

CT PRIME, Inc.

111 Charter Oak Avenue
Hartford CT 06106
860-240-6619

CT SCHEDULE OF EXCESS LOSS COVERAGE

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

Insured: Town of Canton & Board of Education

Policy Number: CTPRIME0014

Effective Date: 7/1/2017

Coverage specified herein is applicable only during the Policy Period from **07/1/2017** to **07/01/2018**, and is further subject to all terms and conditions of this Policy.

Actively at Work/Disability requirement. Applied Waived with Approved Disclosure
The Actively at Work/Disability requirement is explained in the definition of "Covered Person" in the Definitions Section.

SPECIFIC EXCESS LOSS INSURANCE: Yes No

Benefit Period: Covered Expenses Incurred from **01/01/2017** to **07/01/2018** and Paid from **07/01/2017** to **07/01/2018**; however, if the Policy is terminated before the end of the originally scheduled Policy Period set forth above, Covered Expenses must be Incurred from **01/01/2017** to the termination date and Paid from **07/01/2017** to the termination date to be eligible for reimbursement. Covered Expenses Incurred from **N/A** to **N/A** will be limited to **\$N/A**
per Covered Person Family

Specific Deductible Per Covered Person Per family \$150,000

Specific Percentage Reimbursable 100%

Maximum Specific Benefit per Covered Person per family (including Specific Deductible):
 \$500,000 \$1,000,000 \$2,000,000 Other \$ for the Benefit Period described above; no lifetime maximum

Specific Excess Loss Insurance includes: Medical only Medical with Prescription Drug Program
Common Accident Provision: Yes No

Common Accident means if more than one Covered Person in the same immediate family incurs Covered Expenses as a result of the same accident, the Specific Deductible will be applied only once to all Covered Expenses Paid because of that accident for all Covered Person in the family during the same Benefit Period.

Specific Premium Per Month

| Covered Units | Rates |
|---------------|----------|
| 272 | \$103.06 |

AGGREGATE EXCESS LOSS INSURANCE Yes No

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

Aggregate Excess Loss Insurance includes:

- Medical only Medical with Stand Alone Prescription Drug Program
 Dental Care Weekly (Disability) Income
 Vision Care Other

Aggregate Percentage Reimbursable _____%

Maximum Aggregate Benefit: \$ _____

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

Loss Limit Per Covered Person: \$ _____

Monthly Aggregate Factor

| Covered Units | Medical | Prescription Drug | Dental |
|---------------|----------|-------------------|--------|
| | \$ _____ | | |

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

SPECIAL CONDITIONS:


If a claim under the Plan is denied by the Plan, the Plan or the Insured may give notice to the Company of the claim ("Notice of Denied Claim"), including information about the amount of the expenses, the nature of the expenses, when the expenses were Incurred, and the Covered Person who incurred the expenses. If the expenses giving rise to the claim were Incurred by the Covered Person during the Benefit Period set forth above, and the Notice of Denied Claim is given to the Company within the time period required by the Benefit Period for expenses to be Paid, and the Plan's claim decision is later reversed by an IRO pursuant to procedures established by the Plan as required by the federal Patient Protection and Affordable Care Act, the Company will treat the claim as being Paid on the date notice of denial of the claim was sent by the Plan to the Covered Person, subject to the following conditions: (a) the claim must be Paid by the Plan within thirty (30) days after the claim decision is reversed; (b) satisfactory proof of loss complying with all terms and conditions of this Policy must be submitted to the Company within sixty (60) days after the claim decision is reversed; (c) the claim must not be covered under another excess loss policy issued to the Insured, and (d) the Specific Expedited Reimbursement Option will not be available.

"IRO" means an independent review organization that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct external reviews of claim decisions under health plans.

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

| | | PREMIUM |
|---|---|----------|
| (a) AGGREGATE ACCOMMODATION ENDORSEMENT: | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | \$ _____ |
| (b) AGGREGATE TERMINAL LIABILITY ENDORSEMENT: | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | \$ _____ |
| (c) AGGREGATING SPECIFIC DEDUCTIBLE ENDORSEMENT | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | \$ _____ |
| (d) SPECIFIC EXPEDITED REIMBURSEMENT ENDORSEMENT: | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | \$ _____ |
| (e) SPECIFIC TERMINAL LIABILITY ENDORSEMENT: | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | \$ _____ |
| (f) OTHER | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | \$ _____ |

ACCEPTED BY THE INSURED THIS 6th DAY OF July, 2017

Authorized Signature: 

Printed Name: Robert H. Skinner

Title: Chief Administrative Officer

Date: 7/6/2017