

**HCC LIFE INSURANCE COMPANY**  
**STOP LOSS POLICY**  
Independent Review Organization Coverage Endorsement

Policy Number: HCL35835

Endorsement Number: 5

Policyholder: Prince Avenue Baptist Church

Effective Date: 09/01/2020

You and We agree that this Policy is amended as follows:

In the event Covered Expenses are Paid by You for a Covered Person based on an Independent Review Organization's reversal of previously denied claims, and such Covered Expenses are Paid after the last paid date provided in the Contract Basis of this Policy, the Paid Covered Expenses shall be deemed to have been Paid during this Policy's Contract Period, provided that:

1. Such Covered Expenses are not eligible for reimbursement under any other coverage; and
2. Such Plan Benefits are otherwise eligible for reimbursement under the terms of this stop loss policy.

You (or You through your Plan Supervisor) agree to provide notice to Us that an appeal has been sent to an Independent Review Organization on a claim that could or is expected to exceed the specific stop loss deductible under this policy within 30 days of the referral to the Independent Review Organization. We will not reimburse any stop loss claim under this Endorsement if we do not receive such notice within the 30-day time frame.

When filing a reimbursement claim under this Endorsement, You agree to provide us all documentation related to the Independent Review Organization's reversal of the previously denied Covered Expenses. We will not reimburse any stop loss claim where the Independent Review Organization's reversal documentation, along with any other information necessary to process the claim, is not received within 90 days from the last date a claim is eligible for payment under the Contract Period or within 90 days of the date the claim was Paid if Paid after the Contract Period has lapsed.

For purposes of this Endorsement, Independent Review Organization means the organization for external review as required under the external review process of the Patient Protection and Affordable Care Act.

Fees, or any similar expenses, paid to the Independent Review Organization for their services are not reimbursable under this Endorsement. Coverage under this endorsement does not modify any other terms, conditions, deductibles or split funded retentions of this policy. If coverage is available under a subsequent policy issued by Us, coverage shall be provided under this endorsed policy and not the subsequent policy.

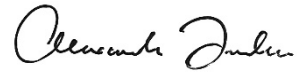
**HCC LIFE INSURANCE COMPANY**  
STOP LOSS POLICY  
Independent Review Organization Coverage Endorsement

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

HCC LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Jay Puteh".

President

A handwritten signature in black ink, appearing to read "Cleoandra J. Miller".

Corporate Secretary

Dated: November 10, 2020

**HCC LIFE INSURANCE COMPANY**  
**STOP LOSS POLICY**  
**QUALIFIED CLINICAL TRIALS ENDORSEMENT**

Policy Number: HCL35835

Endorsement Number: 4

Policyholder: Prince Avenue Baptist Church

Effective: 09/01/2020

YOU and WE agree that this Policy is amended as follows:

ARTICLE I. DEFINITIONS is hereby amended to add the following:

**PATIENT CARE SERVICES.** Health care items or services that are furnished to an individual enrolled in a Qualified Clinical Trial, which is consistent with the usual and customary standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the Qualified Clinical Trial.

Patient Care Services must be determined to be eligible under the Policyholder's Employee Benefit Plan.

Patient Care Services do not include any of the following:

1. An FDA approved drug or device shall be a Patient Care Service only to the extent that the drug or device is not paid for by the manufacturer, the distributor or the provider of the drug or device, or
2. Non-health care services that a patient may be required to receive as a result of being enrolled in the Qualified Clinical Trial, or
3. Costs associated with managing the research associated with the Qualified Clinical Trial, or
4. Costs that would not be covered for non-investigational treatments, or
5. Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Qualified Clinical Trial, or
6. The costs of services, which are not provided as part of the Qualified Clinical Trial's stated protocol or other similarly, intended guidelines.

**QUALIFIED CLINICAL TRIAL.** A Qualified Clinical Trial is a clinical trial that meets all of the following conditions:

1. The clinical trial is intended to treat cancer or another life threatening condition in a patient who has been so diagnosed, and
2. The clinical trial has been peer reviewed and is approved by at least one of the following:
  - a. A federally funded or approved Trial; or
  - b. A clinical trial conducted under an FDA investigation new drug application; or
  - c. A drug trial that is exempt from the requirement of an FDA investigational new drug application.
3. The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.

Article VI, EXCLUSIONS. Item C is amended to include the following:

If your Employee Benefit Plan is compliant with Section 10103(c) of the Affordable Care Act, Covered Expenses for Patient Care Services furnished in connection with participation in Qualified Clinical Trials, as defined herein, will not be considered Experimental or Investigative.

**HCC LIFE INSURANCE COMPANY**  
STOP LOSS POLICY  
QUALIFIED CLINICAL TRIALS ENDORSEMENT

**ADDITIONAL QUALIFIED CLINICAL TRIALS PROVISIONS**

WE may require a copy of the Qualified Clinical Trial's study protocol before determining if any benefits are payable under this Endorsement.

We shall rely on the Employee Benefit Plan in terms of the definition of Life Threatening. Should the Employee Benefit Plan fail to provide a definition of Life Threatening, We will define Life Threatening as a condition that is expected to cause death within 6 months. Such definition will be used solely for the purposes of this policy and adjudication of any claims under this Endorsement.

Stop Loss Policy benefits paid under this Endorsement will be included in the Specific Contract Period Reimbursement Maximum, if applicable.

Stop Loss Policy benefits paid under this Endorsement shall not create any legal presumption that HCC Life Insurance Company has recommended, directed, endorsed or required any Covered Person's participation in the Qualified Clinical Trial.


Stop Loss Policy benefits paid under this Endorsement shall be subject to all terms and conditions of the Policyholder's Employee Benefit Plan.

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

HCC LIFE INSURANCE COMPANY



President



Corporate Secretary

Dated: November 10, 2020

**HCC LIFE INSURANCE COMPANY**  
STOP LOSS POLICY  
ENDORSEMENT TO A POLICY ISSUED IN THE STATE OF GEORGIA

Policy Number: HCL35835  
Endorsement Number: 3  
Policyholder: Prince Avenue Baptist Church  
Effective Date of Endorsement: 09/01/2020

You and We agree that above policy is amended as follows:

Article II, SPECIFIC STOP LOSS INSURANCE, Paragraph E is amended as follows:

- E. Plan Benefits Paid by You which have been reimbursed by Us under Your Aggregate Stop Loss Insurance or by another group health insurance company, a reinsurance company or another Employee Benefit Plan will not be used to:
  - 1. Satisfy the Specific Deductible (or the Specific Family Deductible), or
  - 2. Compute Specific Stop Loss Insurance benefits to You.

Article III, AGGREGATE STOP LOSS INSURANCE, Paragraph E is amended as follows:

- E. Plan Benefits Paid by You which have been reimbursed by Us under Your Specific Stop Loss Insurance, by another group health insurance company, a reinsurance company or another Employee Benefit Plan will not be used to:
  - 1. Satisfy the Annual Aggregate Deductible or Minimum Annual Aggregate Deductible, or
  - 2. Compute the Aggregate Stop Loss Insurance benefits payable to You.

Article VI – EXCLUSIONS, Paragraph B is amended as follows:

- B. Plan Benefits that are covered under any Coordination of Benefits Provision. We may elect to reduce or deny any reimbursement which may be payable to You, to the extent that a payment may be made by another group health insurer, a reinsurer or another Employee Benefit Plan, to either the Employee Benefit Plan or Covered Person. This provision is applicable irrespective of how such payment is characterized and whether or not payment has actually been made for any or all of the Covered Person's losses.

**HCC LIFE INSURANCE COMPANY**  
STOP LOSS POLICY  
ENDORSEMENT TO A POLICY ISSUED IN THE STATE OF GEORGIA

Article VII – GENERAL PROVISIONS, amended as follows:

A. CHANGES AND TERMINATIONS OF THE POLICY

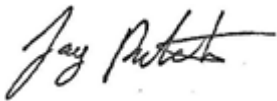
6. We may terminate this Policy at the end of the Contract Period by giving You 60 days written notice of such termination.

N. LEGAL ACTION. No legal action can be brought to recover under this Policy:

1. Until 60 days after the date a reimbursement claim is submitted, or
2. Three years after the date a reimbursement claim is required to be furnished. You shall notify Us in writing within 10 days after receipt of any objection, notice of legal action or complaint regarding Your handling of a claim.

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

HCC LIFE INSURANCE COMPANY



President



Corporate Secretary

Dated: November 10, 2020

**HCC LIFE INSURANCE COMPANY**  
**STOP LOSS POLICY**  
**4-MONTH MDAR ENDORSEMENT**

Policy Number: HCL35835  
Endorsement Number: 2  
Policyholder: Prince Avenue Baptist Church  
Effective Date of Endorsement: 09/01/2020

**MONTHLY DEDUCTIBLE ADVANCE REIMBURSEMENT (MDAR) OPTION**

You and We agree that this Policy is amended as follows:

We will reimburse You for payments made for Covered Expenses, which exceed the Monthly Aggregate Deductible, subject to the following conditions:

1. We will make a MDAR on the 1<sup>st</sup> day of a Contract Month during the Contract Period when the Covered Expenses paid by You during all prior Contract Months of the Contract Period exceed the sum of the Monthly Aggregate Deductibles for the same Contract Months. However, no advance under this provision will be payable by Us until the end of the third month of the Contract Period.

The Monthly Aggregate Deductible, as calculated for purposes of the MDAR, shall in no event be less than one-twelfth (1/12) of the Minimum Annual Aggregate Deductible.

We will reimburse You only after We receive a request for MDAR. We will not advance a MDAR if the amount for which You are eligible is less than \$1,000 in any given Contract Period.

2. If, at the end of the Contract Period, the sum of the Monthly Aggregate Deductibles for all Contract Months in the Contract Period exceed the total payments made by You for Covered Expenses during the same Contract Months, You shall repay Us, within 15 days of Our request, the lesser of:
  - A. The total of all MDARs made during the current Contract Period, or
  - B. The sum of the Monthly Aggregate Deductibles for all Contract Months less any Covered Expenses paid by You during the same Contract Months for which You have not been reimbursed by Us.
3. If, at the end of any Contract Month, any outstanding MDAR has not been repaid, You shall repay Us such outstanding MDAR, subject to the maximum reimbursement payment requirement of Paragraph 2 above, within 15 days of Our request for repayment.
4. If, at the end of any Contract Period, any outstanding MDAR has not been repaid, You shall repay Us such outstanding MDAR, subject to the maximum reimbursement payment requirement of Paragraph 2 above, within 15 days of OUR request for repayment.
5. If Your Aggregate Stop Loss Insurance terminates prior to the end of the Contract Year, You shall repay Us any outstanding MDAR on the day the Aggregate Stop Loss Insurance terminates.
6. The availability of this MDAR option is subject to Your compliance with all terms and conditions of the Contract.
7. At the end of the Contract Period, We reserve the right to review and audit Your records for the purpose of making a final settlement of the account. If such audit establishes that additional payments are due You, such payments will be made immediately. If such audit establishes that additional repayments are due Us, such repayments shall be made within 15 days of Our request.

**HCC LIFE INSURANCE COMPANY**  
**STOP LOSS POLICY**  
**4-MONTH MDAR ENDORSEMENT**

8. At any time during the Contract Period, when the sum of the MDARs exceeds \$50,000, We reserve the right to review and audit Your records prior to releasing any additional MDARs.
9. We will not charge interest on the amount of the outstanding MDAR. However, You will be assessed a late payment penalty each month equal to 2% of the MDAR outstanding if You do not repay the outstanding MDAR to Us within fifteen (15) days from the date the amount of the MDAR repayment is requested.

Outstanding Monthly Deductible Advance Reimbursement (Outstanding MDAR) - means:

1. The total of all Monthly Deductible Advance Reimbursements We have paid to You during a Contract Period less the difference between:
  - A. The Minimum Annual Aggregate Deductible (or the Monthly Aggregate Deductibles for all prior Contract Months, if greater), and
  - B. Any Covered Expenses Paid by You during the Contract Period.
2. Should the difference between the Minimum Annual Aggregate Deductible (or Monthly Aggregate Deductibles for all prior Contract Months, if greater) less any Covered Expenses paid by You during the Contract Period exceed the total of the Monthly Deductible Advance Reimbursements, You will be considered to be in a deficit position in relation to the Minimum Annual Aggregate Deductible, and will be required to return all reimbursements made under the Monthly Deductible Advance Reimbursement Option.

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

Prince Avenue Baptist Church

Full Legal Name of Applicant/Policyholder

[Signature]  
Officer/Partner Signature

Tim Luke  
(print name)

8/27/2020  
Signed At / Date Signed

Grea Yates  
Licensed Agent Signature

Thomas S. O'Neil, Jr.

**FOR HCC LIFE INSURANCE COMPANY OFFICE USE ONLY:**

ACCEPTANCE

Accepted on behalf of the Company, this 10th day of November, 2020

By [Signature]

Title: VP, Compliance



**HCC LIFE INSURANCE COMPANY**  
**STOP LOSS POLICY**  
**CONTRACT ADVANTAGE PLAN (CAP) ENDORSEMENT**

Policy Number: HCL35835  
Endorsement Number: 1  
Policyholder: Prince Avenue Baptist Church  
Effective Date of Endorsement: 09/01/2020

YOU and WE agree that above policy is amended as follows:

In exchange for premium considerations provided for on the attached Application, We guarantee that if You renew Your Specific Stop Loss Insurance with Us for the next Policy Year with the same Agent of Record, Your renewal Stop Loss Policy will not contain any additional Covered Persons with a Separate Individual Specific Deductible. We reserve the right to carry over to the renewal policy any or all Covered Persons that already have a Separate Individual Specific Deductible shown on the attached Application.

Additionally, We guarantee that the Specific Monthly Premium Rates on Your renewal Stop Loss Policy will not be increased more than 50% over the Specific Monthly Premium Rates shown on the attached Application.

If you purchase a Split Funded Endorsement, the Split Funded Liability on Your renewal Stop Loss Policy will increase by this same percentage.

We may decide not to offer this endorsement, at our discretion, upon Your next Renewal or upon any subsequent Renewal of Your Stop Loss Policy. We also reserve the right to change, modify or cancel this endorsement, at our discretion, should You change your Agent of Record or if You amend or change Your Employee Benefit Plan in any way that materially affects our risk or liability with regards to the Policy or this Endorsement, or if Your renewal Stop Loss Policy:

1. Contains coverage options for Covered Expenses related to Plan Benefits that are different than those selected on the attached Application, or
2. Contains a Contract Period that is longer in duration than the Contract Period shown on the attached Application, or
3. Contains coverage for Retirees, If coverage for Retirees was not purchased with this Policy, or
4. Contains a Specific Deductible that is not equal to the Specific Deductible shown on the attached Application, or
5. Contains a Contract Basis that is not identical to the Contract Basis shown on the attached Application, or
6. Contains a Specific Contract Period Reimbursement Maximum that is higher than the Specific Contract Period Reimbursement Maximum shown on the attached Application, or
7. Contains a Specific Percentage Reimbursable that is higher than the Specific Percentage Reimbursable shown on the attached Application.

If you purchase a Split Funded Endorsement, We reserve the right to change, modify or cancel this endorsement if You:

1. Cancel the Split Funded Endorsement on any renewal Stop Loss policy, or
2. Request the Split Funded Liability be decreased on any renewal Stop Loss policy, or
3. Request the Split Funded Liability be increased by a percentage less than the increase of the Specific Monthly Premium Rates as stated in this Endorsement.

**HCC LIFE INSURANCE COMPANY**  
STOP LOSS POLICY  
CONTRACT ADVANTAGE PLAN (CAP) ENDORSEMENT

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

Prince Avenue Baptist Church

Full Legal Name of Applicant/Policyholder

[Signature]  
Officer/Partner Signature

Tim Luke  
(print name)

8/27/2020

Signed At / Date Signed

Greg Yates

Witnessed (Licensed Agent) Signature

Thomas S. Boyd, RNJ

**FOR HCC LIFE INSURANCE COMPANY USE ONLY:**

ACCEPTANCE

Accepted on behalf of the Company, this 10th day of November, 2020

By [Signature]

Title: VP, Compliance

**HCC LIFE INSURANCE COMPANY**

225 Town Park Drive, Suite 350  
Kennesaw, Georgia 30144  
1-800 447-0460

**STOP LOSS POLICY**

THIS IS A LEGAL CONTRACT - PLEASE READ IT CAREFULLY

Policy Number: HCL35835

Policyholder: Prince Avenue Baptist Church

Principal Address: 2201 Ruth Jackson Road  
Athens, GA 30603

Designated Third Party Administrator (TPA): Group Resources, Inc.  
3080 Premiere Parkway, Suite 100  
Duluth, GA 30097-4904

This Policy is issued in consideration of Your Application, Your Plan Document, Your Disclosure Statement and the payment of premiums. The aforementioned documents combine to form this Policy.

The effective date of this Policy is 12:01 a.m., at Your address and the expiration date of this Policy is 11:59 p.m., as shown below at Your principal address.

Effective Date: 09/01/2020

Expiration Date: 08/31/2021

This Policy is issued by Us as of the Effective Date, but is not valid unless countersigned by Our duly authorized representative.

Jurisdiction of Issue: Georgia

This policy is governed by the laws of the jurisdiction of issue.

The self-funded welfare benefit plan of the Plan Sponsor is not regulated nor approved under the insurance laws of Georgia.



President



Corporate Secretary

**NON-PARTICIPATING INSURANCE**

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

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## ARTICLE I. DEFINITIONS

When used in this Policy, the following terms will have the meanings as indicated below:

**ANNUAL AGGREGATE DEDUCTIBLE.** For any one Contract Period, (or any fraction thereof, if the Contract terminates during the Contract Period) the total of the number of Covered Single or Family units multiplied by its corresponding Monthly Aggregate Factor, applied each month that the Contract is in-force. In no instance shall the Annual Aggregate Deductible be less than the Minimum Annual Aggregate Deductible.

**AGGREGATE CONTRACT PERIOD REIMBURSEMENT MAXIMUM.** The maximum amount We will reimburse the Policyholder for Covered Expenses during each Contract Period under the terms of the Aggregate Stop Loss Insurance as shown on the Application.

**AGGREGATE PERCENTAGE REIMBURSABLE.** The percentage of Covered Expenses to be reimbursed that were Paid under the Employee Benefit Plan in excess of the Annual Aggregate Deductible.

**COBRA BENEFICIARY.** Any former Covered Person of the Employee Benefit Plan continuing participation under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments.

**COMPANY.** Company, We, Our, and Us refers to HCC Life Insurance Company.

**COMPLETE CLAIMS HISTORY.** All of the following for a minimum of 12 consecutive months immediately preceding the Policy Year:

1. Participant census, and
2. Eligibility information, and
3. Claims Experience, and
4. Large Claim Disclosures, and
5. Details of any condition shown on the Trigger Diagnosis List in the Disclosure Statement.

**CONTRACT.** All of the following:

1. The Application, and
2. This Policy and any endorsements to it, and
3. The Policyholder's Plan Document.

**CONTRACT BASIS.** The form of coverage shown on the Application that was selected by the Policyholder. The Contract Basis shall be considered in determining what Covered Expenses will be reimbursed by Us.

**CONTRACT MONTH.** A period of one-month that begins on:

1. The effective date of the Policy, or
2. The same day of each following month during the Contract Period.

**CONTRACT PERIOD.** The period of time shown on the Application during which the Policyholder is covered for Aggregate and / or Specific Stop Loss Insurance.

**COST CONTAINMENT PROGRAM.** A program designed to reduce or control the cost of providing Plan Benefits to participants of the Employee Benefit Plan.

**COVERED EXPENSES.** Plan Benefits incurred by a Covered Person (or Covered Family):

1. For which benefits are Paid by the Policyholder under the Employee Benefit Plan, and
2. Which are not in excess of the Reasonable and Customary Charge for those services, and
3. Which are Medically Necessary for the treatment of an illness or injury or for any preventative care covered by the Employee Benefit Plan, and
4. Which are reimbursable under this policy subject to its terms, deductible(s), limitations and exclusions.

Plan Benefits provided by the Employee Benefit Plan that are specifically excluded by this Policy are not considered Covered Expenses. Covered Expenses shall not include any expenses which are not reimbursable under this Policy, such as:

1. The expenses related to processing claim payment, or
2. PPO discounts, network or negotiated discounts, and other reductions from billed charges, whether or not they were actually deducted from Plan Benefits, or
3. Salaries paid to any individual, or
4. Plan Supervisor's fees, or
5. Litigation expenses, or
6. Premiums paid for coverage under this Policy.

**COVERED FAMILY.** The Covered Person and his or her dependents covered under the Employee Benefit Plan.

**COVERED PERSON.** If so indicated on the Application, an individual covered under the Employee Benefit Plan. This includes:

1. Legally employed covered employees, and
2. Covered dependents, and
3. Participating COBRA Beneficiaries, and
4. Retirees.

**COVERED UNITS.** A Covered Person, a Covered Family, or such other defined unit as agreed upon between You and Us in writing.

**DEDUCTIBLE.** The amount of Covered Expenses You must pay before Aggregate Stop Loss Insurance and / or Specific Stop Loss Insurance benefits become reimbursable. The Deductible(s) is / are shown on the Application issued to You. See also:

1. Annual Aggregate Deductible, and
2. Specific Deductible, and
3. Specific Family Deductible.

**ELIGIBLE.** Eligible under the Employee Benefit Plan.

**EMPLOYEE BENEFIT PLAN.** The medical benefits You have agreed to provide under a plan of benefits for Your Eligible employees and their Eligible dependents, whether or not it is subject to the Employee Retirement Income Security Act of 1974, as is or as may be amended.

**EXPERIMENTAL AND INVESTIGATIVE.** A drug, device or medical treatment or procedure is Experimental or Investigative:

1. If the drug or device cannot be lawfully marketed without 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. If 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. If 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.** The date on which medical care or a service or supply is provided to a Covered Person for Plan Benefits under the Employee Benefit Plan for which a charge results.

**LARGE CLAIM DISCLOSURE.** You, with the assistance of Your Plan Supervisor, agree to disclose to us any known or potential shock losses. Shock Losses are:

1. Injuries, and
2. Illnesses, and
3. Diseases, and
4. Diagnoses, and
5. Any condition listed on the Trigger Diagnosis list, and
6. Other losses of the type, which are reasonably expected or are likely to result in significant medical expense or liability.

**LOSS LIMIT.** The maximum amount of Covered Expenses Incurred by each Covered Person (or Covered Family), which can be used to satisfy the Annual Aggregate Deductible. This amount is shown in the Application. The maximum allowable amount of Covered Expenses by a Covered Person who has been assigned a Separate Individual Specific Deductible will be the specified amount as shown under the Loss Limit on the Application, regardless of that Covered Person's Separate Individual Specific Deductible.

MEDICALLY NECESSARY. 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 medical practitioner who is practicing within the scope of his or her license and specialty or primary area of practice, and
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 or Investigative.

MINIMUM ANNUAL AGGREGATE DEDUCTIBLE. For each Contract Period, the number of Contract Months times the Monthly Aggregate Factor times the number of Covered Units. Covered Units shall be based on the first month's enrollment or the quoted enrollment whichever is greater. The Minimum Annual Aggregate Deductible as shown on the Application is based on the quoted enrollment and it is subject to change if the first month's enrollment is greater.

MONTHLY AGGREGATE DEDUCTIBLE. The Monthly Aggregate Deductible is determined for each Contract Month by multiplying the number of Covered Units for that month by the applicable Monthly Aggregate Factor(s) shown on the Application.

MONTHLY AGGREGATE FACTOR. The amount specified in the Application.

MONTHLY SPECIFIC PREMIUM RATES. The amounts specified in the Application.

NET PAID CLAIMS. The sum of Covered Expenses Paid during the Policy Year by You less the sum of all amounts paid by You that exceeds the Loss Limit of any Covered Person(s).

ORIGINAL EFFECTIVE DATE. The first day of the Contract Period of Your initial Stop Loss Policy with Us subject to any Run-In Period as shown on the Application. If coverage has not been continuous with Us, then the Original Effective Date shall be the first day of the most recent continuous coverage.

PAY, PAID, PAYMENT. Charges that, as of the dates shown in the Contract Basis, are:

1. Covered and payable under your Employee Benefit Plan, and
2. Have been adjudicated and approved, and
3. A check or draft for remuneration is issued and deposited in the U.S. Mail, or other similar conveyance or is otherwise delivered to the payee, and
4. Sufficient funds are on deposit the date the check or draft is issued.

Our reimbursements will not be made until all of these conditions are satisfied. Checks or drafts that are returned to the payor unpaid for any reason will not be considered Paid.

PLAN BENEFITS. The medical expense benefits to which Covered Persons become entitled under the Employee Benefit Plan during the Policy Year which are:

1. Incurred after the effective date of this Policy or the first date of the Run-In Period, and
2. Incurred while this Policy is in-force, and
3. Paid during the Policy Year or before the end of the Run-Out Period.

Plan Benefits do not include:

1. Deductibles, or
2. Co-insurance amounts, or
3. Interest, or



4. Expenses, or
5. The amounts of any PPO discounts, network or negotiated discounts, or any other reductions to billed charges, whether or not they were actually deducted, and
6. Claims paid under an Employee Benefit Plan's discretionary clause or similar provision that would not otherwise be payable under the terms and conditions of the Employee Benefit Plan, and
7. Claims that are not covered under the terms and conditions of the Employee Benefit Plan or that are reimbursable from any other source.

An Employee Benefit Plan expense is incurred at the time the service is rendered or the supply is provided.

**PLAN DOCUMENT.** The written document evidencing Your Employee Benefit Plan including any amendments. You will provide Us with a copy of Your Plan Document that is in effect as of the Policy effective date. Amendments are subject to Article VI, Item A and Article VII, Item A.3.a and B of this Policy. We will provide written confirmation of receipt of this Plan Document. The Plan Document does not waive of any provisions of this Policy.

**PLAN SUPERVISOR (TPA).** The person or entity selected by the Plan Sponsor and approved by Us to perform administrative services for the Employee Benefit Plan, including payment of claims.

**POLICY YEAR.** The period beginning on the effective date and ending on the expiration date as shown on the face page of this Policy, or the actual period of time during which the Policy is in force if the Policy terminates prior to the expiration date.

**POLICYHOLDER.** Employer, Insured, You, Your or Plan Sponsor.

**REASONABLE AND CUSTOMARY CHARGE.** 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 PERIOD.** The period of time as defined under the Contract Basis on the Application during which claims for Plan Benefits may be Incurred provided they are Paid during the Contract Period.

**RUN-OUT PERIOD.** The period of time as defined under the Contract Basis on the Application during which claims for Plan Benefits may be Paid provided they were Incurred during the Contract Period.

**SPECIFIC CONTRACT PERIOD REIMBURSEMENT MAXIMUM.** The maximum amount of Covered Expenses We will reimburse You in each Contract Period for any one Covered Person (or Covered Family). This amount shall not exceed the amount shown as the Specific Contract Period Reimbursement Maximum on Your Application, or any maximum benefit amount or limit defined in Your Employee Benefit Plan, whichever is less.

**SPECIFIC DEDUCTIBLE.** If a Specific Deductible is shown on the Application, this is the amount of Covered Expenses that must be Paid by the Employee Benefit Plan for any Covered Person before Specific Stop Loss Insurance benefits are reimbursable under the Policy. It applies separately for each Policy Year and will be determined annually by Us.

**SPECIFIC FAMILY DEDUCTIBLE.** If a Specific Deductible is shown on the Application per a Covered Family, this is the amount of Covered Expenses which must be Paid by the Employee Benefit Plan for any Covered Family member or combination of Covered Family members before Specific Stop Loss Insurance benefits are reimbursable under the Policy. It applies separately for each Policy Year and will be determined annually by Us.

**SPECIFIC PERCENTAGE REIMBURSABLE.** The percentage of Covered Expenses to be reimbursed that were Paid under the Employee Benefit Plan in excess of the Specific Deductible.

## **ARTICLE II. SPECIFIC STOP LOSS INSURANCE**

- A. Subject to the terms, conditions and limitations of this Policy, We will reimburse You for Covered Expenses Paid in excess of the Specific Deductible (or Specific Family Deductible).
- B. We will not reimburse you for any amounts after the Specific Contract Period Reimbursement Maximum has been reached.
- C. We will not reimburse You for Plan Benefits Incurred after the Policy's expiration date.
- D. If the Policy terminates before the expiration date, Plan Benefits paid after the date of termination will not be eligible for reimbursement.
- E. Plan Benefits Paid by You which have been reimbursed by Us under Your Aggregate Stop Loss Insurance or by another insurance company or reinsurance company will not be used to:
  - 1. Satisfy the Specific Deductible (or the Specific Family Deductible), or
  - 2. Compute Specific Stop Loss Insurance benefits payable to You.
- F. The Monthly Specific Premium Rates shown on the Application apply only to the Policy Year shown therein. New Monthly Specific Premium Rates will be furnished for each new Policy Year and will be shown on a new Application provided for each Policy Year.

## **ARTICLE III. AGGREGATE STOP LOSS INSURANCE**

- A. Subject to the terms, conditions and limitations of this Policy, We will reimburse You for Eligible Covered Expenses Paid, less:
  - 1. The Annual Aggregate Deductible or the Minimum Annual Aggregate Deductible, whichever is greater, and
  - 2. Specific Stop Loss reimbursements due or paid to You, and
  - 3. Any amounts paid by you that exceeds the Loss Limit for any Covered Person (or Covered Family).
- B. We will not reimburse you for any amounts after the Aggregate Contract Period Reimbursement Maximum has been reached.
- C. We will not reimburse You for Plan Benefits Incurred after the Policy's expiration date.
- D. If the Policy terminates before the expiration date, any Plan Benefits paid after the date of termination will not be eligible for reimbursement.
- E. Plan Benefits Paid by You which have been reimbursed by Us under Your Specific Stop Loss Insurance, by another insurance company or reinsurance company will not be used to:
  - 1. Satisfy the Annual Aggregate Deductible or the Minimum Annual Aggregate Deductible, or
  - 2. Compute the Aggregate Stop Loss Insurance benefits payable to You.
- F. Plan Benefits Paid by You which exceed the Specific Contract Period Reimbursement Maximum for Specific Stop Loss Insurance as shown on the Application will not be used to:

1. Satisfy the Annual Aggregate Deductible or Minimum Annual Aggregate Deductible, or
  2. Compute the Aggregate Stop Loss Insurance benefits payable to You.
- G. Reimbursement for Aggregate Stop Loss Insurance for any Covered Person (or Covered Family) will be limited to an amount not to exceed the Specific Deductible (or Specific Family Deductible) or the Loss Limit, whichever is less, as set forth in the Application.
- H. The Monthly Aggregate Factor(s) shown on the Application apply only to the Policy Year shown therein. New Monthly Aggregate Factors will be furnished for each new Policy Year and will be shown on a new Application provided for each Policy Year.
- I. The Monthly Aggregate Deductible cannot be reduced by more than 10% per month if the number of Covered Persons decreases for any reason. If any Covered Persons are absent from work due to a strike, lockout, or work stoppage during any Contract Month, the number of Covered Persons will remain at the same level as for the Contract Month preceding the disruption.

#### ARTICLE IV. CLAIMS UNDER THE POLICY

##### A. Specific Claims

1. We will reimburse You for Specific Stop Loss Insurance, subject to the terms, conditions and limitations of this Policy, only after We receive a request for reimbursement with complete claim information.
2. The following documentation is required to file a Specific Stop Loss claim:
  - a. *Specific Claim Notification / Initial Filing form*, and
  - b. A copy of the employee's enrollment card, including the employee's hire date and the original effective date, and
  - c. A copy of the Plan Supervisor's claim form if the claim is for a dependent, and
  - d. Complete details regarding eligibility, and if applicable, information regarding work status, pre-existing / HIPAA documentation, subrogation, Coordination of Benefits, provider discounts and COBRA, including a copy of the COBRA election form and COBRA payment verification for all months, and
  - e. Copies of *Explanations of Benefits* attached to the corresponding itemized bills, and
  - f. Check copies, if not part of an *Explanation of Benefits*, and
  - g. Completion of the *Specific Supplemental Claim Request* portion of the claim form if applicable, and
  - h. Miscellaneous information as applicable, including but not limited to:
    - i. Complete accident details, including how, when and where an accident may have occurred, and
    - ii. Police reports for motor vehicle accidents or for services for which a law enforcement agency is involved, and
    - iii. A *Subrogation and Right of Recovery Reimbursement Agreement* if charges were Incurred as a result of a third party liability, and
    - iv. Coordination of benefits documentation, and
    - v. PPO discount / repricing sheets, and
    - vi. *Large Case Management Reports*, and
    - i. Other documentation We may request.
3. LATE CLAIMS: Any claim that is either submitted, or that remains incomplete, more than 90 days after the last date for which Plan Benefits can be reimbursed under the terms of

the Policy will be denied, whether or not the delay has prejudiced Us. Your or Your Plan Supervisor's failure to file a complete claim in a timely manner may result in an adjustment of Our reimbursement to You to reflect any savings We could have obtained had a timely claim filing taken place pursuant to this provision.

4. 50% NOTIFICATION: You or Your Plan Supervisor must give notice to Us when the total amount of Plan Benefits Paid by You on a Covered Person equals or exceeds 50% of the Specific Deductible, or has the potential to exceed 50% of the Specific Deductible. Your failure to give prompt notice may result in an adjustment of Our reimbursement to You, if any, to reflect any savings We could have obtained had a prompt 50% Notification been given.

B. Aggregate Claims

1. We will reimburse You for Aggregate Stop Loss Insurance, subject to the terms, conditions and limitations of this Policy, only after We receive a request for reimbursement with Complete Claim History.
2. The following documentation is required to file an Aggregate Stop Loss claim:
  - a. Completed *Year End Aggregate Claim Form*, and
  - b. *Paid Claims Analysis report* indicating claimant's name, Incurred date, charged amount, Paid amount and Paid date, and
  - c. Eligibility listing which identifies birth date, effective date, termination date and coverage type, and
  - d. Proof of funding to include bank statements and/or deposit slips, and
  - e. *Void & Refund report*, and
  - f. *Benefit / Service Code report*, and
  - g. *Aggregate Report* (Monthly Loss Summary Reports), and
  - h. *Specific Report* showing which claimants have exceeded the Specific Deductible or Loss Limit, and
  - i. Listing of payments made outside the Aggregate Stop Loss Insurance (i.e. Dental, Weekly Income, Vision, PPO fees capitated and, PCS Administrative Fees), and
  - j. Check Register, and
  - k. Outstanding overpayment and subrogation log, and
  - l. Prescription invoices if Prescriptions are covered under the Aggregate Stop Loss Insurance, and
  - m. Other documentation We may request.

We may also request this information the month following the expiration date of the Policy to review for retroactive adjustments.

3. Any reimbursement payable by Us to You, under this article, will be paid after the end of the Contract Period, unless otherwise endorsed.

4. CLAIM FILING: You must file a request for reimbursement with Us on Our customary Notice / Proof of Loss form within 90 days after the end of the time specified for payment of claims under this Policy. Your failure to file a claim within 90 days will result in claim denial, whether or not the delay has prejudiced Us.
5. DETERMINATION OF THE ULTIMATE AGGREGATE CLAIM: You must submit a Proof of Loss within 90 days of the end of the Policy Year or Run-Out Period, whichever is later, showing the amount of all Plan Benefits Eligible under the Employee Benefit Plan and this Policy which You have Paid. These shall be compared to the greater of the Annual Aggregate Deductible or the Minimum Annual Aggregate Deductible. If the amount of Net Paid Claims eligible under this policy is greater than the appropriate Annual Aggregate Deductible, We will reimburse You for the amount of the excess.

C. All Claims

1. REIMBURSEMENT OF CLAIMS: Prior to making any reimbursement, We have the right to review each claim submitted to Us to determine if You are entitled to any reimbursement under this Policy. This review may include, but is not limited to, an on-site audit or requests for additional documentation. You warrant that You have Paid the providers of Plan Benefits for which reimbursement is sought.
2. SETTLEMENT OF PLAN CLAIMS: We have no duty or obligation to settle or adjust any claims for Plan Benefits filed under Your Employee Benefit Plan.
3. RIGHT OF RECOVERY. If You are entitled to recover from any party Plan Benefits Paid under the Employee Benefit Plan, such amounts cannot be used to satisfy either the Specific and / or Aggregate Deductibles. We also will not reimburse You for any Plan Benefit recovered from any party. If We have reimbursed You for all or part of a Plan Benefit and You recover any part of the Plan Benefit from any party, You must repay Us to the extent of Our reimbursement regardless of whether the policy is still in-force on the date of the recovery. You must reimburse Us first, and in full, before You receive any benefit of the recovery. We retain the right to employ our own independent counsel and You assign to us Your rights and the Employee Benefit Plan's rights to the extent of Our reimbursement(s) to You.

In the event that You reimburse Us in the matter where Our designated counsel is not involved, Your repayment may be reduced by the reasonable and necessary expenses incurred in recovering from the third party.

If You fail to reimburse Us for a valid claim for a Covered Expense against a third party, and We are required to reimburse You for such a Covered Expense, We shall be subrogated to Your rights to pursue the claim.

Any amount We recover shall first be used to pay Our expenses of collection and then apply towards any amount that We reimbursed You under the policy. Any remaining amount will be paid to You.

You are required to provide Us with such information as We request in order to protect Our right to reimbursement.

4. CLAIMS ELIGIBLE UNDER TWO CONTRACTS. If a claim for reimbursement can be filed under two different policy years, it must be filed under the earlier policy year.

## **ARTICLE V. LIMITATIONS OF COVERAGE**

- A. This Policy is between You and Us. No other party has any rights under this Policy.
- B. Coverage for Plan Benefits Incurred for an employee who is not actively at work as a result of sickness, accidental bodily injury, maternity, military service, personal reasons, lay-off, strike, or any other leave of absence (either before or after the effective date of the Policy), or the employee's covered dependent(s), unless the employee or dependent(s) are receiving continuation benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, shall be limited to the length of time specified in the Plan Document.
- C. All Plan Benefits Incurred outside the United States of America will be excluded from coverage unless:
  - 1. The service(s) would have been a Covered Expense if the service(s) had been provided in the United States, and
  - 2. The Covered Person is not covered by any other country's national health care program or any employer's foreign voluntary compensation coverage.

## **ARTICLE VI. EXCLUSIONS**

WE will not reimburse YOU for:

- A. Plan Benefits covered by amendments to the Employee Benefit Plan that were incurred prior to Our written approval of such amendments.
- B. Plan Benefits that are covered under any Coordination of Benefits provision. We may elect to reduce or deny any reimbursement which may be payable to You, to the extent that a payment may be made by another insurer, another Employee Benefit Plan or any other party, to either the Employee Benefit Plan or Covered Person. This provision is applicable irrespective of how such payment is characterized and whether or not payment has actually been made for any or all of the Covered Person's losses.
- C. Plan Benefits paid for any surgery, prescription drugs, device, or procedure, which is defined as Experimental or Investigative and any complications or other expenses arising thereto.
- D. Plan Benefits Incurred by or on behalf of an employee or dependent of an employee of any affiliated or subsidiary company not included in the Application, unless added by Policy endorsement.

## **ARTICLE VII. GENERAL PROVISIONS**

- A. CHANGES AND TERMINATIONS OF THE POLICY
  - 1. Your Policy may be changed at any time with Our written consent.
  - 2. Only an officer of The Company has the authority to alter this Policy, or to waive any of Our rights or requirements, and then only by written endorsement.
  - 3. We reserve the right to change any Specific or Aggregate Premium Rates and Monthly Aggregate Factors with written notice to You as to the extent and effective date of the change at any time during Your Policy Year if:

- a. Your Employee Benefit Plan is changed, or
  - b. The number of Covered Units Eligible under Your Policy:
    - i. Drops below 15, or
    - ii. Increases or decreases by 15% from the number of Covered Units on the first day of the Contract Period, or
    - iii. Increases or decreases by 10% in any Contract Month from the prior Contract Month.
  - c. If we have agreed to reduce the Monthly Aggregate Factors, the Minimum Annual Aggregate Deductible and / or the Monthly Specific Premium Rates in consideration of Your agreement to implement a Cost Containment Program, we may recalculate in accordance with Our normal practice, the Monthly Aggregate Factors, the Minimum Annual Aggregate Deductible and / or the Monthly Specific Premium Rates if you have not followed the procedures relating to the Cost Containment Program as defined in Our agreement.
  - d. Upon the enactment of any law, regulation or amendment thereto, by any state or jurisdiction, which affects our liability under this Policy, and in Our judgment, requires such a change.
4. You may terminate the Policy by giving Us not less than 31 days written notice.
5. We may terminate this Policy prior to the end of a Contract Period by giving you 31 days written notice if You fail to comply with any provision of the Policy.
6. We may terminate this Policy at the end of the Contract Period by giving You 31 days written notice of such termination.
7. All insurance provided hereunder to You will automatically terminate:
- a. At the beginning of any Contract Month for which any premium for either Specific or Aggregate Stop Loss Insurance has not been paid in full by the end of the grace period, or
  - b. On the date You fail to Pay claims promptly or make funds available to Pay claims promptly as required by this Policy, or
  - c. On the date Your agreement with Your Plan Supervisor is terminated, or
  - d. On the date You change Your Plan Supervisor before obtaining Our written consent for a successor Plan Supervisor, or
  - e. On the date Your Employee Benefit Plan terminates or ceases to accept newly Incurred claims, whichever is earlier, or on the date You obtain other coverage for Your Employee Benefit Plan participants, or
  - f. On the date You terminate the Policy for any reason prior to the end of the Contract Period. In this event, We will not be liable for any Plan Benefits Paid after the termination date, or
  - g. At the end of the Contract Period unless You accept in writing Our terms for renewal of the Stop Loss Insurance before the end of the Contract Period, or
  - h. On the expiration date of this Policy.
- B. AMENDMENTS TO THE PLAN: You must give Us at least 31 days written notice of any proposed amendments to Your Employee Benefit Plan. No amendment to Your Employee Benefit Plan will be binding on Us until We have approved the amendment in writing.
- C. ARBITRATION: Any controversy or dispute, involving Us that arises out of or relates to this Policy, shall be settled by arbitration in accordance with the rules of the American Arbitration Association. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction. This provision shall survive the termination of this Policy.

- D. ASSIGNMENT: You may not assign any of Your rights under this Policy without Our prior written consent.
- E. CLERICAL ERROR: Our obligations under this Policy will not be expanded by any clerical error whether by You or Us in creating or maintaining records or calculating rates, factors, premiums, deductibles or claims pertaining to this Policy. A clerical error is a mistake in performing a clerical function, such as typing, but does not include intentional acts or the failure to comply with the provisions of the Employee Benefit Plan or Policy.
- F. CONCEALMENT OR MISREPRESENTATION: This Policy is issued based upon Our understanding that You, Your Plan Supervisor and your agent or broker have provided to Us a Complete Claims History. The Policy will be void if We find that You, your Plan Supervisor and your agent or broker have concealed or misrepresented any material fact or circumstance concerning this coverage or the Employee Benefit Plan's Complete Claims History, whether intentional or not. Our liability will be limited to return of the premium paid by You after deducting the amount of the reimbursements made by Us to You prior to the date of termination. If the amount of reimbursements paid to You exceeds the premium paid to Us, You will pay Us the difference. If We find that You, Your Plan Supervisor, your agent or broker have not provided to Us a Complete Claims History, We may, at Our option, either rescind the policy or re-underwrite coverages under this Policy, using all claims data available to Us.
- G. CONFORMITY WITH STATE AND FEDERAL LAW: Any provision of this Policy, which, on its effective date, is in conflict with the laws of the state of jurisdiction or which is mandated by Federal law, is hereby amended to conform to the minimum requirements of said laws.
- H. COST CONTAINMENT PROGRAM: We have the right to participate, at Our option and expense, in any savings or Cost Containment Program that You have in place. If no such program exists, We have the right to retain the services of a third party to implement a Cost Containment Program.
- I. DISCLAIMER: We act only as an insurer to You. We are not a fiduciary or a party in interest to the Employee Benefit Plan or any participant. We do not assume any duty to perform any of the functions of, or to provide any of the reports required by, You by the Employee Retirement Income Security Act of 1974, as amended or any other applicable state or federal law. We assume no responsibility or obligation for the administration of Your Employee Benefit Plan or Your acts. We reserve the right to determine amounts payable under this Policy without regards to such acts.
- J. ENDORSEMENTS: Any endorsements attached or subsequently issued by us shall become a part of this Policy.
- K. ENTIRE AGREEMENT: This Policy and any attached endorsements, Your attached Application and your Plan Document are the entire agreement between You and Us. We have relied upon the underwriting information (including Complete Claims History and the Plan Document) provided by You in issuing this Policy and You represent such information is complete and accurate. Should We later learn such information was incomplete or incorrect, We have the right to modify the Policy as of the effective date to reflect the complete or correct information or to terminate the Policy.



- L. **INDEMNIFICATION, DEFENSE AND HOLD HARMLESS:** You agree to indemnify, defend and hold Us harmless from any liability, including but not limited to, interest, penalties, attorney fees, extra contractual, exemplary or punitive damages ("expenses") arising from or relating to:
1. Any negligence, error, omission, defalcation or intentional acts by your Plan Supervisor, or
  2. Any dispute involving Covered Person(s), former Covered Person(s), or any person(s) claiming entitlement to benefits under the Employee Benefit Plan, or
  3. Any taxes We are assessed with respect to funds paid to or by You under Your Employee Benefit Plan, except any taxes or amounts paid to Us as premiums for this Policy.
- We will promptly notify You upon discovery of matters to which Your obligations under this provision apply. We have the right to participate in the defense at Our expense. Without limiting the foregoing, if You fail to defend timely, We have the right, but not the duty, to defend and to compromise or settle the claim or other matters on Your behalf, for Your account and at Your risk.
- M. **INSOLVENCY:** In the event of Your insolvency or bankruptcy, subject to the terms, conditions and limitations of this policy, We may pay to Your receiver, trustee, liquidator or legal successor amounts otherwise payable under this Policy. We will make such payments only if You have Paid all required premiums and have complied with Your obligations under this Policy. Nothing in this section shall increase Our liability beyond that which would have existed had You not become insolvent or bankrupt.
- N. **LEGAL ACTION:** No legal action can be brought to recover under this Policy:
1. Until 60 days after the date a reimbursement claim is submitted, or
  2. Two years after the date a reimbursement claim is required to be furnished. You shall notify Us in writing within 10 days after receipt of any objection, notice of legal action or complaint regarding Your handling of a claim.
- O. **NOTICE:** Notice under this Policy will be given to You through Your Plan Supervisor and will be deemed to have been received by You.
- P. **OFFSET:** We may offset payments due to You under this Policy against claims overpayments, cost containment charges and premiums due and unpaid.
- Q. **PAYMENT OF PREMIUMS:**
1. Each premium is payable to HCC Life Insurance Company, P.O. Box 402032, Atlanta, GA 30384-2032 or such other place as We designate in writing.
  2. Specific Stop Loss Insurance premiums are due on the first day of each calendar month, regardless of the effective date of the Policy. If the effective date is other than the first day of a calendar month, the first month's premium will be pro-rated.
  3. Aggregate Stop Loss Premium(s) are due monthly or are payable in advance for the Policy Year, as stated in Your Application.

4. A grace period of forty-five (45) days is allowed for the payment of each premium after the first premium. If the premium is not paid during the grace period, the Policy will terminate without further notice as of the premium due date.

5. If we terminate this Policy for non-payment of premium, application may be made for reinstatement.

All outstanding premiums, including the current month's premium, must be remitted within 10 days of the end of the grace period.

Payment of premiums shall not guarantee reinstatement of the Policy. We reserve the right to conduct a diligent review of the Complete Claims History and re-underwrite the Policy as We deem necessary as part of the terms for reinstatement.

If the Policy is terminated more than one time during a Policy Year for non-payment, no requests for reinstatement will be granted.

6. In no event, will more than three (3) months of retroactive credit be granted for any clerical error(s) in the remittance of any premium.

R. **POLICY NON-PARTICIPATING:** This Policy is non-participating and does not entitle You to share in Our earnings.

S. **RECORDS:** You and / or Your Plan Supervisor will maintain such records as may be required by Us for this Policy and will make them available to us upon Our request. These records may include, but are not limited to, the Complete Claims History. We may audit Your records relating to this Policy and the claims filed under the Employee Benefit Plan at any time during the Policy Year and for two years after the expiration date of such Policy. Your records will include records held by You or by Your Plan Supervisor. As a result of any audit, We may readjust your Monthly Specific Premium Rates, Monthly Aggregate Factors, premiums, deductibles or expenses as may be necessary to reflect Our original intent in underwriting this Policy.

T. **RENEWAL:** Unless terminated for any of the reason(s) described in this Policy, Your insurance will be renewed for another Policy Year if You accept Our renewal terms. We will not change rates more than once in any Policy Year, except as allowed under the Changes and Termination Provisions in Article VII.

We reserve the right to change the renewal premium rates and Monthly Aggregate Factors for the new Contract Period if the average monthly payments made by You for Plan Benefits during the last two months of the current Policy Year vary by more than 30% from the average of the monthly payments made for Plan Benefits during the previous ten (10) Contract Months.

We will not offer a renewal if We are no longer doing business with Your Plan Supervisor.

U. **SUBSIDIARIES AND AFFILIATED COMPANIES:** You must notify Us in the event You acquire a subsidiary or affiliated company that will be included under Your Employee Benefit Plan. If You do acquire a subsidiary or affiliated company that will be included under Your Employee Benefit Plan, You must disclose certain claims information on the acquired subsidiary as a whole and / or on persons whose coverage You will be assuming under Your Employee Benefit Plan. Failure to do so will subject benefits under this Policy to certain limitations, as described under the ENTIRE AGREEMENT provision of this Article.

Acquisition of a subsidiary or affiliated company that will be included under Your Employee Benefit Plan may affect Your Monthly Specific Premium Rates and/or Monthly Aggregate Factors, as described in the CHANGES AND TERMINATIONS provision of this Article.

You must notify Us in the event You cede or dissolve a subsidiary or affiliated company that was included under your Employee Benefit Plan. Failure to do so may subject this Policy to termination or may affect Your Monthly Specific Premium Rates and/or Monthly Aggregate Factors as described in the CHANGES AND TERMINATIONS provision of this Article.

- V. TAXES: You shall hold Us harmless from any taxes, which may be assessed against Us with respect to Your Employee Benefit Plan or with respect to claims for Covered Expenses paid under the Policy, and You shall reimburse Us for such taxes, if any, as determined by Us.
- W. YOUR DESIGNATED PLAN SUPERVISOR (YOUR TPA). We agree to recognize Your Plan Supervisor as Your agent and attorney-in-fact for the administration of Your Employee Benefit Plan. You agree that:
  - 1. Your Plan Supervisor is Your agent and attorney-in-fact, and is not Our agent. You authorize Your Plan Supervisor to act in Your name, place and stead for purposes of this Policy, to include submission of proofs of loss, certifying the Payment of Plan Benefits, transmitting reports and payments of premiums to Us and receiving reimbursements from Us. Payments sent by Us to Your Plan Supervisor are payments to You. Premium payments by You through Your Plan Supervisor will be payments to Us only to the extent We actually receive them.
  - 2. You or Your Plan Supervisor is responsible for administering Your Employee Benefit Plan, preparing reports as required by Us and keeping and making available to Us such data as We may require.
  - 3. You or Your Plan Supervisor will perform such duties and keep such records as are required for You to comply with this Policy.
  - 4. You will pay Your Plan Supervisor for all administrative functions performed in relation to this Policy.
  - 5. We reserve the right to cease doing business with Your Plan Supervisor.

STOP LOSS INSURANCE  
**HCC LIFE INSURANCE COMPANY**  
Three Town Park Commons, 225 TownPark Drive, Suite 350  
Kennesaw, Georgia 30144 (800 447-0460)

**APPLICATION**

<b>1. Full Legal Name of Applicant and Address</b> Prince Avenue Baptist Church 2201 Ruth Jackson Road Athens, GA 30603 Telephone No.:	<b>2. Applicant is a (check one):</b> <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Labor Union <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> PEO <input type="checkbox"/> Partnership <input type="checkbox"/> MEWA Other:
<b>3. Contract Period: Effective Date: 09/01/2020      Expiration Date: 08/31/2021</b>	
<b>4. Full Legal Name of Affiliates, Subsidiaries and other major locations to be included in coverage:</b> Address of Affiliates or Subsidiaries: <input checked="" type="checkbox"/> None <input type="checkbox"/> See attached listing if applicable	
<b>5. Nature of Business of the Applicant to be Insured:</b> Religious Organizations	<b>6. Key Contact Person at Applicant:</b> Tim Luke
<b>7. Enter full name of the Employee Benefit Plan(s):</b> Prince Avenue Baptist Church Employee Benefit Plan A signed copy of such Employee Benefit Plan(s) must be attached and will form part of this contract.	
<b>8. Name and Address of Plan Supervisor:</b> Group Resources, Inc. P.O. Box 100043 Duluth, GA 30096-9343	
<b>9. Agent of Record:</b> Group Resources, Inc.	
<b>10. Estimated Initial Enrollment: Single: 45 Employee + Spouse: 10 Employee + Child: 8 Family: 17 Total Covered Units: 80</b>	
<b>11. Retirees Covered:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<b>12. The Utilization Review vendor will be:</b> CIGNA	
<b>13. Deposit Premium (Minimum of first month's estimated premium):</b> \$ 28,717.99 Please review the deposit premium on the Monthly Premium Accounting Worksheet.	
<b>14. SPECIFIC STOP LOSS INSURANCE:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
A. Covered Expenses Paid under the Employee Benefit Plan for the following Plan Benefits are covered for Specific Stop Loss Insurance (not included unless checked): <input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Prescription Drug Card <input type="checkbox"/> Prescription Drugs Under Medical <input type="checkbox"/> Other:	
B. Specific Deductible in each Contract Period per Covered Person: \$60,000	
C. Contract Basis: 24/12 Covered Expenses Incurred from 09/01/2019 through 08/31/2021, and Paid from 09/01/2020 through 08/31/2021.  Run-in limit: N/A	
D. Unlimited Specific Lifetime Reimbursement Maximum per Covered Person Specific Contract Period Reimbursement Maximum per Covered Person: Unlimited	
E. Separate Individual Specific Deductible: None	
F. Monthly Specific Premium Rates: Single: \$207.71    Employee + Spouse: \$413.75    Employee + Child: \$366.19    Family: \$621.46	
G. Specific Percentage Reimbursable 100%	
H. Specific Terminal Liability Option: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specific Terminal Liability Option premium per Covered Person per month:	

**15. AGGREGATE STOP LOSS INSURANCE:**☒ Yes ☐ No

- A. Covered Expenses Paid under the Employee Benefit Plan for the following Plan Benefits are covered for Aggregate Stop Loss Insurance (not included unless checked):  
☒ Medical ☐ Dental ☐ Weekly Income ☐ Vision ☒ Prescription Drug Card ☐ Prescription Drugs under Medical ☐ Other:

- B. Minimum Annual Aggregate Deductible: **\$942,424.80**  
(Subject to the Definition of Minimum Annual Aggregate Deductible in the Policy)

- C. Contract Basis: **24/12**  
Covered Expenses Incurred from 09/01/2019 through 08/31/2021, and Paid from 09/01/2020 through 08/31/2021.

Run-In Limit: **N/A**

- D. Aggregate Contract Period Reimbursement Maximum: **\$1,000,000**

- E. Monthly Aggregate Factors:

Monthly Factors	Combined	Medical	Dental	Weekly Income	Vision	Prescription Drugs
Single	\$604.64					
Employee + Spouse	\$1,204.44					
Employee + Child	\$1,065.98					
Family	\$1,809.08					

- F. Aggregate Percentage Reimbursable **100%**

- G. Loss Limit: **\$60,000**  
For the purposes of Aggregate Stop Loss Insurance, the Loss Limit is the maximum amount of Covered Expenses Incurred by each Covered Person, which can be used to satisfy the Annual Aggregate Deductible.

- H. Monthly Deductible Advance Reimbursement Option: ☒ Yes ☐ No

- I. Aggregate Terminal Liability Option: ☐ Yes ☒ No

- J. Aggregate Premium:

- ☐ Annual Premium payable in advance for Contract Period:
- ☒ Monthly Premium rate per Covered Unit: **\$ 20.24**
- ☒ Monthly Deductible Advance Reimbursement premium per Covered Unit per month: **\$1.50**
- ☐ Aggregate Terminal Liability Option premium per Covered Unit per month:

**SPECIAL RISK LIMITATIONS are stated on the Addendum to Application (if applicable).**

It is understood and agreed by the Applicant that:

1. The Applicant is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan, and
2. The Plan Supervisor retained by the Applicant will be considered the Applicant's Agent, and not the Company's Agent, and
3. All documentation requested by the Company must be received within 90 days of the Policy effective date, and is subject to approval by the Company and may require adjustment of rates, factors, and / or Special Limitations to accommodate for abnormal risks, and
4. The Stop Loss Insurance applied for herein will not become effective until accepted by the Company, and
5. Premiums are not considered paid until the premium check is received by the Company, is paid according to the rates set forth in the Application, and all items required to issue the Policy have been returned to the Company. Premiums are subject to refund should any outstanding policy requirement not be met within 90 days of the Policy's effective date, and
6. This Application will be attached to and made a part of the Policy issued by the Company, and
7. The Employee Benefit Plan(s) attached shall be the basis of any Stop Loss Insurance provided by the Company and such Employee Benefit Plan(s) conforms with all applicable State and Federal statutes, and
8. Any reimbursement under the Stop Loss Insurance provided by the Company shall be based on Covered Expenses Paid by the Applicant in accordance with the Employee Benefit Plan(s) attached hereto, and
9. After diligent and complete review, the representations made in this Application, the disclosures made, and all of the information provided for underwriters to evaluate the risk, are true and complete.

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.


Full Legal Name of Applicant:

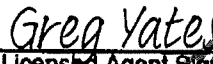

Applicant's Federal Tax I.D. Number:

**Prince Avenue Baptist Church**

Dated at 8/27/2020

this 27 day of August, 2020

  
\_\_\_\_\_  
Officer / Partner Signature (print name)

  
\_\_\_\_\_  
Licensed Agent Signature (print name)  
  
Thomas A. Byrd

**For HCC Life Insurance Company Office Use Only: ACCEPTANCE**

Accepted on behalf of the Company, this 10th day of November, 2020

By:   
\_\_\_\_\_

Title: VP, Compliance

Policy No.: HCL35835

STOP LOSS INSURANCE  
HCC LIFE INSURANCE COMPANY  
ADDENDUM TO APPLICATION

Full Legal Name of Applicant: Prince Avenue Baptist Church

Effective Date: 09/01/2020

SPECIAL RISK LIMITATIONS:

This Policy will not reimburse You for Plan Benefits Incurred after 8/31/2020 on behalf of employee, Michael Cornish or any of his dependents.

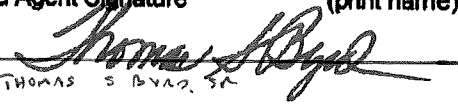
  
\_\_\_\_\_  
Officer / Partner Signature

*Tim Luke*  
\_\_\_\_\_  
(print name)

*Greg Yates*  
\_\_\_\_\_  
Licensed Agent Signature

Greg Yates  
\_\_\_\_\_  
(print name)

[7073944]

  
\_\_\_\_\_  
THOMAS S BYRD, SA