SAMPLE PROPOSAL
Aggregate Advantage Plan
Employee Benefit Plan
Proposal

For

ABC Company, Inc.

Administrative Services Agent:  Group Resources Incorporated

Consultant:  Your Name Here

Effective Date:  January 1, 2006  Proposal Valid Until:  January 15, 2006

About Self-Funding

WHY CHOOSE SELF-FUNDING?

In 1974 the Employee Retirement Income Security Act (ERISA) was passed allowing employers an alternate means of funding their medical and other employee benefit plans. Self-Funding provides an alternative to the high cost of fully insured benefit plans, flexibility of plan design and the potential for savings.

Historically, an employer utilizing a fully-insured program pays a set premium to a carrier for a specified time period. Any premiums paid by the employer to the insurance company which remain after claims costs and incurred expenses are paid become the insurance company’s profits.

A self-funded plan divides its costs into two distinct segments:

- **Fixed costs**: Administrative fees, stop loss premiums (limiting the plan’s liability), network costs and claims management costs.
- **Claims funding**: Funding for actual claims. These funds are held in the plan’s claims account.

The claims account works in conjunction with stop loss coverage, which limits the plan’s liability against large claims and establishes a maximum claims cost for the plan. Savings in the claims account remain an asset of the plan and can be used to reduce the plan’s cost in future years. Stop loss coverage protection falls into two categories - Specific and Aggregate.

- **Specific Stop Loss** limits the employer’s liability on any individual covered under the plan for the plan year.
- **Aggregate Stop Loss** limits the annual claims liability on all participants for the plan for amounts under the specific stop loss limit. Within Aggregate Stop Loss Coverage, Monthly Aggregate Accommodation is usually available and limits the claims liability for all employees on a monthly and year-to-date basis.

**Unique Benefits of a self-funding plan**

- Self-funding provides the potential for savings if an employer has good claims experience. In the instances where claims are equal to or exceed expectations, the employer’s liability is capped under the stop loss policies.
- The only taxable premiums are those paid for specific premium, aggregate premium and aggregate accommodation. Because fully-insured plan premiums are 100% taxable, this reduces the client’s costs by 2% to 5%.
- Self-funding provides our clients with the flexibility to design their own benefit plans and programs subject to federal law, but not subject to state mandated benefits. This differs from traditional, fully-insured programs where a client has no flexibility in plan design and benefit programs other than in choosing “canned” benefit programs as determined by the insurance carrier and offered in conjunction with state mandates.

More than 70% of US employers have some form of self funded benefit programs for employees. With the spiraling cost of health care today, many employers see this approach as the only logical mechanism for the funding of their employee benefit plans.
About Specific Reinsurance

After eligible plan charges reach your specific deductible per insured person per year the specific reinsurance will cover eligible plan charges at 100% up to the maximum benefit payable while covered under this Plan. This insures that catastrophic claims will not have a serious impact on your maximum claims liability.

Sample Employer
Self-funded Benefit Plan Costs

<table>
<thead>
<tr>
<th>2001 Plan Year</th>
<th>Individual Specific Level - $30,000</th>
<th>Specific Contract 15/12</th>
<th>Aggregate Contract 15/12</th>
<th>Factors:</th>
<th>Single</th>
<th>$200.00</th>
<th>Family</th>
<th>$400.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>May-01</td>
<td>Jun-01</td>
<td>Jul-01</td>
<td>Aug-01</td>
<td>Sep-01</td>
<td>Oct-01</td>
<td>Nov-01</td>
<td>Dec-01</td>
<td>Jan-02</td>
</tr>
<tr>
<td>Single Coverage</td>
<td>122</td>
<td>126</td>
<td>122</td>
<td>118</td>
<td>141</td>
<td>120</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Family Coverage</td>
<td>234</td>
<td>236</td>
<td>236</td>
<td>202</td>
<td>197</td>
<td>199</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL EMPLOYEES</td>
<td>356</td>
<td>364</td>
<td>364</td>
<td>320</td>
<td>339</td>
<td>320</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fixed Cost</td>
<td>36,965</td>
<td>39,720</td>
<td>35,250</td>
<td>35,920</td>
<td>36,980</td>
<td>36,777</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Paid Claims*</td>
<td>31,142</td>
<td>35,880</td>
<td>32,400</td>
<td>28,200</td>
<td>29,880</td>
<td>29,877</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL COST</td>
<td>78,107</td>
<td>105,570</td>
<td>105,750</td>
<td>105,520</td>
<td>106,860</td>
<td>106,654</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*Paid Claims includes and time period and within specific claims includes Medical, Dental and Prescription Drug Services.

Total Fixed Cost for this Time Period: 218,674
Total Claims Paid for this Time Period: 561,461
Total Cost to Date: 780,135

Average Number of Employees: 196
Est Annual Cost Per Employee: $7,469

About Aggregate Reinsurance

If all risks were predictable, there would be no need for insurance protection. As a normal course of business we must live with the unexpected, including the fluctuation of medical claims. The estimated maximum claims liability (annual aggregate attachment point) is determined by the reinsurance company’s underwriting guidelines to derive single and family funding factors. This attachment point is calculated based upon your previous year(s) claims coupled with a trend factor for medical inflation as well as an aggregate corridor.

The actual maximum claims liability is calculated at the end of each policy year based on the number of employees with single and family coverage multiplied by the corresponding funding factors, subject to a minimum attachment point.

Aggregate reinsurance protects your Company against the unusual case wherein total paid claims are greater than expected, and your maximum claims liability is reached. Eligible claims which exceed your maximum claims liability are reinsured 100% by HCC Life up to a maximum of $1,000,000.00. As added protection, your liability will cease on any individual claim after it reaches the specific deductible level during the Plan Year. The excess will be reinsured under the specific stop-loss coverage.

Sample Employer Aggregate Analysis

May 1, 2001 to October 31, 2001

<table>
<thead>
<tr>
<th>Individual Specific Level</th>
<th>$300,000</th>
<th>Specific Contract</th>
<th>15/12</th>
<th>Aggregate Contract</th>
<th>15/12</th>
<th>Factors: Single $200,000</th>
<th>Family $400,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>Jun</td>
<td>Jul</td>
<td>Aug</td>
<td>Sep</td>
<td>Oct</td>
<td>Nov</td>
<td>Dec</td>
</tr>
<tr>
<td>No of Single Employees</td>
<td>122</td>
<td>126</td>
<td>122</td>
<td>115</td>
<td>141</td>
<td>120</td>
<td>126</td>
</tr>
<tr>
<td>No of Family Employees</td>
<td>211</td>
<td>205</td>
<td>196</td>
<td>193</td>
<td>197</td>
<td>199</td>
<td>203</td>
</tr>
<tr>
<td>YTD Total Aggregate Claim</td>
<td>26,892</td>
<td>20,802</td>
<td>20,971</td>
<td>19,902</td>
<td>20,152</td>
<td>20,752</td>
<td>20,025</td>
</tr>
<tr>
<td>YTD Total Aggregate**</td>
<td>26,892</td>
<td>20,802</td>
<td>20,971</td>
<td>19,902</td>
<td>20,152</td>
<td>20,752</td>
<td>20,025</td>
</tr>
<tr>
<td>Eligible Aggregate Claims</td>
<td>26,892</td>
<td>20,802</td>
<td>20,971</td>
<td>19,902</td>
<td>20,152</td>
<td>20,752</td>
<td>20,025</td>
</tr>
<tr>
<td>Eligible Aggregate**</td>
<td>26,892</td>
<td>20,802</td>
<td>20,971</td>
<td>19,902</td>
<td>20,152</td>
<td>20,752</td>
<td>20,025</td>
</tr>
</tbody>
</table>

*Aggregate attachment level is the greater of the minimum attachment point or the nearest YTD maximum point.

Aggregate Analysis

Total Amount Due (Under) Aggregate Attachment Level: $(122,640)
Total Year-to-Date Claims (Percent of Aggregate): 75%
Total Year-to-Date Claims (Percent of Expected Claims): 88%
About Your Benefits

You may wish to have your existing Schedule of Health Benefits duplicated. Although this may be feasible, we have shown a suggested plan of benefits for your consideration. When high first-dollar coverage is included in your benefit package the claims level could rise substantially. This will result in less money being available to your Company during the year. Our recommendation is that the employees be given a comprehensive major medical program with realistic coverage that includes cost containment features. Some employers will ask for more comprehensive benefits than we have suggested. Most employers will ask for a reduction in benefit coverage because it is their money that is being used to pay the claims.

How the Plan Works

Group Resources Incorporated will administer claims based on your Plan Document. Claims will be paid from a claims fund that you establish. Your Company will deposit funds into this claims account based upon the maximum claims liability. Funds are then used when submitted claims are processed by Group Resources Incorporated. When changing from a fully insured plan to a partially self funded plan, the normal claims “lag time” should generate a substantial amount of cash – immediately. Group Resources Incorporated will arrange the reinsurance agreement between HCC Life and your Company.
Our Mission

Group Resources Incorporated is committed to providing superior products and services for our clients. We build client, broker and employee confidence by demonstrating dedication, fairness and respect.

Utilizing exceptionally high corporate standards of quality, knowledge and innovation, Group Resources delivers client-driven product design at a competitive rate which produces a fair profit to maintain financial stability.

Our Heritage

Established in 1981 by Thomas S. Byrd, RHU, Group Resources has been dedicated to providing sound plans and solid performance to our clients and their employees. Working exclusively through brokers, agents and consulting firms to achieve this goal, Group Resources serves a wide variety of clients from small private companies to large corporations, school districts, hospitals and municipalities.

As one of the largest privately held and highly respected Third Party Administrators (TPAs) in the country today, our goal of providing a superior product and unparalleled still remains the same. We have been able to continually achieve this goal by investing in our two most important resources – our people and technology. Exceptionally high standards of quality, knowledge and innovation have allowed Group Resources to achieve our ultimate goal of client satisfaction.

Our corporate headquarters are located in Duluth, Georgia, with offices in Dallas and Houston, Texas, Jacksonville, Florida and Phoenix, Arizona.
What Differentiates GRI from Other TPAs?

In the March 4, 2002 issues of Business Insurance, Group Resources Incorporated was ranked as the 9th largest employee benefit TPAs in their rankings.

**Group Resources Incorporated:**

- Is committed to providing superior products and services for our clients for more than 20 years;
- Is staffed with healthcare benefit administration specialists;
- Utilizes leading-edge benefit systems;
- Has access to premier benefit partners such as PHCS, Intracorp, LabOne and many Pharmacy Benefit Management companies (PBMs);
- Provides personalized service including:
  - Dedicated Benefit Advisor/Team assigned to each client;
  - Employees speak directly to the Benefit Advisor that processes their claims;
  - Clients can have their own toll free numbers; and
  - Employees and clients have direct e-mail access to all of their service team members.
- Manages claims and health care costs thru:
  - Disease detection and management – including AWAC™;
  - The utilization of managed healthcare networks;
  - Negotiating discounts for out of network claims;
  - Controlling rising outpatient lab costs;
  - Utilization review/ demand management; and
  - Pharmacy Benefit Management.
- Provides employers, employee and providers immediate 24/7 access to claims and benefit information over the Web.
SUMMARY OF SERVICES

Comprehensive Administrative Services - Analyze current benefit programs to ensure that the plans are meeting both employees' needs and clients' fiscal responsibilities. Experienced Benefit Advisors process claims within 10 working days with a financial accuracy rate of 98.5%. Claims are adjudicated by our proprietary claims payment system, TPA Teamup. Employers, providers, and employees have direct access to their claims payers, eligibility personnel, and claims data through telephonic, e-mail and online access.

Employee Communications - Professional, clearly written program materials including a comprehensive summary of benefits, ID cards, payroll stuffers, and instructions for claim submissions and use of GRI Direct Access.

Plan Documents and Summary Plan Descriptions - Prepare and issue Plan Documents and Summary Plan Descriptions.

Computerized Management Reports - Issue monthly claims management reports including: check registers, aggregate claim reports, experience summaries by employee and dependent and type of coverage, utilization reports, shock claim reports, with the ability to provide customized ad hoc reports.

COBRA Administration - Notify each terminated employee or dependent when we are notified of a qualifying event. Billing and collection of COBRA premiums. Provide monthly activity summaries to the employer.

HIPAA Administration - Assist employers in fulfilling their continually changing obligations set forth by the Health Insurance Portability and Accountability Act of 1996. Track coverages and provide "Certificates of Creditable Coverage".

Group Life Insurance - Provide competitive group term life insurance through a partnership with Fortis Benefits.

Managed Care and Cost Containment - Offer managed care programs that provide both significant Preferred Provider discounts and substantial network utilization.

Pharmacy Benefit Management Services (PBM) - Through multiple PBM arrangements, offer quality service and discounts using Prescription Drug Cards and Mail Order Pharmacies.

Discount Laboratory Services - Offer a LabCard, through LabOne, enabling employees to receive lab work at no charge while reducing employers' lab benefit costs.
Using AWAC™ to Manage Claims

Included within GRI’s administrative fees is the Advanced Warning and Containment system, using technology to identify and manage catastrophic claims.

The AWAC™ system operates on two premises:

• Acting in the best interest of the patient is usually in the best interest of the health plan
• Early identification and intervention in high dollar claims more effectively manages care and controls costs

Early detection of catastrophic illnesses is not only critical to a claimant’s health, it is absolutely vital to managing and containing costs. The first such system of its kind in America, AWAC™ electronically identifies and stratifies risks, infers outcomes and recommends possible actions.

AWAC™ screens pre-certification, claims and prescription drug data from Group Resources® system. Using over 40,000 physician-produced algorithms, the program actually identifies at-risk claimants before they become catastrophic - often on a claim as small as $30. Early detection helps AWAC™ utilize appropriate resources and assures optimum care at negotiated prices.

Major areas of potential impact include:

• Chronic injectables
• Sub-acute care (rehab)
• Chronic oral medications
• In-office infusion therapy
• Dialysis
• Orthotics
• Prosthetics

• Ambulatory Surgical Center Charges
• Durable Medical Equipment
• Diabetic Supplies

Now, AWAC™ technology can identify and manage catastrophic claims, thereby protecting plan assets.
Direct Access is a multi-access portal allowing:

- Employers, employees and providers immediate access to claims and benefit information over the Web.
- Employers the ability to conduct all of their eligibility transactions (additions, changes, terminations) from their desktops.
- Employees the ability to:
  - Access their Summary Plan Description
  - Link to their Preferred Provider Organization (PPO)
  - Request to add or change dependent coverage
  - Change their address
  - Order an ID card

This information is available 24 hours a day, seven days a week.

1. Visit us on the Internet: www.groupresources.com
2. Follow the Direct Access link
3. Click on the employer, employee or provider entrance.

Employers, employees and providers have immediate access to claims and benefit information over the Web.

Employers have the ability to conduct all of their eligibility transactions (additions, changes, terminations) from their desktops.
# Medical Plan

**Preferred Provider (PPO)**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>??</td>
<td>??</td>
</tr>
<tr>
<td>Family</td>
<td>??</td>
<td>??</td>
</tr>
<tr>
<td><strong>Employee Coinsurance</strong></td>
<td>??</td>
<td>??</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Limits</strong> (excluding Deductible)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>??</td>
<td>??</td>
</tr>
<tr>
<td>Family</td>
<td>??</td>
<td>??</td>
</tr>
<tr>
<td><strong>Physician Visit's</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$______ Co-pay, then 100%</td>
<td>Deductible applies</td>
</tr>
<tr>
<td></td>
<td>Co-pay includes office visit, lab, x-rays, and injections if performed in the Physician’s office</td>
<td></td>
</tr>
<tr>
<td>Wellness Expense <em>(Includes immunizations, mammogram, pap smear, prostate exam, routine exam, and Well Baby Care)</em></td>
<td>$______ Co-pay, then 100%</td>
<td>Deductible applies</td>
</tr>
<tr>
<td></td>
<td>$250 maximum/ per year</td>
<td></td>
</tr>
<tr>
<td><strong>Other Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td>Bereavement Counseling</td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td>Birthing Centers</td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td>Chemical Dependency and Mental and Nervous Disorders Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td></td>
<td>30 visits maximum/ per year</td>
<td>30 visits maximum/ per year</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td></td>
<td>30 visits maximum/ per year</td>
<td>30 visits maximum/ per year</td>
</tr>
<tr>
<td>Chemotherapy/Radiation/Dialysis</td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>See Spinal Manipulation</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Lab &amp; X-ray</td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td></td>
<td>90 visits maximum/ per year</td>
<td>90 visits maximum/ per year</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td></td>
<td>$10,000 Lifetime Maximum</td>
<td>$10,000 Lifetime Maximum</td>
</tr>
</tbody>
</table>
### Other Benefits (continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Services</td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td>(Must be pre-certified or a penalty will apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Outpatient Hospital Services</td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td>Penalty for Failure to Pre-Certify Hospital Admission (If pre-certified, will be waived)</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>Physical/Speech/Occupational Therapy</td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td>Physician Services <em>(Services rendered outside of the Physician’s office)</em></td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td>Deductible applies 90 days maximum/ per year</td>
<td>Deductible applies 90 days maximum/ per year</td>
</tr>
<tr>
<td>Spinal Manipulation Treatment</td>
<td>Deductible applies $1,000 maximum/ per year</td>
<td>Deductible applies $1,000 maximum/ per year</td>
</tr>
<tr>
<td>Wellness Expense</td>
<td>Deductible applies</td>
<td>Deductible applies</td>
</tr>
</tbody>
</table>

### Prescription Drug Benefits

#### Retail Drug Card
Includes Legend drugs – which bear the legend: “Caution: federal law prohibits dispensing without a prescription” – insulin and insulin syringes/needles when prescribed and dispensed at the same time as the insulin.

#### Mail-Order Drugs
Includes a 90 day supply of maintenance prescriptions for Legend drugs. Maintenance Drugs must be obtained through this mail-order program (90 day supply) where a co-payment will be applied.

For both Retail and Mail Order, brand name drugs will be reimbursed at the generic maximum allowable cost unless the physician specifies "Dispense as Written".

### Employee Cost Sharing

<table>
<thead>
<tr>
<th></th>
<th>Generic</th>
<th>Preferred Brand</th>
<th>Non-Preferred Brand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Co-pay Per Prescription</td>
<td>$15.00</td>
<td>$25.00</td>
<td>$35.00</td>
</tr>
<tr>
<td>Mail-Order Co-pay Per Prescription</td>
<td>$30.00</td>
<td>$50.00</td>
<td>$70.00</td>
</tr>
</tbody>
</table>

Oral contraceptives are covered.
Exclusions

Exclusions as stated in Plan Document.

Pre-Existing Conditions

Except as stated below, this Plan does not pay benefits for "Pre-Existing conditions." A "Pre-Existing condition" is any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the individual's enrollment date; provided, however, genetic information shall not be treated as a "pre-existing condition" in the absence of a diagnosis of the condition related to such information.

Notwithstanding any other provision of this "PRE-EXISTING CONDITIONS" section of the Plan to the contrary, in no event shall a Pre-Existing condition exclusion apply to either of the following:

1) pregnancy; and
2) a newborn, an adoptee under the age of 18, or a child under the age of 18 placed for adoption with the Employee, so long as the child is enrolled in the Plan within 30 days after birth, adoption, or placement for adoption, whichever is applicable, provided the child is enrolled pursuant to the provisions set forth in the "WHEN COVERAGE BEGINS" section of the Plan.

For purposes of this Pre-Existing condition section, "enrollment date" means the first day of coverage under the Plan or, if earlier, the first day of the Waiting Period under the Plan.

An individual covered under the Plan will be subject to these Pre-Existing condition limitations for the duration of the Pre-Existing condition exclusion period. For purposes of this Plan, the "Pre-Existing condition exclusion period" is the 12-month period (18 months for late enrollees) following the enrollment date, as reduced by any period of "creditable coverage."

For purposes of this section, "creditable coverage" means coverage under any of the following:

1) a group health plan;
2) health insurance coverage;
3) coverage under Medicare;
4) coverage under Medicaid (other than coverage consisting solely of the program for distribution of pediatric vaccines);
5) medical coverage for members of the uniformed services and their dependents;
6) medical care programs of the Indian Health Service or other tribal organizations;
7) a state health benefits risk pool;
8) the Federal Employees Health Benefits Program;
9) a public health plan (as defined in federal regulations); and
10) health coverage under the Peace Corps Act.

For purposes of this section, the Pre-Existing condition exclusion period shall be reduced by the days of creditable coverage, excluding any creditable coverage incurred prior to a "break in coverage."
Disclaimer
This information is intended to be a brief summary of our Benefit Program and is not to be interpreted as the official benefit plan document. In case of a discrepancy, the Summary Plan Description shall govern.

The Benefit Provisions are intended to be illustrative and not comprehensive. Upon your acceptance of this proposal and HCC Life Insurance Company approval of your group application, summary plan descriptions will be issued and should be consulted for exact benefits and exclusions.

Ancillary Coverage

Basic Life & Accidental Death and Dismemberment Benefits

Life is flat $15,000

Age – Life and AD&D Benefits reduce to
  65% at age 65
  45% at age 70
  30% at age 75
  20% at age 80
  and 20% at age 85

All reduction are based on the amount of insurance in force prior to age 65. All coverage terminates at retirement.
PROPOSAL QUALIFICATIONS AND CONTINGENCIES

Quoted terms and conditions are subject to possible revision based upon receipt and review of the following items:

Paid claims experience to the effective date including monthly enrollment figures.

Updated shock loss information to the date HCCB has been notified that the proposal has been accepted by the group. Shock loss information should include injuries, illnesses, diseases, diagnoses, or other losses of the type, which are reasonably likely to result in a significant medical expense claim or disability, regardless of current claim dollar amount. In addition, shock loss information should include any claimant that has incurred claim dollars in excess of $67,500, regardless of diagnosis. Information is also needed on any claims processed and unpaid, pended or denied for any reason. Please refer to our Trigger Diagnosis List, which provides examples of some, but not all, types of shock losses.

We will accept final shock loss disclosure no earlier than 15 days prior to the effective date.

Please see the attached exhibit for plan document assumptions and requirements.

Quote assumes that retirees are not covered. Quote assumes 3 COBRAs are being covered based on the census information provided.

Should a large claim(s), (non-reoccuring and/or ongoing) become known and the initial date of service is prior to the date of written acceptance by HCC Life Insurance Company, we reserve the right to re-underwrite the case.

In the event there is a greater than 10% change in enrollment between the submitted initial enrollment data and the final enrollment data, rates and factors may be recalculated.

Minimum participation level of 75% of all eligible employees is required.

Aggregate Advantage has been included in this proposal. Aggregate Advantage allows the policy holder to purchase reduced aggregate factors in exchange for a portion of any aggregate claims paid by HCC Life to become refundable to HCC Life by the policy holder(Aggregate Advantage Recover). The Aggregate Advantage Recovery will only be recovered in subsequent months where actual paid claims are less than the monthly attachment point, but will become due immediately upon termination or non-renewal of the policy.

Proposal is subject to full disclosure of all claimants who have reached $67,500 in claims or who have a serious condition based on diagnosis. Higher retentions may be placed on claimants with ongoing conditions.

Proposal is subject to documentation of renewal rates.

Quote assumes the use of the following UR vendors: iProcert.

Quote assumes the use of the following PPO Networks: Arizona Foundation for Medical Care: AZ.

NLO - 9.5% has been added to the indicated specific rates for a no laser guarantee renewal rating action of no more than 60%, regardless of the ongoing claim liability at renewal.

Initial the selected proposal option:

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggregate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Premium and Aggregate Deductible are based on the data submitted. Any inaccurate or incomplete data submitted may require changes at final underwriting.

We will not be bound by any typographical errors or omissions contained herein.

Date: ___________________________ By: __________________________________

Agent of Record or Administrator

This proposal expires if applications are not requested before the valid through date.

Plan Document Assumptions

This proposal for excess loss coverage assumes the Plan Sponsor's plan document includes certain standard clauses, exclusions and limitations. These exclusions and limitations include, but are not limited to the following:

1. **Eligibility, Effective Date, and HIPAA Enrollment Date** provisions, which include definitions of employee (including definitions of full-time and part-time), dependent, and retiree, if applicable.

2. **Termination Provisions** which clearly define when eligibility and benefits cease. The Termination Provisions should include specific wording regarding extension of coverage (also known as “extension of active service”) during a period of inactive service due to disability, layoff or leave of absence. These extensions should be limited to twelve (12) months or less. The plan should include COBRA wording consistent with federal requirements.

3. **Transplant** benefit wording that identifies any benefits applicable to the donor (particularly the non-participating donor), the recipient, organ procurement, and any covered transportation, lodging and companion charges. If policyholder participates in HCCL Transplant Solutions on an active basis; please see the suggested transplant plan document language.

4. Industry standard **subrogation** and **coordination of benefits** clauses.

5. Exclude expenses resulting from losses which are due to a riot, revolt, war, or any act of war, whether declared or not.

6. Exclude expenses for injuries incurred during the commission or attempted commission of any criminal act, as defined by the State, involving, but not limited to the following: Involving the use of alcohol or illegal drugs, excluding minor traffic violations; Involving violence or the threat of violence to another person; or In which the Vovered Person uses a firearm, explosive or other weapon likely to cause physical harm or death.

7. Exclude expenses for any surgery, prescription drugs, device, or procedure, which is considered Experimental or Investigative.

8. Fertility Treatment is not considered a covered plan benefit.

9. **Medically Necessary** defined as follows: A Medically Necessary procedure, treatment, service, supply, equipment, drug or medicine must be: (1) Deemed appropriate, essential and is recommended for the diagnosis or treatment of the Covered Person's symptoms by a licensed physician, dentist or other medical practitioner who is practicing within the scope of his or her license; and (2) Within the scope, duration or intensity of that level of care which is required to provide safe, adequate and appropriate diagnosis or treatment; and (3) Is in accordance with generally accepted current professional medical practice and is not considered Experimental or Investigative.

10. **Experimental or Investigative** defined as follows:
    A drug, device or medical treatment or procedure is Experimental or Investigative:
    a. If the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
    b. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
    i. Maximum tolerated dose
    ii. Toxicity
    iii. Safety
    iv. Efficacy
    v. Efficacy as compared with the standard means of treatment or diagnosis; or
    c. If reliable evidence shows that the consensus among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
    i. Maximum tolerated dose
    ii. Toxicity
    iii. Safety
    iv. Efficacy
    v. Efficacy as compared with the standard means of treatment or diagnosis
    Reliable evidence shall mean:
    1. Only published reports and articles in the authoritative medical and scientific literature;
    2. The written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or
    3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

11. Exclude expenses for services furnished by or for the United States Government or any other government, unless payment is legally required.

12. Exclude expenses for any injury or illness arising out of or in the course of any occupation or employment for wage or profit.

13. Exclude expenses related to Alternative Treatment, except when deemed both medically necessary and cost effective when compared to a normal course of treatment.
ELIGIBILITY
All active full-time, non-seasonal employees working for the employer at least 30 hours per week on a regular basis.

BENEFIT SCHEDULE

<table>
<thead>
<tr>
<th>Class</th>
<th>Description</th>
<th>Schedule</th>
<th>Certificate</th>
<th>Salary Multiple</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All employees</td>
<td>Flat</td>
<td>$15,000</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

X Extension of Benefits (Waiver of Premium)

Benefits extend until attainment of Age 65

Employer Contribution Non-Contributory

Number of Eligible Employees 92

<table>
<thead>
<tr>
<th>Life</th>
<th>Volume $1,540,000</th>
<th>Rate $0.20 per $1,000</th>
<th>Monthly Premium $277.20</th>
</tr>
</thead>
<tbody>
<tr>
<td>AD&amp;D</td>
<td>Volume $1,540,000</td>
<td>Rate $0.06 per $1,000</td>
<td>Monthly Premium $77.00</td>
</tr>
</tbody>
</table>

Guarantee Issue Amount $15,000 All Rate(s) include Commissions of 20.00%

The above AD&D rate includes the following optional benefits: Automobile Seat Belt Benefit, Automobile Air Bag Benefit.

AGE REDUCTION
Life and AD&D Benefits reduce to 65% at age 65, 45% at age 70, 30% at age 75, 20% at age 80, and 20% at age 85. All reductions are based on the amount of insurance in force prior to age 85. All coverage terminates at retirement.

PROPOSAL ASSUMPTIONS

- Any 10% change to the amount of coverage (volume) since the effective date, to the initial list of insureds, will result in the right of HCC Benefits to re-evaluate and possibly re-price all coverage provided.
- The Actively at Work provision will not be waived (unless contract currently in force with HCC Benefits).
- Quote assumes an incurred takeover; claims must be incurred after the 03/01/2004 effective date.
- The Life coverage is written on a non-retention basis.
- Quote assumes that Waiver of Premium is currently in place.
- Quote assumes that we are not picking up retirees or disabled.
- Quote assumes that standard HCC Life policy wording will apply.
- Quote assumes the Basic Life/AD&D benefits will be self-administered. HCC Life does not provide list bill services for Basic Life/AD&D coverage.

Life Insurance Quotation is based upon the preliminary census information submitted and may change if the final enrollment census is significantly different than the preliminary submission. Additional Conditions apply as follows:

Life rates are based on the assumption that there is not a group life insurance program currently in place. If there is a program, please furnish the schedule, rates, and claims information so we may customize our quote.