BCS INSURANCE COMPANY

2 Mid America Plaza, Suite 200
Oakbrook Terrace, Illinois 60181
(The "Company")

STOP LOSS INSURANCE POLICY

(The "Policy" or this "Policy")

Policyholder: **City of Ann Arbor**

Policy Number: **ESL-30386**

READ THIS POLICY CAREFULLY

This Policy is issued in reliance on the Application and in consideration of the payment of premiums and shall take effect on the Effective Date. The Application, Schedule, and any Endorsements included as of the Effective Date or added later are all part of this Policy.

The Policyholder is entitled to the reimbursement benefits provided by this Policy. Subject to the terms and conditions of this Policy, all periods of coverage will begin and end at 12:01 A.M. local time at the Policyholder's Corporate Address as set forth Application and may be renewed for subsequent Policy Periods if both the Company and the Policyholder agree upon renewal terms. If this Policy is renewed, the terms and conditions of this Policy may be revised. This Policy is delivered in and governed by the laws of the state of the Policyholder's Corporate Address.

BCS Insurance Company, by its President and Secretary, has caused this Policy to be executed at Oakbrook Terrace, Illinois.

PRESIDENT

SECRETARY

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I. DEFINITIONS

ADMINISTRATOR means the third party administrator designated by the Policyholder in the Application and approved in writing by the Company. The Administrator is not the Company's agent.

AFFILIATE means an entity owned or controlled by or affiliated with the Policyholder and listed in the Application or in an Endorsement to this Policy as a business affiliate. Coverage for an Affiliate shall terminate as of the date the Affiliate ceases to be owned or controlled by or affiliated with the Policyholder.

AGENT means the Policyholder's representative with respect to this Policy, including but not limited to the Policyholder's insurance agent, producer or broker of record, or Administrator. Policyholder will work only with Agents who are at all times properly licensed to conduct business in accordance with all applicable statutory and regulatory requirements.

AGGREGATE PERCENTAGE REIMBURSABLE means the percentage, as stated in the Schedule, of covered Losses in excess of the Annual Aggregate Deductible to be reimbursed by the Company under this Policy's Aggregate Stop Loss coverage.

AGGREGATING SPECIFIC DEDUCTIBLE means the Aggregating Specific Deductible amount as stated in the Schedule. The Aggregating Specific Deductible is a deductible which is in addition to the Specific Deductible, and which must be satisfied before Eligible Expenses are reimbursable under this Policy. The Aggregating Specific Deductible is eroded only by Losses exceeding the Specific Deductible, whether such Losses are from one Covered Person or a combination of Covered Persons.

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

1) The sum of the Monthly Aggregate Deductibles for the Policy Period; or
2) The Minimum Annual Aggregate Deductible.

APPLICATION means the application submitted by the Policyholder to the Company for this or any prior stop loss insurance.

BENEFIT PERIOD means the respective period of time as stated in the Schedule in which Eligible Expenses must be Incurred by a Covered Person and Paid. The Benefit Period does not alter this Policy's Effective Date or Policy Period, and does not waive this Policy's eligibility requirements.

COMPLETE CLAIMS HISTORY means all of the following

1) A census of all Covered Persons which, at minimum, includes Persons legally employed by the Policyholder or an Affiliate, dates of birth, gender, zip code of residence, type of coverage, and summary information about dependents, participating COBRA beneficiaries and retirees; and
2) A member-level specific stop loss summary which includes, at minimum, member name, amount paid and diagnosis for a minimum of thirty-six (36) consecutive months immediately preceding the Effective Date or reinstatement date of the Policy; and
3) Any injury, illness or disease that results in Eligible Expenses Paid or Incurred on behalf of any Covered

Person in an amount in excess of 50% of the Specific Deductible or has the potential to exceed 50% of the Specific Deductible, including, at minimum, amount paid, diagnosis, prognosis, dates of service, claimant status, and case management reports for a minimum of twelve (12) consecutive months immediately preceding the Effective Date or reinstatement date of the Policy; and

4) Any injury, illness or disease that relates to a classification of disease that the Company has designated as a potential Large Claim by virtue of its International Classification of Disease ("ICD") Code; including, at minimum, amount paid, diagnosis, prognosis, dates of service, claimant status, and case management reports for a minimum of twelve (12) consecutive months immediately preceding the Effective Date or reinstatement date of the Policy; and
5) Monthly paid claims and enrollment for a minimum of thirty-six (36) consecutive months immediately preceding the Effective Date or reinstatement date of the Policy (If Aggregate Stop Loss insurance is designated in the Schedule as included within this Policy); and
6) Pre-certifications, utilization reviews, pending and denied claim reports, and claims in audit for a minimum of twelve (12) consecutive months immediately preceding the Effective Date or reinstatement date of the Policy.

COST CONTAINMENT PROGRAM means a program designed to reduce or control the cost of providing benefits to Covered Persons.

COVERED PERSON or COVERED PERSONS means the following categories of persons who are eligible and covered under the Plan Document if each such category of persons is designated in the Schedule as a Covered Person:

1) Persons legally employed by the Policyholder or an Affiliate;
2) Dependents of persons legally employed by the Policyholder or an Affiliate;
3) Participating COBRA beneficiaries; and/or
4) Retirees of the Policyholder or an Affiliate.

COVERED SERVICE(S) means a Medically Necessary service or supply for which a Covered Person has Incurred an expense for which benefits are payable under the Plan Document.

DILIGENT REVIEW means a reasonable investigation by the Policyholder or its Agent(s) prior to the beginning of the Policy Period, prior to the completion of the Disclosure Statement, or prior to any Material Change to this Policy or the Plan, to identify any Large Claims.

DISCLOSURE STATEMENT means the written statement from the Policyholder or its Agent(s) provided to and accepted by the Company in connection with the underwriting of this Policy.

EFFECTIVE DATE means the inception date of the Policy Period as shown in the Schedule.

ELIGIBLE EXPENSE(S) means expenses for a Covered Service (1) for which benefits have been paid in accordance with the terms of the Plan Document and (2) which are not in excess of the Reasonable and Customary Charge for those services.

ENDORSEMENT means a written amendment or addendum issued by the Company which alters the terms of this Policy.

EXPERIMENTAL AND INVESTIGATIVE TREATMENTS means a drug, device or medical treatment or procedure that:

1) cannot be lawfully marketed with approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, or
2) Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials or under study to determine its:
    a) Maximum tolerated dose, or
    b) Toxicity, or
    c) Safety, or
    d) Efficacy, or
    e) Efficacy as compared with the standard means of treatment or diagnosis, or
3) Reliable evidence shows that the consensus among experts regarding the drug, device or medical treatment

or procedure is that further studies or clinical trials are necessary to determine its:

a) Maximum tolerated dose, or
b) Toxicity, or
c) Safety, or
d) Efficacy, or
e) Efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1) Only published reports and articles in the authoritative peer reviewed medical and scientific literature; or
2) The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or
3) The written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

INCURRED means expenses for medical services that are rendered to, or supplies that are provided to, the Covered Person for which the Policyholder is legally obligated to pay in accordance with the terms of the Plan Document.

INCURRED DATE means the date on which the medical services are rendered to, or supplies are provided to, the Covered Person. Each day of a hospital stay is considered to have a separate Incurred Date.

KNOWN means information actually known or which could be actually known through a Diligent Review.

LARGE CLAIM means (1) any injury, illness or disease that results in Eligible Expenses Paid or Incurred on behalf of any Covered Person in an amount in excess of 50% of the Specific Deductible or has the potential to exceed 50% of the Specific Deductible; or (2) any injury, illness or disease that relates to a classification of disease that the Company has designated as a potential Large Claim by virtue of its International Classification of Disease ("ICD") Code.

LOSS or LOSSES means amounts Incurred and Paid for Eligible Expenses during the Benefit Period.

LOSS LIMIT PER COVERED PERSON means the maximum amount of Losses per each Covered Person which can be used to satisfy the Annual Aggregate Deductible and is stated in the Schedule. If a Covered Person has been assigned a separate Specific Deductible, the Loss Limit Per Covered Person in the Schedule will still apply with respect to such Covered Person.

MATERIAL CHANGE means a development occurring or first discovered during the Policy Period, other than Losses during the Policy Period, that is reasonably likely to have a material economic impact on the Company's liability under this Policy. A Material Change includes, but is not limited to, the following:

1) Any increase or decrease of the number of Covered Persons (exclusive of dependents) by more than 15%;
2) The Policyholder adds or deletes an Affiliate;
3) The Policyholder changes the Plan;
4) The Policyholder changes the Administrator;
5) The Policyholder changes its Provider Network;
6) A Covered Person who was not disclosed to the Company during the underwriting of this Policy is reasonably determined to be an unacceptable risk;
7) A bankruptcy proceeding involving the Policyholder or an Affiliate; or
8) Any other material change in factors bearing on the risk assumed by the Company under this Policy, including, but not limited to a change in law or regulations that changes the nature or amount of the risk assumed by the Company under this Policy.

MEDICAL means any healthcare related services allowed under the Plan Document Incurred by a Covered Person, and for purposes of determining Eligible Expenses, includes pharmaceutical drugs that legally require a medical prescription that are administered to a Covered Person while in a hospital or other medical facility.

MEDICAL MANAGEMENT VENDOR means a third party that provides services designed to reduce or control the cost of services or supplies provided to Covered Persons under the Plan.

MEDICALLY NECESSARY means a procedure, treatment, service, supply, equipment, drug or medicine that is:

1) Deemed appropriate, essential and is recommended for the diagnosis or treatment of the Covered Person's symptoms by a licensed physician, dentist or other practitioner who is practicing within the scope of his or her license and specialty or primary area of practice;
2) Within the scope, duration and intensity of that level of care which is required to provide safe, adequate and appropriate diagnosis or treatment; and
3) Prescribed in accordance with the generally accepted, current professional medical practice and is not considered Experimental and Investigative Treatments.

MINIMUM ANNUAL AGGREGATE DEDUCTIBLE means the minimum amount of Eligible Expenses the Policyholder must pay before the Policyholder becomes eligible for Aggregate Stop Loss benefits under this Policy, and if applicable, is stated in the Schedule.

MONTHLY AGGREGATE DEDUCTIBLE means the number of Covered Persons (exclusive of dependents) during the month multiplied by the applicable monthly aggregate factor(s) as stated in the Schedule.

PAID means the Policyholder or Administrator has issued and deposited in the U.S. mail to the payee, or otherwise delivered to the payee, a check or draft, with sufficient funds on deposit to honor the transaction, for the amount of a covered Eligible Expense.

PAID DATE means the date on which the Policyholder or Administrator performs the last action necessary to render an Eligible Expense Paid.

PLAN means the Policyholder's self-funded employee benefit plan that provides benefits to Covered Persons.

PLAN DOCUMENT means the written document that describes the Plan, as adopted by the Policyholder and as approved by the Company prior to the Policy Period. The Policyholder will immediately notify the Company if the Plan Document is modified or terminated. The Plan Document does not waive or amend any provisions of this Policy.

POLICY MONTH means successive intervals of time, while this Policy is in effect, determined on a monthly basis starting on the Effective Date of this Policy. Each new interval will begin on a day that corresponds to the Effective Date of this Policy. If there is no such day in any applicable month, then the last day of the month will be used.

POLICY PERIOD means the period specified in the Schedule beginning on the Effective Date, subject to prior termination in accordance with this Policy's Termination Provisions.

PREMIUM DUE DATE means the Effective Date of this Policy and the first (1^{st}) day of each following Policy Month.

PRESCRIPTION DRUGS, if designated in the Schedule as included within this Policy, and for the purpose of determining Eligible Expenses under this Policy, means pharmaceutical drugs that legally require a medical prescription to be dispensed other than drugs administered to a Covered Person while he/she is confined in a hospital or other medical facility.

PROVIDER NETWORK means a set of doctors, hospitals and other health care providers that have a contract to provide services at a negotiated rate and that have agreed to accept the negotiated rate as payment in full for services rendered.

REASONABLE AND CUSTOMARY CHARGE means charges for medical expenses, including but not limited to, physician services, hospital supplies, hospital bed rates, drugs, ancillary services and durable medical equipment usually made by such providers in the same geographical area using nationally and regionally adjusted data.

RUN-IN LIMIT for Specific Stop Loss coverage, as stated in the Schedule, means the maximum amount of Losses per Covered Person(s) that can be applied towards the Specific Deductible and Aggregating Specific Deductible for Losses Incurred prior to the Effective Date of this Policy. **RUN-IN LIMIT** for Aggregate Stop Loss coverage, as stated in the Schedule, means the maximum amount of Losses that can be applied towards the Annual Aggregate Deductible for Losses Incurred prior to the Effective Date of this Policy.

SCHEDULE means the Schedule for Stop Loss Insurance issued by the Company for this Policy.

SPECIFIC DEDUCTIBLE means the Specific Deductible Per Covered Person, Per Policy Period, as stated in the Schedule. The Specific Deductible applies separately to each Covered Person for the Policy Period.

SPECIFIC PERCENTAGE REIMBURSABLE PER COVERED PERSON means the percentage, as stated in the Schedule, of covered Losses in excess of the Specific Stop Loss Deductible to be reimbursed by the Company under the Specific Stop Loss coverage.

II. REIMBURSEMENT PROVISIONS

A. SPECIFIC STOP LOSS

If Specific Stop Loss insurance is designated in the Schedule as included within this Policy, and while this Policy is in effect, the Company will reimburse the Policyholder, subject to the terms, limitations, conditions and exclusions of this Policy, for Losses in excess of both the Specific Deductible for each Covered Person and the Aggregating Specific Deductible for all Covered Persons, combined. The Company's maximum liability under this Specific Stop Loss coverage for all Losses for each Covered Person shall be the Maximum Specific Reimbursement per Covered Person Per Policy Period as stated in the Schedule.

With respect to Loss otherwise covered under this Specific Stop Loss insurance in excess of the deductibles described above, the Company's liability for such Loss shall apply only to the percentage of such Loss as stated in the Specific Percentage Reimbursable Per Covered Person in the Schedule, and the Company shall not be liable for the remaining portion of such Loss.

If the Policy is terminated prior to the end of the Policy Period, the Specific Deductible will not be reduced and will continue to apply, but the Benefit Period will be revised such that the last date of the Benefit Period is the date of Policy termination, regardless of the date stated as the "Through" date on the Schedule.

B. AGGREGATE STOP LOSS

If Aggregate Stop Loss insurance is designated in the Schedule as included within this Policy, and while this Policy is in effect, the Company will reimburse the Policyholder, subject to the terms, limitations, conditions and exclusions of this Policy, for Losses in excess of the Annual Aggregate Deductible for the Policy Period, subject to the Loss Limit Per Covered Person. The Company's maximum liability under this Aggregate Stop Loss coverage for all Losses for all Covered Persons combined shall be the Maximum Aggregate Benefit per Policy Period as stated in the Schedule.

With respect to Loss otherwise covered under this Aggregate Stop Loss insurance, the Company's liability for such Loss shall apply only to the percentage of such Loss as stated in the Aggregate Percentage Reimbursable Per Policy Period in the Schedule, and the Company shall not be liable for the remaining portion of such Loss.

For purposes of determining amounts payable under this Aggregate Stop Loss insurance, Losses will not include any amounts reimbursed by the Company under any other provision of this Policy. Any Loss that is Incurred when the person to whom the Loss relates is not a Covered Person will not be eligible for Aggregate Stop Loss insurance and will not be considered for the purpose of satisfying the Annual Aggregate Deductible.

If the Policyholder's Aggregate Stop Loss coverage terminates before the end of the Policy Period, the Minimum Annual Aggregate Deductible as stated in the Schedule will be the only applicable Deductible and will not be reduced.

MULTIPLE POLICY PERIODS
If a claim for reimbursement can be filed under two different Policy Periods, it must be filed under, and is subject to coverage under, only the earlier Policy Period.

RECOVERIES AND OVERPAYMENTS
Losses paid by the Company under the Specific or Aggregate Stop Loss insurance may be revised after the

Policy Period and any recoveries of such Losses by the Policyholder or the Policyholder's Agent from another source shall be returned to the Company, including recovery of overpayments and recovery based upon workers' compensation liens or any third party liability liens. The Policyholder shall report any such recoveries to the Company within fifteen (15) days of receipt.

III. CLAIM PROVISIONS

NOTICE OF SPECIFIC LOSS
The Policyholder shall give to the Company a written proof of loss, in a form and content satisfactory to the Company, as soon as reasonably possible after a Covered Person's Paid Losses exceed the Specific Deductible, or within ninety (90) days after the Loss is Paid, whichever is later.

Proof of loss for a Specific Stop Loss claim shall include at least the following:
1) Completed Specific Stop Loss Claim Form;
2) Patient name, incurred services, Incurred Date, provider name/number, procedure code(s), type of service(s), diagnosis, totaled billed amount, Paid amount, and Paid Date;
3) Amounts Paid on a per diem basis, Diagnosis Related Group (DRG) basis, or pursuant to any other contract schedule must clearly state the method and/or rate used in calculating the Paid amount; and
4) Any other documentation that may be required by the Company in order to fulfill obligations under this Policy.

Failure to give notice within such time will not invalidate or reduce any claim for coverage if it is shown not to have been reasonably possible to give such notice in time and that notice was given as soon as was reasonably possible.

NOTICE OF AGGREGATE LOSS
The Policyholder shall give to the Company a written proof of loss, in a form and content satisfactory to the Company, within ninety (90) days after the end of the Policy Period or the Benefit Period, whichever is later, showing the amount of all Paid Losses under the Plan for the Benefit Period.

Proof of loss for an Aggregate Stop Loss claim shall include at least the following:
1) Paid claims report indicating claimant's name, Incurred Date, charged amount, Paid amount and Paid Date;
2) Eligibility for each Covered Person, which identifies date of birth, coverage Effective Date, termination date (if applicable) and coverage type;
3) Aggregate monthly Loss report in a form and content satisfactory to the Company;
4) Specific report showing which Covered Persons have exceeded the Specific Deductible; and
5) Any other documentation that may be required by the Company in order to fulfill obligations under this Policy.

Failure to give notice within such time will not invalidate or reduce any claim for coverage if it is shown not to have been reasonably possible to give such notice in time and that notice was given as soon as was reasonably possible.

Expenses for claims submitted to the Company that are not submitted in accordance with the Proof of Loss provisions of this Policy are not reimbursable under the Policy.

REQUIRED NOTIFICATIONS
The Policyholder or its Agent(s) shall give the Company notice when (1) any injury, illness or disease results in Eligible Expenses Paid or Incurred on behalf of any Covered Person in an amount in excess of 50% of the Specific Deductible or has the potential to exceed 50% of the Specific Deductible, or (2) a Covered Person is diagnosed with any injury, illness or disease that relates to a classification of disease that the Company has designated as a potential Large Claim by virtue of its International Classification of Disease ("ICD") Code. The Policyholder's failure to give notice may result in the delay, reduction or denial of a claim for reimbursement.

CLAIM AND ELIGIBILITY REVIEW
The Company reserves the right to request an on-site review of the claims, eligibility and all records relevant to a claim under this Policy.

TIMING OF REIMBURSEMENTS
The Company will have no obligation to reimburse the Policyholder for Losses under Specific Stop Loss coverage

until after the Company receives proper proof of loss and has verified that the Eligible Expenses have been Paid.

The Company will have no obligation to reimburse the Policyholder for Losses under Aggregate Stop Loss coverage until after the end of the Policy Period and after the Company receives proper proof of loss and has verified that the Eligible Expenses have been Paid.

IV. GENERAL EXCLUSIONS

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

1) Payments the Policyholder makes under the Plan Document as a result of declared or undeclared war, including resistance to armed aggression;
2) Payments the Policyholder makes which are recoverable under the Plan Document's coordination of benefits provision;
3) Payments the Policyholder makes for expenses which are not covered in the Plan Document, or which are outside the requirements of the Plan Document or this Policy;
4) Payments the Policyholder makes for an injury, illness or disease for which the Covered Person has or has a right to compensation under any workers' compensation insurance or similar law, whether or not coverage under such law is actually in force;
5) Judgments and interest on judgments, court costs or penalties, fines or penalties imposed by law, or punitive, exemplary or multiple damages;
6) Cost of administering the Plan Document, including cost of Diligent Review;
7) Legal expenses and fees, including legal expenses and fees incurred on behalf of any Covered Person in connection with obtaining medical treatment;
8) Expenses incurred for Experimental and Investigative Treatments, for research studies, or for services, drugs or supplies not legal in the United States of America. Experimental and Investigative Treatments or expenses for research studies are subject to this exclusion even if it may be the only hope for survival, unless coverage for such expenses under this Policy is mandated by law;
9) Payments the Policyholder makes in connection with a risk Known by the Policyholder or its Agent(s) but not disclosed to the Company prior to the beginning of the Policy Period, prior to the completion of the Disclosure Statement or prior to any material change to this Policy, if the Policyholder's failure to disclose such risk to the Company was either intentional or because a Diligent Review was not conducted;
10) Payments the Policyholder makes which are in excess of the Reasonable and Customary Charge for the services or supplies.

V. PREMIUMS

PAYMENT OF PREMIUMS
No coverage under this Policy will be in effect until the first (1st) premium is paid. For coverage to remain in effect during the Policy Period, each subsequent premium must be paid on or before the Premium Due Date. The Policyholder is responsible for the payment of premiums. Premiums are not considered paid until the premium payment is received by the Company.

GRACE PERIOD
A Grace Period of forty-five (45) days from the Premium Due Date will be allowed for the payment of each premium after the first (1st) premium payment. During the Grace Period, coverage under this Policy will remain in effect provided the premium is paid before the end of the Grace Period. If the Policyholder does not pay all premiums that are due by the end of the Grace Period, this Policy will automatically terminate as set forth in the Termination and Renewal section of this policy.

PREMIUM AMOUNT
The Policyholder's premiums will be calculated using the rates determined by the Company and shown in the Schedule.

PREMIUM REFUNDS
Any correction or change to the Specific Stop Loss or Aggregate Stop Loss premium must be reported to the

Company within ninety (90) days after the end of the Policy Period, and any premium refund as a result of such correction or change will be paid promptly by the Company. If the Policyholder's coverage terminates before the end of the Policy Period, the Company will not refund any portion of the premium paid.

VI. MATERIAL CHANGES

The Company reserves the right to approve any Material Change. The Policyholder, the Administrator, or the Agent must notify the Company of any Material Change in writing prior to the effective date of such Material Change.

Upon receipt of notice of a Material Change, the Company reserves the right to, and will promptly notify the Policyholder of, any of the following responses:

1) Accept the Material Change without revising the premium rates and/or other terms and conditions of this Policy; or
2) Accept the Material Change and, subject to the agreement of the Policyholder, revise the premium rates and/or other terms and conditions of this Policy; or
3) Not accept the Material Change and reimburse for Losses under this Policy as if the Material Change had not occurred; or
4) Not accept the Material Change and terminate this Policy pursuant to the Termination and Renewal section of this Policy.

Payment of any Losses under this Policy based on an accepted Material Change is subject to the Policyholder's written acceptance of any necessary adjustment to the premium rates and/or other terms and conditions of this Policy.

VII. TERMINATION AND RENEWAL

TERMINATION BY POLICYHOLDER
The Policyholder may terminate coverage under this Policy at any time by giving the Company prior written notice. The Policyholder's coverage will end as of the date designated in such notice, but no sooner than thirty one (31) days after the date on which the Company receives written notice.

TERMINATION BY THE COMPANY
The Company may terminate coverage under this Policy at any time by giving the Policyholder or an agent of the Company forty five (45) days prior written notice, but only for the following reasons:

1) The Policyholder fails to comply with a provision of this Policy, including the terms of the Schedule and Application;
2) The Policyholder fails to perform its Policy obligations in good faith;
3) The Policyholder is covering fewer than fifty-one (51) Covered Persons (exclusive of dependents) under the Plan;
4) The Policyholder failed to provide information required in the Disclosure Statement;
5) The Policyholder experiences a Material Change reasonably determined by the Company to be unacceptable; or
6) The Policyholder changes its Provider Network or Administrator.

AUTOMATIC TERMINATION
Coverage under this Policy will automatically terminate:
1) At the end of the Policy Period shown in the Schedule, unless renewed pursuant to the Policy Renewal provisions below;
2) Retroactive to the date for which premiums were last fully paid, if the Policyholder fails to pay all premiums that are due by the end of the Grace Period;
3) Immediately upon the Policyholder's failure to pay claims or make funds available to pay claims as required by the Plan Document;
4) Immediately upon termination of the Plan or Plan Document;

5) The last day of the third (3rd) consecutive month during which there are less than fifty-one (51) Covered Persons (exclusive of dependents) enrolled in the Plan, unless the Company agrees in writing to continue coverage; or
6) The date the Policyholder materially fails to comply with the terms of this Policy.

POLICY REINSTATEMENT
If this Policy terminates as set forth above, the Company may, at its option, approve the Policyholder's request to reinstate the Policy. The Policyholder shall submit to the Company any forms and data the Company may require, including the Policyholder's representation(s) as to Losses Incurred or Losses Paid as of the date of the Policyholder's application for reinstatement. If the Policy is reinstated, the Policyholder shall pay to the Company the premiums due from the date the Policy is terminated. The Company reserves the right to conduct a Diligent Review of the Complete Claims History and re-underwrite the Policy as the Company deems necessary as part of the terms for reinstatement.

POLICY RENEWAL
At the end of the Policy Period, coverage under this Policy may be renewed by mutual consent of the Policyholder and the Company. The Company may refuse to renew this Policy by giving the Policyholder sixty (60) days prior written notice. A new Application and Schedule signed by the Policyholder must be received by the Company, and any changes in the Application and/or Schedule must be approved by the Company, before the Company will be liable for reimbursements under the new Policy Period.

VIII. POLICYHOLDER RIGHTS AND RESPONSIBILITIES

AUTHORIZATIONS TO RELEASE INFORMATION
The Policyholder is responsible for authorizing the Administrator, case manager, or other third party service provider to release to the Company information the Company requests to underwrite, review potential claims, make claim determination, calculate potential reimbursements, or perform other obligations under this Policy. If the Company does not receive requested information, it may result in the delay, reduction or denial of a claim.

DISCLOSURE REQUIREMENTS
This Policy has been underwritten based upon the information the Policyholder, Administrator or Agent provided to the Company concerning all persons eligible for benefits under the Plan on the Effective Date. This includes, but is not limited to, the Complete Claims History. If the Policyholder fails to disclose all information that is, or through a Diligent Review, could have been included in the Complete Claims History, the Company will have the right to revise the premium rates, deductibles, factors and terms and conditions of this Policy in accordance with the Company's underwriting practices in effect at the time the Policy was underwritten, retroactive to the Effective Date.

REPORTING REQUIREMENTS
The Policyholder, either directly or through its Agent or Administrator, is required to provide periodic reports as described below. If the Policyholder, Agent or Administrator does not provide the reports, or does not provide them on a timely basis, the Company reserves the right, once it receives them, to take whatever action the Company could have taken if the reports had been provided when required. Such action may include, but is not limited to, the right to revise premium rates, deductibles, factors and terms and conditions of this Policy, and to do so retroactive to the Effective Date. If the Company does not receive requested information, it may result in the delay, reduction or denial of a claim.

The Policyholder or Administrator shall provide to the Company the following data for the preceding Policy Month on or before the 30th day of each succeeding Policy Month:

1) notice of Large Claims; and
2) number of Covered Persons (If Aggregate Stop Loss insurance is designated in the Schedule as included within this Policy); and
3) total amount of claims paid (If Aggregate Stop Loss insurance is designated in the Schedule as included within this Policy).

If the Policyholder intends to renew this Policy, prior to the end of the Policy Period, the Policyholder or Administrator is required to provide the Company with a report that includes the following information:

1) A census of all Covered Persons which, at minimum, includes Persons legally employed by the Policyholder or an Affiliate, dates of birth, gender, zip code of residence, type of coverage, and summary information about dependents, participating COBRA beneficiaries and retirees;
2) Monthly Paid claims and enrollment data (If Aggregate Stop Loss insurance is designated in the Schedule as included within this Policy);
3) Any injury, illness or disease that results in Eligible Expenses Paid or Incurred on behalf of any Covered Person in an amount in excess of 50% of the Specific Deductible or has the potential to exceed 50% of the Specific Deductible, including, at minimum, amount paid, diagnosis, prognosis, dates of service, claimant status, and case management reports;
4) Any injury, illness or disease that relates to a classification of disease that the Company has designated as a potential Large Claim by virtue of its International Classification of Disease ("ICD") Code; including, at minimum, amount paid, diagnosis, prognosis, dates of service, claimant status, case management reports;
5) Pre-certifications, utilization reviews, pending and denied claim reports, and claims in audit; and
6) A copy of changes adopted or proposed for the Plan.

IX. GENERAL PROVISIONS

ASSIGNMENT
The Policyholder may not assign any of its rights to any benefits, including reimbursement of Losses, under this Policy without the Company's prior written approval.

ADMINISTRATION
If the Policyholder hires an Administrator to perform any functions on its behalf, the Administrator will be the Policyholder's Agent, not the agent of the Company. The Company will not be liable for any act or omission of an Administrator. The Policyholder agrees that the Administrator:

1) acts only on behalf of and in the Policyholder's name for purposes of this Policy, including submission of proof of loss, certifying the payment of plan benefits, transmitting reports and payment of premiums to the Company and receiving reimbursements from the Company. Payments sent by the Company to the Administrator are payments to the Policyholder. Premium payments made through the Administrator will be payments to the Company only to the extent the Company receives them;
2) is responsible for administering the Plan, preparing all reports as required by the Company and making available such data as the Company requires;
3) will perform such duties and keep such records as are required to comply with this Policy; and
4) will be paid by the Policyholder for all administrative functions performed in relation to this Policy.

CHANGES TO THIS POLICY
No alterations to this Policy will be valid unless approved by an officer of the Company and contained in a written Endorsement. No Agent or Administrator has the authority to alter this Policy or to waive any of its provisions, including the provisions of the Schedule. All Endorsements to this Policy as of the Effective Date are listed in the Schedule and appended to this Policy.

CHANGES TO THE PLAN DOCUMENT
This Policy provides coverage on the basis of the Plan Document as approved by and on file with the Company. If the Policyholder makes changes to the Plan Document, such changes will be applicable to this Policy only if and after the Company approves them in writing.

CLERICAL ERROR
Clerical errors, whether by the Policyholder or by the Company, in storing or transmitting any records that pertain to coverage will not invalidate, limit or terminate coverage otherwise validly in force. Clerical errors do not include any failure of the Policyholder, the Administrator or any other appointed Agent of the Policyholder to comply with any requirement of the Loss notification provisions under this Policy or to disclose underwriting information whether or not such failure was intentional and regardless of the actual knowledge of the person(s) providing such information.

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

conform to the minimum requirements of such law.

COST CONTAINMENT
The Company has the right through its own employees or the services of a Medical Management Vendor or other service providers at the Company's expense, to (a) assist the Company with a Cost Containment Program with respect to claims under the Plan or (b) provide services to the Policyholder or the Administrator to reduce cost, risk or expenses under the Plan. The Company may also cause a Medical Management Vendor or other service provider, with whom the Company has negotiated a set or discounted rate, to contact the Policyholder or Administrator if, in the Company's determination, the Medical Management Vendor or other service provider provides a service that may allow the Policyholder to reduce risk, costs or expenses.

DETERMINATION OF ELIGIBLE EXPENSES
Determination of benefits under the Plan is the Policyholder's sole responsibility. However, the Company has the right to interpret the terms and conditions of the Plan as it applies to this Policy. Only the Company has the authority to reimburse or deny coverage for Losses under this Policy.

ENTIRE CONTRACT
This Policy, including the Application, Schedule, and Endorsements, constitutes the entire contract of insurance.

HOLD HARMLESS
The Policyholder agrees to defend, indemnify and hold the Company harmless from and against any and all demands, claims, litigation and causes of action against the Company relating to this Policy or the Plan Document, except to the extent such demands, claims, litigation and causes of action are for actual wrongdoing by the Company. The Policyholder shall pay any and all attorney's fees, costs, expenses, and damages (including compensatory, exemplary or punitive damages) incurred by the Company, or payable by the Company, in connection with any such demands, claims, litigation and causes of action. This hold harmless provision shall not apply to disputes between the Policyholder and the Company relating to this Policy.

INSOLVENCY
Nothing in this Policy shall relieve a bankrupt Policyholder's obligation to pay premiums when due or delay termination of this Policy for failure to do so. The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or the appointed Administrator will not impose upon the Company any liability other than the liability defined in this Policy. The insolvency of the Policyholder will not make the Company liable to creditors of the Policyholder, including Covered Persons under the Plan Document.

LEGAL ACTION
The Policyholder may not file suit against the Company with respect to any loss until sixty (60) days after the date on which the Policyholder submits to the Company proof of loss as required by this Policy. The Policyholder may not file suit against the Company more than one (1) year after the date on which the Policyholder must give the Company proof of loss.

LIABILITY
The Company's sole liability is to the Policyholder, subject to the terms and conditions of this Policy. The Company has no right or obligation to pay any benefits to any Covered Person or provider of professional or medical services. Nothing in this Policy shall be construed to permit a Covered Person or service provider to have a direct right of action against the Company. The Company will not be considered a party to the Plan or to any supplement or amendment to the Plan.

MISSTATED DATA
The Company has relied on the underwriting information provided by the Policyholder or the Policyholder's Agent(s) in the issuance of this Policy. If information required to be disclosed to the Company pursuant to the Application, Disclosure Statement or otherwise is not disclosed to the Company, and if such information would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise this Policy's rates, deductibles, terms or conditions as of this Policy's Effective Date by notifying the Policyholder in writing.

NOTICE FROM THE COMPANY TO THE POLICYHOLDER
For the purpose of any notice required from the Company under the provisions of this Policy, notice to the

Administrator shall be considered notice to the Policyholder and notice to the Policyholder shall be considered notice to the Administrator.

OFFSET PROVISION
The Company has the right to offset any Losses payable to the Policyholder under this Policy against premiums due and unpaid by the Policyholder, but this right will not prevent the termination of this Policy for non-payment of premium.

OTHER INSURANCE
The Company will not reimburse the Policyholder for Eligible Expenses that, at the time they are Incurred, are covered by any other valid and collectible insurance policy or policies (including any insurance established by federal, state or local laws), except in respect of any excess beyond the amount(s) covered under such other policy or policies, provided this provision does not apply with respect to any other policy which is expressly excess of this Policy by specific reference to this Policy.

PARTIES TO THIS POLICY
The Company's sole liability under this Policy is to the Policyholder. This Policy does not create any right or legal relation between the Company and a Covered Person under the Plan Document. This Policy will not make the Company a party to any agreement between the Policyholder and the Administrator.

PAYMENT OF LOSSES UNDER THE PLAN
It is the Policyholder's responsibility, either directly or through the Administrator, to audit, calculate and pay benefits covered by the Plan. No one, including the Policyholder, may pay benefits for the Plan unless named as the Administrator and approved by the Company. The Company will not reimburse the Policyholder for Losses resulting from benefits paid by someone not so authorized to do so.

The Policyholder or the Administrator must pay all benefits within thirty (30) days of the date on which the Policyholder receives satisfactory proof of loss. The Policyholder must make available sufficient funds to pay benefits when due.

RECORDS AND REVIEW
The Policyholder must keep appropriate records as may be required by the Company for this Policy including but not limited to the Complete Claims History and records relating to the administration of the Plan Document. The Policyholder must allow the Company to review and copy, during normal business hours, all records affecting the Company's liability under this Policy. The Policyholder must maintain records for all Covered Persons under the Plan Document during the Policy Period and for a period of seven (7) years after the termination of this Policy.

The Policyholder must maintain a separate record of any and all amounts the Policyholder pays that exceed or are not covered by the benefits under the Plan Document.

SEVERABILITY
Any clause of this Policy 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.

SUBROGATION
The Company has the right to recover any and all payments that the Company has made to the Policyholder under this Policy from any person or entity that has been found to make, or is obligated to make in the future, a first and/or third party payment to a Covered Person, as a result of an accident or illness caused by the negligence of another party.

This right 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 or the Policyholder is no longer covered by the Company.

If the Policyholder recovers any monies from any source for any loss for which the Policyholder received payment under this Policy, the Company will be reimbursed on a priority basis from such recovery to the extent of the Company's payments to the Policyholder before the Policyholder is entitled to receive a recovery. This obligation

of the Policyholder to the Company survives the termination of this Policy and is applicable even if the Policy has expired and/or has been terminated. Any amount recovered by the Policyholder or their designated Agent (Administrator or other service provider) shall be used first to reimburse the Company for any benefit payments made on behalf of any Covered Person, without any reduction unless agreed in writing by the Company prior to settlement.

Any amounts recovered by the Company shall be used to reimburse the Company first for any amount that the Company may have paid or become liable to reimburse to the Policyholder or their Plan under the terms of this Policy, and any remaining amounts after the costs of collection shall be paid to the Policyholder and their Plan. The Policyholder will at all times cooperate with the Company in any recovery efforts. There can be no deduction of the amounts due the Company for legal fees or any costs associated with the recovery of these payments.

The Company may independently pursue any first and/or third party recoveries. However, in the event the Policyholder fails to pursue any or all available recovery sources and the Company has made reimbursements under this Policy, then the Policyholder's right of subrogation against a Covered Person transfers to the Company and the Company will be subrogated to all of the Policyholder's rights to make any recoveries.

If there is to be a settlement for any portion of the funds that is less than 100% of the amount paid to the Policyholder by the Company, any such settlement must first be approved by the Company, or its authorized representative, before the Policyholder agrees to such a settlement with any other person or entity.

TAXES

The Policyholder agrees to hold the Company harmless from any state premium taxes incurred with respect to funds paid to or by the Policyholder through the covered underlying Plan(s). If any state premium tax is assessed against the Company with respect to such funds the Policyholder must reimburse the Company for the amount of the state premium tax liability including any interest, penalty and costs incurred by the Company as a result of the assessment. Taxes incurred with respect to premiums paid for this Policy will be the Company's responsibility.