APPLICATION FOR PRESCRIPTION EXPENSE AGGREGATE EXCESS LOSS REINSURANCE

Company Name: ______________________________

Address: ______________________________

City: ______________________________

State: ______ Zip: ____________

Proposal Date: ____________

Treaty Inception Date: ____________

Treaty Expiration Date: ____________

Application is hereby made for a reinsurance Treaty as specified herein, subject to approval by the Reinsurer. Coverage is subject to a retention amount (referred to as an Attachment Point) as shown below, and such retention amount is applicable only to the Treaty Period. If the Treaty is renewed, the retention amounts for subsequent Treaty Periods will be determined annually by the Reinsurer, and a new Application will be signed.

(A) PRESCRIPTION EXPENSE AGGREGATE EXCESS LOSS COVERAGE

1) Monthly Attachment Factors Per Member Per Month by Plan Design*:
   a) Plan A($2/$9/$9 Plan):

2) Expected Annual Aggregate Attachment Point: ____________

3) Minimum Annual Aggregate Attachment Point: ____________

4) Maximum Annual Benefit Amount (including Specialty Drugs selected): ____________

5) Aggregate Premium Per Member Per Month: ____________

6) Expected Annual Premium: ____________

*Monthly Attachment Factors by Plan are shown for informational purposes only. Coverage is pooled across all plan designs toward the aggregate attachment point.

(B) PLAN DESIGN

Mail Program:	☐ None	☐ EHD	☐ SHD	☐ HDE
Formulary:	☐ HPF	☐ NPF	☐ Prime	
Step Program:	☐ Yes	☐ No		
Network:	☐ 30K	☐ 40K	☐ 50K	
Exclusive Curascript:	☐ Yes	☐ No		
Deductible:				
Max Benefit:				

Participating Pharmacy Copays

Generic

NP Generic

P Brand

NP Brand

Specialty

Mail Service Pharmacy Copays

Generic

NP Generic

P Brand

NP Brand

Specialty

Optional Coverages:

Self Injectibles / Oral Solubles (excluding Oral Oncology):	☐ Yes	☐ No
Oral Oncology:	☐ Yes	☐ No
New Specialty Products:	☐ Yes	☐ No
Medically Assisted Injectibles / Oral Solubles (excluding Oral Oncology):	☐ Yes	☐ No

By applying for this coverage, the applicant hereby represents to Reinsurer and agrees that: (i) the applicant will retain all rights of ownership under the Treaty; (ii) the applicant will be the named beneficiary under the Treaty; (iii) neither the applicant's self-insured employee benefit plan providing prescription drug benefits ("Plan") nor any participant or beneficiary of the applicant has, will have, or may assert, any claim under the Treaty; (iv) no representation has been or will be made to any participant or beneficiary of the applicant's Plan that the Treaty will be used to provide benefits under the applicant's Plan or that the Treaty represents security for the payment of any such benefits; (v) benefits under the applicant's Plan will not be limited or governed by the amount of coverage provided under the Treaty; and (vi) the Treaty will be purchased out of the applicant's funds and no assets of the applicant's Plan will be used to purchase the Treaty.

This Application and attached Binder (if any) are an integral part of your Treaty.

Signed at ______________________________

____
Applicant (correct legal name)

Date ________________________________

____
By (Officer's name and title)