LIBERTY INSURANCE UNDERWRITERS INC.

(A Stock Insurance Company, hereinafter the "Insurer")
55 Water Street, 23rd Floor, New York, NY 10041
Toll-free number: 1-800-677-9163

EXCESS LOSS INSURANCE POLICY

(Liberty Insurance Underwriters Inc., is referenced in this **Policy** as the "Insurer")

(Words and phrases printed in **bold**, other than in the headings, are defined in DEFINITIONS below.)

In reliance upon the truthfulness and accuracy of the statements made in the **Application**, in consideration of, and subject to, the payment of premium when due, and subject to the terms, conditions, limitations, and **EXCLUSIONS** of this **Policy**, the Insurer and the **Policyholder** agree as follows:

The Insurer agrees to reimburse the **Policyholder** for certain **Plan Benefits** the **Policyholder** has provided under a self-funded benefit plan (**Plan**). Such reimbursement will be subject to all the terms, conditions, limitations, and **EXCLUSIONS** of this **Policy**. The **Policyholder** agrees to pay premiums when due and to comply with the **Policy** provisions.

This **Policy** is governed by the laws of the state in which it was issued, except that Federal law may preempt both state law and **Policy** provisions. The provisions on the following pages are a part of this **Policy**.

NOTICE

The **Policy** provides benefits when the **Policyholder's Plan** has **Incurred** expenses beyond the **Specific** and **Aggregate Deductibles** (whichever is applicable) outlined in the **Policy**. Since the **Policy** insures the **Policyholder** and not the individuals covered by the **Policyholder's Plan**, the **Policy** neither adds to nor subtracts from the terms of the underlying **Plan**. Additionally, the **Policy** does not, in any way, affect the **Policyholder's** responsibility to comply with applicable employment laws such as the Americans With Disabilities Act, the Age Discrimination in Employment Act, Title VII of the 1964 Civil Rights Act, the Patient Protection and Affordable Care Act and any applicable state laws.

All periods of coverage will begin and end 12:01 a.m. local time at the principal office of the **Policyholder**.

IN WITNESS WHEREOF, Liberty Insurance Underwriters Inc. has caused this **Policy** to be executed by its President and Vice President and Secretary at the Insurer's Home Office.

PRESIDENT

VICE PRESIDENT and SECRETARY

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

Excess Loss Insurance Policy

Table of Contents

Attachments at Issue:

- Application
- Schedule
- Endorsements
- Plan

DEFINITIONS

Actively-At-Work means:

(a) with respect to a **Policyholder's** employee or member - the employee/member is working the required number of hours to be eligible for coverage under the **Plan** and capable of performing his or her normal job duties. **Covered Persons** absent from work due to regularly scheduled vacation or maternity leave will be considered **Actively-at-Work**.

(b) with respect to a dependent - being able to perform all the normal activities of a person in good health of the same age and sex and not being confined in a provider facility because of injury or sickness.

Aggregating Specific Deductible as shown in the Schedule of Insurance, means a deductible applied in addition to the **Specific Deductible**. At the start of a **Policy Period**, **Plan Benefits** for each **Covered Person** in excess of the **Specific Deductible** will be added together until the cumulative total equals the **Aggregating Specific Deductible** amount shown in the Schedule of Insurance. A **Specific Excess Loss** reimbursement will not be paid by the Insurer until the **Aggregating Specific Deductible** has been satisfied.

Aggregate Deductible for any one **Policy Period** means the greater of the:

(a) cumulative monthly total of **Covered Units** multiplied by the **Monthly Aggregate Factors**; or

(b) Minimum **Aggregate Deductible**.

Application means the complete and total application made by the **Policyholder**, including census data, **Plan Document**, disclosure statements, Proposal, and any other information submitted by the **Policyholder** for the purpose of determining the Insurer's liability under this **Policy**.

Benefit Period means the period of time in which a claim must be **Incurred** by the **Covered Person** and paid by the **Plan** to be eligible for reimbursement under this **Policy**. This period does not alter the **Policy** Effective Date and **Policy Period**.

Covered Person means an individual who meets the express terms and conditions of eligibility for coverage set forth in the **Plan Document**, has enrolled, and for whom required premium contributions to the **Plan** have been made.

Covered Unit for the purposes of determining the premiums payable or the **Aggregate Deductible** means the following **Covered Person(s)**:

(a) Employee/member;

(b) Employee/member with dependents; or

(c) Such other defined unit as agreed between the Insurer and the **Policyholder**.

Experimental or Investigational Treatment ("Treatment") means medical services, supplies or treatments, including drugs, devices and biological products that:

(a) are provided or performed in a special setting for research purposes, under a treatment protocol or as part of a Phase I, II or III clinical trial; or

(b) are provided only if a Covered Person is required to sign a consent form which indicates the proposed treatment or procedure is part of a scientific study or medical research to determine its effectiveness or safety; or

(c) are not considered standard treatment by the majority of the medical community or by Medicare, Medicaid or any other government-financed programs or the National Cancer Institute regarding malignancies; or

(d) have not been granted, at the time they were provided, any required approval by any appropriate federal or state governmental agency; or

(e) do not have FDA approval or have FDA approval only under an interim step in the FDA process, i.e., an investigational device exception or an investigational new drug exemption; or

(f) are provided for off-label usage.

Incurred means a **Plan Benefit** will be considered **Incurred**:

(a) with respect to services, the date on which the services are rendered to the **Covered Person**; or

(b) with respect to supplies, the date on which the supplies are given to the **Covered Person**; or

(c) with respect to disability income benefits, if covered, on the date each periodic benefit payment becomes payable to the **Covered Person**.

Lifetime Limit of Liability per Covered Person means the maximum amount the Insurer will reimburse the **Policyholder** under this **Policy** or any policy issued by the Insurer prior to or later than this **Policy** providing Excess Loss Insurance benefits for **Plan Benefits** payable on behalf of a **Covered Person**. The Lifetime Limit does not include the amount of any **Plan Benefits** used to satisfy the **Specific Deductible** or **Aggregating Specific Deductible**. It will not exceed the lesser of the amount shown in the Schedule of Insurance, or the lifetime maximum amount set forth in the **Plan**.

Loss Limit means the maximum amount of payments for Plan Benefits that will be allowed for any one Covered Person under Aggregate Excess Loss Coverage. The Loss Limit is shown in the Application/Schedule of Insurance. The maximum allowable amount of Plan Benefits for a Covered Person who has been assigned a separate Specific Deductible will be the specified amount as shown under the Loss Limit on the Application/Schedule, regardless of that Covered Person's separate Specific Deductible.

Medically Necessary means care, services or supplies provided by or at the direction of a physician that are:

(a) needed to restore function and prevent deterioration of the Co**vered Person**'s health;

(b) commonly recognized by the medical profession as standard of care for control or cure or the illness or injury being treated by physicians practicing in the same or related specialty; and

(c) within accepted standards of medical practice for the **Covered Person's** injury or sickness and are not otherwise excluded under the terms of this **Policy**.

Medically Necessary does not include any services or supplies that are:

(a) provided only as a convenience to the **Covered Person** or to his or her physician;

(b) exceed the scope, duration or intensity or the level of care needed to provide safe, adequate and appropriate diagnosis and treatment; or

(c) do not otherwise meet the criteria of eligible claim expenses contained in this **Policy**.

Monthly Aggregate Factor means the factors that are multiplied by the number of **Covered Units** for each **Policy** Month to determine the annual **Aggregate Deductible**. The **Monthly Aggregate Factors** are shown in the Schedule of Insurance.

Paid means **Plan Benefits** will be considered paid on the date that the **Policyholder's** check or draft is issued, subject to the following:

(a) there are sufficient funds to cover such check or draft; and

(b) the check or draft is placed in the United States mail or other means of delivery to the payee; and

(c) the check or draft is honored upon presentation by the payee; or

(d) payment is successfully transmitted electronically from the payor's account to the payee's account.

Checks or drafts which are prepared but are not released or which do not adhere to the requirements immediately above shall not be considered **Paid**.

Plan means the **Policyholder's** self-funded benefit plan as described in its signed **Plan Document** and all signed Amendments and Endorsements thereto that were underwritten and approved by the Insurer for issuance of this **Policy**. A copy of the **Plan Document,** including Endorsements approved by the Insurer will be used for the purpose of determining the Insurer's liability under this **Policy**.

Plan Benefits means the amounts properly **Incurred** and **Paid** under the **Plan** to a **Covered Person** or to a provider of services to a **Covered Person**.

Plan Benefits do not include the following:

(a) payments not strictly in compliance with the terms and conditions of the **Plan**; or

(b) any amount for which there is any other group insurance, reinsurance, plan benefits, including insurance or plan benefits established pursuant to federal, state or local legislation or regulation; or

(c) court costs, penalties, interest upon judgments, investigation expense, administrative fees, or legal expense; or

(d) fees applicable to the proper administration of the **Plan**; or

(e) exemplary and punitive damages or liabilities, including but not limited to those resulting from negligence, intentional wrongs, fraud, bad faith or strict liability on the part of the **Policyholder** or the **Policyholder's** agent; or

(f) expenses which are not considered **Medically Necessary**, **Experimental or Investigational Treatment,** are not recognized by the FDA, or are outside the scope of generally accepted standards of medical practice; or

(g) Provider retention costs and administrative fees.

Plan Document means the written expression of the **Policyholder's** self-funded benefit **Plan** as of the date of the **Policy Application** or **Policy** renewal.

Policy means this **Policy** issued to the **Policyholder**.

Policyholder means the entity identified in the Schedule of Insurance as the **Policyholder**.

Policy Period means the specified period in the Schedule of Insurance, however, beginning no earlier than the Effective Date of this **Policy** and continuing until coverage terminates in accordance with the **TERMINATION** provision of this **Policy**.

Reasonable and Customary Charge(s) means the usual charge made by the provider of care for a service, not to exceed the usual charge made by the majority of like providers for the same or like service in the same geographical area in which the service or treatment is performed. If the **Plan** has a contracted fee arrangement with certain health care providers, **Reasonable and Customary Charges** shall mean the lesser of the applicable fee as defined in that fee arrangement contract or the usual charge made by the majority of like providers for the same or like service in the same geographical area in which the service or treatment is performed. If the **Policyholder**, **Plan** or **Third Party Administrator** has a contracted fee arrangement with certain providers, **Reasonable and Customary Charges** shall mean the lesser of the applicable fees as defined in that fee arrangement contract or the amount generally charged by others in the same geographic area who render or furnish the same or similar services, treatments or supplies.

Run-In Expenses means **Plan Benefits Incurred** during the **Benefit Period**, but prior to the **Policy Period**.

Run-In Limit means the maximum amount of **Run-In Expenses** that will be applied to this **Policy**.

Run-Out Expenses means **Plan Benefits Paid** during the **Benefit Period**, but following the **Policy Period**.

Run-Out Limit means the maximum amount of **Run-Out Expenses** that will be applied to this **Policy**.

Specific Deductible means the amount of **Plan Benefits** retained and **Paid** by the **Policyholder** during the **Policy Period**. This amount is not reimbursable under this **Policy**. The **Specific Deductible** applies separately to each **Covered Person**. It is shown in the Schedule of Insurance.

Third Party Administrator means a firm or person shown in the Schedule of Insurance that has been retained by the **Policyholder** to pay claims and/or provide other administrative services on behalf of the **Policyholder**.

SPECIFIC EXCESS LOSS

The Insurer will reimburse the **Policyholder** for the amount of eligible **Plan Benefits** which exceed the **Specific Deductible** on a **Covered Person** during the **Policy Period**, after the total of all **Plan Benefits Paid** by the **Policyholder** exceeds the **Aggregating Specific Deductible** shown in the Schedule of Insurance. Such reimbursement will be made in accordance with the **Benefit Period** and all other coverage provisions, limitations and **EXCLUSIONS** as shown in the Schedule of Insurance and in this **Policy**. Provider discounts must be applied to all **Plan Benefits** before determining the **Specific Deductible.** In order for eligible **Plan Benefits** to be considered for reimbursement under this **Policy**, an initial Proof of Loss must be provided in accordance with the Proof of Loss provision. Reimbursements under this Policy will be paid within 30 days of the Insurer's receipt of satisfactory Proof of Loss.

The Insurer has the sole authority to approve or deny reimbursements under this **Policy**.

AGGREGATE EXCESS LOSS

The Insurer will reimburse the **Policyholder** for the amount of eligible **Plan Benefits** which exceed the **Aggregate Deductible** during the **Policy Period**. Such reimbursement will be made in accordance with the **Benefit Period** and all other coverage provisions, limitations and **EXCLUSIONS** as shown in the Schedule of Insurance and in this **Policy**. Provider discounts must be applied to all **Plan Benefits** before determining the **Specific Deductible.**

Reimbursements to the **Policyholder** for any Aggregate Excess Loss provided under this **Policy** will be made after the end of the **Policy Period** provided:

(a) the Insurer has received all of the information it requires as described in the Proof of Loss provision; and

(b) any audit requested by the Insurer has been completed.

In order for eligible **Plan Benefits** to be considered for reimbursement under this **Policy**, an initial Proof of Loss must be provided in accordance with the Proof of Loss provision.

Plan Benefits on each **Covered Person** in excess of the Loss Limit Per Person under Aggregate as shown in the Schedule of Insurance or Limitations on Coverage Endorsement will not be included for purposes of determining the amount of the Aggregate Excess Loss reimbursement under this **Policy**. Additionally, the following are not included for purposes of determining the amount of the Aggregate Excess Loss reimbursement due to the **Policyholder**:

(a) **Plan Benefits** payable under any Specific Excess Loss or other Excess Loss Insurance issued to the **Policyholder** by the Insurer or any other entity; or

(b) Specific Excess Loss benefits which have been or will be reimbursed by the Insurer under the Specific Excess Loss coverage provided by this **Policy**; or

(c) Benefits **Paid** by any other entity providing the same or similar coverage as the **Plan** during the **Benefit Period**.

While the determination of benefits under the **Plan** is the sole responsibility of the **Policyholder**, the Insurer reserves the right to interpret the terms and conditions of the **Plan** as it applies to this **Policy**. The Insurer has the authority to approve or deny reimbursements under this **Policy**.

If this **Policy** is terminated prior to the end of the **Policy Period**, the **Aggregate Deductible** will not be prorated.

LIMITATIONS

If the **Policyholde**r fails to disclose any required health information on:

(a) a **Covered Person** when **application** is made for this **Policy**; or

(b) on an employee/member, or a dependent of an employee/member, who later becomes eligible for **Plan Benefits,**

the Insurer will not reimburse the **Policyholder** for any **Plan Benefits** related to the illness or condition that was required to be disclosed; and

(a) such **Plan Benefits** paid by the **Plan** may not be used to satisfy the **Specific Deductible** for such **Covered Person**; and

(b) such **Plan Benefits** paid by the **Plan** may not be used to satisfy the **Aggregate Deductible**.

Any amount of **Plan Benefits** paid by the **Policyholder** for any employee/member or dependent who does not enroll into the **Plan** within the time period specified in the **Plan** for eligibility will be disregarded for reimbursements under this **Policy** unless evidence of good health for such employee/member or dependent has been approved by the Insurer prior to the date on which the **Plan Benefit** was **Incurred**.

The Insurer will reimburse **Plan Benefits** for retired employees and their eligible dependents who are covered under the **Plan** only if such Persons are indicated as included in the Schedule of Insurance.

Any reimbursement of **Plan Benefits** for a **Covered Person** covered under Medicare or another health insurance benefit plan shall be reduced by any amount paid or payable under Medicare to the extent any reimbursement under this **Policy** for a **Covered Person** or his or her dependents shall not exceed 100% of the actual expenses otherwise reimbursable under the **Policy**.

EXCLUSIONS

The Insurer will not reimburse **Plan Benefits**, costs, charges, expenses, claim payments, or other loss under this **Policy** incurred by or resulting from any of the following:

A.

(a) Declared or undeclared war or act of war, whether civil or international, and any substantial armed conflict between organized government forces of a military nature.

(b) Participation in a felony, riot or civil disobedience.

(c) An individual is not a **Covered Person** under the **Plan** when the expense is incurred.

(d) The **Plan** is not in effect.

(e) Any payments the **Policyholder** receives for those losses from other insurers or to the extent the **Policyholder** is not liable for expenses covered or would be covered under Medicare or another health insurance plan, regardless of whether Medicare is elected by the **Covered Person**.

(f) Expenses also covered as benefits under Medicare or another health insurance plan. In no event will total payments on behalf of a **Covered Person** for a reimbursement otherwise payable under this **Policy** and any similar Medicare benefit or a benefit under another health insurance plan exceed 100% of the **Covered Person**'s eligible claim expenses.

(g) Any excess of **Reasonable and Customary Charges**.

(h) **Experimental or Investigational Treatment.**

(i) An organ transplant or implant of non-human, artificial or mechanical organs.

B. Claim payments not administered or paid according to the **Plan**, or for which there is no documented Proof of Loss.

C. Any claim payment, or portion of a claim payment for any of the following:

(a) Legal expenses, fines, penalties, damages, judgments or other penalties imposed by law.

(b) Loss or expense caused by or resulting from occupational injury or sickness benefits. This exclusion shall also apply if the **Covered Person** is entitled to insured or self-funded coverage for such expenses under any Worker's Compensation, Employer's Liability or Occupational Disease statute, whether or not such coverage is actually in force.

(c) Expenses related to any occupation or employment for wage or profit.

(d) Any claim payment for expenses resulting from dental, vision, prescription drug, disability income programs, unless such **Plan Benefits** are included in the Schedule of Insurance.

D. A claim for any expense that is not **Medically Necessary**.

E. Plan benefits for any Covered Person covered under, or eligible for coverage under, the Consolidated Omnibus Reconciliation Act (COBRA) whose:

(a) Continuation of coverage was not offered in accordance with COBRA regulations or any amendments thereto;

(b) who coverage under COBRA is continued beyond the timeframes specified by federal law for any reason including clerical error of the Policyholder; and

(c) who do not receive a valid COBRA extension offer within the 44 days immediately following the date of notice of a COBRA qualifying event; and

(d) who fail to make a valid, signed COBRA election within the 60 days immediately following the receipt of COBRA election rights from the Policyholder; and

(e) who fail to remit COBRA premium within the minimum periods specified by federal law.

The Company will require written documentation that these requirements have been satisfied.

F. 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 the **Plan**, **Policyholder** or **Third Party Administrator**.

Whenever 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.

PREMIUMS AND MONTHLY AGGREGATE FACTORS

The Schedule of Insurance shows the Premium Rates and **Monthly Aggregate Factors** for each **Plan Benefit** provided coverage under this **Policy**. The initial premium is due on the Effective Date of this **Policy** and subsequent premiums are due the first day of each succeeding month in the **Policy Period**. The entire amount of the applicable premium shall be paid when due. The Insurer is not obligated to accept or apply any premium paid which is less than the entire amount due for any period. Premium payments shall be credited first to any past due and unpaid premium, in the order in which due. Premiums are not considered paid until the premium payment is received by the Insurer.

Grace Period

A grace period of thirty-one (31) days is allowed for the payment of any premium except the first. The Insurer is not obligated to accept any premium which is received after the grace period and may return any premium payment received after the grace period ends. The payment of any premium will not cause the insurance under this **Policy** to remain in force beyond the day before the next premium due date.

Premium Change

The Insurer may change the premiums and **Monthly Aggregate Factors** effective on any of the following:

(a) the effective date that the **Plan** is amended; or

(b) the effective date that the **Policyholder** adds or deletes subsidiary or affiliated companies or divisions; or

(c) the date an increase or decrease in the number of **Covered Units** exceeds 15% in any one month or 25% over any period of three (3) consecutive months; or

(d) the date the monthly **Paid** Aggregate claims total of the current **Policy Period** exceed the average monthly **Paid** claim total of the prior six (6) months by more than 20%; or

(e) the date that the Insurer is informed of a Clerical Error or discovers material misrepresentation of underwriting information. The Insurer's action will be in accordance with the Misstated Data Provisions under **GENERAL PROVISIONS** of this **Policy**.

The **Policyholder** will furnish to the Insurer any information which is necessary to allow the Insurer to determine the amount of premium due under this **Policy**. The Insurer may examine any records of the **Policyholder** at any reasonable time to confirm that premiums are being calculated and paid in accordance with this **Policy**.

The Insurer will refund to the **Policyholder** any overpayment of premium made in error. Such refund shall be made only for the overpayments made during the **Policy Period** in which the error is uncovered and reported to the Insurer.

CLAIMS PROVISIONS

Administration of Claims Under the Plan

The Insurer will have no obligation under the terms of this **Policy** for the settlement of claims incurred by **Covered Person**s.

The **Policyholder** must cooperate with the Insurer in a timely manner in the administration, investigation, and settlement of any claim payable under this **Policy**. The **Policyholder's** failure to cooperate with the Insurer in administration of a claim may result in denial of all or part of that claim.

The **Policyholder** warrants, upon presentation of a **Plan Benefit** for reimbursement, that all monies necessary to pay for the **Plan Benefit** have been **Paid** to the **Covered Person** or the provider of services to the **Covered Person**.

The **Policyholder** will pay each claim **Incurred** under the **Plan** by a **Covered Person** within sixty (60) days after adequate Proof of Loss is provided to the **Policyholder's Plan**. If the **Policyholder** fails to pay the claim within this time limit, then this claim will not be a covered **Plan Benefit,** will not count towards the satisfaction of the **Specific** or **Aggregate Deductible**, and will not be eligible for reimbursement under this **Policy**. It is understood and agreed that the **Policyholder** will provide funds necessary to pay claims and failure to do so will cause this **Policy** to immediately terminate as provided for in **TERMINATION**.

The **Policyholder** will maintain records showing the complete details concerning any and all amounts paid for benefits not provided under the terms of the **Plan**. These payments for benefits not provided will not be included in determining **Plan Benefits** reimbursable under this **Policy**.

No reimbursements will be made under this **Policy** for losses for which the **Policyholder** is not legally obligated to pay or for payments for services which are not covered under the **Plan**. No reimbursements will be made under this **Policy** for any date of loss for which the **Policyholder** has yet to pay the necessary Premiums that extend coverage through those dates.

Notice of Claim

The **Policyholder** will give written notice of claims to the Insurer on the Insurer's customary proof of loss form within one hundred and one hundred and twenty (120) days or as soon as reasonably possible. Failure to furnish written notice will not invalidate or reduce any claim, if it was not reasonably possible to provide such written notice within the time period required.

The **Policyholder** will also comply with other claim reporting requirements, provided that the Insurer sends written notice to the **Policyholder** of these requirements and allows the **Policyholder** thirty (30) days to begin complying with the new requirements.

Proof of Loss

The **Policyholder** will give written Proof of Loss to the Insurer within thirty-one (31) days or as soon as reasonably possible, but no later than one year after the date the **Policyholder** becomes aware of the existence of facts that would reasonably suggest the possibility that **Plan Benefits** will be **Incurred** which are subject to this **Policy** or which are at least 50% of the **Specific Deductible.**

TERMINATION

This **Policy** will be in force during the **Policy Period** shown in the Schedule of Insurance and will automatically terminate at the end of the **Policy Period** unless it has been terminated earlier as provided in this section, or unless the Insurer and the **Policyholder** have agreed upon terms to renew the **Policy**.

By the Policyholder

The **Policyholder** may terminate this **Policy** on any premium due date by giving the Insurer at least thirty-one (31) days advance written notice.

By the Insurer

The Insurer may terminate this **Policy** effective on any premium due date by giving thirty-one (31) days advance written notice of **Termination** to the **Policyholder**:

The Insurer may terminate this **Policy** effective on the date that any one of the following occurs by giving ten (10) days advance written notice of **Termination** to the **Policyholder.**

(a) it is determined that the **Policyholder** has failed to perform any of its duties or obligations under this **Policy**; or

(b) a petition in bankruptcy is filed with respect to the **Plan** or the **Policyholder**, whether voluntary or involuntary, or the **Plan** or the **Policyholder** become subject to liquidation, receivership or conservatorship; or

(c) the **Policyholder** has failed to provide funds for payment of claims under the **Plan**; or

(d) delegation by the **Policyholder** of its duties under this **Policy** to a **Third Party Administrator** which has not been approved by the Insurer.

Automatic

This **Policy** will terminate without notification required upon the earliest of the following dates:

(a) the date the **Policyholder's Plan** terminates; or

(b) the end of any grace period when the premium due remains unpaid; or

(c) whenever the percentage of **Covered Persons** participating in one or more Health Maintenance Organizations, prepaid plans, or insurance plans exceeds 25% of **Covered Persons** eligible to participate in the **Plan**, unless the Insurer has agreed in writing to continue coverage; or

(d) the date the **Plan** is found to be in violation of Federal law; or

(e) sixty (60) days after the **Policy** Effective Date if the **Policyholder** has failed to furnish the Insurer with any information or materials requested by the Insurer. Such information or materials must be of reasonable nature to allow the Insurer to determine the risk assumed under this **Policy**. If the **Policy** is rescinded for this cause, the Insurer's sole liability will be to return any monies given by the **Policyholder** as consideration for this **Policy**, less any claims or other expenses paid by the Insurer under this **Policy**. If such amounts paid by the Insurer are greater than the amount of the refund due the **Policyholder**, the **Policyholder** shall pay the amount of the deficit to the Insurer within sixty (60) days of receipt of written notice from the Insurer. If repayment in full is not made within this sixty (60) day period, the Insurer will be entitled to assess monthly a late payment fee equal to 1.5% of the outstanding balance, and such other relief allowed.

Effect of Termination

In the event this **Policy** is terminated prior to the end of the **Policy Period**, the **Specific** and **Aggregate Deductible** amounts shown in the Schedule of Insurance will not be prorated. The **Specific** and **Aggregate Deductibles** will be applied as if the **Policy** had remained in effect for the entire original **Policy Period**. The Insurer will not refund any portions of premium paid by the **Policyholder** whose **Plan** terminated during the **Policy Period**.

The Insurer has no obligation to reimburse the **Policyholder** for any **Plan Benefits** that are **Paid** after the date this **Policy** is terminated.

Reinstatement

If this **Policy** terminates for any of the reasons set forth above, the Insurer may approve the **Policyholder's** request to reinstate this **Policy**. The **Policyholder** shall submit to the Insurer any forms and data the Insurer may require. If this **Policy** is reinstated, the **Policyholder** shall pay to the Insurer the premiums due from the date this **Policy** terminated.

Renewal

The Insurer will give the **Policyholder** thirty (30) day notice of the option to renew and any altered terms affecting the renewal. In the event of renewal, the Insurer will issue to the **Policyholder** a Renewal Endorsement and Renewal Schedule of Insurance.

GENERAL PROVISIONS

Entire Policy

The entire **Policy** consists of this **Policy**, the **Policyholder's Application**, including any renewal **Application**, the **Plan Document**, the **Plan, the Policyholder** disclosure statement, the initial and any renewal Schedule of Benefits, and any amendments, riders or endorsements.

Changes to the Policy

This **Policy** may be changed at any time by a written agreement between the **Policyholder** and the Insurer. No change in, modification of, or assignment of interest under this **Policy** shall be effective except when made by a written endorsement to this **Policy** which is signed by an authorized representative of the Insurer. The Insurer will not be bound by any promise or representations made by any other person.

The Insurer may, at any time, change any one or more or all of the items shown in the Schedule of Insurance by endorsement during the **Policy Period** if a change is made to any applicable state or Federal law that may affect the Insurer's liability under this **Policy**.

Parties to the Policy

This **Policy** is a contract between the **Policyholder** and the Insurer. This **Policy** does not create any right or legal relationship between the Insurer and any **Covered Person** under the **Plan**. The Insurer's sole liability under this **Policy** is to the **Policyholder**. Any and all reimbursements payable under this **Policy** will be made solely to the **Policyholder**. This **Policy** will not be deemed to make the Insurer a party to the **Plan**, or any contract or agreement between the **Policyholder** and a third party.

Plan Document

The **Policyholder** will provide to the Insurer a complete copy of the **Plan Document** governing the **Plan**; such **Plan Document** will be made part of this **Policy**. The **Policyholder** will submit to the Insurer, in writing, any proposed change to the provisions of the **Plan**. Such changes must be submitted to the Insurer at least thirty (30) days prior to the effective date of the proposed change. The Insurer will have the right to modify premium rates and/or other terms and conditions of coverage if the Insurer determines that its liability under this **Policy** has been affected by the change in the **Plan**, as described under the **Premium Change** provision. If the Insurer and the **Policyholder** cannot reach agreement with respect to the **Plan** changes, the **Plan** change will not affect the Insurer's liability under this **Policy** and the **Policy** will be administered as if the **Plan** had not changed. The Insurer's liability under the **Policy** will not be affected by any such changes made to the **Plan** unless and until the Insurer has sent its written approval of such changes to the **Policyholder** or its agent.

Third Party Administrator

The **Policyholder** may retain a **Third Party Administrator** to perform some or all of its duties under this **Policy**. Such **Third Party Administrator** must be named in the Schedule of Insurance.

Without waiving any of its rights under this **Policy**, and without making the designated **Third Party Administrator** a party to this **Policy**, the Insurer agrees to recognize the **Third Party Administrator** as the agent for the **Policyholder**. Any action or inaction by the **Third Party Administrator** will be deemed to be the action or inaction of the **Policyholder**. The **Third Party Administrator** is NOT the agent of the Insurer. Notwithstanding its appointment of a **Third Party Administrator**, the **Policyholder** is still obligated to see to the timely performance of its duties and obligations under this **Policy**. Furthermore, the **Policyholder** will hold the Insurer harmless from any liability arising from or related to any negligence, error, omission or malfeasance by the **Third Party Administrator**.

The **Policyholder** may change its **Third Party Administrator**. Notice of any change in the **Third Party Administrator** is subject to the Insurer's approval and must be submitted in writing to the Insurer at least sixty (60) days prior to the effective date of such change. Any changes to the designated **Third Party Administrator** without prior written approval by the Insurer will cause this **Policy** to automatically terminate as provided for in the **TERMINATION** provisions herein.

Independent Review

In the event that eligible **Plan Benefits** are deemed payable by the **Plan** due to a reversal by an Independent Review Organization of a previous denial of coverage, and such eligible **Plan Benefits** are not **Paid** within the **Benefit Period** under this **Policy**, the **Benefit Period** to pay such eligible **Plan Benefits** will be extended for a period of twelve (12) months from the end of the **Benefit Period** shown in the Schedule of Insurance, provided: (a) such **Plan Benefits** are not eligible under any other coverage; and (b) such **Plan Benefits** would otherwise be payable under the terms of this **Policy**.

Subject to all other terms and conditions of this **Policy**, the Insurer agrees to accept as eligible claim expenses all such **Plan Benefits** paid in accordance with the **Plan** that were previously denied and exceed the applicable deductible.

When the Insurer reimburses the **Policyholder** for the amount of any **Plan benefits** payable under this provision, such **Plan benefits** will relate back to the **Policy** under which they were **Incurred** and will be excluded from any other **Benefit Period**.

If the **Policyholder** terminates this **Policy** for any reason prior to the end of the **Policy Period**, this provision does not apply.

Reporting and Audits

The **Policyholder** will furnish the Insurer with any information required by the Insurer pertaining to the risks covered under this **Policy**.

For Specific Excess Loss benefit reporting, the **Policyholder** must give notice to the Insurer when the total amount of **Plan Benefits Paid** by the **Policyholder** for a **Covered Person** equals or exceeds 50% of the **Specific Deductible**, or has the potential to exceed 50% of the **Specific Deductible**. The **Policyholder's** failure to provide prompt notice to the Insurer may result in an adjustment of any Specific Excess Loss benefits payable to the **Policyholder**, if any, to reflect any savings the Insurer could have obtained had prompt notice been given. Similar reporting shall be required for any **Plan Benefits Paid** for a **Covered Person** listed on the Limitations on Coverage Endorsement.

The **Policyholder** is required to provide the Insurer with notice of any potential Specific Excess Loss claim within thirty-one (31) days of the date:

1. A **Covered Person's Plan Benefits** exceed 50% of the **Specific Deductible**; or
2. The **Policyholder** or **Third Party Administrator** are notified that a **Covered Person** has been diagnosed with, or treated for, a condition which, if **Paid**, would result in **Plan Benefits** that would equal or exceed 50% of the **Specific Deductible**.

For Aggregate Excess Loss benefit reporting, the **Policyholder** or the **Third Party Administrator** are required to provide the Insurer with a monthly report that lists:

1. The total amount of **Plan Benefits Incurred** within the reporting month by any **Covered Person** and **Paid** by or on behalf of the **Policyholder** during that month; and
2. The number(s) of participants in the **Plan** on the first day of the reporting month.

The Aggregate Report must be provided to the Insurer within thirty-one (31) days after the end of each benefit month.

The **Policyholder** will be responsible for the investigating, auditing, calculating, and paying all claims **Incurred** under the **Plan.**

The Insurer or its authorized representative will have the right to audit, at its own expense, the records of the **Policyholder**, the **Third Party Administrator** or any other person or entity who is responsible for the administration of the **Plan** pertaining to the matters which affect the Insurer's liability under this **Policy**. The **Policyholder** agrees that payment of any reimbursements under this **Policy** will be conditioned upon the results of any audit requested by the Insurer.

Clerical Error

Clerical error, whether by the **Policyholder** or the Insurer, in keeping any records pertaining to this **Policy**, or the underlying **Plan**, will not invalidate coverage otherwise validly in force nor continue **Policy** coverage otherwise validly terminated. Any clerical error in data that the **Policyholder** or its agent provided to the Insurer must be corrected and promptly reported to the Insurer. The Insurer will within fifteen (15) days of receipt of corrected data decide the corrective course of action under the terms of Misstated Data provision below.

Concealment, Fraud

All statements made by the **Policyholder** are considered by the Insurer to be representations and not warranties. No statement shall be used to void this **Policy** or reduce benefits unless the statement is contained in a written instrument signed by the **Policyholder**, a copy of which has been provided to the **Policyholder**.

After this **Policy** has been in force for two (2) years, the **Policy** shall be voided only:

(a) if, before or after making any reimbursement, the Insurer determines that the **Policyholder** or its agent has concealed or misrepresented any material fact or circumstance concerning this **Policy**, including any losses under the **Plan**; or

(b) in any case of fraud by the **Policyholder** or its agent.

Conformity with State Statutes

If any provision of this Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

Misstated Data

The Insurer has relied upon the underwriting information provided by the **Policyholder** or its agent in the issuance of this **Policy**. If subsequent information becomes known which, if known by the Insurer prior to the issuance of this **Policy**, would have affected the premium rates, **Monthly Aggregate Factors**, **Specific** or **Aggregate Deductibles**, terms or any other conditions for coverage, the Insurer, to the extent permitted under state law, will have the right to adjust the premium rates, **Monthly Aggregate Factors**, **Specific** or **Aggregate Deductibles**, terms or any other conditions for coverage as of the **Policy** Effective Date by providing written notice to the **Policyholder**. If the **Policyholder** rejects any new adjustment or condition imposed, the Insurer can rescind the **Policy** as of the Effective Date.

In the event of **Policy** rescission, the Insurer's sole liability will be to return any monies given by the **Policyholder** as consideration for this **Policy**, less any claims or other expenses paid by the Insurer under this **Policy**. If such amounts paid by the Insurer are greater than the amount of the refund due the **Policyholder**, the **Policyholder** shall pay the amount of the deficit to the Insurer within thirty (30) days of receipt of notice from the Insurer. If repayment in full is not made within this thirty day period, the Insurer will be entitled to assess monthly a late payment fee equal to 1.5% of the outstanding balance.

Insolvency

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the **Policyholder** or its **Third Party Administrator** will not impose on the Insurer any liability other than the liability defined in this **Policy**. The insolvency of the **Policyholder** will not make the Insurer liable to the creditors of the **Policyholder**, particularly the **Covered Persons** under the **Plan**.

Legal Action

No action may be brought to recover under this **Policy** until sixty (60) days after proof of loss has been given to the Insurer. No action can be brought by the **Policyholder** more than three (3) years from the date proof of loss was required to be given.

Liability

The Insurer will not have any obligation or power under this **Policy** to directly pay any **Covered Person** or any provider of services or supplies to a **Covered Person**. The Insurer's sole liability is to the **Policyholder**. Nothing in this **Policy** will be construed to permit a **Covered Person** or any provider of services or supplies to a **Covered Person** to have a direct right of action against the Insurer. The Insurer is not a party to the **Plan** or to any modifications thereto.

Assignment

The **Policyholder** may not assign reimbursements under this **Policy** and the Insurer will not recognize any such assignments.

Recoveries/Subrogation

The Policyholder is required to investigate and prosecute all valid claims that the Policyholder may have against first and third parties arising out of any claim for which benefits were Paid by the Plan. This requirement and obligation is not waived or negated if:

1. the Covered Person is not made whole; or
2. the recovery is allocated to other damages; or
3. the person is no longer covered under the Plan.

If the Policyholder fails to pursue any action against a first or third party and the Insurer has made benefit payments under this Policy, the Insurer will be subrogated to all of the Policyholder's rights to make recoveries. The Policyholder is required to cooperate fully and do all things necessary as required for the Insurer to pursue any action to recover against the first or third party.

Any amounts recovered by the Policyholder, the Policyholder's Third Party Administrator, or the person in such action shall be used first to reimburse the Insurer for any benefit payments made on behalf of any Covered Person, and then to reimburse the expenses of the Policyholder and the Policyholder's Plan, and then to reimburse the expenses of recovery. Any amounts recovered by the Insurer shall be used to reimburse the Insurer for any amount that the Insurer may have paid or become liable to reimburse to the Policyholder or the Policyholder's Plan under the terms of this policy, and then to reimburse the expenses of collection. All remaining amounts shall be paid to the Policyholder or the Policyholder's Plan.

If the Insurer has reimbursed the Policyholder or the Policyholder's Plan for all or part of a particular loss, and the Policyholder or the Policyholder's Plan later recover for that loss from a first or third party, the Policyholder must repay the Insurer to the extent of the Insurer's reimbursements, regardless of whether this Policy is still in force on the date the Policyholder recover.

In the event the Policyholder or the Policyholder's Third Party Administrator do not consider a first or third party to be liable for certain claims Paid under the Policyholder's Plan but the Insurer does, the Insurer shall be subrogated to all of the Policyholder's rights to make recoveries for such claims.

Notice of Appeal

The Insurer must promptly receive written notice of any objection, notice of legal action or Insurance Department complaint received on a claim processed under the **Plan** on which it reasonably appears a reimbursement under this **Policy** will be payable.

Taxes

The payment of reimbursements under this **Policy** will not include:

(a) any taxes which might be paid or payable by the **Policyholder**; or

(b) any tax liability, interest or penalty imposed by any regulatory or taxing authority.

The **Policyholder** agrees to:

(a) hold harmless the Insurer from any tax liability assessed against the Insurer on the basis of the coverage provided under the **Plan** other than any tax levied upon the Insurer for the premium due under this **Policy**; and

(b) reimburse the Insurer for the amount of any such tax liability, interest, penalty or cost incurred by the Insurer as the result of such tax assessment. Such reimbursement shall be due and payable when the **Policyholder** receives the Insurer's notification that reimbursement is due.

Notice

For the purpose of any notice required from the Insurer under the provisions of this **Policy**, notice to the **Third Party Administrator** will be considered notice to the **Policyholder**, and notice to the **Policyholder** will be considered notice to the **Third Party Administrator**. For the purpose of any notice requirement from the **Policyholder** under the provisions of this **Policy**, neither notice from the **Policyholder** to the **Third Party Administrator** nor notice from the **Third Party Administrator** to the **Policyholder** will be considered notice to the Insurer. Notice from the **Policyholder** must be sent to the Insurer or its authorized representative.

Other Insurance

The amounts otherwise payable under this **Policy** shall be reduced by the amount of any other reimbursement or indemnity which the **Policyholder** may be entitled to receive with respect to the Insurer's liability under this **Policy**.

Waiver

Failure of the Insurer to strictly enforce its rights under this **Policy** shall not waive any such right, regardless of the frequency or similarity of the circumstances.

Arbitration

All disputes between the **Policyholder** and the Insurer are to be decided by arbitration in the city of the **Policyholder's** principal place of business. The **Policyholder** and the Insurer will each appoint one arbitrator and the two appointed arbitrators shall appoint a third. If the two cannot agree on a third arbitrator, the appointment shall be made by an authorized officer of the American Arbitration Association. The arbitration shall be settled in accordance with the rules of the American Arbitration Association. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction. This provision will survive the termination or expiration of this **Policy**.

Offset

The Insurer may offset the following against any payments due the **Policyholder** from the Insurer under this **Policy**:

1. Any premiums due and unpaid;
2. Any overpayments made by the Insurer to the **Policyholder**; and
3. Any payments made in error or made due to receipt of incorrect information.

The right of offset shall not prevent the termination of this **Policy** for nonpayment of premium as described in the **TERMINATION** provision of this **Policy**.

Excess Loss Insurance Policy

LIBERTY INSURANCE UNDERWRITERS INC.

(A Stock Insurance Company, hereinafter the "Insurer")
55 Water Street, 23rd Floor, New York, NY 10041
Toll-free number: 1-800-677-9163

EXCESS LOSS
SCHEDULE OF INSURANCE

1.	**POLICYHOLDER**:	**City of Coppell**
	Principal Address:	**255 Parkway Blvd**
		Coppell, TX 75019
	Subsidiaries and Associated Entities included in the Policy:	**n/a**
2.	POLICY NUMBER:	**TRU000003-04**
3.	POLICY PERIOD:	EFFECTIVE DATE: **October 1, 2020**
		TERMINATION DATE: **September 30, 2021**
4.	THIRD PARTY ADMINISTRATOR:	**UMR**
	Address:	**12668 Silicon Drive, Suite 112, San Antonio, TX 78249**

Initial Enrollment: Single 175
Family 204

PLAN BENEFITS INCLUDED

COVERED PERSONS INCLUDE:

☒ Current Employee/Member
☒ Retirees
☒ COBRA Beneficiaries
☒ Disabled
☒ Individuals not Actively at Work on their Effective Dates under the Policyholder Plan

Excess Loss Insurance Policy

SPECIFIC:	☒Medical	AGGREGATE:	☒Medical
	☐Dental		☐Dental
	☐Vision		☐Vision
	☐Prescription Drugs (same as any other)		☐Prescription Drugs (same as any other)
	☒Prescription Drug Card		☒Prescription Drug Card
	☐Other		☐Other

SPECIFIC EXCESS LOSS

SPECIFIC COVERAGE: Yes ☒ No ☐

Claims Basis: ☒ Incurred and Paid (24/12) ☐ Paid ☐ Other _____

Benefit Period: Eligible Plan Benefits Incurred October 1, 2019 through September 30, 2021 and

Paid October 1, 2020 through September 30, 2021.

Specific Deductible (per Covered Person $125,000.00

Aggregating Specific Deductible $50,000.00

☒ Entire Group

☐ Named Individuals Only _____

Policy Period Limit of Liability per Covered Person (Less Specific Deductible): Unlimited

Lifetime Limit of Liability per Covered Person: Unlimited

Specific Percentage Reimbursable After Deductible: 100%

Run-In Limit: $n/a

Run-Out Limit: $n/a

Specific Terminal Liability: ☐ Yes ☒ No $n/a

If the **Policy** is terminated before the end of the **Policy Period** stated above, the Insurer has no obligation to reimburse the **Policyholder** for any **Plan Benefits** that are **Paid** after the date the **Policy** is terminated.

AGGREGATE EXCESS LOSS

AGGREGATE EXCESS LOSS COVERAGE:					Yes ☒ No ☐		
Claims Basis:		☒ Incurred and Paid (24/12) ☐ Paid ☐ Other _____					
Benefit Period: Eligible Plan Benefits		Incurred	October 1, 2019 through September 30, 2021 and				
		Paid	October 1, 2020 through September 30, 2021.				
Aggregate Percentage Reimbursable:			100%				
Monthly Aggregate Factors:							
Covered Unit	# of Units	Medical	Dental	Vision	Prescription Drug (same as any other)	Prescription Drug Card	Other
Single	175	$536.38				Included	
Family	204	$1,571.31				Included	
Minimum Aggregate Deductible: (Based on initial **Covered Units** times Monthly Aggregate Factors times number of months in Policy Period)			$4,972,964.88				
Limit of Liability for the Policy Period:			$1,000,000.00				
Loss Limit Per Person under Aggregate			$125,000.00				
Monthly Aggregate Protection Option:			Yes ☐ No ☒				
Run-In Limit:			$n/a				
Run-Out Limit:			$n/a				
Aggregate Terminal Liability:			Yes ☐ No ☒				
	If the **Policy** is terminated before the end of the **Policy Period** stated above, the Company has no obligation to reimburse the **Policyholder** for any **Plan Benefits** that are **Paid** after the date the **Policy** is terminated.						

PREMIUMS

SPECIFIC PREMIUM RATES PER MONTH		
Covered Units	Number of Units on Effective Date	Rates per Covered Unit
Single	175	$ 42.74
Family	204	$ 136.61

AGGREGATE: $5.36 Monthly

$n/a Monthly Aggregate Terminal Liability

$n/a Monthly Aggregate Protection

Deposit Premium: $37,379.38

If the premium payable is determined to be less than the Deposit Premium, the Deposit Premium is due. If, however, the premium payable is determined to be more than the Deposit Premium, the actual amount of premium payable is due.

ENDORSEMENTS INCLUDED

Specific Advanced Funding Option

Specific Retro Arrangement

Qualified Clinical Trials Endorsement

Plan Mirroring Endorsement

OTHER

n/a

Full Name of your Plan Document(s):

City of Coppell Coppell TX Health Benefit Summary Plan Description 7670-00-410042 Revised 10/01/2018 (Received by TRU 4/04/2019 approved effective 1/01/2019) to coincide with Employee Policies & Procedures Handbook effective 10/15/2014 (recv'd on 10/30/17 and approved eff. 10/1/2016)

PPO Network(s) is considered to be UnitedHealthcare Choice Plus. If this is not the case, an adjustment to the sold rates and factors may be necessary.

Excess Loss Insurance Policy

LIBERTY INSURANCE UNDERWRITERS INC.

(A Stock Insurance Company, hereinafter the "Insurer")

ENDORSEMENT NO. 1

Effective Date:	October 1, 2020
Policy Number:	TRU000003-04
Issued To:	City of Coppell

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

SPECIFIC ADVANCED FUNDING ENDORSEMENT

This Endorsement is made a part of the **Policy** to which it is attached as of the Effective Date shown above. It applies only to **Plan Benefits Incurred** and **Paid** on or after that date. If no Effective Date is shown above, this Endorsement takes effect as of the **Policy** Effective Date.

In consideration of the premium charged, it is hereby understood and agreed that the **Policy** has been changed as follows:

Specific Advanced Funding Option

The Insurer will expedite reimbursement of Specific Excess Loss benefits for **Plan Benefits Incurred** in excess of the Specific Deductible prior to the **Plan**'s actual payment of these benefits. In order for benefits to be payable under this Endorsement, the required premiums due under the **Policy** must be paid current.

In order to request Specific Advanced Funding, the **Policyholder** must:

(a) Process all claims for the **Covered Person** and print the detailed Explanation of Benefits;

(b) Fund claims up to the full amount of the **Covered Person**'s Specific Deductible plus a minimum threshold of a cumulative $1,000.00 in claims in excess of the Specific Deductible in order to satisfy the required reimbursement of claims;

(c) Have paid all premiums current for the **Policy Period** in question;

(d) Complete and submit a Specific Excess Loss claim requesting Specific Advanced Funding and attaching all required filing documentation.

Failure of the **Policyholder** to follow the filing guidelines outlined above will result in a delay in receiving reimbursement.

If the **Policyholder** terminates the **Policy** prior to the end of the **Policy Period**, effective immediately the Specific Advanced Funding Option will no longer be available and no Specific Excess Loss benefits will apply for **Plan Benefits Paid** after the termination date.

All other terms and conditions, and exclusions of the **Policy** remain unchanged.

Executed at the Insurer's Home Office.

PRESIDENT

VICE PRESIDENT and SECRETARY

Excess Loss Insurance Policy

LIBERTY INSURANCE UNDERWRITERS INC.

(A Stock Insurance Company, hereinafter the "Insurer")

ENDORSEMENT NO. 2

Effective Date:	October 1, 2020
Policy Number:	TRU000003-04
Issued To:	City of Coppell

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

SPECIFIC RETRO ARRANGEMENT ENDORSEMENT

This Endorsement is made a part of the **Policy** to which it is attached as of the Effective Date shown above. It applies only to **Plan Benefits Incurred** and **Paid** on or after that date. If no Effective Date is shown above, this Endorsement takes effect as of the **Policy** Effective Date.

In consideration of the premium charged, it is hereby understood and agreed that the **Policy** has been changed as follows:

The **SPECIFIC EXCESS LOSS** provision of the **Policy** is deleted and replaced with the following:

SPECIFIC RETRO ARRANGEMENT

The Insurer will reimburse the **Policyholder** for the amount of eligible **Plan Benefits** that exceed the Specific Deductible on a **Covered Person** during the **Policy Period**. Such reimbursement will be made in accordance with the **Benefit Period** and all other coverage provisions, limitations and exclusions of the **Policy**. Reimbursements to the Policyholder for any Specific Excess Loss provided under the **Policy** will be made when the Insurer receives all the information it requires for payment of reimbursements (Proof of Loss).

In order for the **Plan Benefit** to be considered for reimbursement under the **Policy**, an initial Proof of Loss satisfactory to the Insurer must be received by the Insurer no later than thirty (30) days after the date **Plan Benefits** are **Paid** in excess of the Specific Deductible. No claim will be reimbursed until all satisfactory information necessary for reimbursement has been provided. Pursuant to this Endorsement, the Insurer will not be liable for making such reimbursement until the **Policyholder** has first **Paid** the $ 50,000.00 **Aggregating Specific Deductible** in addition to the required Specific Deductible as shown in the Schedule of Insurance. In no event will the **Policyholder's** liability be considered an expense or loss under the Aggregate Excess Loss.

The Insurer will pay the reimbursement as soon as reasonably possible after a request for payment is made. The Insurer will make a final reconciliation at the end of the **Policy Period**.

The Insurer has the sole authority to approve or deny reimbursements under the **Policy**.

All other terms and conditions, and exclusions of the **Policy** remain unchanged.

Executed at the Insurer's Home Office.

PRESIDENT

VICE PRESIDENT and SECRETARY

Excess Loss Insurance Policy

LIBERTY INSURANCE UNDERWRITERS INC.

(A Stock Insurance Company, hereinafter the "Insurer")

ENDORSEMENT NO. 3

Effective Date:	October 1, 2020
Policy Number:	TRU000003-04
Issued To:	City of Coppell

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

QUALIFIED CLINICAL TRIALS ENDORSEMENT

This Endorsement is made a part of the **Policy** to which it is attached as of the Effective Date shown above. It applies only to **Plan Benefits Incurred** and **Paid** on or after that date. If no Effective Date is shown above, this Endorsement takes effect as of the **Policy** Effective Date.

In consideration of the premium charged, it is hereby understood and agreed that the **Policy** has been changed as follows:

Qualified Clinical Trials Endorsement

The Insurer and the **Policyholder** agree that the **GENERAL PROVISIONS** section of the **Policy** is amended as follows:

The Policy will reimburse eligible **Plan Benefits**, in excess of the Specific Deductible and/or in excess of the **Aggregate Deductible**, for **Routine Patient Care Services** furnished in connection with participation in **Qualified Clinical Trials** as defined by this Endorsement.

Additional Provisions

We may require a copy of the **Qualified Clinical Trial's** study protocol before determining if any benefits are payable under this Endorsement.

Plan Benefits paid under this Endorsement will be included in the Specific and Aggregate Limits of Liability.

Plan Benefits paid under this Endorsement shall not create any legal presumption that the Insurer has recommended, directed, endorsed or required any **Covered Person**'s participation in the **Qualified Clinical Trial**.

Benefits **paid** under this Endorsement shall be subject to all terms and conditions of the applicable **Plan Document**.

The Insurer and the **Policyholder** agree that the **DEFINITIONS** section of the **Policy** is amended to include the following:

QUALIFIED CLINICAL TRIALS means clinical trials that meet all of the following conditions:

(a) The clinical trial is intended to treat cancer and other life-threatening diseases or conditions in a patient who has been so diagnosed, and

(b) The clinical trial has been peer reviewed and is approved by at least one of the following:

i. one of the United States National Institutes of Health;

ii. a cooperative group or center of the National Institutes of Health;

iii. a qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;

iv. the United States Food and Drug Administration pursuant to an investigational new drug exemption;

v. the United States Departments of Defense or Veterans Affairs; or

vi. a qualified Institutional Review Board, and,

(c) The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise; and

(d) The patient meets the patient selection criteria enunciated in the study protocol of participation in the clinical trial; and

(e) The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards; and

(f) The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial; and

(g) The clinical trial does not unjustifiably duplicate existing studies; and

(h) The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.

ROUTINE PATIENT CARE SERVICES means health care items or services that are furnished to an individual enrolled in a **Qualified Clinical Trial**, which is consistent with the usual and customary standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the **Qualified Clinical Trial**. **Routine Patient Care Services** must be determined to be eligible under the applicable **Plan Document**.

Routine Patient Care Services do not include any of the following:

(a) the investigational drug, device or service;

(b) non-health care services that a patient may be required to receive as a result of being enrolled in the **Qualified Clinical Trial**;

(c) costs associated with managing the research associated with the **Qualified Clinical Trial**, or

(d) costs that would not be covered for non-investigational treatments;

(e) any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the **Qualified Clinical Trial**, or

(f) the costs of services, which are not provided as part of the **Qualified Clinical Trial's** stated protocol or other similarly, intended guidelines.

All other terms and conditions, and exclusions of the **Policy** remain unchanged.

Executed at the Insurer's Home Office.

PRESIDENT

VICE PRESIDENT and SECRETARY

Excess Loss Insurance Policy

LIBERTY INSURANCE UNDERWRITERS INC.

(A Stock Insurance Company, hereinafter the "Insurer")

ENDORSEMENT NO. 4

Effective Date:	October 1, 2020
Policy Number:	TRU000003-04
Issued To:	City of Coppell

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PLAN MIRRORING ENDORSEMENT

In consideration of the additional premium charged, it is hereby understood and agreed that the following definitions in the DEFINITIONS section of the **Policy** are deleted.

1. **Experimental or Investigational Treatment ("Treatment")**, and
2. **Medically Necessary**, and
3. **Reasonable and Customary Charges**.

The definitions above will follow the terms and conditions with the same or similarly titled definitions contained within the **Plan**. The Insurer reserves the right to withdraw this Mirroring Endorsement immediately upon written notice to the **Policyholder** if the **Policyholder**:

(i) fails to provide to the Insurer a copy of the current **Plan** within thirty (30) days of the Effective Date of the **Policy**;

(ii) amends or edits the **Plan** to the extent that the Insurer's risk under this Endorsement is affected; or

(iii) submits any stop loss reimbursement claim where a benefits were paid reliant upon the use of a discretionary clause or similar provision contained within the **Plan**; or

(iv) submits any stop loss reimbursement claim where benefits were paid using the terms and conditions of any document other than the **Plan** (e.g. an employee handbook) that has not already been provided for us, reviewed and underwritten, or upon the guidance or advice of any third party.

For the purposes of identifying **Plan Benefits** that are eligible for reimbursement, all conflicts between the **Policy** and **Plan**, if any, shall be resolved in accordance with the terms and conditions of the **Plan**.

This endorsement does not constitute a guarantee that any **Plan Benefit Paid** by the **Plan** will be reimbursable under the **Policy**. To be eligible under the **Policy**, **Plan Benefits** must adhere to the requirements of the **Plan** (or other supporting documents provided in conjunction) and be paid appropriately. The **Policy** will not reimburse for processing or billing errors.

All other terms, conditions and exclusions of the **Policy** remain unchanged.

Executed at the Insurer's Home Office.

PRESIDENT

VICE PRESIDENT and SECRETARY

LIBERTY INSURANCE UNDERWRITERS INC.

(A Stock Insurance Company, hereinafter the "Insurer/Company")

ENDORSEMENT NO. 5

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Named Insured: City of Coppell

Policy Number: TRU000003-04

Effective Date: October 1, 2020

U.S. ECONOMIC AND TRADE SANCTIONS CLAUSE

Whenever 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 or referred to in any certificates or other evidences of insurance or any claim that would be in violation of U.S. economic or trade sanctions as described above shall also be null and void.

IMPORTANT NOTICE	AVISO IMPORTANTE
To obtain information or make a complaint: You may call Liberty Mutual Group's toll-free telephone number for information or to make a complaint at: **1-800-344-0197** You may also write to Liberty Mutual Group at: Presidential Service Team Liberty Mutual Group 175 Berkeley St. MS 10B Boston, MA 02116 PresidentialSvcTeam@LibertyMutual.com You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at: **1-800-252-3439** You may write the Texas Department of Insurance: Mail: PO Box 149091 Austin, TX 78714-9104 FAX # (512) 490-1007 Web: https://www.tdi.texas.gov/ E-mail: consumerprotection@tdi.texas.gov **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim you should contact the (agent) (company) (agent or the company) first. If the dispute is not resolved, you may contact the Texas Department of Insurance. **ATTACH THIS NOTICE TO YOUR POLICY:**This notice is for information only and does not become a part or condition of the attached document.	Para obtener informacion o para someter una queja: Usted puede Illamar al numero de telefono gratis de Liberty Mutual Group's para informacion o para someter una queja al: **1-800-344-0197** Usted tambien puede escribir a Liberty Mutual Group: Presidential Service Team Liberty Mutual Group 175 Berkeley St. MS 10B Boston, MA 02116 PresidentialSvcTeam@LibertyMutual.com Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companies, coberturas, derechos o quejas al: **1-800-252-3439** Puede escribir al Departamento de Seguros de Texas: Mail: PO Box 149091 Austin, TX 78714-9104 FAX # (512) 490-1007 Web: https://www.tdi.texas.gov/ E-mail: consumerprotection@tdi.texas.gov **DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el (agente) (la compania) (agente o la compania) primero. Si no se resuelve la disputa, puede entonces comunicarse con el Departamento de Seguros de Texas. **UNA ESTE AVISO A SU POLIZA:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.