APPENDIX FF. SMALL EMPLOYER STOP LOSS DISCLOSURE

Date Prepared:_____

Insurer Name: _____

Plan Sponsor/Employer: _____

Policy ID/#: _____

Policyholder: _____

Plan Name: _____

Policy Effective Date: _____

Policy Expiration Date: _____

Plan expenses are eligible if incurred from _____ to _____

Plan expenses are eligible if paid from _____ to _____

Individual Attachment Point for Specific Coverage: _____

This Policy [does] [does not] (circle one) have different Individual Attachment Point(s) for certain individuals or conditions.

If it does, describe:

_____

_____

Aggregate Attachment Point: _____

Producer: _____

Important Policyholder/Plan Sponsor Information:

You have purchased a policy that provides reimbursement to you for losses of your self-funded health Plan identified above, subject to the terms and conditions of your Policy.

Your Policy is not a policy that pays for the direct medical expenses incurred by your employees or the beneficiaries of your Plan. Your Policy is NOT A GROUP OR INDIVIDUAL medical insurance policy offering health insurance benefits. You are responsible for payment of your employees' claims covered by your self-funded health Plan.

The insurer issuing this Policy is not responsible for the payment of the benefits provided by your Plan. The insurer is only responsible for reimbursing you for covered claims which you have paid as provided by the Policy.

Self-funding an employer medical benefit plan may subject you to financial obligations and regulatory requirements that are not present when you purchase a group health insurance policy. YOU SHOULD CONSULT WITH A QUALIFIED ACTUARY, PRODUCER, CONSULTANT, OR ATTORNEY REGARDING YOUR OBLIGATIONS AS A SELF-FUNDED PLAN SPONSOR, and YOUR SELECTION OF STOP LOSS POLICY TERMS.

This disclosure is provided as required by Section 7401 of Title 36 of the Oklahoma Statutes, and is for your information only. In the event of a conflict between this disclosure and your Policy, the terms and conditions of your Policy will apply.