City of Grand Island

Tuesday, September 13, 2011
Council Session

Item G30

#2011-255 - Approving Annual Renewal for Health and Dental Contract with Regional Care, Inc (RCI)

Staff Contact: Brenda Sutherland

Council Agenda Memo

From: Brenda Sutherland, Human Resources Director

Meeting: September 13, 2011

Subject: Approving Health Insurance Renewal with Regional Care, Inc.

Item #'s: G-30

Presenter(s): Brenda Sutherland, Human Resources Director

Background

The City manages a general insurance fund within which the Worker's Comp., General Insurance, and Health Insurance are contained. As part of our continuous effort to manage the fund in the combined best interest of the City and its employees, we continually look for ways to provide a meaningful benefit at the best possible price. The changes being proposed in this annual renewal are a direct reflection of our commitment to sustainability.

The Health and dental benefits have an October 1 renewal to coincide with the fiscal year. The renewal being brought forward will continue with RCI as the third party administrator for the health plan and Delta Dental as the administrator of the dental plan.

Discussion

The budget that was recently adopted by Council did not include an increase in the amount budgeted for health and dental insurance. The contract being brought forward for Council approval is showing a slight decrease in the overall fixed costs for the plan. While the cost of the transplant policy is increasing, the reinsurance costs have gone down for an overall decrease of just over 1%. There are three plan changes that are being recommended. The addition of Midlands Choice Premier Network will enable the City greater discounts in the network. The next is the addition of a contract with Dialysis PPO. This plan change will add language to the plan document for the PPO rates that will be paid for dialysis treatment. Dialysis PPO is compensated based on 15% of the savings they obtain through the new pricing. The PPO will reprice claims to be paid at 125% of Medicare allowable charges. The plan language is proprietary until a contract is signed and available through the City Clerk's office for Council members only. Adding the

Dialysis PPO contract will eliminate lasers for employees currently on dialysis. If the Council chooses not to contract with Dialysis PPO there will be a laser(s) added to the plan for 2011/2012. Currently the City has an agreement with multi plan that is similar in that we pay 16% of the savings negotiated by them when we have to move out of our regular network and access other providers. The third plan change is a minor one for the dental plan. Currently there is no orthodontic coverage on the City's dental plan. The next recommended change would be to add a $100 lifetime maximum for orthodontic services for children up to the age of 19. This does not offer much in the way of a direct benefit to the employee through shared reimbursement. It does however open up the door to PPO discounts lowering the out of pocket expenses for the employee. We felt this was a way to assist our employees with discount savings without driving costs in the plan.

The issue before Council is a fairly routine annual renewal of contracts to provide health insurance benefits for employees at the City of Grand Island. Recommendation is made to renew contracts with the following vendors: Regional Care, Incorporated, Strong Financial, Monumental Life Insurance Company/ EBU, Dialysis PPO, Midlands Choice Premier and National Union Fire Insurance Company of Pittsburgh, PA.

Alternatives

It appears that the Council has the following alternatives concerning the issue at hand. The Council may:

1. Move to approve
2. Refer the issue to a Committee
3. Postpone the issue to future date
4. Take no action on the issue

Recommendation

City Administration recommends that the Council approve the annual renewal of insurance contracts to provide health and dental insurance benefits to City employees.

Sample Motion

Move to approve recommended changes and annual renewal of health and dental insurance contracts.

Administrative Service Agreement

Addendum to EXHIBIT A
October 1, 2011 – September 30, 2012

Monthly Service Fee

A monthly Service Fee per Employee Participant will be charged as follows:

Medical Administration	$ 12.00
COBRA/HIPAA	$ 1.00
Utilization Review/Pre-certification	$ 2.00
Network Access Fee (Midland's Choice)	$ 5.00
National Network Access Fee (MultiPlan)	16% of Savings effective 10/1/2010
Dialysis PPO – Dialysis Repricing	15% (10% to Dialysis PPO, 5% to RCI)
Broker Fee – Payable to Strong Financial	*$1500.00 per Month*

****Regional Care, Inc. has agreed to three (3) year Administrative Rate Guarantee (exp. 10/1/2012)****

When covered services are performed out of network, discounts for these services may be negotiated through other existing networks (including the RCI network) In the event no other network(s) can be accessed such claims may also be directly negotiated by RCI. In either circumstance the fee for accessing other networks or directly negotiating discounts will be based on each respective network's access fee or 25% of savings, whichever is less.

These fees cover the cost of the following services:

Invoicing and fund accounting of plan claims
Record keeping and invoicing of fixed costs
Benefit administration
Correspondence, record keeping, documentation
Reporting on claims and financial reports relative to the Plan
Routine assistance to Plan sponsor
COBRA and HIPAA administration as identified in Agreement.
Issuing 1099's to providers
Inpatient Utilization Review conducted by Regional Care, Inc.
- Pre-admission, Concurrent, Retrospective Review
- Large Case Management Referral

Costs Not Covered Under Monthly Fee

Cost of insurance/stop-loss coverage.
Actuarial review of Plan/Plan audit/legal expense
Large Case Management Fees
Dispensing fees charged by prescription drug card plans.
Costs associated with restating Plan and related documents after the initial Plan set-up.

Reinsurance Rates Effective 10/01/2011

Specific Single	$26.53*	Single Transplant Premium:	$ 6.42*
Specific Single + Spouse or + Child (ren)	$48.88*	Family Transplant Premium:	$14.78*
Specific Family	$72.44*	Composite Aggregate Premium:	$ 2.17*

***Rates are NET of Commissions**

_____ For City of Grand Island - Mayor
_____ Date

_____ For City of Grand Island - Attorney
_____ Date

_____ For Regional Care, Inc.
_____ Date

_____ For City of Grand Island - Clerk
_____ Date

Monumental Life Insurance Company

A Stock Company

Administrative Office: 100 LaCosta Lane, Suite 120, Daytona Beach, FL 32114

Phone: (386)274-2600

Monumental Life Insurance Company, ("the Company"), agrees to reimburse the Insured as outlined under the provisions of this Excess Loss Insurance policy ("Policy").

This Policy is legally binding between the Insured and the Company. The consideration for this Policy includes, but is not limited to, the Application and the Payment of premiums as provided hereinafter.

The Insured is entitled to the reimbursement described in this Policy if the Insured is eligible for insurance under the provisions of this Policy. Reimbursement is subject to the terms and conditions of this Policy.

The first premium is due on the first (1st) day of the Policy Period. Subsequent monthly premiums are due on the first (1st) day of each month thereafter. The premium is not considered paid until the premium payment is received by the Company.

All periods of coverage will begin and end 12:01 a.m. local time at the principal office of the Insured.

This Policy is delivered in and is governed by the laws of the state of issue.

IN WITNESS WHEREOF the Company has caused this Policy to be executed by its President and Secretary at our Home Office in Cedar Rapids, Iowa.

Secretary

President

EXCESS LOSS INSURANCE POLICY

SL40CNE (3/07)

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MONUMENTAL LIFE INSURANCE COMPANY

Administrative Office: 100 LaCosta Lane, Suite 120, Daytona Beach, FL 32114
Phone: (386)274-2600

SCHEDULE OF EXCESS LOSS COVERAGE

This Schedule of Excess Loss Coverage is only applicable to Excess Loss Insurance provided by the Company during the Policy Period shown below.

Insured: _____ Policy Number: _____ Effective Date: _____
Coverage specified herein is applicable only during the Policy Period from _____to _____,
and is further subject to all terms and conditions of this Policy.

Actively at Work/Disability requirement. ☐ Applied ☐ Waived with Approved Disclosure

The Actively at Work/Disability requirement is explained in the definition of "Covered Person" in the Definitions Section.

SPECIFIC EXCESS LOSS INSURANCE ☐ Yes ☐ No

Benefit Period: Covered Expenses Incurred from _____through _____ and Paid from _____through _____; however, if the Policy is terminated before the end of the originally scheduled Policy Period set forth above, Covered Expenses must be Incurred from _____through the termination date and Paid from _____through the termination date to be eligible for reimbursement.
Covered Expenses Incurred from _____through _____will be limited to $_____
per ☐ Covered Person ☐ Family

Specific Deductible ☐ Per Covered Person ☐ Per family $_____Specific Percentage Reimbursable_____

Maximum Specific Benefit ☐ per Covered Person ☐ per family (including Specific Deductible):

☐ $500,000 ☐ $1,000,000 ☐ $2,000,000 ☒ Other $_____ for the Benefit Period described above; no lifetime maximum.

Specific Excess Loss Insurance includes:
☐ Medical only ☐ Medical with Stand Alone Prescription Drug Program
Common Accident Provision: ☐ Yes ☐ No
Common Accident means if more that one Covered Person in the same immediate family incurs Covered Expenses as a result of the same accident, the Specific Deductible will be applied only once to all Covered Expenses Paid because of that accident for all Covered Person in the family during the same Benefit Period.

Specific Premium Per Month	
Covered Units	**Rates**
	$
	$
	$
	$

AGGREGATE EXCESS LOSS INSURANCE ☐ Yes ☐ No

Benefit Period: Covered Expenses Incurred from _____ through _____,
and Paid from _____ through _____; however, if the Policy is terminated before the end of the originally scheduled Policy Period set forth above, no reimbursement will be made under Aggregate Excess Loss Insurance. Losses Incurred prior to the Effective Date will be limited to $_____.

Aggregate Excess Loss Insurance includes:
☐ Medical only ☐ Medical with Stand Alone Prescription Drug Program
☐ Dental Care ☐ Weekly (Disability) Income
☐ Vision Care ☐ Other _____

Aggregate Percentage Reimbursable _____ %

Maximum Aggregate Benefit: $_____

Minimum Annual Aggregate Deductible: $_____ or _____% of the first Monthly Aggregate Deductible amount times 12, whichever is greater.

Loss Limit Per Covered Person: $_____

Monthly Aggregate Factors			
Covered Units	Medical	Prescription Drug	Dental
	$	$	$
	$	$	$
	$	$	$
	$	$	$

Aggregate Excess Loss Premium ☐ per Covered Unit per month ☐ annual $_____.

SPECIAL CONDITIONS:

ENDORSEMENTS ATTACHED TO AND MADE PART OF POLICY AT EFFECTIVE DATE:

			PREMIUM
(a)	AGGREGATE ACCOMMODATION ENDORSEMENT:	☐ YES ☐ NO	$_____
(b)	AGGREGATE TERMINAL LIABILITY ENDORSEMENT:	☐ YES ☐ NO	$_____
(c)	AGGREGATING SPECIFIC DEDUCTIBLE ENDORSEMENT	☐ YES ☐ NO	$_____
(d)	SPECIFIC EXPEDITED REIMBURSEMENT ENDORSEMENT:	☐ YES ☐ NO	$_____
(e)	SPECIFIC TERMINAL LIABILITY ENDORSEMENT:	☐ YES ☐ NO	$_____
(f)	OTHER _____	☐ YES ☐ NO	$_____

ACCEPTED BY THE INSURED THIS _____ DAY OF _____, 20_____

Authorized Signature:_____
Printed Name:_____
Title:_____
Date:_____

DEFINITIONS

ACTIVELY AT WORK means the performance of all the regular duties of employment by the Covered Employee for the Insured on a full-time basis (as specified in the Plan Document), at normal pay at the Covered Employee's normal place of business. An employee will be considered Actively at Work on each day of a regular paid vacation or a regular non-working day on which he or she is not disabled, if he or she was Actively at Work on his or her last scheduled work day.

AGGREGATE PERCENTAGE REIMBURSABLE is set forth in the Schedule of Excess Loss Coverage.

ANNUAL AGGREGATE DEDUCTIBLE for any one Policy Period means the greater of: (a) sum of the Monthly Aggregate Deductibles; or (b) the Minimum Annual Aggregate Deductible.

BENEFIT PERIOD means the period of time specified in the Schedule of Excess Loss Coverage in which a Covered Expense must be Incurred by the Covered Person and Paid by the Plan to be eligible for reimbursement under this Policy. This period does not alter the Effective Date, Policy Period, or waive this Policy's eligibility requirements.

COVERED EMPLOYEE means an employee of the Insured who is eligible for coverage under the Plan, and is otherwise eligible for benefits under the Plan and covered under the Plan. If the Insured is an organization whose members or employees of members are eligible for coverage under the Plan, "Covered Employee" means a member or employee of a member who is eligible for coverage under the Plan, and is otherwise eligible for benefits under the Plan and covered under the Plan.

COVERED EXPENSE means medical or other expenses under the Plan to which this Policy applies, as shown in the Schedule of Excess Loss Coverage, and which are not specifically excluded by the terms of this Policy. Covered Expense does not include any payment for the cost of administrating the Plan or other Insured contracted services.

This Policy will reimburse, as a Covered Expense, the patient services tax as imposed by the New York Care Reform Act of 1996 (HCRA) or the surcharge imposed by the Massachusetts Uncompensated Care Pool. Any other tax or surcharge levied by any state or other governmental subdivision will not be considered a Covered Expense under this Policy.

COVERED PERSON means (a) a Covered Employee, (b) a dependent of a Covered Employee which dependent is eligible for coverage under the Plan, and is otherwise eligible for benefits under the Plan and covered under the Plan, or (c) if requested in the application, a covered retired employee as defined by the Plan Document; however, unless the Actively at Work/Disability requirement is waived as shown on the Schedule of Excess Loss Coverage, a Covered Person does not include:

(1) any Covered Employee who is not Actively at Work either on the Effective Date or the effective date of his or her coverage under the Plan, whichever is later, or eligible dependents of such Covered Employee, until the Covered Employee returns to Actively at Work status; or

(2) any dependent of a Covered Employee if such dependent is, on the Effective Date or the effective date of his or her coverage under the Plan, whichever is later, either hospital-confined or unable to perform the normal activities of a person of like sex and age in good health, until the end of such confinement or disability.

Waiver of the Actively at Work/Disability requirement does not affect the obligation of the Insured and the Third Party Administrator to disclose information requested by the Company for underwriting purposes and does not affect the Company's rights in event of failure to disclose such information.

COVERED UNIT means the following: (a) an employee covered as one individual under the Plan; (b) an employee and dependents covered under the Plan; or (c) such other defined unit or units as agreed upon between the Company and Insured. The types of Covered Units and the factors and premium rates for each type are shown in the Schedule of Excess Loss Coverage.

EFFECTIVE DATE is the date set forth in the Schedule of Excess Loss Coverage.

EMPLOYEE BENEFIT PLAN (Also known as the **PLAN**) means the self-funded health care plan established by the Insured to provide certain benefits to Covered Persons.

INCURRED means with respect to medical services or supplies, the date on which the services are rendered or supplies are purchased by the Covered Person; and, with respect to disability income benefits if selected in the Schedule of Excess Loss Coverage, the date each periodic benefit payment becomes payable to the Covered Person

(not the date the disability commences).

INSURED means the entity requesting Excess Loss Insurance.

LOSS, LOSSES means amounts actually Paid by the Plan for Covered Expenses.

LOSS LIMIT PER COVERED PERSON is set forth in the Schedule of Excess Loss Coverage. However, if claims are Paid under the Plan for a Covered Person for benefits that are covered under Aggregate Excess Loss Insurance, but not covered under Specific Excess Loss Insurance, the Loss Limit for that Covered Person will be increased by the amount of such Payment.

MAXIMUM AGGREGATE BENEFIT is set forth in the Schedule of Excess Loss Coverage.

MINIMUM ANNUAL AGGREGATE DEDUCTIBLE is set forth in the Schedule of Excess Loss Coverage.

MONTHLY AGGREGATE DEDUCTIBLE means, with respect to a particular month, the total number of Covered Units for that given Policy month multiplied by the corresponding Monthly Aggregate Factors as specified in the Schedule of Excess Loss Coverage. However, in the event of a reduction in the number of Covered Units under the Plan, the Monthly Aggregate Deductible cannot be reduced to less than one twelfth of the Minimum Annual Aggregate Deductible.

MONTHLY AGGREGATE FACTORS are set forth in the Schedule of Excess Loss Coverage.

PAY, PAID, PAYMENT means checks or drafts issued and deposited in the U.S. Mail or otherwise delivered to the payee, with sufficient funds on deposit to honor all outstanding drafts and checks.

PLAN DOCUMENT means the written document approved by the plan sponsor which describes the Plan. A copy of the Plan Document in effect on the Effective Date is attached to the application for Excess Loss Insurance and made a part of this Policy.

POLICY PERIOD means the specified period in the Schedule of Excess Loss Coverage.

SPECIFIC DEDUCTIBLE is set forth in the Schedule of Excess Loss Coverage. The Specific Deductible will apply separately to each Benefit Period.

SPECIFIC PERCENTAGE REIMBURSABLE is set forth in the Schedule of Excess Loss Coverage.

THIRD PARTY ADMINISTRATOR means a firm or person who has been retained by the Insured to Pay claims and/or provide administrative services on behalf of the Insured/Plan.

CONDITIONS FOR COVERAGE

Coverage under this Policy is not effective until (a) payment of the first (1st) premium; and (b) receipt of a signed Application for Excess Loss Insurance; and (c) receipt, examination and acceptance by the Comp any of the Plan Document and all other information which is material to underwriting or premium rating, whether or not specifically requested.

PREMIUMS AND FACTORS PROVISIONS

PAYMENT OF PREMIUMS For coverage to remain in effect, any subsequent monthly premium must be received by the Company by the first (1st) day of each month. Premiums are not considered paid until the premium payment is received by the Company.

Premiums or other payments made by the Insured to their Third Party Administrator or Agent or Broker shall not be deemed or considered payments to the Company until actually received by the Company.

GRACE PERIOD A Grace Period of thirty-one (31) days from the due date will be allowed for the payment of each premium after the first. During the Grace Period, the coverage will remain in effect provided the full premium is paid before the end of the Grace Period. Coverage will automatically terminate as of the end of the day on the due date of any premium which remains unpaid at the end of the Grace Period.

PREMIUM AMOUNT The premiums will be calculated using rates determined by the Company as set forth in the Schedule of Excess Loss Coverage. The amount of total premium due each month is the sum obtained by multiplying the applicable premium rates shown in the Schedule of Excess Loss Coverage by the actual number of appropriate Covered Units.

The Insured will be liable for any premium taxes assessed at any time against the Company beyond any taxes which may be payable on the premium received by the Company.

All requests for adjustments, credits or refunds because of overpayment of premiums shall be reported, in writing, with accompanying detail within sixty (60) days after termination of the applicable Policy Period.

The Company will not refund any portion of the premiums paid if this Policy terminates during the Policy Period.

SET OFF The Company shall be entitled to set off against reimbursements due the Insured under this Policy any premiums due and unpaid, any overpayments or other reimbursements made in error or upon incorrect information, and any other amounts due the Company.

PREMIUM RATE AND AGGREGATE DEDUCTIBLE FACTOR CHANGE The Company may change the Insured's premium rates or factors as of any of the following:

a) the date when the terms of this Policy are changed;
b) the date the Plan Document changes are accepted by the Company;
c) the date the Insured adds or deletes subsidiary or affiliated companies or divisions;
d) the date the number of Covered Units on any premium due date varies more than ten percent (10%) from the number of Covered Units on the Effective Date; or
e) the date the Insured changes its Third Party Administrator.

The Company reserves the right to recalculate the premium rates and the Monthly Aggregate Factors retroactively for the Policy Period, if there is more than a ten percent (10%) variance between:

a) the average monthly Paid claim cost per Covered Employee under the Plan for the last two (2) months of the prior Policy Period; and
b) the average monthly Paid claim cost per Covered Employee under the Plan for the first ten (10) months of the prior Policy Period.

REIMBURSEMENT PROVISIONS

NOTICE OF LOSS The Insured will give written notice of Losses to the Company on the Company's customary proof of loss form, within thirty (30) days of the date the Insured becomes aware of the existence of facts which would reasonably suggest the possibility that expenses covered under the Plan for a Covered Person will be Incurred which are equal to or exceed fifty percent (50%) of the Specific Deductible or $50,000, whichever is less.

PAYMENT BY PLAN
While the determination of benefits under the Plan is the responsibility of the Plan, or a party designated by the Plan Document, the Company reserves the right, for purposes of determining benefits under this Policy, to make an independent determination as to whether a particular claim or claims are payable or were properly paid by the Plan, without any deference to the Plan's decision. Any provision in the Plan Document giving a particular party authority or discretion to interpret the Plan Document or determine benefits under the Plan will not be binding on the Company for purposes of determining benefits under this Policy.

The Insured agrees to provide funds for payment of all eligible expenses under the Plan. The Insured will Pay all eligible claims under the Plan within thirty (30) days from the date adequate proof of loss is provided to the Insured. If the Insured fails to Pay a claim within the thirty (30) day time limit, that claim will not count toward the satisfaction of the deductibles or be reimbursed under this Policy.

The Insured agrees to provide funds for payment of all eligible expenses under the Plan.

SPECIFIC EXCESS LOSS INSURANCE
The Schedule of Excess Loss Coverage indicates whether Specific Excess Loss Insurance is provided under this Policy. If, while this Policy is in effect, the Losses for a Covered Person for the applicable Benefit Period exceed the Specific Deductible, the Company will reimburse the Insured, subject to the terms and conditions of this Policy including the limits set forth in the Schedule of Excess Loss Coverage, within thirty (30) days after:

(a) the Company's acceptance of the proof of loss as a satisfactory proof;
(b) the Company's receipt of proof of Payment of the benefits by the Insured under the Plan to, or on behalf of, the Covered Persons; and
(c) completion of an audit of the claim, if requested by either the Insured or the Company, which payment by the Insured is expressly agreed to be a condition precedent to payment.

The amount of the reimbursement will be equal to the Specific Percentage Reimbursable times the amount by which Losses exceed the Specific Deductible amount, but will not exceed the Maximum Specific Benefit.

Losses for any Covered Person during the Policy Period will be determined according to the Benefit Period described in the Schedule of Excess Loss Coverage. The Specific Deductible applies separately to each Covered Person during a Benefit Period.

If Specific Excess Loss Insurance terminates before the end of the Policy Period, the Specific Deductible will not be reduced.

AGGREGATE EXCESS LOSS INSURANCE
The Schedule of Excess Loss Coverage indicates whether Aggregate Excess Loss Insurance is provided under this Policy. If the Losses for the applicable Benefit Period subject to the Loss Limit Per Covered Person, exceed the Annual Aggregate Deductible for the Policy Period, the Company will reimburse the Insured, subject to the terms and conditions of this Policy including the limits set forth in the Schedule of Excess Loss Coverage, within thirty (30) days after:

(a) the Company's acceptance of proof of loss as satisfactory proof;
(b) the Company's receipt of proof of Payment of eligible expenses under the Plan; and
(c) completion by the Company of a satisfactory on-site audit of the claims, eligibility and all records relevant to a claim under Aggregate Excess Loss Insurance, if the Company elects to do so.

The amount of the reimbursement will be equal to the Aggregate Percentage Reimbursable times the amount by which Losses exceed the Annual Aggregate Deductible amount, but will not exceed the Maximum Aggregate Benefit.

The Annual Aggregate Deductible for any one Policy Period means the greater of: (a) the sum of the Monthly Aggregate Deductibles; or (b) the Minimum Annual Aggregate Deductible.

For purposes of determining amounts payable under this Aggregate Excess Loss Insurance, Losses pertaining to each Covered Person during the Benefit Period will be limited to the Loss Limit Per Covered Person. Losses will not include any amounts reimbursed by the Company under any other provision of this Policy. Any Loss that is Incurred at a time when the person to whom the Loss relates is not a Covered Person will not be eligible for Aggregate Excess Loss Insurance and will not be considered for the purpose of satisfying the Annual Aggregate Deductible.

However, if coverage terminates before the end of the Policy Period, the Annual Aggregate Deductible will be deemed not satisfied and the Company will not be liable for reimbursement of any benefits under this Aggregate Excess Loss Insurance.

TERMINATION PROVISIONS

This Policy and coverage provided hereunder will terminate upon the earliest of:

a) the premium due date of any premium which remains unpaid at the end of the Grace Period;
b) the premium due date next following receipt by the Company of written notice from the Insured that this Policy is to be terminated;
c) the date of termination of the Plan;
d) the date the Insured suspends active business operations or dissolves; or
e) the end of the Policy Period.

This Policy may also be terminated, at the Company's option on the earliest of:

a) the last day of the third (3rd) consecutive month during which there are less than fifty-one (51) employees enrolled in the Plan, unless the Company agrees, in writing, to continue coverage; or
b) the date the Insured fails to comply with the terms of this Policy.

The Company will not refund any portion of the premiums paid if this Policy is terminated during the Policy Period.

REINSTATEMENT PROVISIONS

If this Policy terminates for any of the reasons set forth above, the Company may, at its option, approve the Insured's request to reinstate this Policy. The Insured shall submit to the Company any forms and data the Company may require. If this Policy is reinstated, the Insured shall pay to the Company the premiums due from the date this Policy terminated.

SUBSEQUENT POLICY PERIOD PROVISIONS

At the end of a Policy Period, a subsequent Policy Period may be agreed upon in writing by the Company and the Insured. The terms and conditions for a subsequent Policy Period will be evidenced by the issuance of a new Schedule of Excess Loss Coverage by the Company which shows the new premium rates, Benefit Period and other new terms. This Policy is not automatically renewable.

GENERAL PROVISIONS

ASSIGNMENT Reimbursement under this Policy may not be assigned by the Insured, and the Company will not recognize any such assignment.

AUDITS The Company will have the right: (a) to inspect and audit all records and procedures of the Insured and Third Party Administrator, developed and maintained for the Plan, that are applicable to the administration of this Policy; and (b) to require, upon request, proof satisfactory to the Company that Payment has been made to the Covered Person or the provider of such services or benefits which are the basis for any Loss by the Insured hereunder.

CHANGES TO THE PLAN DOCUMENT If the Plan Document in effect on the Effective Date is subsequently amended, notice of the amendment will be given to the Company prior to the effective date of the change. If the Company does not give written acceptance of the amendment, the Company will only provide coverage under this Policy consistent with the Plan Document prior to amendment. The Company's reimbursement will be made according to the amended Plan, once the notice is received and accepted.

CHANGES TO THE POLICY Only the President, a Vice President, or the Secretary of the Company have the authority to alter this Policy, or to waive any of the Company's rights and then only in writing. No such alteration of this Policy shall be valid unless endorsed and attached to this Policy. No agent, broker, or Third Party Administrator has the authority to alter this Policy or to waive any of its provisions.

CLERICAL ERROR Clerical errors, whether by the Insured or by the Company, in keeping or transmitting any records pertaining to the coverage, will not invalidate or limit coverage otherwise validly in force nor continue coverage otherwise validly terminated. Clerical error does not include any failure of the Insured, the Third Party Administrator or any agent of the Insured: (a) to comply with the requirements relating to notice of claims or payment of claims; or (b) to disclose underwriting information requested by the Company, whether or not intentional and regardless of the actual knowledge of the person providing the information.

CONCEALMENT, FRAUD This entire Policy will be void (a) if, before or after a claim or Loss, the Insured, the Third Party Administrator or any agent of the Insured has concealed or misrepresented any material fact or circumstance concerning this Policy, including any claim, or (b) in any case of fraud by the Insured, the Third Party Administrator, or any agent of the Insured relating to this Policy.

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.

ENTIRE CONTRACT The Entire Contract between the Company and the Insured will consist of this Policy, the application, approved amendments or endorsements, and a copy of the Plan Document which is on file with the Company.

INSOLVENCY Nothing in this Policy shall either relieve an insolvent or bankrupt Insured from the obligation to pay premiums when due or delay or abate cancellation of this Policy for failure to do so. The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Insured or the Insured's Third Party Administrator will not impose upon the Company any liability other than the liability defined in this Policy. In particular, the insolvency of the Insured will not make the Company liable to the creditors of the Insured, including Covered Persons under the Plan.

INSURED REQUIREMENTS The Insured will submit by the twentieth (20th) day of each month all proofs, reports, and supporting documents required by the Company, including, but not limited to, a monthly summary of all eligible claims Payments processed by the Insured and number of each type of Covered Units under the Plan during the prior month. The Insured will be responsible for the investigation, auditing, calculating and the Payment of all claims under the Plan.

LEGAL ACTION The Insured cannot file suit until sixty (60) days after the date on which proof of loss is given to the Company. The Insured cannot file suit more than three (3) years after the date on which the Insured must give the Company proof of claim. The three (3) year limitation is extended, if necessary, to agree with the period allowed by the laws of the state of issue.

LIABILITY The Company will have neither the right nor the obligation under this Policy to directly pay any Covered Person or provider of professional or medical services. The Company's sole liability is to the Insured, subject to the terms and conditions of this Policy. Nothing in this Policy shall be construed to permit a Covered Person to have a direct right of action against the Company. The Company will not be considered a party to the Plan of the Insured, or to any supplement or amendment to it.

MISSTATED DATA The Company has relied upon the underwriting information provided by the Insured, the Third Party Administrator or any agent of the Insured, in the issuance of this Policy. Should information in existence prior to issuance of this Policy subsequently become known to the Company which would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms or conditions as of the Effective Date of issuance, by providing written notice to the Insured.

NOTICE FROM THE COMPANY TO THE INSURED For the purpose of any notice required from the Company under the provisions of this Policy, notice to the Insured's Third Party Administrator shall be considered notice to the Insured and notice to the Insured shall be considered notice to the Insured's Third Party Administrator.

OTHER COVERAGE The reimbursement provided by this Policy is in excess of other coverage such as group insurance, excess insurance, insurance, plan benefits, including insurance or plan benefits established by any federal, state, or local law.

PARTIES TO THE POLICY The parties to this Policy are the Insured and the Company. The Company's sole liability under this Policy is to the Insured. This Policy does not create any right or legal relation between the Company and a Covered Person under the Plan. This Policy will not be deemed to make the Company a party to any agreement between the Insured and the Third Party Administrator.

RECORDS The Insured will maintain records of all Covered Persons under the Plan during the Policy Period and for a period of seven (7) years after the end of the Policy Period. The Insured will make all such records available to the Company as needed to evaluate its liability under this Policy.

The Insured will maintain a separate record of any and all amounts Paid in excess of benefits eligible under the Plan.

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

TERMINATION OF THE INSURED'S PLAN The Insured will immediately notify the Company, if the Plan is terminated.

THIRD PARTY ADMINISTRATOR The Insured may retain a Third Party Administrator to act as an agent for the Insured in performing any or all of the duties as designated by the Insured. Without waiving any of its rights under this Policy, and without making the designated Third Party Administrator a party to this Policy, the Company agrees to recognize the Third Party Administrator as an agent of the Insured. The Insured will immediately notify the Company in writing if the agreement between the Insured and the Third Party Administrator terminates.

THIRD PARTY RECOVERY The Insured, for itself and on behalf of the Plan, agrees that the Plan shall undertake to pursue any and all valid claims that the Plan may have against third parties arising out of any occurrence resulting in a payment by the Plan or the Company, and to account for and pay to the Company any amounts recovered which were previously paid by the Company to the Insured under this Policy, regardless of whether this Policy is still in force on the date of recovery. Third party shall mean another person, entity, or insurance company. Additionally, the Insured or Plan administrator shall notify the Company immediately upon discovering that a claim against a third party may exist. Should the Insured or the Plan fail to pursue any valid claims against a third party based on an occurrence resulting in a payment by the Company under this Policy, then the Company shall have the right to exercise and enforce all of the Insured and/or Plan's rights against such third party.

The Insured, for itself and on behalf of the Plan, also assigns to the Company all rights of recovery to the extent of any payment by the Company for which the Insured and/or Plan is or becomes entitled to receive payment from a third party.

If the payment received from a third party is less than the total amount paid by the Plan on behalf of the Covered

Person, the Company is entitled to recover first, in full, any amount paid by the Company under this Policy as well as any expenses of collection incurred by the Company. All remaining amounts shall be paid to the Insured.

GENERAL EXCLUSIONS PROVISIONS

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

(a)Any payment which does not strictly comply with the terms and conditions of the Plan Document;

(b) Any payment or expense caused by or resulting from war, declared or undeclared;

(c)Any payment for litigation costs and expenses, extra-contractual damages, compensatory damages, exemplary and punitive damages or liabilities, including but not limited to those resulting from negligence, intentional wrongs, fraud, bad faith or strict liability on the part of the Insured, Plan, Third Party Administrator or any agent or representative of the Insured, Plan or Third Party Administrator;

(d) Any payment or expense for accident or illness arising out of activities performed for profit, including self-employment;

(e)Any payment for occupational accidents or illnesses which are also eligible expenses covered by Workers' Compensation or Occupational Disease law, or similar legislation, whether or not coverage under such law is actually in force;

(f) Any payment which is recoverable under the Plan Document's Coordination of Benefits provision;

(g) Any amount paid which is in excess of the Plan's benefits disclosed, in writing, to the Company;

(h) Any payment under the Plan on account of a benefit which is not shown on the Schedule of Excess Loss Coverage as a Plan benefit for which coverage is provided under this Policy; or

(i) Any payment under the Plan not reported to the Company within six (6) months after the end of the Benefit Period.

Monumental Life Insurance Company
A Stock Company
Administrative Office: 100 LaCosta Lane, Suite 120, Daytona Beach, FL 32114
Phone: (386)274-2600

Aggregate Accommodation Endorsement

This Endorsement forms part of the Excess Loss Insurance Policy to which it is attached.

Insured: _____

Policy Number: _____ Effective Date: _____

AGGREGATE ACCOMMODATION OPTION

In consideration for the additional premium shown in the Schedule of Excess Loss Coverage, the Company will provide Aggregate Accommodation payments subject to all the terms, conditions, limitations, exclusions, and definitions included in the Policy and this Aggregate Accommodation Endorsement. The Effective Date of this Endorsement will coincide with the Effective Date of the Insured's Excess Loss Insurance, and will continue in full force and effect for the duration of that Policy Period.

Aggregate Accommodation Payment If the Losses (determined on the same basis as under the Aggregate Excess Loss Insurance) exceed the Accumulated Accommodation Point by more than $5,000 at the end of any month during the Policy Period, the Company will provide to the Insured an Aggregate Accommodation, if requested. No Aggregate Accommodation may be requested after the end of the eleventh month of the Policy Period.

For purposes of this Endorsement:
"Accumulated Accommodation Point" means the sum of the Monthly Aggregate Deductibles for each of the months commencing with the first month of the Policy Period and ending with the month during the same Policy Period for which the Accumulated Accommodation Point is to be determined. The Accumulated Accommodation Point at the end of any month shall not be less than the Minimum Annual Aggregate Deductible times the proportionate part of the Policy Period elapsed at the end of the month.

"Aggregate Accommodation Outstanding" means the sum of all Aggregate Accommodation payments made to the Insured during the Policy Period, minus any repayment by the Insured of such Aggregate Accommodation payments during the Policy Period.

The Aggregate Accommodation payment will be equal to the Aggregate Percentage Reimbursable times the amount by which Losses exceed the Accumulated Accommodation Point (subject to the Maximum Aggregate Benefit); however, the Aggregate Accommodation payment is reduced by any Aggregate Accommodation Outstanding.

An Aggregate Accommodation Outstanding at the end of the Policy Period shall be deducted from any amount otherwise payable under Aggregate Excess Loss Insurance.

An Aggregate Accommodation is not an advance on any eligible expenses yet to be Paid by the Insured.

A. **Availability** An Aggregate Accommodation will be available to the Insured only if:
   1. all premium payments due for Specific and Aggregate Excess Loss Insurance have been received up to and including the month in which the Aggregate Accommodation is requested; and
   2. the Insured has Paid all claims for eligible expenses under the Plan; and
   3. all claims have been reported as required.

B. **Audits** Prior to releasing any Aggregate Accommodation payment, the Company reserves the right to:
   1. audit the Losses calculation; or
   2. have such an audit done by a third party auditor, if the Company deems necessary.

C. **Repayment** If at any time the Insured's Losses under the Aggregate Excess Loss Insurance are less than the sum of the Accumulated Accommodation Point plus any Aggregate Accommodation Outstanding, the Insured must promptly make repayment to the Company equal to the lesser of:
   1. the amount by which the sum of the Accumulated Accommodation Point plus the Aggregate Accommodation Outstanding exceeds the Insured's Losses under the Aggregate Excess Loss Insurance; or
   2. the full amount of the Aggregate Accommodation Outstanding.

If the Policy terminates before the end of the Policy Period, the Insured will immediately repay all Aggregate Accommodation payments on the date the Insured's coverage terminates.

The Company will have preference over all other claimants for the return of any Aggregate Accommodation payment. Further, the Insured will be liable for all costs and expenses (including reasonable attorney fees) incurred by the Company in the collection of any Aggregate Accommodation payment outstanding. If the Insured fails to make repayment when due, the Company, at its option, may:

i. deduct the outstanding payment due from any reimbursement due under Specific or Aggregate Excess Loss Insurance; or
ii. terminate this Endorsement, or at the Company's option, terminate the Excess Loss Insurance Policy.

At the end of the Policy Period, the Insured's repayment obligation to the Company will equal the amount of any Aggregate Accommodation Outstanding less the amount by which the Insured's Losses under the Aggregate Excess Loss Insurance exceed the Annual Aggregate Deductible. A final repayment of any balance due must be made within thirty (30) days of the end of the Policy Period.

D. **Termination of the Aggregate Accommodation Endorsement** If the Insured fails to make repayment within the specified periods this Aggregate Accommodation Endorsement will terminate automatically for the remainder of the Policy Period.

If eligible Covered Expenses have not been properly Paid, the Company has the right to terminate this Aggregate Accommodation Endorsement.

All terms and conditions, other than as stated above, remain unchanged.

Executed at our Home Office.

N Stacy Boyd
Secretary

President

Monumental Life Insurance Company
A Stock Company
Administrative Office: 100 LaCosta Lane, Suite 120, Daytona Beach, FL 32114
Phone: (888) 500-3284

Aggregating Specific Deductible Endorsement

This Endorsement forms part of the Excess Loss Insurance Policy to which it is attached.

Insured: _____

Policy Number: _____ Effective Date: _____

The Excess Loss Insurance Policy between the Insured and Company is amended as follows:

1. The following definitions will be added to the Definitions section of the Excess Loss Insurance Policy:

   AGGREGATING SPECIFIC DEDUCTIBLE is set forth in the Schedule of Excess Loss Coverage. The Aggregating Specific Deductible will apply separately to each Benefit Period.

   SPECIFIC EXCESS AMOUNT means the amount by which Losses for a Covered Person for the applicable Benefit Period exceed the Specific Deductible, multiplied by the Specific Percentage Reimbursable. The Specific Excess Amount may not exceed the Maximum Specific Benefit.

   TOTAL SPECIFIC EXCESS AMOUNT means the total of the Specific Excess Amounts for all Covered Persons for whom Losses for the applicable Benefit Period exceed the Specific Deductible.

2. The Specific Excess Loss Insurance Provision is hereby deleted and replaced with the following:

SPECIFIC EXCESS LOSS INSURANCE
The Schedule of Excess Loss Coverage indicates whether Specific Excess Loss Insurance is provided under this Policy. If, while this Policy is in effect, the Losses for a Covered Person for the applicable Benefit Period exceed the Specific Deductible, the Company will calculate the Specific Excess Amount for that Covered Person. The Company will monitor the Specific Excess Amounts for all Covered Persons for the applicable Benefit Period. No reimbursement under Specific Excess Loss coverage will be due until the Total Specific Excess Amount exceeds the Aggregating Specific Deductible. The Company will reimburse the Insured the amount by which the Total Specific Excess Amount exceeds the Aggregating Specific Deductible, subject to the terms and conditions of this Policy including the limits set forth in the Schedule of Excess Loss Coverage, within thirty (30) days after:

a) the Company's acceptance of all proofs of loss as a satisfactory proof;
b) the Company's receipt of proof of Payment of the benefits by the Insured under the Plan to, or on behalf of, the Covered Persons; and
c) completion of an audit of the claim, if requested by either the Insured or the Company, which payment by the Insured is expressly agreed to be a condition precedent to payment.

Losses for any Covered Person during the Policy Period will be determined according to the Benefit Period described in the Schedule of Excess Loss Coverage. The Specific Deductible applies separately to each Covered Person or, if applicable, each family during a Benefit Period.

If Specific Excess Loss Insurance terminates before the end of the Policy Period, the Specific Deductible and the Aggregating Specific Deductible will not be reduced.

3. All other provisions of the Excess Loss Insurance Policy remain unaffected by this Endorsement.

Executed at our Home Office.

N Stacy Boyer — Secretary

Hays S Hayes — President

ASD-1 (03/07)

Monumental Life Insurance Company
A Stock Company
Administrative Office: 100 LaCosta Lane, Suite 120, Daytona Beach, FL 32114
Phone: (386)274-2600

Aggregate Terminal Liability Endorsement

This Endorsement forms part of the Excess Loss Insurance Policy to which it is attached, effective on the Effective Date, unless otherwise stated herein.

Insured: _____

Policy Number: _____ Effective Date: _____

AGGREGATE TERMINAL LIABILITY OPTION

If, effective on the last day of the Policy Period, the Insured terminates Excess Loss Insurance with the Company the Insured has the option to modify the Annual Aggregate Deductible and the Benefit Period as set forth below, subject to the following terms and conditions:

A. This option is only available if the Insured has paid the additional premium set forth in the Schedule of Excess Loss Coverage.

B. In order to exercise this option, the Insured must, within 15 days after the end of the Policy Period, notify the Company in writing of its intention to exercise this option.

C. This option is only available for newly issued policies as of inception of the initial Policy Period and will remain in effect for a subsequent period only if this option is renewed for that period.

If the Terminal Liability Option is exercised in accordance with this Endorsement, the following terms will apply to the Policy Period that ends on the date the Insured terminates Excess Loss Insurance with the Company:

A. The Annual Aggregate Deductible for the Policy Period shall be revised to equal the greater of:

1. 125% of the Annual Aggregate Deductible calculated for that Policy Period, or
2. the sum of the Monthly Aggregate Deductibles for the three (3) months prior to the last day of the Policy Period, plus the Annual Aggregate Deductible calculated for that Policy Period.

B. The Benefit Period for Aggregate Excess Loss Insurance will be revised so that the time period during which Covered Expenses must be Paid by the Plan shall be extended by an additional ninety (90) days.

C. Specific Excess Loss Insurance is terminated effective at the end of the Policy Period.

All terms and conditions, other than as stated above, remain unchanged.

Executed at our Home Office.

N Stacy Byu
Secretary

President

AGTERM-1

Monumental Life Insurance Company
A Stock Company
Administrative Office: 100 LaCosta Lane, Suite 120 Daytona Beach, FL 32114
Phone: (888) 500-3284

Specific Expedited Reimbursement Endorsement

This Endorsement forms part of the Excess Loss Insurance Policy to which it is attached.

Insured: _____

Policy Number: _____ Effective Date: _____

SPECIFIC EXPEDITED REIMBURSEMENT OPTION

An additional provision is hereby added to the terms and conditions for Specific Excess Loss Insurance in the Policy as follows:

SPECIFIC EXPEDITED REIMBURSEMENT Without waiving any rights under the Excess Loss Insurance Policy, the Company hereby establishes Specific Expedited Reimbursement. The additional terms and conditions under which Expedited Reimbursement will be provided for Specific Excess Loss claims are as follows:

(A) The claim must be fully processed by the Third Party Administrator and must be ready for payment under the Employee Benefit Plan within the Benefit Period during which the claim was Incurred; and

(B) The Insured must have Paid under the Employee Benefit Plan, the Specific Deductible for the Covered Person to whom the claim relates, plus, in addition to the Specific Deductible Amount, at least $1,000; and

(C) The claim, and supporting documentation satisfactory to the Company, must be received by the Company no later than five (5) days prior to the end of the Benefit Period during which the claim was Incurred and processed; and

(D) The claim must be for more than $1,000.

If the foregoing requirements are satisfied, the Company will promptly send to the Insured reimbursement for the amount that is eligible for reimbursement under Specific Excess Loss Insurance. Upon receipt of the Expedited Reimbursement, the Insured must pay the Employee Benefit Plan's payment within five (5) days. The Company's reimbursement may not be deposited until the Employee Benefit Plan's payment has been paid. If the Insured does not pay the Employee Benefit Plan's payment within the five (5) day period, the reimbursement must be refunded to the Company.

If any portion of the Company's reimbursement is not used to pay the applicable benefits under the Employee Benefit Plan, due to discounting or any other reason, such portion must be returned to the Company within five (5) working days after it is received by the Insured by refund, credit, or otherwise.

If the Insured fails to comply with all of the above conditions, the right to receive Specific Expedited Reimbursement shall be rescinded.

Except as specifically set forth herein, all terms and conditions of the Excess Loss Insurance Policy shall remain in full force and effect.

This Endorsement is intended solely to provide an optional expedited method of reimbursement between the Company and the Insured, and shall not affect the Employee Benefit Plan or the Insured's obligations under the Employee Benefit Plan in any way, and this Endorsement shall not create any rights in favor of any third party.

All terms and conditions, other than as stated above, remain unchanged.

Executed at our Home Office.

N Stacy Boyer
Secretary

President

Monumental Life Insurance Company
A Stock Company
Administrative Office: 100 LaCosta Lane, Suite 120, Daytona Beach, FL 32114
Phone: (386)274-2600

Specific Terminal Liability Endorsement

This Endorsement forms part of the Excess Loss Insurance Policy to which it is attached, effective on the Effective Date, unless otherwise stated herein.

Insured: _____
Policy Number: _____ Effective Date: _____

SPECIFIC TERMINAL LIABILITY OPTION

If, effective on the last day of the Policy Period, the Insured terminates Excess Loss Insurance with the Company the Insured has the option to modify the Benefit Period for Specific Excess Loss Insurance as set forth below, subject to the following terms and conditions:

A. This option is only available if the Insured has paid the additional premium set forth in the Schedule of Excess Loss Coverage.

B. In order to exercise this option, the Insured must, within 15 days after the end of the Policy Period, notify the Company in writing of its intention to exercise this option.

C. This option is only available for newly issued policies as of inception of the initial Policy Period and will remain in effect for a subsequent period only if this option is renewed for that period.

If the Terminal Liability Option is exercised in accordance with this Endorsement, the Benefit Period for Specific Excess Loss Insurance will be revised so that the time period during which Covered Expenses must be Paid by the Plan shall be extended by an additional ninety (90) days. Aggregate Excess Loss Insurance is terminated effective at the end of the Policy Period.

All terms and conditions, other than as stated above, remain unchanged.

Executed at our Home Office.

N Stacy Byu
Secretary

President

Monumental Life Insurance Company
A Stock Company
Administrative Office: 100 LaCosta Lane, Suite 120 Daytona Beach, FL 32114
Phone: (888) 500-3284

Specific Transplant Step-Down Deductible Endorsement

This Endorsement forms part of the Excess Loss Insurance Policy to which it is attached, effective on the Effective Date, unless otherwise stated herein.

Insured: _____

Policy Number: _____ Effective Date: _____

SPECIFIC TRANSPLANT STEP-DOWN DEDUCTIBLE OPTION

The Specific Deductible under Specific Excess Loss Insurance as contained in the Schedule of Excess Loss Coverage will be reduced as follows for a Covered Organ Transplant which is performed in a Transplant Network Facility at the Transplant Network Facility's contracted rate when a signed Transplant Network Access Agreement is in place.

Specific Retention Amount	Reduction Percentage
$10,000 - $19,999	50%
$20,000 - $39,999	40%
$40,000 - $69,999	30%
$70,000 and over	25%

The reduced Specific Deductible (Per Covered Person) will be a one-time reduction per Covered Organ Transplant. Specific Deductible (Per Covered Person) reduction will apply in the Policy Period in which the Covered Organ Transplant occurs. Retransplants shall be considered a new Organ Transplant.

Covered Organ Transplant: Means any human to human organ or tissue transplant which is a Covered Expense in the Employer's Plan Document and is performed at a Transplant Network Facility at the Transplant Network Facility's contracted rate at the time the Covered Organ Transplant occurs. Multiple organ transplants performed at the same time such as heart/lung are considered to be one Covered Organ Transplant.

Transplant Network Facility: Means a facility that is a member of one of the following networks: OptumHealth, INTERLINK, or LifeTrac.

The Company is not responsible for any Covered Person's decision to receive treatment, services, or supplies from a Transplant Network Facility nor does the Company make warranties or representations regarding the qualifications of providers of treatment services or supplies provided by the Transplant Network Facility.

Executed at our Home Office.

N Stacy Boyer
Secretary

President

TRANS-1

Monumental Life Insurance Company
A Stock Company

Administrative Office: 100 LaCosta Lane, Suite 120, Daytona Beach, FL 32114
Phone: (386)274-2600

In Facility Exclusion Endorsement

This Endorsement forms part of the Excess Loss Insurance Policy to which it is attached.

Insured: _____

Policy Number: _____ Effective Date: _____

An additional provision is hereby added to Policy as follows:

IN FACILITY COVERED EXPENSES Covered Expenses incurred at will be calculated at % when determining Losses relating to such expenses. The billed amounts to which the foregoing percentage is applied mu st be based on the level of charges and preferred provider organization discounts that are typical for patients utilizing these facilities.

All other provisions of the Excess Loss Insurance Policy remain unaffected by this Endorsement.

Executed at our Home Office.

Secretary President

EXCESS LOSS INSURANCE POLICY

MONUMENTAL LIFE INSURANCE COMPANY
ADMINISTRATIVE OFFICE
100 LACOSTA LANE, SUITE 120
DAYTONA BEACH, FL 32114

MONUMENTAL LIFE INSURANCE COMPANY

A Stock Company
Administrative Office: 100 LaCosta Lane, Suite 120, Daytona Beach, FL 32114
Phone: (386)274-2600

APPLICATION FOR EXCESS LOSS INSURANCE

The undersigned Applicant requests the Excess Loss Insurance Benefits shown herein and provided by Monumental Life Insurance Company, and agrees to be bound by the terms and provisions of the Excess Loss Insurance Policy.

Full Legal Name of Applicant: **City of Grand Island**
Address (street, city, state, and zip): **100 East 1st Street, Grand Island, Nebraska 68801**
Key Contact: _____ Telephone: **(308) 385-5444** Tax ID: _____
Applicant is a: ☐ Corporation ☐ Labor Union ☐ Partnership ☐ Proprietorship ☐ Other: _____
Nature of Business of the Group to be Insured: **9111 Executive offices**

Requesting retiree coverage? ☐ YES ☒ NO
Requested Effective Date: **October 1, 2011**

Affiliates or Subsidiaries: **Addresses of Affiliates or Subsidiaries:**

_____ _____

SPECIFIC EXCESS LOSS INSURANCE: ☒ YES ☐ NO
Benefit Period: Covered Expenses Incurred from **10-1-2010** through **9-30-2012**,
and Paid from **10-1-2011** through **9-30-2012** ; however, if the Policy is terminated before the end of the originally scheduled Policy Period set forth above, Covered Expenses must be Incurred from **10-1-2010** through the termination date and Paid from **10-1-2011** through the termination date to be eligible for reimbursement.
Covered Expenses Incurred from **10-1-2010** through **9-30-2011** will be limited to $**150,000** per ☒ Covered Person ☐ Family.
Specific Deductible per ☒ Covered Person ☐ Family: $**150,000**
Aggregating Specific Deductible is: $**50,000**
Specific Percentage Reimbursable: **100**%
Maximum Specific Benefit Per Covered Person (including Specific Deductible):
☐ $500,000 ☐ $1,000,000 ☐ $2,000,000 ☒ Other $**Unlimited** for the Benefit Period described above; no lifetime maximum

Covered Expenses under Specific Excess Loss: ☐ Medical ☒ Medical with Stand Alone Prescription Drug Program

Specific Premium Rates per Month See item i on page 2 of application for special conditions		
Single	Number of lives: **103**	$ **26.53**
EE+SP	Number of lives: **120**	$ **48.88**
EE+CH	Number of lives: **35**	$ **48.88**
Family	Number of lives: **208**	$ **72.44**

1.	Specific Expedited Reimbursement Endorsement:	☒ YES	☐ NO	
2.	Specific Terminal Liability Endorsement:	☐ YES	☒ NO	$**N/A**
3.	Aggregating Specific Deductible Endorsement:	☒ YES	☐ NO	$**Included**
4.	Other Endorsement: _____	☐ YES	☒ NO	$**N/A**

Minimum Annual Specific Premium **is 90% of the first month enrollments x rates x 12.**
AGGREGATE EXCESS LOSS INSURANCE: ☒ YES ☐ NO

Benefit Period: Covered Expenses Incurred from **10-1-2010** through **9-30-2012**,
and Paid from **10-1-2011** through **9-30-2012**; however, if the Policy is terminated before the end of the originally scheduled Policy Period set forth above, no reimbursement will be made under Aggregate Excess Loss Insurance.
Covered Expenses Incurred from **10-1-2010** through **9-30-2011** will be limited to $**1,106,296** or **100**% of the Annual Aggregate Deductible.
Covered Expenses under Aggregate Excess Loss Coverage: ☐ Medical ☒ Medical with Stand Alone Prescription Drug Program
☐ Dental ☐ Vision ☐ Weekly (Disability) Income ☐ Other (Please Specify) **N/A**

Aggregate Percentage Reimbursable: **100**%
Maximum Aggregate Benefit: ☐ $500,000 ☒ $1,000,000 ☐ Other $**N/A**
Minimum Annual Aggregate Deductible: $**6,146,090** or **100**% of the first Monthly Aggregate Deductible amount times 12, whichever is greater.

Loss Limit per Covered Person $ **150,000**

Aggregate Excess Loss Premium:	☒ Monthly	☐ Annually	$**2.17 pepm**
1. Aggregate Terminal Liability Endorsement:	☐ YES	☒ NO	$**N/A**
2. Aggregate Accommodation Endorsement:	☐ YES	☒ NO	$**N/A**
3. Other Endorsement: _____	☐ YES	☒ NO	$**N/A**

Monthly Aggregate Factors								
	Medical	# of lives	Prescription Drugs	# of lives	Dental	# of lives	**N/A**	#of lives
Single	**$522.22**	**103**	**Included**	**103**	**N/A**	**N/A**	**N/A**	**N/A**
EE+SP	**$973.41**	**120**	**Included**	**120**	**N/A**	**N/A**	**N/A**	**N/A**
EE+CH	**$973.41**	**35**	**Included**	**35**	**N/A**	**N/A**	**N/A**	**N/A**
Family	**$1478.40**	**208**	**Included**	**208**	**N/A**	**N/A**	**N/A**	**N/A**

Full Name of Third Party Administrator: Regional Care Inc
Address: (street, city, state, and zip): **905 West 27th Street, Scottsbluff, Nebraska 69361**
Key Contact: _____Telephone: **(800) 795-7772**

Agent or Broker: _____

SS No. or Tax ID: _____

Address: _____

It is understood and agreed by the undersigned that:

a. As a condition precedent to the approval of this Application, the undersigned shall furnish to the Company a copy of the executed Plan Document describing the benefits provided by the Plan which shall be kept on file in the office of the Company. No Excess Loss Insurance will be effective nor reimbursement made unless a Plan Document is received and accepted by the Company. In the event of a material variance, in the judgement of the Company, between the Plan Document received by the Company and the Plan benefit provisions upon which the terms and rates of the Aggregate and Specific Excess Loss Coverage were based, any Policy that has been issued will not take effect unless a Plan Document is received, accepted, and on file in the Company's office.

b. The undersigned will provide or employ a Third Party Administrator (TPA) to administer the Plan and to process and pay claims according to the Plan Document. The undersigned acknowledges that the TPA is the undersigned's agent and that statements and answers given by the TPA are binding on the undersigned.

c. The receipt by the Company of the first month's premium and deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event the Company does not approve this application, its sole obligation shall be to refund such premium to the undersigned.

d. Any Aggregate and/or Specific Excess Loss Insurance shall be described in the Policy issued.

e. Experience, census, and other information contained in the underwriting information as furnished by the Applicant directly, or through its representative, are the primary data elements on which the Company's proposal was based. The undersigned will provide any additional underwriting information required by the Company.

f. Any coverage resulting from this Application shall be subject to the terms and provisions of the Policy herein applied for. Coverage shall become effective on the date specified in this Application if all requirements of the Company, including underwriting requirements, have been met and the required premiums paid.

g. The undersigned represents that the statements, declarations and representations made in this Application, any request for proposal, the underwriting information provided by or on behalf of the undersigned and the Plan Document accurately and completely reflect the true facts. The undersigned understands that any Policy is issued in reliance upon the truth of such statements, declarations, and representations; and that such statements, declarations, and representations are part of this Application.

h. The Company will evaluate the undersigned's risk, and may require adjustments of rates, factors, and/or special limitations to accommodate for abnormal risks.

i. Other: **Review of experience & shock losses from September 2011 to the policy inception.**

This Quote assumes a fully insured Transplant policy will be in-force.

D. McVay is approved at case deductible subject to a 12-12 contract limitation provided estimated dialysis charges are not significantly higher than the $103,000 proposed. If the final dialysis estimate is higher, we reserve the right to underwrite based on final estimate.

The undersigned has read the entire Application for Excess Loss Insurance and understands that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.

Full Legal Name of Applicant:_____

Signature of Authorized Person: _____

Print Name:_____ Title:_____

Date: _____

Signature of Agent or Broker:_____

Print Name of Agent or Broker:_____

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

ARKANSAS

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

ALASKA

"A person who knowingly and with intent to injure, defraud, or deceive an insurance company files claim containing false, incomplete, or misleading information may be prosecuted under state law."

ARIZONA

"**For your protection, Arizona law requires the following statement to appear on this form**. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties".

ARKANSAS, LOUISIANA, TEXAS and WEST VIRGINIA

"Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

CALIFORNIA

For your protection California law requires the following to appear on this form.

"Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison".

COLORADO

"It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading fact of information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement for award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies."

DELAWARE, IDAHO, and INDIANA

"Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a state of claim containing any false, incomplete or misleading information is guilty of a felony."

DISTRICT OF COLUMBIA

"WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

FLORIDA

"Any person who knowingly and with intent to injure, defraud, or deceive any Insurance Company files a statement of claim containing any false, incomplete or misleading information is guilty of a Felony of the Third Degree."

KENTUCKY

"Any person who knowingly and with intent to defraud any insurance company or other person files a 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."

MAINE

"It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits."

MINNESOTA

"A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

NEW HAMPSHIRE

"Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided by RSA 638:20."

NEW JERSEY

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

NEW MEXICO

"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties."

OHIO

"Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

OKLAHOMA

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA

"Any person who knowingly and with 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."

TENNESSEE, MAINE, and VIRGINIA

"It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

ALL OTHER STATES

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

RESOLUTION 2011-255

WHEREAS, the City subscribes to health insurance for its employees and other eligible participants, as authorized by the City of Grand Island Personnel Rules and federal regulation; and

WHEREAS, an Insurance Committee consisting of union and non-union, management, and non-management employees, along with the Human Resources Director, the Finance Director, and the Attorney/Purchasing Agent meet and review plan changes; and

WHEREAS, Regional Care, Inc. of Scottsbluff, Nebraska is the Third Party Administrator; and

WHEREAS, The reinsurance coverage is provided under a contract with Monumental Life Insurance Company/EBU and the transplant coverage is provided under a contract with National Union Fire Insurance Company of Pittsburgh, PA, the Dialysis PPO contract provides dialysis discounts, and the broker is Strong Financial Services, however all contracts would be administered by Regional Care, Inc; and

WHEREAS, contracts are necessary for the provision of such services and associated stop loss and transplant coverage; and

WHEREAS, a Business Associate Agreement and an Administrative Service Agreement will be entered into with Regional Care, Inc. and costs associated with providing insurance services are listed on the Administrative Services Agreement, for the aforementioned contracts for other insurance services;

NOW, THEREFORE BE IT RESOLVED BY THE MAYOR AND COUNCIL OF THE CITY OF GRAND ISLAND, NEBRASKA, that the renewal contracts with Regional Care, Inc. for the administration of health insurance as set out by the contracts is hereby approved.

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Adopted by the City Council of the City of Grand Island, Nebraska, September 13, 2011.

_____
Jay Vavricek, Mayor

Attest:

_____
RaNae Edwards, City Clerk