RetireeFirst

Version 1

2026 Renewal Package

Prepared For:

Brazoria County, TX

RetireeFirst
1000 Midlantic Drive, Suite 100, Mount Laurel, NJ 08054-1513

RetireeFirst

Brazoria County, TX
237 East Locust Street
Angleton, TX, 77515

2026 RetireeFirst Renewal Rates and Requirements

Dear Plan Sponsor:

Thank you for choosing RetireeFirst to provide Retiree Benefits Management and Advocacy Services for your members. We are committed to supporting your Plan by delivering effective healthcare solutions and advocating for your retirees.

To prepare for your upcoming renewal, we have reviewed market trends, engaged carriers to secure competitive bids, and negotiated on your behalf to present the best available options for your Plan and its members.

The following materials are enclosed for your review:

- **Population Demographics**
- **Incumbent Renewal Rate**
- **Market Analysis**
- **Renewal Addendum**

Next Steps:

To finalize your renewal, please:

1. Mark your carrier selection by checking the appropriate box on the Plan Selection page
2. Sign and date the form below the box.

If we do not receive your response by this date, the Plan will automatically renew with the incumbent carrier to allow sufficient time (90 days) for processing.

It is a privilege to work with you in serving your members. Please don't hesitate to reach out if you have any questions or need further assistance.

Sincerely,

Shannan Wilkerson-Brown
VP, Client Relations

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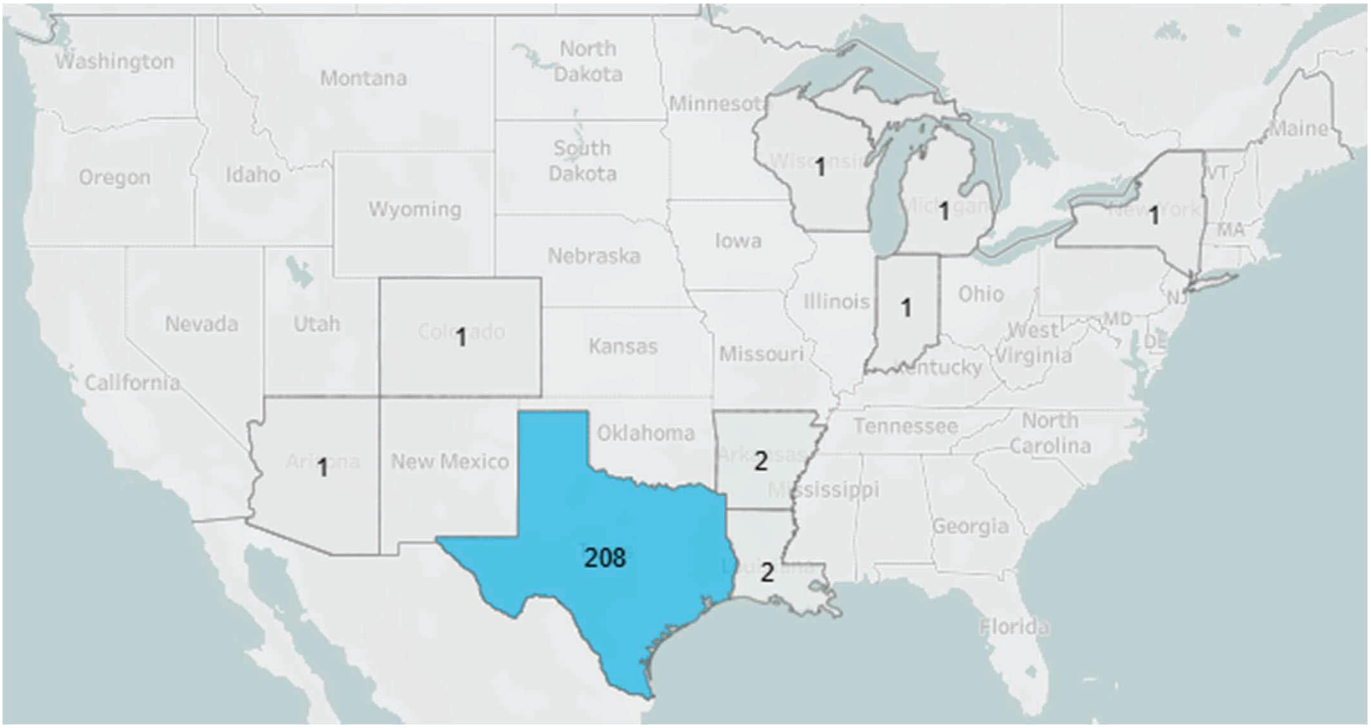
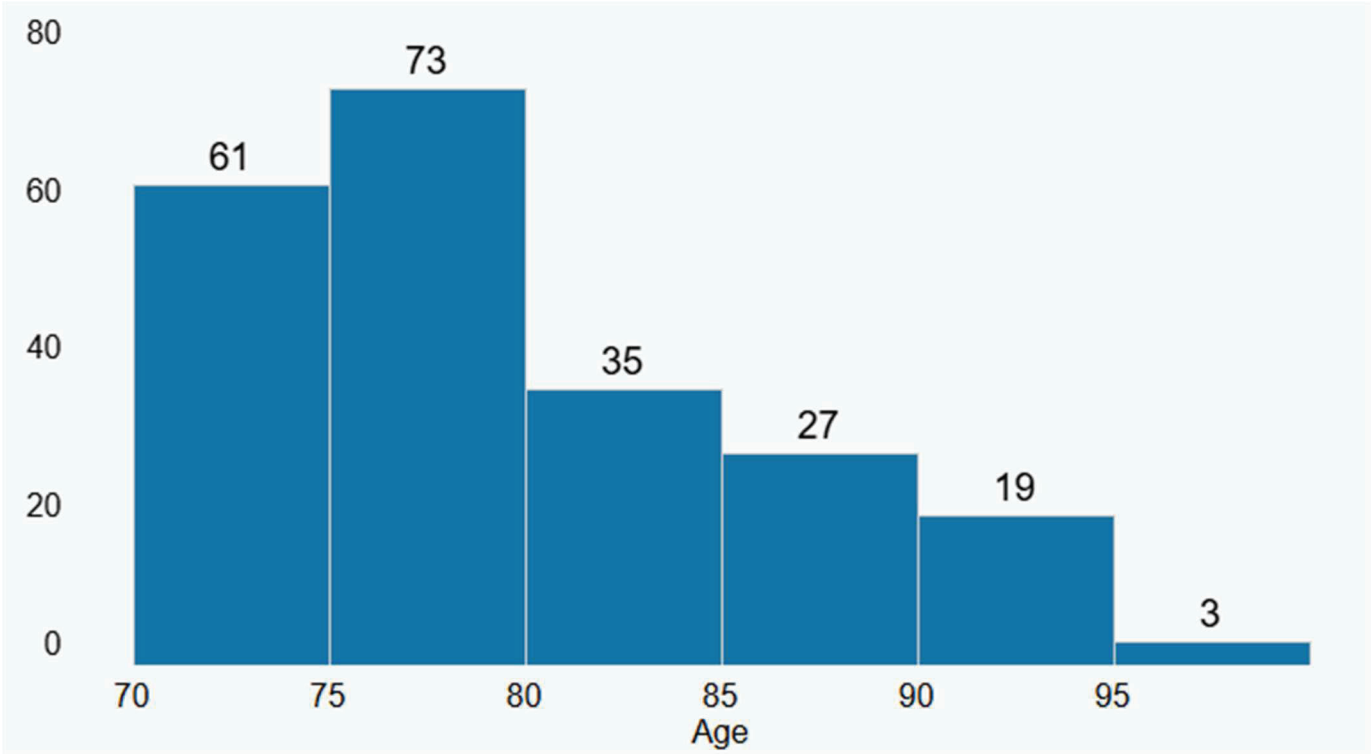
Brazoria County, TX Population Demographics

Geographic Retiree Residence Chart **(218 Approximate Total Participants)**



Retiree Population Age Chart **(218 Approximate Total Participants)**



*Eligibility counts may vary slightly based on the date/ time when the data was extracted.

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Key Changes Contributing to Renewal

There are many factors that affect renewal rates including: claims activity, CMS subsidy amounts, market demographics, and regulatory changes. With changes in the regulatory landscape, there are corresponding changes impacting group underwriting. Below, please see key highlights of CMS changes for 2026.

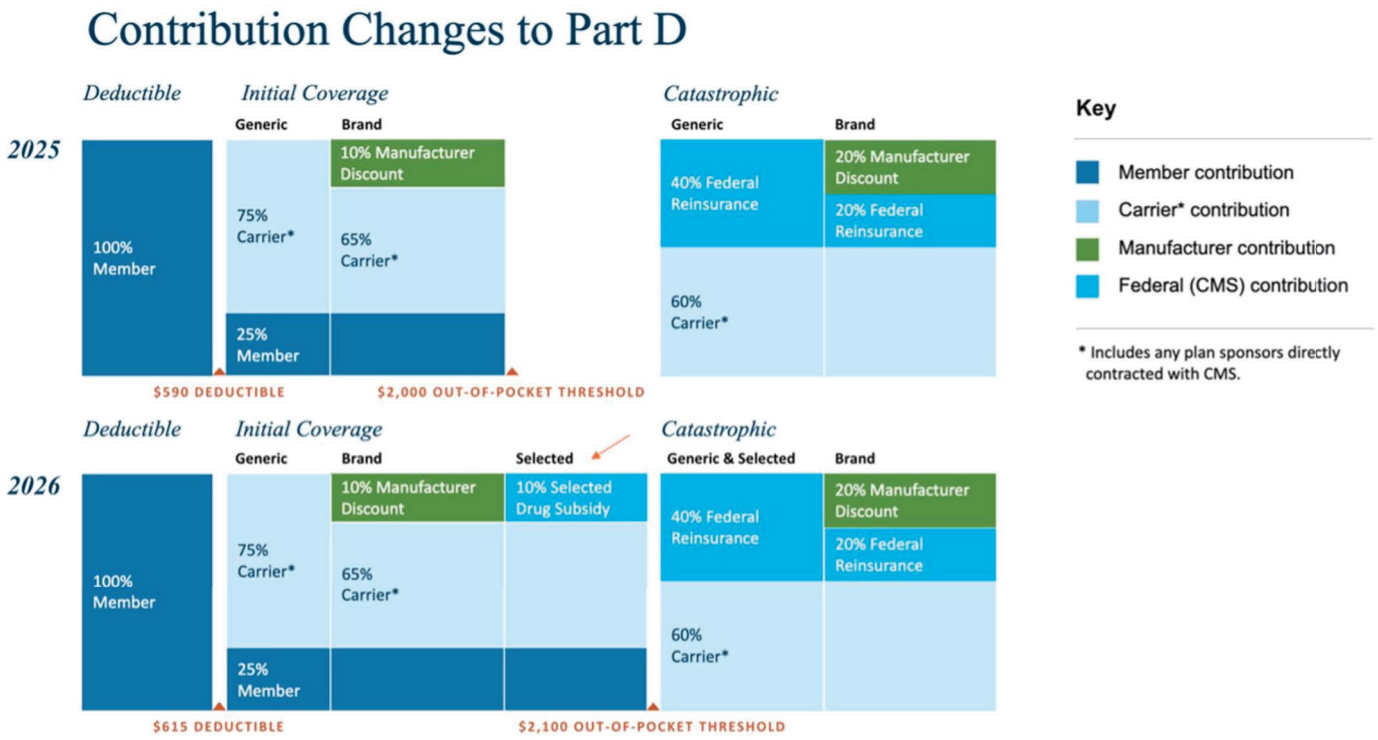
Part D

Inflation Reduction Act — The Inflation Reduction Act of 2022 was signed into law and continues to make changes to Part D plans.

These key changes will be made to the base Part D benefit and will also impact the group benefit and the underlying pricing models for Part D prescription drug coverage:

- Increase in the annual member out-of-pocket spending cap to $2,100 from $2,000 for 2026
- Annual deductible increase to $615 from $590 for 2026
- Out-of-pocket insulin prices will continue to be capped at $35 for a one-month supply
- Out-of-pocket costs for adult vaccines covered under Part D will be $0
- Continued option for members to enroll in the Medicare Prescription Payment Plan (M3P) to spread out their out-of-pocket prescription drug cost over 12 months
- Establishment of the Selected Drug Subsidy program where Part D sponsors will receive a 10% subsidy, until the $2,100 out-of-pocket cap is met, for drugs that are part of the Medicare Drug Price Negotiation Program
- Implementation of the Medicare Drug Price Negotiation Program effective 1/1/26.
- One of the most significant provisions of the IRA will allow the government, for the first time ever, to negotiate pricing on 10 well-known and highly utilized, high-cost drugs starting 1/1/2026. These drugs are used to treat some of the most common diseases such as heart failure, diabetes, blood clot prevention, psoriasis, rheumatoid arthritis, Crohn's disease, and blood cancer. The targeted drugs include Eliquis, Jardiance, Xarelto, Januvia, Farxiga, Entresto, Enbrel, Imbruvica, Stelara, and Fiasp/NovoLog.

See below for a visual of the Part D plan design in 2025 and 2026 with key changes to the financial contribution by CMS, drug manufacturers, the member, and Part D sponsor.



Medicare Advantage Implications

Each year, CMS updates their payment methodologies which drive payments from CMS to the carriers. Changes in payment methodologies typically drive changes to carrier premiums and benefit offerings. Highlights for 2026 include:

Year 3 of the risk adjustment model changes– reflecting the ICD9 to ICD10 coding change including:

- Streamlining disease categories
- Reducing number of codes available for some key disease states
- Creating pressure on risk scores as phased in over three-years (2024 - 2027)
- CMS increased the growth rate to 9.04%, higher than the 5.93% in the Advance Notice
- The growth rate calculation is based on CMS expected growth in costs for Medicare
- Represents CMS prediction of growth trends reflecting the year over year change in costs for Medicare
- CMS included payment data from 4Q2024 which helped drive the increase in growth rate
- CMS estimated payments to the health plans expected to increase on average by 5.06% from 2025 to 2026, which is an increase of 2.83% from the Advance Notice.

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Looking Forward

The Medicare Price Negotiation Program is expected to continue in future years. CMS has selected 15 additional drugs covered under Part D for negotiation for 1/1/2027 that include drugs for treatment of chronic conditions such as diabetes, asthma, cardiovascular disease, irritable bowel, cancer, bipolar disorder, and autoimmune disease and up to 15 more drugs for 2028 (including drugs covered under Part B and Part D), and up to 20 more drugs for each year after that, as outlined in the Inflation Reduction Act.

The targeted drugs for 1/1/2027 include Ozempic/Rybelsus/Wegovy, Trelegy Ellipta, Xtandi, Pomalyst, Ibrance, Ofev, Linzess, Calquence, Austedo, Breo Ellipta, Tradjenta, Xifaxan, Vraylar, Janumet, and Otezla.

The IRA updates and changes, including the Medicare Drug Price Negotiation program effective 1/1/26, will continue to contribute to the Part D plan costs for 2026 and beyond. For RDS plans, these changes will continue to impact credible coverage for 2026 and beyond.

As CMS continues to define the requirements of these key elements, we will be working closely with our carrier partners on implementation activities throughout this process.

Please note: The information provided is based on initial review of the language and is not intended to constitute legal advice. We suggest that you consult with your attorney for legal advice and interpretation.

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2025 Medicare Advantage with Prescription Drug

Deductible		$0
Annual Out-of-Pocket Max		$0
Primary Care		$0
Specialist		$0
Emergency		$0
Urgent Care		$0
Ancillary Benefits	Foreign Travel	$0, Emergency Room & Urgently Needed Care
	Hearing	$0, Routine Hearing Exam, 1 per year $500 Total Hearing Aid Allowance, every 3 years
	Vision	$0, Routine Eye Exam, 1 per year $100 Eyewear Allowance, every 2 years
	Dental	Medicare Covered Services Only
	Podiatry	$0, 6 Visits per year
	Chiropractic	$0, 20 Visits per year
	Acupuncture	Medicare Covered Services Only
	Private Duty Nursing	-
	Fitness Benefit	SilverSneakers

For complete benefit details please refer to the carrier issued materials. This document includes a simplified summary of benefits and does not create any contractual rights.

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2025 Medicare Advantage with Prescription Drug (Cont.)

Part D Deductible	$0		
	30 Day Retail	**90 Day Mail Order**	**90 Day Retail**
Tier 1-A Preferred Generics	$15 Preferred / $20 Standard	$30	$45 Preferred / $50 Standard
Tier 1 Generics	$15 Preferred / $20 Standard	$30	$45 Preferred / $50 Standard
Tier 2 Preferred Brands	$30 Preferred / $35 Standard	$60	$90 Preferred / $95 Standard
Tier 3 Non-Preferred Brands	$50 Preferred / $55 Standard	$100	$150 Preferred / $155 Standard
Tier 4 Specialty	$50 Preferred / $55 Standard	Limited to a one month supply	Limited to a one month supply
Rx Out-of-Pocket Max	$2,000 CMS Requirement		
Part D Gap Coverage	Full-Coverage *Due to the Inflation Reduction Act, effective 1/1/2025, Part D plans will not have a Gap Phase		
Formulary	Most Comprehensive (Open)		
Bonus Drug List	Included		
Catastrophic Coverage	Members pay $0 *Due to the Inflation Reduction Act, effective 1/1/2025, members will pay $0 after reaching their $2,000 annual Rx out-of-pocket threshold		
Utilization Management	Prior Authorizations, Quantity Limits and Step Therapy		

For complete benefit details please refer to the carrier issued materials. This document includes a simplified summary of benefits and does not create any contractual rights.

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2026 Incumbent Renewal and Market Analysis

PRODUCT: **Medicare Advantage with Prescription Drug Plan**
MAPD Incumbent: **Blue Cross Blue Shield of Texas**

	MAPD - BCBSTX - Brazoria County - 2025	MAPD - BCBSTX - Brazoria County - 2026
Total Rate PMPM	$432.00	$444.20
Annualized *	$1,130,112.00	$1,162,027.20
Annualized Change	-	$31,915.20
% Change	-	2.82%

* Annualized amounts are based on 218 retirees
* Plans are quoted with robust formularies to minimize disruption.
* Please note that medications can change tiers between carriers and between plan years.

Please refer to Appendix - Terms, Stipulations, and Rating Assumptions.

Plan Differences

* Please refer to the Plan Comparison for plan Enhancements and Deviations.

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RetireeFirst Renewal Contract Addendum

This Renewal Addendum extends the terms and conditions of the Retiree Benefit Management Services Agreement contract. This is to serve as notice of the 2026 renewal rates for your organization's retiree benefit plan for the period 1/1/2026 through 12/31/2026.

The parties hereby accept the 2026 rate selected below which will be effective from 1/1/2026 through 12/31/2026. All other terms and conditions of the Retiree Benefit Management Services Agreement previously executed between the parties shall remain in full force and effect for the new renewal term. Please refer to Appendix – Terms, Stipulations, and Rating Assumptions.

Subsidiaries and Affiliates. Client acknowledges and agrees that certain services hereunder may be performed or provided by Manager's subsidiaries or affiliates, including, without limitation, RetireeFirst, LLC, a licensed insurance agency. Client further acknowledges that all insurance products and services offered herein are provided by our affiliate RetireeFirst, LLC (d/b/a LaborFirst Insurance Solutions, LLC in CA and LaborFirst Insurance Brokerage, LLC in NY), a licensed insurance agency, on behalf of one or more insurance companies. All descriptions or illustrations of coverage provided by RetireeFirst are for general informational purposes only and do not amend, alter, or modify any insurance policy or guarantee any specific price, quote or coverage. Not all products and services are available in all states or to all customers. Nothing herein is intended or should be interpreted as the sale or solicitation of insurance by RetireeFirst. To the extent any of Manager's subsidiaries or affiliates provide services hereunder, Manager represents and warrants that such subsidiaries and affiliates shall adhere to all terms and conditions of this Agreement. All payments are made to LaborFirst or designated affiliate.

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Please sign and return as soon as possible

Plan Selection

Medicare Advantage with Prescription Drug Plan Options	Monthly Rate	Select With "X"
Blue Cross Blue Shield of Texas - MAPD - Brazoria County - 2026	**$444.20 PMPM**	

Plan Sponsor Representative Signature **Date**

David Zawrotny

933C9C6146D140DBE9313C25EA669B1B contractworks.

09/22/2025

RetireeFirst Representative Signature **Date**

Please refer to Appendix – Terms, Stipulations, and Rating Assumptions.

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Re: Consolidated Appropriations Act

To Whom It May Concern,

1) On behalf of our clients, RetireeFirst supports a host of services, which vary by client, and may include, but are not limited to, the following:

A. Pre-Implementation and Implementation Services

1. Perform market analysis for benefit programs provided through qualified Insurance Vendors.
2. Work with Client to finalize Insurance Vendor's quotes and proposals for benefit programs that are consistent with Client's benefit plan requirements.
3. Review the selected Insurance Vendor's benefit design and documentation to ensure it accurately reflects the quote and proposal that has been accepted and approved by the Client's Trustees.
4. Implement selected qualified Insurance Vendor's benefit to provide a fully insured group Plan that will constitute approved benefits for purposes of this Agreement ("Approved Plans").
5. Handle all aspects of transition to the Approved Plan with Insurance Vendor; and
6. Provide implementation manager experienced in retiree healthcare plans to manage the transition process and is a dedicated point of contact for Client.
7. Obtain all necessary information from Client on Eligible Members and Eligible Dependents.
8. Obtain and review an electronic eligibility return file generated from CMS.
9. Host onsite or virtual kick-off meeting/retiree educational seminar (including providing service members after the meeting for one-on-one individual meetings if needed) if applicable.
10. In coordination with Insurance Vendor send all qualified Eligible Members and Eligible Dependents a Welcome Kit and Insurance card.

B. Ongoing Plan Management Services

1. Help manage all eligibility maintenance and convert to a CMS's approved format;
2. Compare the Client's eligibility information against Medicare to ensure no deceased members are on file and to ensure PII and address accuracy;
3. Accept eligibility updates electronically as determined by the Client;
4. Provide carrier Electronic Data Interchange (EDI) services for Member eligibility support, where applicable;
5. Provide the Client with support as needed with all CMS filing and reporting requirements;

6. Administer all group billing, administration, and collections as required by the Client
7. Manage premium aggregation services for the various Insurance Vendors;
8. Verify eligibility and provide the Client with full monthly eligibility, including amount paid to the Insurance Vendor and names of Eligible Members for whom payments are made each month;
9. Submit payment to Insurance Vendors in timely fashion to ensure uninterrupted coverage;
10. Prepare and make available reports, on services provided under this Agreement including:
    a. Member Interaction Logs – A comprehensive report with information on what issues members are calling about and average call times, so problems can be identified for individual members;
    b. Call Summaries – Provide individual call recording summaries upon request.
11. Coordinate with Insurance Vendors to provide Client with monthly eligibility maintenance and reporting;
12. Assist in preparation of benefit summaries for the selected Insurance Vendor's Approved Plan that are consistent with the Client's benefit plan requirements (including any Summary of Material Modification ("SMM") and Summary of Benefits and Coverage ("SBC"), where applicable;
13. Perform all functions in compliance with CMS;
14. Manage all CMS Part D filings and requirements including Late Enrollment Penalty ("LEP") and Opt-Out assistance and low income subsidy ("LIPS") assistance;
15. Provide dedicated Client Account Representative who is an experienced Medicare professional who manages the overall service experience for the Client's account;
16. Provide Account Management team to assist Client with all aspects of plan maintenance;
17. Provide members with group specific regional dedicated client call-center number and live member support (all calls can be handled in over 300 languages are TTY compatible), including 10-year retention on all call recordings;
18. Provide Member Advocates whose services are dedicated to Client and who are licensed, AHIP certified health professionals and experts in the details of the Medicare system to:
    a. Assist members with obtaining and retaining Medicare eligibility and enrollment in accordance with CMS requirements;
    b. Guide Eligible Members and Eligible Dependents through multiple plan options when applicable;
    c. Provide claims, billing and premium payment support;
    d. Assist disabled members and members turning 65 with applying for Medicare;
    e. Provide pharmacy and physician support to Eligible Members and Eligible Dependents;
    f. Assist with pharmacy related questions such as generic availability, prior authorizations, and mail-order services;

g. Interface directly with Social Security, CMS, pharmacies and physicians on behalf of Eligible Members to solve problems;
h. Assist Members and Dependents with copay/coinsurance and assist members with getting discrepancies rectified;
i. Provide assistance with Part B medications and supplies;
j. Provide Eligible Members with potential solutions if formulary disruptions occur;
k. Assist with provider selection and alternative provider assistance;
l. Make completion calls to Eligible Members and Eligible Dependents to ensure that issues raised have been resolved;
m. Assist with appeals to Medicare or the Insurance Vendor if there is a coverage denial to ensure Eligible Members and Eligible Dependents are obtaining all of the benefits of the Approved Plan and Medicare;
n. Assist Insurance Vendor with well care management initiatives including wellness programs, health coaching, etc. including but not limited to health risk appraisals and tools, outreach to high-risk retirees, targeted risk education, ongoing wellness support and preventative outreach;

19. Maintain records of the Client for the duration of the Agreement and for ten (10) years from the date of issuance or occurrence, including records and notations of all calls.

C. Benefit Renewals & Request for Proposal ("RFP") Work Services

1. Provide report to Trustees with comprehensive review of Insurance Vendor's Approved Plan (including competitive pricing and cost review);
2. Provide recommendations to the Trustees on the renewal options for subsequent calendar year(s);
3. Negotiate with proposed Insurance Vendors to obtain best price for vendor agreements for the following calendar year; and
4. Assist Trustees in handling renewal management and ongoing maintenance of Insurance Vendor contracts.

D. CMS Plan Regulatory Notification Procedure Services

1. Prepare CMS mandated Member communications;
2. Prepare Client Specific Announcement Letters; and
3. Prepare and file Group Creditable Coverage attestation filing, as necessary.

E. Health and Wellness Services

1. Provide member access to a dedicated advocacy team;
2. Educate and facilitate annual wellness visit scheduling;
3. Educate and facilitate annual diabetic eye visit scheduling;
4. Educate and facilitate annual flu shots, breast cancer screening, colon cancer screenings;
5. Facilitate PCP Assignment;
6. Educate members and refer to carrier-based care programs where applicable;
7. Increase medication adherence through member education and mail order penetration;
8. Coordination with various carrier clinical programs, e.g. behavioral health, MTM, home care, etc.;
9. Provide pharmacy and provider support services via the dedicated advocacy team.

2) RetireeFirst does not serve as a Fiduciary to the Fund. However, we do manage billing and collection of client Medicare premiums and handle those Funds in a Fiduciary capacity.

3) Direct and Indirect Compensation

The Consolidated Appropriations Act ("CAA") requires a covered service provider to provide: (i) a description of all direct and indirect compensation that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with the specified brokerage or consulting services that the covered service provider performs under a contract or arrangement with a covered plan; and (ii) a description of any compensation paid among the covered service provider, an affiliate, or a subcontractor in connection with such specified services if the compensation is set on a transaction basis.

RetireeFirst is compensated in a variety of ways for the services we are contracted to provide to our clients. Our direct and indirect compensation often is results-driven and/or contingent on performance requirements, the satisfaction of which cannot be determined in advance. Final compensation amounts frequently are unknown before the close of a given plan year. RetireeFirst may receive compensation on a transaction basis from various health insurance companies and their subcontractors in connection with services such as hosting in person educational seminars, producing pre-recorded and/or live online educational materials, creating, printing and mailing member materials, taking inbound member phone calls, assisting with the scheduling of annual wellness visits, etc.

For the forthcoming plan year, we estimate that our total compensation may range from 2% to 4% of insurance carrier revenue for a given client, with specific compensation amounts in connection with a client potentially dictated by performance and/or results over the course of a given plan year. RetireeFirst continues to report final reconciled compensation for any given client and plan year as required under IRS Form 5500 Schedule A and / or Schedule C reporting requirements.

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Appendix – Terms, Stipulations, and Rating Assumptions

Blue Cross Blue Shield of Texas - 2026

- We make every reasonable effort to honor the rates listed herein, and reserve the right to revise such rates quoted at any time before or during the contract period if these assumptions change or as otherwise outlined below.

- We may modify the rates quoted herein any time before or during the contract period if:

(1) Changes to any federal, state, or local law or regulation (or amendment or clarification thereto) applicable to the Medicare Advantage or Part D program that will have an impact to the program costs or revenue;

(2) Changes are announced by the Centers for Medicare and Medicaid Services (CMS) in the Final Medicare Rate Notice and/or the actual national average Part D bid for CMS contract periods in effect during the plan's contract period.