QBE INSURANCE CORPORATION
Administrative Address:
Wall Street Plaza
88 Pine Street, 16th Floor
New York, NY 10005

APPLICATION FOR EXCESS POLICY

1. Full legal name of Policyholder: **City of La Crosse** (as it will appear in the Policy) — Tax id number: **39-6005490**

2. Principal Office Address:

400 La Crosse Street	La Crosse	WI	54601
(street)	(city)	(state)	(zip)

3. Contact Person: Wendy Oestreich, Director of Human Resources

4. Nature of Business: **9199** **General Government, NEC**

5. If Employee Welfare Benefit Plans of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal names and addresses of such companies and the nature of their business: _____

6. Full name of YOUR Employee Welfare Benefit Plan: _____

A copy of YOUR ERISA Employee Welfare Benefit Plan Document, and those of any subsidiary or affiliated companies that are to be included, must be attached to, and shall form a part of, this Application. If YOUR Employee Welfare Benefit Plan is for a MEWA (Multiple Employer Welfare Agreement) or an MET (Multiple Employer Trust), YOUR Application will not be accepted for consideration unless YOU provide a clear and concise statement from the U.S. Department of Labor that it is exempt from ERISA requirements.

7. Requested Effective Date: **01/01/2017**

8. Requested Endorsements: **Wisconsin Endorsement QBSL-0130 (09-02)**

9. OUR Underwriting Manager: **N/A**

10. YOUR Designated Third–Party Administrator (for purpose of claims administration under YOUR Employee Welfare Benefit Plan):

Name:	**Gundersen Lutheran Health Plan**
Address:	**3190 Gundersen Drive**
City, State, Zip:	**Onalaska, WI 54650**
Telephone:	**(608)881-8271**

Name:	**Benefit Plan Administrators of Eau Claire, Inc.**
Address:	**402 Graham Avenue 3rd Floor**
City, State, Zip:	**Eau Claire, WI 54702**
Telephone:	**(715)832-5535**

11. YOUR broker/agent of record:

Name:	The Horton Group., HCSC Benefit Division
Address:	N19 W 24101 N. Riverwood Drive
City, State, Zip:	Waukesha, WI 53188
Telephone:	(262)347-2600

12. **COVERAGES REQUESTED**

The Coverage shown applies only during the Policy Period from **01/01/2017** (Effective Date) Through **12/31/2017** (Expiration Date) and is further subject to all the provisions of the Policy.

A. SPECIFIC EXCESS LOSS COVERAGE ☒ Yes, included ☐ No, not included

1) Coverage to be included:

Yes	No	
☒	☐	Medical
☒	☐	Prescription Drugs
☐	☒	Dental
☐	☒	Vision

2) Specific Attachment Point (unless adjusted by Endorsement)
☒ Per Covered Person: **$ 100,000**
☐ Per Covered Family: **$ 0.00**
☒ Aggregating Specific Deductible: **$ 100,000**

3) Specific Reimbursement Percentage: **100%**

4) Specific Policy Period Maximum Reimbursement per Covered Person: **Unlimited upon satisfaction of Specific Attachment Point.**
☒ Of this amount, reimbursement for treatment of drug or alcohol abuse will be limited to:
☒ **The terms, conditions and limits as stated in the accepted plan document.**
☐ _____days
☐ _____days, up to $_____
☐ Treatment of drug or alcohol abuse considered as any other illness

5) Basis of Specific Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from:	01/01/2017	through:	12/31/2017
And paid from:	01/01/2017	through:	03/31/2018

Plan Benefits Incurred prior to the Effective Date (Run-In-Period) will be limited to:
☐ N/A per Covered Person
☐ N/A for all Covered Persons combined:

6) Premium Rates (per month):

Covered Unit Description		Amount	Covered Unit Description	Amount
Single	168	$ 61.96		
Family	448	$ 138.76		
Total	616			

7) Minimum Annual Specific Premium: N/A. **Estimated specific annual premium based on quoted enrollment is: $ 870,885.00.**

B. AGGREGATE EXCESS LOSS INSURANCE ☐ Yes, included ☒ No, not included

1) Coverage to be included:

Yes	No	
☐	☒	Medical
☐	☒	Dental
☐	☒	Vision
☐	☒	Prescription Drugs
☐	☒	Weekly Disability Income Maximum _____, per covered employee per Policy Period
☐	☒	Other:

2) Monthly Aggregate Factor:

Covered Unit Description	Medical	Dental	Vision	Prescription Drugs	Weekly Disability Income	Other	Total
Single:							$ 0.00
Family:							$ 0.00

3) Number of Covered Units: ☒ Quoted ☐ Actual

Covered Unit Description	Medical	Dental	Vision	Prescription Drugs	Weekly Disability Income
Composite:	N/A	N/A	N/A	N/A	N/A

4) Minimum Annual Aggregate Attachment Point: $ 0 **(Estimated)**
(12 times Monthly Aggregate Factor(s), times total Number of Covered Units)

5) Aggregate Reimbursement Percentage: 0%

6) Individual Claim Limit: $ 0

7) Maximum Aggregate Reimbursement (per Policy Period): $ 0

8) Basis of Aggregate Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from: N/A through: N/A

And paid from: N/A through: N/A

Plan Benefits Incurred prior to the Effective Date (Run-In-Period) will be limited to:
☐ N/A per Covered Person
☐ N/A per all Covered Persons combined

9) Premium Rates (per month):

Covered Unit Description	Amount	Covered Unit Description	Amount
N/A	$ 0		

10) Minimum Annual Aggregate Premium: N/A. **Estimated annual aggregate premium based on quoted enrollment is: $ 0.**

13. Eligible for coverage:

Yes*	No	
☒	☐	Retired Employees
☒	☐	COBRA Continuee
☒	☐	Disabled Persons
☒	☐	Employees who are not Actively at Work

☐ ☒ Late Entrants
☒ ☐ Transplants
☐ ☒ Other:

***All "Yes" answers must have disclosure information attached to this Application.**

14. Additional Information

a. Policy Information:

1. Your PPO is: Gundersen Lutheran, Health Traditions, HealthEOS.

2. Your Utilization Review Provider is: Gundersen Lutheran, Health Traditions.

3. The definition of Specific Lifetime Maximum Reimbursement in the *Definitions* Section of this Policy, is deleted and replaced with:

Specific Policy Period Maximum Reimbursement means the maximum amount WE will reimburse YOU with respect to any Covered Person under this Policy during the Policy Period shown in the *Schedule*. The Policy Period Maximum excludes the Specific Attachment Point amount. The Policy Period Maximum will not exceed the lesser of:

1. the amount shown in the Schedule; and
2. the maximum benefit amount set forth in the Plan.

4. Section II, *Specific Excess Loss Coverage*, is deleted and replaced with the following:

Section II, SPECIFIC EXCESS LOSS COVERAGE
WE will reimburse YOU for Plan Benefits Paid in excess of the Specific Attachment Point, not to exceed the Policy Period Maximum Reimbursement amount shown in the Schedule. WE will reimburse YOU after YOU have provided an acceptable proof of loss and satisfactory proof of Paid Plan Benefits.

The Specific Excess Loss benefit applies to a Policy Period or fraction thereof (due to termination). As determined with regard to each Covered Person, it is the lesser of:

1. the Policy Period Maximum Benefit; and
2. eligible Plan Benefit Payments made with regard to a Covered Person, less the Specific Attachment Point, the result of which is then multiplied by the Specific Reimbursement Percentage.

In addition, the Specific Excess Loss Benefits Payable under this Policy will be reduced by the Aggregating Specific Deductible.

b. Special Limitations:

[redacted] has an alternative Specific Attachment Point of $750,000.

Eligible claims incurred would apply to both the alternative Specific Attachment Point and toward satisfaction of the Aggregating Specific Deductible prior to potential reimbursement.

15. Initial premium deposit accompanying the application:
(Specific) $72,573.00.

16. Minimum Plan Enrollment: N/A Covered Units, or 75 % of initial enrollment

YOU have read the foregoing and understand and agree with the terms and conditions of the coverage as set forth by US and as reflected in the Application. YOU represent that YOU have formed YOUR Employee Welfare Benefit Plan in compliance with and in reliance on the applicable provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other applicable law or regulation. It is agreed that the statements in the Application or in any materials submitted with this Application or attached to it are YOUR representations and shall be deemed material to acceptance of the risk by US and that the Policy is issued by US in reliance on the truth and accuracy of such representations. Should subsequent information become known which, if known prior to issuance of the Policy, would affect the premium rates, factors, terms or conditions for coverage thereunder, WE will have the right to revise the premium rates, factors, terms or conditions as of the Effective Date, by providing written notice to YOU. Any fraudulent statement will render the Policy null and void and claims, if any, will be forfeited. Any revision to the Policy or termination of the Policy is subject to the Time Limit on Certain Defenses provision.

QBE INS
CORPORATION

THIS APPLICATION DOES NOT BIND COVERAGE. Upon approval of the application, the Policy evidencing that the coverage is in force will be issued by US through OUR Underwriting Manager. Coverage will commence on the Effective Date set forth in the Policy. This application will attach to and form part of the Policy.

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 may be guilty of insurance fraud.

ACCEPTED BY THE POLICYHOLDER:

Signed at La Crosse, Wis.
City, State

Date _____

City of La Crosse
Policyholder (correct legal name)

_____
By (Officer's name and title)

Rae Anne Beaudry, Consultant
Signature of Policyholder's Broker/Agent of Record

Rae Anne Beaudry, The Horton Group
Print Broker/Agent of Record

ACCEPTED BY THE COMPANY:

Signed at **Marblehead, Massachusetts**

_____
On behalf of the Company
QBE Insurance Corporation

Date **November 18, 2016**

Steven L. Gransbury, President of A&H

QBE North America
By (Officer's name and title)

QBE INS
CORPORATION

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WISCONSIN ENDORSEMENT

This endorsement modifies insurance provided under the following:

SECTION V – LIMITATIONS

SECTION VI – EXCLUSIONS

SECTION VII – PREMIUMS AND FACTORS

SECTION VIII – TERMINATION

SECTION X – CLAIMS PROVISIONS

SECTION XI – GENERAL PROVISIONS

This endorsement changes the policy effective on the Policy Effective Date unless another date is indicated below.

Policy Number: **LGS00537-17**	Endorsement Effective: **01/01/2017**
Named Insured: **City of La Crosse**	Signed for the Company by: Russell Johnston, President

SECTION V – LIMITATIONS has been revised as follows:

The **Disclosure** provision has been deleted in its entirety and replaced with the following:

Disclosure
WE have relied upon the information provided by YOU and YOUR TPA in the issuance of this Policy. Should subsequent information become known which, if known prior to issuance of this Policy, would affect the premium rates, factors, terms or conditions for coverage thereunder, WE will have the right to revise the premium rates, factors, terms or conditions as of the Effective Date, by providing written notice to YOU. Subject to the Time Limit on Certain Defenses provision any fraudulent statement will render this Policy null and void and claims, if any, will be forfeited.

SECTION VI – EXCLUSIONS has been deleted in its entirety and replaced with the following:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

SECTION VI
EXCLUSIONS

WE will not reimburse YOU for any loss or expense caused by or resulting from:

1. expenses Incurred while the Plan is not in force with respect to the Covered Person, or for a person not covered under the Plan;
2. expenses covered by Plan changes made prior to OUR written approval of such changes;
3. expenses which result from any prescription care service, mail order prescription plan or any pre-paid prescription drug plan, dental, vision, or weekly disability income benefits, unless specifically included on the Schedule and approved by US.
4. liability or obligations assumed by YOU under any contract or service agreement other than the Plan;
5. expenses for services or supplies which are in violation of any law;
6. expenses for services or supplies billed above the Usual and Customary Charges for the area where provided or which are greater than the Plan benefit;
7. expenses resulting from or caused by war, whether declared or undeclared, civil war, invasion, hostilities, riot or resistance to armed aggression;
8. expenses for an injury or sickness arising out of, or in the course of an employment for wage or profit or for a sickness for which the Covered Person is entitled to benefits under any Workers' Compensation or occupational disease law, whether or not the Covered Person applies for such benefits.
9. cost of the administration of claims, including cost of investigation, payments, or other service(s) provided by YOUR TPA, consulting fees and/or expenses of any litigation;
10. expenses from the commission of or attempt to commit any felony;
11. any amount used to satisfy deductibles or coinsurance amounts under the Plan;
12. expenses or costs resulting from non-contractual damages, court costs and legal fees, including but not limited to compensatory, exemplary and punitive damages, fines or statutory penalties;
13. medical expenses in connection with Experimental or Investigational surgery or treatment as defined in this Policy.
14. Payments recoverable through YOUR Plan's Coordination of Benefits or similar provision;
15. expenses Incurred by an employee or dependent of an employee of any affiliated or subsidiary company not included in the Application, unless added by Endorsement;
16. legal expenses and fees including legal expenses and fees Incurred on behalf of any Covered Person in obtaining medical treatment or expenses Incurred in connection with a judgment or settlement arising out of YOUR negligence in providing, arranging, or falling to provide or arrange a benefit to a Covered Person;
17. Payments YOU make under YOUR Plan for services and supplies which are not included in YOUR Plan or which are outside the requirements of YOUR Plan Document or this Policy;
18. expenses Incurred after the Expiration Date;
19. in the event this Policy is terminated before the Expiration Date, expenses Incurred after the date of such termination;
20. YOUR TPA's failure to provide timely Payment to providers which results in non-receipt of any discounted fees for services or supplies. WE will reimburse only for the amount of the discounted amount had timely Payment been made by YOUR TPA.

SECTION VII – PREMIUMS AND FACTORS has been revised as follows:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

The **Grace Period** provision has been deleted in its entirety and replaced with the following:

Grace Period
A Grace Period of 31 days from the due date will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the coverage will remain in effect, provided the premium is paid before the end of the Grace Period. If YOU do not pay the premium during the Grace Period, this Policy will terminate without further notice, at the end of the Grace Period. YOU will be liable for the payment of a pro rata premium for the time the policy was in force during the Grace Period.

SECTION VIII – TERMINATION has been deleted in its entirety and replaced with the following:

SECTION VIII
TERMINATION

This Policy and all coverage hereunder will end upon the earliest of the following:

1. At the end of any Grace Period for which the premium is paid, if the subsequent premium is not paid as provided in the Grace Period provision.
2. On the date YOU tell US YOU want to cancel this Policy, provided YOU have given US at least 1 days advance written notice. If YOU cancel within 30 days after the Effective Date, YOU may ask for a full refund of the premium. If YOU do so, this Policy will terminate on the Effective Date. If YOU cancel this Policy at a later date, WE may keep the premium earned to the date of termination.
3. The Expiration Date of this Policy.
4. On the date stated in the notice of termination, if, within 60 days after the Effective Date:
   a. YOU fail to provide US any information or materials requested by US; or
   b. YOU fail to comply with any condition imposed by US when this Policy is issued.

   Notice of termination will be sent to YOU at least 10 days prior to the effective date of the termination. If the policy is terminated, WE will return the premium paid by YOU, less the amount of any reimbursements WE made to YOU before the time this Policy was terminated. If the amount reimbursed to YOU exceeds the premium paid to US, YOU will pay US the difference.
5. The date the Plan terminates.
6. On the date stated in the notice of termination if the administrative agreement between YOU and YOUR TPA terminates, unless WE consent in writing to YOUR naming of a new TPA. If the policy is terminated, a notice of termination will be sent to YOU at least 10 days prior to the effective date of the termination.
7. On the date stated in the notice of termination if YOU fail to maintain the Minimum Plan Enrollment as stated in the Schedule, unless WE agree in writing to continue coverage. If the policy is terminated, a notice of termination will be sent to YOU at least 10 days prior to the effective date of the termination.
8. The date YOU:
   a. Suspend active business operations; or
   b. are placed in bankruptcy or receivership, or
   c. dissolve.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

9. On the date stated in the notice of termination if YOU do not pay claims or make funds available to pay claims as required by the Plan. If the policy is terminated, a notice of termination will be sent to YOU at least 10 days prior to the effective date of the termination.

Concealment or Fraud
Subject to the Time Limit on Certain Defenses provision, this entire Policy will be cancelled:

1. if, before or after a claim or loss, YOU or YOUR TPA have concealed or misrepresented any material fact or circumstance concerning this Policy, including any claim; (This includes failure to provide the required disclosure of health history of Disabled Persons, Large Claims or Potentially Catastrophic Losses.) or
2. in any case of fraud by YOU or YOUR TPA relating to this coverage.

SECTION X – CLAIMS PROVISIONS has been revised as follows:

The **Management of Large Claims (LC's) and Potentially Catastrophic Losses (PCL's)** provision has been deleted in its entirety and replaced with the following:

Management of Large Claims (LC's) and Potentially Catastrophic Losses (PCL's)
Notice of LC – YOU or YOUR TPA must notify US in writing of any LC (regardless of whether charges have been Paid or are pending Payment) as soon as practically possible but in no event later than one year when the claim exceeds or it appears that the claim will reach or exceed the defined limits for a LC.

Notice of PCL – YOU or YOUR TPA must notify US in writing of any PCL as soon as practically possible but in no event later than one year when receiving any information indicating that the claim (regardless of whether charges have been Paid or are pending Payment) is potentially catastrophic.
(See Exhibit I of this Policy.)

Failure to Notify – If for any reason a LC or PCL is not properly submitted to the TPA, YOU shall promptly notify the TPA of the claim. In the event YOU or YOUR TPA fails to follow the notification requirements set forth in this provision, YOUR losses related to such LC or PCL may not be considered for reimbursement under this Policy.

If YOU receive information that any claim may be or become a PCL, YOU will immediately notify YOUR TPA.

SECTION XI –GENERAL PROVISIONS has been revised as follows:

The **Entire Contract** provision has been deleted in its entirety and replaced with the following:

Entire Contract
This entire contract consists of:

1. this Policy, including any Endorsements;
2. YOUR Application and Schedule and any attachments thereto, a copy of which is attached to this Policy, and
3. a copy of YOUR Plan.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

All statements made by YOU or any Covered Person are, in the absence of fraud, understood to be representations and not warranties. Such statements will not be used to contest coverage unless contained in the Application and Schedule or any attachments to the Application and Schedule.

In case of a conflict between the Plan and this Policy, this Policy will prevail. WE have relied on the information YOU provided to issue this Policy. YOU represent such information is accurate. Should subsequent information become known which, if known prior to issuance of this Policy, would affect the premium rates, factors, terms or conditions for coverage thereunder, WE will have the right to revise the premium rates, factors, terms or conditions as of the Effective Date, by providing written notice to YOU. Any fraudulent statement will render this Policy null and void and claims, if any, will be forfeited. Any revision to this Policy or termination of this Policy is subject to the Time Limit on Certain Defenses provision.

THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.

QBE INSURANCE CORPORATION
Administrative Address:
Wall Street Plaza
88 Pine Street, 16th Floor
New York, NY 10005

SCHEDULE FOR EXCESS POLICY

This Schedule forms part of the Policy to which it is attached.

Policy Number: **LGS00537-17**

1. Policyholder :
   City of La Crosse
   (as it will appear on the Policy)

2. Principal Office Address:

400 La Crosse Street	**La Crosse**	**WI**	**54601**
(street)	(city)	(state)	(zip)

3. Effective Date: **01/01/2017**

4. Expiration Date: **12/31/2017**

5. Attached Endorsements: **Wisconsin Endorsement QBSL-0130 (09-02)**

6. Third–Party Administrator (for purpose of claims administration under the Plan):

Name:	**Gundersen Lutheran Health Plan**
Address:	**3190 Gundersen Drive**
City, State, Zip:	**Onalaska, WI 54650**
Telephone:	**(608)881-8271**

Name:	**Benefit Plan Administrators of Eau Claire, Inc.**
Address:	**402 Graham Avenue 3rd Floor**
City, State, Zip:	**Eau Claire, WI 54702**
Telephone:	**(715)832-5535**

7. **COVERAGE**

The Coverage shown applies only during the Policy Period and is further subject to all the provisions of the Policy.

A. SPECIFIC EXCESS LOSS COVERAGE ☒ Yes, included ☐ No, not included

1) Coverage to be included:

Yes	No	
☒	☐	Medical
☒	☐	Prescription Drugs
☐	☒	Dental
☐	☒	Vision

2) Specific Attachment Point (unless adjusted by Endorsement)
☒ Per Covered Person: **$ 100,000**
☐ Per Covered Family: **$ 0.00**
☒ Aggregating Specific Deductible: **$ 100,000**

3) Specific Reimbursement Percentage: **100 %**

4) Specific Policy Period Maximum Reimbursement per Covered Person: **Unlimited upon satisfaction of Specific Attachment Point.**
☒ Of this amount, reimbursement for treatment of drug or alcohol abuse will be limited to:
☒ **The terms, conditions and limits as stated in the accepted plan document.**
☐ ____days
☐ ____days, up to $_____
☐ Treatment of drug or alcohol abuse considered as any other illness

5) Basis of Specific Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from: **01/01/2017** through: **12/31/2017**
And paid from: **01/01/2017** through: **03/31/2018**

Plan Benefits Incurred prior to the Effective Date (Run-In-Period) will be limited to:
☐ **N/A** per Covered Person
☐ **N/A** for all Covered Persons combined

6) Premium Rates (per month):

Covered Unit Description		Amount
Single	**168**	**$ 61.96**
Family	**448**	**$ 138.76**
Total	**616**	

7) Minimum Annual Specific Premium: **N/A. Estimated specific annual premium based on quoted enrollment is $ 870,885.00.**

B. AGGREGATE EXCESS LOSS INSURANCE ☐ Yes, included ☒ No, not included

1) Coverage to be included:

Yes	No	
☐	☒	Medical
☐	☒	Dental
☐	☒	Vision
☐	☒	Prescription Drugs
☐	☒	Weekly Disability Income Maximum _____, per covered employee per Policy Period
☐	☒	Other:

2) Monthly Aggregate Factor: **N/A**

3) Number of Covered Units: **N/A**

4) Minimum Annual Aggregate Attachment Point: **N/A**

5) Aggregate Reimbursement Percentage: **N/A**

6) Individual Claim Limit: N/A

7) Maximum Aggregate Reimbursement (per Policy Period): N/A

8) Basis of Aggregate Excess Loss coverage benefit payment (Benefit Period): N/A

9) Premium Rates (per month): N/A

10) Minimum Annual Aggregate Premium: N/A

8. Eligible for coverage:

Yes	No	
☒	☐	Retired Employees
☒	☐	COBRA Continuee
☒	☐	Disabled Persons
☒	☐	Employees who are not Actively at Work
☐	☒	Late Entrants
☒	☐	Transplants
☐	☒	Other:

9. Additional Information

a. Policy Information:

1. Your PPO is: Gundersen Lutheran, Health Traditions, HealthEOS.

2. Your Utilization Review Provider is: Gundersen Lutheran, Health Traditions.

3. The definition of Specific Lifetime Maximum Reimbursement in the *Definitions* Section of this Policy, is deleted and replaced with:

Specific Policy Period Maximum Reimbursement means the maximum amount WE will reimburse YOU with respect to any Covered Person under this Policy during the Policy Period shown in the *Schedule*. The Policy Period Maximum excludes the Specific Attachment Point amount. The Policy Period Maximum will not exceed the lesser of:

1. the amount shown in the Schedule; and
2. the maximum benefit amount set forth in the Plan.

4. Section II, *Specific Excess Loss Coverage*, is deleted and replaced with the following:

Section II, SPECIFIC EXCESS LOSS COVERAGE

WE will reimburse YOU for Plan Benefits Paid in excess of the Specific Attachment Point, not to exceed the Policy Period Maximum Reimbursement amount shown in the Schedule. WE will reimburse YOU after YOU have provided an acceptable proof of loss and satisfactory proof of Paid Plan Benefits.

The Specific Excess Loss benefit applies to a Policy Period or fraction thereof (due to termination). As determined with regard to each Covered Person, it is the lesser of:

1. the Policy Period Maximum Benefit; and
2. eligible Plan Benefit Payments made with regard to a Covered Person, less the Specific Attachment Point, the result of which is then multiplied by the Specific Reimbursement Percentage.

In addition, the Specific Excess Loss Benefits Payable under this Policy will be reduced by the Aggregating Specific Deductible.

b. Special Limitatic **has an alternative Specific Attachment Point of $750,000.**

Eligible claims incurred would apply to both the alternative Specific Attachment Point and toward satisfaction of the Aggregating Specific Deductible prior to potential reimbursement.

10. Minimum Plan Enrollment: **N/A** Covered Units, or **75** % of initial enrollment

ACCEPTED BY THE POLICYHOLDER:

Signed at La Crosse, Wis
City, State

City of La Crosse
Policyholder (correct legal name)

Date _____

By (Officer's name and title)

Rae Anne Beaudry, Consultant
Signature of Policyholder's Broker/Agent of Record

Rae Anne Beaudry, The Horton Group
Print Broker/Agent of Record

ACCEPTED BY THE COMPANY:

Signed at **Marblehead, Massachusetts**

On behalf of the Company
QBE Insurance Corporation

Date: _____

Steven L. Gransbury, President of A&H

QBE North America
By (Officer's name and title)