MASTER SERVICE AGREEMENT

Aetna Life Insurance Company
Stop Loss Application and Schedule of Insurance

151 Farmington Avenue
Hartford, CT 06156

Policyholder Information

Policyholder name (full legal name of entity): Hillsborough County Aviation Authority

Street:	Tampa Airport Level 3 Blue SD		
City:	Tampa	State: FL	Zip Code: 33607
Email:	ldavis@tampaairport.com	Phone: (813) 554-1493	

Policy period start: 08/01/2022 Policy period end: 07/31/2023

Total number of employees/covered units covered under the policy: 584

Pre-65 Retirees: ☑ Included ☐ Excluded | Retirees 65+: ☑ Included ☐ Excluded

Medical paid claims basis: ☑ Issued ☐ Cleared ☐ N/A

Business Type: ☐ Corporation ☑ Government ☐ Association ☐ Union ☐ Other

Affiliates or subsidiaries included? ☑ No ☐ Yes If yes, list name(s) and address state of the primary location(s) below.

Affiliate full legal name(s):	Address state of Primary location(s):
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Third Party Administrator? ☑ No ☐ Yes If yes, complete for each administrator or vendor.

Medical:

Prescription drug:

Other:

Individual Stop Loss Coverage (ISL)

Individual Stop Loss coverage? ☐ No ☑ Yes | Individual Stop Loss amount: $150,000

Does individual Stop Loss amount differ by plan or class? ☑ No ☐ Yes

If yes, please include the plan(s)/class(es) and amounts below.

Plan/class:	Individual Stop Loss amount: $
Plan/class:	Individual Stop Loss amount: $
Plan/class:	Individual Stop Loss amount: $

Plan/class: Individual Stop Loss amount: $

Plan/class: Individual Stop Loss amount: $

High risk individual Stop Loss amount(s)* included? ☐ N/A ☑ No ☐ Yes **See Coverage Limitations identified below.*

Covered benefits: ☑ Medical ☑ Prescription drug ☐ Other

Contract type: Claims incurred from through or ☑ paid basis

Claims paid from 08/01/2022 through 07/31/2023

Maximum run-in claims: ☑ N/A or $ ☐ per covered person ☐ in total

Individual coinsurance percentage reimbursable: 100%

IOE transplant Stop Loss amount: ☐ N/A ☑ No or $

Family individual Stop Loss amount: ☐ N/A ☑ No or $

Aggregating Specific Stop loss amount: ☐ N/A ☑ No or $

Maximum lifetime individual Stop Loss payment amount: ☑ Unlimited or $

Experience Refund Option included? ☐ N/A ☑ No ☐ Yes

Experience refund period: Start date through

Loss ratio threshold: % Refund share: %

Maximum refund: % Large claim adjustment: ☑ No or Adjustment is:

Large claim identifier: Date of birth:

Large claim identifier: Date of birth:

Large claim identifier: Date of birth:

Large claim identifier: Date of birth:

Large claim identifier: Date of birth:

Premier product included? ☐ N/A ☑ No ☐ Yes

Renewal risk cap included? ☐ N/A ☑ No ☐ Yes Cap: %

Other rate cap included? ☐ N/A ☑ No ☐ Yes Cap: %

Terminal run-out coverage for claims incurred prior to policy termination and paid after termination? ☐ No ☑ Yes

Terminal reserve or liability period: 3 months

Reimbursement types:

Immediate reimbursement (Aetna as claims administrator): ☐ N/A ☐ No ☑ Yes

Individual accelerated claim reimbursement (TPA as claims administrator): ☐ N/A ☑ No ☐ Yes

Other conditions or provisions:

Aggregate Stop Loss Coverage (ASL)

Aggregate Stop Loss coverage? ☐ No ☑ Yes | Aggregate Stop Loss percentage: 125%

Covered benefits: ☑ Medical ☑ Prescription Drug ☐ Dental ☐ Vision ☐ Other

Contract type: Claims incurred from through or ☑ paid basis

Claims paid from 08/01/2022 through 07/31/2023

Maximum run-in claims: ☑ N/A or $ ☐ per covered person ☐ in total

Individual Stop Loss insurer: ☑ Aetna or

Minimum aggregate Stop Loss amount: ☐ N/A $ 17,229,448

Individual internal limit: ☐ N/A ☑ No ☐ Yes If yes, amount: $

Maximum annual aggregate Stop Loss payment amount? ☐ N/A ☐ No ☑ Yes If yes, amount: $2,000,000

Deficit recoup provision? ☐ N/A ☑ No ☐ Yes If yes, deficit cap: %

Termination provision? ☐ N/A ☑ No ☐ Yes

Terminal run-out coverage for claims incurred prior to policy termination and paid after termination? ☐ No ☑ Yes

Terminal reserve or liability period: 3 months

Reimbursement types:

Monthly budget feature (Aetna as claims administrator): ☐ N/A ☐ No ☑ Yes

Aggregate accelerated claim reimbursement (TPA as claims administrator): ☐ N/A ☑ No ☐ Yes

Other conditions or provisions:

Coverage Limitations

Mental Health claim expenses are ☑ Included ☐ Excluded

Transplant coverage is ☑ Included ☐ Excluded

Is the policyholder a hospital or hospital group? ☑ No ☐ Yes

If yes, are drafts suppressed for domestic claims? ☑ N/A ☐ No ☐ Yes

If yes, domestic claims are reimbursed at? ☑ N/A ☐ 100% ☐ 0% ☐ Other %

Are any of these limitations included under this Stop Loss policy?

Pre-existing conditions exclusion?	☑ No	☐ Yes
Dependent non-confinement?	☑ No	☐ Yes
Actively at Work?	☑ No	☐ Yes

High Risk Individual Stop Loss amounts:

Member Identifier	Date of Birth	Amount	Description
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	

Premium Rates and Factors

Premium rate:

*Composite: $180.81 per employee per month (PEPM)

*If individual and aggregate Stop Loss coverage is included, the premium rate is combined.

Terminal liability premium rate:

*Composite: $180.81 per employee per month (PEPM) or ☐ N/A

*If individual and aggregate Stop Loss coverage is included, the premium rate is combined.

Aggregate Stop Loss factor:
Composite: $2,458.54 per employee per month (PEPM) or ☐ N/A

Terminal Liability Stop Loss factor:
Composite: $2,458.54 per employee per month (PEPM) or ☐ N/A

Certification and Signature

You hereby represent that the information contained in this *Stop Loss Application and Schedule of Insurance*, any *Disclosure* statement, and all other information and documents provided by you to us, is true and complete to the best of your knowledge and belief.

Printed name of authorized representative: Signature of authorized representative:

Official Title: Date:

Agent of Record

Agent's name: on file
Agent's firm: on file Tax ID #: on file
Agent's FL License #: on file
(If countersignature laws require commission sharing with a duly licensed resident agent in another jurisdiction, the above designation will be modified to the extent required by law.)

Fraud Notice

WARNING: 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.

State-specific notices:

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

AR: 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.

CO: 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 facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KY: 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 material fact thereto, commits a fraudulent insurance act, which is a crime.

LA: 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 fines and confinement in prison.

ME: 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.

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

NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NM: 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.

NY: 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 material fact thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH: 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.

OK: 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.
OR: 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 may be guilty of a crime and may be subject to civil fines and criminal penalties.
RI: 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 fines and confinement in prison.
TN: 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.
VA: Any person who, with the 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 may have violated state law.
WA: 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.
WV: 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 fines and confinement in prison.

AGREEMENT TO CLARIFY AND ADD SUPPLEMENTAL TERMS

This Agreement is dated March 31, 2022 and is between Aetna Life Insurance Company, a Connecticut company, in its role as a stop loss insurer ("Aetna"), and Hillsborough County Aviation Authority in its role as insured under a stop loss policy ("HCAA").

HCAA has purchased stop loss coverage from Aetna and is covered under Stop Loss Policy number 724379 ("Policy"). In discussions between HCAA and Aetna, both parties want to clarify the meaning and interpretations of certain terms in the Policy and include additional terms not otherwise addressed in the Policy.

HCAA and Aetna therefore agree as follows:

1. **Scope of Agreement.** The Policy shall be interpreted and construed in accordance with the language contained in this Agreement. In the event the Policy and this Agreement directly conflict, the terms of this Agreement shall prevail. The terms of this Agreement shall be incorporated into the Policy.

2. **Term.** This Agreement shall be effective as of August 1, 2022 and shall remain in force for the term of the Policy.

3. **Clarifications.**
   a. The arbitration provision in the Policy is deleted in its entirety.
   b. HCAA's indemnification obligations to Aetna (in the second paragraph of the Policy under "Indemnification") are deleted in their entirety.
   c. The first bullet of "Notice of legal actions," under the Policy is revised to read as follows:
      - "Notify us immediately upon our request of any event or development that might result in an action or law or equity related to this policy."
   d. The third bullet of "Notice of legal actions," under the Policy is revised to read as follows:
      - "Immediately provide to us a copy of any documents filed by or against you in any court in connection with any litigation under the plan which we request."
   e. The second paragraph under "Notice of legal actions" under the Policy (regarding HCAA's responsibility to pay fees and damages incurred by Aetna in connection with litigation) is deleted in its entirety.

4. **Supplemental Terms**. The Supplemental Terms and Conditions agreed upon by the parties through the ITN and related negotiations in connection with the Policy are hereby included in this Agreement and are attached hereto as Attachment A.

5. **Entire Agreement.** This Agreement supersedes all other agreements, whether written or oral, between the parties on clarifications and interpretations of the Policy. It does not supersede or limit HCAA's rights under the Policy but provides common understanding between the parties regarding terms in the Policy.

The parties are signing this Agreement on the date stated in the introductory clause.

Hillsborough County Aviation Authority
By:
Its:

Aetna Life Insurance Company
By: Daniel Finke
Its: President, Aetna Life Insurance Company

Attachment A

Supplemental Terms and Conditions

The Awarded Respondent (hereinafter "Supplier") agree as set forth below:

A. Indemnification and Hold Harmless

To the maximum extent permitted by Florida law, in addition to Supplier's obligation to provide pay for and maintain insurance as set forth elsewhere in this Term of Award, Supplier will indemnify and hold harmless the Authority, its members, officers, agents, employees, and volunteers from that portion of liabilities, suits, claims, procedures, liens, expenses, losses, costs, fines and damages (including but not limited to claims for attorney's fees and court costs) ("Losses") caused in whole or in part by the:

1. presence on, use or occupancy of Authority property;
2. acts, omissions, negligence (including professional negligence and malpractice), errors, recklessness, intentional wrongful conduct, activities, or operations;
3. any breach of the terms of this Term of Award;
4. performance, non-performance or purported performance of this Term of Award;
5. violation of any law, regulation, rule, Advisory Circular or ordinance;
6. infringement of any patent, copyright, trademark, trade dress or trade secret rights; and/or
7. contamination of the soil, groundwater, surface water, storm water, air or the environment by fuel, gas, chemicals or any other substance deemed by the Environmental Protection Agency or other regulatory agency to be an environmental contaminant

by the Supplier or the Supplier's officers, employees, agents, volunteers, subcontractors, invitees, or any other person directly or indirectly employed or utilized by the Supplier, Supplier is not relieved of its indemnity obligation with respect to claims caused in part by negligence, acts or omissions of the Authority, its members, officers, agents, employees, and volunteers, however Supplier is only responsible to the Authority for the portion of such Losses that are directly attributable to Supplier as set out above.

In addition to the duty to indemnify and hold harmless, Supplier will have the separate and independent duty to defend the Authority, its members, officers, agents, employees, and volunteers from all suits, claims, proceedings or actions of any nature seeking damages, equitable or injunctive relief, liens, expenses, losses, costs, royalties, fines, attorney's fees or any other relief in the event the suit, claim, or action of any nature arises in whole or in part from the:

1. presence on, use or occupancy of Authority property;
2. acts, omissions, negligence (including professional negligence and malpractice), errors, recklessness, intentional wrongful conduct, activities, or operations;
3. any breach of the terms of this Term of Award;
4. performance, non-performance or purported performance of this Term of Award;
5. violation of any law, regulation, rule, Advisory Circular or ordinance;
6. infringement of any patent, copyright, trademark, trade dress or trade secret rights; and/or
7. contamination of the soil, groundwater, surface water, storm water, air or the environment by fuel, gas, chemicals or any other substance deemed by the Environmental Protection Agency or other regulatory agency to be an environmental contaminant

by the Supplier or the Supplier's officers, employees, agents, volunteers, subcontractors, invitees, or any other person directly or indirectly employed or utilized by the Supplier regardless of whether it is caused in part by the Authority, its members, officers, agents, employees, or volunteers. This duty to defend exists immediately upon presentation of written notice of a suit, claim or action of any nature to the Supplier by a party entitled to a defense hereunder. This defense obligation expressly applies, and shall be construed to include, any and all claims caused by the negligence, acts or omissions, of the Authority, it's members, officers, agents, employees and volunteers.

If the above indemnity or defense provisions or any part of the above indemnity or defense provisions are limited by Fla. Stat. § 725.06(2)-(3) or Fla. Stat. § 725.08, then Supplier agrees to the following:

To the maximum extent permitted by Florida law, Supplier will indemnify and hold harmless the Authority, its members, officers, agents, employees, and volunteers from any and all liabilities, damages, losses, and costs, including, but not limited to, reasonable attorneys' fee, to the extent caused by the negligence, recklessness, or intentional wrongful conduct of the Supplier and persons employed or utilized by the Supplier in the performance of this Term of Award.

If the above indemnity or defense provisions or any part of the above indemnity or defense provisions are limited by Fla. Stat. § 725.06(1) or any other applicable law, the monetary limitation on the extent of the indemnification shall be the greater of the (i) monetary value of this Term of Award, (ii) coverage amount of Commercial General Liability Insurance required under this Term of Award, or (iii) $1,000,000.00. Otherwise, the obligations of this Article will not be limited by the amount of any insurance required to be obtained or maintained under this Term of Award.

In addition to the requirements stated above, to the extent required by FDOT Public Transportation Grant Agreement and to the fullest extent permitted by law, the Supplier shall indemnify and hold harmless the State of Florida, FDOT, including the FDOT's officers and employees, from liabilities, damages, losses and costs, including, but not limited to, reasonable attorney's fees, to the extent caused by the negligence, recklessness or intentional wrongful misconduct of the Supplier and persons employed or utilized by the Supplier in the performance of this Term of Award. This indemnification in this paragraph shall survive the termination of this Term of Award. Nothing contained in this paragraph is intended to nor shall it constitute a waiver of the State of Florida's and FDOT's sovereign immunity.

Supplier's obligations to defend and indemnify as described in this Article will survive the expiration or earlier termination of the Term of Award until it is determined by final judgment that any suit, claim or other action against the Authority, its members, officers, agents, employees, and volunteers is fully and finally barred by the applicable statute of limitations or repose.

Nothing in this Article will be construed as a waiver of any immunity from or limitation of liability the Authority, or its members, officers, agents, employees, and volunteers may have under the doctrine of sovereign immunity under common law or statute.

The Authority and its members, officers, agents, employees, and volunteers reserve the right, at their option, to participate in the defense of any suit, without relieving Supplier of any of its obligations under this Article, however, Supplier shall provide and control the defense and settlement with respect to claims to which its indemnification obligation applies.

If this Article or any part of this Article is deemed to conflict in any way with any law, the Article or part of the Article will be considered modified by such law to remedy the conflict.

B. Warranty of Services
Supplier warrants that the services performed under this Term of Award will be in accordance with the highest applicable professional or industry standards, first quality workmanship, and on-time as specified in the project schedule.

C. Non-Discrimination
During the performance of these services, the Supplier, for itself, its assignees and successors in interest, agrees as follows:

1. The Supplier will comply with the regulations relative to non-discrimination in federally assisted programs of the Department of Transportation (DOT) Title 49, Code of Federal Regulations, Part 21, as amended from time to time (hereinafter referred to as the Regulations), which are incorporated herein by reference and made a part of this Term of Award.

2. Civil Rights. The Supplier, with regard to the work performed by it under this Term of Award, will not discriminate on the grounds of race, color, or national origin in the selection and retention of subcontractors, including procurements of materials and leases of equipment. The Supplier will not participate directly or indirectly in the discrimination prohibited by the Acts and the Regulations, including employment practices when the Term of Award covers any activity, project, or program set forth in Appendix B of 49 CFR Part 21. During the performance of this Purchase Order, the Supplier, for itself, its assignees, and successors in interest agrees to comply with the following non-discrimination statutes and authorities, including but not limited to:
    a. Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq., 78 stat. 252), (prohibits discrimination on the basis of race, color, national origin);
    b. 49 CFR part 21 (Non-discrimination In Federally-Assisted Programs of The Department of Transportation—Effectuation of Title VI of The Civil Rights Act of 1964);
    c. The Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, (42 U.S.C. § 4601), (prohibits unfair treatment of persons displaced or whose property has been acquired because of Federal or Federal-aid programs and projects);
    d. Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. § 794 et seq.), as amended, (prohibits discrimination on the basis of disability); and 49 CFR Part 27;
    e. The Age Discrimination Act of 1975, as amended, (42 U.S.C. § 6101 et seq.), (prohibits discrimination on the basis of age);
    f. Airport and Airway Improvement Act of 1982, (49 USC § 471, Section 47123), as amended, (prohibits discrimination based on race, creed, color, national origin, or sex);
    g. The Civil Rights Restoration Act of 1987, (PL 100-209), (Broadened the scope, coverage and applicability of Title VI of the Civil Rights Act of 1964, The Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1973, by expanding the definition of the terms “programs or activities” to include all of the programs or activities of the Federal-aid recipients, sub-recipients and contractors, whether such programs or activities are Federally funded or not);
    h. Titles II and III of the Americans with Disabilities Act of 1990, which prohibit discrimination on the basis of disability in the operation of public entities, public and private transportation systems, places of public accommodation, and certain testing entities (42 U.S.C. §§ 12131 – 12189) as implemented by Department of Transportation regulations at 49 CFR parts 37 and 38;
    i. The Federal Aviation Administration’s Non-discrimination statute (49 U.S.C. § 47123) (prohibits discrimination on the basis of race, color, national origin, and sex);
    j. Executive Order 12898, Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations, which ensures nondiscrimination against minority populations by discouraging programs, policies, and activities with disproportionately high and adverse human health or environmental effects on minority and low-income populations;
    k. Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination because of limited English proficiency (LEP). To ensure compliance with Title VI, the Supplier must take reasonable steps to ensure that LEP persons have meaningful access to the Supplier’s programs (70 Fed. Reg. at 74087 to 74100); and
    l. Title IX of the Education Amendments of 1972, as amended, which prohibits the Supplier from discriminating because of sex in education programs or activities (20 U.S.C. 1681 et seq).
3. In all solicitations either by competitive bidding or negotiation made by the Supplier for work to be performed under a subcontract, including procurement of materials or leases of equipment, each potential subcontractor or supplier must be notified by the Supplier of Supplier’s obligations under this Term of Award and the Regulations relative to nondiscrimination on the grounds of race, color or national origin.
4. The Supplier will provide all information and reports required by the Regulations or directives issued pursuant thereto and must permit access to its books, records, accounts, other sources of information and its facilities as may be determined by the Authority or the Federal Aviation Administration (FAA) to be pertinent to ascertain compliance with such Regulations, orders and instructions. Where any information required of the Supplier is in the exclusive possession of another who fails or refuses to furnish this information, the Supplier will so certify to the Authority or the FAA, as appropriate, and will set forth what efforts it has made to obtain the information.

5. In the event of the Supplier's non-compliance with the non-discrimination provisions of this Term of Award, the Authority will impose such contractual sanctions as it or the FAA may determine to be appropriate, including, but not limited to, withholding of payments to the Supplier under this Term of Award until the Supplier complies, and/or cancellation, termination or suspension of this Term of Award, in whole or in part.
6. The Supplier will include the provisions of Paragraph C, Non-Discrimination, Items 1 through 5 above in every subcontract and subconsultant contract, including procurement of materials and leases of equipment, unless exempt by the Regulations or directives issued pursuant thereto. The Supplier will take such action with respect to any subcontract or procurement as the Authority or the FAA may direct as a means of enforcing such provisions, including sanctions for non-compliance. Provided, however, that in the event the Supplier becomes involved in or is threatened with litigation with a subcontractor or supplier as a result of such direction, the Supplier may request the Authority to enter into such litigation to protect the interests of the Authority and, in addition, the Supplier may request the United States to enter into such litigation to protect the interests of the United States.
7. The Supplier assures that, in the performance of its obligations under this Term of Award, it will fully comply with the requirements of 14 CFR Part 152, Subpart E (Non-Discrimination in Airport Aid Program), as amended from time to time, to the extent applicable to the Supplier, to ensure, among other things, that no person will be excluded from participating in any activities covered by such requirements on the grounds of race, creed, color, national origin, or sex. The Supplier, if required by such requirements, will provide assurances to the Authority that the Supplier will undertake an affirmative action program and will require the same of its subconsultants.

D. Compliance
1. Supplier shall be subject to and in compliance with all Rules and Regulations, Policies, Standard Procedures and Operating Directives of the Authority.
2. Supplier shall have in its possession all applicable permits or licenses that may be required by federal, state, or local law to furnish goods, materials, machinery, apparatus or services required under the scope of this Term of Award.
3. Supplier shall be subject to and in compliance with all federal, state, or local law in the performance of this Term of Award.

E. Accounting Records and Audit Requirements
1. Books and Records
   In connection with payments to Supplier under this Term of Award, it is agreed Supplier will maintain full and accurate books of account and records customarily used in this type of business operation, in conformity with Generally Accepted Accounting Principles (GAAP). Supplier will maintain such books and records for five years after the end of this Term of Award. Supplier will not destroy any records related to this Term of Award without the express written permission of the Authority.
2. Financial Reports
   Supplier will submit all financial reports required by Authority, in the form and within the time period required by Authority.

3. Authority Right to Perform Inspections, Audits, or Attestation Engagements

   At any time or times during the term of this Term of Award or within two years after the end of this Term of Award, Authority, or its duly authorized representative, will be permitted to inspect (at the Authority's expense) Supplier's records directly pertaining to Supplier's performance under this Award (the "Records") for the sole purpose of determining compliance with this Term of Award and to request annual attestations of compliance with any or all terms of the Award. When conducting an inspection, Supplier will grant Authority reasonable access to examine the Records and Supplier's processes, facilities and systems for compliance with the terms of this Award. Except as otherwise permitted by law, the parties agree that: (a) such inspection may only occur during normal business hours at the Florida locations where Supplier's personnel provide

Services or retain such Records or remotely through electronic means if available, and only after 20 business days' advance notice; (b) inspections will be conducted in a manner that is designed to minimize any adverse impact on normal business operations; and (c) any Records accessed by Authority in the performance of any such inspection will be deemed to be the Confidential Information of Supplier unless otherwise required by applicable law or court order.

Supplier agrees to deliver or provide access to all records requested by Authority auditors within fourteen (14) calendar days of the request. The parties recognize that Authority will incur additional costs if records requested by Authority auditors are not provided in a timely manner and that the amount of those costs is difficult to determine with certainty. Consequently, the parties agree that Authority may assess liquidated damages in the amount of one hundred dollars ($100) per day for each record requested that is not received. Such damages may be assessed beginning on the fourteenth (15th) day. Accrual of such damages will continue until specific performance is accomplished. If as a result of any engagement, it is determined that Supplier has overcharged Authority in Premium Payments, Supplier will re-pay Authority for such overcharge and the Authority may assess interest of up to twelve percent (12%) on the overcharge from the date the overcharge occurred. If it is determined that Supplier has overcharged Authority by more than three percent of the reimbursable amount, excluding any lump sum amount, contained in this Term of Award, Supplier will also pay for the entire cost of the engagement.

Supplier agrees to comply with Section 20.055(5), Florida Statutes, and to incorporate in all subcontracts the obligation to comply with Section 20.055(5), Florida Statutes. Supplier will include a provision providing Authority the same access to business records at the subconsultant and subcontractor level in all of its subconsultant and subcontractor agreements executed related to this Term of Award. The requirements of this provision are applicable to subcontractors engaged by Supplier to provide dedicated services to the Authority under this Term of Award.

F. Applicable Law and Venue

This Term of Award will be construed in accordance with the laws of the State of Florida. Venue for any action brought pursuant to this Term of Award will be in the Circuit Court of Hillsborough County, Florida, or in the Tampa Division of the U.S. District Court for the Middle District of Florida. Supplier hereby waives any claim against Authority, and its officers, Board members, agents, or employees, for loss of anticipated profits caused by any suit or proceedings directly or indirectly attacking the validity of this Term of Award or any part hereof, or by any judgment or award in any suit or proceeding declaring this Term of Award null, void, or voidable, or delaying the same, or any part hereof, from being carried out.

G. Dispute Resolution

1. Dispute Resolution
    a. A claim is a written demand or assertion by one of the parties seeking, as a matter of right, an adjustment or interpretation of this Term of Award, payment of money, extension of time or other relief with respect to the terms of this Term of Award. The term claim also includes other matters in question between Authority and Supplier arising out of or relating to this Term of Award. The responsibility to substantiate claims will rest with the party making the claim.
    b. If for any reason Supplier deems that additional cost or time is due to Supplier for work not clearly provided for in this Term of Award, or previously authorized changes in the work, Supplier will notify Authority in writing of its intention to claim such additional cost or time. Supplier will give Authority the opportunity to keep strict account of actual cost and/or time associated with the claim. The failure to give proper notice as required herein will constitute a waiver of said claim.
    c. Written notice of intention to claim must be made within ten (10) days after the claimant first recognizes the condition giving rise to the claim or before the work begins on which Supplier bases the claim, whichever is earlier.

d. When the work on which the claim for additional cost or time is based has been completed, Supplier will, within ten (10) days, submit Supplier's written claim to Authority. Such claim by Supplier, and the fact that Authority has kept strict account of the actual cost and/or time associated with the claim, will not in any way be construed as proving or substantiating the validity of the claim.
e. Pending final resolution of a claim, unless otherwise agreed in writing, Supplier will proceed diligently with performance of this Term of Award and maintain effective progress to complete the work within the time(s) set forth in this Term of Award.
f. The making of final payment for this Term of Award may constitute a waiver of all claims by Authority except those arising from:
(1) Claims, security interests or encumbrances arising out of this Term of Award and unsettled;
(2) Failure of the work to comply with the requirements of this Term of Award;
(3) Terms of special warranties required by this Term of Award;
(4) Latent defects.

2. Resolution of Claims and Disputes
a. Authority will review claims and may (1) request additional information from Supplier which will be immediately provided to Authority, or (2) render a decision on all or part of the claim. Authority will notify Supplier in writing of the disposition of the claim within 21 days following the receipt of such claim or receipt of the required additional information.
b. If Authority decides that the work relating to such claim should proceed regardless of Authority disposition of such claim, Authority will issue to Supplier a written directive to proceed. Supplier will proceed as instructed.

H. Conflict of Interest
Prior to doing business with the Authority and throughout this Term of Award, the Supplier shall notify the Authority if any Supplier's corporate officer or member is related to an Authority employee or member of the Authority Board of Directors.

I. Compliance with Public Records Law
IF THE SUPPLIER HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE SUPPLIER'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS PURCHASE ORDER, CONTACT THE CUSTODIAN OF PUBLIC RECORDS AT (813) 870-8721, ADMCENTRALRECORDS@TAMPAAIRPORT.COM, HILLSBOROUGH COUNTY AVIATION AUTHORITY, P.O.BOX 22287, TAMPA FL 33622.

Supplier agrees in accordance with Florida Statute Section 119.0701 to comply with public records laws including the following:
1. Keep and maintain public records required by Authority in order to perform the services contemplated by this Term of Award.
2. Upon request from Authority custodian of public records, provide Authority with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119 Fla. Stat. or as otherwise provided by law.
3. Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of this Term of Award and following completion of this Term of Award.
4. Upon completion of this Term of Award, keep and maintain public records required by Authority to perform the services. Supplier shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to Authority, upon request from Authority custodian of public records, in a format that is compatible with the information technology systems of Authority.

The Supplier specifically waives any claims against the Authority related to the disclosure of any materials if made under a public records request.

Aetna Life Insurance Company

151 Farmington Avenue
Hartford, CT 06156

Stop Loss insurance policy

This **policy** is made by and between **Aetna Life Insurance Company** (**Aetna**) and

[ABC Entity] (**policyholder**)

Policy number:
Policy effective date:
State of issuance:
Date of issuance:

Welcome to **Aetna**. This is your Stop Loss **policy**, including the *Stop Loss Application and Schedule of Insurance*. This **policy** replaces any Stop Loss **policies** previously provided and may have riders or amendments added that alter the coverage.

Throughout the **policy**:

- "You" and "your" mean the **policyholder**
- "Us," "we," and "our" mean **Aetna**
- Words in **bold** are defined in the *Glossary* section

This **policy** is underwritten by **Aetna** and governed by applicable federal law and the laws of the state of issuance shown above.

The **policy** is issued based on the **policyholder's** signed *Stop Loss Application and Schedule of Insurance*, the *Disclosure* statement, if required, and premium payments made in compliance with the terms stated in this **policy**. In return, **Aetna** agrees to pay the **policyholder** for **eligible claim expenses** for benefits covered by the self-insured **plan(s)** and exceeding the Stop Loss coverage amounts, in accordance with the *Stop Loss Application and Schedule of Insurance*, terms, and conditions of the **policy**.

All periods of coverage begin at 12:00 a.m. and end at 11:59 p.m. local time for the principal location of the **policyholder**.

Signed at **Aetna's** home office, 151 Farmington Ave, Hartford, CT 06156.

Karen S. Lynch
President, Aetna Life Insurance Company

Angela Woodard
Director, Insurance and Risk Management

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The policy

The entire policy

This Stop Loss **policy** is [non-]participating. It consists of the following documents:

- Your signed *Stop Loss Application and Schedule of Insurance*
- A signed *Disclosure*, if required
- This **policy**
- Any riders or amendments to the **policy**
- A copy of the self-insured **plan** document(s) for each benefit **plan** covered by this **policy**

A non-participating **policy** is one that you do not share (do not participate) in any surplus earnings or profit made by us. A participating **policy** is one that you share (participate) in any surplus earnings or profit made by us.

Your *Stop Loss Application and Schedule of Insurance*

We relied on your answers to all questions in the process to request coverage when we issued the **policy** to you. It is your responsibility to make sure the *Stop Loss Application and Schedule of Insurance* is accurate and complete. It is important that you notify us immediately of any mistakes that you find in your *Stop Loss Application and Schedule of Insurance*.

By applying for coverage under this **policy** and accepting its benefits, you (or the person acting for you):

- Represent that all information in your *Stop Loss Application and Schedule of Insurance* and statements given to us as part of your process to request coverage under this **policy** are true, correct and complete, to the best of your knowledge and belief
- Agree to all terms, conditions and provisions of the **policy**

If we learn that you, your **agent**, or a **covered person** defrauded us or misrepresented or omitted material facts when providing us information in the *Stop Loss Application and Schedule of Insurance*, *Disclosure*, application process, or submission requesting coverage, we may cancel the **policy**. We may also report fraud to criminal authorities. See the *Fraud, deception, or misrepresentation* section of this **policy** for more information.

Effective date

Coverage under this **policy** is not effective until:

- We have received, examined, and accepted your **plan** document(s) and all other information relevant to underwriting or premium rating, whether or not specifically requested
- We have received, examined, and accepted your signed *Disclosure* statement, if applicable
- We have received the signed *Stop Loss Application and Schedule of Insurance*
- We have received your first premium payment

Conformity with law

In the event of a conflict or apparent conflict between or among the terms and provisions of this **policy** and applicable laws of the state of issuance or federal law, the provisions in this **policy** will be given their broadest interpretation in order to reconcile the conflict or apparent conflict. If an interpretation is not possible and any provision in this **policy** conflicts with any applicable law of the state of issuance or federal law, the provision is amended to conform to the minimum requirements of the law.

Severability
Any provision or condition of this **policy** deemed void, voidable, invalid, or otherwise unenforceable does not make any of the remaining provisions of this **policy** invalid.

Incontestability
We can take legal or other action, using statements made in signed applications, disclosures, or other documents by you, your **agent**, or any **covered person**, during the first 2 years after the **policy effective date**. However, in the event of fraud, we may take legal or other action at any time as permitted by applicable law.

The validity of this **policy** will not be contested, except for non-payment of premium, after it has been in force for 2 years from the **policy effective date**.

Policy changes
Modifications
This **policy** may be changed in whole or in part. Any change will be valid upon approval, in writing, by an officer of **Aetna**. The approved change must be endorsed and made part of this **policy**. No other person or entity has the authority to alter this **policy** in any manner.

When your consent is needed, payment of premium by the **effective date** of any change will be considered as your consent.

Waiver
Only an officer of **Aetna** may waive a requirement of the **policy**. No waiver will be valid unless it is endorsed and made a part of the **policy**.

We may fail to implement or enforce compliance with a provision of the **policy** at any given time or under any circumstance. Our failure to do so is not a waiver of our right to implement or enforce compliance with that provision at any other time or under the same or different circumstances.

Right to recalculate
Aetna has the right to recalculate premium rates and Stop Loss factors for each **policy renewal date**.

Aetna also reserves the right to change the premium rate or any **aggregate Stop Loss factor** as of the date of any change to the underlying assumptions or information that impacts the risk assumed for the insurance we are providing under the **policy** or if the change affects the initial underlying assumptions made, as of the **effective date** of coverage. Changes include, but are not limited to:

- Any change of +/- 15% in **employees** or **covered units**
- Any change to the **plan** document(s) that will change the risk assumed under this **policy**
- Any change to this **policy**
- Any addition or deletion of a unit, division, subsidiary, affiliated or associated company from this **policy**
- Any change in federal or state law or regulation that impacts this **policy** or the coverage provided
- Any change impacting the risk we have assumed, including but not limited to: age, gender, geography, occupation, incorrect or incomplete information provided in *Disclosure* statements, etc., that we determine impacts the nature of the risk by more than 15%
- Any change in **claims administrator**, provider network or cost containment vendor, provided we have consented to the change in writing

- Any change in the **claims administrator's** claim payment system or payment practices that causes a variation of +/- 5% versus the most recent 12 month average of claims processing time

Any failure by **Aetna** to adjust any premium rate or Stop Loss factor during a **policy period** will not prohibit us from making an adjustment during any subsequent **policy period**.

Changes to the plan

This section is applicable if **Aetna** is not your **claims administrator**, network provider, or cost containment vendor for any **covered benefit**. **Aetna** has the right to approve any change to the **plan** if the change impacts the **eligible claim expenses** or assumptions under this **policy**.

You must notify us promptly, in writing, at least 30 days before the **effective date** of any **plan** change or change in **claims administrator**, provider network, or cost containment vendor. **Aetna's** prior written agreement is required before the coverage under the **policy** will apply to the changes. Otherwise, benefits under the **policy** will be paid based on the **plan** as it existed when last approved by **Aetna**, and **Aetna** reserves the right to terminate the **policy** upon discovery of such change.

Fraud, deception, or misrepresentation

Aetna pursues all appropriate and available legal remedies in the event of insurance fraud.

The decision to issue this **policy** to you, as well as the premium rates and any Stop Loss factors associated with it, are based on information provided by you, a **covered person**, your **agent**, or **claims administrator**. If we learn that you or anyone acting on your behalf defrauded us or misrepresented or omitted material facts that we relied upon in the decision to issue this **policy** at the coverage levels and premium rates identified in this **policy**, we reserve the right to take actions that can have serious consequences for your coverage. Any behaviors on your part include, but are not limited to:

- Filing a false claim
- Providing false, incomplete, or misleading information during the underwriting process

Potential serious consequences include, but are not limited to:

- Denial of claims
- Recalculation of premium rates or redetermination of the terms and conditions of this **policy**
- Termination of this **policy**, including retroactively back to its **effective date**
- Recovery of amounts we have already paid
- Prosecution to the full extent under state and federal law

Bankruptcy

Other than the liability required by this **policy**, we are not liable to you, your **plan**, or your **claims administrator** for:

- Bankruptcy
- Insolvency
- Financial impairment
- Receivership
- Voluntary plan of arrangement with creditors
- Your dissolution or the dissolution of your designated **claims administrator(s)** and/or vendor(s)

Your insolvency will not make **Aetna** liable to your creditors, including **covered persons** under the **plan**. In the event of your insolvency or bankruptcy, subject to the terms and conditions of this **policy**, we may pay to your receiver, trustee,

liquidator or legal successor amounts otherwise payable to you under this **policy**. We will make payments only if you have paid all required premiums and have complied with your obligations under this **policy**. Nothing in this section increases our liability beyond what would have existed had you not become insolvent or bankrupt.

What is covered

Aetna will reimburse you for **eligible claim expenses** paid under the **plan** and according to the coverage levels and features indicated in the *Stop Loss Application and Schedule of Insurance* and the terms and conditions of this **policy**.

Individual Stop Loss

If the *Stop Loss Application and Schedule of Insurance* indicates an **individual Stop Loss amount** is included under this **policy**, we will pay you the amount that a **covered person's** total **eligible claim expenses** exceed the **individual Stop Loss amount** during the **policy period**, adjusted for any **contract type**, if applicable. The amount payable will also be adjusted by any applicable individual coinsurance percentage, **family individual Stop Loss amount**, or aggregating specific Stop Loss amount. The total amount payable is also subject to any **maximum annual individual Stop Loss payment amount** or **individual lifetime Stop Loss payment amount**, as indicated on the *Stop Loss Application and Schedule of Insurance*.

If the *Stop Loss Application and Schedule of Insurance* indicates an **IOE transplant Stop Loss amount** is included under this **policy**, we will pay you the amount that a **covered person's** total **eligible claim expenses** exceed the **IOE transplant Stop Loss amount** during the **policy period**, adjusted for any **contract type**, if applicable. The amount payable will also be adjusted by any individual coinsurance percentage, **family individual Stop Loss amount** or aggregating specific Stop Loss amount. The total amount payable is also subject to any **maximum annual individual Stop Loss payment amount** or **individual lifetime Stop Loss payment amount**, as indicated on the *Stop Loss Application and Schedule of Insurance*.

A **high risk individual Stop Loss amount** may be assigned to any **high risk covered person** during the underwriting process for any **policy period**, in accordance with the terms and provisions of this **policy** and as indicated in the *Stop Loss Application and Schedule of Insurance*.

If individual Stop Loss coverage terminates before the end of the **policy period**, the **individual Stop Loss amount** will not be reduced.

Individual coinsurance percentage

Once the **individual Stop Loss amount** or **IOE transplant Stop Loss amount** is met for a **covered person**, we will pay you the percentage of **eligible claim expenses** as indicated on the *Stop Loss Application and Schedule of Insurance*.

Aggregating specific amount

As indicated on the *Stop Loss Application and Schedule of Insurance*, the aggregating specific amount is an optional Stop Loss feature that adds to your liability by providing a second amount (the aggregating specific amount) that must be met before **eligible claims expenses** are reimbursed under individual Stop Loss coverage. **Eligible claim expenses** in excess of the **individual Stop Loss amount** for any **covered person** are added together until the cumulative total equals the aggregating specific amount. Once the aggregating specific amount is met, whether by one or multiple **covered persons**, it is considered satisfied for the **policy period**.

When you elect this feature, we will not pay an individual Stop Loss benefit until you have also met the aggregating specific Stop Loss amount. **Eligible claim expenses** used to satisfy the aggregating specific Stop Loss amount will apply toward the **aggregate Stop Loss corridor**.

Aggregate Stop Loss

If the *Stop Loss Application and Schedule of Insurance* indicates aggregate Stop Loss is included under this **policy**, we will pay you the amount that total **eligible claim expenses** exceed the **aggregate Stop Loss corridor** during the **policy period**

adjusted for any **contract type,** if applicable. The amount payable will be reduced by any **eligible claim expenses** exceeding any:

- **Individual Stop Loss amount**
- **IOE transplant Stop Loss amount**
- **High risk individual Stop Loss amount**
- **Individual internal limit**
- Other provision of this **policy**, as applicable

The total amount payable is also subject to the **minimum aggregate Stop Loss amount** and any **maximum annual aggregate Stop Loss payment amount**, as indicated on the *Stop Loss Application and Schedule of Insurance*.

Stop Loss reimbursements

Aetna will make Stop Loss reimbursements due under the terms of this **policy** and according to the **contract type** indicated on the *Stop Loss Application and Schedule of Insurance*. If **Aetna** is not your **claims administrator**, we will reimburse you after satisfactory proof of loss is submitted by you or your **claims administrator**, according to the conditions and provisions of this **policy**.

Aetna has the right to deduct any due but unpaid premium that would otherwise be payable by you from any Stop Loss reimbursement. This right will not prevent the termination of this **policy** for non-payment of premium in accordance with the *Termination* section of this **policy**.

Any **eligible claim expense** that is reimbursable under this **policy** due to exceeding the individual, aggregate, or any other Stop Loss amounts, and that is also funded as a reimbursable **eligible claim expense** under another Stop Loss policy:

- Is not eligible for reimbursement under this **policy**
- Must be repaid to us if we previously reimbursed it

[**Immediate reimbursement**

Benefits

Immediate reimbursement is only available when **Aetna** is the **claims administrator** for your **plan**. If you purchase individual Stop Loss coverage, **eligible claim expenses** that exceed the **individual Stop Loss amount** under this **policy** may be reimbursed on an immediate funding basis. Availability of immediate funding for individual Stop Loss reimbursements is dependent upon the **individual Stop Loss amount** and other **policy** features that you select. You will be notified by us, in writing, before the **effective** or **renewal date** if the coverage you have selected is not eligible for immediate reimbursement.

Immediate reimbursement is provided subject to the following terms and conditions:

- Essential legal documents of the **policy** must be fully executed by all applicable parties and on file with us
- Only **covered benefits** that **Aetna** administers are eligible
- The coverage levels and **policy** features selected by you must be available (i.e. system-supported) for immediate reimbursement
- **Eligible claim expenses** must exceed the **individual Stop Loss amount** and any other applicable Stop Loss amount available under individual coverage before any individual Stop Loss payment will be made

Certain claims are not eligible for immediate reimbursement. These include, but are not limited to:

- Claims paid by a third party **claims administrator**
- **Eligible claim expenses** paid outside of system-supported claim processing procedures

- Run-in claims and, under certain circumstances, run-out claims (i.e. coverage crossing multiple reimbursement periods and/or **policy periods**)
- **Eligible claim expenses** that exceed the **individual Stop Loss amount** and paid during a terminal liability period

Immediate reimbursement is not a guarantee of coverage. After the end of each **policy period**, as adjusted for any **contract type**, we will perform a reconciliation to verify all individual Stop Loss reimbursements were made in accordance with the terms of the **policy**.]

[**Monthly budget feature**

When **Aetna** is the **claims administrator** of your **plan** and you purchase aggregate Stop Loss coverage under this **policy**, the monthly budget feature provides protection against monthly claim fluctuations by applying a monthly cap on **eligible claim expenses**. The **aggregate Stop Loss corridor** is converted to a monthly cash flow limit, based on enrollment and the number of **policy months** in your **policy period**. If your cumulative **eligible claim expenses** exceed the **aggregate Stop Loss corridor** for the month, the monthly budget feature operates as follows:

- From the monthly cash flow limit, **eligible claim expenses** that you paid during the month are subtracted:
  - If the **eligible claim expenses** that you paid during the month are less than the monthly cash flow limit, the unused cash flow limit is carried forward to the next month to fund future **eligible claim expenses** that you pay.
- If the **eligible claim expenses** that you paid during the month exceed the cumulative monthly cash flow limit, the amount over the limit is funded by **Aetna** and recovered in future months when **eligible claim expenses** are less than the monthly cash flow limit.
- If at any time during the **policy period**, the **eligible claim expenses** exceed the total **aggregate Stop Loss corridor**, we will fund any **eligible claim expenses** in excess of the **aggregate Stop Loss corridor**, up to any **maximum annual aggregate Stop Loss payment amount** indicated on the *Stop Loss Application and Schedule of Insurance*.
- In no event can the **aggregate Stop Loss corridor** be less than the **minimum aggregate Stop Loss amount** as indicated in the *Stop Loss Application and Schedule of Insurance*. This includes a mid-year **plan** termination.

The monthly budget feature is provided subject to the following terms and conditions:

- Essential legal documents must be fully executed by all applicable parties and on file with us
- Only **covered benefits** for which **Aetna** is the **claims administrator** are eligible
- The coverage levels and **policy** features selected by you must be available (i.e. system-supported) for the monthly budget feature to apply

Certain claims are not eligible for the monthly budget feature. These include, but are not limited to:

- Claims paid by a third party **claims administrator**
- **Eligible claim expenses** paid outside of system-supported claim processing procedures
- Run-in claims and, under certain circumstances, run-out claims (i.e. coverage crossing multiple reimbursement periods and/or **policy periods**)
- **Eligible claim expenses** paid during a terminal liability period

After the end of each **policy period**, as adjusted for any **contract type,** we will perform a reconciliation to verify any Stop Loss reimbursements were made in accordance with the terms of the **policy**.]

[Terminal liability option

Benefits

If you purchase terminal liability coverage prior to the **effective date** of the **policy period**, as indicated on the *Stop Loss Application and Schedule of Insurance*, you may exercise it by providing us with 30 days written notice prior to termination of the **policy**, unless the **policy** terminates for non-payment of premium. We will insure you for **eligible claim expenses**:

- **Incurred** under the **plan** by **covered persons** during the **policy period** immediately prior to termination of the **policy** and in excess of the applicable **aggregate** and **individual Stop Loss amounts**.
- When benefits are paid during the [3 month] period following termination of the **policy**. This period following termination when we will pay benefits is referred to as the terminal liability period.

The amount of any terminal liability premium due but unpaid may be deducted from any Stop Loss payment otherwise owed to you.

Special provisions

When **Aetna**:

- Is your **claims administrator**, the terminal liability option may only be exercised if **Aetna** continues to administer run-out claims for the **plan** during the terminal liability period
- Is not your **claims administrator**, the terminal liability option may only be exercised if your current **claims administrator(s)** indicated in the *Stop Loss Application and Schedule of Insurance* continues to administer run-out claims for the **plan** during the terminal liability period

When you choose to exercise the terminal liability option:

- **Eligible claim expenses** will continue to accrue towards the **individual Stop Loss amount** through the [3 month] period following termination of the Stop Loss **policy**.
- The **aggregate Stop Loss corridor** will be increased to include an additional amount to cover the terminal liability period. The amount of this increase will be calculated of the product of three factors:
  - The number of **employees** or **covered units** on the first day of the last **policy month**, times [2], times the terminal liability Stop Loss factor indicated in the *Stop Loss Application and Schedule of Insurance*.
  - This additional amount will be added to the **aggregate Stop Loss corridor**, and the sum will be subject to the **minimum aggregate Stop Loss amount** indicated in the *Stop Loss Application and Schedule of Insurance*.
- Premium for the terminal liability period, in addition to any past due premium, is due by the date of termination of the **policy**. This premium will be calculated as the product of three factors:
  - The monthly terminal liability premium rate indicated in the *Stop Loss Application and Schedule of Insurance*, times the number of **employees** or **covered units** on the first day of the last **policy month**, times [2].

Limitations

- The terminal liability option may only be exercised if at least 4 **policy months** have elapsed in the **policy period**.]

[Experience refund option

Benefits

In consideration of additional premium included in the premium rate indicated on the *Stop Loss Application and Schedule of Insurance*, **Aetna** will refund individual Stop Loss premium to you in accordance with the terms and conditions indicated below and in the *Stop Loss Application and Schedule of Insurance*.

Experience refund calculation

For the experience refund period, any experience refund will be calculated as the net individual Stop Loss premium, times the refund shared, times the difference of the loss ratio threshold, less the actual loss ratio, up to a maximum refund payable of 15% of the net individual Stop Loss premium. If the actual loss ratio for individual Stop Loss coverage is greater than the loss ratio threshold, no experience refund is payable.

If the experience refund period is longer than a single 12 month **policy period**, a preliminary reconciliation will be calculated at the end of each 12 month **policy period** included in the experience refund period, based on the calculation above. When this occurs, 20% of any refund payable to you under any preliminary reconciliation will be held by us until reconciliation of the entire experience refund period occurs.

For the experience refund calculation above:

- The loss ratio threshold is the maximum percentage below which an experience refund may be payable for the experience refund period and indicated on the *Stop Loss Application and Schedule of Insurance*.
- The experience refund period is the continuous period of time indicated on the *Stop Loss Application and Schedule of Insurance* that the individual Stop Loss experience will be used to determine if a refund is payable.
- The refund share is the proportion of the individual Stop Loss experience below the loss ratio threshold that is payable to you and indicated on the *Stop Loss Application and Schedule of Insurance*.
- The net individual Stop Loss premium is the total individual Stop Loss premium paid by you for the experience refund period less:
  - Any commissions included in the premium.
  - Any premium adjustment applied to the experience period's premium rate in lieu of any **individual Stop Loss amount** specific to a certain **covered person(s)**, as indicated in the *Stop Loss Application and Schedule of Insurance*.
- The actual loss ratio for the experience refund period equals the individual Stop Loss claims paid by us, divided by net individual Stop Loss premium paid by you. Total claims will be reduced by any individual Stop Loss claims for any **covered person** where a premium adjustment is reflected in the premium rate and where the premium adjustment was excluded in the calculation of net individual Stop Loss premium for that experience refund period.

Experience refund payment

At our option, any refund payment due to you will be made either by check, as a premium credit applied to the next available premium due, or both.

Special provisions

If an experience refund is due, we will pay you the due amount assuming each of the following is true:

- We offer you a renewal and you renew the **policy** with us for at least 12 months
- You remain continuously insured with us until the date that we are obligated to calculate whether an experience refund is due
- You are not late in making any Stop Loss premium payment due on or before the date we are obligated to calculate whether or not there is an experience refund
- You are in compliance with all other terms and conditions of this **policy**

If any individual Stop Loss claims related to a **policy period** that an experience refund has already been made to you are paid, the experience refund will be recalculated for that experience refund period. If there is a resulting reduction in the experience refund, you will reimburse us for any due amount within 30 days after receiving written notice from us. We may, at our option, be reimbursed for any reduction on a previously-paid experience refund by subtracting the reduced amount due from any future payable claim.

The inclusion of experience refund coverage classifies this as a participating **policy**.]

[Deficit recoup provision

Benefits

If the *Stop Loss Application and Schedule of Insurance* indicates a deficit recoup provision is included under this **policy**, we may exercise the deficit recoup at the end of any **policy period** and/or upon termination of the **policy**. This applies whenever there is a cumulative deficit and a surplus in the **aggregate Stop Loss corridor**:

- At the end of the current **policy period**
- At termination of this **policy**
- At termination of the aggregate Stop Loss coverage under this **policy**
- At termination of the deficit recoup provision under this **policy**

Calculation and payment

You will reimburse us when a cumulative deficit from prior **policy periods** exists and there is a surplus in the current **policy period.** The deficit recoup will be the lesser of the cumulative deficit or the amount of the surplus, where:

- A deficit is calculated as the amount we have reimbursed you for **eligible claim expenses** in excess of the **aggregate Stop Loss corridor** during the **policy period**. In no event will the deficit amount exceed 5% of the **aggregate Stop Loss corridor** in any **policy period**.
- A cumulative deficit is calculated as the sum of all previous **policy periods'** deficits less any deficit recoup payments previously made by you to us.
- A surplus is calculated as the amount that the **aggregate Stop Loss corridor** exceeds the total **eligible claim expenses** in a **policy period**.

[Upon termination of this Stop Loss **policy**, the aggregate Stop Loss coverage under the **policy** or the aggregate deficit recoup provision of the **policy**, in addition to any deficit recoup amount calculated above, you will owe a percentage of the cumulative deficit to us, in accordance with the following schedule:

Termination schedule

Termination on or prior to the end of:	**Percentage of total deficit owed:**
First **policy period**	75%
Second **policy period**	50%
Third **policy period**	25%
Fourth **policy period** or later	0%]

Special provisions

A deficit recoup payment must be made by you to us within 30 days written notice to you of the deficit recoup amount. We may reduce any other payment due to you under this **policy** by the amount of any deficit recoup payment due and unpaid.]

What is not covered – exclusions and limitations

This section outlines what is not covered as an **eligible claim expense** under this **policy**.

Exclusions related to eligibility and enrollment

- Expenses paid for an **employee**, **covered unit**, and any associated dependents that did not enroll according to the terms of the **plan** until they are enrolled in accordance with the terms of the **plan**.
- Expenses **incurred** by any individual who is not a **covered person** under the **plan** when the expense is **incurred**.
- Expenses paid for **covered persons** of a unit, division, subsidiary, affiliate, or associate company added after the **effective date** of this **policy** unless approved in writing by us prior to their **effective date** of coverage under the **plan**.
- [Expenses paid under the **plan** for your covered retirees and associated dependents as indicated on the *Stop Loss Application and Schedule of Insurance*.]
- Expenses paid for a **covered person** following termination of coverage under the **plan** for any class, unit, or division of participants that includes the **covered person** and any associated dependents.
- Expenses **incurred** by a late Consolidated Omnibus Budget Reconciliation Act (COBRA) enrollee. Except for a clerical error as described in the *General provisions* section of this **policy**, the **policy** will exclude any claim expenses for a **covered person** whose eligibility for, or coverage under, COBRA is continued beyond the timeframes specified by federal law for any reason including your clerical error. This exclusion includes those individuals who:
  - Do not receive a valid COBRA extension offer from you, in accordance with federal law, within the 30 days immediately following a COBRA qualifying event
  - Fail to make a valid, signed COBRA election within the 60 days immediately following the receipt of COBRA election rights from you
  - Fail to make COBRA premium payments within the time period specified by federal law

  We may require written documentation that these requirements have been satisfied.
- [For persons who become eligible for coverage under the **plan** after the **effective date** of this **policy**, expenses paid for a pre-existing condition during the first consecutive 365 days following the **covered person's** enrollment date under the **plan**. A pre-existing condition is an injury or illness a **covered person** sustained during the 90 days immediately prior to the most recent enrollment date under the **plan** where treatment or services were received or drugs or medicines were prescribed. This exclusion will not apply to:
  - Any **employee**, **covered unit**, or dependent who becomes a **covered person** after the **effective date** of this **policy** when expenses were paid under the **plan** in accordance with our current standard underwriting practices established for applying pre-existing condition limitations to accident and health insured **plans** per the Health Insurance Portability and Accountability Act (HIPAA), Public Law No. 104-191
  - A dependent child to the extent required by a Qualified Medical Child Support Order as defined by Section 609(a) of ERISA
  - An adopted child to the extent required by Section 609(c) of ERISA
  - The first $4,000 of benefits paid under the **plan** in connection with a pre-existing condition]
- [Expenses in connection with an injury or illness that exists at any time while a **covered person** who is a dependent of an **employee** or **covered unit** is confined at home, in a hospital or elsewhere on the **effective date** of this **policy**, or who has been confined in a hospital during the 30 days prior to that date, until they have been free from confinement for a 30 day period. This exclusion will not apply to:
  - A child to the extent required by a Qualified Medical Child Support Order as defined by Section 609(a) of ERISA, for as long as the Order is in force
  - An adopted child to the extent required by Section 609(c) of ERISA
  - A child born on or after the **effective date** of this **policy** who becomes covered under the **plan** within 30 days after he or she is eligible]

- [Expenses paid for an injury or illness that exists at any time while the **employee** or **covered unit** is either injured or ill and away from work on the **effective date** of this **policy**, until the date the **employee** returns to full-time work for one full day.]

Exclusions related to plan administration

- Costs related to the administration of the **plan** including, but not limited to:
  - Claim payment functions
  - Cost containment administrative fees
  - Large case management
  - Audit
  - Negotiation
  - PPO access fees
  - Premium functions
  - Claim review
  - Consultant fees

  [However, this exclusion will not apply to the first 30% of cost savings for out-of-network claims or hourly charges for the above services and these fees will be limited to $25,000 per covered person per policy period.]
- Costs associated with extra-contractual damages, compensatory damages or punitive damages assessed against you.
- Legal expenses, court costs, or interest upon judgments.
- Expenses for taxes, fees, assessments and surcharges that may be assessed on claims under the **plan** by any government body. This exclusion does not apply to the MA Uncompensated Care Pool, Minnesota Care Provider Tax, or New York Health Care Reform Act surcharges unless the surcharge relates to excess or punitive payments made on behalf of you to fund indigent care and graduate medical education solely as a result of your decision not to pay directly into the pool.

Exclusions related to claim administration

- Expenses paid by you or the **claims administrator** that are **incurred** prior to the **effective date** of this **policy** unless otherwise indicated in the *Stop Loss Application and Schedule of Insurance*.
- Expenses for drugs or medications, treatment, services or supplies that are considered **experimental or investigational**, and any service or treatment resulting from complications of **experimental or investigational** treatment.
- Expenses paid for services, medications, or supplies that are not **medically necessary**, and any service or treatment resulting from related complications.
- Expenses resulting from treatment provided outside the United States, and any service or treatment resulting from related complications, unless approved by us in writing before the service is provided.
- [Expenses associated with a **transplant**.]
- Expenses paid at your direction but that we determine are not payable under the **plan**, in accordance with our current established claim practices or in excess of the **reasonable and customary** charge.
- Expenses resulting from capitation payments, defined as contractually determined, regularly-scheduled payments to certain providers based on the number of **plan** participants entitled to receive services from that provider. In return, the providers provide certain agreed-upon services to eligible **plan** participants.
- Incentive payments, care coordinator payments, risk share payments, and other non-fee-for-service payments paid or received in connection with an agreement with an accountable care or similar provider organization.
- **Eligible claim expenses** not submitted to us within 6 months after the end of the **policy period**. If the *Stop Loss Application and Schedule of Insurance* indicates coverage under a terminal liability period, terminal reserve period, or **run-out period** associated with a specific **contract type**, the 6 month submission period will begin at the end of these periods.

- Expenses for claims not submitted to the **claims administrator** within 12 months of the date **incurred**.
- Expenses for benefits that are reimbursable under any under workers' compensation or a similar program under local, state, or federal law for any illness or injury related to employment or self-employment, even if the **covered person** fails to claim rights to those benefits.

General exclusions

- If you have valid and collectible insurance, reinsurance, indemnity, or any reimbursement agreements covering **eligible claim expenses** in excess of individual, aggregate, or aggregating specific amounts also covered by this **policy**, this **policy** is in excess of and will not contribute with the other insurance, reinsurance or indemnity.
- Expenses paid for any benefits not indicated on the *Stop Loss Application and Schedule of Insurance* as **covered benefits** under any applicable i**ndividual Stop Loss amount** or **aggregate Stop Loss corridor**.
- Expenses not **incurred** or paid within the **contract type** as indicated in the *Stop Loss Application and Schedule of Insurance*.
- Expenses paid according to changes or an amendment to the **plan** not agreed to in writing by us.
- Expenses not specifically covered under the terms of the **plan**.
- Expenses for any other benefits that you and we mutually agree will not be subject to the Stop Loss insurance as indicated in this **policy**.
- **Eligible claims expenses** paid or benefits that were originally denied by the **claims administrator** and are adjusted by the **claims administrator** more than 2 years after the original coverage determination date are not eligible for coverage under the **policy**.
- Expenses for a **covered person** if the **covered person's** medical conditions or claim information was not disclosed to us as part of the underwriting of this **policy** or upon request.
- Any expense that is determined to be fraudulent.

Premium

Premium – rates

The **policy period's** monthly premium rate is indicated in the *Stop Loss Application and Schedule of Insurance*.

Premium due – calculation

Premium:

- Will be calculated and payable on a monthly basis or any other basis you and we mutually agree upon
- Is based on the premium rate indicated in the *Stop Loss Application and Schedule of Insurance* and the number of **employees** or **covered units** covered at the time the invoice is prepared
- May be adjusted due to factors outlined in the *Right to recalculate* section

Premium due – how billed and paid

We may bill you electronically and you may pay premium due to us electronically. If you are not billed electronically, you must send your premium to us at the address shown on the invoice on or before the **premium due date**.

Payment occurs when we receive sufficient funds. A check does not constitute payment until it is honored by a bank. We may return a check issued against insufficient funds without making a second deposit attempt. We may accept a partial payment of premium without waiving our right to collect the entire amount due. Premium payments will be credited first to any past due and unpaid premium, in the order it is due.

We may choose not to accept premium that is paid for you by someone else unless we are required to by law.

If the total actual premium due (determined at the financial accounting) is less than the amount of premium paid, the difference will be paid to you at the time the accounting is provided to you. If the total actual premium due exceeds the amount paid, you must pay us the difference within 30 days of the date the accounting is provided to you.

Premium – when due

Premium is due on the **premium due date**.

You will pay all premium payments in U.S. dollars no later than the **premium due date**. If we have not received premium due by the due date, the **policy** will automatically terminate without further notice to you and all rights to benefits under this **policy** will end. Premiums will be due for any period the **policy** was in force. Refer to the *Termination* section of this **policy**.

Premium – insufficient funds and overdue amounts

A service charge may be assessed when there are insufficient funds to pay premium due.

If you don't pay your premium on time, we may charge you interest in the amount of 12% per annum on the amount that is overdue. Overdue premium includes amounts not paid by the **premium due date**. We may also recover from you the costs of collecting any unpaid premium, including reasonable attorney fees and costs of suit.

Aetna will reduce any payment due to you under this **policy** by:

- The amount of any premiums due and unpaid
- Any overpayments or other reimbursements made in error if incorrect information is received
- Any other amounts due to us

Termination

Automatic termination

This **policy** will terminate if:

- You have not paid us all premiums due. The **policy** and all coverage will automatically terminate on the last day of the period that premiums have been paid.
- The **plan** terminates. This **policy** will automatically terminate on the same date and time that the **plan** terminates.

Termination by the policyholder

You may terminate coverage under this **policy** effective on any **premium due date** by providing us at least 30 days advance written notice. The **policy** may also be terminated on any other date you and we agree to.

Termination by Aetna

We may terminate the **policy** and all coverage it provides under the following conditions:

- If you, your **agent**, or a **covered person** perform any act or practice that constitutes fraud or if you, your **agent**, or a **covered person** make any misrepresentation of, or any omission of, a material fact relevant to the coverage, we may cancel the **policy** and all coverage it provides, either prospectively or retroactively to the date the fraudulent event occurred or back to the **effective date** if the event occurred prior to the **effective date**. See the *Fraud, deception, or misrepresentation* section.
- If a **claims administrator**, network provider, or vendor is added, canceled, or changed without our prior written consent, we may terminate the **policy** as of the date of the change in **claims administrator**, network provider, or vendor.
- If the **plan** is changed and we have not agreed in advance and in writing to continue the **policy**, we may terminate the **policy** as of the date and time the **plan** change is effective.
- If you fail to pay claims under the **plan** or make available funds to pay claims as required by the **plan**, we may terminate the **policy** as of the first day that you failed to fund claims.
- If you fail to meet the underwriting requirements we have established in our current underwriting guidelines, including any applicable participation or contribution requirements, or fail to have a minimum 51 eligible **employees** or **covered units** under the **plan**, we may terminate the **policy** as of the first day of the first month when the underwriting requirement was not met.
- If you do not comply with or fail to meet your obligations under any material terms and conditions of the **policy**, including, but not limited to, providing required reports or other information we have reasonably requested from you that is related to our administration of the **policy**, we may terminate the **policy** as of the date you failed to comply.
- If you suspend active business operations, become insolvent, or are placed in bankruptcy or receivership, we may terminate the **policy** as of the date any of these occur.
- If there is any change in federal or state law or regulation that materially impacts this **policy** or the coverage provided, we may terminate the **policy** effective on the date the change in the law is effective.
- If you are an employer group and cease to be a group as defined under applicable state law, we may terminate the **policy** as of the date you no longer qualify as an employer group.

Non-renewal for failure to respond

We require you tell us if you intend to renew the **policy**. You must reply, in writing, within 2 weeks of your receipt of the request or within 15 days prior to the **renewal date**, whichever is later. If you do not reply, we will terminate coverage as of the **renewal date**.

Effective time of termination

The **policy** and its coverage end as of 11:59 p.m. local time at your principal location on the day of termination.

Effect of termination

Following termination, you and we continue to be responsible for duties we acquired prior to the termination of the **policy**. One of your duties includes payment of premium due for coverage up to the date of termination. We are required to continue paying you for coverage of **eligible claim expenses incurred** and paid under the **plan** prior to the **termination date**.

You and we also continue to be responsible for any duties that the **policy** states are to occur following termination.

If the **policy** terminates before the end of the **policy period**:

- The **contract type** under this **policy** is limited to **eligible claim expenses incurred** and paid up to the **termination date**
- The **individual Stop Loss amount** will not be reduced
- The **minimum aggregate Stop Loss amount** will not be pro-rated

Reinstatement

You may request that we reinstate the **policy** and coverage after we terminate it. You must make the request within 30 days of the **termination date**. We are not obligated to reinstate the **policy** as of the **termination date**. If we do, we will require you to pay all amounts due in full before reinstatement and give us reasonable assurances that you can and will fulfill all of your obligations under the **policy**.

Optional policy renewal

Unless the **policy** has terminated or is subject to termination in accordance with the *Termination* section on or before the end of the **policy period**, we may offer you a renewal. At that time, we have the right to revise the terms and conditions of the **policy**, including, but not limited to, premium rates, factors, and coverage levels by providing written notice to you. If you accept the renewal provisions, the **policy** will renew on the **policy renewal date**, subject to receipt of your acceptance in writing prior to the **renewal date**.

If you use a separate **claims administrator**, a renewal offer for this **policy** is contingent upon receipt of any requested **plan**, census, or claim information for use in the underwriting process prior to the beginning of the subsequent **policy period**.

Responsibility and conduct

Responsibility for our employees

We are responsible to you for what our employees and others that work on our behalf do as it pertains to Stop Loss coverage under this **policy**. If **Aetna** is also your administrator, any disputes regarding administration of the **plan** must be brought under the terms of the *Master Services Agreement*, which determines claims administration.

We are not responsible to you for what is done by others, commonly referred to as "independent contractors."

Appeals process

You may appeal any claim determination made by us under this **policy** by submitting a written appeal to: **Aetna**, 151 Farmington Avenue, Hartford, Connecticut 06156. You must file an appeal within 60 days after the date of our determination. Your appeal must state the detailed basis of your disagreement with our determination and must include all documentation and information supporting your appeal that has not been previously provided to us.

If any claim determination made by us meets one or more of the following conditions:

- Not **medically necessary**
- Cosmetic
- **Experimental or investigational** treatment
- Requires medical judgment

then the appeal of the claim determination must include an Independent Review Organization (IRO) report that includes each panel member's report and the panel's consensus report. The IRO's report is to be provided at your expense. The members of the IRO must be mutually acceptable to you and us.

In addition, the individual Stop Loss **contract type** and the aggregate Stop Loss **contract type**, as indicated in the *Stop Loss Application and Schedule of Insurance*, will be extended for a period not to exceed 3 months to cover only reversals of claim denials. See the *IRO overturn of claim denials* section in this **policy**.

Any **eligible claim expenses** reimbursed pursuant to the terms and conditions of this **policy** will apply to the **policy period** that it was **incurred** and will be treated as if it had been paid on the date you sent notice of denial to the **covered person**. These **eligible claim expenses** will be excluded from any other **policy period**.

Indemnification – in general

To the extent allowed by law, we agree to indemnify and hold you harmless against that portion of your liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by our willful misconduct, criminal conduct, or material breach of this **policy**.

These indemnification rights and obligations apply during the term of the **policy** and to a claim made in writing within one year after termination of the **policy**.

Your and our rights and duties in this section survive termination of the **policy**.

Indemnification – liability

We have neither the responsibility nor the obligation under this **policy** to directly pay any **covered person** or provider of **eligible claim expenses** for any benefit you have agreed to provide through the terms of the **plan(s)**. Our only liability under this **policy** is to you, subject to the terms, conditions, and limitations of this **policy**.

No Employee Retirement Income Security Act (ERISA) of 1974 liability

Under no circumstances will we accept responsibility as an administrator or be deemed a **plan** fiduciary under your **plan**, as these terms are defined and used in the ERISA Act of 1974 and as amended.

General provisions

This section provides details on additional terms and conditions under this **policy**.

Recovery of overpayments

If **eligible claim expense** amounts change as a result of a coordination of benefit change, a subrogation recovery, audit, or billing or payment errors, we may have overpaid you. If we have overpaid you, you will promptly refund the overpaid amount to us. If you fail to refund the overpayment to us in a timely manner, we have the right to reduce any future payments due under this **policy** by the amount we overpaid until repayment is made in full. If this **policy** terminates, any reimbursements made for claims paid by you after the date of termination will immediately be refunded to us.

Reports

You will promptly provide us with any information we determine is necessary to carry out the provisions of this **policy**.

Assignment and delegation

You will not assign any right or delegate any duty under the **policy** unless we approve it in writing, and in advance. This includes assignment to any person or entity, including, but not limited to, any **covered person**, medical provider, or creditor. If you do so without our written approval, we are not bound by your assignment or delegation.

If you use any **claims administrator**, vendor, or **agent**, you are responsible for authorizing the release of any information we request to underwrite, review potential claims, make claim determinations, calculate potential reimbursements, or perform other obligations under this **policy**. If we do not receive requested information, it may result in the delay, reduction or denial of a reimbursement request.

Aetna may delegate some of our functions under this **policy** to third parties, (i.e. an authorized representative, subsidiary, affiliate or parent of **Aetna**). We may also change or end these delegations. We do not need your consent or need to give you advance notice to enter into, change, or end these arrangements. These delegations will not increase or reduce our or your rights or responsibilities under this **policy**.

We may also assign this **policy** to an affiliate within our corporate family without your consent. An assignment will not increase or reduce either of our rights or responsibilities under this **policy**.

IRO overturn of claim denials

Coverage under the **policy** will be extended for a period not to exceed 3 months from the last **paid date** of the **policy period** to cover only reversals of claim denials related to an adverse benefit determination when the claim denials by the **plan** are subsequently overturned by Independent Review Organizations (IROs), subject to the following:

- Your **plan** is subject to external review under the Affordable Care Act (ACA) and this status is communicated to us during the underwriting of the **policy**
- **Eligible claim expenses** are paid, in whole or in part, for a **covered person** due to, and consistent with, the overturning of a claim denial by an IRO conducted pursuant to the applicable external review process established under the ACA
- **Eligible claim expenses** associated with a previously denied claim were **incurred** by the **covered person** during the **policy period**
- **Eligible claim expenses** paid after the last paid claims date of the **policy period** indicated in the *Stop Loss Application and Schedule of Insurance* are not eligible for payment under any other coverage, but are otherwise payable under the terms of the **policy**

- You or your **claims administrator** advises us that the denied claim for **eligible claim expenses** has been submitted to the IRO within 10 days of being submitted to the IRO
- You have received notice from the IRO that a decision was made to pay the denied claim and that you must pay the denied claim within 10 days of receiving the decision
- You or your **claims administrator** advises us of the IRO's decision prior to payment of the claim
- Satisfactory proof that you paid the denied claim and complied with all terms and conditions of the **policy** must be submitted to us by you or your **claims administrator** within 30 days of payment of the claim

An **eligible claim expense** reimbursed pursuant to the terms and conditions above will relate back to the **policy period** it was **incurred** and will be treated as if it had been paid on the date you sent notice of claim denial to the **covered person**. These **eligible claim expenses** will be excluded from any other **policy period**.

Correcting clerical errors

A clerical error may be made by you, any **claims administrator**, a **covered person**, vendor, **agent**, or us in keeping records or providing required information. A clerical error alone will not determine whether there is coverage. We will determine the facts and decide if coverage is in force and its amount. We will make a fair adjustment in premium or factors if correction of the error or delay changes coverage or the risk assumed. **Aetna** is not required to honor a notification of a **covered person's** enrollment or termination of eligibility which **Aetna** receives more than 30 days after the qualifying event.

We may correct, withdraw, or replace the **policy**, *Stop Loss Application and Schedule of Insurance*, and any other document issued with an error or issued in error. A clerical error does not include your:

- Intentional acts
- Intentional omissions
- Failure to comply with the **plan** or this **policy**

When you use a **claims administrator** that is not **Aetna**, your failure to report the existence of a **covered person** or claimant or your failure to report notice or proof of claim loss in a timely manner does not constitute clerical error.

Legal action

The time limit on legal actions related to coverage under the **policy** is subject to applicable law in the state where the **policy** was issued.

We encourage you to complete the appeal process before you take any legal action against us for any disapproval of coverage. If you disagree with our coverage decision, you may not start legal or other action against us regarding your claim until 60 days after proof of **eligible claim expense** has been rejected by **Aetna**.

No legal action may be brought against us after 2 years from the time written proof of loss is required from you.

Cost containment

If you use a **claims administrator** or other vendor other than **Aetna**, we have the right to participate in any cost savings or cost containment program that you may have in connection with your **plan**. At our expense, we have the right to retain the services of a medical management vendor or other service provider to perform the following duties:

- Assist us with cost containment with respect to claims under the **plan**
- Provide services to you to reduce cost, risk, or expenses under the **plan**

We may also request a medical management vendor or other service provider that we may have negotiated a set or discounted rate to contact you if, in our determination, the medical management vendor or other service provider described above provides a service that may reduce the risk, costs and expenses under the **plan**.

Notice of legal actions

You agree to:

- Notify us immediately upon our request of any event or development that might result in an action of law or equity related to this
  policy
- Forward promptly to us copies of any pleadings and reports of investigation that we request
- Immediately provide to us a copy of any documents filed by or against you in any court in connection with any litigation under the **plan which we request**

If any time limitation in this **policy** is less than that permitted by the law of the state that the application was signed, the limitation is hereby extended to agree with the minimum period permitted by the law.

Taxes

You will hold us harmless for any taxes we are assessed that are beyond any tax payable on premium we have received. You are responsible for reimbursing us for any taxes we paid that are beyond any tax payable on premium we received.

Workers' compensation or state disability insurance

This **policy** does not replace or affect the requirements for coverage under any workers' compensation or state disability insurance.

Subrogation - right to recovery

Your **plan** is required to include a comprehensive provision for subrogation and reimbursement in its Summary Plan Description. The **plan** must enforce this provision. If you fail to pursue any recovery or action against a responsible party, then you agree that **Aetna** will:

- Be subrogated to or assigned your reimbursement rights
- Will assume the **plan's** rights to pursue any recovery against any and all parties

You will be responsible for any and all reasonable expenses incurred in the pursuit of recovery, including the fees and costs charged by any contracted subrogation vendor or attorney and any additional legal costs.

We have the right to pursue any and all recoveries covered under this **policy** and paid by the **plan**, and to pursue these actions in the name of the **plan**. This includes both the portion of the **plan** benefits that the **plan** has been paid under this **policy** and the portion of the claim consisting of benefits paid by the **plan** but not payable under this **policy**.

You:

- Must notify **Aetna** within 30 days of receiving any information that may lead to our subrogation rights
- Must cooperate fully with us and do all things necessary and required for **Aetna** to pursue any action to recover against a responsible party
- May not take any action, or neglect to take any action, that will prejudice or impair our rights to pursue recovery from any other responsible party

- May not, without our written consent, settle or give release for any claim to any other party if doing so would impair or prevent **Aetna** from exercising its rights of recovery

If the **plan:**

- Receives a recovery prior to our reimbursement of any **eligible claim expenses** under the **policy**, the **plan** must deduct the amount of the recovery from any reimbursement request
- Receives a recovery after we have made payment to the **plan** for some or all of a particular claim, the **plan** must reimburse us to the full extent of the payment made by us

We are under no obligation to reduce the amount we are due for any reason, even to help you pay for a lawyer or pay other costs you incurred to get a recovery.

The **plan** must:

- Still reimburse us regardless of whether this **policy** is still in force on the date of recovery
- Reimburse us within 30 days of any recovery by the **plan** or **plan** sponsor
- Account to us for all amounts recovered

The rights and obligations of the **plan** in this section extend beyond the termination of the **policy**.

Aetna's additional responsibilities

We will prepare the legal documents of the **policy** as required by applicable federal and state laws. We will provide them to you in electronic form. We will also provide them to you in paper form if you request it.

We will provide the coverage stated in the **policy** and *Stop Loss Application and Schedule of Insurance*. We will administer the coverage as required by the **policy** and applicable federal and state laws.

We will protect personal health information, as required by federal and state laws. We will use it and share it with others only as needed to help us administer the **policy**. For a copy of our Notice of Privacy Practices log on to https://www.aetna.com/.

Our duties in this section survive termination of the **policy**.

[When Aetna is not your claims administrator

Third party administrator (TPA) responsibilities

When **Aetna** is not your only administrator or ancillary services vendor (i.e. subrogation, case management, etc.), you are solely responsible for the actions of your designated TPA, including **claims administrators**, network providers, vendors, and **agents**.

Without waiving any of our rights under this **policy**, and without making the TPA a party to this **policy**, we agree to recognize the TPA for the administration of your **plan(s)**, subject to these conditions:

- Your TPA is responsible on your behalf for:
  - Auditing, calculating, and processing all **eligible claim expenses** for the underlying **plan** within a reasonable amount of time
  - Preparing reports as required by us
  - Maintaining and making available to us, at all times, any information as we may reasonably require for proof of coverage
- Your TPA must perform any other duties as we may reasonably require, including, but not limited to, maintaining an accurate record of **covered persons** under the **plan**
- We are not responsible for, nor will this **policy** reimburse, any compensation or fees due to the TPA for functions performed by them on your behalf in relation to this **policy**

Notice from us to your TPA under the provisions of this **policy** will be considered notice to you. Also, notice from us to you will be deemed notice to the TPA.

If you engage a TPA without our prior approval, in addition to any other rights we have by law or under this **policy**, we may:

- Terminate the **policy** as of the date the unapproved TPA began to administer the **plan**
- Exclude any **eligible claim expenses** paid by the unapproved TPA

Proof of eligible claim expenses

Proof of **eligible claim expense** losses must be provided to us and must establish the nature and extent of the covered loss. **Eligible claim expenses** that are not submitted to us in accordance with the requirements of this section of the **policy** are not reimbursable and are not be considered **eligible claim expenses** under the **policy**.

Individual Stop Loss

If the *Stop Loss Application and Schedule of Insurance* indicates individual Stop Loss coverage under this **policy**, you must provide us with written proof of **eligible claim expenses** within 60 days after any **individual Stop Loss amount**, **high risk individual Stop Loss amount**, or **IOE transplant Stop Loss amount** has been exceeded by a **covered person**. If it is not possible to submit proof within this time period, proof must be given as soon as reasonably possible. Proof of loss may not be given later than 6 months after the end of the **policy period** that the **claims administrator** paid the loss, adjusted for any **contract type**, if applicable.

Proof must be provided in a form and content satisfactory to us and must consist of the following:

- Completed claim form(s)
- Proof of the **covered person's** original enrollment record under the **plan**, and any changes and other applicable eligibility information, including the most current certification of coverage as required by state or federal law
- For each **covered person** exceeding the **individual Stop Loss amount**, **high risk individual Stop Loss amount**, or **IOE transplant Stop Loss amount**, proof of payment by the **plan** for **eligible claim expenses** submitted for reimbursement, including a paid claim detail report which includes for each claim:

  - **Incurred** date
  - Provider name and tax identification number (TIN)
  - Billed amount, allowed amount, and paid amount
  - **Paid date**
  - Relevant International Classification of Diseases (ICD-10) codes, Current Procedural Technology (CPT) codes, and National Drug Code (NDC) codes
- Copies of all relevant provider bills, reports and electronic data transactions
- Copies of relevant pre-certification forms and case management reports
- Proof of deductible and out-of-pocket maximums, if applicable
- For all accident claims, copies of the police report and any signed subrogation agreement
- Any other information we may need to fulfill our obligations under this **policy**

Aggregate Stop Loss

If the *Stop Loss Application and Schedule of Insurance* indicates aggregate Stop Loss coverage under this **policy**, you must give us written proof of loss within 60 days after the end of the **policy period** adjusted for any **contract type**, if applicable. If it is not possible to give proof within this time period, proof must be given as soon as reasonably possible. Proof of loss may not be given later than 6 months after the end of the **policy period** that the **claims administrator** paid the loss adjusted for any **contract type**, if applicable.

Proof must be provided in a form and content satisfactory to us, and must consist of the following:

- A written request for reimbursement, including the calculation of the aggregate reimbursable amount
- A detailed claim history report by claimant for all **eligible claim expenses incurred** and paid during the **policy period** as adjusted for any **contract type**, including:
  - **Incurred** date
  - Provider name and tax identification number (TIN)
  - Billed amount, allowed amount, and paid amount
  - **Paid date**
  - Relevant International Classification of Diseases (ICD-10) codes, Current Procedural Technology (CPT) codes, and National Drug Code (NDC) codes
- A listing of all **covered persons** eligible for benefits under the **plan** at any time during the **policy period**
- If prescription drug coverage is indicated as an **eligible claim expense** on the *Stop Loss Application and Schedule of Insurance*, a detailed claim report of all prescription drug claims including:
  - The amounts of any rebates you received
  - A copy of the check register
  - A summary of claimants exceeding the **individual Stop Loss amount**
  - A summary of the benefit analysis
  - A copy of the loss ratio report
  - Any other information we may need to fulfill our obligations under this **policy**

Required reporting

You and your **claims administrator** or other **agents** will maintain records as may be required by us for the administration of this **policy**. You will provide us with all information we determine is necessary to carry out the provisions of the **policy** upon our request.

You must provide us with a copy of your underlying health benefit **plan** document(s), including any amendments or modifications. Any amendments or modifications must be submitted to us at least 60 days prior to the **effective date**.

Reports are to be provided within 30 days after the end of each **policy month**, in a form and content satisfactory to us, including:

- Aggregate Stop Loss
  - Total monthly paid claims for all **covered persons** in a format and with content that is satisfactory to us including:
    - The number of each type of **employee** or **covered unit** as of the first day of the **policy month**
    - Total **eligible claim expenses** for all **covered persons** that you paid for the **month**
    - A listing of claims for any **covered person** whose total **eligible claim expenses** on a paid basis during the month exceeds $25,000
    - Any other information that may be reasonably required
- Individual Stop Loss
  - Notice of any potential catastrophic claim via written submission on a form acceptable to us within 30 days of when:
    - A **covered person's eligible claim expenses** exceed 50% of the **individual Stop Loss amount**
    - If applicable, a family's **eligible claim expenses** exceed 50% of the **family individual Stop Loss amount**
    - You, your **claims administrator**, or any other **agent** acting on your behalf, are notified that a **covered person** has been diagnosed with or treated for any injury, illness or disease that is reasonably likely to result in **eligible claim expenses** expected to exceed 50% of the **individual Stop Loss amount** during the 12 months following notification
    - Any other information that may be reasonably required

You will provide all claim information and will not withhold or delay information on a particular claim beyond 30 days. If there are special circumstances, the 30 days may be extended for a mutually agreed upon time. If you or your **claims administrator** do not provide the required information on a timely basis, we reserve the right to revise premium rates, monthly factors, or coverage levels retroactively to the **policy effective date** or **renewal date**, as applicable, once the information is received.

Inspection and audit

We are permitted to inspect your, your **claims administrator's**, or any other vendor's or **agent's** records and procedures pertaining to the **plan** at any reasonable time while your **policy** is in force and within 3 **policy** years after termination to the extent that the records relate to the premium basis or **eligible claim expenses** under this **policy**.

We reserve the right to employ a third party, at our expense, to assist us with any audits. If you, your **claims administrator**, or any other **agent** fails to provide requested information, we will not reimburse you for **eligible claim expenses** under this **policy**.]

Glossary

Aetna
Aetna Life Insurance Company, an affiliate, or third party vendor under contract with **Aetna**.

Agent
A designated person or entity that has, or reasonably appears to have, the authority to act on behalf of the **policyholder**. This includes:

- Consultants
- Brokers
- Counsel
- HR Representatives
- Any other person or entity that the **policyholder** designates as an **agent**

Aggregate Stop Loss corridor
When aggregate Stop Loss coverage is elected, it is the total dollar amount of **eligible claim expenses** that you must pay for all **covered persons** during the **policy period** before aggregate Stop Loss benefits are payable. The amount is determined at the end of the **policy period** and is the greater of:

- The sum of each month's number of **employees** or **covered units** multiplied by the **aggregate Stop Loss factor**, or
- The **minimum aggregate Stop Loss amount**

The **aggregate Stop Loss corridor** does not include claim payments made during a **policy period** for a **covered person** in excess of any:

- **Individual Stop Loss amount**
- **IOE transplant Stop Loss amount**
- **High risk individual Stop Loss amount**
- **Individual internal limit**
- Any other provision of this **policy**, as applicable

Aggregate Stop Loss factor
When aggregate Stop Loss coverage is elected, it is determined prior to the start of the **policy period**. It is calculated as the expected **eligible claim expenses** for the **policy period**, multiplied by the **aggregate Stop Loss percentage**, divided by the expected number of **employees** or **covered units** at the beginning of the **policy period**, and divided by the number of months in the **policy period**.

Aggregate Stop Loss percentage
When aggregate Stop Loss coverage is elected, it is the percentage amount above expected **eligible claim expenses** that you are liable for under the terms and conditions of the **policy** as indicated on the *Stop Loss Application and Schedule of Insurance*. Under no circumstances will the **aggregate Stop Loss percentage** be less than the percentage required by state or federal law.

Claims administrator
A firm or person you have designated and have a written agreement with to process claims and provide administrative services for your health **plan**. The term **claims administrator** as used in this **policy** does not refer to the **plan** administrator used under ERISA, unless a participating employer has specifically appointed the administrator for that

purpose. We must approve any administrator in advance and in writing, in accordance with the terms and conditions of this **policy**.

Contract type
Establishes the time periods that **eligible claim expenses** must first be **incurred** by a **covered person** through the **plan** and then paid by **Aetna** or the approved **claims administrator**.

Covered benefits
The benefits provided by the **policyholder** to **covered persons** included under the **plan** and included as reimbursable under this **policy** as indicated in the *Stop Loss Application and Schedule of Insurance*.

Covered person
Any person who meets the eligibility requirements of and is covered by the underlying self-insured health benefit **plan**.

Covered unit
A **covered unit** means the same as employee.

Domestic claim expenses
The medical expenses **incurred** for services delivered to **covered persons** within the healthcare facilities being insured by the Stop Loss **policy**.

Effective date
The date coverage begins under this **policy** in accordance with the *Effective date* section of this **policy**.

Eligible claim expenses
Expenses for **covered benefits** you paid based on the **plan** and that are included under the terms of this **policy**. **Eligible claim expenses** will include payments made to the MA Uncompensated Care Pool, Minnesota Care Provider Tax, or in New York, on your behalf, to fund indigent care and graduate medical education when paid directly into the pool.

Employee
An **employee** is defined in accordance with the eligibility requirements of, and is covered by, the underlying self-insured health benefit **plan**.

For purposes of premium, terminal liability, terminal reserve, and aggregate Stop Loss calculations, **employee** means an enrolled contract or unit (i.e. single individual, individual + spouse, individual + child(ren), family).

Also see **covered unit**.

Experimental or investigational
Any drug, device, procedure, treatment, or test not yet accepted by physicians or by insurance plans as standard treatment of a condition or illness.

They are **experimental or investigational** if:

- There is not enough outcome data available from controlled clinical trials published in peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved.
- The needed approval by the FDA has not been given for marketing.

- A national medical society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II, or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility or provider state that it is **experimental or investigational**.
- The **plan** deems a drug, device, procedure, test, or treatment as **experimental or investigational**.

Aetna's experimental or investigational determinations are documented in **Aetna's** Clinical policy bulletins.

Family individual Stop Loss amount

When indicated on the *Stop Loss Application and Schedule of Insurance*, it is the dollar amount of **eligible claim expenses** per covered family (eligible **employees** or **covered units** and their enrolled dependents) that you must pay prior to any family individual Stop Loss benefit becoming payable under this **policy**.

High risk covered person

A **covered person** that has **eligible claim expenses** under the plan expected to exceed the **individual Stop Loss amount**. The **covered person** may have a separate higher **individual Stop Loss amount** or may be excluded from coverage under this **policy** as indicated on the *Stop Loss Application and Schedule of Insurance*.

High risk individual Stop Loss amount

The dollar amount of **eligible claim expenses** for a **high risk covered person** that you must pay before any individual Stop Loss benefit is payable under this **policy** as indicated in the *Stop Loss Application and Schedule of Insurance*.

Incurred

The date services are rendered or supplies are received by a **covered person** for medical services and supplies.

[Inpatient facility charges with continuous facility stays that fall over two or more **policy periods** will be considered on a pro rata/per diem basis by dividing the total amount of **eligible claim expenses** by the total number of days of confinement and multiplying by the number of days of confinement per **policy period**. Professional visits that are billed for inpatient facility charges will be considered on the date they were provided to the **covered person**.]

Individual internal limit

As indicated on the *Stop Loss Application and Schedule of Insurance*, it is the limit on **eligible claim expenses** that are paid by the **claims administrator** for any one **covered person** during the **policy period** that can be used to satisfy the **aggregate Stop Loss corridor** or included in the aggregate benefit amount calculation for the **policy period**.

Individual lifetime Stop Loss payment amount

When indicated on the *Stop Loss Application and Schedule of Insurance*, it is the maximum amount of **eligible claim expenses** that **Aetna** will fund as individual Stop Loss payments under the **policy** for any one **covered person** during their lifetime. If the **eligible claim expenses** paid by us under the individual Stop Loss coverage reach the **individual lifetime Stop Loss payment amount**, all subsequent **eligible claim expenses** for that **covered person** will be funded by you.

Individual Stop Loss amount

The dollar amount of **eligible claim expenses** per **covered person** that you must pay before any individual Stop Loss benefit is payable under this **policy** as indicated in the *Stop Loss Application and Schedule of Insurance*. Under no circumstances will the **individual Stop Loss amount** be less than the minimum amount allowed by state or federal law.

IOE transplant Stop Loss amount

When indicated on the *Stop Loss Application and Schedule of Insurance*, and if the **covered person** elects to have the **transplant** performed at one of **Aetna's** Institute of Excellence® (IOE) facilities, it is the amount of **eligible claim expenses** for a **covered person** receiving a **transplant** at an IOE facility during the **policy period** that you must pay before any individual Stop Loss benefit is payable under this **policy**. For **transplant** claims and **eligible claim expenses** covered in the **policy period** that the **transplant** benefit is paid by the **claims administrator**, the **IOE transplant Stop Loss amount** is applied instead of the **individual Stop Loss amount**.

The **IOE transplant Stop Loss amount** may not be applicable to certain **transplant** types or a **covered person's transplant** claims as indicated in the *Stop Loss Application and Schedule of Insurance*.

Maximum annual aggregate Stop Loss payment amount

When indicated on the *Stop Loss Application and Schedule of Insurance*, it is the dollar limit that **Aetna** will pay in any **policy period** under the aggregate Stop Loss coverage. If the **eligible claim expenses** paid by us under the aggregate Stop Loss coverage reach the **maximum annual aggregate Stop Loss payment amount**, all subsequent **eligible claim expenses** in that **policy period** will not be eligible for reimbursement by us.

Maximum annual individual Stop Loss payment amount

When indicated on the *Stop Loss Application and Schedule of Insurance*, it is the maximum amount of **eligible claim expenses** that **Aetna** will fund as individual Stop Loss payments under the **policy** for any one **covered person** in a **policy period**. If the **eligible claim expenses** paid by us under the individual Stop Loss coverage reach the **maximum annual individual Stop Loss payment amount** in a **policy period**, all subsequent **eligible claim expenses** for that **covered person** will be funded by you.

Medically necessary

In addition to any **medically necessary** definition cited in the **plan**, a health care service, drug, or device that we determine a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that we determine is:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, physician, or other health care provider
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Following the standards set forth in our clinical policies and applying clinical judgment

Minimum aggregate Stop Loss amount

The **minimum aggregate Stop Loss amount** applies when aggregate Stop Loss coverage is elected. It is the minimum amount of **eligible claim expense** liability that you must pay before any aggregate Stop Loss benefits may be payable. For any **policy period**, the **aggregate Stop Loss corridor** is subject to a **minimum aggregate Stop Loss amount**. This is the greater of:

- The **minimum aggregate Stop Loss amount** indicated on the *Stop Loss Application and Schedule of Insurance*
- The sum of the product of the number of **employees** or **covered units** on the first day of the first **policy month**, multiplied by the **aggregate Stop Loss factor**, multiplied by the number of months in the **policy period**, determined by mutual agreement between you and us at the beginning of the **policy period**

Paid date

The date the payment for **eligible claim expenses** is [issued] [cleared] [paid] by **Aetna** or an **Aetna**-approved TPA, **claims administrator**, vendor, or ancillary provider. The payment instrument must be supported by sufficient funds to be honored upon presentation and will coincide with the claims **paid date** definition of the administrative services, ancillary, and vendor agreement(s). If funding is not available, the expense will not be deemed to have been paid until funding is available to cover the full amount of the draft as determined by us.

[In an issued basis funding arrangement, check issuing systems issue payments and transmit them to the claims reporting system. These checks are processed and immediately accumulate towards the Stop Loss **policy**.]

[In a cleared basis funding arrangement, check issuing systems issue payments and transmit them to the claims reporting system. These are processed and held until the checks clear the banking channels. Once checks clear the banking channels, the transactions then accumulate towards the Stop Loss **policy**.]

Any EFT payments are immediately funded and apply towards the Stop Loss **policy**.

Plan

Describes the self-insured health benefits you provide for **covered persons**. The **plan** is subject to ERISA, as applicable, and as is or as may be, amended and approved by **Aetna**. The health benefits are included under either individual Stop Loss, aggregate Stop Loss, or both as indicated in the *Stop Loss Application and Schedule of Insurance*.

Policy

Your Stop Loss **policy** consists of the following essential legal documents:

- Your signed *Stop Loss Application and Schedule of Insurance*
- *Disclosure*, if required
- This document (the **policy**)
- Any riders or amendments to the **policy**
- A copy of the self-insured **plan** document(s) for each benefit **plan** covered by this **policy**

Policyholder

The insured entity as defined on the cover page of this **policy**.

Policy month

A **policy month** is the same as a calendar month. The first **policy month** begins on the **effective date** of this **policy** and the last **policy month** ends on termination of this **policy**.

Policy period
A **policy period** typically coincides with the **plan's** benefit period. The first **policy period** begins on the **effective date** of this **policy**. Any **policy period** after the first **policy period** begins on the **policy renewal date**.

Premier product
In consideration of additional premium paid, the **Premier product** provides a commitment of no new **high risk individual Stop Loss amounts** or rate-ups for **covered persons'** medical conditions upon **policy** renewal.

Premium due date
When premium is not funded by automatic electronic funds transfer, the premium is due as of the date shown on the invoice.

Rate cap
The **rate cap** is a commitment that upon renewal, if offered, the premium increase will be capped at a specified percentage.

Reasonable and customary
Reasonable and customary is the portion of a bill for a drug, device, procedure, test, or treatment that is eligible for coverage based on the geographical area of service. It is the amount of any non-preferred or non-network charge under a network based plan or all charges under a non-network plan. **Reasonable and customary** charge means the same as allowed amount, recognized charge, and usual and customary charge. The actual **reasonable and customary** amount will be determined in accordance with the underlying **plan** that has been reviewed and approved by **Aetna**.

Renewal date
Each anniversary of the **effective date** of the **policy**, unless changed by written agreement between the **policyholder** and **Aetna**.

Renewal risk cap
The **renewal risk cap** is a commitment that upon renewal, if offered, there will be no new lasers and the premium increase will be capped at a specified percentage.

Run-in amount
The maximum amount we will pay per **covered person** as applied towards the annual **aggregate Stop Loss corridor** on **eligible claim expenses incurred** prior to the **policy effective** or **renewal date** and paid on or after the **policy effective** or **renewal date**.

Run-in period
The period of time immediately prior to the **policy effective** or **renewal date** when **eligible claim expenses** are **incurred** but not paid until after the **effective** or **renewal date** of this **policy**. All run-in **eligible claim expenses** paid by us or by your **claims administrator** must be paid based on the **plan** in effect during the **run-in period** and our current standard claim practices.

Run-out amount
The maximum amount we will pay per **covered person** as applied towards the annual **aggregate Stop Loss corridor** for **eligible claim expenses incurred** during the **policy period** but paid after the **policy period** end date.

Run-out period

The period of time immediately following termination of the **policy** when **eligible claim expenses incurred** prior to the **termination date** are being paid by you. The **run-out period** will apply only if the same **claims administrator** administers benefits for the **plan** during the **run-out period**.

Termination date

The date coverage under this **policy** ends at 11:59 p.m., in accordance with the *Termination* section.

Transplant

The **transplant** of human solid organs, specifically:

- Heart
- Heart/lung
- Lung
- Double lung
- Liver
- Pancreas
- Kidney
- Cornea

Transplant also includes:

- Bone marrow
- Peripheral blood stem cell **transplant**
- CAR-T cell therapy
- Transfusion
- Re-infusion

A **transplant** occurrence is considered to begin at the point of evaluation for a **transplant** and end either:

- 365 days from the date of the **transplant**
- On the date the **covered person** is discharged from the hospital or outpatient facility for the admission or visits related to the **transplant**, whichever is later