

Excess Loss Insurance Policy

PartnerRe America Insurance Company

Wilmington, DE
NAIC# 11835

Mailing Address:
6900 Wedgwood Road, Suite 120
Maple Grove, MN 55311
800 263 6546

This Policy is issued to:

Policyholder Brazoria County
Policy Number P0400001802
Policy Period From: October 1, 2025 To: October 1, 2026

(All insurance begins and ends at 12:01 A.M. standard time at the Policyholder's Principal Address as shown in the Schedule)

The Company agrees to reimburse the Policyholder subject to all the terms and conditions of this Policy.

This Policy is issued in consideration of:

- the Application made by the Policyholder;
- Disclosure and receipt of Claim Information;
- the payment of the initial premium as of the Effective Date of this Policy;
- the payment of all subsequent premiums when due; and
- the continual compliance by the Policyholder with all terms and conditions of this Policy.

This Policy is governed by the laws of the state of Texas.

The provisions on the following pages are a part of this Policy. This Policy is not automatically renewable. **Please review this Policy carefully.**

Company obligations under this Policy are limited to the terms, conditions and limitations of this Policy. We are not a party to, responsible for or a guarantor of the benefits provided under the Benefit Plan. We are not a Benefit Plan administrator or a fiduciary with respect to the Benefit Plan as those terms are used in the Employee Retirement Income Security Act of 1974, as amended.

IN WITNESS WHEREOF, the Company has caused this Policy to be executed and attested and, where required by law, this Policy shall not be valid unless countersigned by its duly Authorized Representative(s):



Kelly J. Munger
President, PartnerRe Health
PartnerRe America Insurance Company



Joy L. Langford
Corporate Secretary
PartnerRe America Insurance Company

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SECTION I - SCHEDULE OF INSURANCE

In the event of a conflict between the terms, conditions and limitations of this Schedule and the Excess Loss Insurance Policy, this Schedule will control.

1. POLICYHOLDER: Brazoria County
Principal Address: 111 East Locust
Angleton, Texas 77515
2. POLICY NUMBER: P0400001802
3. POLICY PERIOD: Effective Date: October 1, 2025
Termination Date: October 1, 2026

(All insurance begins and ends at 12:01 A.M. Standard Time at the Policyholder's Principal Address as shown in this Schedule.

4. CLAIM ADMINISTRATOR: Aetna
Type of Coverage: Medical
Address: 151 Farmington Ave.
Hartford, Connecticut 06156

CLAIM ADMINISTRATOR: Caremark/CVS
Type of Coverage: Rx
Address: 750 W John Carpenter FWY, Suite 1200
Irving, Texas 75039

5. PREMIUM PAYABLE and RATES: Monthly

a.	<u>Specific Excess Loss Insurance Premium</u>	<u>Covered Individuals (estimate as of Effective Date)</u>	<u>Premium Rate</u>
	Composite:	1,478	\$84.30
b.	<u>Aggregate Excess Loss Premium</u>	<u>Covered Individuals (estimate as of Effective Date)</u>	<u>Premium Rate</u>
	Composite:	1,478	\$3.16

6. EXCESS LOSS INSURANCE:

a. SPECIFIC EXCESS LOSS INSURANCE:

- i. Plan Benefits To Be Covered:
Medical
Prescription Drug Plan
- ii. Coverage Period:
Eligible Expenses Incurred from October 1, 2023 through October 1, 2026 and Paid from October 1, 2025 through October 1, 2026

- iii. Specific Deductible: \$350,000 ☒ per Covered Person ☐ per Family

Covered Persons subject to an Adjusted Specific Deductible:

- iv. Reimbursement Percentage for Specific Excess Loss Insurance: 100%
- v. Maximum Specific Reimbursement:
Unlimited for the Coverage Period, described above; no lifetime maximum applies.

b. AGGREGATE EXCESS LOSS INSURANCE:

- i. Plan Benefits To Be Covered:
Medical
Prescription Drug Plan

- ii. Coverage Period:
Eligible Expenses Incurred from October 1, 2023 through October 1, 2026 and Paid
from October 1, 2025 through October 1, 2026

iii. <u>Aggregate Excess Loss Insurance Coverage</u>	Covered <u>Individuals</u> (estimate as of the <u>Effective Date</u>)	Monthly Expected <u>Claims</u>	Aggregate <u>Deductible</u> <u>Percentage</u>	Monthly Aggregate <u>Deductible</u>
Composite:	1,478	\$1,485.53	120%	\$1,782.64

Minimum Annual Aggregate Deductible: \$31,616,903

Maximum Aggregate Reimbursement: \$1,000,000 per Coverage Period

- iv. Reimbursement Percentage for Aggregate Excess Loss Insurance: 100%

7. GENERAL CONDITIONS:

- a. All retirees are included under Specific and Aggregate Excess Loss Insurance Coverage
- b. Actively at Work requirement waived: Yes ☒ No ☐
- c. Other: For Member ID# PREBRA 1025-01, a \$400,000 Specific Deductible will apply for prescription drugs and medical services rendered in connection with the diagnosis of Lipomatosis.
- d. Other: Eligible Aggregate Expenses Incurred prior to the Effective Date of the Policy and Paid during the Coverage Period will be limited to a maximum of \$3,952,113.

8. OPTIONAL ENDORSEMENTS OR ADDENDUMS:

- a. The following endorsement(s) are included in the Specific Excess Loss Insurance coverage:
- i. Specific Advanced Funding
 - ii. Plan Mirroring Coordination
 - iii. Renewal Rate Cap

SECTION II – EXCESS LOSS INSURANCE PROVISION

SPECIFIC EXCESS LOSS INSURANCE:

The Schedule indicates whether Specific Excess Loss Insurance is provided under this Policy.

WHEN REIMBURSEMENT IS PAYABLE

No Specific Excess Loss Insurance reimbursement will be made until Your Plan Document is received and accepted by the Company. Any reimbursement under the Specific Excess Loss Insurance will be subject to the terms and conditions of this Policy including the Schedule and any Endorsements.

Reimbursement under the Specific Excess Loss Insurance will be paid when a Covered Person has exceeded the Specific Deductible or Adjusted Specific Deductible, if applicable, during the Coverage Period shown on the Schedule, subject to all of the terms, conditions and limitations of this Policy. Upon Our acceptance and approval of Proof of Loss, We will reimburse You for Eligible Expenses as set forth under the Schedule and this Policy.

AMOUNT OF REIMBURSEMENT PAYABLE

The Specific Excess Loss Insurance reimbursement amount is subject to the Maximum Specific Reimbursement shown on the Schedule and shall be equal to the product of:

1. The Reimbursement Percentage for Specific Excess Loss Insurance, multiplied by
2. Eligible Expenses which exceed the Specific Deductible or Adjusted Specific Deductible, if applicable.

The Reimbursement Percentage for Specific Excess Loss Insurance, Specific Deductible and Coverage Period are shown on the Schedule. If this Policy terminates before the end of the Policy Period, the Specific Deductible will not be reduced.

AGGREGATE EXCESS LOSS INSURANCE:

The Schedule indicates whether Aggregate Excess Loss Insurance is provided under this Policy.

WHEN REIMBURSEMENT IS PAYABLE:

No Aggregate Excess Loss Insurance reimbursement will be made until Your Plan Document is received and accepted by the Company. Any reimbursement under the Aggregate Excess Loss Insurance will be subject to the terms and conditions of this Policy including the Schedule and any Endorsements or Addendums.

Reimbursement under the Aggregate Excess Loss Insurance will be paid after the end of the Coverage Period if the Annual Aggregate Deductible, described below, is satisfied, subject to all terms, conditions and limitations of this Policy. Upon acceptance and approval of Proof of Loss, We will pay benefits to You for Eligible Expenses that exceed the Annual Aggregate Deductible for claims Paid.

Eligible Expenses, subject to Aggregate Excess Loss Insurance, do not include:

1. Benefits payable under any other Specific Excess Loss Insurance or Excess Loss Insurance issued to You by Us or any other insurer.
2. Eligible Expenses in excess of the Specific Deductible or Adjusted Specific Deductible, as applicable.
3. Any other benefits Paid by any other entity providing the same or similar coverage as the Benefit Plan during the Coverage Period.
4. Expenses which are not Eligible Expenses, or otherwise excluded, under the terms and conditions of this Policy.

AMOUNT OF REIMBURSEMENT PAYABLE

The Aggregate Excess Loss Insurance reimbursement payable shall equal the product of:

1. The Reimbursement Percentage for Aggregate Excess Loss Insurance shown on the Schedule, multiplied by;
2. The amount of Eligible Expenses Paid, which are subject to Aggregate Excess Loss Insurance, that exceeds the Annual Aggregate Deductible for the Coverage Period.

In no event will We reimburse more than the Maximum Aggregate Reimbursement as shown on the Schedule.

ANNUAL AGGREGATE DEDUCTIBLE

The Annual Aggregate Deductible for a Policy Period will be the greatest of the:

1. An amount equal to the sum of 12 monthly amounts for the Policy Period where such monthly amount is equal the Monthly Aggregate Deductible, as shown on the Schedule, multiplied by the number of Covered Individuals covered under the Benefit Plan on the first day of each month of the Policy Period.

If the number of Covered Individuals decreases, the decrease in the number of Covered Individuals may not be reduced by more than 5% of the previous month's Covered Individuals. During any period in which any of Your employees are absent from work due to a strike, lock out, or work stoppage, the number of Covered Individuals will remain at the same level as for the month before the disruption began.

If the Policy Period is less than 12 months or if this Policy terminates during a Policy Period, the Annual Aggregate Deductible will be based on a Policy Period of 12 full months. The sum of monthly amounts for the months completed will be divided by the number of months completed in the Policy Period and multiplied by 12. Calculation of the Annual Aggregate Deductible in this manner will not affect the termination of Aggregate Excess Loss Insurance benefits on the date this Policy actually terminates; or

2. Monthly Aggregate Deductible multiplied by 1,478, multiplied by 12; or
3. The Monthly Aggregate Deductible multiplied by 85% of the number of Covered Individuals under the Benefit Plan at the beginning of the eleventh month of the prior Policy Period, multiplied by 12; or
4. The Minimum Annual Aggregate Deductible shown on the Schedule.

SECTION III – PREMIUM PROVISION

PAYMENT OF PREMIUMS: The initial premium for this Policy is due on its Effective Date and subsequent premiums must be received by the Company by the first (1st) day of each succeeding month of the Policy Period, unless otherwise specified on the Schedule. For coverage under this Policy to remain in effect, each premium must be paid on or before its due date, subject to the Grace Period.

Payment to your Claim Administrator, broker or other third party is not deemed payment to the Company. Premium is not considered paid until payment is received by Company and sufficient funds are on deposit to process payment.

If the Premium received by the Company through the end of the Policy Period is less than the Minimum Premium set forth on the Schedule, the Policyholder shall remit a payment for such difference within ten (10) days after the termination of this Policy.

GRACE PERIOD: A Grace Period of 31 calendar days will be allowed for the payment of each premium due after the first premium has been paid. This Policy will continue in force during the Grace Period. If a premium is not paid by the end of the Grace Period, this Policy will automatically terminate as of the last date for which premium was paid.

PREMIUM RATES: The initial premium rates are stated in the Schedule. We may change the premium rates:

1. Whenever You amend the Benefit Plan; or
2. There is a Material Change as set forth in SECTION VI - MATERIAL CHANGE AND MISREPRESENTATION/MISSTATED DATA; or
3. Coverage changes due to the addition or deletion of Endorsements or Addendums to the Policy.

PREMIUM DATA: You must provide a report to Us with each premium payment, in a form satisfactory to Us, that lists:

1. The number(s) of Covered Individuals in the Benefit Plan on the first day of the Benefit Month, as categorized (e.g., Employee + Family) on the Schedule; and
2. The amount of premium paid.

You acknowledge and understand that We use such premium data reports solely to process premium. Such premium data reports do not replace any report required, or which may be required, under the Records and Reporting Requirements in SECTION IV – CLAIM AND REPORTING PROVISIONS in this Policy.

SECTION IV – CLAIM AND REPORTING PROVISIONS

NOTICE OF CLAIM: The Policyholder is responsible to aggregate multiple Claim Administrator reports for notifications and claim reimbursements. The Policyholder must provide written notice to the Company:

1. Within 30 days of the Policyholder, or any party working on behalf of the Policyholder including the Claim Administrator, receiving information reasonably indicating Eligible Expenses have been Incurred or will be Incurred, for a Covered Person, that equal or exceed the lesser of:
 - a. 50% of the Specific Deductible or applicable Adjusted Specific Deductible, if any; or
2. Immediately upon notice to the Policyholder, or any party working on behalf of the Policyholder including the Claim Administrator, that a Covered Person has been diagnosed with, or treated for, any condition, illness or injury that is reasonably likely to result in a Serious Claim, as defined in this Policy; and
3. Immediately upon notice of any potential or planned organ transplant; and
4. Within 30 days of the date that total Eligible Expenses, Incurred and Paid during the Coverage Period for all Covered Persons exceeds 5% of the Annual Aggregate Deductible.

Notice must be provided in a Company acceptable format agreed upon in advance, which must include, at a minimum, the following items:

1. Name of the Covered Person; and
2. Date of accident or diagnosis of sickness; and
3. Nature of injury or sickness; and
4. Estimated total cost of the claim; and
5. Transplant contracts, case management notes, and any other documentation that may be needed in order for Us to properly determine how the Claim Administrator adjudicated the claim. If such items are considered proprietary by the Claim Administrator a written statement from the Claim Administrator providing the substance of the requested items may be accepted; and
6. Documentation of any Experimental or Investigational, or Medical Necessity review performed by the Claim Administrator in the determination of the eligibility of benefits paid under the Benefit Plan.

Your failure to provide prompt notice may result in an adjustment of any Specific Excess Loss Insurance reimbursement payable to You, if any, to reflect any savings We could have obtained had prompt notice been given.

For Aggregate Excess Loss Insurance reporting, You or the Claim Administrator are required to provide Us with a monthly report that lists:

1. The total amount of Eligible Expenses Incurred within the Coverage Period by any Covered Person and Paid by or on behalf of You during that Benefit Month; and
2. The number(s) of participants in the Benefit Plan on the first day of the Benefit Month, as categorized as Eligible Benefits To Be Covered as shown under the Aggregate Excess of Loss section of the Schedule. The Aggregate Report must be provided to Us within 31 days after the end of each Benefit Month

PROOF OF LOSS:

You, or Your Claim Administrator, must request payment and provide complete and accurate Proof of Loss, in a form and content acceptable to Us, to support a claim no later than 90 calendar days after the end of the Coverage Period.

If Proof of Loss for any claim is submitted to Us more than 90 calendar days after the Coverage Period, the claim will be denied. If We request additional information to process a claim, You must provide the additional information by the later of 90 calendar days after the Coverage Period or the date which is 30 calendar days after You receive the request for additional information. If the additional information is received after this time, the claim will be denied.

Although determination of benefits under the Benefit Plan is the responsibility the party authorized under the terms of the Benefit Plan, the Company reserves the right for determining reimbursement under the terms and conditions of this Policy, including whether a claim is reimbursable, whether charges are Reasonable and Customary, and whether claims were properly paid under the terms of the Benefit Plan.

Any objection, notice of legal action, or complaint, which is received on a claim processed by You or Your Claim Administrator, and on which it reasonably appears that reimbursement will be payable under this Policy, must be brought to Our attention within 90 days of receipt by You.

PAYMENT OF CLAIMS: All reimbursements payable under this Policy will be paid to the Policyholder within 60 days after:

- a) the Company's acceptance of Proof of Loss as complete; and
- b) Completion of an audit confirming that Specific Excess Loss Insurance or Aggregate Excess of Loss Insurance reimbursement is payable, if an audit was requested by the Policyholder or the Company.

The Policyholder must cooperate with the Company or its representative in a timely manner in the administration, investigation, and the settlement of any claim payable under this Policy.

In the event charges for Eligible Expenses Incurred and Paid by the Policyholder during the Coverage Period stated in the Schedule exceed, or are expected to exceed, the Specific Deductible, the Company shall have the right to appoint an administrator to represent its interest in the ongoing administration of the claim. Any cost incurred for the Company's administration of the claim shall be borne by the Company.

REIMBURSEMENT OF CERTAIN FEES: Eligible Expenses will include the following fees Incurred and Paid by the Policyholder, if approved in advance of claim by Us:

1. Hospital bill audits; and
2. Access to non-directed Provider networks; and
3. Access to transplant Provider networks; and
4. Negotiation of out-of-network bills; and
5. Cost Containment Vendors; and
6. Access to Gene Therapy(ies) and Cell Therapy(ies) Provider and manufacturer networks.

Such fees shall be considered Eligible Expenses only if You can demonstrate to Us that the services that generated the fees resulted in a cost savings to the Benefit Plan and Us. If You can demonstrate such a cost savings, We will consider such fee an Eligible Expense, up to 25% of such cost savings per Covered Person.

INDEPENDENT REVIEW ORGANIZATION DETERMINATIONS: In the event an Independent Review Organization overturns an Adverse Benefit Determination ("ABD") and You are required to pay the claim that is subject to the ABD, such claim will be:

1. deemed Paid on the date the ABD is sent to the Covered Person; and
2. eligible for reimbursement under this Policy, subject to all terms, conditions, limitations and exclusions of this Policy.

For a claim to be reimbursable under this provision:

1. the ABD must be sent to the Covered Person before the Paid date deadline within the Coverage Period expires; and
2. the claim must be Paid within 30 days following the Independent Review Organization decision to overturn the ABD; and
3. We must be notified by You in writing within (30) days before the Paid date deadline within the Coverage Period that the ABD, if overturned, may result in a claim under this Policy.

When Eligible Expenses are Paid pursuant to the terms, conditions and limitations of the Independent Review Organization extended benefit, such expenses will relate back to the Coverage Period in which they were Incurred and will be excluded from any other Coverage Period.

If You terminate this Policy for any reason prior to 12 months following the Effective Date shown on the Schedule, this provision will not apply.

RECORDS AND REPORTING:

In addition, information otherwise required under this Policy, You, and/or Your Claim Administrator, will:

1. maintain and make available to Us, within 15 days upon request, such information, as We may reasonably require, confirming proof of payment of Eligible Expenses reimbursable under this Policy.
2. maintain a record of any and all amounts paid in excess of payments required by the Benefit Plan.
3. maintain records reasonably required by Us, and furnish to Us, upon Our request, all pertinent data with respect to Covered Persons.
4. maintain books and records related to this Policy for a period of no less than seven (7) years or the term required by the state of jurisdiction, after the Policy expires or is terminated according to the provisions of this Policy. This clause shall survive the termination of this Policy, provided there are outstanding liabilities under this Policy.

SECTION V – EXCLUSIONS AND LIMITATIONS

The Company will not reimburse the Policyholder for any of the following:

1. Any expense that does not strictly comply with the terms and conditions of:
 - a. Your Plan Document, including any discretionary, extra-contractual expenses authorized by Your Claim Administrator; and
 - b. this Policy, the Schedule and any Endorsement thereto.
2. Any expense arising from modification or amendment of the Benefit Plan that was not disclosed to and accepted in writing by the Company.
3. Any expense Incurred by a person who is not eligible under the terms and conditions of the Benefit Plan.
4. Any expense Incurred by a Covered Person whose Known medical conditions were not accurately disclosed, to Us by You, Your designated representative or Claim Administrator.
5. Any expense Incurred or Paid outside of the Coverage Period of this Policy.
6. Any expense Incurred by an affiliate or subsidiary of the Policyholder that was not included in the Application or Schedule.
7. Expenses which are Experimental or Investigational.
8. Expenses in excess of Reasonable and Customary.
9. Expenses resulting from Provider error(s) and/or facility-acquired conditions deemed “reasonably preventable” through the use of evidence-based guidelines, taking into consideration but not limited to Centers for Medicare and Medicaid Services (CMS) guidelines.
10. Billing errors, duplicate bills, duplicate items, or Unbundled Charges.
11. Deductibles, co-payment amounts, or any other charges or payments which the Policyholder is not obligated to pay under the Benefit Plan, or are payable to You from any other source.
12. Any expense that is reimbursable to the Policyholder pursuant to or as a result of any of the following:
 - a. Another group health benefit plan or another excess of loss insurance policy.
 - b. A government or privately supported medical research program.
 - c. The Covered Person is covered under, or eligible for, Medicare, the Railroad Retirement Program, or any similar federal, state or local program or statute.
 - d. Services or supplies for the treatment of an occupational injury or sickness which are paid under any Workers’ Compensation, occupational disease law or similar law whether or not the Covered Person claims his or her rights to such benefits.
 - e. Any coordination of benefits or non-duplication of benefits provisions of the Benefit Plan.
 - f. Prescription drug rebates refunded to the Policyholder by a Pharmacy Benefit Management (PBM) vendor.
13. Expenses associated with the administration of the Benefit Plan including, but not limited to, salaries to your employees, claim payment fees, PPO access fees, premium functions, medical review and consultant fees unless otherwise payable under the Reimbursement of Certain Fees in SECTION IV- CLAIM AND REPORTING PROVISIONS, and any tax liability, interest, or penalty imposed by any regulatory or taxing authority.
14. Expenses incurred as a result of any lost savings or discounts offered by a facility or Provider due to untimely payment of the bill by You or Your Claim Administrator, unless such untimely payment is approved by Us in writing.
15. Expenses resulting from any litigation; extra or non-contractual damages or actions; compensatory damages, exemplary and punitive damages or liabilities of any kind; fines, penalties or sanctions; legal fees or expenses of any kind, including, but not limited to, those resulting from negligence, intentional wrongs, fraud, bad faith or strict liability or non-

compliance with applicable law on the part of You, the Benefit Plan, Your Claim Administrator, Your agent or broker, or any agent or representative You, the Benefit Plan, Your Claim Administrator, Your agent or broker.

16. Expenses Incurred outside of the U.S. except in emergency situations. Emergency situations are defined as instances of a serious injury, the onset of a serious condition which requires immediate medical intervention to prevent death, or a serious impairment of health. Emergencies do not include elective care or care of minor illness or injury.
17. U.S. Economic and Trade Sanctions. If any coverage provided by this Policy would be in violation of any U.S. economic or trade sanctions such as, but not limited to, those sanctions administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"), such coverage shall be null and void. Similarly, any coverage relating to any claim that would be in violation of U.S. economic or trade sanctions as described above shall also be null and void.
18. Payments under the Benefit Plan arising out of or caused by or contributed to or in consequence of war, hostilities (whether war be declared or not), invasion or civil war.
19. Expenses associated with preventable errors, including those considered Never Events by Medicare. Never Events are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a material problem in the safety and credibility of a health care facility.

SECTION VI – MATERIAL CHANGE AND MISREPRESENTATION/MISSTATED DATA

MATERIAL CHANGE: You must give Us written notice within 31 days prior to the effective date of any Material Change which may have a material adverse financial, economic or other effect on Our liability under this Policy. **Failure to provide such notice could result in termination or denial of reimbursement under this Policy.**

A Material Change includes, but is not limited to, a change to, or of, any of the following:

1. A change to, or of
 - a. terms of this Policy, including the modification addition or deletion of Endorsements.
 - b. Your Plan Document.
 - c. Claim Administrator.
 - d. Managed Care Network.
2. The information disclosed by You upon which Our assessment of risk was based;
3. An increase or decrease in the number of Covered Persons that exceeds 15% of the current number covered under the Benefit Plan;
4. The insolvency or inability to pay obligations of You or the Benefit Plan; or
5. A merger, acquisition, divestiture, or similar transaction involving You or any of Your affiliates, subsidiaries or divisions.

If You amend the Benefit Plan, Managed Care Network, Claim Administrator or change Your business so as to result in a material adverse financial, economic or other effect on Our liability or risk under this Policy, We will have the right to (i) recalculate Monthly Expected Claims and Specific Excess Loss Insurance Premium Rates as shown on the Schedule and continue this Policy, or (ii) terminate this Policy in accordance with the Policy Termination provision of this Policy. If We elect to continue this Policy, the new Monthly Expected Claims and Specific Excess Loss Insurance Premium Rate will be effective on the date specified by Us.

Any revision to Your Monthly Expected Claims or Specific Excess Loss Insurance Premium Rate due to an amendment will become effective on the effective date of the amendment. If We do not

receive notice from You prior to the effective date of the Benefit Plan amendment, We will determine if benefits are payable based on Your Monthly Expected Claims and Specific Excess Loss Insurance Premium Rate calculated (1) without the amendment or (2) with the amendment, whichever is greater.

MISREPRESENTATION/MISSTATED DATA: The Company has relied upon underwriting information provided by You, the Claim Administrator or other party acting on Your behalf.

If:

1. You make any material misstatement, omission or misrepresentation, whether intentional or unintentional, in the information or documentation that You, the Claim Administrator or any other party acting on Your behalf provide to Us, and which We rely upon during the underwriting of this Policy; or
2. After this Policy is issued, We learn of any expense or claim that was Incurred or Paid, but not reported to Us during the underwriting of this Policy, then, in such event:

We reserve the right to deny any such claim, rescind this Policy or to revise the premium rates, deductibles, and terms, conditions and limitations of this Policy in accordance with Our underwriting practices in effect at the time the Policy was underwritten. Any such revisions may be made retroactive to the Effective Date.

SECTION VII – TERMINATION PROVISIONS

POLICY TERMINATION: This Policy will terminate on the earliest of the following circumstances:

1. If You fail to pay the required premium by the end of the Grace Period, this Policy will terminate in accordance with the Premiums provision of this Policy.
2. On the date the Benefit Plan terminates.
3. If You fail to maintain a minimum of 200 Covered Individuals covered under the Benefit Plan at any time during the Policy Period, We may elect to terminate this Policy at the end of the first month during which there are less than such minimum number of enrolled Covered Individuals.
4. The end of the Policy Period.
5. If You fail to satisfy any of Your obligations under this Policy, We reserve the right to terminate this Policy by giving You 60 days advance written notice.
6. The date You suspend active business operations or You are in liquidation or receivership;

We will not refund any portion of the premium paid by You if this Policy terminates during a Policy Period.

If this Policy terminates prior to the end of the Policy Period, the Policy Period will be revised to end on the date of termination, and any specified number of months of the Coverage Period as shown on the Schedule will be reduced by the number of months by which the original Policy Period was shortened.

REINSTATEMENT: If this Policy is terminated for any of the reasons shown above, the Company may, at its option, approve the Policyholder's request to reinstate this Policy. The Policyholder shall submit to the Company any forms and data that the Company may require. If the Policy is reinstated, the Company may request to be paid all outstanding premiums plus interest due from the effective date of reinstatement at a rate of not less than one and one-half percent (1.5%) per month compounded monthly. This Policy will not be reinstated until We confirm such reinstatement to You in writing and any premiums have been paid.

SECTION VIII – GENERAL PROVISIONS

ASSIGNMENT: You may not assign, pledge or transfer, in whole or in part, this Policy or any interest therein or any benefits payable hereunder without Our prior written consent. Any such action will be void and of no effect.

CLAIM ADMINISTRATOR: The Claim Administrator acts on Your behalf and as Your agent. If claims are Paid by a Claim Administrator, We may require that You provide Us with any information possessed by the Claim Administrator that will assist Us in administering this Policy.

You are solely responsible for the actions of the Benefit Plan administrator, the Claim Administrator and any other agent of Yours. We are not responsible for any compensation owed to, or claims by, the Claim Administrator or other agents for services provided to, or on behalf of, You or the Benefit Plan. This Policy does not make Us a party to any agreement between You and the Claim Administrator, nor does it make the Claim Administrator a party to this Policy.

CLERICAL ERROR: No clerical error, whether made by You, the Claim Administrator, or Us, that relates to recordkeeping, reporting, payment of benefits or premiums, will invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. However, upon discovery of such error or delay an equitable adjustment of premiums or reimbursements will be made.

Clerical Error does not include failure of the Policyholder or any agent of the Policyholder, including the Claim Administrator, to:

1. Comply with the provisions of the Benefit Plan or this Policy, including Policy requirements relating to notice and/or payment of Eligible Expenses; or
2. Disclose underwriting information requested by the Company, whether such failure was intentional or unintentional, and regardless of the actual knowledge of the person providing such information.

This provision shall not be construed in any way to impair Our rights under the Misrepresentation provision of this Policy.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy which, on the Effective Date of this Policy, conflicts with any law of the state where this Policy is delivered, shall be deemed to be automatically amended to conform to the minimum requirements of such law.

ENTIRE CONTRACT: The entire contract between You and Us consists of:

1. The Policy; and
2. Your Excess Loss Insurance Application (a copy of which is attached to this Policy when issued); and
3. The Schedule; and
4. The Claim Disclosure Statement (a copy of which is attached to this Policy when issued); and
5. Any Endorsements or Addendums included with and made part of this Policy.

All statements made by You shall be deemed representations and not warranties.

INDEMNIFICATION: You agree to indemnify, defend and hold Us harmless from any liability, damages of any kind, interest, penalties, or expenses (including without limitation, attorney fees) arising from, relating to or concerning in any way whatsoever, any dispute or legal action by or involving a Covered Person, or a provider of services to a Covered Person or any other person claiming entitlement to benefits under the Benefit Plan.

LEGAL ACTION: Legal action may not be taken to receive benefits until 90 days after the date Proof of Loss is received in accordance with the terms of this Policy. Legal action must be taken within three (3) years after the date Proof of Loss is submitted.

This Policy is deemed made in the state in which it was delivered, as shown on the face page of this Policy.

PARTIES TO THE POLICY: The parties to this Policy are the Policyholder and the Company. The Company's liability under this Policy is solely to the Policyholder. The Policy does not create any rights, liability or legal relation between the Company and a Covered Person under the Benefit Plan. No third-party, including your Claim Administrator, is an intended or unintended third-party beneficiary under this Policy.

NON-PARTICIPATING: This Policy does not pay a dividend and shall not be entitled to share in Our surplus earnings.

OFFSET: The Company has the right to offset reimbursement payable to the Policyholder under this Policy and any other policies issued to You by Us against any premiums due and unpaid by the Policyholder, overpayments made by the Company to the Policyholder, any reimbursements made in error or made due to receipt of incorrect information, and any other amounts due to the Company. This right will not prevent the termination of this Policy for non-payment of premium under SECTION VII – TERMINATION PROVISIONS.

POLICY AMENDMENTS/CHANGES: No change in this Policy is valid unless it is approved and signed by one of Our designated corporate officers or an Assistant Secretary. Agents or brokers do not have the right to change this Policy, waive any of its provisions, or bind Us in any way.

PREPARATION OF POLICY: As You and We are both sophisticated entities, in the event of an ambiguity in or dispute regarding the interpretation of this Policy, interpretation of this Policy shall not be resolved by any rule providing for interpretation against the party who causes the uncertainty or against the drafter, and both You and We expressly agree that in the event of an ambiguity or dispute regarding the interpretation of this Policy, the Policy will be interpreted as if both You and Us had fully participated in the negotiation and preparation of this Policy.

RIGHT OF RECOVERY: You must pursue any and all valid claims against third parties arising out of any occurrence resulting in an Eligible Expense payment under the Benefit Plan in accordance with applicable law. You must account for any amounts recovered. Should You fail to pursue any valid claims against third parties for good cause and We then become liable to make payment to You under the terms and conditions of this Policy, We will be subrogated to all of Your rights to all recoveries from a third party (whether by lawsuit, settlement, or otherwise) for that portion of the total recovery which is due Us for reimbursements made to You. Our share of the recovery will not be reduced because the Covered Person has not received the full damages claimed, unless We agree in writing to a reduction.

You must take such action, furnish such information and assistance, and execute such papers as We may require to facilitate enforcement of Our rights, and You must take no action prejudicing Our rights and interests under this Policy.

Any amounts that We recover will be used to pay Our expenses of collection, and to reimburse Us for any amount that We may have paid, or become liable to pay, to You under the terms of this Policy. All remaining amounts will be paid to You.

STATE ASSESSMENT LOADS: State and Federal laws may assess excess loss insurance carriers based on the number of that state's residents who are covered under excess loss policies. We shall have the right to increase premium rates to cover expected state assessment costs, based on the most current applicable assessment rates.

STATE HEALTH CARE SURCHARGES: If You pay a state health care surcharge in connection with the payment of Eligible Expenses, the health care surcharge shall be considered an Eligible Expense provided that the charges were submitted and duly noted as such. Penalties or fines associated with the health care surcharge or the underlying expenses will not be considered Eligible Expenses.

U.S. ECONOMIC AND TRADE SANCTIONS: If any coverage provided by this Policy would be in violation of any U.S. economic or trade sanctions such as, but not limited to, those sanctions administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"), such coverage shall be null and void. Similarly, any coverage relating to any claim that would be in violation of U.S. economic or trade sanctions as described above shall also be null and void.

WAIVER: Our failure to require Your strict compliance with any requirement or provision of this Policy at any time, under any circumstance, will not constitute a waiver of such requirement or provision by Us at any time under the same or different circumstances.

YOUR BANKRUPTCY OR INSOLVENCY: Your bankruptcy or insolvency neither relieves Your obligation to pay premiums when due nor abates the termination of this Policy for failure to make such premium payments. Subject to the terms, conditions and limitations of this Policy, We may pay to Your receiver, trustee, liquidator or legal successor amounts otherwise payable under this Policy. Nothing in this provision shall increase Our liability beyond that which would have existed had You not become insolvent or bankrupt. Further, such bankruptcy or insolvency will not make the Company liable to creditors of the Policyholder, including Covered Persons under the Benefit Plan.

SECTION IX – DEFINITIONS

When used in this Policy, the following terms will have the meanings as indicated below.

Actively At Work means that on the Effective Date of this Policy, legally employed Covered Individuals working for You at his or her usual place of work or such other place or places as required by You in the course of such work for the full number of hours and at the full rate of compensation as set by Your employment practices.

Acute Care means services provided to treat Covered Persons medically or surgically with an immediate and/or severe Injury or Illness in a Hospital.

Adjusted Specific Deductible means a separate Specific Deductible, if any, for certain Covered Persons identified in the Schedule, which must be satisfied prior to any Specific Excess Loss Insurance reimbursement under this Policy with respect to those Covered Persons.

Adverse Benefit Determination means a denial, reduction or termination of a Plan benefit; or a failure to provide or pay for a Plan benefit (in whole or part); or a denial of participation in the Plan.

Aggregate Deductible Percentage means the Aggregate Deductible Percentage as shown on the Schedule, which is multiplied by Monthly Expected Claims to determine the Monthly Aggregate Deductible.

Aggregate Excess Loss Insurance means the reimbursement provided by the Company to You under this Policy for Eligible Expenses that exceed the Annual Aggregate Deductible, subject to the terms and conditions of this Policy, including SECTION II – EXCESS LOSS INSURANCE PROVISION of this Policy and the limits set forth in the Schedule.

Annual Aggregate Deductible means the amount of Eligible Expenses which must be Incurred and Paid by You under the Benefit Plan that is wholly retained by You, and which must be met before Eligible Expenses are reimbursable under the Policy, as shown on the Schedule.

Application means the final signed application, for the Excess Loss Insurance Policy, submitted by You to Us, hereby attached to and made part of this Policy.

Benefit Month means any calendar month during which this Policy is in force.

Benefit Plan means a self-funded plan of benefits which the Policyholder provides for eligible Covered Persons. The benefits are described in a written plan document.

Cell Therapy(ies) means a treatment or drug used for the transplantation of live human cells to replace or repair damaged tissue and/or cells. Cell Therapies not approved by the FDA for the specific condition for which the Covered Person is diagnosed, are Experimental or Investigational under the terms of the Policy. Cell Therapy includes CAR-T therapies.

Claim Administrator means an entity which has entered into a written agreement with You to pay claims for the Benefit Plan. The Claim Administrator acts on Your behalf and as Your agent and not as Our agent.

Claim Information means Complete Claims following a Diligent Review by the Policyholder or a designated representative, of data requested by the Company in connection with any pended, Incurred or Paid claim.

Claim Disclosure Statement or Disclosure means the document submitted and signed by the Policyholder, or a designated representative, following a Diligent Review, and accepted by the Company in connection with the underwriting and issuance of this Policy.

COBRA (COBRA Continuee) means a Covered Person that elects to extend his or her coverage under the Plan as entitled under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Company, We, Us and Our means PartnerRe America Insurance Company.

Complete Claim(s) means detailed information including but not limited to the Covered Person's name, member number or other unique identifier, date of birth, admission date, estimated discharge date, diagnosis, prognosis (unless prognosis cannot be obtained due to reasons beyond the control of the Policyholder or its designated representative), expenses incurred to date, any other requested information reasonably necessary for the Company to establish Proof of Loss under this Policy.

Coverage Period means the period of time, shown on the Schedule, during which Eligible Expenses must be Incurred by a Covered Person and Paid by You to be eligible for reimbursement under this Policy.

Covered Individual(s) means an employee who is both eligible and enrolled for coverage under the Benefit Plan. Covered Individual(s) for purposes of this Policy does not include any spouse, partner or dependents who may also be enrolled under the same Benefit Plan.

A Covered Individual includes:

1. Legally employed covered employees of Yours;
2. Participating COBRA Continuees ; and
3. Retirees, as defined by the Benefit Plan, if they are included on the Schedule.

Covered Person(s) means a Covered Individual, or the spouse, partner or dependent of the Covered Individual, who meets the terms and conditions of eligibility for coverage set forth in Your Benefit Plan who is entitled to receive benefits under that Benefit Plan while this Policy is in force.

Cost Containment Vendor means a third party contracted to reduce or control the cost of services or supplies provided to Covered Persons under the Benefit Plan.

Deductible(s) means the Specific Deductible(s), Adjusted Specific Deductible(s), or Aggregate Deductible as shown in the Schedule and as detailed in SECTION II, EXCESS LOSS INSURANCE PROVISION.

Diligent Review means a complete review of claims by the Policyholder, its designated representative, or its Claim Administrator prior to Disclosure, for any Known and potential Serious Claims. Such complete review requires a Policyholder, or its designated representative, to contact and secure information regarding Known and potential Serious Claims from its Claim Administrator; utilization review firms; employees who may have information regarding case management; claims administrations or other relevant claims information; other designated representatives; insurance carriers; and any other party who may have such information.

Domestic Claims are Eligible Expenses provided by the Policyholder or at facilities listed as an associated entity in the Schedule to a Covered Person and for which benefits are payable through the Benefit Plan.

Effective Date means the first day of the Policy Period set forth in the Schedule.

Eligible Expense(s) means expenses Incurred under the Benefit Plan to which the Policy applies and is:

1. Incurred while the Benefit Plan is in effect;
2. Paid in accordance with the terms of the Plan Document;
3. Medically Necessary;
4. a Reasonable and Customary charge;
5. Incurred and Paid as set forth in the Policy's Coverage Period, or otherwise allowed under this Policy, an endorsement or by the Company;
6. Included under the applicable Plan Benefits To Be Covered section of the Schedule; and
7. Not otherwise excluded under the terms of this Policy

Endorsement(s) means the document(s) attached to this Policy that modifies the coverage under the Policy.

Excess Loss Insurance means the coverage provided under this Policy, which reimburses You when Eligible Expenses, exceed the Deductibles defined in this Policy.

Expected Claims means the amount of claims that, in the absence of an excess loss policy or other insurance or evidence of coverage, are projected by Us to be Incurred under a Benefit Plan covering health care expenses.

Experimental Or Investigational, for the purpose of determining Eligible Expenses under this Policy, means a treatment, device, or drug that:

1. is prescribed by a non-licensed Provider; or
2. has not been approved by the United States Food and Drug Administration ("FDA") for the particular condition at the time the treatment, device or drug is provided except for drugs certified by National Comprehensive Cancer Network for a particular condition; or
3. is provided as part of an ongoing Phase I or II or III clinical trial as defined by the National Institutes of Health, National Cancer Institute or the FDA. In the event that an FDA approved drug or device is used for a particular condition during an ongoing Phase I or II or III clinical trial, and one or more other drugs or devices not FDA approved for such trial are also used, then all FDA approved and FDA non-approved drugs or devices shall be considered Experimental or Investigational; or
4. is documented in a major published U.S. peer-reviewed medical or scientific journal stating that further research, studies, or clinical trials are necessary to determine the safety, toxicity or efficacy of the treatment, device or drug; or
5. arises from, relates to, or is provided in connection with the Experimental or Investigational treatment or drug whether or not the treatment, or drug, on its own, is considered standard of care or Medically Necessary.

The Company will determine what is considered Experimental or Investigational for the purpose of determining Eligible Expenses under this Policy by reviewing the Claim Administrator's evaluation of the treatment, device or drug as well as studies, opinions and references to or by the American Medical Association, FDA, Department of Health and Human Services, National Institutes of Health, Council of Medical Specialty Societies, American Hospital Formulary Services Drug Information, American Academy of Pediatrics and any other association, federal program or agency that has the authority to approve medical testing or treatment. Conflicting information will be subject to evaluation by the Company or its designated representative.

Gene Therapy(ies) means a treatment or drug used to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use. Gene Therapies not approved by the FDA for the specific condition for which the Covered Person is diagnosed, are Experimental or Investigational under the terms of the Policy.

Hospital means an institution that:

1. is licensed and operated as a Hospital under the laws or the jurisdiction where it is located;
2. provides, as its primary functions, on an inpatient basis;
 - a. facilities for medical and surgical diagnosis and therapy;
 - b. treatment and care for the sick and injured; and
3. is under the direction of a staff of Physicians;
4. provides 24-hour-a-day nursing services by Registered Nurses; and
5. has facilities on the premises for major surgery

An institution that lacks surgical facilities may still be considered a Hospital if it has a written contractual arrangement with an accredited Hospital for the performance of major surgery.

For the purposes of this Policy, Hospital does not include an institution used as a facility for:

1. rest;
2. custodial care;
3. nursing;

4. care for the aged; or
5. care for alcoholics or drug addicts.

Hospital Inpatient Services means the services provided to a Covered Person who is a registered bed patient in a Hospital, for which there is a room and board charge. These services may be provided on an Acute Care or Sub-Acute Care basis.

Incurred means the date on which services relating to an Eligible Expense were provided to a Covered Person under the Benefit Plan.

Independent Review Organization means an organization that is accredited by the Utilization Review Accreditation Committee, or by a similar nationally recognized accrediting organization, to conduct external review of Adverse Benefit Determinations in accordance with the Patient Protection and Affordable Care Act.

Known means information affecting the administration or underwriting of this Policy, which can be reasonably assumed that the Policyholder, its designated representative or its Claim Administrator had knowledge of, prior to or at the time of that such information was requested by or due to the Company, had a Diligent Review been conducted.

Managed Care Network means a Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Point of Service Plan (POS), Health Maintenance Organization (HMO), or any Managed Care Network offered by You as part of your Benefit Plan.

Maximum Specific Reimbursement means the limit of the Company's liability under the Specific Excess Loss Insurance for the Policy Period, as shown on the Schedule.

Medically Necessary and Medical Necessity means a treatment, device, or drug that meets all of the following criteria:

1. It is recommended for the diagnosis or treatment of the Covered Person by a licensed physician, dentist or other medical practitioner who is practicing within the scope of his or her license; and
2. It is the standard of medical practice and care for the diagnosis and treatment of the particular condition; and
3. It is approved by the FDA for the particular condition at the time of treatment, if applicable.

A treatment, device, or drug will not be considered Medically Necessary if:

1. it is part of a treatment plan that is considered to be Experimental or Investigational or for research purposes; or
2. it is provided primarily as a convenience to the Covered Person or the Covered Person's family or a Provider.

The fact that a physician may prescribe, order, recommend or approve a treatment, device or drug does not, of itself, make it Medically Necessary.

Minimum Premium means the minimum premium, as shown in the Schedule, that must be paid for coverage under this Policy.

Monthly Aggregate Deductible means the Monthly Expected Claims multiplied by the Aggregate Deductible Percentage, as shown on the Schedule.

Monthly Expected Claims means the amount of Expected Claims per month per Covered Person. The initial Monthly Expected Claims are stated on the Schedule. We will re-determine the Monthly Expected Claims on the effective date of each Material Change to the Benefit Plan.

Paid means the latest of the following dates:

1. The Eligible Expense is approved by You according to the terms of the Benefit Plan; and
2. The draft or check is mailed, or the date the wire or other legal electronic transfer of funds has been issued by the Policyholder to the payee; and
3. Sufficient funds are on deposit on the date the check, draft or electronic transfer is issued to permit the check, draft or electronic transfer to be honored.

Plan Document means the written document in effect on the Effective Date of this Policy. Amendments to the Plan Document will be covered by this Policy, when they become effective under such plan, only to the extent they are submitted and approved by the Company, as provided in the Material Change provision of this Policy. Notwithstanding the foregoing, the Plan Document, as defined herein, does not include documents and instruments outside the Plan Document, including but not limited to employee handbooks.

Policy means this Excess Loss Insurance Policy.

Policyholder, You and Your mean You, the Policyholder, shown on the face page of this Policy, who is described in the Excess Loss Insurance Application and to whom this Policy is issued.

Policy Period means the time period of this Policy as shown on the Schedule, subject to the Policy Termination provision under SECTION VII – TERMINATION PROVISIONS of this Policy.

Prescription Drug Plan means either a benefit provision of the Benefit Plan or a separate benefit plan maintained by You, under which prescription drug expenses are Paid independently of other medical expenses.

Proof of Loss means Proof of Loss as defined in SECTION IV – CLAIM AND REPORTING PROVISIONS of this Policy.

Provider means any hospital, physician or other person or entity that is licensed or otherwise operating within the scope of that license to provide health care services.

Reimbursement Percentage means the percentage of Eligible Expense the Company will reimburse the Policyholder after the application of the applicable deductible(s) and subject to any other Policy terms and conditions.

Related Services means the services incurred within 120 days from the date of the administration or supply of the treatment, device, drug or therapy provided to a Covered Person.

Reasonable and Customary means the usual charge made by a Provider who renders or furnishes covered services, treatments or supplies; provided the charge is not in excess of the general level of charges made by other Providers who render or furnish the same or similar services, treatments or supplies to persons: 1) in the same geographical area; and 2) whose Injury or Illness is comparable in nature and severity.

In situations where a Reasonable and Customary charge cannot be determined as provided in the paragraph above, a charge that does not exceed 250% of the Medicare reimbursement rate, or average wholesale price (AWP) for drugs, and/or manufacturer's retail pricing (MRP) for supplies

and devices, in effect at the time services were provided, will be deemed a Reasonable and Customary charge.

To be considered Reasonable and Customary, charges must be in compliance with CMS's multiple procedure payment guidelines, when applicable.

If the Policyholder, Benefit Plan or Claim Administrator has a contracted fee arrangement with certain Providers, Reasonable and Customary shall mean the lesser of the applicable fee as defined in that fee arrangement contract or the charge determined in accordance with the preceding paragraphs.

Schedule of Insurance and **Schedule** means SECTION I - SCHEDULE OF INSURANCE setting forth the Specific Excess Loss Insurance and/or Aggregate Excess Loss Insurance provided under this Policy.

Serious Claim(s) means any claim for Eligible Expense(s) Incurred, or expected to be Incurred, by a Covered Person, regardless of Claim disposition, that may reasonably exceed 75% of the Specific Deductible in this or in the immediately preceding Policy Period.

Specific Excess Loss Insurance means reimbursement provided by the Company to You under this Policy for Eligible Expenses that exceed the Specific Deductible, or Adjusted Specific Deductible(s), as applicable, subject to the terms and conditions of this Policy, including the limits set forth in the Schedule.

Specific Deductible means the amount of Eligible Expenses that must be Incurred by a Covered Person and Paid under the Benefit Plan, which is wholly retained by You and must be met before Eligible Expenses are reimbursable under the Specific Excess Loss Insurance, as shown on the Schedule.

Sub-Acute Care means services, provided to treat Covered Persons medically, which are rehabilitative, restorative in nature, specialized and/or post-surgical care associated with the transition between a Hospital and home.

Unbundled Charges means billed charges for hospital services, supplies, equipment and/or items based on Company's determination constitute unbundled, fragmented or otherwise duplicative charges which should reasonably be included in another charge which Provider has billed for the same Covered Person on the same day.

Workers' Compensation means benefit payments to any eligible Covered Person as required by state law for accidents or occupational disease arising out of, or in connection with, the Covered Person's employment.

Specific Advanced Funding Endorsement

PartnerRe America Insurance Company
Wilmington, DE

Mailing Address:
6900 Wedgwood Road, Suite 120
Maple Grove, MN 55311
800 263 6546

Endorsement No.: ONE

Effective Date: October 1, 2025

Policyholder: Brazoria County

Attached to and forming a part of Policy No.: P0400001802

This Endorsement modifies insurance provided under the Excess Loss Insurance Policy. It is hereby understood and agreed that the following changes are made and incorporated into the Policy:

At Your written request, We will advance Our payment of Eligible Expenses that exceed the Specific Deductible ("Advanced Funding") provided all of the following conditions are met:

1. Premium must be paid through the month in which the claim was submitted.
2. The Specific Deductible for a Covered Person has been met;
3. Each request for Advanced Funding must be greater than or equal to the lesser of 15% of the Specific Deductible or \$50,000 per Covered Person;
4. This Endorsement will not apply during the last month of the Policy Period or if received within 30 days of premature cancellation or termination of the Policy;
5. Claims submitted for Advanced Funding must be determined by Us to (i) have been reviewed and fully approved by the Claim Administrator and (ii) be ready for payment;
6. We have the right to confirm with Providers, the Claim Administrator, or other claim administrators the amount and the fact that payments have been made for which Advanced Funding has been requested;
7. You or the Claim Administrator agree to immediately pay the Eligible Expenses to the Provider upon Our determination of Our liability for the Specific Excess Loss Insurance claim and notification to You or to the Claim Administrator;
8. Within five (5) days of the claim being funded and released, notification of the simultaneous funding transaction must be submitted to Us;
9. If We request, You agree to send Us copies of proof of payment of Eligible Expenses within thirty (30) days of the request; and
10. Any remaining Advanced Funding funds that are not used by You to pay Eligible Expenses due to any type of discounting, rebating or other type of claim reduction or refund, must be repaid by You to Us within ten (10) business days after payment of such Eligible Expenses.

All other terms, conditions and limitations of the Excess Loss Insurance Policy apply to this Endorsement.

In the event of a conflict between the terms, conditions and limitations of this Endorsement and the Excess Loss Insurance Policy, this Endorsement will control.

This Endorsement is made part of the Policy to which it is attached.

IN WITNESS WHEREOF, the Company has caused this Endorsement to be executed and attested and, where required by law, this Endorsement shall not be valid unless countersigned by its duly Authorized Representative(s):



Kelly J. Munger
President, PartnerRe Health
PartnerRe America Insurance Company



Joy L. Langford
Corporate Secretary
PartnerRe America Insurance Company

Plan Mirroring Coordination Endorsement

PartnerRe America Insurance Company
Wilmington, DE

Mailing Address:
6900 Wedgwood Road, Suite 120
Maple Grove, MN 55311
800 263 6546

Endorsement No.: TWO

Effective Date: October 1, 2025

Policyholder: Brazoria County

Attached to and forming a part of Policy No.: P0400001802

This Endorsement modifies insurance provided under the Excess Loss Insurance Policy. It is hereby understood and agreed that the following changes are made and incorporated into the Policy:

This Endorsement does not constitute a guarantee that any Eligible Expense Paid by You will be reimbursable under the Policy if You do not abide by the requirements stated herein. The Policy will not reimburse for processing or billing errors.

Upon receipt of Proof of Loss acceptable to Us, We will reimburse You for payments of Eligible Expenses under Your Benefit Plan that are:

1. Paid in strict compliance with the terms and conditions of Your Plan Document and not in excess of the amount allowable under Your Benefit Plan;
2. Incurred and Paid during the Coverage Period shown on the current Schedule of Insurance; and
3. Covered under this Policy as set forth under the Plan Benefits To Be Covered section of the Schedule.

The expenses Paid by You shall be considered Eligible Expenses but will be subject to exclusions 1-6, 8-11, 12 (a-c, e & f only) 13, & 15-19 of SECTION V - EXCLUSIONS AND LIMITATIONS of the Excess Loss Insurance Policy.

We reserve the right to not provide coverage under this Endorsement from the inception of the Policy upon written notice to You if You:

- a) fail to provide Us a copy of the current Benefit Plan within 30 days of the Effective Date of the Policy;
- b) amend or edit the Benefit Plan to the extent that Our risk under this Endorsement is materially affected; or
- c) submit a claim where benefits were Paid reliant upon the use of a discretionary clause or similar provision contained within the Benefit Plan; or

d) submit any claim where benefits were Paid using the terms and conditions of any document other than the Benefit Plan (e.g. an employee handbook) that has not already been provided, reviewed, underwritten, and approved by Us.

For the purposes of determining Eligible Expenses, any conflict between the Policy and Benefit Plan shall be resolved in accordance with the terms and conditions of the Benefit Plan.

All other terms, conditions and limitations of the Excess Loss Insurance Policy apply to this Endorsement.

In the event of a conflict between the terms, conditions and limitations of this Endorsement and the Excess Loss Insurance Policy, this Endorsement will control.

This Endorsement is made part of the Policy to which it is attached.

IN WITNESS WHEREOF, the Company has caused this Endorsement to be executed and attested and, where required by law, this Endorsement shall not be valid unless countersigned by its duly Authorized Representative(s):



Kelly J. Munger
President, PartnerRe Health
PartnerRe America Insurance Company



Joy L. Langford
Corporate Secretary
PartnerRe America Insurance Company

Renewal Rate Cap Endorsement

PartnerRe America Insurance Company
Wilmington, DE

Mailing Address:
6900 Wedgwood Road, Suite 120
Maple Grove, MN 55311
800 263 6546

Endorsement No.: THREE

Effective Date: October 1, 2025

Policyholder: Brazoria County

Attached to and forming a part of Policy No.: P0400001802

This Endorsement modifies insurance provided under the Excess Loss Insurance Policy. It is hereby understood and agreed that the following changes are made and incorporated into the Policy:

If this Excess Loss Insurance Policy is renewed, We guarantee that Your Premium rate(s) will not be increased more than 50% over the Monthly Premium rate(s) shown on the Schedule, provided that:

1. There are no changes to the Benefit Plan that materially alter the risk under Your current Excess Loss Insurance Policy;
2. The renewal Excess Loss Insurance Policy contains no material changes from the current Policy, including, but not limited to, changes to: (i) the length of the Policy Period, (ii) Eligible Expenses, (iii) coverage for retirees, (iv) the Specific Deductible, (v) the Coverage Period, (vi) the Reimbursement Percentage for Specific Excess Loss Insurance, (vii) the commission payable, (viii) the Policyholder's Claim Administrator, or (ix) Managed Care Networks or (x) the Maximum Specific Reimbursement,;
3. There are no material changes between the demographic distribution of the group covered under Your current Excess Loss Insurance Policy and the group covered under the renewal Excess Loss Insurance Policy;
4. No new unit, division, subsidiary, affiliated company or class of Covered Persons is added to or removed from this Excess Loss Insurance Policy; and
5. There is no change in any assessment or tax levied against Us by the state in which this Excess Loss Insurance Policy was delivered.

We reserve the right to determine whether any of the changes described in clauses (1) through (5) above constitute a material change. If We determine that any change is material, the Renewal Rate Cap will be adjusted by Us accordingly.

After this, and the following, Policy Period, We reserve the right to revise the deductibles and any other terms, conditions and limitations of this Policy.

Upon renewal, We will not apply any new Adjusted Specific Deductible unless requested to do so in writing by You.

The renewal of this Policy does not guarantee the renewability of the Renewal Rate Cap Endorsement.

All other terms, conditions and limitations of the Excess Loss Insurance Policy apply to this Endorsement. In the event of a conflict between the terms, conditions and limitations of this Endorsement and the Excess Loss Insurance Policy, this Endorsement will control.

This Endorsement is made part of the Policy to which it is attached.

IN WITNESS WHEREOF, the Company has caused this Endorsement to be executed and attested and, where required by law, this Endorsement shall not be valid unless countersigned by its duly Authorized Representative(s):



Kelly J. Munger
President, PartnerRe Health
PartnerRe America Insurance Company



Joy L. Langford
Corporate Secretary
PartnerRe America Insurance Company

CLAIMS DISCLOSURE STATEMENT

Excess Loss Insurance

Policyholder: Brazoria County
Policy Period: October 1, 2025 to October 1, 2026

Policyholder Obligations:

To complete the underwriting process, the Policyholder, or its Claim Administrator; utilization review firm, and/or any other party who may have such information, must perform a diligent and complete review to identify and report, to PartnerRe America Insurance Company ("PartnerRe"), any and all claims incurred or expected to be incurred, by a covered person, during the immediately preceding 12 months or during the Policy Period that has or may reasonably be expected to exceed 50% of the Specific Deductible selected by the Policyholder.

Policyholder acknowledges and affirms that PartnerRe will rely upon such information in making underwriting decisions and that PartnerRe may, based upon its sole option, exclude reimbursement for any claim(s) and/or adjust premium, deductibles and other policy terms if Policyholder fails to disclose claims incurred or claims expected to be incurred as required under this form. PartnerRe's receipt and review of such information does not validate or confirm, to any extent, the accuracy or completeness of such information or the diligence of the Policyholder's review.

Disclosure Information (Completed by PartnerRe after receipt of the required information):

In accordance with this required disclosure, PartnerRe has received the following information:

- | | | |
|---------------------------------|--|--|
| ▪ 50% Claim Report | ☒ Received | ☐ Not Received |
| ▪ Trigger Diagnosis Report | ☐ Received | ☒ Not Received |
| ▪ Large Case Management Reports | ☐ Received | ☒ Not Received |
| ▪ Pended Claim Reports | ☐ Received | ☒ Not Received |
| ▪ Transplant Waiting List | ☐ Received | ☒ Not Received |
| ▪ Other (Specify) | ☐ Received | ☒ Not Received |

Final Sold Quotation:

In reliance upon the validity, accuracy and completeness of the information provided under this required disclosure, PartnerRe has issued a Final Sold Quotation to the Policyholder.

This Claims Disclosure Statement is attached to and forms part of the Final Sold Quotation.

Completed by: Angela Szeto, Senior Underwriter Date: 8/22/2025

Excess Loss Insurance Application

PartnerRe America Insurance Company

Wilmington, DE
NAIC# 11835

Mailing Address:
6900 Wedgwood Road, Suite 120
Maple Grove, MN 55311
800-263-6546

The Applicant hereby applies for the Excess Loss Insurance Policy.

1. POLICYHOLDER: Brazoria County
Principal Address: 111 East Locust
Angleton, TX 77515

Are subsidiary or associated entities to be included? ☐ Yes ☒ No

2. POLICY PERIOD: Effective Date: October 01, 2025
Termination Date: October 01, 2026

3. CLAIM ADMINISTRATOR: Aetna
Type of Coverage: Medical
Address: 151 Farmington Ave.
Hartford, CT 06156

CLAIM ADMINISTRATOR: Caremark / CVS
Type of Coverage: Rx
Address: 750 W John Carpenter FWY, Suite 1200
Irving, TX 75039

4. EXCESS LOSS INSURANCE:

- a. Specific Excess Loss Insurance: ☒ Yes ☐ No

- i. Specific Deductible: \$350,000 per Covered Person
Covered Persons subject to an Adjusted Specific Deductible: Member ID#: **PREBRA
1025-01** Subject to: \$400,000
- ii. Coverage Period:
Eligible Expenses Incurred from October 01, 2023 through October 01, 2026 and
Paid from October 01, 2025 through October 01, 2026

b. Aggregate Excess Loss Insurance: ☒ Yes ☐ No

i. Monthly Aggregate Deductible: \$1,782.64 per Composite per month

ii. Coverage Period:
Eligible Expenses Incurred from October 01, 2023 through October 01, 2026 and
Paid from October 01, 2025 through October 01, 2026

5. The following endorsement(s) are elected:
Specific Advanced Funding Endorsement
Plan Mirroring Coordination Endorsement
Renewal Rate Cap Endorsement

I, the undersigned, understand and agree that:

This Application is based upon claim details, enrollment, eligibility, Benefit Plan and other information provided by Applicant to PartnerRe America Insurance Company ("PartnerRe"). Any known material change in such information must be reported to and agreed upon by PartnerRe prior to coverage becoming effective. Additional underwriting adjustments, including changes to terms, premium or specific deductibles on certain individuals, may be required.

The coverage afforded by this Application is to be effective from 12:01 A.M. standard time on the Effective Date stated above at the Policyholder's address, provided the first month's premium is paid in full and that the Claim Disclosure Statement and this Application are accepted and approved by PartnerRe. The coverage afforded by this Application is subject to all terms and conditions of the Policy in current use by PartnerRe. This Application and Claim Disclosure Statement will become a part of the Policy when issued.

This Application assumes the Producer/Agent of Record is duly licensed as required by law and has been appointed with PartnerRe America Insurance Company in the state in which the Policyholder is located and the Policy is to be delivered.

By signing this Application and the Claim Disclosure Statement, the Applicant represents that all statements, answers and information provided to PartnerRe are complete and true to the best of its knowledge. Applicant further acknowledges and agrees (i) that such statements, answers and information provided and in the Claim Disclosure Statement, together with a copy of the Benefit Plan and other information attached to this Application or furnished to PartnerRe, are submitted by the Applicant as an inducement to and will be relied upon by PartnerRe in underwriting this risk and determining whether to accept this Application and issue the policy being applied for; (ii) if such statements, answers and information is/are incomplete or untrue and such incompleteness or falsity is material to the risk to be insured by PartnerRe, any policy issued by PartnerRe may be rescinded and/or any benefits that might otherwise be payable thereunder may be denied; and (iii) the Applicant has fully read and understands this completed Application and the Claim Disclosure Statement.

I hereby agree to the terms as stated above and warrant that I am duly authorized to execute this acceptance:

Applicant Signed By:



Its Corporate Officer or Authorized Representative

09-05-25

Date

L.M. "Matt" Sebesta, Jr. - County Judge

Title

FEIN#

Accepted by PartnerRe America Insurance Company:



Signature

September 11, 2025

Date

Senior Underwriter

Title

INSURANCE FRAUD WARNING

Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading, is guilty of insurance fraud and is subject to criminal and/or civil penalties.

Your Employer Stop Loss Partner

PartnerRe

Proposal

Brazoria County

SA Benefit Services, LLC

Effective: **10/01/2025**

Cameron Katrena

cameron.katrena@partnerre.com,

Angela Szeto

angela.szeto@partnerre.com,

partnerre.com/risk-solutions/health

Cornerstones of our ESL Value Proposition

“Our team offers a unique customer experience, combining personalized ‘small town’ warmth with ‘big city’ capabilities and expertise.”

Ease of doing business

- We believe true partnerships are built on trust and straight-forward communication
- We provide direct access to the breadth and depth of our expertise

Smooth customer journey

- We ensure a seamless onboarding process by providing active guidance and support
- We deliver on our promises, offering an efficient claim handling process

Ongoing education & insights

- Our **PULSE** + Plus® team offers complementary services customized to each employer group to achieve the best clinical and financial outcomes

Financial Quote

SPECIFIC STOP LOSS COVERAGE

Plan Description		Option 1
Annual Specific Deductible per Individual		\$ 350,000
Except for		
PREBRA 1025-01 Subject to:		\$ 400,000
Plan Benefits Included		Medical, Rx Card
Coverage Period		36/12
Retiree Coverage		All Retirees Covered
Specific Lifetime Maximum		Unlimited
Specific Annual Maximum		Unlimited
Quoted Rate(s) Per Month	Enrollment	
Composite	1,478	\$ 84.30
Estimated Annual Premium		\$ 1,495,145
Commission %		0.00 %
Additional Options		
No New Laser with Rate Cap		50.00%
Plan Mirroring		Included
Specific Advancement		Included

AGGREGATE STOP LOSS COVERAGE

Plan Description		Option 1
Plan Benefits Included		Medical, Rx Card
Coverage Period		36/12
Aggregate Deductible %		120%
Loss Limit per Individual		\$ 350,000
Maximum Aggregate Reimbursement		\$ 1,000,000
Reimbursement Percentage		100%
Quoted Rate(s) per Month	Enrollment	
Composite	1,478	\$ 3.16
Estimated Annual Premium		\$ 56,046
Commission %		0.00 %
Aggregate Run-In Limit		\$ 3,952,113
Monthly Aggregate Claim Factors	Enrollment	
Medical, Rx Card		
Composite	1,478	\$ 1,782.64
Composite	1,478	\$ 1,782.64
Estimated Annual Aggregate Deductible		\$ 31,616,903
Minimum Annual Aggregate Deductible		\$ 31,616,903

PROPOSAL QUALIFICATIONS AND CONTINGENCIES

1. This quotation is subject to the completion and signature of the Application.
2. For inclusion of prescription drug (Rx) coverage under the Specific and/or Aggregate coverage(s) when there is a separate PBM, PartnerRe requires written documentation for underwriting purposes that all Rx experience reports have been received. Otherwise, Rx will not be a covered expense under the Stop Loss Policy. PartnerRe is not responsible for aggregating medical and Rx claims data during quotation or Policy coverage periods.
3. All claim reporting submitted from the selected Administrator should be provided to PartnerRe in a sortable Microsoft Excel format throughout the Policy and Proof of Loss Periods. Failure to do so could result in a delay of claim reimbursements.
4. Actively at Work is waived with receipt and acceptance of the PartnerRe Claim Disclosure Statement.
5. This quotation assumes that the Agent/Broker is operating under the appropriate license in which the risk is domiciled. The Agent/Broker license and appointment with PartnerRe will be required prior to binding coverage.
6. The statements herein may vary from the final Policy wording. The final Policy wording along with the Excess Loss Insurance Application and Claims Disclosure Statement shall govern over any inconsistency with the wording herein.
7. This quotation is subject to the verification and approval of the Policyholder by PartnerRe through the economic and trade sanction watch lists enforced by the Office of Foreign Assets and Control (OFAC).
8. Current copies of the Plan Document, all Amendments and Restatements of the Plan Document and proposed changes are required to be submitted and approved by PartnerRe prior to binding coverage.
9. The Plan Mirroring provision has been quoted. A review of the Plan Document will be required prior to approval.
10. No New Laser with Rate Cap: If the Excess Loss Insurance Policy is renewed, We guarantee that Your premium rate(s) (and Aggregated Specific Deductible, if applicable), as shown on the Schedule of Insurance will not be increased more than the indicated percentage, provided that there are no Material Changes that alter the risk under the current Excess Loss Insurance Policy. See Policy Endorsement for complete details.
11. Upon renewal, We guarantee no new lasers for the options shown above in which No New Lasers at Next Renewal is Guaranteed.
12. ***Member PREBRA 1025-01, a \$400,000 Specific Deductible will apply for drugs and services related to the Lipomatosis diagnosis.***
13. ***Liability basis is 36/12.***
14. TPA: Aetna; Network: Aetna

OPTIONS SUMMARY

PROPOSAL ACCEPTANCE PROCEDURES

Please check next to the selected proposal option:

Option	Specific Deductible	Specific Contract	Client's Liability	Total Specific Premium	Option	Aggregate Contract	Total Aggregate Premium	Attachment Point
☐ 1	\$ 350,000	36/12	\$ 0	\$ 1,495,145	☐ 1	36/12	\$ 56,046	\$ 31,616,903

About Us

PartnerRe

Key Facts and Figures

- Founded in 1993, headquartered in Bermuda
- Privately owned by Covéa since July 2022
- When engaging with our partners we live by our values:
 - Integrity
 - Performance
 - Straightforward Communication
 - Collaboration
 - Respect & Care

Financial Strength Ratings

A+	A+	A1
A.M. Best	S&P	Moody's

Total Capital

\$10.3bn

Gross Premium Written in 2023

\$9.1bn

As at June 30, 2024

PartnerRe US Health

We are a financially strong leader with a focus on exceptional partner relationships.

- Direct writer of Employer Stop Loss business for 25+ years
- Broad and deep industry experience across all U.S. Health market segments, including HMO Reinsurance, Medical Excess Reinsurance, and Provider Excess

Gross Written Premiums

\$375+ Million

Covered Lives

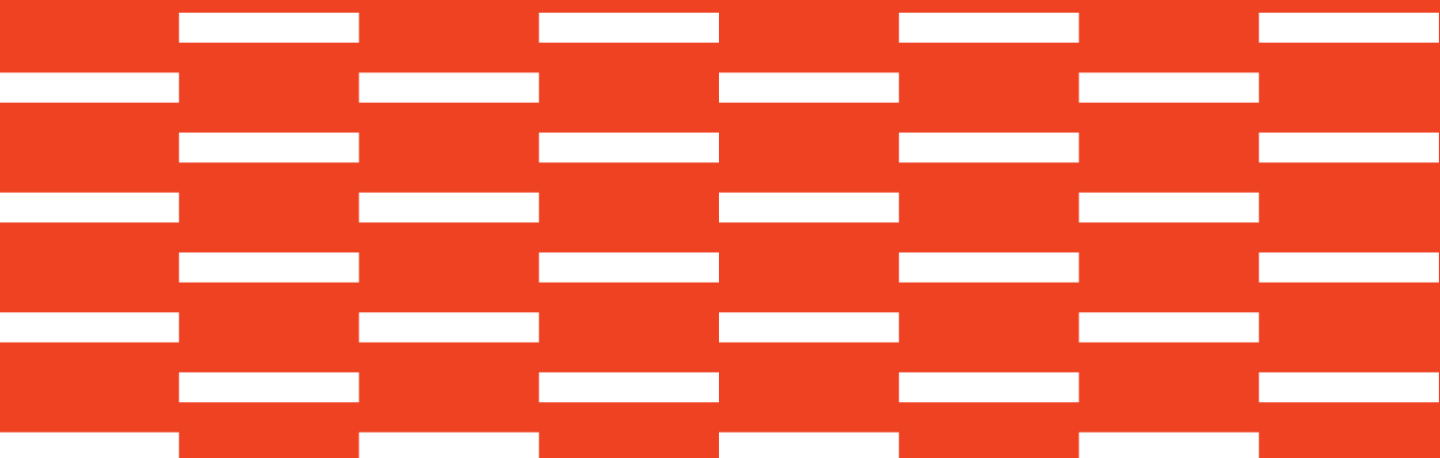
9+ Million

Experience of ESL Underwriters (average)

20+ Years

As of April 30, 2024

partnerre.com



IMPORTANT NOTICE TO ALL POLICYHOLDERS TEXAS

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

PartnerRe America Insurance Company

To get information or file a complaint with your insurance company:

Call: Director, Vice President Compliance at 1-612 234 4938

Toll-free: 1-800-263-6546

Email: prehcompliance@partnerre.com

Mail: 6900 Wedgwood Road, Suite #120, Maple Grove, MN 55311

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: : Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

PartnerRe America Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros:

Llame a: Director, Vice President Compliance al 1-913-871-7208

Teléfono gratuito: 1-800- 263-6546

Correo electrónico: prehcompliance@partnerre.com

Dirección postal: 6900 Wedgwood Road, Suite #120, Maple Grove, MN 55311

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 2030, Austin, TX 78711-2030