Endorsement
AMD-8302	Qualified Clinical Trials Endorsement
AMD-8303	Exclusions/Limitations for Named Persons Endorsement
AMD-8304	Domestic Claims Endorsement
AMD-8305	Specific Terminal Liability Endorsement
AMD-8306	Aggregate Specific Attachment Point Endorsement
AMD-8307	Right to Medically Underwrite Endorsement
AMD-8308	Aggregate Terminal Liability Endorsement
AMD-8309	Aggregate Accommodation Option Endorsement
AMD-8310	Specific Advance Option Endorsement
AMD-8311	Addition of Subsidiary or Other Affiliated Group Endorsement
AMD-8312	Policy Termination Endorsement
AMD-8313	Prescription Drugs Covered Under Plan Endorsement
AMD-8314	Coverage of Disabled Persons Endorsement
AMD-8315	Change in Premium Endorsement
AMD-8316	Change in Specific Excess Loss Coverage Endorsement
AMD-8317	Change in Basis of Coverage Endorsement
AMD-8318	Change in Monthly Aggregate Factor Endorsement
AMD-8319	Change in Aggregate Excess Loss Coverage Endorsement
AMD-8320	Blank Endorsement