REINSURANCE AGREEMENT

(herein referred to as “Agreement”)

Between

AMERICAN FIDELITY
ASSURANCE COMPANY

Oklahoma City, OK

(herein referred to as “The Company”)

And

GENERIC HEALTH PLAN

City, State

(herein referred to as “Plan”)

Effective Date: XXXXXX, 2011

Reinsurance Agreement Number XXXXXXX

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ARTICLE 1

Reinsurance Coverage

1.1 **INSURING CLAUSE:** The Plan will cede to The Company and The Company will reinsure the Percentage Payable of Eligible Expenses Incurred per member per Contract Year that exceeds the applicable Attachment Point, up to any applicable maximums for specified Lines of Business, situs of Plan and/or the date the Eligible Expenses were incurred.

OR

1.1 **INSURING CLAUSE:** The Plan will cede to The Company and The Company will reinsure the Percentage Payable of Eligible Expenses Incurred per Member per Contract Year that exceed the applicable Attachment Point, up to any applicable maximums for specified Lines of Business, subject to all terms of this Agreement. The percentage payable of Eligible Expenses that exceed the applicable Attachment Point will be applied toward an Aggregating Specific Deductible. When applicable, reimbursement is based on the situs of Plan and/or the date the Eligible Expenses were incurred.

OR

1.1 **INSURING CLAUSE:** The Plan will cede to The Company and The Company will reinsure the Percentage Payable of Eligible Expenses Incurred per Member per Contract Year that exceed the applicable Attachment Point, plus the Aggregate Retention Point, up to any applicable maximums for specified Lines of Business. The percentage payable of Eligible Expenses that exceed the applicable Attachment Point up to any Aggregate Retention Point will be applied toward an Aggregating Specific Deductible. When applicable, reimbursement is based on the situs of Plan and/or the date the Eligible Expenses were incurred.

OR

1.1 **INSURING CLAUSE**: The Plan will cede to The Company and The Company will reinsure the Percentage Payable of Eligible Expenses Incurred per Member per Contract Year that exceeds the applicable Attachment Point, up to any applicable maximums for specified Lines of Business, subject to the Retained Corridor. When applicable, reimbursement is based on the situs of Plan and/or the date the Eligible Expenses were incurred.

1.2 **CARRYFORWARD:** Eligible Expenses may include expenses Incurred by a member in the last 31 days of an Agreement issued to the Plan by The Company immediately preceding this Agreement if the applicable Attachment Point was not reached with respect to that member under that preceding Agreement.

ARICLE 2

Schedule

2.1 **LINE(S) OF BUSINESS:**

Medicare

Self-funded employees are not covered under this Agreement, unless they are employees for which the Plan has risk, and they are specifically listed above as a Line(s) of Business.

2.2 **MONTHLY PREMIUM PER MEMBER:**

Line(s) of Business	
Medicare	

2.3 **ATTACHMENT POINT(S) PER MEMBER:**

Line(s) of Business	
Medicare	

See attached Eligible Expense Matrix for Eligible Expenses.

2.4 **INDIVIDUAL CONTRACT YEAR MAXIMUM: $ XXXX**

2.5 **PERCENTAGE PAYABLE**

A. Percentage Payable 90%

B. Increased Percentage Payable
If the following requirements are met 95%

To ensure Eligible Expenses on each member are reimbursed at the Increased Percentage Payable, items 1) and 2) below must be fulfilled prior to Plan payment of provider.

1) **Early Notice of Claim**: Plan will give The Company written notice by completing an Early Notification Form, including medical management contact information, within 30 days of Plan's knowledge of:

   a. Any claim or potential reinsurance claim that exceeds or is expected to exceed 50% of the Attachment Point during the Contract Year; or

   b. Even if not at 50% of the Attachment Point, a member having any of the following during the Contract Year:

      i. Cancer (ICD9 Codes 200-208.99)
      ii. Pending transplant
      iii. Neonatal Intensive Care Unit (NICU) stay greater than 10 days
      iv. End Stage Renal Disease (ESRD) with dialysis (ICD9 Code 585)
      v. Severe burns (ICD9 Code 948.5-948.99 and 949.3-949.5)
      vi. Multiple trauma (ICD9 Code 959.8)
      vii. Clotting disorder (ICD9 Code 286.99)
      viii. Congestive heart failure (ICD9 Codes 428-428.09)
      ix. Cardiomyopathy (ICD9 Code 425)

The Plan will submit a monthly update to The Company of changes to potential reinsurance claims.

2) **Cost Containment Program (CCP):** Upon **Early Notice of Claim** in 1) above, Plan will implement all The Company recommended CCPs for that Member. If The Company reviews the case and does not offer a written CCP recommendation the lower Percentage Payable applies. If Plan chooses not to implement all The Company recommends CCPs for that Member, the lower Percentage Payable will apply to that Member for the Contract Year.

If there are savings to the Plan a result of the implemented CCP, the Plan and The Company will pay proportionately for related expenses, except for transplant access fees. Transplant access fees will be reimbursed as negotiated between Plan and The Company.

2.6 **ELIGIBLE EXPENSE LIMITATIONS PER MEMBER:** Eligible Expenses are limited to the lesser of:

A. The billed charges (unless paid at a Medicare DRG. The Medicare DRG code or DRG calculation worksheet will be provided by the Plan for all Inpatient confinement payments paid at a Medicare DRG); or

B. The amount paid by the Plan; or

C. any other limits shown in this Agreement

2.7 **COVERED ACUTE CARE, INCLUDING PHARMACEUTICALS:**

A. Eligible Expense Limitations for Covered Acute Care is limited to the following Average Daily Maximum (ADM):

Average Daily Maximum	
Transplants	$ XXXXXX
All other Covered Acute Care - Days 1-10	$ XXXXXX
All other Covered Acute Care - Days 11+	$ XXXXXX
The ADM limits do not apply to Eligible Expenses that are:	
Incurred during the Transplant Confinement for Transplants: • Paid at a Fixed Fee	
For: • Transplant Acquisition Expense • Ambulance • DME	
Paid at: • A Medicare DRG when paid at a fixed case rate for the fixed case rate portion only. Payment documentation will be required which clearly illustrates the DRG calculation, including the Fixed case rate portion, and when the outlier begins. If a daily outlier is reached, the ADM applies for those days beyond the outlier. If a cost outlier is reached, the ADM applies to the entire confinement.	

B. Transplant Acquisition Expenses: $ XXXXXX per Contract Year

2.8 **SUB-ACUTE CARE AND LONG TERM ACUTE CARE:**

Limitations. The following limits will apply to Eligible Expenses listed below:

Eligible Expenses that are for:	**Limitation:**
All Sub-Acute Care and Long Term Acute Care	$ XXXX per day

These limits do not apply to Eligible Expenses that are for:

- Ambulance
- DME
- Pharmaceuticals

2.9 **HOME HEALTH CARE**

Limitations. The following limits will apply to Eligible Expenses listed below:

Eligible Expenses that are for:	**Limitation:**
All Home Health Care	$ XXX per day

These limits do not apply to Eligible Expenses that are for:

- Ambulance
- DME
- Pharmaceuticals

2.10 **PROFESSIONAL CARE:**

Limitations. The following limits will apply to Eligible Expenses listed below:

<table>
<tr><th>Eligible Expenses that are for:</th><th>Limitation:</th></tr>
<tr><td>Transplants</td><td>100% of Medicare Allowable or 50% of billed charges if no Medicare Allowable</td></tr>
<tr><td colspan="2">These limits do not apply to Eligible Expenses that are:</td></tr>
<tr><td colspan="2">Incurred during the Transplant Confinement for Transplants
• Paid at a Fixed Fee</td></tr>
<tr><td colspan="2">For:
• Ambulance
• DME
• Pharmaceuticals</td></tr>
</table>

2.11 **PHARMACEUTICALS:**

Eligible Expenses that are for:	**Limitation:**
Pharmaceutical received in a Sub-Acute Care, Long Term Acute Care, or Outpatient Care setting	50% of billed charges
Pharmaceuticals received in a Home Health Care or Professional Care setting.	100% of Medicare Allowable or 50% of billed charges if no Medicare Allowable
All Pharmaceuticals other than in a Covered Acute Care or Professional Care setting	$ XXXXX per Contract Year

ARTICLE 3

Definitions

3.1 **AMBULANCE:** Transportation for an emergency or from one Facility to another Facility.

3.2 **AVERAGE DAILY MAXIMUM ("ADM"):** The average expense per day for each period of continuous confinement for Covered Acute Care during the Contract Year.

OR

3.2 **AVERAGE DAILY MAXIMUM ("ADM"):** The average expense per day over all confinements for Covered Acute Care during the Contract year. The number of days used to determine the tiering for the ADM is the cumulative number of days of inpatient Facility confinements per member occurring during any one Contract Year.

3.3 **BLOOD PRODUCTS**: Blood products, including blood-clotting factors, derived from blood or recombinant (synthetic) sources and used to treat serious condition, including blood-clotting disorders. Blood clotting factors include, but are not limited to, Factor Vlla (recombinant), Factor VII (human, porcine, recombinant), Factor IX (nonrecombinant and recombinant), and von Willebrand Factor.

3.4 **COST CONTAINMENT PROGRAM**: A program recommended by The Company that is designed to improve quality and reduce or control the cost of providing healthcare services and supplies covered.

3.5 **CHEMOTHERAPY**: Chemotherapy drugs (as indicated in HCPCS book for codes J9000-J9999 or any replacement codes or an equivalent NDC code) and any medications used to treat cancer or the side effects of chemotherapy.

3.6 **CONTRACT YEAR**: The period that begins on the Effective Date and ends upon the earlier of 12 months beyond the Effective Date or the termination of this Agreement.

3.7 **COVERED ACUTE CATE**: The subset of medically necessary services and supplies for treatment of a Member for the period where:

A. The Member is a registered inpatient in a Facility; and

B. the member is receiving daily evaluation and treatment from a licensed physician or registered nurse under the supervision of a licensed physician; and

C. The Company determines, using reasonable guidelines, that the Member's care:

1) Would qualify for inpatient hospital acute medical care (medical, surgical, intensive care units); and

2) Is not care solely for intensive, acute, or other rehabilitation.

Covered Acute Care does include Professional Care, Long Term Acute Care, and Sub-Acute Care. Covered Acute Care does include the Infusion of bone marrow or peripheral blood stem cells in an outpatient setting during a Transplant Confinement.

3.8 **CUSTODIAL CARE:** Services and supplies provided to a member that are for maintenance, not mainly rehabilitative or restorative, or mainly to assist in the activities of daily living (such as help in eating, getting out of bed, bathing, dressing, toileting, or taking drugs).

3.9 **DIALYSIS:** Process by which toxic substances are removed from the blood artificially when the kidneys have failed (renal failure).

3.10 **DURABLE MEDICAL EQUIPMENT ("DME"):** Medical equipment ordered by a health care provider including, but not limited to, orthotics, prosthetics, or implants.

3.11 **ELIGIBLE EXPENSE(S):** Expenses for health care services and supplies provided to a Member that are Incurred during the Contract Year and are:

A. Covered by the Membership Service Agreement as the responsibility of the Plan to provide to a member; and

B. Shown on the attached Eligible Expenses Matrix(ces) as an Eligible Expense under this Agreement; and

C. performed by a Plan participating provider; or performed by a nonparticipating provider utilized (1) due to a referral by the Plan, (2) due to an emergency, (3) due to the Member being inpatient confined on the date they became a Member; and

D. Not excluded under this Agreement.

3.12 **ELIGIBLE EXPENSE MATRIX(CES):** The attached forms listing:

A. Which services and supplies meet part B of the definition of Eligible Expense, and which do not; and

B. Which services and supplies apply to each Attachment Point, if this Agreement has more than one Attachment Point.

3.13 **EXPERIMENTAL**: Means medical services, supplies or treatments, including drugs, devices and geological products, provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II, or III). The covered service will also be considered Experimental in any setting if the Covered Person is required to sign a consent form that indicates the proposed treatment, procedure, medical service, supply, drug, device or biological product is part of a scientific study or medical research to determine its effectiveness or safety. Medical treatment, which is not considered standard treatment under the particular medical circumstances by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental. Off-label usage of any drug will be considered Experimental. A drug, device or biological product is considered Experimental if is does not have FDA approval or it has FDA approval only under an interim step in the FDA process, i.e., an investigational device exception or an investigational new rug exception or is used off-label.

3.14 **FACILITY(IES**): Any hospital, specialized medical institution, skilled nursing facility or rehabilitation facility, that bills for its services and supplies on form CMS-1450 or any form that replaces this form.

3.15 **FIXED FEE**: The per diem or per case rate the Plan paid a Facility for health care services and supplies. Fixed Fee excludes:

A. The per diem or per case rate if the entire payment reverted to a discounted rate once an outlier or stop loss level was reached; or

B. Any amounts that exceeded an outlier or stop loss level that the Plan paid at a discounted rate; or

C. Any payment that included billed charges as part of its calculation.

3.16 **HOME HEALTH CARE**: The subset of medically necessary health care services and supplies that are mainly rehabilitative or restorative in nature and are for treatment of a Member in a home setting. Home Health Care does not include Custodial Care.

3.17 **INCURRED:** The date the services or supplies to which the expense relates are provided.

3.18 **INDIVIDUAL CONTRACT YEAR MAXIMUM**: The maximum liability of The Company, per Member under this Agreement per Contract Year as indicated by the amount specified in the Schedule.

3.19 **INJECTABLES:** Drugs other than oral medications (as indicated in HCPCS book for codes J0001- J8999 and Q codes or any replacement codes or any NDC equivalent codes) for non-chemotherapy medications, excluding clotting factors (J7190-J7199) and Blood Products.

3.20 **LONG TERM ACUTE CARE:** Comprehensive services for a Member who is a registered inpatient requiring specialized, complex services, and is stable enough to move to a Long Term Acute Care Hospital. These services require daily physician monitoring and intensive nursing care, generally with a length of stay for 25 days or more. Examples include ventilator dependent patients and patients requiring wound care management, IV therapy, dialysis and telemetry. Long Term Acute Care does not include Professional Care, Covered Acute Care, Sub-Acute Care or Custodial Care.

3.21 **LONG TERM ACUTE CARE HOSPITAL (LTACH):** A Facility, or hospital within a hospital, licensed by the State as a LTACH.

3.22 **MATERIAL CHANGE:**

A. A change or combination of changes in a Membership Service Agreement, provider reimbursement levels, number of Members in a Line of Business increases or decreases, or the Plan's service area, that The Company determines would increase expected reinsurance claims 5% or more; or

B. The Plan acquires the assets of another company or foundation or merges with or comes under control of another person, company or foundation; or

C. Any change in senior operating management, any fundamental change in its management service contract, or any change in majority ownership of the Plan.

Material Changes require notification (Article 7), and may be excluded (Article 5) or result in premium changes (Article 4) or termination (Article 8).

3.23 **MEDICARE ALLOWABLE**: Fees set by Medicare.

3.24 **MEMBER:** A person or dependent enrolled by the Plan and eligible to receive services under a Membership Service Agreement.

3.25 **MEMBERSHIP SERVICE AGREEMENT(S):** Those contractual agreements between the Plan and its Members for those specified Lines of Business listed in Article 2, that are made a part of this Agreement.

3.26 **OUTPATIENT CARE**: Services and supplies provided by a Facility to a Member who is not a registered inpatient in that Facility.

3.27 **PHARMACEUTICALS:** Blood Products, Chemotherapy, Injectables, and prescription medications dispensed by a retail pharmacy.

3.28 **PROFESSIONAL CARE**: Services and supplies, including medical, surgical, diagnostic, therapeutic, and preventative services provided to a Member by any health care professional, paraprofessional or facility that bill on a form CMS-1500, or any form that replaces these forms. Professional Care does not include Home Health Care.

3.29 **SUB-ACUTE CARE**: The subset of medically necessary health care services and supplies that are mainly rehabilitative or restorative in nature and are for treatment of a Member when the Member is a registered inpatient in a Facility. Sub-Acute Care does not include Long Term Acute Care, Custodial Care or Professional Care.

3.30 **TRANSPLANT**: A surgical procedure in which a dysfunctional organ is replaced by a functional human organ from either a deceased or living donor or the infusion of bone marrow or peripheral blood stem cells to reconstitute the immune system following preparative regimens of chemotherapy administered to treat disease.

3.31 **TRANSPLANT ACQUISITION EXPENSE**: Search fees and expenses to remove (from either a deceased or a living donor), preserve, and transport a donated organ, bone marrow, or peripheral stem cells.

3.32 **TRANSPLANT CASE RATE**: The rate that is negotiated for a Transplant for a defined number of days. When per diem outliers until discharge are negotiated, the Transplant Case Rate will include such per diem outliers.

3.33 **TRANSPLANT CONFINEMENT**: The period of time for which the Transplant Case Rate applies or, if there is no Transplant Case Rate, the period of time that begins one day prior to the Transplant and ends upon hospital discharge or on the date of the Transplant and ends 40 days later for outpatient bone marrow and peripheral stem cell transplants.

3.34 **TRAVEL EXPENSE**: Commercial transportation to and from the site of a Transplant and lodging and meals costs of the Member receiving the Transplant and his/her companions, when the Member resides more than 50 miles from the Transplant site and when the Member receives a Transplant during the Contract Year.

ARTICLE 4

Reinsurance Premiums

4.1 **PREMIUM RATE**: The reinsurance premium payable each month is the amount per Member listed in Article 2, times the number of Members enrolled in the Plan for that month for each of the specified Lines of Business listed in Article 2.

4.2 **DUE DATE:** Premium is due to The Company at its office in White Plains, NY on the first day of each month of the Contract Year.

4.3 **GRACE PERIOD:** There is a grace period of 31 days after the due date to pay the premium. If premium is not paid before the end of the grace period, this Agreement automatically terminates as of the end of the period for which premium has been received.

4.4 **REINSTATEMENT:** The Company may, at its sole discretion, reinstate this Agreement upon receipt of all outstanding and current month's premium after the grace period along with any claim information determined by The Company. Payment of premiums will not guarantee reinstatement of the Agreement. Rates, terms and conditions are subject to change as a condition of reinstatement. The parties agree that past reinstatements create no right or presumption of future reinstatement.

4.5 **SIGNED STATEMENT**: Each premium payment must be accompanied by a statement signed by an authorized representative of the Plan as to the number of Members in each of the specified Lines of Business listed in Article 2, and any adjustments from previous statements.

4.6 **PREMIUM RATE CHANGE:** The Company may change premium as of the date of any Material Change if The Company notifies the Plan of the change in premium within 30 days of The Company being notified of the Material Change.

ARTICLE 5

Additional Limitations

5.1 **OBLIGATIONS:** This is an Agreement solely between and solely benefiting the Plan and The Company. The parties intend no benefit by this Agreement to creditors, Members, or health care providers. The Plan is responsible for all health care and health care expenses for Members. The Company has no obligation to provide any service or payment, directly or indirectly, to anyone but the Plan.

5.2 **COORDINATION OF BENEFITS/SUBROGATION**: If the Plan receives or will receive any payment or reduction in expense by reason of a coordination of benefits provision in the Membership Service Agreement or by any right of subrogation, that payment or reduction is a reduction in Eligible Expenses. If The Company has already paid a claim that included these Eligible Expenses, the Plan will reimburse The Company the amount of this reduction.

5.3 **MULTIPLE POLICIES:** If Plan has another Agreement insuring the same risk assumed under this Agreement for these same Lines of Business, The Company will pay only the pro rata portion of the amount otherwise payable under this Agreement, subject to the Agreement maximums and limitations.

5.4 **ADDITIONAL LIMITATIONS**: The Company is not liable to the Plan, and the Plan will hold harmless and indemnify The Company, for the following:

A. Amounts in excess of the maximums set forth in this Agreement or limitations shown in the Schedule.

B. Professional liability or liability for any act or omission, tortuous or otherwise, in connection with any services for any person or group of persons by the Plan or any group, entity, or person employed by or contracted with the Plan.

C. Extra contractual damages or liability of the Plan in excess of Plan's Membership Service Agreements, including amounts paid for services or expenses that are not covered by the Plan’s Membership Service Agreement.

D. Medical expenses due to declared or undeclared war.

E. Expenses that the Plan has not paid or Capitated Services unless listed under specified Lines of Business in Article 2.

F. Expenses that result from services done for cosmetic purposes, unless:
a. performed to correct functional disorders or congenital anomalies; or
b. due to accidental injury occurring while the individual is a Member.

G. Additional liability of The Company caused by a Material Change, unless The Company expressly accepts the Material Change.

H. Expenses that result from any procedure or treatment to change physical characteristics to those of the opposite sex; and any other treatment or studies related to sex change.

I. Expenses for an illness or injury for which the Member is eligible for benefits from, or receives benefits from, a workers compensation, occupational disease, or similar government law.

J. Expenses incurred for Experimental procedures as defined, or for research or studies or for any services or supplies not considered legal in the United States of America.

K. Liabilities, expenses, or losses that are based upon any noncompliance or violation of any Federal or State statute, rule, or regulation by the Plan.

L. Treatment, services or supplies that are listed as "Not Covered" on the attached Eligible Expense Matrix(ces).

M. Any liability arising from any benefit denial or restriction made by the Plan, or arising from any product design or advertising of the Plan.

5.5 **MULTIPLE INTERPRETATIONS:** In the event that an Eligible Expense can be calculated in more than one way under the terms and provisions of this Agreement, only the amount calculated to generate the lesser amount of Eligible Expense will be considered covered hereunder.

ARTICLE 6

Notice of Claims and Reimbursement

6.1 **WRITTEN NOTICE OF CLAIM**: The Plan will give The Company written notice by completing an Early Notification Form, including medical management contact information, within 30 days of the Plan's knowledge of any claim or potential reinsurance claim that exceeds or is expected to exceed 50% of the Attachment Point during the Contract Year. The Plan will also submit a monthly update to The Company of changes to potential reinsurance claims.

6.2 **PROOF OF CLAIM:** In order to consider a claim submission for processing, the Plan must file completed and itemized proofs of loss by sending to The Company the information required under 6.3B.

6.3 **LOSS OF COVERAGE:** There is no reinsurance of an Eligible Expense when:

A. The Company does not receive a completed Early Notification Form, or any other form, electronic file, or format designated by and approved by The Company that contains the same fields as the Early Notification Form, related to the Eligible Expense, prior to 6 months after the end of the Contract Year; and

B. The Company does not receive the following information related to the Eligible Expenses prior to 6 months after the end of the Contract Year;

1) A completed claim form;

2) Enrollment documents including eligibility verification on each submission;

3) A The Company approved or mutually agreeable claim detail report with all the required data elements, including, but not limited to billed and paid amounts, dates of service, diagnoses and claim service codes (Rev, CPT, HCPC) in CMS standard coding, proof of payment, provider name and identifier; and

4) Any other documentation The Company reasonably deems necessary to properly determine the reinsurance payable. This includes, but is not limited to, copies of the completed CS-1450 or CMS-1500, or if electronically billed by a provider, a copy of the electronic submission.

However, this limitation does not apply to Eligible Expenses if prior to 9 months after the end of the Contract Year the Plan has in writing pursued a right by coordination of benefits, subrogation or otherwise to recover or reduce such expenses, and has notified The Company of such action.

6.4 **CLAIM FORMS:** The Company will furnish Plan with a supply of claim forms initially, and upon request of the Plan.

6.5 **APPEAL OF CLAIM DETERMINATION**: The Plan must submit a written request for review of any claim processed under this Agreement within 60 days after receipt of a Claim Determination. This request must include the specific reason for the review.

ARTICLE 7

Reports, Records and Audits

7.1 **NOTICE OF MATERIAL CHANGE**: The Plan will give written notice to The Company of any Material Change no later than 30 days after the Material Change.

7.2 **NOTICE OF SUPERVISION BY THE STATE:** If the Plan is placed under supervision by the state, the Plan will give written notice to The Company within 15 days.

7.3 **ENROLLMENT:** The Plan will keep a record of the monthly enrollment of Members covered by its Membership Service Agreements and the Eligible Expenses for each Member while covered under this Agreement. Such record will be kept during the time this Agreement is in effect and for a three (3) year period after its termination date or for the period during which claims are pending, whichever is longer.

7.4 **BOOKS AND RECORDS:** The Plan's books, records, and Membership Service Agreements will be made available to The Company for inspection and audit at any time during normal business hours while this Agreement is in effect and for a three (3) year period after its termination date or for the period during which claims are pending, whichever is longer.

7.5 **NOTICE OF INVESTIGATION:** The Plan will give written notice to The Company of any investigation or request for information of a material nature (not including routine reports and requests), by a regulatory agency regarding the conduct of the Plan. Such written notice must be provided by the Plan to The Company within 30 days following the date the Plan receives notice, written or otherwise, of such investigation or request.

ARTICLE 8

Effective Date, Duration and Termination

8.1 **EFFECTIVE DATE:** This Agreement is effective on the date indicated on the face page.

8.2 **TERMINATION:** This Agreement terminates on the earliest of the following:

A. Nonpayment of premium as set forth in the Reinsurance Premium provisions.

B. The date a petition is made for a declaration of receivership or rehabilitation of a party, or the date a party ceases operations.

C. The date of a Material Change if The Company notifies the Plan of termination for this reason within 30 days of The Company being notified of the Material Change.

D. The end of the Contract Year.

E. Upon the date of a material breach of this Agreement. The party terminating for this reason must give the other party notice of the actions or inactions that constitute the breach and 5 business days to cure the breach to the satisfaction of the notifying party.

8.3 **TERMINATION OF RIGHTS:** Termination of this Agreement does not affect the rights and liabilities of the Plan or The Company arising during any period when this Agreement was in effect. However, this does not extend liability of The Company for expenses that are Incurred after the termination of this Agreement.

8.4 **INSOLVENCY:** In the event of the insolvency of the Plan all Reinsurance will be payable directly to the liquidator, receiver, or statutory successor of the Plan, on the basis of the liability of Plan in this Agreement without diminution due to the insolvency of the Plan.

8.5 **NOTICE OF TERMINATION:** Except for termination at the end of the Contract Year, the terminating party must give written notice of termination by registered mail to the State of ____Insurance Commissioner at least ____days prior to termination.

ARTICLE 9

General Provisions

9.1 **ENTIRE AGREEMENT:** This document, any attached endorsements, the Eligible Expense Matrix(ces), any Disclosure Statement and any documents incorporated by reference constitute the entire Agreement between the Plan and The Company.

9.2 **AGREEMENT CHANGES:** This Agreement may be amended by mutual written consent of officers of the Plan and The Company.

9.3 **ASSIGNMENT:** This Agreement and any amounts payable under this Agreement are not assignable.

9.4 **WAIVER:** Waiver of any provision of this Agreement is not a waiver of that provision or other provisions at a later date.

9.5 **RIGHT OF OFFSET**: Amounts owed by the parties to each other, with respect to this Agreement may be offset and then only the balance will be owed. The right of offset will not be affected or diminished because of the insolvency of either party.

9.6 **CLERICAL ERROR:** If The Company fails to comply with a provision of this Agreement because of an error, the underlying status of this Agreement will not be changed so long as the error is rectified as soon as possible after discovery. Then both parties will be restored to the position they would have occupied had such error not occurred. An error is an inadvertent clerical mistake. It does not include errors in judgment, errors that expand the definition of Membership Service Agreement or reduce the effect of the limits in this Agreement, negligent acts, and repetitive errors in administration, or other errors. Neither party may invoke a right to rectify its error after 12 months after the end of the Contract Year.

9.7 **WARRANTY AND REPRESENTATIONS**: The Plan warrants and represents that the information provided during the underwriting and on the claims disclosure statement with respect to this Agreement is accurate. Any omission, misrepresentation, concealment or fraud relating, directly or indirectly, to:

A. The information supplied during the underwriting and on the claims disclosure statement with respect to this Agreement;

B. Any statement, warranty or declaration made by the Reinsured or its representatives whether in writing or otherwise, to the Company; or

C. The making of a claim hereunder

Shall render this Agreement null and void at the sole discretion of the Company, and the Plan agrees to reimburse the Company for all claims paid by the Company and for any other liability the Company incurred or incurs as a result of such. Should the Company choose not to render this Agreement null and void the Company may instead adjust the terms, rates or conditions of this Agreement retroactive to the effective date of this Agreement.

9.8 **PERSONAL INFORMATION: Confidentiality:**

A. Personal Information means nonpublic personal information as described in Title V of the Gramm Leach Bliley Act and protected health information as described in privacy regulations of the Department of Health and Human Service (HHS) that may be identified with a Member and that The Company obtains.

B. The Company may use Personal Information to underwrite and perform terms of this Agreement and in other ways permitted by applicable privacy laws. The Company will:

1) Use safeguards to prevent non permitted use or disclosure; and
2) Restrict access to only those employees involved in the permitted uses; and
3) Report to the Plan any non permitted use or disclosure of which it becomes aware; and
4) Make Personal Information and related records available as described in privacy regulations of HHS.

The Company may disclose Personal Information to a person assisting in permitted uses if that person agrees in writing to be bound to terms similar to Article 9.8.

C. Article 9.8 does not apply if:

1) The Personal Information is available to the public other than as a result of any disclosure by The Company or its representatives; or
2) The Personal Information was available to The Company or its representatives on a non confidential basis before it was obtained for uses permitted in Article 9.8; or
3) The Plan and the Member consent in writing to the disclosure; or
4) The law requires disclosure.

D. The Company will destroy Personal Information, if feasible, after seven years after this Agreement terminates.

9.9 **BINDING ARBITRATION:** If any dispute arises out of or relates to this Agreement or its breach, termination or validity, the parties agree that first, senior management will try in good faith to settle the dispute. If they do not reach a solution within 90 days, the dispute will be settled by arbitration administered by the American Arbitration Association (“AAA”) according to its Commercial Arbitration Rules. The parties will each pay the costs of its counsel, witnesses, experts and proofs. The parties will share the cost of the arbitration administration. The arbitrator may award specific performance, rescission, or monetary damages in an amount that does not include punitive or other damages in excess of contractual damages. The arbitration shall take place in Oklahoma City, Oklahoma.

9.11 **ADD STATE VARIABLE LANGUAGE:**

ARTICLE 10

Experience Refund

10.1 **EXPERIENCE REFUND:** If The Company issues the Plan an Agreement subsequent to this Agreement that provides coverage for an additional Contract Year and coverage is continuous from the effective date of this Agreement through the entire Contract Year of the subsequent Agreement, the premium for this Agreement provides for an experience refund of 30% of The Company's net profit for this Agreement, if any. When applicable, all experience refunds are subject to any Net Profit deficits carried forward from Agreements issued to Plan by The Company during the previous 2 years.

10.2 **NET PROFIT:** The net profit is calculated as follows:

A. The sum of all premiums paid by the Plan for coverage under this Agreement; minus

B. The sum of all expenses Incurred by The Company that are equal to 40% of premium paid by the Plan for this Agreement; minus

C. The sum of all reinsurance claims paid by The Company under this Agreement.

D. The sum of all fees paid by The Company under this Agreement for access to medical providers and/or to any unaffiliated company or person to investigate, manage or audit a claim.

10.3 **CALCULATION OF REFUND:** The Company will calculate and distribute to the Plan any experience refund XX months after the end of the Contract Year.

ARTICLE 11

Retrospective Premium Adjustment

11.1 **CALCULATION:** XX (xx) months after the termination of this Agreement, The Company will calculate premiums paid and net loss for this Agreement and provide the Plan with a copy of this calculation and any supporting documentation.

11.2 **NET LOSS**: For purposes of this calculation, net loss is calculated as:

A. The sum of all expenses Incurred by the Plan that are equal to 40% of premium paid by the Plan for this Agreement; plus

B. The sum of all claims paid by The Company under this Agreement.

11.3 **ADDITIONAL PREMIUM**: The Plan shall pay The Company an additional premium equal to any amount of net loss that is greater than premiums paid for this Agreement but less than 105% of premium paid.

11.4 **PREMIUM REFUND:** The Company shall pay the Plan an amount equal to any net loss that is less than premiums paid but greater than 60% of premiums paid. If net loss is less than 60% of premium paid, the Plan will receive a premium refund equal to 20% of premiums paid.

11.5 **PAYMENTS:** Any additional premium owed by the Plan or any premium refund owed by The Company shall be paid within 30 days of the date of the calculation. Any payment made after 30 days shall accrue interest at the 90-day T-bill rate plus 3-percent, calculated on a monthly basis.

11.6 **REVISED STATEMENT:** The Company shall provide the Plan with a revised statement that accurately reflects premiums paid and net profit based on the payment of additional premium or a premium refund.

ARTICLE 12

Retained Corridor

12.1 **DEFINITIONS:** The following definitions apply to this Article:

A. Loss Ratio: The ratio of Agreement Claims as of the date of claim adjudication to annual premium under this Agreement;

B. Corridor Ceiling: 80% of annual premium under this Agreement;

C. Agreement Claims: The percentage payable of Eligible Expenses that exceed the applicable Attachment Point under this Agreement, up to any applicable maximums.

12.2 **CALCULATION:** If the Loss Ration reaches 60%, the Plan will retain the risk for all Eligible Expenses in excess of the Loss Ration up to the Corridor Ceiling. Once the Corridor Ceiling has been reached, The Plan will resume payment of Agreement Claims in excess of the Corridor Ceiling. The annual premium shall be calculated as year to date premium plus the most recent month's premium as an estimate for the remaining months. At the end of the Contract Year, a "true up" calculation will be performed based on the actual annual premiums paid and the duration of the Agreement for that Contract Year. Additional amounts owed the Plan will be paid within 60 days from the end of the Contract Year. Additional amounts owed The Plan will be used to offset claims, until the proof of claim period has expired, at which time, any amounts still owed The Plan will be paid within 60 days.

This Agreement will automatically terminate at the end of the Contract Year (Article 8).

IN WITNESS WHEREOF, the Plan and The Company have, by their respective officers, executed and delivered this Agreement, in duplicate effective from the date set out on the face page of this Agreement.

GENERIC HEALTH PLAN

Dated: ______________________ By: ______________________

Attest: ______________________ Title: ______________________

AMERICAN FIDELITY ASSURANCE COMPANY

Dated: ______________________ By: ______________________

Attest: ______________________ By: ______________________